# Human Resources for Health Observer

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# Policies and practices of countries that are experiencing a crisis in human resources for health: tracking survey

**World Health Organization**

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## Acronyms

| | |
|---|---|
| **AFR** | WHO African Region |
| **AFRO** | WHO Africa Regional Office |
| **AMR** | WHO Region of the Americas |
| **AMRO** | WHO Regional Office for the Americas |
| **BLDP** | Bilateral development partner |
| **CCM** | Country coordinating mechanism |
| **CCS** | Country Cooperation Strategy (WHO) |
| **CSO** | Civil society organization |
| **EMR** | WHO Eastern Mediterranean Region |
| **EMRO** | WHO Regional Office for the Eastern Mediterranean |
| **GAVI** | Global Alliance for Vaccines and Immunization |
| **GFATM** | Global Fund to Fight AIDS, Tuberculosis and Malaria |
| **GHI** | Global health initiative |
| **GHWA** | Global Health Workforce Alliance |
| **HR** | Human resources |
| **HRH** | Human resources for health |
| **KD** | Kampala Declaration |
| **KIT** | Koninklijk Instituut voor de Tropen (Royal Tropical Institute), Amsterdam |
| **MLDP** | Multilateral development partner |
| **MoH** | Ministry of health |
| **M&E** | Monitoring and evaluation |
| **MTEF** | Medium-term expenditure framework |
| **NGO** | Nongovernmental organization |
| **PAHO** | Pan American Health Organization |
| **PFP** | Private for-profit |
| **PNP** | Private non-profit |
| **PRSP** | Poverty Reduction Strategy Paper (WHO) |
| **SEAR** | WHO South-East Asia Region |
| **SEARO** | WHO Regional Office for South-East Asia |
| **SWAp** | Sector-wide approach |
| **WHO** | World Health Organization |
| **WPR** | WHO Western Pacific Region |
| **WPRO** | WHO Regional Office for the Western Pacific |

# Acknowledgements

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# Executive summary

In 2006, The World Health Report[1] identified 57 countries with critical shortages of skilled health workers. Two years' later, the Kampala Declaration of the First Global Forum on Human Resources for Health (March 2008)[2] recognized the need for immediate action to resolve the accelerating crisis in the global health workforce and called on countries to take urgent, effective action to address human resources for health (HRH) challenges, and on the international community to support the countries in this endeavour.

The human resources for health crisis has now become a priority issue and, in the majority of the countries surveyed, policies and plans are being developed to address it. Documentation on HRH policies and plans, on the existence and capacity of governing and management bodies, and on implementation can improve our understanding of the status of implementation and the effect of these policies and practices on the HRH situation.

This desk review of HRH policies and practices in the 57 countries took place between June and December 2009. Human resources for health policies and plans, evaluation reports and other HRH-related documents of these countries were reviewed, entered into a database and categorized according to four dimensions: strategic directions, governance and leadership, partnerships and commitment.

The majority of countries (45 out of 57) were found to have HRH plans, but there is evidence that only 55% of them are being implemented. This slow implementation seems to imply that countries face major operational challenges.

The plans showed a variety of strategies to address HRH problems. Worldwide, education receives the most attention in national health policies and plans, while issues such as supervision and performance management are addressed relatively infrequently. The monitoring and evaluation (M&E) of implementation was addressed in 53% of the plans.

The assessment of leadership and governance capacity in the ministries of health proved difficult due to the lack of documentation. Although 90% of the countries reviewed have a HRH unit, it has not been possible to extract information on their functions and capacity. However, increasing numbers of national HRH observatories are emerging as mechanisms to strengthen information, and evidence-based participatory policy dialogue and decision-making.

Partnerships are important for the development and implementation of HRH plans. Countries that have mechanisms within their ministries of health to coordinate stakeholders' activities and policies are more likely to have a HRH plan. However, no information was found to confirm that implementation benefited from these partnerships.

In general, plans are developed in concert with various stakeholders. However, it was found that the involvement of the private sector, an important sector for the delivery of health care, is lower than that of the international donor community. This is mainly due to the low proportion of countries in the WHO African Region (AFR) that involve the private sector in the development of the plans. It was not possible to analyse the reasons for this low level of participation, as such information is not included in the HRH plans.

Government commitment to address the HRH crisis was assessed by counting the number of HRH plans that mentioned that the investment of the national government would be appropriate, or at least increased, to enable the plan's implementation. This was the case in only 42% of the countries. The fact that such a low proportion of the countries foresaw increased investment in HRH, when 71% of the plans had a budget, further explains why successful implementation of the plans appears to be so difficult.

Although there are no clearly defined indicators to monitor the action espoused in the Kampala Declaration, progress can be assessed on the basis of some pointers in each of its articles. It is proposed that the tracking survey and database set up for this survey be utilized to monitor the follow-up of the declaration at country, regional or global levels. This report, therefore, provides some highlights and a baseline for further monitoring of the Kampala Declaration.

The tracking survey has provided an overview of the current situation in terms of policies, plans, capacities and processes in countries with a critical health workforce deficit. Although limited in scope due to being based on secondary data, it has provided a better understanding of some of the critical issues.

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[1] *World Health Report 2006 – working together for health*. Geneva, World Health Organization, 2006 (http://www.who.int/whr/2006/whr06_en.pdf, accessed 2 November 2010).

[2] *Health workers for all and all for health workers: the Kampala declaration and agenda for global action. First Global Forum on Human Resources for Health, Kampala, 2–7 March 2008*. Global Health Work force Alliance, 2008 (http://www.who.int/workforcealliance/forum/2_declaration_final.pdf, accessed 2 November 2010).

# Introduction

In drawing attention to the growing crisis in the health workforce and related challenges, the World Health Report 2006[1] underlined the chronic deficit of well-trained health workers worldwide, both in terms of insufficient numbers of clinically and otherwise skilled health workers, and the necessary administrative and logistics staff at all system levels.

There are 57 countries identified with a critical deficit of skilled health workers (Table 1). The Kampala Declaration of the First Global Forum on Human Resources for Health (March 2008)[2] recognized the need for immediate action to resolve the accelerating crisis in the global health workforce, and called on countries to take urgent effective action to address human resources for health (HRH) challenges, and on the international community to support the countries in this endeavour.

Of the 57 countries, 36 are in the WHO African Region (AFR), 5 in the WHO Region of the Americas (AMR), 7 in the WHO Eastern Mediterranean Region (EMR), 6 in the WHO South-East Asia Region (SEAR), and 3 in the WHO Western Pacific Region (WPR). Thus, 63% of the countries included in the review are from AFR while 12% are from SEAR, 11% from EMR, 9% from AMR and 5% from WPR. This should be taken into consideration in the interpretation of the distribution of findings.

In order to understand and monitor the progress in developing and implementing HRH policies in the countries experiencing a critical deficit in the health workforce, this desk study set out to collate essential information by reviewing all relevant docu-ments, rather than by overloading these countries' ministries of health with extra work.

The scope of the study focuses on four dimensions, which are considered essential in developing a strong health workforce and in enabling progress to be monitored:

1. strategic directions, such as HRH policies, including the education of health workers and the establishment of HRH management systems;

2. leadership/governance capacity for HRH;

3. partnerships that include the participation of different stakeholders in policy processes and their response to HRH challenges;

4. commitment to HRH which is explored through investment in and financing of HRH.

Each dimension is presented with detailed findings followed by discussion of the implications. Following the presentation of the results, highlights are used as a baseline for the monitoring of progress towards the objectives in the Kampala Declaration (KD).

After the initial analysis, it emerged that more issues could be explored with further analysis of the database that was setup as a result of the survey, using Datacol©, which covers information on all the dimensions explored in the survey template.

It is expected that this publication will contribute to stimulating the debate on HRH policies and practices at international level, and within the countries concerned.

Table 1 List of countries with critical deficit of health workforce

| AFR | | | AMR | EMR | SEAR | WPR |
|---|---|---|---|---|---|---|
| Angola | Eritrea | Mauritania | El Salvador | Afghanistan | Bangladesh | Cambodia |
| Benin | Ethiopia | Mozambique | Haiti | Djibouti | Bhutan | Lao People's Democratic Republic |
| Burkina Faso | The Gambia | Niger | Honduras | Iraq | India | Papua New Guinea |
| Burundi | Ghana | Nigeria | Nicaragua | Morocco | Indonesia | |
| Cameroon | Guinea | Rwanda | Peru | Pakistan | Myanmar | |
| Central African Republic | Guinea-Bissau | Senegal | | Somalia | Nepal | |
| Chad | Kenya | Sierra Leone | | Yemen | | |
| Comoros | Lesotho | Togo | | | | |
| Congo | Liberia | Uganda | | | | |
| Côte d'Ivoire | Madagascar | United Republic of Tanzania | | | | |
| Democratic Republic of the Congo | Malawi | Zambia | | | | |
| Equatorial Guinea | Mali | Zimbabwe | | | | |

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1 & 2 (See footnotes page iv)

# 1

## Methodology

This study performed a stocktaking exercise to document the actions taken in the 57 countries undergoing a health workforce crisis, which yielded an enormous amount of information. In the majority of the countries reviewed, national strategic health policies or plans and/or specific human resources for health plans were found. For some of the countries, evaluation reports were available which gave insight into how the implementation of these policies and plans is progressing.

### 1.1
### Study design and testing phase

A survey outline and an initial survey template were developed. These documents were shared with WHO regional offices and some HRH experts. Based on their comments, the draft survey template was elaborated. Following the development of the template, some feedback was received from reviewers, and a testing phase and discussions were held before it was finalized.

Nine countries were selected on three continents: Angola, El Salvador, Haiti, Indonesia, Lesotho, Malawi, Mali, Papua New Guinea and Yemen. The testing phase provided a set of search strategies comprising a list of 'do's' and 'don'ts', and Internet web sites to facilitate the work (for the final survey template, see Annex 1).

### 1.2
### Searching for information

The search procedure was sometimes complicated by the need to avoid giving extra work to the ministries of health, but the information identified in the search was often only available in ministry of health (MoH) offices.

The procedure for retrieving relevant data comprised the following steps:

1. searching for the WHO Country Cooperation Strategies (CCS) – if they exist, they are always available on the Internet;

2. collecting proposals and documents from the Global Alliance for Vaccines and Immunization (GAVI) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GAFTM) Rounds 5–8;

3. searching MoH or government web sites – not all MoH have web sites and, when they have, they are not always written in Arabic, English, French, Portuguese or Spanish (the languages of the research team); generally, the documents could not be downloaded from the MoH web sites and were, therefore, collected from WHO regional and country offices, consultants, etc.;

4. consulting the World Bank web site;

5. if the questions in the survey template were still not answered, searching Google using the following key words:
   - 'health national plan' and country
   - 'human resources for health' and country
   - 'strategic health plan' and country
   - 'health policy' and country
   - 'workload study health' and country
   - 'donor coordination' and country
   - 'health workers' and country
   - 'health evaluation' and country.

Annex 2 provides a list of the principal documents reviewed for the survey.

### 1.3
### Processing and analysing the data

All data were entered into the templates, which were then sent to the WHO regional offices for comments and validation of the information. These data were entered into a database using DataCol©. The scope of this database is such that it enables detailed country data entry, which is very useful when searching for information on an individual country.

The analysis of data on country actions addressing the HRH crisis was performed for four components – strategic directions, leadership/governance capacity, partnerships and commitment (Annex 3). Proxy indicators were developed so that current progress in each country could be assessed within these four components.

In total, the policies, where available, and practices of 57 countries were documented and reviewed. A policy review was carried out for 45 countries with separate HRH plans. A review of practices (implementation, monitoring, evaluation, participation in planning, establishment of HRH units, etc.) was carried out for all 57 countries, if documents reporting on these issues were available.

### 1.4
### Limitations

Although the majority of the HRH plans were obtained, this study nevertheless had certain limitations.

- It was often not possible to access monitoring and evaluation (M&E) reports to verify if plans were being implemented.

- Several components can, in reality, only be assessed on site or through interviews in the countries, e.g. the capacity of the HRH units within the MoH. Even an

on-site check by the WHO regional offices could not provide all this information.

- There are various interpretations for several concepts that were used in the survey, such as 'skills mix', 'scope of practice' and 'mobility of staff'. In the literature, as in the national policy and strategic plans of the various countries, the interpretation of these concepts can also differ. In the survey, some concepts are, therefore, self-defined and assessed based on the definitions used by the countries in the available documents.

- Interpretation of the global analysis has its limitations. This review provides tables and graphs in which data are given proportionately. One could question the validity of these regional comparisons because of the variation in the number of countries affected per region (see Table 1). The data collected are qualitative as well as quantitative. Most of the analysis was carried out by calculating percentages of policies and activties, but in some cases the report includes descriptive findings.

# 2

## Findings

## 2.1
## Strategic directions

This first section of the survey template investigated the existence of a HRH plan and its 'strategic direction'. For this analysis, it was decided that a country had a separate HRH plan if there was evidence of the existence of a:

- separate plan for HRH

- separate chapter devoted to HRH in the national health plan

- separate plan in a general national HR plan.

If a country had a HRH plan, it was reviewed on the strategic directions chosen. Consequently, this part of the analysis covers only the findings of the countries that have a national HRH plan.

**The availability of a national HRH policy/plan**
As many as 45 of the 57 countries have a national HRH plan (79%) (AFR 31, AMR 3, EMR 3, SEAR 6, WPR 2) (Figure 2.1). For a few countries, there is evidence that HRH plans are planned or are currently being developed (Djibouti, Honduras, Papua New Guinea and Zimbabwe). There is no information on when these plans will be finished and these countries are not considered in this survey as having a HRH plan.

**Integration of the HRH plan to national plans and policies**
The linkage to the national health policy was chosen as the proxy indicator for the integration of the HRH plans into national poli-

Figure 2.1 Number of countries with a HRH plan and experiencing a HRH crisis, in WHO regions
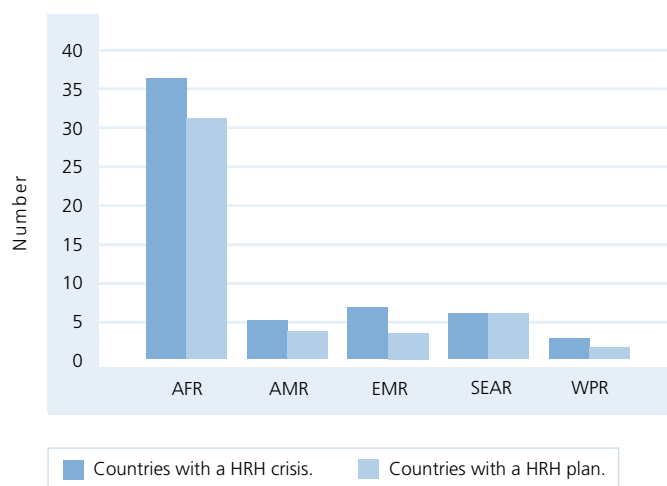


cies and plans. Globally, 40 out of 45 (89%) of the HRH plans are integrated into the national health plans. In EMR, SEAR and WPR all plans are integrated into the national health policies. Only five of the countries that have a national HRH plan were not linked to the national health plan (4 in AFR and 1 in AMR).

**The development of the plan**
In some countries, the results of various types of studies focusing on different aspects of HRH contributed to the development of the HRH plans. Globally, this was found for 16 out of 45 (36%) countries.

**Content of the plan**
For all regions, the review identified the 'top five' issues highlighted in the HRH plans with strategies to address them (Figure 2.2). The top five issues addressed in the 45 HRH plans, and the proportion of countries that included the issue are shown here:

1. pre-service education

2. in-service education

3. educational targets[3]

4. career development

5. incentives[4].

This top-five list varies per region and it was observed that:

- pre-service education and in-service education are dominant in the HRH plans in all WHO regions;

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[3] Educational target refers to the inclusion of the number of health workers that have to be trained.

[4] The kinds of incentives were not pre-defined in the template. This question was answered with a 'yes' if the national HRH plans used this terminology. The comments informed us that incentives would often be related to payment, housing and transport.

- the development of a HRH information system is within the top five issues in all regions except for SEAR, however, when development of a HRH information system is not mentioned, it may indicate that those countries already have a functioning information system;

- the workplace environment is only found in the top five in WPR;

- the top five issues in WPR countries do not vary – all issues in the top five are mentioned in all countries;

- supervision, performance management and mobility of staff do not appear in the top five in any region.

Figure 2.2 Percentage of top five issues addressed in HRH plans of surveyed countries
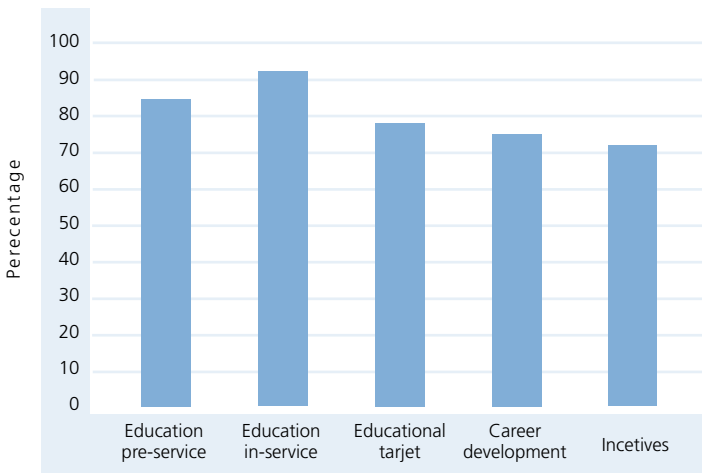


**Education**
Education (in-service and pre-service combined) seems to be the most frequently cited strategy to increase the quantity and quality of the health workforce. Globally, 39 out of 45 countries (87%) addressed both aspects of education in their HRH plans.

**Recruitment**
The proportion of plans that address both processes and targets for the recruitment of health workers is globally 23 out of 45 countries (51%). Recruitment is less often addressed in plans in AFR with only 14 out of 36 countries (39%) doing so.

Only the Liberian national plan referred to recruitment and the international market:

> Guidelines for hiring expatriate health professionals will be produced by the Ministry.
> Many experts will have to be procured from the international market, due to lack of skills on national market (preferable senior experts for long term)....

**Incentives**
In HRH plans, incentives refer to a remuneration package, housing and transport. These three types of incentives are addressed regularly in the HRH plans. However, learning

opportunities and career development are items that can also be regarded as incentives for staff (Figure 2.3) and are included as such in this analysis:

- incentives related to payment, housing and transport are in the global top five in 34 out of 45 countries (76%);

- career development appears in the global top five in 35 out of 45 countries (78%), in 3 countries in AMR, and in 2 countries in WPR;

- learning opportunities are not in the global top five in 27 out of 45 countries (60%). However in AFR, learning opportunities are in the top five in 23 out of 31 countries (74%).

Figure 2.3 Number of HRH plans that address the various types of incentives in surveyed countries
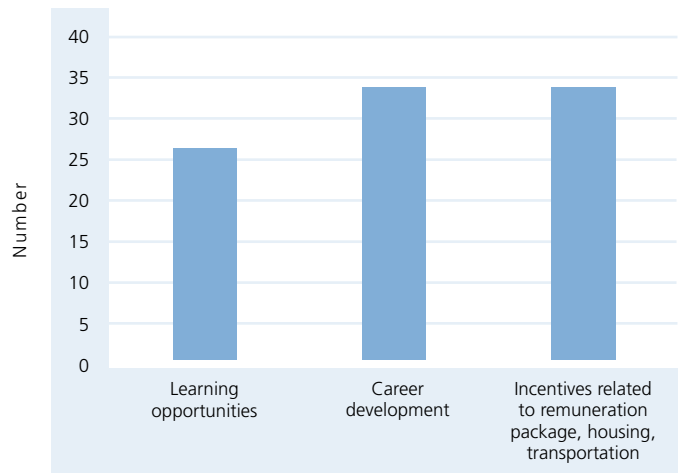


**Deployment and distribution**
Deployment and distribution of staff is addressed in 30 out of 45 countries (67%) of the plans globally.

**Skills mix**
Government efforts to determine the appropriate health worker skills mix are difficult to assess. The assessment was made by reviewing how many countries discuss an appropriate skills mix in their HRH plans, either discussing appropriate skills mix or establishing mechanisms to identify appropriate skills mix. Globally, this is 24 out of 45 countries (53%). In SEAR, it is 5 out of 6 countries (83%).

**HRH information system**
Inclusion of the development of a HRH information system in HRH plans is globally quite high at 30 out of 45 countries (67%). All countries in AMR, EMR and WPR, address the development of a HRH information system in their plans.

**HRH needs projections**
With regard to projections for HRH needs, it was found that, globally, 35 out of 45 countries (78%) included some projections in their plans, at least for some categories of the health workforce. However, only 17 of these 35 cover the

needs of the private sector. In AMR, EMR and WPR, private sector needs were found in all of the projections. In AFR, 10 of the countries that made these projections included the needs of the private sector, while in SEAR, only 1 country included the private sector.

Regarding the inclusion or exclusion of the private sector in the projections, it was observed that 6 of the countries (5 in AFR and 1 in SEAR) that excluded the private sector from their projections, argued that there was too little information available from the private sector to do so. In 1 country (Lesotho), it was explicitly mentioned that the private non-profit (PNP) sector (faith-based nongovernmental organizations (NGOs)) was included but the private for-profit (PFP) sector was excluded.

In all countries where the HRH needs projections included the private sector's needs, it was not clear if all the private services in the country were taken into account.

### Decentralized systems and HRH management
Globally, 28 out of 45 countries (64%) mentioned decentralized HRH management in the HRH plans. In WPR, decentralization was never mentioned in the HRH plans. However, from the review of the documents, it was not always clear if the countries with a HRH plan had a decentralized health system. If not, there was certainly no need to address decentralized management of HRH in their plans. Furthermore, decentralization has been assessed based on the information provided in the national strategic health plans and policies of the countries surveyed and, as such, it is a self-defined concept of the country.

### Monitoring and evaluation of a HRH plan
The monitoring and evaluation of HRH plans in this survey was appropriately addressed when:

- indicators for monitoring were included in the HRH plan;
- an evaluation of the HRH plan was included in the plan.

From the countries that have a HRH plan, only 24 out of 45 countries (53%) addressed the monitoring and evaluation of HRH plans according to the above-mentioned criteria. There is wide variation in the number of countries per region (for example, AFR 20, EMR 1, SEAR 1, WPR 2 and none in AMR).

### Implementation of the HRH plan
Evidence that the plans are being implemented was found globally for 25 out of 45 countries (55%). For 7 countries (AFR 5, AMR 1, EMR 1), evidence was found that the plans are not being implemented. For one third of the other

countries, there were no reports or articles found to confirm that implementation was being carried out. Explanations for non-implementation included: the current unsafe/war situation in the country (Guinea-Bissau); financial constraints (Iraq); and slow process because of the involvement of intersectoral actors (Nicaragua).

### Monitoring, evaluation and implementation of the HRH plan
When the proportion of countries that have a monitoring and evaluation system for the HRH plan and that implemented the plan was reviewed, only 14 out of 45 countries (31%) met these criteria. The highest proportion was found in 11 countries in AFR.

The inclusion of a monitoring and evaluation mechanism in the HRH plan seems not to be a factor that influences the implementation of the programme. In AMR, EMR and SEAR, the proportion of HRH plans implemented was higher than the proportion of countries that had included a M&E mechanism in their plans (Figure 2.4). The survey did not provide information about the quality of the implementation.

Figure 2.4 Proportion of countries where M&E of the programme is foreseen compared to the evidence that the HRH plan is implemented, in WHO regions and globally
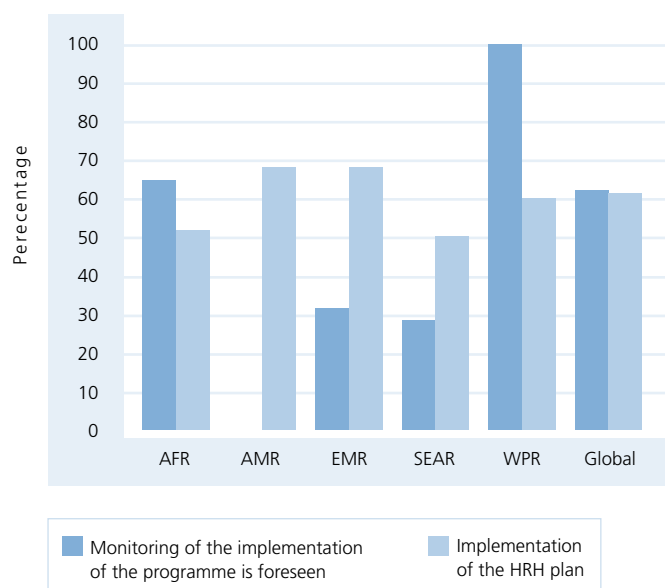


### Implications
The more frequently addressed strategy in the HRH plans to mitigate the HRH crisis is education (both pre-service education and in-service training courses) followed by recruitment policies and incentive schemes. Other strategies to strengthen the performance of the health workforce, such as skills mix, career development, workplace improvement and deployment policies, are addressed in a smaller number of plans.

Education was the most frequently cited strategy to improve on performance over other strategies and is common to national HRH plans, and to development partners. Frequently, development partners' support is directed at pre-service training (70%) and in-service training (74%). This part of the analysis includes HRH plans and documents relating to donor programmes, which are separate from national plans. This survey does not show whether this donor preference for education influences the strategic directions of national HRH plans, or whether donors decide to support it because the countries include it in their plans.

Although the majority of the plans cover HRH projections (35 out of 45 countries), these projections were limited to the public sector's HRH requirements for nearly half of these plans (18 out of 35 countries). This means that in only 30% (18 out of 57 countries) is there evidence to suggest that public and private needs for HRH were taken into account when planning for future HRH requirements. There is no reason to think that ministries of health in HRH crisis countries intentionally exclude the private sector, but information on the needs of the private sector with respect to HRH is not always available/known to the ministries. Not including an important part of the health providers' needs in projections limits the development of effective strategies to improve the use of all HRH in the country.

Human resources for health plans mainly address the challenges of the health workforce that is already in the system (education, deployment, retention), but they rarely focus on strategies to increase the number of human resources by exploring the possibilities in (international or national) labour markets.

The availability of national HRH plans is just a first step in successfully addressing the HRH crisis. The implementation of HRH plans (partially) could only be confirmed in 55% of the countries. The reason for non-implementation is only given in a few cases. Non-implementation can be related to the low attention paid to vital aspects needed to operationalize the plan. As much as 71% of the HRH plans were accompanied by an implementation budget, 53% of which included an M&E system to follow up on implementation.

## 2.2
## Leadership/governance capacity within the ministry of health

The second section of the survey template addresses leadership and governance capacities of a country with respect to HRH. There is more information available for those countries with a national HRH plan, but on certain aspects it was possible to include information on those countries that do not have one.

**Existence of a HRH unit within the ministry of health**
Globally, 89% of the countries surveyed have a HRH department in the ministry of health (51 out of 57 countries).

Globally, 42 out of 45 countries (91%) have both a HRH plan and a separate unit for HRH within the MoH. The variation between the regions is small. In AMR, EMR and WPR, all countries that have a HRH plan also have a HRH unit. In the majority of cases, the functions and capacity of these units could not be assessed because the requisite information (number/qualification of staff, office space, Internet access, availability of computers and software) was seldom provided in the available documents. Only one evaluation was found *(Fast evaluation of the health system of Benin (USAID), 2007)* that discussed the capacity of the HRH unit. Any information on capacity that was available was not found in official documentation, but was provided by WHO regional offices (e.g. in Iraq, the number of staff is 35). However, information on the functions and background of the staff is limited.

For most of the countries, the documents and HRH plans did not provide a great deal of information on the place of the HRH unit within the organizational structure or on the units' reporting responsibilities. Moreover, it was not clear whether these units coordinate their activities with human resources departments in other ministries. In Afghanistan, HRH is recognized as an important part of the Ministry of Public Health (MOPH). There is a General Directorate for HRH that reports directly to the Deputy Minister of Administrative Affairs of the Ministry of Health.

**Human resources for health observatory[5]**
The survey found that 14 out of 57 countries (25%) have a national HRH observatory (or a similar mechanism). The observatories are mostly found in countries in AMR (4 out of 5 countries). According to the WHO Regional Office for Africa, the establishment of a national observatory for HRH is under way in many countries (Angola, Côte d'Ivoire, Guinea Bissau, Malawi, Mozambique, Niger, Nigeria and Zimbabwe).

**Implications**
Governance and leadership capacity was assessed in this analysis by identifying:

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[5] The Human Resources for Health Observatory is a cooperative initiative among the countries and partners to produce, analyse and share information and knowledge necessary for: (i) integrating human resources in the health policy agenda; and (2) improving the development of evidence-based policies on human resources. The national level HRH observatories bring together different stakeholders at country level, including all relevant ministries, institutions, professional associations, academia and development partners. It creates a forum for policy dialogue, which is guided by evidence and information that allows the researchers, information producers and decision-makers to interact with each other.

- whether a HRH unit exists in the MoH;
- the place of the HRH unit in the organizational structure;
- whether a HRH observatory, as a mechanism for stakeholders' involvement and policy dialogue, exists in a country.

For some of these issues, the assessment was difficult because this information is not always included in the HRH plans or other country documents. In general, HRH units do exist in the MoH, but their capacity and functioning, and exact place in the organization, cannot be assessed by reading the plans and reports. This puts limits on the determination of the role of HRH units in HRH planning and policy development; the possibility that these units contribute to strategic planning; and on their authority to coordinate HRH actions. These issues warrant a separate study.

Human resources for health information systems to support evidence and information-based policy-making are under development in the majority of the countries with a HRH plan. However, it was not possible to identify how many countries already have a HRH information system, as there was no clear reference to this issue in most of the countries' documentation. It is highly likely that almost all the countries have at least payroll information, but there was no information on how they use it. For this reason, it was difficult to determine whether policy and management decisions are taken with the guidance of such an information system.

National observatories on HRH have proven that they can be effective mechanisms to strengthen evidence and information-based policy dialogue and decision-making[6]. Initiated in AMR in 1999, most countries now have a national HRH observatory. The Africa Health Workforce Observatory and the Eastern Mediterranean Region Observatory on Human Resources for Health were established in the 2000s. The establishment of observatories is 'in process' in many regions and countries. In SEAR, the regional HRH observatory is soon to be launched.

It could be argued that the survey did not provide enough information on the countries' governance and leadership capacity, but provided more on the management structure within the MoH. However, governance capacity can also be assessed by examining the way the HRH crisis is addressed, for example, the development of sound HRH plans can be a result of leadership/governance capacity, but the implementation of the plans may be a better way of measuring this capacity.

[6] Gedik G et al. Chapter 12: Getting information and evidence into policy-making and practice: strategies and mechanisms. In: Dal Poz M et al, eds. *Handbook on monitoring and evaluation of human resources for health*. Geneva, World Health Organization, 2009.

## 2.3 Partnerships

The third section of the survey template addresses 'partnerships'. These partnerships are reflected in two main elements.

1. The involvement of various stakeholders in the development of a HRH plan. This part of the analysis discusses the findings for the countries that have a plan. However, it should be noted that there might be other possibilities and ways of involving stakeholders.

2. The availability of a coordination mechanism for various stakeholders in the MoH. This part of the analysis includes countries without a plan.

**Involvement of stakeholders in the development of the HRH plan**
The various stakeholders are divided into three categories:

- the public sector – ministry of education (ministry of finance or public service commission or civil service commission);
- the private sector – private for-profit (PFP) and private non-profit (PNP);
- multilateral development partners (MLDPs), bilateral development partners (BLDPs) or a global health initiative (GHI).

It appears that 36 out of 45 countries (80%) developed their HRH plans with stakeholders from at least two of the three categories. This percentage may be higher because, in some of the documents reviewed, the page with acknowledgements for the HRH plan was missing (e.g. the Gambia).

The involvement of the public sector is highest at 36 out of 45 countries (80%). The participation of public service commissions/ministries of labour, etc. is lowest at 15 out of 45 countries (33%), globally (Figure 2.5).

The private sector is involved in the development of the HRH plans in 21 out of 45 countries (47%) (Figure 2.6). The private education sector contributes mostly to this in 18 out of 45 countries (40%). In EMR and SEAR, the private sector has been involved in the HRH plans of all countries. In AFR, the involvement of the private education sector is particularly low at 9 out of 31 countries (29%).

The involvement of local faith-based NGOs is only documented in Anglophone Africa (6 out of 13 countries) and in WPR 1 out of 2 countries (the Lao People's Democratic Republic). In the 6 African countries, this involvement is probably due to existing umbrella organizations for Christian health organizations.

Figure 2.5 Proportion of countries that developed HRH plans with stakeholders from the public sector, in WHO regions and globally



The review of the international donor community's involvement in the development of the HRH plans in all regions revealed that MLDPs are involved in 26 out of 45 countries (58%), BLDPs are involved in 24 out of 45 countries (53%), and GHI in 7 out of 45 (16%), the lowest rate (Figure 2.7).

Figure 2.7 Proportion of countries that developed HRH plans with various stakeholders from the international community, in WHO regions and globally



There was involvement of professional associations in 18 out of 45 countries (40%). This aspect shows a wide variation in the regions with high proportions of involvement in AMR (100%) and WPR (67%). There is also variation in the involvement of local NGOs in the different regions. International nongovernmental organizations (INGOs) and civil society organizations (CSOs) are hardly involved in the development of HRH plans.

Figure 2.6 Involvement of private sector stakeholders in the development of HRH plans, in WHO regions and globally
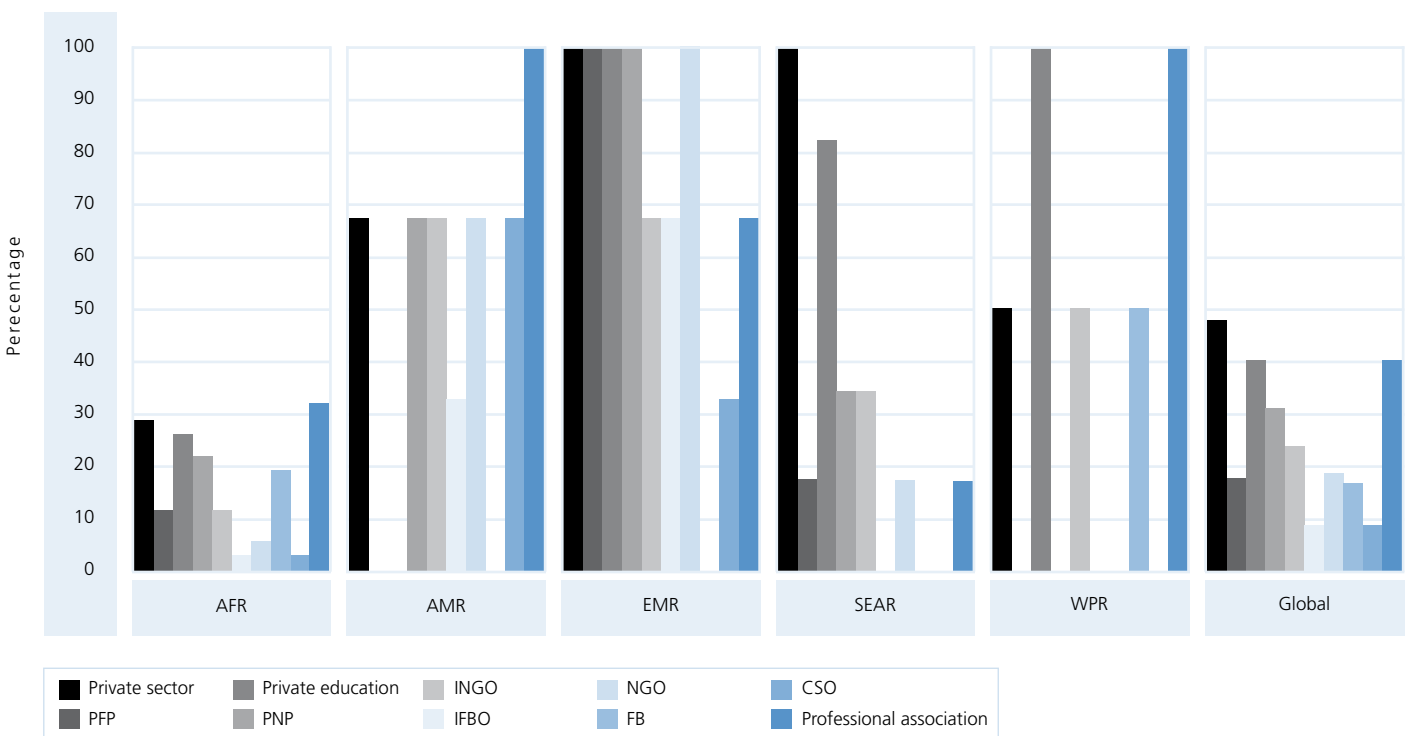
The data show that, globally, only 6 countries (13%) have a HRH plan where no coordination mechanism (SWAp) is in place; all 6 countries are located in Africa. If countries have a coordination mechanism within their MoH, they often also have a HRH plan, which was the case in 38 out of 45 (84%) of the countries with a separate HRH plan.

**Implications**
Partnerships are important for the development and implementation of the HRH plans. Countries that have mechanisms in place within the MoH to coordinate stake-holders' activities and policies are more likely to have a HRH plan. However, there is no information on the implementation benefits from such partnerships.

In general, plans are developed with a variety of stakeholders. Involvement of the private sector, an important sector for the delivery of health care, is lower than the involvement of the international donor community. This is mainly due to the low proportion of countries in AFR that involve the private sector in the development of the plans. It was not possible to analyse the reasons for this, as they are neither documented in the HRH plans nor in other documents.

## 2.4
## Commitment (investment)

The fourth section of the survey template addresses 'commitment', which examines the investment that stakeholders make to support the realization of the HRH plans. In this section, the interests of donors to invest in diverse HRH activities that are not part of a national HRH plan (e.g. GAFTM) are part of the analysis.

**Costing the HRH plan**
Globally, 32 out of 45 countries (71%) with HRH plans include an implementation budget, but this varies between regions. For example, in EMR, only 1 country (Iraq) was found while all WPR countries made a budget for the HRH plan.

Even in those plans that include a budget, not all costs are covered. For example, the plans in the Gambia and Ghana only included a budget for education activities while in Niger the budget covers education and recruitment costs. Salary costs are not always reflected in the plans, probably because these are paid from the budgets of other ministries (i.e. finance, public services, etc.).

**Appropriate or increased allocation from national resources**
Globally, appropriate or increased allocation from national resources to implement the plans is low at 17 out of 45 countries (38%). This is lower than the proportion of plans that are costed. Countries in AFR pay most attention to this

with 15 out of 31 countries (48%) planning to invest in the implementation of the plan.

**Donor commitment to the plan**
Overall, 29 out of 45 countries (64%) receive donor funding for the plans. The lowest proportion of countries that receive donor funding is in AFR at 17 out of 31 countries (55%).

It was found that costed plans are more likely to receive donor funding, and the review showed that, globally, 23 out of 32 countries (72%) received such funding. In AFR, fewer countries receive donor funding for their HRH plans, although 15 out of 31 countries (48%) commit themselves in the plans to increase their budgets, a high percentage when compared to the other regions (Figure 2.8).

Figure 2.8 Proportion of costed HRH plans that receive donor funding compared to the commitment of countries to increase their budget allocation from national funds, in WHO regions and globally
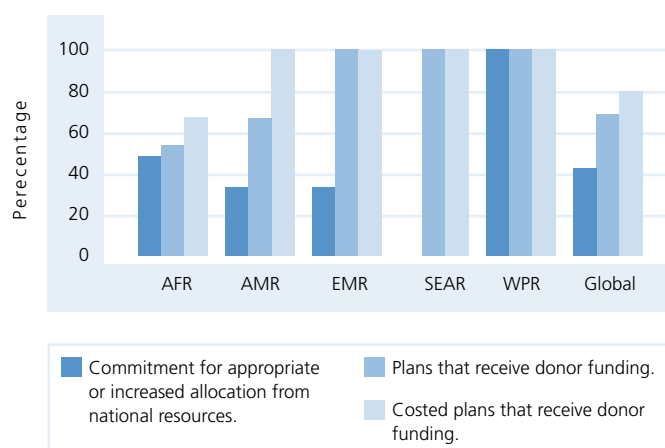


**Type of HRH development activities supported by the international donors**
For this part of the analysis the national HRH plan and documentation from donor agencies were reviewed. In this case, the countries without a national HRH plan but receiving donor funding for HRH activities were included in the analysis.

Out of the 57 countries, the international donors' support the following activities:

- pre-service education in 40 countries (70%);

- in-service training in 42 countries (74%);

- development of HRH policies and plans in 33 countries (58%);

- HRH information system in 29 countries (51%);

- incentives in 23 countries (40%);

- recruitment (mainly salary support but, in some cases, also support for recruitment mechanisms) in 19 countries (33%).

The variation between regions is small. It seems that donors are quite consistent in their preferences for supporting HRH (Figure 2.9). However, it should be noted that reference is made to the number of countries that received some kind of support, but the magnitude of the support is not mentioned.

Figure 2.9 Proportion of the type of HRH activities supported by development partners, in WHO regions and globally



**Donors that support HRH activities**

The percentage of donors that support HRH activities was not analysed as it was reported in the documents reviewed that funding is regularly given through basket funding. For this reason, it is not possible to provide a comprehensive list of the most important donors.

**Implications**

The countries' commitment to addressing the HRH crisis was assessed by counting the number of HRH plans that mentioned that the investment of the national government would be appropriate or at least increased to enable the plan's implementation. This was the case for only 40% of them. The fact that such a low proportion of the countries foresaw increased investment in HRH, when 71% of the plans had a budget, further explains why successful implementation of the plans is so difficult.

The analysis revealed that the financial commitment of the international donor community is higher for the budgeted HRH plans (71%) as compared to all the plans that receive donor funding (64%), demonstrating that donors pay attention to the budgets of HRH plans.

It was not possible to analyse what proportion of public health expenditure or gross domestic product (GDP) is used or reserved for HRH because of a lack of information in the documents reviewed.

## 2.5
## Progress in the implementation of the Kampala Declaration

As mentioned earlier in this report, the First Global Forum on Human Resources for Health was held in March 2008 with the participation of governments, multilateral, bilateral and academic institutions, civil society, the private sector, and health workers' professional associations and unions. The Kampala Declaration expresses the commitment of governments and the international community to mitigate the global HRH crisis, especially in the 57 countries that were declared to be in "crisis".

The database resulting from the tracking survey can be of assistance in monitoring the follow-up of the Kampala Declaration at country, regional and global level. The declaration comprises of 12 action articles. However, some of the articles under the Kampala Declaration (KD) cannot be tracked at country level, such as KD 7 ("accelerate negotiations for a code of practice on international recruitment of health personnel") and KD 12 (charging the Secretariat, "to re-convene this Forum"). Article 8 (calling on countries to, "work collectively to address current and anticipated global health workforce shortages") is also difficult to monitor through country-level activities.

Even though there were articles to capture issues such as regulation and education investment, KD 4 ("Governments to devise rigorous accreditation systems for health worker education and training, complemented by stringent regulatory frameworks developed in close cooperation with health workers and their professional organizations.") could not be assessed due to the lack of information. This is quite significant and implies a gap in practices in these areas, especially on accreditation and regulation.

Leadership and management as highlighted in KD 5 ("Governments, civil society, private sector, and professional organizations to strengthen leadership and management capacity at all levels.") have always been difficult areas to monitor. Some proxy indicators need to be identified. In the case of HRH, the capacity and roles of HRH units can be used as one of the proxy indicators, as in KD 1.

Although there are no clearly defined indicators to follow up on the implementation of the Kampala Declaration, progress can be assessed on the basis of some indications in each of the articles. This section provides some highlights and a baseline for further monitoring of the Kampala Declaration, based on the findings of the tracking survey.

**KD 1.** "Government leaders to provide the stewardship to resolve the health worker crisis, involving all relevant stakeholders and providing political momentum to the process."

The existence of HRH plans and strategies, and HRH units/departments, were considered as proxies to provide some indicators. Out of 45 countries that have HRH plans, 41 (91%) of them have other public agencies, development partners or private agencies participating in HRH planning. Overall, there are 55 countries that have at least one of the following four characteristics: a HRH plan, a HRH unit, stakeholder involvement or the plan implemented.

A costed HRH plan developed in participation with the public sector was found in 25 countries out of a total of 57 crisis countries (44%), and multilateral development partner involvement was tracked in 23 out of the 57 countries (40%) of the total crisis countries. For all other partners, this percentage was even lower.

However, the reasons for the low result in respect to countries that have costed HRH plans developed by relevant stakeholder vary per region. In EMR, a low proportion of countries have costed their HRH plans (Figure 2.10). In AFR, a low proportion of countries have developed plans with the participation of the private sector.

**KD 2.** "Leaders of bilateral and multilateral development partners to provide coordinated and coherent support to formulate and implement comprehensive country health workforce strategies and plans".

Figure 2.10 Proportion of surveyed countries that have a costed HRH plan developed in participation with various stakeholders
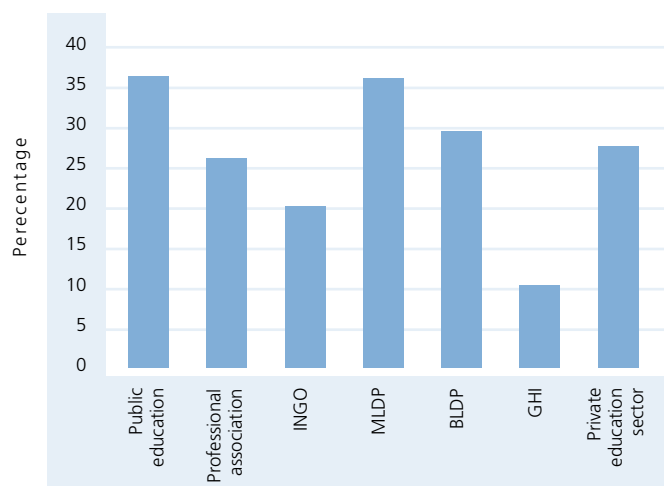


For this KD, the number of countries with a HRH coordination mechanism and with coordinated national action plans was considered. The review showed that 29 countries received donor support, at least for part of the plan. Out of the 45 countries with national HRH plans, 28 of them (62%) received support from donors to develop HRH policies and plans. Out of the 57 countries with a HRH crisis, 48 of them (84%) received donor support for HRH activities, such as pre-service and in-service training, recruitment, incentive schemes and HRH information systems. Although they did not have HRH plans, 10 countries (17%) received support for their HRH activities.

**KD 3.** "Governments to determine the appropriate health workforce skill mix and to institute coordinated policies, including through public private partnerships, for an immediate, massive scale-up of community and mid-level health workers, while also addressing the need for more highly trained and specialized staff."

The review explored the contents of the plan, but these questions address health workers in general and are not specific to community health workers, middle-level health workers or to a specialized health workforce. There are 24 countries that have policies or plans addressing skills mix. In all, 42 countries reported having pre-service education as part of the plan and 31 countries reported having recruitment targets.

**KD 6.** "Government to assure adequate incentives and an enabling and safe working environment for effective retention and equitable distribution of health workforce." Enacting measures conducive to an equitable distribution of the health workforce, and attracting and retaining health workers in rural areas, in particular, is a challenge faced by many countries. By using incentives and work environment combined as an alternative to retention issues, data from the tracking survey showed that only 6 countries fully implemented KD

6 by involving stakeholders in the planning process, and applying retention and equitable distribution approaches. Data from the tracking survey indicated that 6 countries, namely, Afghanistan, Ghana, Malawi, Peru, Rwanda and Zambia are implementing plans that cover incentives, working environments, deployment and distribution of health workforce.

**KD 9.** "Governments to increase their own financing of the health workforce, with international institutions relaxing the macroeconomic constraints of their doing so."

The number of countries in which budgetary allocations have increased for HRH as a proportion of the health sector budget is used as a proxy for this KD. There is scarce information on HRH financing at the country level and also on relaxing macroeconomic constraints. The findings of the tracking survey show that there are 17 countries that have committed to increasing allocations from national resources or have strategies to do so.

**KD 10.** "Multilateral and bilateral development partners to provide dependable, sustained and adequate financial support and immediately to fulfill existing pledges concerning health and development."

This KD reflects global commitment to health and development in general. There are 30 countries that receive support from multilateral and/or bilateral partners for the implementation of HRH plans.

**KD 11.** "Countries to create health workforce information systems, to improve research and to develop capacity for data management in order to institutionalize evidence-based decision-making and enhance shared learning."

The tracking survey enquired whether HRH statistics were regularly updated. The responses revealed that there are 17 countries with regularly updated HRH statistics, and 14 countries with national HRH observatories or similar mechanisms, which bring together different stakeholders for evidence-based policy dialogue, information sharing and monitoring. Human resources for health information systems are part of the function of the HRH units in 22 countries, and 13 countries address HRH information in their HRH plans.

# 3

## Policy discussion

The tracking survey has provided an overview of the current situation in terms of HRH policies, plans, capacities and processes in countries with critical health workforce deficits. Although it has been limited by drawing solely on secondary data, it has, nevertheless, contributed to a better understanding of some of the crucial issues.

The findings show that the majority of the countries with a HRH crisis (45 out of 57) developed plans to address it. They generally pay more attention to the planning of straightforward HRH activities (education, incentives, etc.) than to aspects related to the potential to implement the plan successfully (monitoring, evaluation and financing).

In the countries with a HRH crisis, there is an understanding that HRH is a priority in strengthening health systems and health service delivery, but the low implementation rate of these plans, and the lack of attention being paid to monitoring and evaluation, and to financing are signs of weak government capacity – politically, technically and administratively – to address the HRH crisis.

The survey also suggests the importance of strengthening HRH information systems, which is a mostly neglected area. Improved HRH information collection can also enable better monitoring of HRH development. The tracking survey provided a baseline to this end, but the challenge ahead is to ensure that mechanisms for the continuous monitoring of progress are in place. The database developed through this survey could be used for further analysis.

However, the major challenge lies with implementation. A more thorough understanding of the underlying reasons hampering implementation is critical. This is most likely due to insufficient commitment and inadequate capacity, which remains to be further documented. Thus, these are the critical intervention areas for immediate action.

As pointed out, this tracking survey is based on a desk review of secondary data sources. Health workforce observatories are working with countries to develop HRH country profiles to provide more detailed analyses of the human resources for health situation in the countries. These will be regularly updated and will provide an opportunity to monitor progress at country level.

The World Health Organization and other agencies are also undertaking studies to further explore some of the issues and develop strategies to address the challenges. The assessment of capacity within HRH units and departments is an example of this. The need for increased investment in human resources for health is very clear and there is an ongoing global effort to draw attention to issues related to aid effectiveness and ensure that investment in HRH accelerates the implementation of plans and strategies.

# Annex 1. Survey research template

Template for review
Country name:
Papers reviewed:

1.
2.
3.
...

| Questions | Findings | Remarks (if any) | Source and web link (if available) |
|---|---|---|---|
| **1.STRATEGIC DIRECTION** | | | |
| **1.1 National HRH policy, strategy, plan** | | | |
| 1. Is there a national development policy/strategy/ plan for Human Resources for Health (HRH)? | Yes ( )  No ( ) | | |
| (a) A Separate HRH plan | | | |
| (b) A separate chapter devoted to HRH in the national health plan | | | |
| (c) A separate plan in a national general HR plan | | | |
| 2. IF NO, is there recognition of the HRH issues and an expressed intention/commitment to develop a HRH development plan? | Yes ( )  No ( ) | | |
| IF YES, | | | |
| 3. Is the current plan the first HRH policy/strategy/ plan? | Yes ( )  No ( ) | | |
| 4. What is the period covered by current the plan? | ................... | | |
| 5. Is it linked to an overall national development plan? | Yes ( )  No ( ) | | |
| 6. Is it linked to a PRSP? | Yes ( )  No ( ) | | |
| 7. Is it linked to a national health policy | Yes ( )  No ( ) | | |
| 8. Is the plan being implemented? | Yes ( )  No ( ) | | |
| **Contents** | | | |
| 9. Does the policy/strategy/plan include projections of the HRH needs for providers of services | Yes ( )  No ( ) | | |
| 10. Do the projections cover the public, private for profit and non-profit sectors? | Yes ( )  No ( ) | | |
| 11. Is the policy/strategy/plan linked to macroeconomic context of the country (i.e. MTEF, PRSP, recruitment ceilings, etc.)? | Yes ( )  No ( ) | | |
| 12. Does the policy/strategy/plan address issues of: | | | |
| (a) education: pre-service | Yes ( )  No ( ) | | |
| (b) education: in-service | Yes ( )  No ( ) | | |
| (c) educational targets (number of health workers to be trained) | Yes ( )  No ( ) | | |
| (d) recruitment processes | Yes ( )  No ( ) | | |

| Questions | Findings | Remarks (if any) | Source and web link (if available) |
|---|---|---|---|
| (e) recruitment targets (number of workers | Yes ( )  No ( ) | | |
| (f) deployment and distribution | Yes ( )  No ( ) | | |
| (g) skill mix | Yes ( )  No ( ) | | |
| (h) remuneration | Yes ( )  No ( ) | | |
| (i) incentives | Yes ( )  No ( ) | | |
| (j) supervision | Yes ( )  No ( ) | | |
| (k) learning opportunities | Yes ( )  No ( ) | | |
| (l) workplace environment | Yes ( )  No ( ) | | |
| (m) career development | Yes ( )  No ( ) | | |
| (n) performance management | Yes ( )  No ( ) | | |
| (o) mobility of staff | Yes ( )  No ( ) | | |
| (p) scope of practice | Yes ( )  No ( ) | | |
| (q) regulation | Yes ( )  No ( ) | | |
| (r) HRH information | Yes ( )  No ( ) | | |
| Other | | | |
| 13. In decentralized systems, does the policy/strategy/plan address decentralization of decision-making on HRH issues, e.g. management functions such as payroll, promotion, discipline? | Yes ( )  No ( ) If yes, what type of studies: ..................... | | |
| 14. Have workload and other studies been performed to address rectifying HRH imbalances between levels of care and the urban rural environment? | Yes ( )  No ( ) | | |
| **Monitoring and evaluation mechanisms** | | | |
| 15. Is there a monitoring and evaluation mechanism to document the implementation of the policy/strategy/plan? | Yes ( )  No ( ) | | |
| 16. Is there a national plan for monitoring and evaluation of national HRH strategic objectives? | Yes ( )  No ( ) | | |
| 17. Are there regularly updated HRH statistics? | Yes ( )  No ( ) | | |
| 18. What are the sources of HRH data, i.e. administrative data, facility survey, population census, etc? | Sources within and outside the health sector Sources of the MoH only Sources not explicitly specified Please further specify ……….…..... | | |
| 2. LEADERSHIP AND GOVERNANCE CAPACITIES | | | |
| 2.1 HRH Governance capacity in MoH | | | |
| 19. Is there a HRH department/unit/team in the MoH responsible for developing, implementing and monitoring HRH strategies? | Yes ( )  No ( ) | | |
| 20. If yes, what are the functions of the department/unit/team? | | | |
| HRH policy development | Yes ( )  No ( ) | | |
| HRH planning | Yes ( )  No ( ) | | |
| Personnel administration | Yes ( )  No ( ) | | |
| Training and development | Yes ( )  No ( ) | | |

| Questions | Findings | Remarks (if any) | Source and web link (if available) |
|---|---|---|---|
| HRH information system | Yes ( )   No ( ) | | |
| Research, studies, documentation | Yes ( )   No ( ) | | |
| Monitoring and evaluation | Yes ( )   No ( ) | | |
| Other | | | |
| 21. What is capacity of the HRH unit, in terms of staffing and, if the information is available, what are their qualifications? | No. of staff ………………… | | |
| a.  Adequate office space | Yes ( )   No ( ) | | |
| b.  Adequate  computers, relevant software | Yes ( )   No ( ) | | |
| c.  Internet access | Yes ( )   No ( ) | | |
| d.  Others | Please specify ……………….. | | |
| 22. What is the level of the HRH unit in the organizational chart of the MoH? | Please explain: | | |
| 23. Who does the unit report to? | Please explain: | | |
| 24. Are there other HRH units in other sectors (i.e. defence, etc. or "national planning commission" or civil service office may have a cross-sector HR offices which influence health)? | Yes ( )   No ( ) If yes, please specify | | |
| 25. If yes, is there any relation of these units to the HRH unit in MoH? | Yes ( )   No ( ) If yes, please specify ……………… | | |
| 26. Is there a national HRH observatory or a similar mechanism bringing together different stakeholders for evidence based policy dialogue, sharing information and monitoring? | Yes ( )   No ( ) In process ( ) Please specify ……………… | | |
| **3. PARTNERSHIP** | | | |
| **3.1 Stakeholders coordination** | | | |
| 27. Is a SWAp or other coordinating mechanism or body in the health sector (donor coordination, interdepartmental coordination, etc.)? | Yes ( )   No ( ) If yes, please specify ……………… | | |
| 28. Have various stakeholders (public, private, NGO, CSO, international) been involved in the process of creating the HRH policy/strategy/plan? | Yes ( )   No ( ) If yes, please specify ……………… | | |
| **Public sector** | | | |
| Ministry of education | Yes ( )   No ( ) | | |
| Ministry of finance | Yes ( )   No ( ) | | |
| Ministry/commission of public service | Yes ( )   No ( ) | | |
| Others | If yes, please specify ……………… | | |
| **Nongovernmental participation** | | | |
| Private for profit sector | Yes ( )   No ( ) | | |
| Private education sector (training schools, universities) | Yes ( )   No ( ) | | |
| Private non-profit | | | |
| International secular NGO | Yes ( )   No ( ) If yes, please specify ……………… | | |
| International faith-based | Yes ( )   No ( ) If yes, please specify ……………… | | |

| Questions | Findings | Remarks (if any) | Source and web link (if available) |
|---|---|---|---|
| National (secular) NGO | Yes ( )  No ( ) | | |
| Faith-based NGO | Yes ( )  No ( ) | | |
| CSO | Yes ( )  No ( )<br>If yes, please specify ………………. | | |
| Professional associations | Yes ( )  No ( )<br>If yes, please specify ………………. | | |
| Multilateral development partners | Yes ( )  No ( )<br>If yes, please specify ………………. | | |
| Bilateral  development partners | Yes ( )  No ( )<br>If yes, please specify ………………. | | |
| Global Health Initiatives and Foundations | Yes ( )  No ( )<br>If yes, please specify ………………. | | |
| | | | |
| 29. Has the Plan been approved at inter-ministerial level (Education, Finance, Public Service, MoH)? | Yes ( )  No ( ) | | |
| **4. COMMITMENT (INVESTMENT )** | | | |
| **4.1 Investment on HRH** | | | |
| 30. Has the policy/strategy/plan been costed? | Yes ( )  No ( ) | | |
| 31. Is there an investment plan for training and education? | Yes ( )  No ( ) | | |
| 32. Is there a commitment or strategy for appropriate or increased allocation from national resources? | Yes ( )  No ( ) | | |
| 33. What is HRH expenditure as % of public health expenditure? | | | |
| 34. What is HRH expenditure as % of GDP | | | |
| **4.2 Partnership and international support** | | | |
| 35. Has the donor commitment been ensured, at least for part of the plan? | Yes ( )  No ( ) | | |
| 36. List the main international and bilateral partners which support HRH development | Please specify<br>…………………. | | |
| 37. How much of the donor support is allocated to HRH? | In US$ | | |
| 38. What percentage of total aid to health this above amount represents? | | | |
| 39. What types of HRH development activities are supported by the development partners (i.e. policy / plan development, in-service training, preservice training, recruitment, incentive schemes, etc.)? | | | |
| (a) policy & plan development | Yes ( )  No ( ) | | |
| (b) pre-service training | Yes ( )  No ( ) | | |
| (c) in-service training | Yes ( )  No ( ) | | |
| (d) recruitment | Yes ( )  No ( ) | | |
| (e) incentive schemes | Yes ( )  No ( ) | | |
| (f)  HRH information systems | Yes ( )  No ( ) | | |

## Annex 2. Documents and web sites reviewed for the human resources for health tracking survey

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### Web sites

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## Annex 3. Tables presenting qualitative and quantitative data from the HRH tracking survey

### A. strategic directions

Table 1 HRH policies and plans, and their comprehensiveness

| Strategic directions<br>Whether there are HRH policies and plans and their comprehensiveness | AFR | AMR | EMR | SEAR | WPR | Global |
|---|---|---|---|---|---|---|
| Total number of countries | 36 | 5 | 7 | 6 | 3 | 57 |
| Countries with separate HRH plans | 31 | 3 | 3 | 6 | 2 | 45 |
| Plans well integrated into national policies | 27 | 2 | 3 | 6 | 2 | 40 |
| HRH plan includes projections of the HRH needs | 25 | 3 | 3 | 3 | 1 | 35 |
| Projections cover the public/PFP/PNP sector | 10 | 3 | 3 | 1 | 1 | 18 |

Table 2 Top five topics found in HRH plans

| Strategic directions<br>The top five for topics found in the HRH plans | AFR | AMR | EMR | SEAR | WPR | Global | Global* |
|---|---|---|---|---|---|---|---|
| Total number of countries with a HRH plan | 31 | 3 | 3 | 6 | 2 | 45 | – |
| (a) Pre-service education | 29 | 3 | 3 | 5 | 2 | 42 | 42 |
| (b) In-service education | 25 | 3 | 3 | 5 | 2 | 38 | 38 |
| (c) Educational targets | – | – | 3 | 5 | 2 | 32 | 32 |
| (d) Recruitment processes | – | – | 3 | 5 | – | – | 24 |
| (e) Recruitment targets | – | – | 3 | – | 2 | – | 31 |
| (f) Deployment and distribution | – | – | 3 | – | 2 | – | 31 |
| (g) Skill mix | – | – | – | 5 | – | – | 24 |
| (h) Remuneration | – | – | – | – | 2 | – | 31 |
| (i) Incentives | 25 | – | – | – | 2 | 34 | 34 |
| (j) Supervision | – | – | – | – | – | – | 24 |
| (k) Learning opportunities | 23 | – | – | – | – | – | 27 |
| (l) Workplace environment | – | – | – | – | 2 | – | 24 |
| (m) Career development | 23 | 3 | – | – | 2 | 35 | 35 |
| (n) Performance management | – | – | – | – | – | – | 25 |
| (o) Mobility of staff | – | – | – | – | – | – | 19 |
| (p) Regulation | – | 3 | – | – | – | – | 14 |
| (q) HRH information | – | 3 | 3 | – | 2 | – | 30 |
| Other issues addressed in the plans | | | | | | | |
| Projection of HRH needs are included in the HRH plan | 25 | 3 | 3 | 3 | 1 | 35 | – |
| HRH projections cover the public/ PFP/PNP sector | 10 | 3 | 3 | 1 | 1 | 18 | – |
| Decentralization | 21 | 2 | 2 | 3 | – | 28 | – |

* The last column reflects the total number of countries that mentioned the strategic direction in its HRH plan.

Table 3 Content of the HRH plans

| Strategic directions<br>The scaling up of health worker education and training | AFR | AMR | EMR | SEAR | WPR | Global |
|---|---|---|---|---|---|---|
| Total number of countries with a HRH plan | 31 | 3 | 3 | 6 | 2 | 45 |
| Plans that cover the education (pre- and in-service) of health workers | 25 | 3 | 3 | 6 | 2 | 39 |
| Working conditions to improve retention | | | | | | |
| Plans that cover processes and targets for recruitment of health workers | 14 | 2 | 3 | 4 | – | 23 |
| Plans that include remuneration of health workers | 21 | 2 | 2 | 2 | 1 | 28 |
| Plans that address skill mix/scope of practice | 17 | 1 | 1 | 5 | – | 24 |
| Deployment and distribution of staff are included in the plan | 20 | 2 | 3 | 4 | 2 | 31 |
| Incentive schemes addressed are included in the plan | 23 | 2 | 2 | 3 | 2 | 32 |
| The workplace environment is addressed in the plan | 17 | 1 | 2 | 2 | 2 | 24 |

Table 4 Content of the HRH plans: implementation and M&E of the programme

| Strategic directions<br>Implementation  and  M&E of the programme | AFR | AMR | EMR | SEAR | WPR | Global |
|---|---|---|---|---|---|---|
| Total number of countries | 36 | 5 | 7 | 6 | 3 | 57 |
| Total number of countries with a HRH plan | 31 | 3 | 3 | 6 | 2 | 45 |
| Implementation of the HRH plan | 17 | 2 | 2 | 3 | 1 | 25 |
| Monitoring of the implementation of the programme is foreseen | 20 | – | 1 | 1 | 2 | 24 |
| A plan, implemented together with a mechanism for M&E and a national plan for evaluation | 11 | – | – | 1 | 2 | 14 |
| HRH plans are (partially) developed on the basis of national studies | 11 | 1 | 1 | 2 | 1 | 16 |

**B. Leadership/governance capacity**

Table 5 Existence of HRH management units and their capacity

| Leadership/governance capacity<br>Existence of HRH management units and their capacity | AFR | AMR | EMR | SEAR | WPR | Global |
|---|---|---|---|---|---|---|
| Total number of countries | 36 | 5 | 7 | 6 | 3 | 57 |
| Countries with a HRH unit | 33 | 4 | 6 | 5 | 3 | 51 |
| Countries with a national HRH observatory | 8 | 4 | 2 | – | – | 14 |
| Total number of countries with a HRH plan | 31 | 3 | 3 | 6 | 2 | 45 |
| Countries with a HRH plan and a HRH unit | 29 | 3 | 3 | 5 | 2 | 42 |
| HRH plans are (partially) developed on the basis of national studies | 11 | 1 | 1 | 2 | 1 | 16 |

## C. Partnerships

Table 6 Participation with stakeholders

| Stakeholders | AFR | AMR | EMR | SEAR | WPR | Global |
|---|---|---|---|---|---|---|
| **Number of countries with a HRH plan** | 31 | 3 | 3 | 6 | 2 | 45 |
| Stakeholders involved in the planning of the HRH plan: | | | | | | |
| Public sector: | 24 | 3 | 3 | 4 | 2 | 36 |
| - ministry of education | 17 | 2 | 3 | 3 | 1 | 26 |
| - ministry of finance | 18 | 1 | 3 | 3 | 2 | 27 |
| - ministry of labour/public service commission | 9 | 1 | 1 | 3 | 1 | 15 |
| Private sector: | 9 | 2 | 3 | 6 | 1 | 21 |
| - private for-profit sector | 4 | – | 3 | 1 | – | 8 |
| - private education sector | 8 | – | 3 | 5 | 2 | 18 |
| - private non-profit sector | 7 | 2 | 3 | 2 | – | 14 |
| - International nongovernmental organizations | 4 | 2 | 2 | 2 | 1 | 11 |
| - international faith-based organizations | 1 | 1 | 2 | 0 | – | 4 |
| - nongovernmental organizations | 2 | 2 | 3 | 1 | – | 8 |
| - local faith-based organizations | 6 | – | – | – | 1 | 7 |
| - civil society organizations | 1 | – | – | – | 1 | 2 |
| - professional associations | 10 | 3 | 2 | 1 | 2 | 18 |
| Multinational development partners | 15 | 3 | 3 | 4 | 1 | 26 |
| Bilateral development partners | 14 | 3 | 2 | 3 | 2 | 24 |
| Global health initiatives | 3 | – | 2 | 1 | 1 | 7 |
| | | | | | | |
| **Countries that have developed the plan with various stakeholders** | 25 | 3 | 3 | 3 | 2 | 36 |

Table 7 The presence of a SWAp mechanism

| Context | AFR | AMR | EMR | SEAR | WPR | Global |
|---|---|---|---|---|---|---|
| **Number of countries with a HRH plan** | 31 | 3 | 3 | 6 | 2 | 45 |
| **Number of countries with a separate HRH plan that has a SWAp mechanism** | 24 | 3 | 3 | 6 | 2 | 38 |

**D. Commitment**

Table 8 Commitment of national governments and the international donor community to implementation of the plan

| Investment in HRH interventions | AFR | AMR | EMR | SEAR | WPR | Global |
|---|---|---|---|---|---|---|
| **Number of countries with a HRH plan** | 31 | 3 | 3 | 6 | 2 | 45 |
| Countries with a separate costed HRH plan | 23 | 2 | 1 | 4 | 2 | 32 |
| Commitment for appropriate or increased allocation from national resources | 15 | 1 | 1 | – | – | 17 |
| Plans that receive donor funding | 17 | 2 | 3 | 5 | 2 | 29 |
| Costed plans that receive donor funding | 15 | 2 | 0 | 4 | 2 | 23 |

| Type of HRH activities supported by development partners | AFR | AMR | EMR | SEAR | WPR | Global |
|---|---|---|---|---|---|---|
| Total number of countries | 36 | 5 | 7 | 6 | 3 | 57 |
| Pre-service training | 22 | 3 | 6 | 6 | 3 | 40 |
| In-service training | 26 | 5 | 6 | 3 | 2 | 42 |
| Recruitment | 11 | – | 5 | 2 | 1 | 19 |
| Policy and plan development | 21 | 2 | 6 | 3 | 1 | 33 |
| Incentives | 13 | 2 | 5 | 2 | 1 | 23 |
| HRH information | 17 | 4 | 5 | 1 | 2 | 29 |

In order to understand and monitor the progress in developing and implementing HRH policies in the 57 countries experiencing a critical deficit in the health workforce, this tracking survey provides an overview of the current situation in terms of HRH policies, plans, capacities and processes. The scope of the study focuses on four dimensions, which are considered essential in developing a strong health workforce and in enabling progress to be monitored: strategic directions, governance and leadership, partnership and commitment. It contributes to a better understanding of some of the crucial issues and it is expected that this publication will contribute to stimulating the debate on HRH policies and practices at international level, and within the countries concerned.

## About Human Resources for Health Observer

The WHO-supported regional health workforce observatories are cooperative mechanisms, through which health workforce stakeholders share experiences, information and evidence to inform and strengthen policy decision-making. The Human Resources for Health Observer series makes available.

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