Rapid Assessment on the effectiveness of the Country Coordination and Facilitation (CCF) process in Sudan, Zimbabwe and Zambia

Consolidated Report
Acknowledgement

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CCF assessment carried out in last quarter of 2011

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### Abbreviations

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<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AHS</td>
<td>Academy of Health Sciences</td>
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<tr>
<td>ART</td>
<td>Anti-Retroviral Treatment</td>
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<td>CDC</td>
<td>Centre for Disease Control</td>
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<tr>
<td>CHA</td>
<td>Community Health Assistant</td>
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<td>CHWs</td>
<td>Community Health Workers</td>
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<td>CPD</td>
<td>Centre for Continuing Professional Development</td>
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<tr>
<td>DFID</td>
<td>Department for International Development</td>
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<td>EC</td>
<td>European Community</td>
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<td>EPI</td>
<td>Expanded Programme on Immunization</td>
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<td>FMoH</td>
<td>Federal Ministry of Health</td>
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<td>GAIN</td>
<td>Global Alliance for Improved Nutrition</td>
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<td>GAVI</td>
<td>Global Alliance for Vaccination and Immunization</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<tr>
<td>GFATM</td>
<td>Global Fund to fight against AIDS, Tuberculosis and Malaria</td>
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<td>GHWA</td>
<td>Global Health Workforce Alliance</td>
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<tr>
<td>GNI</td>
<td>Gross National Income</td>
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<tr>
<td>HIV/AIDS</td>
<td>Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome</td>
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<td>HMPP</td>
<td>Health Management, Planning and Policy</td>
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<td>HRH</td>
<td>Human Resources for Health</td>
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<td>HRH-TF</td>
<td>HRH Task Force</td>
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<td>JICA</td>
<td>Japan International Cooperation Agency</td>
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<td>IPH</td>
<td>Institute of Public Health</td>
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<td>MoHE</td>
<td>Ministry of Higher Education</td>
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<td>MOUs</td>
<td>Memoranda of Understanding</td>
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<td>MAP</td>
<td>World Bank’s Multi-country AIDS Programme</td>
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<td>MDGs</td>
<td>Millennium Development Goals</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>MoHCW</td>
<td>Ministry of Health and Child Welfare</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and evaluation</td>
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<td>MoF</td>
<td>Ministry of Finance</td>
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<td>MoL</td>
<td>Ministry of Labour</td>
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<td>NGOs</td>
<td>Non Governmental Organizations</td>
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<td>NHRHO</td>
<td>National Human Resources for Health Observatory</td>
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<tr>
<td>NHS</td>
<td>National Health Services</td>
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<tr>
<td>ODA</td>
<td>Official Development Assistance</td>
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<tr>
<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
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<tr>
<td>SF</td>
<td>Stakeholders’ Forum</td>
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<tr>
<td>TSC</td>
<td>Standing Committee</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>ZACH</td>
<td>Zimbabwe Association of Church-related Hospitals</td>
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1. EXECUTIVE SUMMARY

The existing gaps between population health needs and health workforce planning, development and deployment in 57 human resources for health (HRH) crisis countries, predominantly from Sub-Saharan Africa, have prompted a serious rethinking and reorganization of this precious component of the health system. The existing gap is further exacerbated by the inequitable distribution of these limited resources, where the rural and hard-to-reach areas and regions within each of these countries bear the brunt of the health workforce shortage because of the problem of maldistribution, as well as the existing mismatch between production of the health workforce and available employment opportunities. The World Health Organization (WHO) Report of 2006 “Working together for health” sounded the alarm on the unacceptable global health workforce situation and the need for a concerted universal action, especially in the above-mentioned 57 crisis countries. The establishment of the common platform of the Global Health Workforce Alliance (the Alliance), mandated with the mission of promoting action on health workforce challenges, has accorded a tangible proportion of the attention to this critical issue. Through its framework of action, the Alliance has launched a Country Coordination and Facilitation (CCF) approach embodying the principles and process for an integrated country level health workforce response. This approach was implemented in 16 HRH priority countries in five regions during 2010. In 2011, six additional countries have been included to access the Alliance’s CCF catalytic support. To adopt a more proactive health workforce development approach, the Alliance has carried out a Rapid Assessment on the effectiveness of the process in a sample of implementing countries, demonstrating the value-added to key stakeholders and partners and making recommendations based on the results of the assessment.

A three-country assessment conducted in Sudan, Zambia and Zimbabwe found the coordination of health workforce development efforts to be critical to the effectiveness of the delivery of essential health care services and a major challenge that has constrained the deliberation of coherent policies prior to the CCF process launch. At that juncture, the relevant stakeholders lacked the platform for policy dialogue and strategic decision making with a concrete long-term vision and plans. This coordination mechanism has brought together, under the leadership of the government, all the sectors and development partners that could influence and contribute to HRH development. The multisectoral HRH committee platform based upon the CCF principles and process promoted by the Alliance has soon gained its significance and attracted a wider partnership of national and international stakeholders committed to assume explicit HRH priority roles and functions.

Following the Alliance’s successful launch of the CCF approach in each country, a set operational framework of action was pursued encompassing activities related to six steps including: HRH coordination mechanism, HRH situation analysis, evidence based, comprehensive and costed HRH plan, Resources mobilization, HRH plan implementation, and monitoring and evaluation, while engaging the key stakeholders. However, recognizing the local contextual realities and existing distinct challenges and priorities, different CCF implementation entry points have been adopted in each country. Through the consolidated CCF process, the following important operational milestones were achieved:

1.1. Consolidating the HRH coordination

As the principal building block of this initiative, a national HRH committee was established and/or strengthened in each country with representation from different stakeholders engaged in one or more aspects of the HRH domain. The HRH committee was assigned to define the country-specific HRH priorities, develop under the government leadership auspices, a national HRH strategic plan and make the necessary collective efforts to mobilize resources from their respective sectors to effectively address and resolve the critical challenges facing this component of the health system. In a short period, through this multistakeholder coordination process, each country was able to
develop a national HRH profile, encompassing the health workforce production and training, deployment, distribution, retention, migration, workplace conditions and management, and delineating the critical priorities to which the country has to respond. Although the efforts made by all the three countries were successful in mobilizing a large number of national stakeholders, more work was being pursued by Sudan in enlisting greater participation by development partners, but had the strongest secretariat for the CCF Stakeholders’ Forum/the CCF committee. Moreover, the CCF institutional strengthening and capacity building support have meaningfully enabled the different partners to generate the necessary evidence for their collective HRH actions.

1.2. Country-specific HRH priorities

Although the shortage of human resources for health has been a major concern and a common feature in all the three countries, the priority ranking of the challenges encountered differed from one country to another. In HRH production, Sudan has numerous medical institutions that graduate a sufficient number of the health workforce every year, though confronted with serious employment limitations. Conversely, the number of medical graduates produced by Zambia and Zimbabwe are far below the level of their health system needs. With regard to the other health professional categories, all three countries are underperforming, although with the launch of the CCF approach, governments and development partners have been making laudable moves to bridge the shortage of nurses and midwives. In the deployment of skilled workforce, Zambia’s positive aspect of high capacity in HRH sanctioned positions offered significantly greater employment opportunity relative to Sudan and Zimbabwe where the limited HRH sanctioned positions are posing serious constraints to rural deployment, when retention in each country has reached a crisis point. Moreover, the equitable distribution of the health workforce has been a shared challenge, although the higher incentives provided to health professionals in Zambia have eased the problem. Although the rural-urban migration is a common feature across the three countries, the loss of skilled and experienced professionals to outmigration in Sudan and Zimbabwe has been high, while the set financial and non-financial incentives set in Zambia have mitigated the problem. These challenges illustrate the different prevailing HRH challenges that each country’s HRH committee has to address.

1.3. The HRH strategic planning process: A unique contribution through the CCF process

Developing evidence based and costed HRH strategic plan was the most important accomplished expected outcome through the CCF approach, in which the ministries of health were able to reshape the organization and the operational focus of their health workforce. The HRH strategic plans were developed corresponding to the prepared HRH profiles and national health system priorities. Specific strategic objectives were defined by each country addressing the different workforce shortage attributes. These plans were inclusive in nature with the fully engaged HRH committees, with outstanding government ownership and leadership drive. This level of commitment has created shared accountabilities for resource mobilization and implementation of the plan. Health workforce production and training, equitable deployment and retention were clearly the three most valued attributes at national level on which the HRH strategic plans have focused. The HRH plans have been duly integrated with the national health policies in these three countries. Monitoring and evaluation was also an integral component of the HRH strategic plan in which all the three countries were required to scale up their implementation and level of efforts. The CCF approach has provided to these governments and their HRH committees, legitimate and effective resource mobilization platforms and raised the accountability and transparency levels in their pursuit of implementation of the plan.

1.4. Challenges and lessons learned

The landmark HRH development endeavours pursued at country level and the collective ownership and commitments shown by the different stakeholders are gains to be sustained. Through this
The rapid assessment of the CCF process has allowed the preparation of specific accounts for each of the countries covered by this review including Sudan, Zambia and Zimbabwe. For each country, a detailed description of the CCF process implementation was prepared, along with the contextual realities and the underlying causes for the prevailing health workforce shortages, the challenges these countries have to address and how they could translate the learned lessons into operational opportunities. Specific recommendations were also deliberated for each country setting. The following are some of the salient achievements that have been registered during the assessment of the CCF process implementation

- The HRH plans were developed through an inclusive coordination process consistent with the CCF approach with key stakeholders’ active participation and government leadership.
- The HRH plans were based on the results of each country’s HRH profile and updated situation analyses. In Sudan, the observatory was an effective source of the evidence being generated, and in all the countries, the desk review data was complemented by surveys or data transferred from care provider institutions.
• Key HRH priorities were incorporated in the HRH strategic plan for precedence consideration and the objectives clearly defined for their translation into action supported by relevant monitoring indicators.

• The stipulated HRH plans reflected a minimum feasible resource outlay in which the government and development partners have jointly contributed to its design.

• The pressing health needs of the rural community were agreed to additionally be addressed with community health worker interventions launched in all the three countries that have gained faster expansion in Zambia relative to the other two countries.

• Retention was desired to be a central priority component of these plans, a commitment shared by all the three countries in which production, capacity building and improving work place environment constituted integral components of this endeavour.

• The HRH strategic plans’ costing was made in all the three countries to guide implementation and accordingly, these were complemented with detailed operational plans that are time bound and with specific interventions and monitored outputs and outcomes.

• The HRH plans did specify general and some specific roles and contributions for most participating stakeholders, where one or more development partners have already committed their technical and financial support to components of the plan.

• The monitoring components of these HRH plans were well elaborated but have not yet been practically taken up effectively by the HRH committees.

1.6. Recommendations

The process of HRH coordination is known by different names in different countries and globally referred to as the “Country Coordination and Facilitation” approach promoted by the Alliance. This has established a strong base for addressing the shortages and geographically skewed distributions of the national health workforce. The different CCF-related initiatives and interventions coordinated by the HRH committees provide a robust foundation to further strengthen this forged cooperation and sustain the investment in HRH capacity building. The following are among the key advanced recommendations for consideration and action:

i. Consolidate the CCF process by periodically reviewing and updating the stakeholder analysis in relation to the progress of their engagement and stewardship. The process recognizes the success and coherence of their roles, responsibilities and contributions to the core programmatic inputs, outputs and outcomes through the implementation of mutually acceptable solutions to the prevailing HRH challenges.

ii. Improve the health information system by including HRH information from all related sectors and creating or strengthening HRH Observatories that produce the knowledge base necessary for formulating a coordinated HRH policy and evidence based management decisions concerning human resource development.

iii. Translate the HRH strategic plans into costed operational plans for effective financing and monitoring support and ensure government and development partners’ successful collaboration with emphasis on government leadership, alignment with the health policies, harmonization, shared accountability and management for results as elements of aid effectiveness.

iv. Sustain national efforts aimed at improving the HRH public financial management to enhance transparency, trust and quality, as well as the utilization efficiency of earmarked public sector inputs and aid grants through improved leadership and scaled up partnerships, focused on the projected result frameworks.

v. Enhance the management capacity of the senior and midlevel professionals operating at the HRH directorates to create the required technical and leadership capabilities, enabling the government to provide meaningful support to HRH coordination, build partnerships and advance the HRH contribution to the national health system, while bridging the stakeholders’ identified gaps in capacity.
vi. Extend the action response to the HRH shortage by not limiting the solution to the sole strategy of increasing the number of training institutions or enhancing the recruitment in the health system, but supplementing these by effective and sustainable retention schemes addressing the diverse needs of the health workforce including effective incentive schemes, skill mix and task shifting as necessary and the creation of a supportive working environment along with their due professional recognition and career development.

vii. Provide institutional support to the introduced innovative strategies of the community health workers (CHWs) and the fast track midwifery training programmes to partly address the chronic health workforce distribution inequity in the rural and hard-to-reach areas, with task shifting potentials, as HRH shortages constrain access to essential health services, especially in countries hardest hit by the HIV/AIDS epidemic.

viii. Establish a national level support for creating migration inventory and assessment desks in the HRH directorates that can regularly report on national human resource outmigration to explore solutions to compensate the shortage and identify strategies to strengthen health workforce retention as per the WHO Global Code of Practice on the International Recruitment of Health Personnel seeking the technical support of the Alliance and WHO.

ix. Improve the composition and monitoring capacity of the HRH committee, its ability to deliver the assigned functions and advance linkages with other national mechanisms that influence the health system as well as enhancing the monitoring and reporting on the critical components of the HRH strategic plan, such as recruitment and retention especially in rural settings and remote facilities.

x. Maintain the catalytic support of the Alliance to the CCF approach to maintain the successfully attained human resource gains and scale up the stakeholders and government-led commitment and capacity as well as their constructive engagement in the implementation oversight of the strategic plans being pursued.

xi. Sustain the collaboration between the Alliance and member states by jointly organizing national CCF/HRH annual progress review meetings that extend support to critical country-specific challenges and by organizing inter-country meetings attended by national and stakeholder partners allowing the countries to learn from each other’s experiences in terms of advocacy, CCF processes, HRH strategic planning, resource mobilization, effective implementation and coherent monitoring and evaluation.

1.7 Conclusion

The solutions envisaged for the management of human resource training, production, migration and retention challenges in the three countries have been integrated into the on-going human resource development efforts, an endeavour that needs to be sustained to significantly impact on healthcare service delivery systems. The CCF approach has undeniably created multistakeholder platforms and added value gains, uniquely providing the opportunity for an open dialogue among stakeholders and promoting consensus, commitment and cooperation on the key HRH priorities for mutual support and action.
ASSESSMENT ON THE EFFECTIVENESS OF THE COUNTRY COORDINATION AND FACILITATION PROCESS:

2. BACKGROUND AND INTRODUCTION

In Sub-Saharan Africa, the concern of growing inequalities in health status, the prevailing challenges of access to essential care and the unsatisfactory perceived rates of return on investment in health care has been a prominent feature in these low-income countries. The latter demonstrates the growing alarm caused by the global critical shortage of the health workforce, amounting to 2.4 million professionals predominantly doctors, nurses and midwives [1]. Many of these countries assigned a high priority to health as an essential part of the fight against poverty and made tangible efforts to scale up their budgetary outlays to the sector. However, the majority still remains short of the 2001 African Union Abuja commitment of 15% of the government funds to health [2].

Favourable attention was also provided by the multilateral and bilateral international organizations to health, introducing a major investment in the sector especially with regard to the acceleration of the expanded programme on immunization (EPI) through the support of the Global Alliance for Vaccines and Immunization, the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria, the President’s Emergency Plan for AIDS Relief (PEPFAR), the World Bank’s Multi-country AIDS Programme (MAP), the Global Alliance for Improved Nutrition (GAIN) and through many other partnerships generously investing in health [3,4,5,6]. Despite this enormous potential, there remain evident human resources for health (HRH) underinvestment in the domains of training, deployment, creation of decent working conditions and proper management has negatively affected production, recruitment, equitable deployment and retention. This has led to a growing migration from the public to private sector, rural to urban areas, the health sector to other sectors or outright migration to other more stable countries with better economic conditions, resulting in a serious inequitable human resource geographical distribution in addition to their general shortage in the overwhelming majority of Sub-Saharan African states [1, 7].

The World Health Organization (WHO) Report of 2006 [8], estimated that countries with fewer than 2.28 doctors, nurses, and midwives per 1,000 population were unable to ensure the coverage and access to essential health care services that would guarantee the attainment of the Millennium Development Goals (MDGs). WHO found that 57 countries, 36 of which are in Sub-Saharan Africa, fall short of that threshold. The report also outlined the existing imbalance in skill mix, urban-rural distribution and the inadequacy of working conditions and unsatisfying compensations, further restraining the accessibility and affordability of healthcare services.

The Global Health Workforce Alliance (The Alliance) envisioned in 2004, was launched in 2006 as a common platform for action and a partnership that brings together a variety of national and international actors dedicated to identifying and implementing solutions to the health workforce crisis [9, 10]. The Alliance had the vision that ‘all people everywhere will have access to a skilled, motivated and supported health worker, within a robust health system’, and mission ‘to advocate and catalyse global and country actions to resolve the human resources for health crisis, to support the achievement of the health-related millennium development goals and health for all’, and pursue its core functions of “mobilizing knowledge and learning, disseminating information and communications and harmonizing actors for workforce alignment” supported through Advocacy, Brokering Knowledge and Convening partnerships and country actions [9, 10].

The Alliance convened the first Global Forum on HRH in Kampala, Uganda in March 2008 that deliberated and concluded the Kampala Declaration and Agenda for Global Action (KD&AGA), committing the national and global leaders to take immediate actions towards addressing the health workforce crisis, providing to all people access to skilled and motivated health workers within a robust health system, addressing the critical lack of capacity for the creation and analysis of HRH
information, developing evidence based and costed HRH plans, adequately investing in health workforce, scaling up health workers’ 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 investments in the health workforce [11].

In light of the KD&AGA and decisions from its Board, the Alliance provided catalytic support to eight pathfinder countries to accomplish the processes found essential to address the HRH shared crisis [12]. Based on the lessons learnt from the pathfinder countries, the Alliance conceived the Country Coordination and Facilitation (CCF) principles and process in 2009 and validated it with partner countries. Since 2010, the Alliance has been offering catalytic support to the selected human resource for health (HRH) crisis countries for the CCF process implementation, generating a single national coordination platform among stakeholder partners to address the health workforce issues. The principles underlying the CCF approach include the coordination of the national stakeholders and development partners through an HRH committee with delineated membership and functions that forge linkages with other coordination mechanisms to pursue an integrated health workforce response. In its implementation process, the multisectoral HRH committee is expected to develop an evidence based and costed HRH plan, support and oversee the financing of the HRH plan, raising the capacity of the stakeholders and ensuring the sustained implementation of the HRH plan within the national health policies and strategies with a unified monitoring and evaluation framework.

The Second Global Forum on Human Resources for Health held in Bangkok in January 2011 reiterated the KD-AGA and called on concerned governments and the international community to declare the health workforce crisis as a national agenda, integrate it into the health development strategies and plans, and strengthens HRH governance institutional capacities [13]. While country ownership was re-emphasized, the forum called upon the national governments and development partners for mutual accountability and adherence to the principles of aid effectiveness enshrined in the Paris Declaration, and to abide by the 2001 Abuja declaration of scaling up health sector budgetary share to a minimum of 15% of the national budget and the Official Development Assistance (ODA) to 0.7% of the Gross National Income (GNI) [2, 14]. The Bangkok forum stressed on strengthening HRH strategic planning at the national level and the imperative to address training, recruitment, employment, deployment and retention and emphasized the role of CHWs who could adequately meet the health needs of the community once their assigned interventions were outlined appropriately.

A side-session was organized on the multisectorality of the HRH at the outset of the forum to share and deliberate on the country experiences on the CCF approach effectiveness in HRH planning and implementation, where the relevance of government ownership and political support and the stakeholders’ critical roles were recognized [15]. The proceedings of the side-session have shown the tangible progress made by most of the countries during the short span of the CCF approach implementation. To forcefully pursue this path, the participants called for the CCF process to assume a central role in guiding the national efforts for human resource development, scale up national ownership and international partners’ aligned support, acknowledge the indispensability of the community health workers (CHWs) to ensure universal coverage and access to essential health services, involve national institutions and build their capacities to offer the necessary back-up support to the CCF approach and establish concrete HRH implementation targets and technical networks that reach out to all the 57 HRH crisis countries, while consolidating monitoring and evaluation of the set HRH implementation plans [13].

Through this framework of action, the Alliance has assumed catalytic and global convener roles, bringing together different stakeholders for dialogue and joint action. The Alliance has also supported the country level CCF implementation in 16 HRH priority countries in five regions during 2010, while in 2011; six additional countries have been included to access the Alliance’s catalytic
support on the CCF approach. To adopt a more pro-active health workforce development approach, the Alliance desired to carry out a Rapid Assessment on the effectiveness of the CCF process in the implementing countries and its performance value for money. The assessment aimed to assist the Alliance in consolidating the CCF process and materials to better support the member states committed to the development of their health workforce. The countries targeted by this assessment were Sudan, Zambia and Zimbabwe, each one going through serious health workforce shortages and inequitable distribution. Furthermore, Zambia and Zimbabwe are managing large scale Anti-Retroviral Treatment (ART) programmes, creating an additional growing demand for health care and the employment of larger numbers of health workers.

3. OBJECTIVES AND EXPECTED OUTCOMES OF THE RAPID ASSESSMENT

The following is an outline of the key objectives and expected outcomes and deliverables of the rapid assessment

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Expected Outcomes</th>
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<tr>
<td>1. To identify the evidence base for the effectiveness, the added value and limitations of the CCF process implementation</td>
<td>1. A comprehensive rapid assessment report illustrating the available evidence on the added value, effectiveness and limitations of the CCF process implementation</td>
</tr>
<tr>
<td>2. To make recommendations on the current CCF approach based on the results of the assessment</td>
<td>2. A set of recommendations that address key HRH issues and deliberate on the necessary future action</td>
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4. METHODOLOGY

The three country studies applied a standard rapid assessment methodological approach, gathering information relevant to the CCF process. The assessment tools were developed through a process guided by the Alliance Secretariat in a manner reflective of the CCF principles and process as well as country-level implementation experiences gained so far. As the CCF process was not launched at the same period in the different intervention countries, this assessment was envisaged to concentrate on the level of progress that each country has made, relative to their respective stages of CCF process implementation. The scope of the country focused assessment covering the different dimensions of the CCF process and related framework of objectives and expected outcomes were defined by the Alliance secretariat. In conformity with this outline, a concise set of assessment guidelines and tools were developed under the close supervision of the Alliance. These ranged from obtaining consensus and operational support at national level for undertaking the assessment, preparation of assessment tools including desk reviews, key stakeholder interviews, focus group discussion (FGD) and use of checklists, and the data collection and analysis process. During the assessment, interviews were conducted with government executives at the ministries of health, senior partners whose organizations were represented in the HRH-TF, heads of training institutions, health foundations, private not-for-profit service providers, and private enterprises contracted to manage health resources and other stakeholders where possible. The focus of the assessment was directed on the CCF process and expected outcomes and their influence on the HRH situation. The assessment primarily focused on the CCF process steps being pursued by each country, and provided a prospective view about the way forward in resolving the unremitting HRH crisis. The study assessed the inputs, processes, outputs and outcomes of the CCF activities and the policy and strategy entailed (fig 1).
The study particularly assessed the HRH committees’ coordination roles and management directions, the attained success in building coalitions of jointly engaged partners, capacity development on the CCF core competencies and the preparation of a comprehensive and costed HRH strategic plan. At country level, the WHO Country Offices and the human resource directorate of the ministries of health have provided all the necessary facilitations to the assessment process, enabling valuable contacts with the HRH committee member organizations and other relevant stakeholders. During the implementation of this study, a range of assessment tools were used in an effort to generate the data relevant to the CCF process evaluation. The applied methods for the implementation of this rapid assessment process included desk reviews, key stakeholders’ interviews and assessment questionnaires and checklists. Upon the conclusion of each country assessment process, debriefing meetings were convened, sharing the preliminary study findings with the MoH and members of the HRH committees as made available.

A limitation of this study is the relatively small number of individual interviews conducted in each country and the potential quality gaps of the recording systems related to HRH management and coordination or the variance in the interviewees’ own sense of judgement about the subject. The latter may prompt the risk of underestimating some of the functions executed during the CCF process, and the contributions availed from the stakeholders.

5. **ASSESSMENT FINDINGS**

5.1. **The HRH coordination process**

HRH constitutes a major component of the health system of the three assessed countries, with coordination posing a serious challenge for being critical to the efficiency and effectiveness of the delivery of essential health care services. Prior to the launch of the CCF approach, HRH coordination was not institutionalized and the involvement of the relevant stakeholders in its decision making process remained unclear, as the existing platforms lacked concrete long-term harmonization vision.
Against this backdrop, the CCF principles and process were well received by the ministries of health and the large platform of committed and engaged national and international partners of the health sector. Consistent with the CCF coordination centred principles, a multistakeholder HRH committee was established-expanded in each country, bringing together not only the traditional health partners but also those sectors whose potential roles could contribute to the HRH development in the country. The HRH committee is a government-led coordination instrument with the task to define the national priorities on HRH, mobilize the necessary financial resources, harmonize donors’ support aligned with national strategic policies and plans, and avoid any duplication and parallel implementation.

Through the Alliance’s catalytic support, a knitted partnership is created between the government as the lead and the established or consolidated HRH committee to jointly pursue the implementation of the CCF functions and produce their expected outcomes. Through this process comprehensive HRH situation analyses were carried out, HRH strategic plans and their monitoring framework developed, and resources mobilized for their implementation with close follow up of the performance outputs and outcomes. In this juncture, the aid effectiveness principles of government ownership, alignment, harmonization, accountability and management for results were emphasized upon as important instruments that contribute to ensure the success of the HRH development process and coordination. The diagram below depicts the HRH coordination at the country level.

**Fig 2: Illustration of the Country Level HRH Coordination**

5.2. **HRH committees’ structure, functions and capacity organization**

The central hub of the CCF process at country level is the establishment of the HRH committee that triggers the consolidation of the CCF principles and realization of its operational functions. To accomplish the diverse and complex HRH development managerial roles and functions, the ministries of health and their national and international partners have devised as stipulated in the CCF approach, the necessary structures and operational mechanisms that would guarantee the smooth sailing of the HRH agenda. In this exercise efforts were made to assign roles to different thematic HRH sub-committees for the rapid scaling up of the critical health workforce domains. Accordingly, governments have built strategic alliances with partners to increase the levels of HRH targeted resource mobilization and their efficient and effective investment and utilization. Table 1
illustrates the structures and mechanisms pursued to advance the country level agenda for human resource development.

<table>
<thead>
<tr>
<th>HRH committee: attributes</th>
<th>Expected strategic roles for advancing the HRH agenda</th>
<th>Country level actions and responses</th>
</tr>
</thead>
</table>
| **1. Structures of the HRH committee** | a) All countries to streamline and consolidate the HRH committees based upon the CCF principles and process, making it an inclusive multi-stakeholder coordination forum with participation of national stakeholders and multilateral and bilateral development partners.  
  b) Countries to acknowledge the importance of responding positively to the interests expressed by additional stakeholders willing to join the HRH committee to expand the scope and coordination of HRH support at national level.  
  c) Countries to outline the collective and explicit roles and functions to HRH committees and its members with inherent accountability, with the following elements:  
    - Countries assigning top priority to human resources for health  
    - Endorsing that the assigned HRH mandate extends beyond the current ministries of health confined to health services’ scope  
    - Expanding national partners’ membership to include other relevant stakeholders such as the private sector and professional associations  
    - Enhancing HRH structural managerial profiles in all the ministries of health with the establishment of powerful directorates to lead the HRH coordination  
    - Resource mobilization for HRH to become a collective responsibility of the forum partners | - HRH committees are operational in all the three countries after being established or significantly reorganized and strengthened with inclusion of key stakeholders through the CCF approach  
  - The fundamental principles were shared by the three countries along with a strong commitment and ownership by the ministries of health that was a key determinant of the success of these committees.  
  - Roles of different stakeholders outlined in country case studies |
| **2. Participation** | a) National stakeholders widely represented from relevant constituencies  
  b) HRH committee inclusiveness allowed, with more to join based upon the results of the stakeholders analyses  
  c) International partners participation to be encouraged in view of their valuable support coordination and HRH forum joint action | In all three countries, special emphasis was put on wider national participation as international partners mostly expressed interest when engaged or willing to assist HRH endeavours  
  - International partners’ participation varied (least in Sudan and largest in Zimbabwe but meaningful in all) |
| **3. Criteria for identifying the HRH stakeholders** | a) Countries using inclusive standard criteria for engaging the stakeholders in HRH coordination, such as:  
  - Members representing the related public sector, private sector, professional associations, staff unions, academic or research institutions, regulatory bodies, civil society organizations and bilateral or multilateral partners supporting HRH  
  - Members having managerial or technical roles in HRH development or influence on HRH resource planning and allocation  
  - Members with capacity to enhance the effectiveness of HRH interventions and offering complementarity and synergy and supportive to aid effectiveness principles and hence willing to align investment with national HRH priorities | - The criteria pursued by the different countries were consistent with set expected norms and participation of all key stakeholders highly encouraged  
  - All countries significantly enhanced the membership of their committees with HRH issues being addressed more comprehensively |
| **4. Thematic subcommittees** | b) Establishing thematic sub-committees reflecting the top HRH priorities in production, deployment and retention that guide and facilitate planning, implementation, resource mobilization and monitoring | All three countries have constituted thematic HRH-subgroups (see table 3) |
| **5. Stakeholders’ analysis** | a) HRH committee members’ capacities recognized and assigned roles and responsibilities as per their comparative advantages with clear interface between health system strengthening and HRH development with focus on accountability and results | Formal discussions and consensus on HRH support capacities were expressed by the HRH committee member organizations and agreement on roles and responsibilities |
| **6. HRH committee members exposed to the CCF principles and process** | b) Committee members to be oriented on CCF principles and process and in view of enlisting new members to join the forum or due to the regular turnovers of senior staff, the need to organize periodic briefs for sustained information sharing | - The CCF process orientation attained at the outset by all countries and periodic updates currently being considered to brief the new members and also evolve the process at national level |
| **7. HRH committee members’ access to national and WHO material and information materials from the web, and acquiring support by HRH committee secretariat in this regard** | a) HRH committee members regularly accessing national, the Alliance and WHO material and information materials from the web, and acquiring support by HRH committee secretariat in this regard  
  b) HRH committees commissioning numerous HRH studies and surveys as per the HRH set priorities of each country, generating solid evidence on | HRH committee secretariat dissemination of information needed improvement in all three countries  
  - Different studies were commissioned in each country to address one or more priority HRH |

Rapid Assessment on the effectiveness of the Country Coordination and Facilitation (CCF) process in Sudan, Zimbabwe and Zambia

11
The HRH committee: attributes | Expected strategic roles for advancing the HRH agenda | Country level actions and responses
--- | --- | ---
international HRH tools and materials | the challenges facing the health workforce | domains to generate information for action

* The different designations given to the HRH multi-stakeholder forum in the three countries: Sudan (HRH Stakeholders Forum), Zambia (The HRH Technical Working Group) and Zimbabwe (HRH Task Force)

5.3. The HRH coordination process: Salient outputs

The table below illustrates key salient outputs to which the CCF approach has directly contributed to their launching or scaled up implementation. The credit of the sustained progress of these interventions goes to government-led institutions that spearhead the process and to the sustained support provided by the HRH committee member organizations [16, 17, and 18].

Table 2: The coordination role of the HRH committee and its effect on operations: Salient outputs and outcomes facilitated by the CCF approach with prominent governments’ leadership support

<table>
<thead>
<tr>
<th>Variables</th>
<th>Outputs</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generating data for planning</td>
<td>a) Conducted HRH census and surveys and/or desk reviews in each country and updated HRH information profile/situation analysis carried out in all three countries as a basis for planning, implementation and monitoring</td>
<td>- Generated HRH-information data used for evidence-based decision making during the HRH plan development with improved stakeholder participation</td>
</tr>
<tr>
<td>HR data use</td>
<td>b) National HRH Observatory strengthened in Sudan while in Zambia and Zimbabwe the HRH information system was strengthened with process to develop the HRH Observatory</td>
<td>- Collective support to financing HRH implementation attained in the three countries but with outstanding gaps in their HRH budgetary outlays</td>
</tr>
<tr>
<td>Institutional capacity building</td>
<td>c) Institutional capacity building scaled up through improved coordination at central and regional / state levels</td>
<td>- National MOH HRH institutional capacity building attracted more investment and enhanced production in all the three countries</td>
</tr>
<tr>
<td>Development of an evidence based and costed HRH Strategic Plan</td>
<td>a) An evidence based and costed HRH Strategic Plan developed by each country – Sudan developed new plan while Zambia and Zimbabwe developed second generation HRH plan</td>
<td>- All three countries have costed and started financing their plans, though not following a standard framework (while Zambia included all budgeted HRH costs, Zimbabwe emphasized on capacity building, and Sudan accounted only for the incremental expenditures necessary)</td>
</tr>
<tr>
<td>Coordination with similar health mechanisms</td>
<td>Linkages with other coordination mechanisms established allowing synergies between different HRH interventions with many stakeholders being concurrently members in HRH committee and Global Alliance for Vaccines and Immunization (GAVI) and Global Fund coordination mechanisms generating wider HRH support</td>
<td>- HRH committee coordination with Global Fund CCM and GAVI-support harmonized HRH planning and decision making process (In Zimbabwe, the resource scarcity challenge faced by the HRH retention incentive scheme were being actively addressed through the HRH committee negotiation process with gap filling solutions)</td>
</tr>
<tr>
<td>HRH committee meetings and minutes for follow-up and monitoring performance</td>
<td>a) In all three countries, HRH committee meetings were conducted quarterly or more frequently, and the prepared meeting minutes shared and recorded for deliberated actions’ follow up</td>
<td>- HRH committee meetings were substantiated in all three countries by their chronologically recorded minutes, and decisions followed up in subsequent meetings with emerging accountability and focus on results</td>
</tr>
<tr>
<td>Stakeholders’ commitment for HRH funding partnerships</td>
<td>HRH committee members ensured the active participation of their sectors and have committed their funding support to the HRH strategic plan implementation</td>
<td>- All three countries used the HRH committee forums and successfully catalysed resource mobilization for the HRH plan implementation that improved synergy and averted duplication</td>
</tr>
</tbody>
</table>
The above matrix has briefly outlined the key CCF process interventions and the results attained during the period of its implementation. The structures pursued by the three countries were comparable at all levels although the speed and range of stakeholders’ mobilization has differed between the different countries. The HRH committees adhered to the operational procedures for planning and management as set out by the CCF process, with minor adaptations to the governance structures of the ministries of health and other relevant national stakeholders, as well as to the level of international partners’ engagement in the health sector of each country. Although the general roles and responsibilities were comparable in the three countries, there was a notable variation in priority ranking of the HRH challenges to be addressed, hence the diversity in the assigned support to their specific HRH interventions. To effectively address the numerous tasks of the HRH committees, HRH sub-groups were established in each country with specific assignments to perform. The table below illustrates the HRH subgroups constituted by the HRH committees.

<table>
<thead>
<tr>
<th>Functions Assigned to HRH Committee Subgroups*</th>
<th>Sudan**</th>
<th>Zambia</th>
<th>Zimbabwe</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. Retention scheme</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>ii. Recruitment</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>iii. Performance management/Service Delivery/Development and management</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>iv. Development and Training/Research and Production</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>v. Community Health Assistants and Task shifting</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>vi. HIS and HR Strategic Planning</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>vii. Financial tracking and Budget/HRH Financing</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

* In Sudan and Zimbabwe the sub-committees hold one or more of the above functions while in Zambia there was a distinct committee for each

** The Observatory is well established and coordinated by a technical team with oversight by the HRH committee

5.4. Preparation of HRH situation analysis in the three assessed countries

A major thrust supported with the active participation of the HRH committee members was the HRH situation analysis. In each of the three countries, the national and international partners that were interviewed during the rapid assessment process expressed their satisfaction on the CCF process support to this initiative, the HRH profiles’ content output and the depth of the analyses carried out on its different components [19, 20, 21]. In all three countries, the collected data was not limited to the workforce operating under the ministries of health, but this information was complemented by other public sector institutions, the private-not-for-profit (PNFP) and faith-based organizations and to the extent possible the private sector. The profiles contained information on the general attributes of the health workforce as well as targeted analysis on HRH priority areas specific for each country context and situation. The analyses reflected the HRH shortages, the challenges being faced, the production, recruitment, contractual terms and retention status at country level, distribution and equity dimensions, utilization and internal and external migration. Other relevant areas covered by the situation analyses included the work place conditions and safety constraints, the regulation status of the private sector, the role of professional associations, the existing gaps between curricula of educational institutions and health system needs and the performance quality of educational institutions and their production capacities. The important government HRH management capacities were identified and existing development gaps projected to be used for high level policy dialogue and decision making for planning and for resource mobilization. However, some of these attributes would need more exhaustive assessment to allow sufficiently informed strategic deliberations.

Figure 3 illustrates the key areas on which the three HRH profiles have deliberated. The resulting products of the situation analyses were the major resources used in designing the HRH strategic plan of each country. The attributes outlined in the diagram reflect the characteristics to be factored in the strategic plans as aggregate priorities.
5.5. Human resource needs: Common features but separate ranking of priorities

The health workforce is recognized by all three governments as a top priority and an integral component of the national development agenda. However, the ranking of the HRH aspects having the largest influence on the national health system did vary from one country to another. In the field of manpower production and pre-service training, Sudan has, through its large number of public and private medical institutions, the possibility to graduate several thousand doctors every year, while the numbers produced by the other two countries are far below their domestic need. However with regard to nurses and midwives training and production, all the three countries are underperforming, although Sudan has moved at a faster pace through its recently scaled up academies of health sciences with high nursing and midwifery yearly intakes. In the induction and deployment of trained professionals to the health system workforce, Zambia, with its high ceiling of sanctioned positions and better economic conditions, fairs better, relative to the other two countries where the resource crunch and limited number of regulated sanctioned positions do not provide the necessary space for proper staffing or employment in the under-privileged rural and hard-to-reach geographical areas.

On the other hand, the equitable distribution of the health workforce is a shared challenge, although the higher incentives provided to health professionals in Zambia have facilitated workforce retention. The latter was also facilitated by the government policy of tying the deployment of the employed expatriate cadre with a pre-set deployment plan. In Sudan and Zimbabwe, the equitable distribution of the qualified health workforce and their retention are serious outstanding problems of the health system, making it difficult to recruit the needed professionals with the right skills in the right places of the health system network. The internal migration was visible in all three countries with flow from rural to urban and from public to private health sector with impeding effect on health system strengthening efforts in each country. The latter phenomenon is further compounded by the high outmigration rates in Sudan and Zimbabwe. The table below summarizes the status of these attributes in the three countries illustrating both the strengths and weaknesses of human resource development.
Table 4: Qualitative review of the HRH critical attributes in the three assessed countries: Strengths and weaknesses in Human Resource Development

<table>
<thead>
<tr>
<th>HRH Attributes</th>
<th>Sudan</th>
<th>Zambia</th>
<th>Zimbabwe</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HRH training and production</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Doctors</td>
<td>++++</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Nurses</td>
<td>++</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Midwives</td>
<td>++</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td><strong>HRH employment opportunities for newly graduated patches</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establishment sanctioned positions</td>
<td>+</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>Medical Doctors</td>
<td>+</td>
<td>+++</td>
<td>++</td>
</tr>
<tr>
<td>Nurses</td>
<td>++</td>
<td>+++</td>
<td>++</td>
</tr>
<tr>
<td>Midwives</td>
<td>++</td>
<td>+++</td>
<td>++</td>
</tr>
<tr>
<td><strong>Workforce distribution and retention</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equitable distribution</td>
<td>+</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>Retention (averting voluntary attrition)</td>
<td>+</td>
<td>+++</td>
<td>+</td>
</tr>
<tr>
<td><strong>Outmigration</strong></td>
<td>++++</td>
<td>-/+</td>
<td>+++</td>
</tr>
<tr>
<td><strong>Health facilities' working environment</strong></td>
<td>++</td>
<td>++</td>
<td>++</td>
</tr>
</tbody>
</table>

Severely inadequate (+), inadequate (++), Adequate* (+++) and highly satisfactory (++++)

Adequate*: Pertains to a condition when a variable i.e. number of trainees, employment opportunities, existing measures for retention or working environment was perceived to be Satisfactorily contributing to the desired health system needs

Table 4 depicts the need for a comprehensive approach in HRH development as the strength that one country has in an area of the HRH paradigm, though necessary, will not be sufficient to exert the required levels of capacities by the health system, unless the right efforts are also made to strengthen the other weaker but critical HRH domains. This vision is evidently imbedded in the national strategic plans that took advantage of the benefits provided through the widely accepted CCF process by all three countries.

5.6. The HRH strategic planning: A unique contribution through the CCF process

The development of the HRH strategic plans were preceded by comprehensive situation analyses of the HRH profiles at each country level, though with varying success in covering the private sector [19-21]. These data were generated from desk reviews, analysis of primary and secondary HRH data, review of plans and budgetary outlays and surveys and HRH census with data triangulation for validation purposes. The drafts of these profiles were widely circulated and discussed through consultation workshops. The HRH committees were fully engaged in these processes. The latter being nationally led had the close oversight of the ministries of health for ownership and final approval.

Developing an evidence-based HRH strategic plan was a new experience in Sudan, although the less-successfully implemented pre-CCF HRH plan in Zambia faced funding constraints, while Zimbabwe encountered the HRH retention challenge. To reform their HRH development processes, Zambia and Zimbabwe developed their second generation HRH plans under the CCF platform. The methodological approach pursued for the development of the HRH strategic plans has emulated in terms of stakeholders’ participation that of the HRH profiles’ development, with several rounds of consultation workshops. In each of these meetings the documents presented by the drafting committees were critically reviewed and the necessary suggestions for inclusion shared [15-17]. The human resources directorates coordinated the entire process in close liaison with the HRH committees and leadership of the ministries of health.

This undertaking was one of the most important expected outcomes of the CCF approach upon which strongly hinge the other two major desired outcomes, namely resource mobilization and capacity building. The HRH strategic planning, facilitated through the CCF process and coordinated by the MoH HRH directorates, was described by some members of the HRH committees as a transformation process through which the ministries of health were reshaping the organization and the operational focus of their health workforces and preparing them to effectively meet the
challenges of their respective health systems. Governments took advantage of the CCF approach and realized its inherent opportunities in forming partnerships on defined HRH objectives that are aligned with national priorities, and implemented through a technical assistance that is harmonized and supported by the mutual accountability in achieving the HRH expected programmatic results. As a reflection of the government commitment, ministers of health have championed for HRH as a national priority, while the multisectoral context of the plan was widely acknowledged by the MoH and HRH committees. Operational plans complementing the stipulated strategic plans and having HRH defined specific interventions, budgets and monitoring details are under process in all three countries.

Table 5: The HRH Strategic Plans of the three countries: Coherence of priorities on focus

<table>
<thead>
<tr>
<th>Sudan</th>
<th>Zambia</th>
<th>Zimbabwe</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Supporting health service needs through adequate HRH planning, envisaging adequate information systems and long-term projections</td>
<td>1. Increasing the number of adequately trained HRH, expanding training institutions and promoting in-service training</td>
<td>1. Development of an HRH Information System and the promotion of research supporting the implementation of the strategic plan goals</td>
</tr>
<tr>
<td>2. More equitable geographical distribution of health workforce especially doctors and nurses with relevant incentive packages</td>
<td>2. Increasing the number of employed and equitably distributed HRH with appropriate skills mix and harmonizing the HRH plan with health sector infrastructure development and plans</td>
<td>2. Production, Training and Development- this component of the plan relates to the education and training of health professionals</td>
</tr>
<tr>
<td>3. Improving individual performance management systems through performance-based reward systems</td>
<td>3. Deployment, utilization, management and retention of health personnel enabling them to play a critical role in the delivery of a sustainable health services system</td>
<td>3. Deployment, utilization, management and retention of health personnel enabling them to play a critical role in the delivery of a sustainable health services system</td>
</tr>
<tr>
<td>4. Enhancing production and orientation of education and training towards health service needs through quality pre-service training and continuing professional development</td>
<td>4. Human Resources Planning and Financing with focus on workforce estimates and supply projections and the kinds of skills, knowledge and attitudes required to meet the set health status objectives</td>
<td>4. Human Resources Planning and Financing with focus on workforce estimates and supply projections and the kinds of skills, knowledge and attitudes required to meet the set health status objectives</td>
</tr>
<tr>
<td>5. Strengthening HR functions at the decentralized levels with effective organizational structures and retention strategies</td>
<td>3. Improving performance and utilization of HRH through improved leadership, planning and management and enabling working environment</td>
<td></td>
</tr>
</tbody>
</table>

The national HRH strategic plans of the three countries had great commonalities, although the identified priority problems differed from one country to another. However, through this exercise, the relevance of planning was recognized as a major milestone for HRH development. Similarly, the training and production of sufficient human resources for the health system and their deployment, the inevitability of effective retention strategies and the equitable distribution and management of HRH were areas jointly acknowledged by the three countries.

The following is a summary of the assessment findings with regard to the HRH strategic planning processes that were pursued and adopted by the three countries.

- The HRH plans were developed through an inclusive coordination process consistent with CCF principles with key stakeholders’ active participation and government leadership ensured.
- The HRH plans were based on the results of each country’s HRH profile and updated situation analyses. In Sudan, the observatory was an effective source of the evidence being generated, and in all the countries, the desk review data was complemented by surveys or data transferred from care provider institutions.
- Key HRH priorities were incorporated in the HRH strategic plan for precedence consideration.
- The objectives reflected in the HRH strategic plans were further classified into specific objectives for their translation into activities supported by relevant monitoring indicators.
• The stipulated HRH plans reflected a minimum feasible resource outlay in which the government and development partners have jointly contributed to its design.
• The pressing health needs of the rural community were agreed to additionally be addressed with community health worker interventions launched in all three countries that have gained faster expansion in Zambia relative to the other two countries.
• Retention was desired to be a central priority component of these plans, a commitment shared by all the three countries.
• HRH production, capacity building and improving workplace environment are integral components of all three HRH strategic plans.
• The different barriers to the implementation of the plans were outlined. However, the risks that include the constraints and uncertainties that the plan is confronted with need to be comprehensively analysed and relevant solutions prospected for action.
• HRH plans cost estimate were made to guide implementation.
• The ministries and the HRH committees have realized the need to complement the HRH strategic plans by detailed operational plans that are time bound and with specific interventions and monitored outputs and outcomes.
• The plans did specify general and some specific roles and contributions for most participating stakeholders, where one or more development partners have already committed their technical and financial support to components of the plan.
• HRH monitoring components of these plans were well elaborated but have not yet been practically taken up effectively by the HRH committees.
• The comprehensiveness of the plans varied between countries especially with regard to resource estimation where Zambia and Zimbabwe reflected the entire required budgetary outlays and outsourced several HRH interventions, while in Sudan only incremental necessary resources were outlined, while the traditional regular government HRH budget was separately reflected in government budget and fiscal plans.
• The engagement of the non-state actors in the HRH planning and implementation was more prominent in Zambia and Zimbabwe relative to Sudan reflecting the prevailing contextual differences related to health system organization in the three countries.

5.7. HRH Strategic Plan: The imperative of Resource Mobilization

Resource mobilization is, in its own right, one of the expected outcomes of the HRH strategic plan components. The HRH committee participating organizations used this forum for harmonized resource mobilization that can effectively expand the gamut of fund-raising avenues. Resource mobilization has therefore become an integral component of each HRH strategic plan, promoting the collaborative relationships cultivated between the government and development partners. This process is closely coordinated and aligned with the preparation of the national health development plan boosting its lobby for support and funding. The latter was strengthened as the governments raised their policy support to HRH development in the three countries and enhanced through the HRH government budgetary outlays. Efforts are also underway to encourage the participation of NGOs and private funding sources to collectively address country level specific HRH challenges.

Based on the above premise, the three countries have embarked on the development of their HRH strategic plans that include a defined resource mobilization road map, making part of the HRH plan, as charted by the CCF approach. Successful efforts were made to ensure the consideration of HRH funding through the global health initiatives already operating in the three countries, though at different intensities. To maintain the quality of resource mobilization, HRH committees will need to assess and update on yearly or biennial basis, the resource needs based on the actual HRH requirements and supply potential.

Table 6 shows the process through which the resource mobilization component of the HRH strategic plan was prepared. This process has improved the leadership capabilities of HRH committees in
general and that of the national HRH directorate teams in particular, with significant contribution to trust building and transparency.

### Table 6: Mobilizing resources for the Strategic Plan implementation

<table>
<thead>
<tr>
<th>Variables</th>
<th>Resource mobilization for the implementation of the HRH plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mechanisms of resource mobilization for funding the HRH strategic plan</td>
<td>Resource mobilization relied mainly on the government treasury inputs and on the financial and technical support that donors and development partners have provided to the HRH plan components as per their comparative advantages.</td>
</tr>
<tr>
<td>Available funding mechanisms</td>
<td>HRH funds were mobilized through GAVI, EU, USAID, CDC, Global Fund, DFID, WHO, UNFPA, UNICEF and other partner organizations at times through pooled approaches as was the case in Zambia and Zimbabwe or merely by coordinating the funding, as predominantly was the case in Sudan, together with direct government funding and execution pursued by all the three countries or by outsourcing the programme financial management to competent third parties as the CHAs programme in Zambia. Moreover, contributing international partners were limited in Sudan relative to Zambia and Zimbabwe.</td>
</tr>
<tr>
<td>Government resource commitment</td>
<td>The governments of Zimbabwe and Sudan showed commitment to improve their non-competitive HRH salaries guided by available resources while the non-financial incentives (improving working environment, better training opportunities, career paths, housing, security etc.) were considered by all three countries.</td>
</tr>
<tr>
<td>Support of other ministries to the HRH strategy</td>
<td>In all three countries, ministries of finance have joined the HRH committees, while in Sudan the ministries of higher education and labour also joined the HRH committees. Efforts are being made in Zambia and Zimbabwe to expand the HRH committees to ensure the participation of all relevant partner organizations and institutions.</td>
</tr>
<tr>
<td>Stakeholders’ resource contribution</td>
<td>Stakeholders’ alignment with national HRH priorities was facilitated in all three countries by their direct and active participation in the HRH committees, and this has improved their coherence in harmonizing their financial inputs and aligning these with HRH national priorities.</td>
</tr>
<tr>
<td>Future resource mobilization potentials for HRH issues</td>
<td>The HRH strategic plan has created an avenue for partnership and shared commitment for implementation with greater potential support from the development partners in all three countries, with more partners engaged with bigger portfolios in Zambia and Zimbabwe.</td>
</tr>
<tr>
<td>HRH funding through partnerships</td>
<td>In all three countries, pursuing a comprehensive HRH development will inevitably require the forging of national and international partnerships to support the unfunded gaps of the set HRH strategic plans.</td>
</tr>
</tbody>
</table>

The CCF approach provided the added value of sharing unified coordination platforms through the established and/or consolidated HRH committees. Moreover, the active participation of a wide range of national stakeholders has created a strong national force, collectively catalysing HRH collaborative ventures with development partners. It was a shared opinion among many members of the HRH committees that the strategic planning and the established coordination are two central CCF attributes that have significantly improved both the scope and quality of resource mobilization, reflecting the criticality of public sector financing for the health sector in which priority has been assigned to its HRH component.

Through the analysis of the HRH plans of the three countries, a potential discrepancy was noted. While in Zambia and Zimbabwe, the cost of on-going HRH development budgetary outlays may have been costed into the plan’ in Sudan, only the incremental cost of the new activities outlined in the plan were considered in the costing exercise, creating a significant variance between the presented country budgetary outlays. From this analysis the HRH plans of Sudan, Zambia and Zimbabwe reflected different budgetary outlays, amounting to about US$ 1.7 million, 0.485 million and 0.393 million respectively, corroborating the above indicated divergence. While Sudan and Zambia have distributed these funds among the different set objectives of their strategic plans, Zimbabwe has earmarked almost the entire budget to training and capacity building interventions for human resource development, implying that additional resources will be mobilized for the comprehensive implementation of the plan [17, 22, and 23].

Through the unified HRH strategic plan, the countries have realized their ability to expand both the efficiency and scope of HRH resource mobilization, first by enlisting all the HRH interventions carried out by the different programmes and service providers of public and not-for-profit private sources.
and subsequent harmonization with the plan to maximize efficiency. The HRH committees have also understood the importance of the public sector enhanced commitment and augmented HRH budgetary outlay, as a pull factor for international support through predictable and adequate funding. The Alliance may facilitate the application of the unified HRH development costing tool and methodology to objectively compare the levels of human resource investment among different developing countries through the application of the CCF approach.

Through the CCF approach, the partners in the three countries have actively promoted the HRH agenda which is the most critical among the three key inputs of the health system, the others being the physical capital and consumables. Through this process, inputs were jointly committed by the different partner organizations, producing some tangible outputs and outcomes that have significantly scaled up the policy, strategic and operational dimensions of human resource development. In Zambia, special human resource training interventions were supported by partners significantly scaled up the policy, strategic and operational dimensions of human resource development.

Table 7 illustrates some salient inputs, outputs and outcomes of this undertaking.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Implementation progress at country level</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INPUTS AND PROCESS</strong></td>
<td></td>
</tr>
<tr>
<td>Stakeholders’ participation in the coordination process being active and</td>
<td>✓ National &amp; international partners participation enhanced and expanding</td>
</tr>
<tr>
<td>members dedicating time for HRH issues</td>
<td></td>
</tr>
<tr>
<td>Government leadership in the CCF process exerted through visible</td>
<td>✓ Sustainability ensured by the strong government policy support</td>
</tr>
<tr>
<td>involvement and commitment</td>
<td></td>
</tr>
<tr>
<td>Shared commitment to the formation of the HRH committee founded on the</td>
<td>✓ HRH support scope extended beyond ministries of health</td>
</tr>
<tr>
<td>CCF principles and process to which all the health stakeholders will have</td>
<td></td>
</tr>
<tr>
<td>legitimate membership and roles</td>
<td></td>
</tr>
<tr>
<td>Recognition of the necessity to resolve HRH issues through consensus</td>
<td>✓ The positive conciliation experience of Zambia is a case in point “see case study”</td>
</tr>
<tr>
<td>building and partnership</td>
<td></td>
</tr>
<tr>
<td>Partners committing technical resources to advance the HRH development</td>
<td>✓ Forged greater coherence between partners</td>
</tr>
<tr>
<td>process</td>
<td></td>
</tr>
<tr>
<td>Partners committing financial support aligned with the implementation of</td>
<td>✓ Accountability to sustain and expand</td>
</tr>
<tr>
<td>the HRH plan</td>
<td></td>
</tr>
<tr>
<td>Consensus at the HRH Task Force level to bridge the budgetary gaps</td>
<td>✓ The HRH plan stood as a unifying factor for action</td>
</tr>
<tr>
<td>through government and partners’ resource mobilization</td>
<td></td>
</tr>
<tr>
<td>Consensus at the HRH Task Force level in endorsing the inclusiveness</td>
<td>✓ Inclusiveness fully endorsed with enhanced participation</td>
</tr>
<tr>
<td>principles for attracting additional stakeholders to join the HRH-TF</td>
<td></td>
</tr>
<tr>
<td><strong>OUTPUTS</strong></td>
<td></td>
</tr>
<tr>
<td>The CCF process introduction workshops conducted successfully at</td>
<td>✓ Refresher workshops under implementation</td>
</tr>
<tr>
<td>launching phases</td>
<td></td>
</tr>
<tr>
<td>Senior nationals exposed to regional and/or international conferences</td>
<td>✓ Learning and advocacy perceptions enhanced</td>
</tr>
<tr>
<td>for learning and experience-sharing facilitated by the Alliance</td>
<td></td>
</tr>
<tr>
<td>HRH Task Force constituted according to the CCF principles</td>
<td>✓ Forged solid partnerships</td>
</tr>
<tr>
<td>Evidence-based, comprehensive and costed HRH plan developed</td>
<td>✓ Shared commitment for HRH action</td>
</tr>
<tr>
<td>HRH plan financed through contributions from the government and</td>
<td>✓ Enabled a shared implementation process</td>
</tr>
<tr>
<td>development partners through joint partnerships</td>
<td></td>
</tr>
<tr>
<td>HRH plan launched into implementation phase</td>
<td>✓ Pursued at different stages of progress</td>
</tr>
<tr>
<td>Strengthening of training institutions promoted and additional investment</td>
<td>✓ Commitment with long-term impact</td>
</tr>
<tr>
<td>budgeted</td>
<td></td>
</tr>
<tr>
<td>HRH recruitment and deployment for equity set as a priority and acted on</td>
<td>✓ Equity projected as a shared goal by all partners</td>
</tr>
<tr>
<td>by the government establishment institutions</td>
<td></td>
</tr>
<tr>
<td><strong>OUTCOMES</strong></td>
<td></td>
</tr>
<tr>
<td>The CCF process and relevance of coordination endorsed by national</td>
<td>✓ CCF has become an icon for HRH coordination</td>
</tr>
<tr>
<td>and development partners as a modus operandi to pursue</td>
<td></td>
</tr>
<tr>
<td>Duplication and parallel HRH interventions significantly reduced as</td>
<td>✓ Participation in HRH-TF by all partners added efficiency</td>
</tr>
<tr>
<td>major partners have aligned with the plan</td>
<td></td>
</tr>
<tr>
<td>Supported HRH training institutions gained capacity and scaled up</td>
<td>✓ Governments enhanced their HRH investment</td>
</tr>
<tr>
<td>induction for larger production to address prevailing gaps</td>
<td></td>
</tr>
</tbody>
</table>

Rapid Assessment on the effectiveness of the Country Coordination and Facilitation (CCF) process in Sudan, Zimbabwe and Zambia

19
• Facilitated recruitment and offered retention incentives increased health workers’ attraction to join or stay in service
• Retention schemes assumed central role in national health system strengthening endeavours
• CHWs’ initiative endorsed and planned for implementation at national level promising greater equitable access to essential health care services

| ✓ | Resource availability and restrictive regulation challenges being addressed |
| ✓ | A shared challenge but most prominent in Zimbabwe |
| ✓ | Launched by all countries but Zambia’s efforts strongest |

* ✓ reflects action taken by all the three countries but tangible variances noted if any

5.8. Monitoring the implementation of the HRH strategic plan

Monitoring and evaluation (M&E) has been a major component of the HRH strategic plans and envisaged to measure progress towards achieving the objectives set out during implementation. The monitoring component was not sufficiently considered in the Zimbabwe HRH strategic plan, while Sudan and Zimbabwe have set a series of monitoring indicators addressing the health services provision, the HRH equitable distribution and the performance efficiency and productivity [16-18]. Zambia, through its earlier experience, has shown that the vertical approach of the HRH monitoring has not been successful, opting for a monitoring system integrated in the general monitoring of the health system. These indicators are expected therefore, to be reported through the quarterly annual narrative and financial progress reports, facility-based performance assessments, technical Supportive Supervision reports and annual and midterm reviews. In Sudan, however, a monitoring and evaluation team for HRH will be formulated to address this task, reviewing health workforce indicators, collecting and analysing the data and preparing the annual reports. During the CCF rapid assessment and review of the implemented components of the HRH plans, it was evident that full scale monitoring activities were yet to be regularly carried out. However, some monitoring feedback was being received through the progress activity reports infrequently circulated during the HRH committee meetings, although in Sudan and Zambia, a set of specific M&E activities were prepared for implementation. However, the HRH committee members’ participation in direct monitoring was found to be weak. Accordingly, the ministries of health and the HRH committees need to pay the necessary attention to this important management tool, usually forming an integral component of the HRH health information system.

Fig 3: Monitoring and evaluation of the HRH strategic plan implementation
Figure 4 illustrates the monitoring and evaluation implementation landmarks, while executing the HRH strategic plans and pursuing the range of monitoring indicators prepared by the three assessed countries. In this regard, the capacity of the HRH committee members needs to be enhanced to actively engage in the HRH monitoring process, review the performance monitoring indicators and oversee the implementation of the solutions outlined and their effect on the outcome results of the plan.

5.9. Taking advantage of the evolving development landscape

Despite the presence of a level of HRH coordination in the countries prior to the launch of the CCF approach, these efforts fell short of building a wide range consensus among the different national and international stakeholders to substantively unite their efforts under a single HRH coordination platform of action. The CCF approach was launched when the HRH challenge was better defined and assumed a global attention and when the aid effectiveness principles gained wider recognition in the development landscape. Linking the CCF coordination agenda with defined structures, functions and expected outcomes has created an enabling environment for collective action and generated a vibrant partnership led by the national governments. Table 8 illustrates the pre-CCF status, the progress made through the CCF process and the factors that were imperatively necessary to be sustained.
Table 8: The CCF effectiveness added value: Reported pre-CCF country experience, the collective efforts made through the process and the imperatively necessary factors to sustain progress

<table>
<thead>
<tr>
<th>The Pre-CCF prevailed HRH challenges</th>
<th>Progress made through the CCF Process</th>
<th>Attributes of CCF process effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vertical programmatic focus attaining preferential donor support often resulted in fragmented HRH interventions in each country through geographically and programmatically tied competing incentive schemes with remuneration inequities across programmes and regions</td>
<td>Close partnerships were established between different stakeholders enabling greater dialogue and communication</td>
<td>Application of the Aid Effectiveness principles of ownership, harmonization, alignment, accountability and management for results with close monitoring and yearly performance reviews</td>
</tr>
<tr>
<td>HRH practices in vertical programmes have at times challenged the health sector’s envisaged priority and equity based development strategies and created discontent among health workers denied eligibility to the given incentives</td>
<td>Creation of a platform for joint HRH development planning with clear unity of purpose, direction and action</td>
<td>Producing the desired results in the context of the HRH development and performance framework</td>
</tr>
<tr>
<td>The lack of long-term financial sustainability of the HRH provisioned support through vertical programmes remained a major government concern</td>
<td>Generating greater efficiency by averting duplication, competition and operations overlap, while building synergies for greater effectiveness</td>
<td>Sustaining the coherence of HRH commitments by stakeholder organizations linked to horizontal health system strengthening support</td>
</tr>
<tr>
<td>Introduction of programme-driven skill shifts had challenging influence by conflicting with the HRH policies and were difficult to sustain or replicate on the long-term</td>
<td>Catalyzing strong partnerships and inducing positive effects on the health system performance</td>
<td>Maintaining the inclusiveness of the HRH coordination platform and allowing additional stakeholders to join</td>
</tr>
<tr>
<td>Application of discordant reporting and monitoring systems and benchmarks by the different vertical partners supported programmes complicated HRH performance assessments and unified routine reporting for evidence-based decision making</td>
<td>Managing to attain commitments from different partners allowing coherent division of roles, improving predictability of resource mobilization and offering opportunities to sustain HRH development interventions</td>
<td>Coordination of the monitoring activities coupled with unified reporting systems with consistent tracing indicators, timely information sharing and focus on consensus-building dialogue</td>
</tr>
<tr>
<td>Government ownership and coordinated leadership visibly weakened by HRH training and management activities driven by one or more development partners</td>
<td>Encouraging the government to implement key innovative HRH intervention through the forged technical and financial collaborative partnerships i.e. CHWs, bonding and retention incentive schemes, capacity building of educational institutions etc.</td>
<td>Assigning priority to resolve unjust and unfair health inequities and planning and implementing HRH interventions guaranteeing unimpeded access to essential health services</td>
</tr>
<tr>
<td>Lack of unified national multisectoral vision and mission for universal coverage and access to essential health care services</td>
<td>Creation of an intersectoral partnership through a consortium of national and international stakeholders sharing the interest of working together in the HRH domain</td>
<td>Maintaining the coordination platform, focusing on HRH broader strategies and outcomes with flexibility and adaptability to contextual realities</td>
</tr>
<tr>
<td>Lack of flexibility with funds as HRH support inputs are often tied to specific geographical areas or time limited programmatic interventions</td>
<td>A single shared HRH plan harmonizing partners’ support and encouraging on the transparent coordination of their contributions</td>
<td>Setting jointly negotiated medium and long-term HRH priorities with clear performance targets, transparently setting M&amp;E tools with adequate and predictable national and donor resources</td>
</tr>
</tbody>
</table>
5.10. The CCF added value

In the three countries covered by the CCF assessment process, the public health sector employs over 80% of the serving health workforce, which accounts for 50% or more of the recurrent health expenditures. However, the lack of collectively designed HRH targeted interventions has jeopardized national aspirations for universal access to essential care and made the attainment of MDGs highly improbable in the absence of an adequate health workforce at all levels alongside their effective deployment and equitable distribution. This chronic legacy has failed to generate the necessary human resource policies and interventions with appropriate budgetary outlays and predictable medium and long-term financing commitments by the national and international partners within the health sector. The introduction of the CCF approach has, however, in a short period of time, generated a chain of events ranging from strong government policy support for scaling up HR development, the creation of an inclusive task force to guide the planning and implementation of a national HRH reform process to the mobilization of additional resources for addressing the shortage of human resources and retaining the health professionals in the field. Through improved coordination and the single platform of the HRH task force, the domains of production, deployment, motivation and retention were jointly factored into the prioritized health system strengthening efforts in the countries. It is self-evident that this accelerated national effort for promoting HRH action was also instrumental in building an intersectoral support from a wide range of health stakeholders. The accomplished chain of milestones achieved by the all three countries and illustrated in figures 5, 6 and 7, can be principally attributed to the systematic interventions catalysed by the CCF approach, validating the significance of this approach and its ability to bring about the desired change. The figures outlined below illustrate how the CCF approach was able to catalyse the rapid chain of events and build a solid alliance on an action-oriented framework for human resource development.
Fig 4: The added value of the CCF Process Chain of Events in Sudan: One Coordination Platform and One HRH Plan

**SUDAN**
- Public Health Sector Employs over 80% of the serving health workforce in the country.
- Over 60% of the public health sector recurrent expenditures being spent on HRH.
- The 70% rural population of Sudan access only 30% of the health workforce.
- Through the CCF process support effort, government inducted 18,000 midlevel professional trainees in the upgraded national academy of health sciences and its affiliate state academies.
- The HRH-TF contributed to the Observatory growth while the latter provided venue & secretarial support to the HRH-TF.

**Desired Phase:**
- Health system performance optimized.
- Coverage & access notably advanced.
- Health outcomes improved.
- Resource predictability & supportive coordination.
- HRH development becoming integral part of health system strategic policy & strengthening.
- Monitoring & evaluation strengthened and ready for execution.
- Government leadership consolidated.
- Equity factored into employment & distribution.
- Training of CHWs launched.
- HRH retention support actions promoted.
- Efforts for all partners’ participation pursued.
- HRH Production scaled up:
  - Building training institutions at national & state level.
  - Continuous professional development activated.
  - HRH operational research introduced.
  - Linking with National Migration Board to assess trends.
- CHWs programme endorsed & introduced.
- Stakeholders mapped and roles defined.
- MOH role in training & licensing mid level professionals regulated.

**Pre-CCF:**
- HRH Observatory launched.
- Informal partnerships mobilized.
- First HRH census initiated.

**CCF Launch in 2010:**
- CCF launched: Sudan as Pathfinder.
- HRH Observatory efforts supported HRH Stakeholder Forum (HRH-TF) formalized.
- Members exposed to CCF process & principles & expanded.
- HRH Directorate at MOH upgraded.
- HRH profile completed and priority needs assessed.
Fig 5. The added value of the CCF Process Chain of Events in Zambia: One Coordination Platform and One HRH Plan

ZAMBIA

Public Health Sector employs over 80% of the serving health workforce in the country and 12% by Churches Health Association of Zambia

Over 50% of the public health sector recurrent expenditures being spent on HRH

The 71% rural population in Zambia accesses about 53% of the health workforce and only 24% of the medical doctors

Pre-CCF
- HRH Partnerships organized without official notifications
- Initiated Joint partners funding practices but faced challenges
- HRH shortages persisted despite evidence growth in national economy
- CHWs lacked with no verified structured training, no government remuneration and no supervision
- First HRH Plan Developed 2006-2010

CCF Launch 2011

CCF Launch
- CCF launched: Senior government exposed to the process
- HRH-TF formalized, partners notified and roles assigned
- HRH-TF members exposed to CCF process & principles
- HRH Directorate at MOH upgraded
- HRH profile completed and priority needs assessed
- First HRH Plan Developed 2006-2010

Desired Phase:
- HRH development assuming central role in health sector development
- Monitoring & evaluation strengthened and ready for execution
- Government leadership consolidated
- Efforts are being made to ease public sector recruitment freeze to address HRH shortage
- Training of CHWs launched with due political support
- Partners building cohesion & gaining confidence

HRH Strategic Plan Developed 2011-2015
- Plan costed
- HRH-TF become instrumental in strengthening coordination and consensus for problem solving
- Aide Memoir on Financial Management, Accounts and Procurement institutionalized

Fig 6. The added value of the CCF Process Chain of Events in Zimbabwe: One Coordination Platform and One HRH Plan

ZIMBABWE

Zimbabwe faced high HRH attrition with vacancy rate in 2009 for nurses & medical officers being 70% & 62% respectively but serious efforts were introduced to reverse the situation with substantive success

Public Health Sector employs over 80% of the serving health workforce in the country

Establishment of Health Services Board (HSB): A body exclusively created in 2002 to manage HRH outside the Public Service Commission to introduce HRH reforms independently from other public sector workers

Through the CCF process support, government endorsed the CHWs as an integral part of the health system with remunerated support

Pre-CCF
- No formally notified stakeholder Task Force operated
- The country came across severe HRH crisis that increased the HRH shortage in the country
- CHWs existed with no unified standard training, no government remuneration and no supervision

CCF Launch 2011

CCF Launch
- CCF launched: Senior government officers exposed to the process
- HRH-TF formalized, partners notified and roles assigned
- MOCW, HSB and HRH-TF working together mitigate the impact of public sector recruitment freeze to fulfill HRH needs of the health system

Desired Phase:
- HRH development assuming central role in health sector development but challenges abound
- Monitoring & evaluation strengthened and ready for execution
- Government leadership consolidated
- Training of CHWs being launched with due political support
- Doris support to health sector gaining momentum with priority support to HRH

HRH Strategic Plan Developed
- Plan costed
- HRH-TF become instrumental in strengthening coordination and enabled additional resource mobilization
- HRH-TF became a forum to address imminent challenges facing HRH such as retention issue

HRH contribution optimized:
- Health system performance optimized
- Coverage & access notably advanced
- Health outcomes (MDGs) improving
- Resource predictability & supportive coordination availed

HRH contribution optimized:
- Health system performance optimized
- Coverage & access notably advanced
- Health outcomes (MDGs) improving
- Resource predictability & supportive coordination availed

Rapid Assessment on the effectiveness of the Country Coordination and Facilitation (CCF) process in Sudan, Zimbabwe and Zambia
5.11. Challenges, lessons learned and recommendations

Despite the short experience in CCF implementation, the three countries were able to define the challenges faced and the lessons learned, based on which a set of relevant recommendations were outlined. The following is a summary relevant to the three countries, where country-specific experiences may become relevant to the other CCF implementing countries. The entire experience may also be of value to the counties aiming to introduce the CCF process to their health systems.

a) Challenges

The HRH challenges faced by the national health system are being addressed regularly at central, state and provincial levels of the national health system. However, this domain has also become a major task of the HRH committees that are required to analyse these problems and identify solutions enabling the delivery of best possible care to the population, especially the vulnerable and hard to reach. To effectively connect the HRH committee member organizations’ network to the HRH national cause and engage them with responsibility and accountability, both the internal CCF-specific and the general HRH challenges need to be addressed:

CCF-specific challenges

i. The HRH committees are often constrained by the lack of assigned dedicated secretarial support that can organize the committees’ meetings, manage and facilitate communications, prepare minutes, follow up deliberations, assist in the distribution of documents and maintain the financial records of HRH support contributions. Although these additional functions were being carried out laudably by the HRH directorates, they deserve the attention and support of all partners.

ii. The substantial CCF-led improvement in the national commitment and mobilized partner support is commendable, yet the cohesiveness of the HRH committees’ internal coordination has remained a challenge, because of the inherent unsettled conflicts of interests and the inability of some members to meet their accepted HRH obligations.

iii. Although the expansion of the HRH committees is currently being pursued by all three countries as a response to the inclusiveness of the HRH domain is a step in the right direction, it has raised the challenge of building the necessary cohesion and efficiency in the HRH platform and a demand to provide to all new members comprehensive and up-to-date information about the CCF approach to effectively contribute to the HRH reform process.

Existing HRH challenges being addressed

The following are some of the existing HRH challenges that are being addressed by the HRH committees in one or more of the three countries assessed:

i. The risks posed by the lack of resources predictability, with a possible premature phasing out of the support to health workforce retention mechanisms provided by the Global Fund could lead to a serious HRH crisis as in the case of Zimbabwe.

ii. The challenge of low production of health workforce is being faced by the three countries except for medical graduates in Sudan, impeding the effective delivery of primary health care services to the population.

iii. The mismatch between the limited number of officially sanctioned vacancies in the public health sector and the high demand for skilled health workforce is posing a hindrance to the health system and limiting the employment opportunities in the health sector.
iv. The weak retention capacities of the national health systems particularly with regard to the highly skilled professionals and specialists cadre is impacting negatively on the comprehensiveness and quality of health services delivery.

v. The high rate of health professionals’ outmigration, especially medical doctors and nurses, is draining the capacities of the health systems and annulling the relatively tangible investments aimed at enhancing the production of health workforce for the national health system.

vi. The highly understaffed primary health care network and the poor working conditions are accelerating migration from rural to urban areas and weakening the efforts being made for health equity with an adverse impact on the poor.

vii. Human resource management and leadership challenges were reported by the different HRH committee members related to limited focus on health outcomes, inapt leadership to resolve HRH problems, non-encouraging working environments and difficulties in performance measurement, deployment, compensations, and continuing professional education with negative impact on the HRH development process.

viii. Although the multisectoral nature of HRH development with its strong aspects of coordination and information sharing has taken shape through the formation of the HRH committees, the institutional culture both within health provider organizations and relevant line ministries still face the challenges of mobilizing clear accountabilities and capacities for effective participation.

b) Lessons learned

i. The CCF approach providing a real momentum for HRH development: The CCF process and the HRH committee coordination forum are powerful enabling forces bringing together a critical mass of stakeholders that provide opportunities for cross-fertilization through the exchange of knowledge and expertise for joint planning, coordinated support to the HRH strategic plan implementation and the shared managing for results-based action. Moreover, the multisectoral nature of HRH development and prospects for effective coordination of the HRH plan implementation will positively influence resource mobilization and encourage shared accountability for attaining the set performance health outcomes.

ii. Strong and committed HRH directorates provided the best support to CCF process: The committed and technically strong HRH directorates in the three assessed ministries of health have corroborated the criticality of this level of managerial leadership, and substantiated the need for strong and sustained HRH managerial capacities at all tiers in general and at the centre in particular. The three countries represent model examples through their HRH directorates’ leadership drive, a lesson of immense value.

iii. HRH information system is a powerful tool for HRH evidence-based decision making, advocacy and action: The CCF-supported process has created a legitimate demand for generating the necessary evidence to guide the processes of decision making on critical HRH domains such as the development of the HRH strategic plan, priority ranking of capacity building interventions, effectiveness of retention schemes and efficiency of the HRH innovative community-based interventions that improve access to essential health services. The HRH committee partners have also commissioned assessments and surveys on priority areas such as HRH profiles and situation analysis and on priority HRH management components that have facilitated the development of the HRH strategic plans strongly linking to national health strategies and policies.

iv. Building complementarity and synergy: The partners in the forum recognized the value of creating complementarities and synergies between the technical expertise and financing capacities they hold to avert duplication and ensure higher efficiency in resource utilization for better results. The complementarity has also generated the opportunity to collate and analyse HRH-related information from all sectors and partners through their engagement in the HRH coordination process.
v. **Government ownership and leadership in coordination legitimized:** The forum has generated greater recognition for the government’s legitimate leadership and ownership of the HRH development process, while the HRH committee has acknowledged the added value role of every national and international stakeholder partner.

vi. **Division of roles and responsibilities rewarding:** The partners established the shared understanding of assuming roles and responsibilities matching the comparative advantages of their organizations, consolidating their unity of purpose and improving the prospects for successful financing and implementation of the HRH strategic plans, while averting partners’ fragmentation with its inherent costs and inefficiencies.

vii. **Effective use of resources:** The HRH committees have successfully encouraged the establishment of systematic approaches for resource pooling or coordinating their effective utilization to support priority and critical HRH interventions, especially those targeting the underprivileged population groups through improved HRH deployment, capacity building and retention. The Health Transition Fund in Zimbabwe is a case in point to this regard.

viii. **Comprehensive incentive schemes impact better on health workforce motivation:** Financial incentives are essential but not sufficient unless complemented by other relevant benefits including the provision of accommodation, an enabling working environment (safety, infrastructure, supplies and equipment) with adequate opportunities for professional and career development, while fragmented non-harmonized retention schemes were found ineffective. The HRH full support and close follow up of the Zimbabwe fragile retention scheme and Sudan’s HRH committee catalysed national efforts for improving retention to corroborate the link of these processes to the CCF initiative.

ix. **Enhanced national commitment has positively influenced the predictability of donors’ support:** The CCF-driven HRH coordination mechanism has created a paradigm shift with enhanced national leadership support and commitment to HRH issues, catalysing the flow of more substantive and predictable development partners’ support, an experience witnessed in the three countries.

x. **The HRH committee intersectoral decision-making processes attained higher national attention:** The HRH committees have realized the value inherent in addressing the HRH intersectoral nature and acknowledged the need for cross-sectoral HRH focus through the HRH committees’ catalysed partnerships at national level.

xi. **Expanding HRH action potentials by enhancing the inclusiveness of HRH committees:** The pursued CCF principles of comprehensive participation and inclusive representation in the HRH committees have encouraged many stakeholders, especially the operationally less prominent to join the forum in all three countries for its greater potential for coherence and effectiveness. This shared platform provides unified HRH objectives and opportunities to eliminate duplication.

xii. **Improved transparency through the HRH committee forum enhanced partners’ collaboration:** The forum has enhanced the transparency among the participating organizations, which in turn raised the opportunity for consensus building, evidence-based decision making and a better joint planning, implementation and monitoring oversight.

xiii. **Health equity has become a shared target:** HRH committees have eagerly promoted the health equity dimension and succeeded in promoting and supporting interventions that contribute to this effect such as the support provided by the Alliance and WHO to the Academy of Health Sciences in Sudan,, the shared support to the Community Health Assistant programme in Zambia and the retention scheme in Zimbabwe.

xiv. **HRH committees have successfully encouraged governments to launch innovative interventions to improve access to care:** The HRH committee participating organizations have successfully tested solution models of innovative strategies such as community health workers and midwives cadre to enhance access to essential health services especially in the rural and underprivileged provinces and districts. The Zambia high level commitment to the Community Health Assistants’ programme fully supported by the HRH committee and the evident interest shown by the other two countries in launching these programmes, all supported by the Alliance, are clear examples of the utility of this coordination.
retention incentive scheme outlined above for attracting health workers to rural and hard-to-reach areas and the introduced bonding scheme are other innovative efforts that can strengthen the health system.

c) Recommendations

Country-specific recommendations

Sudan

i. **Enhance HRH committee inclusiveness:** Additional efforts are to be made through the CCF principles and process to attract civil society organizations and international health partners to actively participate in the stakeholders’ forum coordination to better align HRH resource inputs and avert duplication.

ii. **Harmonize HRH coordination committees at federal and state Level:** Consolidate the strategic and operational linkages between the central HRH committee parallel structures established at the state level to harmonize HRH development in the country.

iii. **Introduce comprehensive HRH costing:** Undertake a detailed and comprehensive costing exercise that encompasses the entire health workforce, using the RRT and/or OneHealth tool (HRH module) for detailed costing to enable the stipulation of the right strategic policies and accurate projection of the funding necessary for this vital component of the health system.

iv. **Introduce strategic policies that retain the newly graduated medical officers:** The mismatch between the tangible number of graduate medical officers every year and the limited attraction to deploy and retain them in the health system need to be carefully examined and combined efforts made to resolve this problem through national efforts both at central and state level.

Zambia

i. **Improve HRH investment predictability:** Strengthen the roles of the HRH committee member organization and ensure their active engagement in monitoring the HRH strategic plan and improve the predictability of resource mobilization efforts for its priority interventions to avert the experienced conditions of resource scarcities in the past.

ii. **Regulate the introduced bonding scheme:** Complement the establishment of the bonding scheme for those whose education was sponsored through public resources with a community services scheme for those who have self-sponsored their education as well as for those who had opportunities for in-service training, combined by an attractive retention scheme when deployed in the rural and remote hard-to-reach areas.

iii. **Encourage the private sector in HRH development:** Strengthen functions and roles of the regulatory system through the creation of national incentives for the private sector to engage in addressing the shortage of health workers through the advancement of HRH training programmes.

iv. **Improve public financial management and aid effectiveness:** Sustain national efforts aimed at improving transparency and public financial management to enhance the quality of public sector aid resources utilization efficiency through leadership, with scaled up implementation, monitoring and focus on the results framework with enhanced health partners’ collective compliance with aid effectiveness principles through better cooperation and partnership.
Zimbabwe

The government and the HRH-TF may lend critical considerations to the following as the prospective agenda for action:

i. **Improve government HRH management**: Review and improve government HRH management capacities and resource utilization and translate the HRH strategic plan into an operational plan for effective financing and monitoring support.

ii. **Harmonize implementation with non-public sector care providers**: Coordinate and harmonize the implementation of the HRH plan with the Ministry of Finance and international partners to enhance resource contributions and generate greater efficiency in service coverage and access.

iii. **Engage HRH committee in monitoring the Plan**: Actively engage the HRH committee in monitoring and evaluation to improve the process oversight and its resultant outcomes and organize reviews to assess the HRH implementation plan, the collective progress attained and outstanding health challenges yet to be resolved.

iv. **Strengthen the HRH secretariat**: Strengthen the technical and organizational capacities of the HRH-TF secretariat to provide the necessary support to the national HRH directorate that ably leads the HRH committee partners’ coordination.

v. **Ensure retention scheme funding**: The government has to make a serious effort to compensate a tangible part of the potential financial loss threatening the national HRH retention scheme and encourage partners to enhance their contributions by linking these interventions with the workforce performance outputs and outcomes at the operational level.

### 5.12. General recommendations

The HRH process of coordination and its established technical working groups, known by different names in different countries and globally referred to as the “Country Coordination and Facilitation” process, has established a strong base for addressing the shortages and geographically skewed distributions of the national health workforce. The different CCF initiatives and interventions coordinated by the HRH committees provide a strong foundation to further strengthen this forged cooperation and sustain the investment in HRH capacity building. The following recommendations are being presented for consideration and action:

i. **Update stakeholder analysis**: Consolidate the CCF process by periodically reviewing and updating the stakeholder analysis in relation to the progress of their engagement, recognizing the success of their contributions, improve the roles and responsibilities they have to assume through the development of clear ToRs and SOPs, encouraging honest and open communication to promote the relevant negotiation skills and implement mutually acceptable solutions to the prevailing HRH challenges.

ii. **Harmonize HRH plans with national health plans**: Further harmonize HRH plans with national health plans and policies to improve the synergy in implementation and indicate its clear linkages with the programmatic intervention of the public health sector and other for-profit and not-for-profit care providers.

iii. **Improve the health information system**: Generate the necessary HRH information data from all related sectors and create or consolidate the HRH Observatory to sustainably produce a sufficient HRH knowledge base that guides policy decisions and management of human resource development.

iv. **Translate the HRH strategic plans into operational plans**: This exercise facilitates the processes of effective financing and monitoring and ensures government and development partners’ successful collaboration with an emphasis on government leadership, alignment with the HRH
strategic plans, harmonization, shared accountability and management for results as functions of aid effectiveness.

v. **Improve HRH public financial management:** Sustain national efforts aimed at improving the HRH public financial management to enhance transparency, trust and quality, as well as the utilization efficiency of earmarked public sector inputs and aid grants through improved leadership and scaled up partnerships, focused on the projected result frameworks.

vi. **Enhance national coordination capacities:** Enhance the management capacity of the senior and midlevel professionals operating at the HRH directorates to create the required technical and leadership capabilities, enabling the government to provide meaningful support to HRH coordination, build partnerships and advance the HRH contribution to the national health system.

vii. **Develop multi-pronged retention strategies:** Extend the action response to the HRH shortage by not limiting the solution to the sole strategy of increasing the number of training institutions or enhancing the recruitment in the health system, but supplementing these by effective and sustainable retention schemes and addressing the diverse needs of the health workforce including effective retention schemes, skill mix and task shifting as necessary, the creation of a supportive working environment, recognition and professional and career development.

viii. **Increase the national support for the community Health Worker programmes:** Provide institutional support to the introduced innovative strategies of CHWs and the fast track midwifery training programmes to partly address the chronic health workforce distribution inequity in the rural and hard-to-reach areas with task shifting potentials, as HRH shortages constrain access to essential health services, especially in countries hardest hit by the HIV/AIDS epidemic.

ix. **Implement close oversight on HRH migration:** Establish a national level support for creating migration inventory and assessment desks in the HRH directorates that can regularly report on national human resource outmigration to explore solutions to compensate the evolving shortage and identify strategies to strengthen health workforce retention as per the WHO Global Code of Practice on the International Recruitment of Health Personnel, while ensuring the support of the Alliance and WHO for these efforts and for promoting the global compliance with its guiding principles.

x. **Monitoring HRH plan implementation:** Improve the monitoring of critical components of the HRH strategic plan, such as recruitment and retention especially in rural settings and remote facilities and combine financial remunerations with non-financial effective incentives. This can be complemented with developing each country-specific monitoring framework.

xi. **Sustain the catalytic support of the Alliance:** Maintain the Alliance’s support to CCF processes, to preserve the successful human resource gains and scale up the government-led commitment and stakeholder engagement and oversight to strengthen their pursuit of implementing the set strategic plans. The latter could be attained by organizing national CCF/HRH progress review meetings, support to critical country-specific challenging areas of the CCF process and by organizing inter-country meetings attended by national and stakeholder partners to enable countries to learn from each other’s experience. The Alliance’s support will also accelerate country actions in terms of advocacy, filling operational gaps identified in the CCF processes, encouraging CCF committee membership inclusiveness and participation, pursuing active and predictable resource mobilization and conducting national HRH conferences engaging all stakeholders.

xii. **Introduce HRH strategic plan standard costing tools:** The OneHealth tool for planning and costing HRH strategic plans that was developed by a UN interagency working group on costing will provide countries with the opportunity to prepare standardized costing, follow up reviews and accountability.
5.13. Conclusion

In the three country assessments, the coordination of health workforce development efforts were found to be critical to the effectiveness of the delivery of essential health care services and a major challenge that has constrained the deliberation of coherent policies prior to the launch of the CCF approach. The CCF coordination mechanism has brought together, under the leadership of the government, all the sectors and development partners who could influence and contribute to HRH development. The established HRH committees have soon gained significance and attracted a wider partnership of national and international stakeholders able to develop a range of activities spearheaded by the national HRH strategic plans of each participating country. The solutions envisaged for the management of human resource training, production, migration and retention challenges in the three countries, are currently being integrated into the on-going human resource development efforts. These efforts need to be sustained in the long-term to significantly impact on health systems strengthening through the expansion of primary health care services to the rural areas and other underserved geographical localities.

The assessment outlined the workforce challenges being faced by the health sectors of these countries, and the myriad of health workforce shortages and other complexities related to production and training, deployment, retention and migration. However, each country also had its specific workforce issues and problems for which specific solutions were required. Through the CCF rapid assessment review process, key lessons were extracted from the case studies of the three countries. These lessons corroborated the HRH committee’s role as a powerful instrument capable of bringing together a critical mass of national and international stakeholders under a strong single coordination platform in support of HRH development. The importance of the Human Resource Information System was further substantiated through its quality-updated information indispensable for effective and evidence-based decision making. The latter paves the way for the application of aid effectiveness principles with improved public management systems that contribute to HRH development. The CCF approach has undeniably created multi-sectoral platforms, uniquely providing the opportunity for an open dialogue among stakeholders and promoting consensus, commitment and cooperation on key HRH priorities for mutual support and action. The HRH coordination added value gains hence need to be sustained.
6. ANNEXES: CASE STUDIES
6.1. Sudan case study

i. Background and introduction: Health system brief overview

Sudan is a country endowed with rich and vast agricultural and water resources of the River Nile and a wealth of livestock and mineral resources including oil. Although the country has been confronted by complex challenges, it has been seriously pursuing the attainment of its MDGs. The decades-long conflict in the South has ended with the signed peace agreement that has led to the referendum and separation of the South Sudan region on July 2011. The country has a vibrant health sector addressing a range of human resource challenges especially in its rural settings [24]. Accordingly, human resource planning and development has become a major component of the health system strengthening efforts in Sudan, where the availability and capacity of the health workforce is known to play a major role in the attainment of the MDGs [25, 26]. The national decentralization policy has generated greater demand for increasing the access of the rural population to essential primary and secondary care services. The imperative pathway of partnership building has therefore become a reality, requiring the active engagement of a number of stakeholders in the training, recruitment, deployment and retention of medical doctors, nurses, midwives and other allied health professionals [27]. Although the production of medical graduates is substantive in Sudan, the health system is unable to employ the required numbers and deploy them successfully to the rural areas. On the other hand, the shortage of nurses and midwives is exacerbating in the underserved rural areas in view of the limited opportunity for task shifting, encumbering an added burden on an already fragile health care system. To improve the performance of the health system and address these key challenges, the country responded to the call of the Alliance for partnership and coordination.

The introduced Country Coordination and Facilitation process has enabled the Federal Ministry of Health (FMoH) to mobilize the different stakeholders that directly address one or more aspects of human resource development, including academic institutions and professional associations in addition to the ministries of higher education, labour and finance as well as the international partners for their relevant role to the development of this vital component of the health system. Through this paradigm, the MoH has recognized the HRD as a national priority with commitment to strengthen the HRH division at federal and state level ministries of health [28, 29, 30]. The human resource development and management functions that were designated in the ministry’s organizational structure in a small unit of personnel management was upgraded to a full-fledged Directorate General. The comprehensive and key functions assigned to the newly established directorate include the preparation of HRH policies and strategic plans, annual plans of action, developing, coordinating and managing the HRH information system database, and enhancing the national and state level institutional capacity in human resource management. The HRH directorate has also been assigned to build partnerships and collaborative efforts between national institutions and international partners and reform the health training institutions affiliated with the health sector to improve training and scaling up of the performance of the health system once these health workers are recruited and deployed effectively. The Directorate General performs its prescribed functions through four directorates of HRH including policy and planning, training, human resource management systems and decentralization support. The HRH directorate has in its orientation endorsed the health action framework giving prominence to HR strategic policy, financing, education, partnership, leadership and HRH management systems. To address these priorities, the federal and state ministries of health have evolved the shared vision of operating from a common platform in their commitment to working closely with other sectors and collaborating with a range of development partners assisting the health sector through a
coordination process led by the government. To attain the necessary technical support for a robust HRH coordination process, the MoH has welcomed the Alliance-launched Country Coordination and Facilitation initiative that brings together the key stakeholders working for the development and management of HRH at country level. The partnership established with the Alliance has generated a successful pathway in HRH coordination and led to the implementation of a range of technical catalytic support interventions [31, 32, 33].

The public sector health services system network in Sudan that employs over 80% of the HRH is a federal and states-managed structure. At the top of the pyramid the country has the teaching, general and specialist hospitals with tertiary referral support capacities employing a large number of the health workforce. This level is complemented by a large number of rural hospitals that provide a secondary referral support that absorbs a tangible number of health professionals as these hospitals have a nominal capacity to operate medical, surgical, paediatric and gynaecology and obstetrics with a backup of basic laboratory and x-ray facilities indicating the demand for sufficient numbers of qualified resources. The third level consists of urban and rural health centres, dispensaries and dressing stations, while at the grass root level the deployment of community health workers is being launched. Moreover, the private health sector is growing rapidly and is predominantly concentrated in urban areas.

ii. Profile of the health workforce

The health system performance and health indicators in Sudan are regarded to be poor with figures lagging behind the benchmarks of the Millennium Development Goals (MDGs) and the health care is generally underfinanced [19,24,25]. Public per capita health care spending is in the order of US$ 13 according to 2006 figures. The total health care expenditure as percent of Gross Domestic Product (GDP) is estimated to be 4.5% in 2006 of which only 1.5% is public. Although the health care budget has been increased considerably over the last 5 years due to oil, the general spending on health as percent of total government spending is still low at 5.1% [15, 25, 26].

Sudan has been one of the pioneer African countries in advancing education in general and health professionals training in particular. The health workforce stock in the country has approached 100,000, consisting of 20 different medical and health science professional cadres of which 51% are females [19, 28]. The majority of the health workers are employed by the public sector and only 9% work exclusively in the private sector, although dual practice in both private and public institutions is very common. The pre-service training and production of health workers in 145 medical schools and health training institutes affiliated to different universities comes under the jurisdiction of the Ministry of Higher Education. Moreover, the Sudan Medical Council is entrusted with registration and licensing of doctors, pharmacists and dentists, while the Council for Allied Health Professions is dealing with the rest of the health workforce. The country is experiencing an aggravating skill mix mismatch in which the ratio between doctors and nurses was 1:1.7 in 2006. However, when considering the current pre-service induction rates, the ratio has deteriorated further with a turn round of 6:1, resulting in doctors to nurses’ ratio, while among those in service during 2010 the ratio was 4:1 reflecting the preceding mismatch of doctors and nurses’ production rates in the country.

The cumulative density of medical doctors, nurses and midwives were estimated at 1.23 per 1000 population, illustrating the critical shortage when compared with the WHO threshold of having not less than 2.3 health care professionals per 1000 population in order to achieve at least 80% coverage of essential health services [16,19]. The administrative and support staff however was consistent with their desirable 25% ratio of the health workforce. The
out-migration of health professionals in Sudan constitutes a major challenge that has affected 60% of the doctors and 25% of the pharmacists in the country. Moreover, the inequitable distribution is also reflected by the fact that close to 70% of the health workforce is serving the 30% urban population of Sudan, the situation being more dismal with regard to the specialist cadre. At the production level the country has 41 medical and dental colleges, 12 pharmacy schools and over 50 nursing and midwifery training institutions and the numbers are growing fast. The above noted shortage is confronted by the commitment of the national government to ensure the right skill mix staffing of the basic health units assigned for every 5,000 population, the health centers debuted for every 20,000 population in rural area and 50,000 in urban area and the provision of one rural hospital for every 150,000-250,000 population within the next 15 years [16, 19, 26]. The health workforce is expected to sustain the desired level of performance in this huge health system network. To address these prevailing HRH challenges, the established HRH Directorate General has through its directorates and subordinate units availed the strong WHO technical support and the Alliance assistance in launching the country coordination and facilitation process easily customized to the unique country needs and its contextual operation realities, that would improve the performance quality of the health workforce and produce the desired outcomes from the health system [34, 35].

iii. The HRH committee: The stakeholders forum

At the outset of the CCF initiative Sudan was declared a ‘pathfinder’ country, taking a lead role in devising and testing different approaches to health workforce development. The CCF process has hence reactivated the HRH coordination process and created a momentum where the MoH has availed the supportive partnership of a powerful forum that has facilitated a range of programmes and activities having considerably strengthened the development process of this vital component of the health system. Through this initiative the GHWA technical and modest resource inputs have led to the development of HRH departments particularly at the state level, scaled up HRH information system with focus on the observatory, extended support to HRH policy and managerial capacities, facilitated the establishment of the HRH Stakeholders Forum, assuming the role of the HRH committee to bring together national and international development partners to work in unison and harness all the available potentials in the country, promoting coherent human resource development action, supported HRH rapid survey to generate the additional data required for the preparation of the HRH strategic plan and contributed to its development, supported health professional education institutions to bridge the prevailing shortage of critical health workforce and contributed to the development of community health worker cadre for the rural and hard to reach areas of the country. To scale up the human resource development in the country the coordination of the national and international stakeholders was considered central to the CCF approach.

The HRH committee envisaged by the CCF approach has been legitimized in Sudan through the Stakeholders’ Forum (SF) that convenes all the key national institutions that address one or more aspects of the HRH development [28, 30]. The National HRH Observatory (NHRHO) acts as a technical secretariat for the SF facilitating its meetings and reporting on its decisions that affect the forum’s work. The SF draws its membership from the ambit of public sector ministries, academic institutions and professional associations relevant to the different health workforce categories (fig). Each of these institutions addresses and manages one or more HRH domains. The federal and state ministries of health employ more than 80% of the serving health workforce, which accounts for more than 60% of the recurrent expenditures of the public health sector. The SF has endorsed the CCF guiding principles deliberated by the Alliance with the role of coordinating the HRH development process, supporting the development of the national HRH profile, facilitating the development of a
comprehensive and costed national HRH strategic planning, implementation monitoring, assisting in resource mobilization and supporting the HRH observatory as a major hub for HRH information and a credible source for generating evidence for sound decision making [36, 37]. The SF has also contributed to HRH policy and strategic planning, human resource training, deployment and retention. The forum also performs the role of the board of the observatory on HRH supporting and guiding its critical functions and affiliated HRH development processes as well as its role of overseeing HRH surveys, data analysis and identifying gaps in the generated data or in strengthening the HRH response interventions. The forum has grown from a small number of members to a much larger partnership through the catalytic role played by the CCF process. The following outline illustrates the members of the SF of Sudan with briefly delineated roles and responsibilities.

<table>
<thead>
<tr>
<th>The Stakeholder</th>
<th>Roles and Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Federal Ministry of Health</td>
<td>Employing and managing the health workforce</td>
</tr>
<tr>
<td>2. State Level Ministries of Health</td>
<td>Managing the health workforce operating under the payroll of the state ministries</td>
</tr>
<tr>
<td>3. Ministry of Human Resources Development</td>
<td>Addressing the strategic policies of the National HRH development including training and improvement of HRH professional capacities</td>
</tr>
<tr>
<td>4. Ministry of Higher Education (MoHE)</td>
<td>Governing higher education including medical, dental and pharmaceutical professional training with direct role on policies on production of HRH, licensing, monitoring and supervision of medical and affiliated health training institutions and faculty development</td>
</tr>
<tr>
<td>5. Ministry of Labour (MoL) along with the Chamber of Civil Service (CCS) and National Council for Training (NCT)</td>
<td>Responsible for employment and for the general terms and condition of service for health staff, salary structure and promotion of the health workers executed through a coordinated mechanism</td>
</tr>
<tr>
<td>6. Ministry of Finance (MoF)</td>
<td>Responsible for the provision of salaries for public sector staff, regulating the range of incentives for health staff and funding the allowances and incentive packages for staff placement</td>
</tr>
<tr>
<td>7. Sudan Medical Council (SMC):</td>
<td>Having the tasks of licensing and registration of physicians, dentists and pharmacists, accreditation of medical, dental and pharmacy schools and ensuring safety of practice by doctors and dealing with related public complaints</td>
</tr>
<tr>
<td>8. Council for Allied Health Professions (CAHP):</td>
<td>In-charge of licensing and registration of nurses, technicians and paramedical staff</td>
</tr>
<tr>
<td>9. Sudan Medical Specialization Board (SMSB):</td>
<td>In-charge of postgraduate training of doctors, dentists and pharmacists and for the CPD for medical doctors</td>
</tr>
<tr>
<td>10. Army Medical Corps (AMC)</td>
<td>Managing the health workforce employed by the Army Forces and Planning, distribution, management and training of affiliated staff</td>
</tr>
<tr>
<td>11. Police Health Services</td>
<td>In-charge of the HRH employed by the Police forces with regard to planning, distribution, management, and training to the affiliated medical and other health care professionals</td>
</tr>
<tr>
<td>12. Health Insurance Fund:</td>
<td>Managing the health staff insurance and the health staff employed by the insurance fund</td>
</tr>
<tr>
<td>13. Sudan Doctors Union (SDU):</td>
<td>Organizing opportunities for doctors’ professional development through conferences and other continuing education avenues and providing support to doctors in general services as necessary</td>
</tr>
<tr>
<td>14. Sudan Health and Social Professions Trade Union (SHSPTU):</td>
<td>Engaging in areas related to condition of services and trade union activities for all health workers with focus on nursing and paramedics</td>
</tr>
<tr>
<td>15. Sudanese Technicians Association (STA)</td>
<td>Supporting the professional development of technical staff with oversight of their condition of work and scope of practice</td>
</tr>
<tr>
<td>16. Private sector represented by private academic teaching institutions:</td>
<td>Engaged in the production of HRH basic pre-service and postgraduate training, employment and management of staff including the services of the public sector staff working on part-time basis in private care facilities</td>
</tr>
<tr>
<td>17. Sudan Centre for Migration:</td>
<td>Overseeing the interest of the migrated health workforce</td>
</tr>
<tr>
<td>18. WHO</td>
<td>Providing technical support to the HRH directorate and supporting the coordination process for HRH development and for consolidating the partnership</td>
</tr>
<tr>
<td>19. UNFPA:</td>
<td>Providing technical support with special focus on reproductive health services and related interventions</td>
</tr>
</tbody>
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iv. Developing the HRH strategic plan
The national HRH strategic plan in Sudan has aimed to define the operational pathways to be implemented at all levels of the health system through a comprehensive approach taking into account all the relevant attributes outlined by the CCF process. Following the completion of the HRH situation analysis and profile, a participatory strategic planning process was established where, under the leadership of the MoH represented by the HRH Directorate and the active and close participation of the Stakeholder Forum partners, cycles of drafting, redrafting and review consultations were organized to ensure the quality of the product and build the required consensus. The high national health policy makers were regularly engaged to build ownership and provide support for resource mobilization and implementation. In view of the magnitude of the challenges, the HRH plan focused on defined priorities for which strategic goals and objectives were set and the necessary policy framework outlined. The plan focused on issues related to HRH planning, production, distribution and management systems. It has also aimed to produce the required result outcomes through improved performance and scaled-up training of the different cadres of the health workforce. Moreover, the strategic plan provides the basis for resource mobilization on key priority issues. The document also generates a shared accountability for its implementation by the member organization represented in the stakeholders’ forum. Following its completion, the plan was presented to the national health sector coordination council, headed by the President of Sudan with the Minister for Finance and National Economy as a member providing the required political support for its implementation. The WHO country office has also mainstreamed the HRH strategic objectives in its forthcoming biennial country joint programme. Similarly, negotiations are underway to ensure the alignment of the health partner organizations to join the stakeholder forum and support the HRH priorities stipulated by the plan. The following is an outline of the five set objectives that attained the consensus and support of the government and the HRH Stakeholder Forum partners:

Box 2: The objectives set for the HRH strategic plan in Sudan

1. **Support health service needs through adequate HRH planning envisaging accurate information system for long-term projections:** developing 10-year workforce plan, strengthening planning and data analysis systems, improving access to data (HRH observatory) and strengthening and supporting HR committee of the National Coordinating Council for Health

2. **Equitable geographical distribution of health workforce especially doctors and nurses with relevant incentive packages:** conducting situation analysis of the health workforce distribution in Sudan, developing effective Deployment policy and guidelines, developing appropriate and flexible incentive packages (financial and non-financial), advocating for placement of new training institutes in rural areas and developing a female-friendly policy for jobs in the underserved areas

3. **Improve individual performance management systems through performance based rewards and Developing systems for reducing staff absenteeism:** increasing application of effective job descriptions, developing a system for performance-based rewards and sanctions and developing revalidation system and assessment of health workers

4. **Improved production and orientation of education and training towards health service needs through quality pre-service training and continuing professional development:** adequate capacity for pre-service training, increasing output and quality of the CPD system, and increasing its access to non-medical and public health cadres, expanding geographic access to CPD and ensuring adequate capacity for Postgraduate education and professional training

5. **Strengthen HR functions at the decentralized levels with effective organizational structures and retention strategies:** developing terms of reference and appropriate organizational structure (OS) for all HRH functions, developing job description and proper person specifications for HRH functions, developing appropriate strategies to attract and retain the HRH staff, recruitment and transference of HRH staff, provision of Training for HRH staff, developing and strengthening appropriate HRH systems, enforcement and advocacy for the HRH policies, guidelines and standards, developing good links on HRH between federal and state levels and enforcement and building-up the Leadership capacity at the decentralized levels
v. Costing of the HRH strategic plan

The comprehensive costing of the plan is a fundamental step of its future implementation. It also provides the means to harmonize the funding with the costing approaches of the Ministry of Health. In Sudan it was estimated that the implementation of the HRH strategic plan will cost US$ 1,690,000 in its current projected funding scenario. From this budgetary outlay, allocations were made for each of its five strategic objectives to allow the prioritization of interventions as per the cost-effectiveness of their intervention activities. The figures 8 and 9 illustrate the cost estimate of each strategic objective specified earlier in box 2 and the allocations made for each year respectively.

Fig 5: Cost estimates of the HRH strategic plan of Sudan 2011-2016 by objective

![Cost estimates of the HRH strategic plan of Sudan 2011-2016 by objective](image)

Fig 6: Cost estimates of the HRH strategic plan of Sudan 2011-2016 by year

![Cost estimates of the HRH strategic plan of Sudan 2011-2016 by year](image)

vi. Strengthened HRH interventions under the CCF principles and process
a) The National Human Resources for Health Observatory, Sudan

Strategic and relevant health workforce information is fundamental for setting HRH strategic policies and plans. However, in Sudan, although intensive efforts were made to generate HRH information, the country lacked the relevant technical capacities and tools necessary to comprehensively generate and analyse the necessary data or to translate the limited available information into sound decision making processes and actions. To build national capacity and maintain and share the required knowledge about the HRH information in the country, a National HRH Observatory (NHRHO) was established in 2007 through WHO/GWHA support complemented by the efforts of a committed national management team raising it to a satisfactory level of operational capacity. The observatory is a network based on the participation and functional oversight of different stakeholders related to HRH development. The observatory is managed through the SF as the board headed by the Undersecretary for Health. In its operations, the observatory has led a national HRH public sector census survey aiming to produce the necessary evidence to improve HRH management and planning. It has also contributed to HRH institutional development through a strong liaison with the HRH stakeholders’ forum, generated opportunities to carry out comparisons and trend analyses about the health workers’ performance in the health system and their contribution to the population’s health. Realizing the importance and potential capacities of this institution, the Alliance assisted the observatory through a series of enabling capacity-building efforts and its strengthening transcending across all three components of the observatory: the HRH database, the HRH knowledge communication and coordination and the HRH issues related health systems research. The SF has also an oversight role on the observatory ensuring the quality of its performance and contribution to HRH strategic and policy deliberations. A database Technical Standing Committee (TSC) was formed whose members were drawn from the information technology units of the HRH stakeholder partner institutions. These professionals were trained on a web linked database system network and on generating the required HRH digital information. The TSC has the function to provide guidance and improve the regular flow of HRH data and resolve the encountered IT problems at the centre and at the levels of participating organizations including the HRH satellite information centres at the state level. The NHRHO has played a major catalytic role in preparing and endorsing the national HRH strategic plan for the country as a vibrant technical resource of the HRH Directorate General of the Federal Ministry of Health.

b) The Academy of Health Sciences: Catalyzing the building of a network of training institutions

The need for scaling up the production of human resources is reflected by the severe shortage of nurses and midwives and other allied health professionals. The existing medical institutions produce approximately 3,000 medical graduates per year compared to 450 nurses with a ratio of less than 6/1, while the requirement for nurses is estimated at about 8,000 per year. Similarly, with regard to midwives, Sudan has about 11,000 while 31,000 are needed in the next seven years. As for allied health workers, the present number is estimated at 6,000 only while the need is 26,000. To bridge these massive gaps, and accelerate the production of these essential health workers, Sudan has established an Academy of Health Sciences in the capital Khartoum and created similar institutions in 15 states. The headquarters of the academy in Khartoum is responsible to formulate policies, HRH strategy, and prepare operational guidelines, curricula and set standards and oversee the quality of teaching and learning. The AHS has also the responsibility to guide the operational research in human resource development to steer HRH policy analysis and advocate and lobby for introducing the relevant regulatory changes, improve intersectoral
coordination and mobilize technical and institutional development support to its state branches.

The national AHS is headed by a President supported by an administrative board consisting of academic and legal advisory council and a vice president. The state branches, each headed by a dean, are coordinated by an institutionally based state coordination council. The academy was upgraded to a degree awarding institution through a joint agreement signed between the Federal Ministry of Health (MoH) and the Federal Ministry of Higher Education, upgrading the education of nursing, paramedical and allied health staff to diploma and B.Sc. degree level studies. A unified tool was developed to map these institutions, in which the compiled report is aimed to guide the structural and academic development of the AHS affiliated training institutions. The stipulated plan will then be shared with the federal and state ministries of health and with the stakeholders’ forum at the federal level and its counterpart coordination forum at the state level for support and implementation.

Sudan established the Academy of Health Sciences (AHS) in 2005 with its headquarters in the capital, Khartoum for scaling up the production of nurses, midwives and allied health professionals. Later, the country established its affiliated branches in 15 states (5 branches before and 10 after 2009). Along with WHO, the Alliance through the CCF process contributed in their strengthening. The annual enrolment capacity of the AHS has increased from 2,000 in 2005 to about 5,000 in 2011. This has made it possible to enrol over 18,000 candidates in 14 disciplines, including nurses (80%), midwives, assistant dentists, medical assistants, immunization technicians, laboratory technicians, radiology technicians, anaesthesia technicians, operation theatre technicians, assistant pharmacist, assistant ophthalmologist, opticians, and physiotherapists etc. [30]. This initiative will partially rectify the shortage and inequitable distribution of these health workforce categories, as 70% of the population of Sudan that live in the rural areas currently access the health services provided by only 30% of the health workforce. The Alliance support complemented with WHO technical support created a critical mass of interventions that have facilitated a range of activities offering opportunities for institutional development in the field of human resource training. To promote a sustained technical partnership for institutional and faculty capacity development for the network of AHSs, an agreement was signed between the AHS and the Nuffield Centre for International Health and Development, Leeds University on an agreed road map for partnership. This has resulted in the organization of faculty training workshops in Khartoum attended by the different AHSs, addressing the major limitation of qualified tutors to many of these institutions. The organized training through this partnership has included courses on human resources policy and planning, human resources management and development in addition to other academic training and institutional capacity building efforts. Through this initiative WHO and the Alliance have extended support to the AHS library offering the relevant academic and reference books, thus addressing the real shortage of the necessary literature knowledge base that these institutions and their faculty require. Skill labs and basic structural and equipment support were also provided to create a better educational environment, improve students’ competencies and facilitate the learning process. To sustain this effort the national and state ministries of health and development partners have to maintain the minimum necessary levels of investment. There is indeed a real opportunity that the employment of these qualified, capable and motivated professionals by the health system will improve performance. However, this legitimate aspiration will only thrive with the implementation of relevant and effective multifaceted retention strategies and actions.
c) Continuing Professional Development Centre

The scarcity of in-service training programmes in the public sector has led to the establishment of the Continuing Professional Development (CPD) Centre with the aim of enhancing and sustaining the knowledge and skills of health professionals. A special focus was directed through this initiative to enhance the capacity of the tutors of the existing and newly established health professional training institutions providing an impetus to the wider CCF-supported HRH interventions. Through the efforts of the HRH general Directorate, the CPD programme was able to train more than 15,000 health care providers of different categories during the past five years, ending a period when the overwhelming majority did not receive any CPD training for many years. The CPD legislation effort pioneered by the Federal Ministry of Health and the Sudan Medical Council was a step in the right direction. However, this legislation was confined to the medical professionals alone and did not cover the other categories of the health workforce, making it imperative to link the scaling up of the CPD with a mandated opportunity for the health workers to access this systematic training. The latter is being facilitated by the six regional CPD centres that were subsequently established. The CPD training programmes promoted by the centre include advanced life support on obstetrics, advanced trauma life support, basic surgical skills, basic life support, neonatal resuscitation programme courses, new-born care and infection control, basic nursing skills, simplified life support, water supply and sanitation in emergencies, disaster management, medical waste, food hygiene safety, environmental health impact assessment, methods of vector control, epidemiological surveillance of communicable diseases and strategic planning.

d) The public Health Institute for training of public health managers

The limited number of trained public health professionals in health planning and management motivated Sudan’s Ministry of Health to respond to the necessity of developing a public health cadre that is equipped with the relevant management skills and with a widely applicable capacity in solving the immense leadership and managerial challenges facing the health sector in the country. On this realization, the Public Health Institute (PHI) was established under the domain of MoH and its directorate of HRH development. The Sudan Medical Specialization Board has recognized the PHI to train students registered by the board as community health registrars. In the current year, twenty such registrars are receiving training at PHI who will be amply exposed to the health system development in Sudan and to the management of its human resources. The PHI has signed a memorandum of understanding with University of Leeds, jointly agreeing on a detailed project proposal that envisages the establishing of Masters in Hospital Management, and on Health Management, Planning and Policy courses to be carried in PHI. This initiative constitutes a major step in HRH development with a potential to improve the performance of the health system, hence the need for sustained SF support. On the other hand, the MoH and the HRH SF need to engage in a dialogue with the Ministry of Higher Education to revise the curricula of the five public health training institutions affiliated with the universities and reform the teaching of health system, leadership and management capacities to match these with the real needs of the national health care system. The government and development partners have to realize the high cost attached to public health training abroad and the cost-effectiveness of in-country training programmes and the opportunities this investment generates for a wider-range of the health workforce.

Moreover, the CCF approach has been instrumental in building a coordination culture that enhances partnerships, upgrades HRH management structures at the MoH level, mobilizes high political support and adopts a multi-stakeholder approach in HRH strategic policies, plans and monitoring of implementation. The CCF approach has also been influential in
accelerating the number, capacity and networking of HRH teaching institutions, scaling up the utilization of partners’ technical support, building linkages with international centres of excellence, making HRH operational research coordination, an integral component of the programme and realizing the decentralization of health workers’ training institutions by linking induction with geographical quotas.

The centrality and the catalytic role of the observatory to the HRH information system and to the realization of the Stakeholder forum/HRH Committee’ value added in the coordination of the nation-wide HRH interventions, has been a unique characteristic of the CCF development process in Sudan as reflected in figure 10.

Fig 7: The Critical Role of the Stakeholders Forum and National Observatory as the Action platform for HRH Development in Sudan

AHS= Academy of Health Sciences, PHI= Public Health Institute, CPD= Continuing Professional Development

e) HRH operational and implementation research

To address the HRH operational and implementation challenges an action-oriented research unit was established as an integral part of the observatory network and liaising with the SF. The unit has developed a nationally tailored standard methodological framework to assess the allied health professionals’ training institutions and other HRH challenges and guide their development in the established decentralized context of Sudan. The unit is staffed by young and energetic public health professionals requiring the necessary encouragement and support to work closely with the operational and HRH strategic and programmatic interventions and extend this capacity to the state health professional teaching institutions. Three HRH research priorities were identified, namely the gender dimensions, the challenge surrounding migration and the high turnover and poor retention of health workers.
Considering the decentralized political structure of Sudan, the coordination of HR planning and management needs to be addressed by the federal and state ministries of health, jointly endorsing the inter-sectoral action vision deliberated by the SF. The decentralization of the health system empowers the state ministries of health to devise their HRH strategic and operational plans, reinforce human resource training, deployment and management and lead the coordination process at the state level. The federal ministry has the strong role of extending technical, managerial and resource support to the states, enabling them to carry out these functions successfully. The partners’ support has to recognize this strong partnership and align its efforts and contributions with the federal and state deliberated operational strategies and priority programmatic interventions, streamlining their technical assistance through the established stakeholders’ coordination system for harmonization and efficiency.

f) Developing a Community Health Workers programme

With 70% of the population in Sudan living in the rural areas, a tangible proportion is settled in hard to reach localities posing serious challenges to the delivery of essential primary health care services. Recognizing the current paucity of health workforce, the government has launched the community health workers programme in the country to provide care to the underserved population at their doorsteps. The planning of this initiative and its initial launching was supported by the Alliance and WHO. The health system strengthening window of the Global Fund will extend support to the expansion of this programme. At this stage, the programme is in the pilot phase with over 300 CHWs inducted to follow this training course in two states, where the lessons learned will contribute in the development of a comprehensive proposal for a nation-wide scaling up of the programme.

vii. High level policy support for HRH multi-sectoral coordination

Through MoH efforts and the support provided by the SF member institutions and ministries, the HRH development case was presented in May 2010 to the government cabinet chaired by the President of the country. The support of the cabinet was substantiated by the formation of a presidentially nominated committee for providing answers to the challenges facing the HRH issues. The committee deliberations were approved by the government for implementation. The following table illustrates a summary of these deliberations and the HRH priority areas and challenges they have addressed.

Table 8: Deliberations presented by the Committee nominated by the Cabinet Ministers Meeting Chaired by the President to provide answers to the prevailing HRH issues and challenges

<table>
<thead>
<tr>
<th>Identified Challenges</th>
<th>Proposed Key Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shortages in the targeted recruitment of health workers from all categories</td>
<td>Increase HRH production as per stipulated HRH strategic plan and strengthen coordination through the multi-sectoral Stakeholders’ Forum</td>
</tr>
<tr>
<td>Skill mix imbalance</td>
<td>Improve HRH policies to encourage skill mix and strengthen and support the Academy of Health sciences to expand its production of nurses, midwives and allied health science professionals</td>
</tr>
<tr>
<td>Weak investment in training</td>
<td>Increase HRH resource allocation and the training in areas with severe shortage of cadres and improve coordination with international partners to improve efficiency</td>
</tr>
<tr>
<td>Recruitment and Absorption problems</td>
<td>Sanction permanent employment positions to absorb the trained manpower and fill the service delivery gaps with ensured coordination</td>
</tr>
<tr>
<td>Effectiveness and quality of HRH service delivery</td>
<td>Improve the remuneration of health professionals, standardize competencies and introduce the continuing professional education through sustained training programmes</td>
</tr>
<tr>
<td>Inequity in the distribution of the health services and provide incentives to improve retention in the rural areas</td>
<td>Implementing policies that are coherent and supportive to the state health services and provide incentives to improve retention in the rural areas</td>
</tr>
</tbody>
</table>
Identified Challenges | Proposed Key Solutions
--- | ---
workforce | Strengthening human resource retention strategies and facilitate and encourage return of staff
Human resource policies and plans | 

viii. The Alliance’s catalytic support: Strategic and necessary

The Alliance’s catalytic support to the development of the above outlined national and state HRH operational capabilities encouraged the Federal and state ministries of health to exert a national commitment that created a unique network of quality training institutions for the different categories of health professionals that were in short supply nationwide, especially in the rural and far flung geographical areas. At the inception of the CCF approach an assessment was made in 2007 to explore Sudan’s operational needs and the modalities of strengthening the national coalition of stakeholders to generate the required multi-sectoral support necessary to scaling up the HRH development in the country. This was followed by a joint planning and a targeted support to HRH coordination and institutional capacity development interventions. Through its endeavours, the modest Alliance resources including those obtained as a pathfinder country and those earmarked to the Sudan CCF support amounting to US$ 335,774 with a utilization level of 91.2%. This technical support has truly catalysed a process that brought for the first time the MoH, a range of national stakeholders and a multitude of development partners together. This new partnership has on its turn ensured the sustained progress of the HRH development in the country.

The areas covered by the Alliance technical support in close partnership with the ministry of health and WHO and pursuing the principles and expected outcomes of the CCF approach included the strengthening of HRH multi-stakeholder coordination, building the capacity on HRH policy and management and supporting the National HRH Observatory, as a hub for human resources health information system. The Alliance also provided support for developing the national HRH profile and situation analysis and the HRH national strategic plan, assisted Health professionals’ education institutions and guided the development of community health workers’ national training programme introducing task shifting and promoting skills training for those operating in conflict-affected areas.

ix. Challenges

Despite the committed government support to the HRH strategy and the range of capacity building institutional development efforts made through the partners’ technical support, the capacity development gaps and needs in human resource remain high. The critical targeted strategic and operational challenges include:

a) CCF process related challenges

- The HRH resources contributed by different stakeholders both at central and state level are not fully coordinated through the HRH process as a tangible number of the international partners are not represented in this forum though all partners are coordinated at MoH Permanent Secretary’s Level
- The decentralization of the federal system has devolved major HRH development domains to the states, making the national HRH coordination a challenge demanding strong political commitment, regulation and norms for the building of a sustainable and effective network of national and state level HRH Committees
b) **HRH-operational challenges**

- The limited institutional mechanisms to absorb the large production of medical doctors in the country
- The severe underproduction of nurses and midwives
- The weak retentions capacities of the national health system particularly with regard to highly skilled professionals and specialist cadre
- The high rate of health professionals’ migration specially medical doctors and nurses to the wealthier Middle East Gulf countries
- The highly understaffed primary health care network with significant negative impact on the performance and continuity of care as compared to urban settings
- The less conducive working conditions, security concerns in particular areas and the modest unattractive financial and non-financial remunerations are serious HRH constraints that impact on induction, deployment and retention
- The existing gap between the universities’ run public health school professional training on the one hand and the managerial and leadership needs of the national health system on the other, define the exiting limitations in attaining the HRH competencies most appropriate for the health sector.

x. **Lessons learned**

a) The presence of a national HRH coordination and facilitation mechanism has gained acceptance at national level for its added values of bringing together all the relevant stakeholders on a subject of common interest
b) Intersectoral collaboration and coordination through the CCF process approach has built a wider support to the HRH issues that have gained the attention of the highest political support in the country
c) The HRH information system regularly and timely produced by the observatory and the capacity building support it has extended to the network of SF participating institutions has generated a highly valued evidence, retaining the partners’ interest and promoting their consensus in decision making processes
d) The dependence on the MoH in undertaking and managing the training of a large number of health professionals and senior public health managers will better harmonize the professionally attained competencies with the field level demanded skills and required leadership capacities
e) The fact that 40% of the higher health professionals training institutions and 40% of the hospitals are in the private sector, mandates a greater government and SF coordination on HRH development issues such as the regulation and accreditation of health care systems and services
f) The high national commitment of addressing the essential health needs of the grassroots population reflected by the federal and state ministries’ endorsement to introduce the community health workers’ programme remunerated by the public sector is a significant reform step that will advance both the coverage and access to care

xi. **Recommendations**

a) **Enhance HRH Committee inclusiveness:** Additional efforts are to be made through the CCF process to attract civil society organizations and international health partners to actively participate in the stakeholders’ forum coordination to better align HRH resource inputs and avert duplication
b) **Harmonize HRH coordination Committees at Federal and State Level:** Consolidate the strategic and operational linkages between the central HRH Committee parallel structures, established at the state level to harmonize HRH development in the country
c) **Introduce Comprehensive HRH Costing:** Undertake a detailed and comprehensive costing exercise that encompasses the entire health workforce, using the One Health tool (HRH module) for detailed costing, to enable the stipulation of the right strategic policies and accurate projection of the funding necessary for this vital component of the health system.

d) **Introduce Strategic Policies that Retain the Newly Graduated Medical Officers:** the mismatch between the tangible number of graduate medical officers every year and the limited attraction to deploy and retain them in the health system need to be carefully examined and combined efforts made to resolve this problem through national efforts both at central and state level.

e) **Maintain the Alliance’s catalytic support to the CCF process:** To sustain the successful human resource gains and scale up the government led commitment and stakeholders’ engagement and oversight, the Alliance catalytic technical support and coordination role should be maintained by facilitating country level progress review meetings, assisting the critically challenging HRH area of implementation and organizing inter-country and regional meetings to enable member states to learn from each other’s experiences.

f) **Consolidate the Observatory Network to strengthen the critical HRH Information system:** The HRH information system engendered through the observatory need to be consolidated as it has successfully improved the records of the diverse HRH data, with further analysis of migration of health professionals. The latter will measure the effectiveness of the retention phenomena, evaluate the impact of the introduced rewards be them financial, career and continuing professional development, improved residential and working conditions and the creation of satisfactory levels of service delivery with better management and greater recognition of health professionals. Its scope should also be broadened to regularly collate HRH related information from all sectors and provide evidence based policy briefs to the decision makers.

g) **Enhance the quantity of Mid-level health workers:** Promote the midlevel health workers to attain the targeted deployment levels and health outcomes in the rural and hard to reach areas.

h) **Scale up HRH recruitment and training capacities:** Increase the number of training institutions and pre-service education programmes coupled by effective deployment and retention policies and programmatic interventions.

i) **Expand the CHWs’ Initiative:** To address the problem of inequity in HRH distribution, faced primarily by the rural areas, where health facilities are severely understaffed, the innovative CHWs’ strategy need to be introduced, expanded and sustained with the imperative of providing formal and sustained remuneration through the health system framework.

j) **Ensure HRH equitable distribution:** Ensure the HRH equitable distribution to respond to the population health needs and scale up health system operations in the framework of primary health care, where community and rural based health workers and facilities are supported by appropriate levels of secondary care facilities.
6.2. Zambia Case Study

i. Background and introduction: Health system brief overview

Zambia is a lower middle income country that has recently carried out major improvements in macro-economic performance, which however have not yet significantly impacted on the socio-economic well-being of the entire population. In the health sector, Zambia is committed to attain a nation-wide equity of access to a health services system with assured cost-effective quality and as close to the family as possible. The challenges facing the health sector are reflected by the epidemiological transition, with sustained burden of communicable diseases, in which HIV/AIDS, tuberculosis and malaria are prevalent together with the problem of maternal and child health and malnutrition, associated with the burden of non-communicable diseases in view of the increasing lifestyle and behavioural risk factors [20, 38]. The infant mortality rate is 70 per 1000 live births, while the maternal mortality ratio is estimated at 591 per 100,000 live births [20]. HIV/AIDS is a major cause of morbidity and mortality with 16% of the females and 12% of males being HIV positive, while Malaria accounts for an overwhelming proportion of all visits to health facilities and tuberculosis continues to be a major public health problem, all the three diseases posing serious social and economic burden to the country’s population [17].

In Zambia, there are three categories of health service providers: the public sector, faith-based organizations under the coordination of the Churches Health Association of Zambia (CHAZ) and the private and non-governmental sector, accounting for 80%, 12% 8% of the health workforce stock respectively [17,20]. The formal health system is organized into health post facilities at its lowest level serving a population of about 7,000 and rural and urban health centres serving a population of 10,000 and 30,000-50,000, respectively. This network of health facilities is supported by three levels of hospitals that provide different levels of referral support. There are 81 level-one hospitals located in districts, each serving 80,000-200,000 population with medical, surgical, obstetric and diagnostic services. The 22 Level-two provincial general hospitals have a catchment area of 200,000 to 800,000 people, with services in internal medicine, general surgery, paediatrics, obstetrics and gynaecology, dental, psychiatry and intensive care services. The level-three six central hospitals serve a catchment population of 800,000 people and above and offer sub-specialization services.

The performance of the above health system network structures are influenced significantly by the size, distribution, and skills of its health workforce. There are severe shortages of doctors, nurses and midwives compounded by considerable distributional imbalances with urban and rural ratios of 1:6.5, 1:2.5 and 1:2.7 respectively [20]. These shortages have been difficult to rectify in view of the poor conditions of service, poor working conditions, and weak human resource management systems with inadequate education and training system. To address these challenges, the government has pursued multipronged strategies, ranging from increasing the medical education yearly intake, launching a one year long independent midwifery courses, enhancing the remuneration of the workforce to attractive levels, encouraging the induction of foreign doctors into the health system and introducing the community health workers (Community Health Assistants) that will operate at the grassroots level. Of the current MoH budgetary outlay, about 50% is spent on human resources. In order to successfully implement the above programmes the government has committed to increase the health sector budgetary outlay by over 50%, corresponding to 10.5% of total Government expenditure [17, 39].
ii. Profile of the health workforce

Zambia is faced with a critical HRH shortage, especially with regard to medical officers, pharmacists, midwives and nurses and the country currently operates with less than half of its required health workforce and this challenge is considered to be a major impediment in achieving the health MDGs. In a country with a population of approximately 12 million, the HRH workforce ratio is about 0.12% although the HRH stock trend shows an upward trend of an average of 0.02%. To improve the management, monitoring and evaluation of the HRH situation the MoH has planned the establishment of HRH observatory [20]. To compensate the prevailing deficiency in health information, systematic surveys were periodically carried out and a close coordination of the partners ensured to maximize information sharing between the three categories of health care providers, namely the public sector, the faith based institutions and the private sector with a service coverage of about 78%, 11% and 8% of the population respectively. In early 2010, there were a total of 27,328 Health workers on the payroll. The 2010 ratio of doctors, nurses and midwives was 1:9:3, while, the male to female ratio for doctors and nurses was 68.5% and 14.8% respectively. However, the large majority, about 64.7% of health workers in Zambia are female. The authorized staff establishment increased from 30,883 in 2007 to 31,048 in 2008. Although this ceiling was relatively, 22% lower than the actual staff need in the country, yet compared to many sub-Saharan Africa, this threshold was significantly higher than the actual enrolment under the government exchequer, providing amble space for recruitment of new professionals to the health system.

Zambia has pursued several strategies to address the shortage of the health workforce that include the health workers retention scheme [40]. The latter was initially covering only medical doctors, but subsequently extended to cover other professional categories, although the range of the beneficiaries is still modest. On the other hand, the expansion of training institutions was set out where initially non-operational schools of nursing were reopened and direct-entry midwifery training institutions introduced with 75% increase in the total student enrolment since 2008/2009 academic year.

The distribution of all health workers across districts in Zambia is highly inequitable with 16 districts having less than 0.5 health workers per 1,000 population and only 4 districts have more than 2 health workers per 1000 population. The inequity is also visible in the urban rural distribution where the 71% rural population accesses about 53% of the health workforce and only 24% of the medical doctors, although the latter deficiency is compensated by the 66% of the clinical officers working in the rural areas who through task sharing are performing many of the functions carried out by physicians. When considering the coverage per 1,000 population, urban areas have roughly 2.2 times more health workers, 8 times more doctors, and two times more nurses as compared to the rural areas [17, 20, 41]. Of the 46 national training institutions, 28 were operated by the public sector, 11 by private not-for-profit and the rest by the private for-profit-sector. There are single institutions for the training in medicine, dentistry and pharmacy and 37 nursing and midwifery schools that are all short of producing the required workforce in the country.

iii. The HRH committee/the HRH technical working group

The HRH Technical Working Group (HRH-TWG) provides strategic direction and support for the programs and processes related to human resources for health. Through the technical support of the Alliance and the introduction of the CCF process, the MoH in Zambia has realized that the HRH crisis cannot be redressed through its sole efforts, as many of the necessary HRH interventions require the implementation of programmatic activities not within the mandate of the MoH. Such activities are carried out with the participation of
other public, autonomous and private sector stakeholders, while others can successfully be implemented by forging partnerships with international and bilateral donors in the country. The CCF initiative has hence catalysed the formation of the HRH-TWG comprehensively addressing the coordination of the HRH development process. Box 3 illustrates the participating organizations in the HRHWG, while efforts are being made to invite the Ministry of Education (MoE) and the Ministry of Science and Technology to join this forum. The HRH-TWG is chaired by the Director of HR of the Ministry of Health and has the following Task Groups collectively supporting the implementation and management of the key objectives outlined in the HRH strategic plan: retention scheme, recruitment, performance management, development and Training, community Health Assistants and Task shifting, HIS and HR Strategic Planning and financial tracking and Budget Technical working Group.

Each Task Group has a team leader ensuring that the Task Group meets prior to the HRTWG monthly meeting and report about their observations, findings and deliberations. There were concerns however, that these Task groups were not fully operational as necessary, putting the onus on the HRHWG to ensure that this multi-stakeholder forum performs its strategic HRH coordination and development support functions effectively.

To address the HRH issues, the government has recognized the importance of the coordination role of the established HRH-TWG, especially after the freeze of the grants that were being contributed by other cooperative partners in 2009, resulting from an alleged misuse of funds at the central level that negatively affected a range of HRH institutional and capacity building activities including the scaling up of HRH production. The HRH-TWG has been a major instrument to rebuild the trust and explore mutually accorded governance solutions that sustain the implementation of priority health interventions as well as the introduction of transparent management procedures. The latter was attained through the establishment of the “Governance Management Strengthening Plan” that allow the development of auditable financial procedures and shared oversight and accountability. The HRH-TWG has played a major role in negotiating these solutions and building intermediate strategies that ensure the flow of resource grants to the agreed priority HRH interventions. The leadership and earnestness shown by the MoH was instrumental in facilitating the process, while the event provides a lesson for future HRH partnerships and their management.

### Box 3. The National HRH Task Force Structure and Assigned Roles and Responsibilities

<table>
<thead>
<tr>
<th>National HRH Task Force Committee Structure</th>
<th>Brief Description of Assigned Roles and Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ministry of Health</td>
<td>Overall coordination of activities on HRH</td>
</tr>
<tr>
<td>2. Ministry of Education</td>
<td>Overall responsible for training</td>
</tr>
<tr>
<td>3. Ministry of Finance</td>
<td>Financial allocations to the sector</td>
</tr>
<tr>
<td>4. Health Professional Associations</td>
<td>Advocacy and professional standards</td>
</tr>
<tr>
<td>5. Staff Associations / Unions</td>
<td>Advocacy and industrial relations</td>
</tr>
<tr>
<td>6. Educational/Training Institutions</td>
<td>Training activities</td>
</tr>
<tr>
<td>7. Regulatory bodies</td>
<td>Regulation</td>
</tr>
<tr>
<td>8. Public Service Commission</td>
<td>Recruitment policy</td>
</tr>
<tr>
<td>9. Civil society and Faith Based Organizations</td>
<td>Service delivery</td>
</tr>
</tbody>
</table>

Through their consensus building processes and active government leadership, the HRHTWG members have a major leverage in advancing the planning, implementation, resource mobilization and monitoring of HRH priority domains and interventions in the country.
iv. Developing the HRH strategic plan

The 2006-2010 national human resource (HRH) strategic plan clearly stipulates key priority interventions that were not implemented successfully to effectively address the HRH outstanding challenges [40]. This slow progress is attributable to scarcity of funding after the partners’ restriction of their grants’ release and the inability of the national training institutions to produce the required health workforce outputs [42]. Accordingly, the increases made in the employment of additional workforce throughout the duration of the plan could not compensate the large vacancies reflected by the Establishment although compensatory efforts were made by the government exchequer, yet remaining with considerable gaps in HRH recruitment and deployment. The plan was reviewed in close coordination with the HRH Committee and this collective effort has led to the new 2011-2015 HRH strategic plan [17].

Box 4: The objectives set for the HRH strategic plan in Zambia

1. Increased number of adequately trained HRH
   - Creation of a “National Health Training Coordinating Committee (HTCC)” mechanism
   - Review existing training programmes and develop new ones to respond to the sector’s needs and facilitate career progression
   - Strengthen functions and roles of regulatory bodies in relation to training
   - Improve access to pre-service programmes for students from rural and remote areas
   - Strengthen In-service Training
   - Establish a rural and remote bonding and community services scheme for all new students in health training programmes and enforce bonding scheme for all in-service trainees
   - Improve attraction and retention of health service providers in rural and remote facilities

2. Increased number of employed and equitably distributed HRH with appropriate skills mix
   - Harmonize HRH plans with the MoH infrastructure development plans and medical equipment plans
   - Distribute HRH with appropriate and equitable skills mix
   - Improve attraction and retention of health service providers in rural and remote facilities

3. Improved performance and utilization of HRH
   - Strengthen the leadership and management capacities
   - Strengthen the planning and management systems and procedures at all levels and institutions
   - Improve communication and collaboration between and within levels, institutions and communities
   - Provide enabling and supportive learning and working environments for all students and HRH
   - Provide healthy and safe learning and working environments for students and HRH
   - Increase productivity and quality of work of HRH
   - Ensure gender mainstreaming in all aspects of planning, development and management of HRH
   - Increase number of facilities with a service-oriented, client-centered and gender-sensitive workforce

v. Costing the HRH strategic plan

The Zambian HRH strategic plan underwent a detailed and comprehensive costing exercise to attract the government’s attention in providing the bulk of the required budgetary outlay, while encouraging other stakeholders to participate in its implementation and support workforce auditing and performance optimization [17, 43, 44]. The costing of the HRH plan was an integral part of the CCF process desired outcomes emphasized by the Alliance. In Zambia it was estimated that the implementation of the HRH strategic plan will cost US$458 million in its current projected funding scenario. Estimates were also made for each of its five strategic objectives to allow the prioritization of interventions as per the cost-effectiveness of their intervention activities. This process was encouraged and supported by the Alliance. The figures below illustrate the cost estimate of each strategic objective as well as the cost estimates per year.
vi. Strengthened HRH interventions under the CCF principles and process

The critical shortage of qualified human resources in the country especially in the rural areas and at the community level has impeded Zambia’s efforts to provide essential health care services to these underserved populations.

a) Implementation of the Community Health Assistant (CHA) strategy

To address the HRH challenge, the government has desired to reform the large community health volunteers who did not have any formal training or any proper supervision by launching the National Community Health Worker Programme (NCHWP) as a priority intervention, through formal selection and training [45, 46]. To effectively prepare for the development of the NCHWP, the Ministry of Health, with the support of the Global Health Workforce Alliance, carried out a Situational Analysis in 2009 to better understand the roles, scope, and challenges engaged. As a result of this exercise, the NCHWP is being implemented in seven provinces and 48 districts through a one year training programme, effectively supported, remunerated and supervised by the district health system. A major implementing partner working with the Ministry of Health and with the other member organizations of the HRH-TF is Clinton Health Access Initiative. The Ministry will deploy this trained workforce to scale up a range of primary health care interventions that include maternal and child health and HIV/AIDS treatment and care. The national health workers optimization analysis has shown the immense value this cadre adds to the performance of the health system [43].
b) Bonding system among health care workers

Zambia faces a severe shortage of health workforce despite recent efforts of increased training institutions’ intake, attractive retention strategies, launching community health workers programme and fast tracked midwifery training. The presently deployed healthcare workforce is at 39% of the Recommended Establishment, and 58% of adopted optimization model, with doctors, nurses and midwives’ vacancy rates of 64%, 55%, and 30%, respectively. Moreover, 16% of the graduating health workforces do not enter or fail to be retained by the health system. To avert the latter phenomenon, the ministry has introduced the bonding system that would demand the health workers to sign a contractual obligation to work for a duration equivalent to their government funded education, while those breaching the agreement are required to repay a portion of their education costs [47]. For the success of this initiative, the support of the different concerned government departments will be ensured, and the financial and non-financial remunerations of those posted in rural areas diligently addressed. This will also require the support and monitoring of the HRH Committee with the prospective evaluation of the outcome. This initiative was successfully implemented with the technical support of UNFPA by bonding nurses for two years following a similar period of sponsored training at provincial level. However, the processes and outcomes related to this initiative need to be evaluated for effectiveness and sustainability.

vii. High level policy support for HRH multi-sectoral coordination

Zambia’s Ministry for Health has been the prime advocate for human resource development, recognizing this component of the health system as the highest priority within the health sector and an integral part of the national agenda for action. “We have taken steps to scale up the production by creating new institutions, increasing the overall admission rate, involve the private sector, while strengthening the quality standards of these educational centres” stated the Permanent Secretary of the Ministry of Health. The ministry expressed its expectation that partners align their support with the implementation of the HRH strategic plan by choosing the objectives that match their comparative advantages [17, 48]. The CCF approach has consolidated the MoH realization of the necessity to pursue the multi-stakeholder approach to promote greater levels of understanding and trust between the HRH partners. To enhance equity the ministry also introduced the hardship allowance for the workforce deployed in rural and hard to reach areas.

viii. The Alliance’s catalytic support: Strategic and necessary

The government agenda to invest in and improve human resources for health has enabled the Alliance to introduce the CCF approach to Zambia. The hub of this endeavour is the establishment and/or consolidation of HRH-Technical Working Group (HRH Committee) that coordinates and attracts the different stakeholders whose actual or potential supportive roles are critical to this vital component of the health system. Several strategies were pursued by the alliance to build up the CCF process in the country. Senior policy makers from the Ministry of Health, accompanied by members from cooperative partners were exposed to regional and global HRH conventions and consultation avenues that include the Kampala forum, and the Cairo and Nairobi meetings. “These meetings have strengthened our understanding about the relevance of the HRH coordination process realizing the need for its consolidation.” Said the Director of HRH in the MoH

To address the national HRH challenges spearheaded by the shortage of the workforce, the Alliance supported a national consultation on the subject to explore avenues for alleviating this problem attributed primarily to bottle necks in the training and production of health resources.
workers, such as medical doctors, nurses and midwives. By exposing the partners to the CCF principles and process, the role of the HRH Committee in designing evidence based and costed HRH strategic plan was emphasized. The development of the HRH plan was actively supported by the national intersectoral partners engaged in the HRH coordination process and by the international partners supporting national health programmes. The plan ensures having a strong monitoring and evaluation and results-based framework that will form the basis for cooperation and joint action. Moreover, the Alliance supported the government initiatives of community health workers’ programme organizing a study tour to Ethiopia for the senior management to view and realize the practical scope of the programme, the process and the pace of its implementation and the attainable outcomes from this intervention. The Alliance also extended its support to the midwifery training initiative of accelerated production, a programme technically assisted by UNFPA, WHO and other partners. Through its endeavours, the modest Alliance resources earmarked to the Zambia CCF initiative amounting to US$ 304,787 with a utilization level of 99.9% have truly catalysed a process that brought along the MoH, a range of national stakeholders and a multitude of development partners together that have in their turn ensured the sustained progress of the HRH development in the country.

ix. Challenges

a) Building trust to enhance collaboration: Although radical steps were taken by the government to rebuild trust with health sector cooperative partners following the 2009 freeze on ODA financial resources grants, corroborated by the establishment of appropriate financial management structures and systems that are auditable and transparent, yet more mutual efforts are required to regain a result oriented unity of purpose and trust

b) Recruitment challenges: Although the employment positions sanctioned by the Establishment provide satisfactory margins for the recruitment, these positions can only be filled when Treasury Authority is granted that is constrained by the limited budgetary outlays awarded to the health sector

c) Shortage in medical graduates: The low annual production of medical graduates has forced the ministry to induct expatriate doctors to fill the gap accounting to approximately 30% of the doctors serving in Zambia, raising questions about their voluntary retention on the medium and long-term perspective.

x. Lessons learned

a) The HRH Committee promoted by the CCF approach has created an excellent negotiation platform able to resolve the emerging divergences among its stakeholders and the government and creating a commonly agreed managerial road map that sustain the HRH partnership and the shared ownership of the stipulated plan

b) To ensure government and cooperative partners success collaboration within the HRH domain sustainability and predictability analysis need to be carried out as an integral part of the negotiation process for shared accountability, this being a function of the aid effectiveness

c) The HRH committee participating organizations can successfully test solution models for HRH operational challenges, create innovative strategies and while sustaining the efforts to urge the Establishment to sanction and maintain the optimal numbers, compete for resource mobilization at government and at the level of partners

d) The costing of each strategic objective and its specific components is a powerful facilitating tool for the MoH and cooperative partners to legitimately fight for budgetary increases and ODA grants
e) The raised financial salary remunerations in Zambia relative to many other sub-Saharan African countries has been a powerful retention tool that was further strengthened in relation to other retention attributes such as allowances on housing, occupational risk, being on-call and deployment in rural and hardship areas, as well as the development of infrastructures with the provision of electricity and safe water, the construction and renovation of residential houses, career and educational development and insurance

x. Recommendations

a) Improve Investment Predictability: Strengthen the roles of the HRH Committee member organization and ensure their active engagement in monitoring of the HRH strategic plan and improve the predictability of resource mobilization efforts for its priority interventions to avert the experienced conditions of resource scarcities in the past

b) Regulate the Introduced Bonding Scheme: Complement the establishment of the bonding scheme for those whose education was sponsored through public resources with a community services’ scheme for those who have self-sponsored their education as well as for those who had opportunities for in-service training combined by an attractive retention scheme when deployed in the rural and remote hard to reach areas

c) Encourage the Private Sector in HRH Development: Strengthen functions and roles of regulatory requirements by creating national incentives for the private sector to engage in addressing the shortage of health workers through the advancement of HRH training programmes

d) Increase the national support for the Community Health Workers’ programme: Establish a national programme implementation unit with imbedded branches at provincial and district levels that ensure the quality of training, the regular provision of medicines and medical supplies, the close supervision and the oversight and analysis of the community based monthly health information reports

e) Improve Public Financial Management and Aid Effectiveness: Sustain national efforts aimed at improving transparency and public financial management to enhance the quality of public sector aid resources’ utilization efficiency through leadership, with scaled up implementation, monitoring and focus on the results’ framework with enhanced health partners’ collective compliance with aid effectiveness principles through better cooperation and partnership

f) Introduce Regular Briefs on HRH Information: Undertake regular updating of the HRH information system and job and competence profile and consider skill mix and task shifting to improve the performance of the health system
6.3. Zimbabwe case study

i. Background and introduction: Health system brief overview

The Republic of Zimbabwe has a population estimated at 12 million of which approximately two-thirds are residing in the rural areas, and 40% are under the age of 15 years. Maternal mortality is estimated at 750 per 100,000 live births, while the infant mortality rate and under-five mortality rates are 61.5 and 95.5 per 1,000 live births respectively [49,50]. These indicators show a major drop relative to the health status data of the 1990s. The socio-economic challenges faced by Zimbabwe during 2007-2008 have evidently led to a sharp fall in government and development partners’ funding to the health sector, leading to a deterioration of the health infrastructure and decline in the general quality of health care services [49].

The health system in Zimbabwe is organized into three major levels. Primary health care (PHC) forms the first level consisting of village health workers, community-based distributors, and small clinics primarily in the rural areas providing basic prevention, basic MCH and curative services. These facilities are predominantly run by nurses. The secondary care level of the health system consists of 51 district hospitals that provide referral support to the PHC facilities of which five are missionary hospitals, each district hospital serving a catchment area population of 140,000 and providing emergency and general health services. The primary and secondary care service consisting of 1,200 rural health clinics, rural hospitals, and urban polyclinics provide coverage and access to essential services to about 80% of the services provided by the health system in the country. The tertiary care level, together with the specialized centres, consists of seven provincial hospitals and six central hospitals providing advanced specialist care. The public sector is complemented by the Zimbabwe Association of Church-related Hospitals (ZACH) operating six mission district hospitals and 80 clinics in the country.

With the establishment of the Government of National Unity in 2009, the country embarked on the “Getting Zimbabwe Moving Again” initiative through the launching of the Short-term Emergency and Recovery Programme (STERP). Concurrently the MOHCW has convened an Emergency Health Summit reiterating the notion and setting concrete recommendations under the platform of “Getting the Zimbabwe Health Care Moving Again”. Through this drive a National Health Strategy emphasizing on inclusiveness and participation in the implementation of the national health action was designed with the mission to revitalize the health system and put the country back on track towards achieving the MDGs [51, 52].

The establishment of the Health Services Board in 2005, the HRH Directorate in 2007 and the HRH Task Force in 2008 provided a platform to streamline the HRH agenda in the national health development framework.

ii. Profile of the health workforce

Zimbabwe, with its population of around 12 Million people was ranked as one of the 57 human resources for health (HRH) crisis countries affected by a tangible shortage in its human resources. In 2009, the country was being served by a public health workforce of approximately 27,840. The medical doctors, pharmacists and nurses’ population ratios were estimated at 0.07, 0.03 and 1.35 per 1000 respectively, while the cumulative health workforce ratio at national level was 2.25 per 1000 population [21, 50]. However, there was a severe inequity in HRH distribution, where the highest health worker population ratios of 2.3 and 3.6 per 1000 population were observed in the provinces of Harare and Bulawayo respectively, while the lowest ratio in a province was 0.9 health workers per 1000
population. According to the 2008 traditional medicine register, there were 3,943 community/ traditional health workers and 4,013 Village Health Workers. However, these are not formal health workers and as such are not paid by the government, though supported by various programmes within MoHCW. The 64 pre-service training institutions include two public medical colleges, two public sector pharmacy schools and 44 nursing and midwifery schools of which 23 are in the private sector. The different training programmes covering 13 categories of health professionals had a cumulative yearly admission of a little over 2000 trainees. To improve the retention of the health workforce the national retention policy and scheme were introduced with substantive positive impact on the health sector employment in general and on the essential health services delivery at national level in particular[53].

Many of the health gains attained during the first decade of independence in terms of survival have retarded as a result of the growing shortage in the skilled and experienced health workers, particularly when the delivery of health care services is confronted by the challenges posed by HIV/AIDS and by the growing demand for essential primary, secondary and tertiary health care [54]. Zimbabwe has recorded a more impelling shortage in its cadres of doctors and nurses, especially in the economically deprived geographical locations directly impacting the poor. The HRH attrition rates were on the increase since 1999 and in 2004 alone 25% of the professional health workforce had their permits processed to enter UK, rendering skilled and experienced health workers the most common category of professionals leaving Zimbabwe in recent years. The latter is corroborated by the high vacancy rates for doctors estimated at 42% (and as high as 77% for specialist doctors) and 30% (and as high as 74% for nurse midwives), a pace exceeding the compensation capacities of the training institutions in the country. However, serious efforts were introduced by the government to reverse the situation with substantive success. The World health report 2006 has deliberated that countries with a density of fewer than 2.28 physicians, nurses and midwives per 1000 population generally fail to achieve a targeted 80% coverage rate for skilled birth attendance and child immunization.

To assist the government in this critical phase of its public health development, the Alliance has introduced the CCF approach in Zimbabwe to facilitate the building of a cohesive nationally led partnership addressing the HRH needs and deliberating on the required priority solutions of this component of the health system. Through the CCF, the vision of the HRH coordination process was streamlined by actively and officially involving the different stakeholders to collectively support the HRH development coordination and implementation process, thus creating a policy dialogue platform and a thrust for more investment on HRH with special attention on the retention of the qualified health workforce and their equitable distribution.

iii. The stakeholders’ forum: The HRH task force (HRH-TF)

The HRH-TF was established by the Ministry of Health and Child Welfare (MoHCW) in 2008 to contribute to the HRH development process and address the challenges related to training, recruitment, deployment and retention. Although the forum was formally set up, it required a stronger government leadership, defined roles to pursue, greater coherence and adequate capacities for coordinating HRH strategic policies, plans and programmes. Through the Alliance support, the HRH-TF led by the Directorate of Human Resources was empowered through a comprehensive exposure to the CCF principles and processes, making it the hub that brings together the national and international stakeholders whose mandates of technical cooperation and influence fall within the health sector domain. Numerous national organizations have subsequently demanded membership in the HRH-TF. Through the CCF process and its results framework, the HRH-TF was to harness the technical and
resource contributions and the comparative advantages of their organizations to resolve the evolving and urgent needs of the health workforce. The achievements made by the HRH-TF include updating the HRH information system and mobilizing support for its institutional development, the setting of a national HRH strategic plan and the collective support to the priority HRH retention scheme as well as sourcing technical assistance to key priority human resource interventions.

The core functions of the HRH-TF include the promotion policy dialogue on human resources operational strategies and programmatic interventions, strengthening the HRH information system for planning and management, development of the HRH strategic plan, mobilizing adequate resources that meet the commitments stipulated in the plan, advocacy for a larger government budgetary outlay for HRH development, harnessing intersectoral support for HRH high priorities with the participation of the private sector, oversee and monitor the implementation of the plan and generate shared accountability for a common result based framework. To better organize its functions, the HRH Directorate and the HRH-TF created the following four sub-committees to improve the performance of their coordination: Management and Retention, HRH Planning and Financing, HRH Information Systems and Research and Production, Training and Development.

The table below lists the participating member organizations in the Zimbabwe HRH-TF, which is currently under revision as several additional stakeholders realizing the operational and technical added values of this coordination process have submitted applications to join the Task force and participate in this collective effort. At its inception, the different stakeholders engaged in health support interventions or considered to be of potential relevance to HRH development were invited to this forum and the shared interest consolidated through the introduction of the CCF approach in the country.

Table 9: National HRH Task Force Structure and Assigned Roles and Responsibilities

<table>
<thead>
<tr>
<th>National HRH Committee Structure</th>
<th>Brief description of assigned roles and Responsibilities</th>
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<tbody>
<tr>
<td>1. Ministry of Health and Child Welfare (MOHCW)</td>
<td>Coordination of HRH activities</td>
</tr>
<tr>
<td>2. Ministry of Education</td>
<td>Offering diplomas and graduate and post graduate level degree programmes.</td>
</tr>
<tr>
<td>4. Ministry of Finance</td>
<td>Resourcing the implementation of the HRH plan especially payment of salaries and supporting health facilities</td>
</tr>
<tr>
<td>5. Local Government</td>
<td>Provision of Health facilities in urban and district councils</td>
</tr>
<tr>
<td>6. Health Professional Associations</td>
<td>Professional conduct promoted</td>
</tr>
<tr>
<td>7. Staff Associations / Unions</td>
<td>Link between health worker and employer</td>
</tr>
<tr>
<td>8. Educational/Training Institutions</td>
<td>Production of health workers</td>
</tr>
<tr>
<td>9. Regulatory bodies</td>
<td>Regulating the practice of health professions</td>
</tr>
<tr>
<td>10. Health Service Board</td>
<td>Employment of health workers and their conditions of service</td>
</tr>
<tr>
<td>11. Private sector/Faith Based organizations</td>
<td>Provision of private health care and training at post diploma level to a limited extent</td>
</tr>
<tr>
<td>12. Development Partners and Donors including EC, DFID, UNICEF, CDC, JICA, WHO, ESP</td>
<td>Provision of technical assistance as per the various mandates and specific comparative advantages of each organization and support to strategic planning, implementation and monitoring</td>
</tr>
</tbody>
</table>

iv. Developing the HRH strategic plan 2010-2014

The MOHCW and Health Services Board are responsible for the management of the health workforce including their employment contracts and conditions of service with particular emphasis on attracting and retaining them in the public sector [18]. The HRH Directorate in close liaison with the HRH-TF stakeholder partners developed the HRH Strategic Plan, addressing the training, deployment, management and financing of the health workforce in the public health sector. The development of the plan was carried out through a series of
consultative meetings led by the government and actively participated by the stakeholder partners who were involved right from its policy deliberation, with constant dialogue with the health sector national leadership to build consensus and commitment to its processes and deliberated outcomes.

Box 5: The objectives set for the HRH strategic plan in Zimbabwe

1. HRH Information and Research: The focus here is geared to the development of an HRH Information System and the promotion of research supporting the implementation of the goals of the strategic plan with the following set of specific objectives:
   - Develop and strengthen the HRHIS to assist planning and rationalize HRH management functions
   - Provide data and information for HRH evidence based policy formulation, planning and management

2. Production, Training and Development: This component of the plan relates to the education and training of health professionals and addresses the following specific objectives:
   - Strengthen capacity for training of human resources for health
   - Increase production outputs of the health workers with critical post basic and postgraduate qualifications
   - Support health workers to undertake Diploma/Higher National Diploma programmes
   - Identify, develop and establish centres of specialization
   - Develop and implement national frameworks and mechanisms for exchange programmes and attachments
   - Develop and implement Induction programmes
   - Train all managers in leadership and management skills on a continuing basis

3. Deployment, utilization, management and retention of health personnel enabling them to play a critical role in the delivery of a sustainable health services’ system. This strategy addresses the following specific objectives
   - Ensure equitable distribution of qualified staff at the recruitment phase
   - Ensure equitable distribution of qualified staff during their deployment
   - Ensure equitable distribution of qualified staff and warrant their retention
   - Ensure equitable distribution of qualified staff and strengthen management and utilisation

4. Human Resources planning and financing: Planning for Human Resources for Health focuses on the estimation of the projections of numbers of professions, the kinds of skills, knowledge and attitudes required to meet the set health status objectives. This strategy addresses the following specific objectives
   - Operationalize the HRH plan at all levels
   - Review, develop and implement human resources for health policies and strategies on attraction and retention
   - Facilitate the management of the impact of HIV and AIDS on HRH in the Service (and include T.B.)
   - Establish a platform for strategic partnerships on HRH with various national, regional, continental and international groupings
   - Review the framework for health workers skills mix for the country, based on prevailing needs within the region
   - Update and use the HRHIS to assist planning and to rationalize all HRH management functions

v. Costing the HRH strategic plan

The total cost of the human resource strategic plan 2010-2014 amounts to $393.011 million US dollars over the five-year period [23]. The largest proportion of this cost (approximately 90-95%) is borne by the investment in training and upgrading new and existing staff in the health sector. Within this grouping, over 70% of costs relate to training of doctors (about 25%) and nurses (nearly 50%) at both undergraduate and postgraduate level.
vi. Strengthened HRH interventions under the CCF Principles and Process

a) Retention scheme and its implementation: The imperative of the HRH coordination role

The health system of Zimbabwe is confronted with the challenge of recruiting and retaining the needed critical health workforce. Recognizing this problem, initial efforts were made by the government and development partners by introducing several retention schemes based on the programmatic interventions supported by the engaged stakeholder organizations [55]. Three such mechanisms that did provide financial incentives for retention included the Vital Health Services Support Programme, the Emergency Support Programme and the Global Fund, with different levels of sustained assistance, creating disharmony not only amongst health workers but also within the districts implementing these programmes. Following a joint consultation by the HRH stakeholders/partners, a harmonized retention policy was developed stressing on the need to sustain and expand this support to the largest possible number of health workers, especially the skilled and essential workforce cadre. The scheme financially supported by the Global Fund is aimed at motivating the health workers and sustain a high level of performance at all levels of the health system. The successes of
this initiative is substantiated by the significant drop of the public sector nurses’ vacancy rate from 30% in 2008 and 2009 to 13% in 2011 with the corresponding increase in the institutional deliveries from about 50% to over 75% during the same period.

The government and the overwhelming majority of the development partners represented in the HRH-TF are of the view that without this support, the country’s ability to provide essential and life-saving health care services and attain the MDGs will be highly compromised, prompting the launch of a multi-donor pooled transition fund for health [56]. The workforce retention scheme covers 18,860 skilled professionals (52% of the health workforce), with significant improvement of the health workforce withholding capacity. However, this retention scheme is currently faced with a serious challenge, with the resources provided by the Global Fund allocations being gradually phased out with a yearly reduction of this incentive by 25%, to be totally discontinued in 2013. The HRH-TF partners and the Ministry of Health coordination mechanism is actively engaged in working out solutions to this problem, exploring opportunities within the Global Fund and with the development partners’ framework. The Health Transition Fund (HTF) is un-earmarked multi-donor pooled fund with EU and DFID as major contributors and aiming to support the MoHCW efforts to enhance access to essential care focusing on reducing maternal and child mortalities, on nutrition and on combating HIV, Malaria and other diseases. HRH management, training and retention constitute integral components of the core thematic support areas of the HTF. The government is also exploring modalities to contribute to this shared accountability. It is obvious that the retention resource shortage challenge will be a critical test for the ability of the government, the HRH-TF and the development partners to resolve this imminent HRH crisis in the country. The 2010 government freeze on recruitment, though with some lenience within the health sector will lead to less induction and hence less compensation of the risky high potential of attrition rate levels. The HRH-TF has to mobilize its coordination network to avert a high rate of health workforce migration from Zimbabwe.

To corroborate the criticality of the retention scheme, the Director of Human Resources in the MoHCW indicated that “Our first priority is the retention of the employed health workforce. If we fail in this, the other components of the health system will not be able to deliver”, while two committed development partners noted that: “HRH is not only a priority, it is a necessity as health without its workers cannot function” and stressed on: not letting us not lose our human resources, the investment we have built over the years”.

b) Establishment of the Health Services Board

The government of Zimbabwe has recognized the special, challenging and risky health functions of the health workforce and desired to independently address issues related to the management of their employment, conditions of service, administration, incentives and career development by transferring the workforce engaged in public health services delivery from the Public Service that manage the entire public sector workforce, to a service under a Health Service Board (HSB) established through a health service act in June 2005 [18]. This Board has been made responsible under the auspices of the MOHCW, to manage HRH recruitment, deployment, career development, monitoring HRH policy planning and technical performance as well as the HRH financial management and resource mobilization. This establishment has allowed the health sector to introduce key HRH related interventions such as the retention scheme providing special privileges to this workforce.
vii. High level policy support for HRH multi-sectoral coordination

The Ministry of Health and Child Welfare in Zimbabwe has attached the due attention to the CCF process approach and recognized the importance of HRH development in the health sector. The relatively higher remuneration and incentives provided by the government to different health professional cadres and the high threshold of sanctioned public sector positions for recruitment substantiate this national commitment. This commitment is also corroborated by the enhanced budgetary outlay for the ministry of health in general and HRH in particular as well as the substantive efforts invested in partnership building for HRH advancements. These contributions and the establishment of the Health Services Board have facilitated the work of the HRH-TF in setting HRH strategic plans that address the HRH dimensions without the usual bureaucratic restrictions faced by the Public Service management system. However, despite this ample mandated authority, health policy remain concerned about the migration of highly trained and skilled workforce, a major challenge requiring close monitoring by the HRH-TF and the government to introduce relevant mitigating operational strategies in line with the WHO Global Code of practice on the international recruitment of health personnel [57, 58].

viii. The Alliance’s catalytic support: Strategic and necessary

The Government of Zimbabwe has welcomed The Alliance’s CCF principles and process initiative acknowledging its relevance and contribution to the HRH coordination challenges facing the health system in which diverse service providers are engaged. The CCF process has through the stakeholders/partners forum created a policy dialogue addressing the resource crunch facing the health sector and the need for harmonized avenues for partnership support, the structural difficulties responsible for the low production of skilled workforce and the induction and retention challenges of the health system as well as the high levels of health professionals’ migration to neighbouring countries and overseas. The retention scheme package launched in 2008 was aligned and encouraged by the HRH Kampala Declaration and Agenda for Global Action. The launching of the CCF process has effectively catalysed a range of interventions from the consolidation of the HRH-TF, the development of the National HRH Strategic Plan and the successful resource mobilization for key HRH interventions together with the shared commitment to address the HRH evolving challenges such as the envisaged discontinuation of the Global Fund support to the retention scheme. Through its endeavours, the modest Alliance resources earmarked to Zimbabwe CCF initiative amounting to US$ 113,000 with a utilization rate of 73.5% have truly catalysed the HRH development process through the active participation of a range of national and international stakeholder partners led by the MoHCW.

ix. Challenges

a) Although the value added of the HRH Committee is apparent, yet the governance of this coordination process requires the full deputation of relevant organizational capacity, while the absence of this managerial support will reduce the effectiveness of this important stakeholder forum

b) The fact that the Global Fund retention allocations are being phased out in 2013 with no equivalent foreseeable compensatory financial resource outlay, is posing a serious risk to the years’ long gains that in 2008 and 2009 resolved the loss of a large number of skilled and experienced health professionals in the country

c) The low production of health workforce will have its highest negative impact on the rural and hard to reach localities and districts, although the government has shown commitment to introduce innovative strategies such as the community health workers
and fast track community midwives’ training programmes fully streamlined into the health system.

d) The HRH-TF monitoring role of the HRH strategic plan implementation is not robust enough to allow for shared accountability and management for results.

x. Lessons learned

a) CCF process is a powerful enabling force that brings together a critical mass of stakeholders and provides opportunities for joint planning, coordinated support to the HRH strategic plan implementation and the forging of intersectoral action.

b) The fragmented non-harmonized retention schemes cannot be effectively sustained and are detrimental to HRH performance motivation because of the diverse financial incentives supported by different stakeholders but pursued for similar health workforce categories, while the pooling of resources delivers better results.

c) Strong HRH directorate with committed leadership is a valuable prerequisite for creating an enabling environment for the HRH-TF to function coherently and create opportunities of support for HRH priority interventions and needs.

d) HRH reform recognizing the need for creating distinct management structures can free the health system from the chronic public sector bureaucratic management barriers generating a new paradigm that unreservedly utilizes the available resources and opportunities for HRH development, founded on partnerships and shared accountability at all levels of the health system.

e) The motivation and performance of the health workforce are linked to a range of facilities of which the financial incentives are essential but not sufficient unless complemented by other relevant benefits including provision of accommodation, an enabling working environment (safety, infrastructure, supplies and equipment) with adequate opportunities for professional and employees’ career development.

xi. Recommendations

The government and the HRH-TF may lend critical considerations to the following as the prospective agenda for action:

a) Update Stakeholder Analysis: Review stakeholders’ comparative advantages, roles and responsibilities and assess and resolve existing gaps in the HRH situation analysis.

b) Improve the Health Information System: Generate the necessary HRH information data from all related sectors and create HRH Observatory to sustainably produce sufficient HRH knowledge base that guides policy decisions and management of human resource development.

c) Improve government HRH management: Review and improve government HRH management capacities at all levels of the health system, strengthen accountability and effective resource utilization and translate the HRH strategic plan into yearly operational plans for effective implementation, monitoring and focus on results.

d) Harmonize Implementation: Coordinate and harmonize the implementation of the HRH plan with Ministry of Finance and international partners enhancing resource contributions and generating greater efficiency.

e) Engage HRH Committee in monitoring the Plan: Actively engage the HRH-Committee in monitoring and evaluation to improve the process oversight and its resultant outcomes and organize reviews to assess the HRH implementation plan, the collective progress attained and existing health challenges to resolve.

f) Strengthen the HRH Secretariat: Strengthen the technical and organizational capacities of the HRH-TC secretariat, to provide the necessary support to the national HRH Directorate that leads the HRH Committee partners’ coordination.
g) **Implement close Oversight on HRH Migration:** Establish a national level support for creating migration inventory and assessment desks in the HRH Directorate that can regularly report on national human resource outmigration to explore solutions to compensate the shortage and identify strategies to strengthen health workforce retention as per the WHO Global Code of Practice on the International Recruitment of Health Personnel and seek partnership for its implementation.

h) **Ensure Retention Scheme Funding:** The government has to make a serious effort to compensate the development funds that may be lost by the retention scheme and encourage partners to enhance their contributions by linking these interventions with the workforce performance outputs and outcomes at the operational level.
7. REFERENCES


7. Christmas K and Hart KA. Workforce shortages are a global issue. Nurs Econ. 2007 May-Jun,25(3):175-7


10. Human resources for health: overcoming the crisis, joint learning initiative. ISBN 0-9741108-7-6, 2004


55. Yoswa M Dambisya. Regional Network for Equity in Health in east and southern Africa: a review of non-financial incentives for health worker retention in east and southern Africa. Health Systems Research Group, Department of Pharmacy, School of Health Sciences, University of Limpopo, South Africa, May 2004.


8. OFFICIALS MET DURING THE CCF RAPID ASSESSMENT MISSION

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Prof Zein Alabdin A/Raman Karrar President Sudan Medical Council
Dr Anshu Banerjee WHO Country Representative
Dr Ehsanullah Tarin WHO-Senior Medical Officer on Health System
Prof Taha MoHammad Osman Council of Medical Specialization
Majdi Bayumi Chief Health UNICEF
Professor Elhadi Adbsalamad Migration Study Centre
Prof Osman Taha MoHammed Osman Sudan Medical Specialization Board
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Dr Nour Ahmed Yousuf National HRH Observatory- Coordination and partnerships
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Mr Jere Mwila Director – Human Resource Administration
Mr Mukita Luwabelwa Deputy Director Planning and Budgeting
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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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