GFF HUMAN RESOURCES FOR HEALTH OPERATIONAL PLAN: 2023-2025

OVERVIEW

The GFF cannot achieve better health for women, children and adolescents without the doctors, nurses, midwives, allied health and care professionals, and community health workers (CHWs) needed to deliver comprehensive, high-quality reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N) services. However, the coverage, distribution, skills, and coordination of health and care workers in GFF-eligible countries are insufficient to achieve universal health coverage (UHC) and other global health goals, in part due to limited policy implementation, inadequate data, and fragmented investments. Where historically external support to national human resources for health (HRH) strategies has been uncoordinated, opportunistic, and reactive to gaps, the GFF partnership has an opportunity to help address systematic drivers of insufficient HRH quality, coverage, and integration toward more resilient and responsive health systems. Better coordinated and aligned GFF investments in HRH can deliver a "triple return": for health outcomes, global health security, and economic growth (WHO 2016).

At the June 2022 IG meeting, Ministers of Health highlighted the foundational challenges and fiscal constraints that they face to finance and support their existing health workforces. The GFF Investors Group (IG) approved the HRH Agenda[i] and requested the Secretariat to develop this HRH Operational Plan. To oversee the plan's development, the Secretariat solicited IG members for an HRH Technical Working Group (TWG), which convened from August through October 2022. In addition, the Secretariat conducted an HRH portfolio analysis for selected GFF countries, a GFF partner landscape analysis, and survey to IG members. With support from technical partners and building on the HRH Agenda's proposed actions, the IG HRH TWG reviewed these analyses, discussed global HRH priorities, technical and investment gaps to recommend strategic actions for this GFF HRH Operational Plan.

The GFF Secretariat identified specific opportunities for better coordinating and aligning its existing HRH development and strengthening efforts across the partnership globally. This process also provided greater clarity on the GFF's comparative advantage to broker multisectoral dialogue and provide more system-level technical support to governments to understand and address health labor market challenges and fiscal space constraints for the health workforce. At the country level, the GFF will lend from existing HRH technical expertise, support global guidance and tool uptake, contribute high-quality HRH data within country-led systems, and support policy implementation at subnational levels to strengthen specific health workforce management and optimization issues critical to the partnership's mandate.

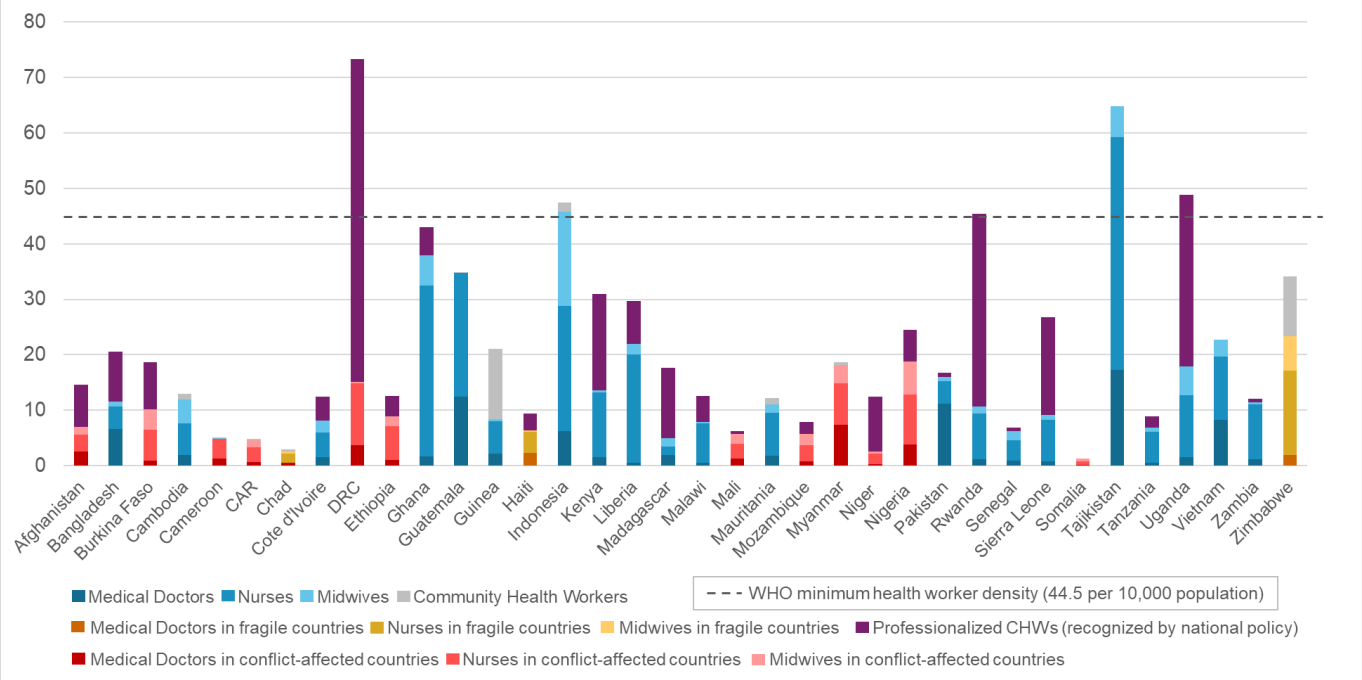
ACTION REQUESTED

The Investors Group (IG) is requested to endorse the recommendations developed by the technical working group, described in the operational plan.

I. HRH situation analysis in GFF countries

Few GFF countries have enough adequately skilled, equitably distributed health workers. The mean HRH density (22.1 health workers per 10,000 people) is half of the WHO-recommended threshold (44.5) (Figure 1). Representing one-third of all GFF countries, those classified as fragile- and conflict-affected[ii] have three times fewer health workers than the WHO recommends (16.4 health workers per 10,000 people).[iii] Health worker maldistribution, insufficient skill mix, high attrition, migration, occupational segregation, and limited quality hinder the access, quality, and equity of essential health services, including reproductive, maternal, newborn, child and adolescent health, and nutrition (RMNCAH-N)[iv]. While country-level data are limited, most frontline health workers in GFF countries are female. In GFF countries with available data, the average proportion of nurses and midwives that are female is 67% and 95%, respectively – versus 39% of medical doctors. Too often gender perspectives are not accounted for in health workforce efforts. Empowered, well supported majority-female nursing, midwifery and community health workforces can play a catalytic role towards achieving UHC through primary health care.

Figure 1. In nearly all GFF countries, health worker density per 10,000 people does not meet global thresholds. Most countries are heavily reliant on nurses and midwives to deliver health services.



Source: WHO, NHWA. Latest data available.

GFF countries seek support to create and sustain health sector jobs. A significant portion of the public sector budgets are allocated to recurrent salaries. For example, from 2011 to 2021, they were 72% of Nigeria's public health sector budget.[v] Where the contribution of domestic government health expenditure against current health expenditure is only 26% in low-income countries, and 44% in lower middle-income countries[vi], country governments are constrained to create and sustain jobs in health. In Sierra Leone more than half of health workers providing services in public facilities were volunteers, e.g., not supported by payroll[vii]. Domestic and partner contributions to health workforce policies, financing, and data, HRH management are often under resourced or verticalized within programs. The private sector is often underexploited to support and sustain health worker jobs. Many health partners lack the

convening power to advocate with ministries of finance, education, labor, or gender to plan and implement sustainable HRH strategies to achieve health goals. Country leaders seek support to address these deep health labor market and HRH fiscal space challenges and mitigate negative impacts on health system responsiveness, quality PHC provision, and pandemic preparedness and response (PPR).

While most GFF/IDA investments in HRH are providing fragmented, short-term, stop-gap solutions (e.g., in-service training or CHW stipends), the GFF has an opportunity to leverage the World Bank's multisectoral health systems and financing expertise. Our 20-country portfolio analysis[1] analyzed IDA investments across key HRH dimensions adapted from the USAID PEPFAR HRH Effort Index[viiiix] (Table 1). GFF/IDA projects specified three highly subscribed HRH dimensions across: development & training (20/20 or 100%), optimization (14/20, 70%) and financing (10/20, 50%), as defined in Table 1 below.

Table 1. GFF TF/co-financed HRH investments by dimension in select countries

DIMENSION	Afghanistan	Bangladesh	Burkina Faso	CAR	Cote d' Ivoire	DRC	Guinea	Haiti	Kenya	Liberia	Malawi	Mali	Mozambique	Niger	Nigeria	Rwanda	Senegal	Sierra Leone	Uganda	Zambia	TOTAL (%)
HRH Leadership & Advocacy *Central- or subnational-level support to strengthen leadership for HRH*						x	x										x	x			4 (20%)
HRH Policy & Governance *Support to develop a national HRH plan, strategy, or policy to define health worker: scopes of practice, remuneration, address gender and/or diversity and inclusion, private sector engagement, regulation.*		x		x	x	x		x						x		x					7 (35%)
HRH Financing *Support to cost or finance HRH policies/plans; funding to directly remunerate or provide stipend; support to government payroll of HRH.*	x		x				x	x	x	x		x				x	x	x			10 (50%)
HRH Information Systems & Data *Support for human resource information systems (HRIS), or HMIS/DHIS2 for assessing HRH performance; licensure/registration system; availability of HRH data for planning. Support to communications/technology infrastructure specifically for HRH.*		x		x	x	x						x									5 (25%)
HRH Development & Training *Support to HRH education strategy, pre-service health professional institutions; training; in-service training, continuing professional development*	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	20 (100%)
HRH Management *Support for HRH recruitment, deployment, distribution, and retention strategies. HR manuals/guidelines, career path development.*		x			x		x			x			x				x	x		x	8 (40%)
HRH Optimization *Support for performance evaluation, supervision; mentoring, coaching; support to strengthen referral systems between CHWs and facility-based workers.*	x		x		x		x	x	x	x	x	x		x		x		x	x	x	14 (70%)
Other HRH sub-specialty *Support for HRH within PPR, conflict/fragile settings*				x							x								x	x	4 (20%)
TOTAL	3	4	3	4	5	4	5	4	3	4	3	4	2	3	1	5	4	5	3	4	

Source: World Bank, Project Appraisal Documents and restructuring papers.

[1] The analysis included 27 country Project Appraisal Documents (PADs) and 13 restructuring papers. PADs were selected for active projects and accompanying restructuring papers, where applicable. We also assessed the availability of national HRH strategies: thirteen countries had accessible national HRH strategies, eleven countries have national CHW policies and 10 have published community health roadmaps.

GFF/IDA has co-financed HRH development/training and HRH optimization in primarily substitutional ways. Most projects support the health sector to deliver pre-service training for community-based services, or in-service training and performance support to improve the quality of care. Given the COVID-19 pandemic, GFF/IDA investments were also leveraged for emergency response. More strategic, systems-level support to strengthen capacity for HRH education was outlined in just 5 of the 20 country portfolios reviewed (Afghanistan, Cote d'Ivoire, Liberia, Senegal, Sierra Leone). GFF/IDA projects investing in HRH optimization generally focused on enhancing health system functions for on-the-job performance support, supervision, mentoring, and coaching for improvements to HRH motivation and quality of care; in several instances projects also sought to integrate CHWs in performance-based financing (PBF).

About half of the GFF/IDA projects reviewed also directly financed health and care worker salaries or other financial support, including CHWs. Seven of the ten projects are filling a temporary HRH financing gap by maintaining salaries (Afghanistan), financing CHW program costs (Liberia) project staff costs (Sierra Leone), or providing financial incentives, including for PBF (Haiti, Mali, Rwanda). In Guinea, project finances were allocated to recruit health workers currently serving health facilities as volunteers, contracted with conditions and salaries aligned with the civil service. In Senegal, the project finances contracts for skilled health workers in marginalized areas for three years, with the ministry commitment to transition them to government payroll. Only in Burkina Faso were project resources allocated to strengthening MOH capacity for developing long-term reform strategies.

Current GFF/IDA technical investments in HRH are limited. While the GFF Secretariat and Trust Fund have invested in HRH TAA, public expenditure reviews (PER), fiscal space analysis for the health sector[2,x], and HRH-specific TAA, such as the Lesotho medical education case study[xi] and the Governance for GFF (G4GFF) supported Mali Health Workforce Management study.

While this portfolio analysis is limited in scope, it clarifies that the GFF has not yet adequately brokered its value-add to address systemic, multisectoral, longer-term HRH challenges in GFF countries. Limitations of this portfolio analysis are that it covers only 20 countries, and it does not capture project implementation details, nor progress, of each activity described.

II. The GFF Partnership landscape for HRH

Considering GFF's position within the WB, the greatest comparative advantages for the GFF Secretariat and Trust Fund to improve the effectiveness and sustainability of HRH support are to: better coordinate and align GFF/IDA's investments in HRH with global best practices and partnerships; leverage the GFF/World Bank's expertise in health financing and domestic resource mobilization; and harness its convening power for multisectoral HRH policy dialogue and implementation. The IG recognizes the critical role of the health workforce for achieving GFF's goals. The IG also acknowledges that technical leadership for the global HRH agenda rests with the WHO, as coordinating agency for the UN system on health. The GFF Secretariat identified specific opportunities for better coordinating and aligning its existing HRH development and strengthening efforts across the partnership globally. This process also provided greater clarity on the GFF's comparative advantage to broker dialogue on health

[2] In 2010, the World Bank refined this concept by recognizing five pillars for fiscal space for health expansion in low- and middle-income countries (LMICs): (i) economic growth, (ii) budget prioritization, (iii) earmarking of certain revenues, (iv) improved efficiency of spending in health and (v) external resources. GFF countries with recent fiscal space analyses in the health sector include Bangladesh (2016), Indonesia (2013), Malawi (nd), Uganda (2013)

workforce challenges with ministries of finance, education, gender, and labor, and provide more system-level technical support to governments to understand and address health labor market challenges and fiscal space constraints for the health workforce.

Coordinate and align GFF/IDA investments in HRH with global best practices - At the global level, the GFF will support the WHO in its normative and technical role for health and the health and care workforce – including contributions to the global Working for Health 2022-2030 Action Plan. The GFF will contribute to global efforts by focusing on health and care worker cadres that are most critical to its RMNCAH-N mandate: primarily doctors, nurses, midwives, allied health and care professionals, and CHWs. In addition, the GFF Secretariat should increase engagement on HRH issues with technical partners across the GFF Partnership on global HRH initiatives, including for community health workers and addressing gender within the health workforce. For partners focusing on/providing key health worker cadres for RMNCAH-N service provision (e.g., UNFPA, WHO and PMNCH for nurses and midwives; Global Fund, Gavi, USG PEPFAR and PMI for CHWs), the GFF will leverage their technical expertise accordingly.

At the country level, improved coordination and analytics should translate into more strategic and impactful HRH investments through the IDA co-financing portfolio. New GFF investment cases (ICs) will seek to integrate HRH issues based on country demand. Through a country-led process, existing HRH investments in priority GFF countries leverage existing country-led platforms (e.g., national HRH TWGs or observatories). The GFF partners in priority countries will commit to aligning to global HRH best practices, strategies, policy recommendations and frameworks for health workforce strengthening. Where poor quality health workforce data hinders evidence-based HRH financing decisions, the GFF can support global HRH data mechanisms and standards (e.g., WHO's National Health Workforce Accounts [NHWA] and country human resources information systems [HRIS]) with technical and financial resources to improve analytics for HRH financing decisions, including for HRH quality, equity, and retention. This may include partner commitments to:

- account for HRH investments using the GFF RMET adapted for HRH (see below)
- generate disaggregated HRH data captured within country-level health information systems
- streamline investments in HRH pre-service training, in-service training, continuing professional development, supportive supervision, and performance management
- enhance private sector engagement and regulation
- co-develop costed, country-level plans for sustainable HRH financing (including for national CHW programs) and medium- to long-term roadmaps for transition to government payroll when appropriate, e.g., lending from USG/PEPFAR experience.

Address strategic gaps in understanding fiscal space for sustainable health sector employment – Globally, there is a need to view health workers as a global public good, integrate HRH investments within country-led health systems, and cost the financial and non-financial supports needed to train, qualify, deploy, manage, and retain the health workforce in the long-term. The GFF will leverage the broader governance, financing, and public financial management (PFM) expertise of the World Bank along with the domestic resource utilization and mobilization (DRUM) process to elucidate the country-level fiscal space for health and care workforce jobs. Beyond support to short-term payroll subsidies or stipends, the GFF should engage with country leaders to consider their needs for strategic HRH planning, public expenditure reviews, budgeting and operationalization of national and subnational HRH strategies and policies, including community health worker programs.
Leveraging the GFF country platform or national HRH TWGs, the GFF can improve coordination and resource tracking support for investments in HRH from multilateral global health initiatives and other agencies providing HRH salaries, stipends, and other financial support (e.g., the Global Fund, United

States Government PEPFAR and PMI for CHWs). This includes analyzing government and partner contributions to HRH financing and its share within national public sector health budgets, aligning on pay scales and incentives, and developing sustainability roadmaps when applicable to transition external HRH expenditures to domestic sources (public or private sector). Based on country need, the GFF can also mobilize resources for more focused TAA on HRH.

Leverage multisectoral capabilities for improved HRH policy implementation, governance, and reforms – Worldwide, there is a need to operationalize existing HRH policies on health worker protections, regulation for quality of care, scope of practice, and remuneration, especially in decentralized contexts. This requires a multisectoral approach implicating the education, labor, gender, and finance sectors. The GFF will leverage its convening power and the World Bank's long-standing relationships with governments to engage these sectors to adequately plan and finance HRH policy implementation and civil service reforms. Where the GFF is supporting system-wide health sector efforts, governance capacity needs to be strengthened to link health workforce regulation and the quality of essential health services. The GFF can also consider if Development Policy Lending (the world Bank's budget support) could incentivize a reform on health worker hiring or firing, accreditation, or other policy decision.

III. Operational Plan Goal and Objectives

The GFF will operationalize the HRH agenda in GFF countries with the following goal and objectives:

Goal:
Improved strategic investments for HRH availability, quality, and sustainability in GFF countries to achieve RMNCAH-N outcomes

Objectives:

1) Improve the GFF partnership's alignment and coordination of HRH investments with country leadership and ownership by leveraging partner strengths, contextualizing global guidance and tools, and addressing HRH priorities and gaps within HSS and UHC[3]
2) Increase the GFF Secretariat's strategic support for understanding HRH fiscal space and financing gaps
3) Increase the GFF Secretariat's multisectoral support to HRH policy implementation, governance strengthening and strategic support to reforms

IV. Recommended strategic actions

[3] These objectives align with the WHO Global HRH Strategy: Workforce 2030 and reinforce objectives set forth in its Working 4 Health Action Plan 2022-2030 objectives to bolster, scale and sustain "data-driven planning and investment in the workforce".

The following recommended strategic actions are intended to leverage the GFF Secretariat and Trust Fund's areas of comparative advantage, as well as across the GFF Partnership.

1. Global-level activities for the GFF Secretariat

1.1. Led by at least one HRH expert, guide the GFF's global HRH engagement and support country-level actions (both in terms of IDA co-financing and TAA) in collaboration with GFF focal points, WB teams and country governments.

1.2. Facilitate regular IG sessions on HRH to monitor and discuss global alignment in HRH policy implementation, (e.g., optimization and task sharing) with GFF partners, in particular the lead HRH technical experts (WHO, ILO, OECD, USAID, others) and lead HRH financiers (country governments, private sector, World Bank, GF, GAVI, USAID). Gaps identification will build on the IG survey inputs provided in September 2022.

1.3. With PMNCH, WHO and health care professional associations, develop an HRH advocacy brief focusing on financing, policy, and service delivery with to align more partners around these values set forth in using HRH resources optimally.

1.4. Engage at global fora to refine how the GFF can contribute to global HRH goals with a primary focus on health worker cadres needed to achieve RMNCAH-N outcomes.

- WHO's Global Human Resources for Health Strategy: Workforce 2030 and its Working 4 Health 2022-2030 Action Plan (ongoing)
- 3rd CHW Symposium (February 2023)
- Fifth Global Forum on Human Resources for Health (April 2023)
- World Health Assembly (May 2023, annually)
- Community Health Roadmap (ongoing)

1.5. Develop and pilot a customizable checklist, tools, and guidance for integrating HRH issues into GFF investment cases (see activities under section 2). Guidance will include engaging key HRH stakeholders such as government leaders, ministry of finance, education, gender and labor, civil society, health professional institutions, and professional associations or councils, where applicable. It will also emphasize the importance of focusing on the primary HRH cadres who deliver RMNCAH-N services at the PHC level: nurses, midwives, and community health workers.

1.6. Develop and pilot an HRH financing assessment to integrate into GFF-supported public expenditure reviews conducted with support from WB teams.

1.7. Support relevant in-country platforms for better alignment on various partner investments, including the government. The approach will leverage each partner's comparative advantage, expertise, and commitments to HRH strengthening across the GFF partnership, which varies from country to country:

- Gavi: planning and advocacy efforts for frontline health workers' safe working conditions
- Global Fund: 1) optimizing the health workforce to ensure equitable access to care and scale up IPCQS; 2) improving HRH performance and quality of care; and 3) strengthening community level integrated service delivery.
- JICA: Technical expertise in operationalization and implementation of the HRH strategic plan at the country level with the county ownership and coordination with partners

- PMNCH: constituency engagement, including healthcare professional associations
- UNFPA: strengthening and sustaining midwifery education
- WHO: advocacy and technical support to implement global guidance and apply best practice tools
- USG/USAID: HRH technical expertise, financial support to national CHW programs, including CHW remuneration in the short- to mid-term

1.8. Develop recommendations and checklist for integrating a person-centered, gender-sensitive, youth-friendly approach to HRH development and strengthening that promotes youth engagement. Activities may include country-level gender- and age-disaggregated health workforce analyses, pre-service and in-service curricula review to integrate gender and youth competencies, support to subnational supervision and performance support teams, guidance to assess quality of gender-sensitive and youth-friendly services within PBF schemes.

1.9. Integrate and monitor key HRH indicators into the overall GFF monitoring and evaluation framework (see Section VI)

2. Country-level activities through GFF Trust Fund/co-financing and on the GFF platform

2.1 Integrate HRH into investment cases, and those undergoing revision, as the primary mechanism through which there is GFF partner alignment.

2.2 Leverage IDA and the WB convening power for multisectoral support for implementing the relevant HRH agenda at country level (Health, Governance, Development Policy Financing instruments)

- When HRH reforms are undertaken, explore option for Development Policy Operations (DPOs), to facilitate HRH policy and institutional reforms. With a focus on equity, DPOs for HRH reform should address short- to medium-term health workforce needs to deliver RMNCAH-N services.

2.3 Conduct GFF partner mapping, including:

- HRH-related investments at the country level HRH (e.g., policy/governance, leadership/advocacy, financing, information systems/data, development/training, management, optimization, other sub-specialty, multisectoral engagement)
- Inventory of existing country-level platforms (e.g., HRH, CHW or NHWA TWGs), special studies, HRH data availability, and contextualized diagnostic tools for HRH

2.4 Deliver technical assistance and support improved analytics to facilitate evidence-based decision making for HRH, particularly for HRH policy and financing, based on needs identified through the GFF partner mapping.

2.5 Adapt the RMET and DRUM process for HRH for country-level implementation.

- Use the most current HRH data (e.g., collected from country led HRIS when possible)
- Capture HRH costs related to policymaking, salaries, management, training, and performance support to map external contributions and coordinate TAA.
- Develop tool to document partner contributions that finance HRH salaries, stipends, or support to account for overall partner spending vis-à-vis government spending
- Assess the role of the private sector to sustain health and care workforce jobs, including private deployment to the public sector

2.6 Use tools and operationalize global HRH guidance, especially at decentralized health system levels.

2.7 Engage in the relevant country platforms and dialogue to coordinate with other GFF partners at the country level to leverage their comparative advantage. This is often done through the MOH HRH department who convenes other relevant sectors (labor, finance, education, gender, local government) and constituencies (professional associations, civil society, public and private health and care workers, education institutions) and other government counterparts to engage in priority strategic processes, such as: health labor market analyses, new HRH strategic plans or policies. The country platform may also be leveraged to determine who would be the best technical partner to support a GFF/IDA-financed health worker training.

2.8 Share standardized HRH data within the national HRIS and NHWA processes, disaggregated by sex, skills, cadre, location, training and service skills, and financial information when available. Where the GFF collects data to support evidence-based, sustainable HRH financing strategies, it may also be able to contribute to countries' progressive efforts to capture data for NHWA. Data indicators to capture and report to NHWA via country focal points include:

- Module 4: Education Finances
  - 4 – 01 Total expenditure on higher education
  - 4 – 02 Total expenditure on health workforce education
  - 4 – 03 Average tuition fee per student
  - 4 – 04 Investment in transformative education and training
  - 4 – 05 Expenditure per graduate on health workforce education
  - 4 – 06 Cost per graduate of medical specialist education programmes
  - 4 – 07 Cost of qualified educators per graduate
  - 4 – 08 Total expenditure on in-service training and continuing professional development
- Module 5: Health labor market flows
  - 5 – 06 Unemployment rate
  - 5 – 07 Vacancy rate
- Module 6: Employment characteristics and working conditions
  - 6 – 04 Regulation on minimum wage
  - 6 – 07 Regulation on dual practice
- Module 7: Health workforce spending and remuneration
  - 7 – 01 Total expenditure on health workforce
  - 7 – 02 Total official development assistance on health workforce
  - 7 – 03 Total expenditure on compensation of health workers
  - 7 – 04 Public expenditure on compensation of health workers
  - 7 – 05 Entry-level wages and salaries
  - 7 – 06 Policies on public sector wage ceilings
  - 7 – 07 Gender wage gap

2.9 Support the development and implementation of country-led, harmonized, costed HRH strategies that leverage the GFF's area of comparative advantage for HRH.

- Integrate considerations for sustainable HRH financing within PERs
- Financing for HRH recruitment, retention, and supervision at decentralized levels
- Explore how countries with results-based financing can be leveraged to support financial and non-financial incentives for HRH

V. Monitoring & Evaluation

The GFF Secretariat will monitor its support to the HRH agenda through existing mechanisms and processes:

- Annual report documenting progress in terms of Investment Case implementation
- Regular updates on the portfolio level through the Investors Group

VI. Acknowledgements

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