High-Level Forum on the Health MDGs

ADDRESSING AFRICA'S HEALTH WORKFORCE CRISIS: AN AVENUE FOR ACTION

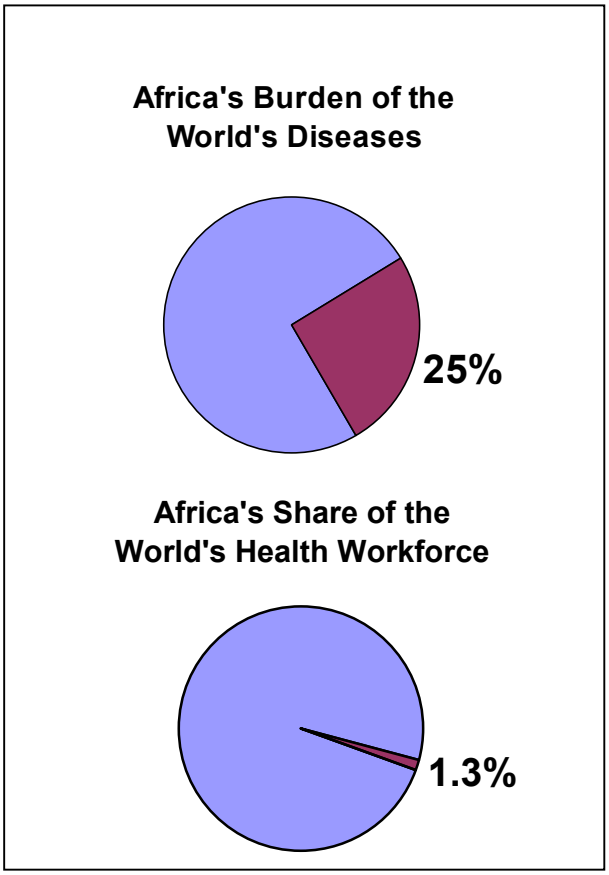
Abuja December 2004

Addressing Africa's Health Workforce Crisis[1]

It is widely acknowledged that Africa's insufficient health workforce will continue to be a major constraint in attaining the millennium development goals (MDGs) for reducing poverty and disease. The High Level Forum (HLF) in January 2004 also recognized the challenges posed in developing Human Resources for Health (HRH) and the need for actions and strategies to accomplish this. The work of Joint Learning Initiative (JLI) also indicated the Africa's health workforce crisis. At an international meeting on HRH in Cape Town in September, 2004, the need for an urgent action was highlighted to scale up HRH which requires a concerted action of countries and all other partners and an avenue for action emerged building on a number of efforts in the recent years.

1: Extent of the health workforce crisis

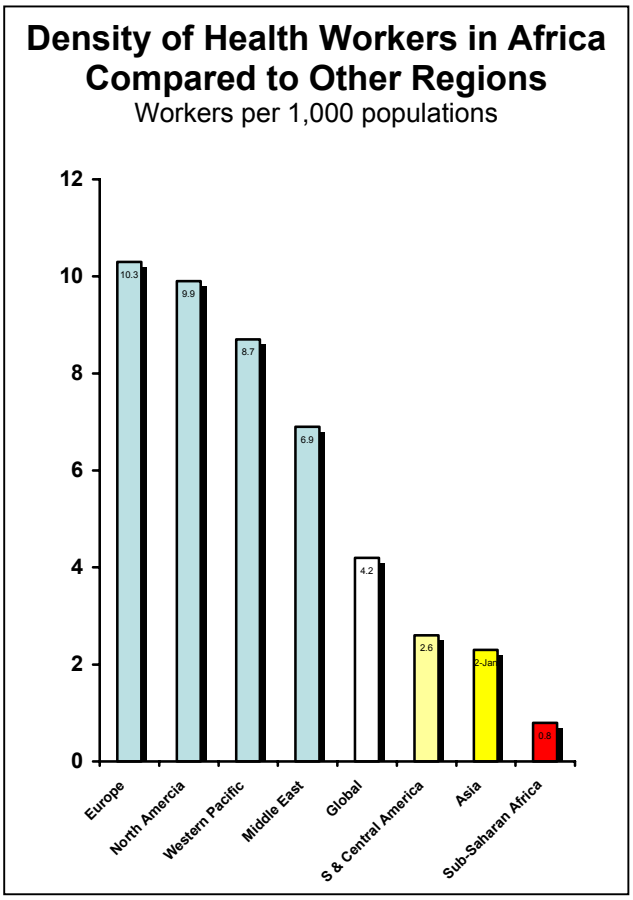
The development of the health sector workforce in low-income countries has suffered from years of national and international neglect. As new resources are being mobilized to fight HIV/AIDS, tuberculosis, malaria and other diseases, the health workforce crisis in Africa is becoming more apparent. There is simply insufficient human capacity in many developing countries to absorb, apply and make efficient use the interventions being offered by many new health initiatives.



The problem is most acute in Sub-Saharan Africa and scope of the health workforce crisis is appalling. Overall, there are an estimated 750 000 health workers in a region that serves 682 million people. By comparison, the ratio is ten to 15 times higher in OECD countries. This estimated workforce of doctors, nurses and allied health workers in sub-Saharan Africa, which compose 1.3 % of the world's health workforce while Africa suffers from 25% of the world's burden of diseases.

[1] At its first meeting in Geneva in January 2004, the High-Level Forum concluded that human resources, particularly in the poorest countries, are in crisis, yet absolutely critical for achieving the MDGs. It called for an action alliance to address this issue in ways that reinforce country work and harness global flows, recognizing that problems and solutions vary between and within Regions.
This strategy paper focuses exclusively on Africa, but it is recognized the health workforce crisis also afflicts other regions, and that there is an urgent need to address it outside of Africa as well. The High-Level Forum on the Health MDGs for the Asia Region, currently scheduled to take place in June 2005 in Tokyo, is expected to review strategies to address the challenge of human resources for health throughout Asia.

To achieve the Millennium Development Goals, the minimum level of health workforce density is estimated at 2.5 health workers per 1,000 people. Out of 46 countries in Africa, only 6 have workforce density over 2.5 per population. Indeed, Africa's health workforce density averages 0.8 workers per 1000 population; significantly lower compared to the other regions and to the world median density of 5 per 1,000 populations.

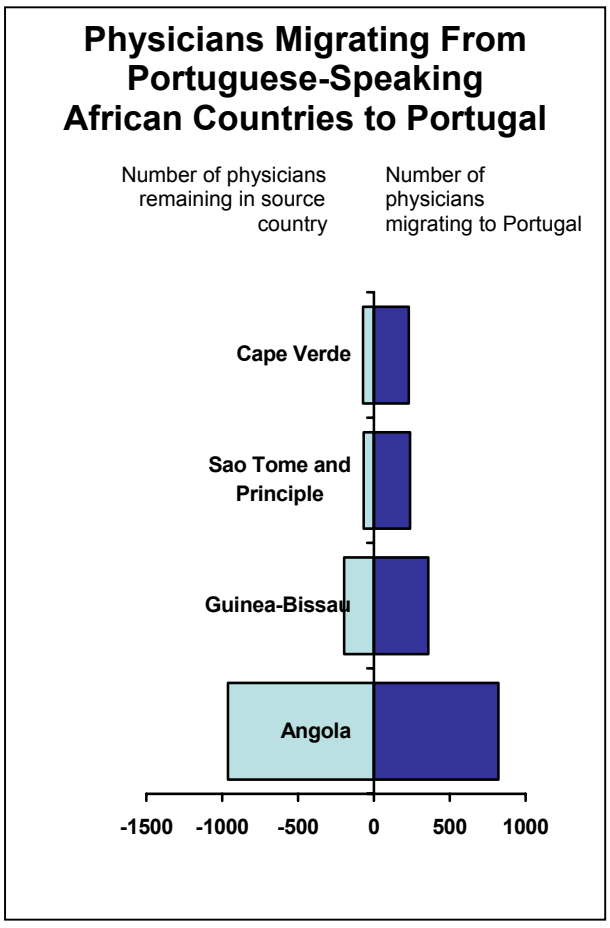


The low density of health workforce, thus, the absolute shortage is severely threatened by high attrition rates underscored by four key "hot buttons":

- *Insufficient Training Opportunities.* Africa is woefully lacking in facilities to train health workers. Two-thirds of sub-Saharan African countries have only one medical school, and eleven sub-Saharan countries have no medical schools at all.[1]

- *Deteriorating Health of the Workforce.* With the increasing death toll, AIDS is devastating the fabric of African societies and turning the health and development clock back by several decades. Nowhere is Africa more vulnerable than in protecting the health of those who are on the front lines of fighting the disease. In many sub-Saharan African countries between 18% and 41% of the workforce is already infected with HIV.[2]

- *Rural/Urban Imbalance.* In Tanzania, the city of Dar-es-Salaam alone has nearly 30 times as many medical officers and medical specialists as other rural districts.[3] Only about 5 of Uganda's 100 or so surgeons work outside of urban areas.[4]



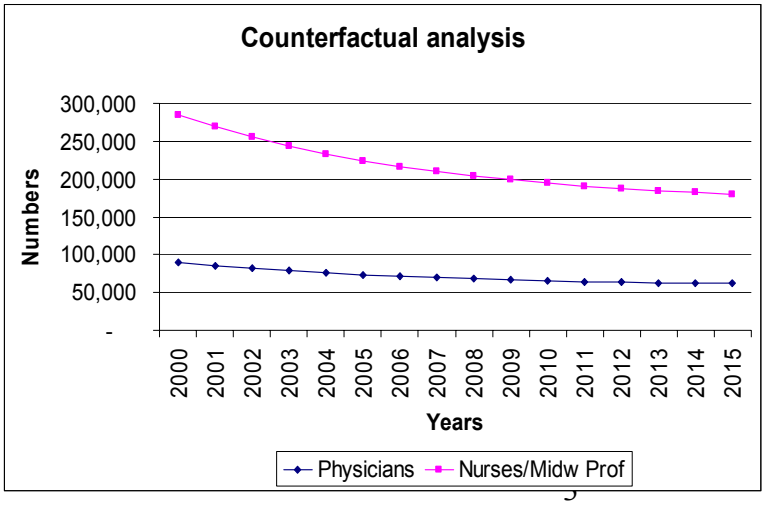
- *The "Brain Drain",* the trans-national flows of health professionals in the era of globalisation is serious. It is alarming that more Malawian doctors may be practicing in Manchester, England than in all of Malawi[5] and similar examples can be added easily. The immediate picture of that poor countries subsidizing the needs of the rich is triggering calls for restrictions or compensation (unlikely or unreasonable as they might be).

  There are "demand" issues which encourage the exodus of African health workers to wealthy countries. The investment in health in OECD countries is predicted to increase ten-fold in the next 50 years[6]. It is estimated that England will need 25 000 doctors and 250 000 nurses more than it did in 1997 by 2008.[7] It is also estimated that a further one million nurses will be needed over the next 10 years to meet the shortfall in the United States.[8]

  There are also "supply" issues which encourage African health workers to look for more promising work opportunities abroad. The biggest would have to be the low level of compensation provided to most health workers in Africa. Cost of living adjusted wages[9] indicate registered nurses make about $489 a month in Malawi. By comparison, monthly pay for a nurse in the UK's National Health Service is about $2576. In Ghana and Zambia, the average monthly salary for a doctor is just over $400.

While there is clearly a need to scale up the health workforce in sub-Saharan Africa , the macroeconomic and fiscal reality that the region is facing present a significant challenge. Real GDP in sub-Saharan Africa is expected to grow at an average rate of 5.8% per year and real per capita GDP is expected to grow at 3.3% for all of Africa in the short term. As a result, increases in recurrent salary expenditures that will accompany any large scale increase in the health workforce, may need to be gradual in order that they are sustainable. The reality is that domestic resources in many countries may not be sufficient to support scaling up the health workforce to the levels required to address population needs.

Projection of health workforce in Africa based on current trends



Due to years of neglect and under-investment in Africa's health workforce to match population growth and epidemiological developments, Africa is faced with a critical dearth of means to train health workers, HIV/AIDS decimation of the health personnel, an unavailability of health services in rural areas, and a "brain drain" of health professionals to

wealthy countries. This situation is only predicted to grow worse, as the accompanying graph shows, if no action is taken.

The health workforce situation in Africa, therefore, represents an **exceptional case for additional investment in the health sector.** Boosting Africa's health workforce would require an unprecedented infusion of resources to the health sector. Unless a serious and brave action is taken, the situation will continue to deteriorate and other plans for reaching "3 by 5" and the Millennium Development Goals will be rendered implausible.

This can not be addressed in the way 'business as usual'.

2: Five core principles for addressing Africa's health workforce crisis

Africa will require one million additional health worker*s* to ensure the staffing required to deliver basic health interventions -- 2.5 health workers for every 1000 people – is available. Currently, there are only about 750,000 health workers in Africa, or 0.8 health workers for every 1000 people. The range of partners, scope of the plans and scale of activities required to more than double Africa's health workforce will be huge. A more modest set of core values and principles are proposed here on how to best move forward in accomplishing this task.

FIRST: Country-led action, global responsibility and collective solidarity! The context in each country varies significantly. Each response needs to emerge from country level which also implies political commitment and appropriate resource allocation at country level. The targets for action would be defined at each country level to address the urgent requirements of priority health interventions. However, such an action influence by the transnational flows and with significant resource requirement implies collective solidarity and responsibility globally and regionally and requires a participatory process engaging key stakeholders in Africa (i.e. countries, NEPAD, African Union) and abroad.

SECOND: Learn from experience and build on it! Some countries have been trying to address their health workforce crisis for many years now. Efforts to facilitate and accelerate the action need to be built on ongoing work. The experience in these countries can provide inspiration and evidence for the activities in other countries. Engagement of national academic institutions in implementation research and ongoing learning with feed back into policy will be essential. Multi-stakeholder action alliances, within countries and at regional and global levels will enrich the learning and maintain momentum.

THIRD: Go beyond the health sector in seeking solutions! For too long, we have made health systems issues impenetrable to most anyone who has not attended a public health or medical school. Now, we must more effectively communicate these critical issues to key decision makers and those who influence them. For example, the ILO and Ministries of

Labour, Finance, Education, and others need to be engaged early on. Political planning and local leadership will be required to manage the sectoral dimensions of selective investments in health workforce as compared to the rest of the civil service (teachers, etc).

FOURTH: Seize the opportunities! We must seize political and social opportunities which can help to raise awareness, advocacy and commitment for addressing Africa's health workforce crisis. For example, the political attention generated by the MDGs has opened an unprecedented window of opportunity for the health and development agenda. While significant sums are being mobilized to address the MDGs and AIDS, these investments may not be strengthening health systems. In fact, they might actually distort them and creating greater inefficiencies and unsustainable systems after 2015. Better system integration of such big investments will not occur by default.

FIFTH: Train, Retain and Sustain! At the core of creating sustainable health systems in Africa is improving and increasing the *training* of African health workers, and addressing issues such as adequate compensation and working conditions to ensure these skilled workers are *retained* in a sustainable way.

3: Action agenda

The action agenda for HRH has been shaped through a number of efforts building on each other. The Joint learning Initiative and High Level Forum served as good triggers for advocacy and action. A number of multilateral and bilateral agencies (i.e WHO, World Bank, UNDP, UNAIDS, DfID, NORAD, SIDA, CIDA) joined their efforts and the action avenue has been framed through intensive consultations.

Experience in a number of countries has showed scaling up HRH is possible with determined and sustainable action. The achievements in such an action could be based on performing a good mix of *country strategies and global responsibilities* with community focus. The main pillars of the initiative are:

Recent developments which contributed to shaping this action agenda

- *Sept 1998*: Adoption of the Regional Strategy for the Development of Human Resources for Health by the 48th Regional Committee of WHO Africa Region
- *Jan 2002:* Meeting in Addis [WHO, WB, RF] makes a call to address the HRH crisis in Africa
- J*ul. 2002*: Decision of the African Heads of State and Government to hold a special summit on Human resources for health with special focus on HIV/AIDS , Tuberculosis and Malaria
- *Sept 2002:* Meeting in New York; RF convenes a Joint Learning Initiative on HRH [7 global working groups]
- *Sept 2003:* Special Session of Ministers of Health of the WHO Africa region on Migration of health workers during the 53rd Session of the Regional Committee (Recommended tabling of the WHA resolution on International migration of health workers which was eventually adopted in May 2004)
- *Jan, 2004:* HLF meeting makes HRH a priority
- *May, 2004:* WHA passes resolution on HRH
- *Sept, 2004:* HRH meetings in Cape Town
- *Oct 2004:* consultations within and outside WHO
- *Nov 2004:* JLI report launched at Mexico Summit

Action One: Country- led leadership

The action agenda needs to emerge from country level in accordance

with the context of each country building on what is already ongoing. HRH interventions, especially such a rapid scaling up require political commitment, political management, strategic policy direction, coalition building, generation of intelligence that can only be managed if a good stewardship function is in place.

Taking into account that political difficulties have been faced in the past in taking HRH agenda forward, the countries has to tackle political dimension with the support of global advocacy.

Improving motivation and retention

It is critical to plug the loss, while opening the tap. Strategies to ensure accountability and boost performance and retention of the health workforce are essential, though they may have significant spillovers in the rest of the civil service. It may be politically difficult to provide pay increases and incentives in the health sector but not in other parts of the public sector. The political commitment to design and implement strategies to recruit, retain and sustain practitioners is crucial and has to be supported by practical implementation plans, funded and monitored.

Efforts for strengthening management capacity will require external support, but eventually a strong cadre of managers and leaders, with appropriate and accountable organizational systems will be required. Capacity building, research and knowledge management are all key components of developing a cadre of strong managers and leaders.

Mobilizing the trained staff into workforce

A number of countries have members of the trained health workforce either unemployed or working in other sectors, when there is a serious shortage in the health system. Recruiting these trained staff is essential for rapid scale up. Recruitment opportunities can be restrained by recruitment ceilings imposed by the IMF /WB or by insufficiency of resources. Methods of support from other agencies can also be reviewed to support processes and strategies for additional recruitment and retention.

Engaging not-for-profit and for-profit private sector

Currently, a significant proportion of available health workforce works in the private sector and in many cases are not considered to be part of the available health human resources. If contractual mechanisms do not exist to engage the workforce in the not-for-profit and for-profit sectors, their potential contribution in health care may be lost. Innovative schemes can be considered to ensure that capacity in these sectors is fully used. It is essential to ensure mechanism to benefit from their services better, such as contractual agreements, involving them in policy and planning, expanding the capacity building efforts to not-for-profit and for-profit private sector.

Improving productivity of health workforce

Expanding the health system infrastructure and its support is critical for improving productivity. A proper balance and effective interface between various resource inputs need to be established and maintained to deliver health interventions efficiently in response to needs and expectations. Health workers, even if available in sufficient numbers, the right composition and with adequate competencies, would not produce the desired impact without adequately planned, built, equipped, supplied and managed facilities. Weak absorption capacity, e.g. for infrastructure/equipment planning and management, prevents many health systems fully capturing and using the potential benefits of new and existing technologies. ,

A team approach and appropriate task delegation supported by necessary skills upgrading can ensure better utilization of existing staff. This may require some regulatory amendments which can be accelerated if committed. Use of IT support can also improve their capabilities and working conditions.

Action Two: Overcoming macroeconomic constraints and recruitment ceilings

A careful adjustment of the macroeconomic framework is needed for developing countries to make use of the larger workforce. The necessary increase in the workforce will drive health care expenditure up through both public and private mechanisms. The exceptional nature of the emergency calls for a significant increase in health sector investment and careful monitoring of its impact at country level. Strategies that countries adopt in scaling up their health workforce must be consistent with overall fiscal expenditure reforms, economic growth projections.

The recruitment ceilings adopted by governments may need reconsideration for raising of the ceilings and readjusting the sectoral allocations, especially if donors provide significant support that would enable the hiring of additional health workers. WHO, UNDP, World Bank and IMF can work together with the Governments to facilitate the dialogue and understanding the implications better.

If increased expenditures are financed in part by external resources, there must be a clear action plan on how recurrent salary expenditures will be absorbed into government budgets once external funding is phased out. It is important that dialogue between governments and institutions such as the World Bank and the IMF takes into consideration the need to scale up the health workforce while ensuring that prospects for overall economic growth and long-term fiscal sustainability are maintained.

In short, health workforce policies related to scaling up should be conceived and implemented considering key macroeconomic and fiscal reforms. This should involve major lenders and ministers of health, finance, education, and planners.

This can be achieved by making sure that health workforce policy takes place within the current PRSP process within countries, is consistent with the medium term expenditure framework and is supported by donors through the current SWAp.

In some countries this will involve scaling up already existing health workforce operations while in others it will involve introducing and emphasizing health workforce objectives in the PRSP process. It is crucial that health workforce policies related to scaling up are carried out within the current poverty reduction strategy process.

Action Three: Exploring mechanisms to resource educating health workers in Africa

The rate of production of health workers has not risen to compensate for the heavy loss and both immediate and longer term action is required by countries to ensure that health systems in Africa continue to function effectively. Investing in education is critical in increasing the number of available health workers, but more educational opportunities for health workers at all levels can ensure that there is a long term strategy to address high attrition rates including brain drain. Investing in education needs to address the quality of health workforce besides quantity.

It is also widely recognized that traditional methods of educational delivery are inadequate to produce the health workforce needed for African development, and that there are inefficiencies in the current health system paradigm. On the other hand, there is an increasing view among educators and medical practitioners that information and communication technology (ICT) in general has the potential to revolutionize the way health care professionals are trained, and to boost their performance on the job.

Building and resourcing educational facilities - though requiring heavy initial investment - offers opportunities not only for increasing pre-service education, but also continuing professional development for health workers. It is also crucial to ensure the availability of teachers and lecturers. Training of the appropriate teachers and lecturers would require further investment. It is unlikely that the least developed countries of Africa will be able to resource programmes of educational regeneration of such magnitude. One possibility may be to establish a special educational fund, administered from Africa and open to application from each country for funding of its education investment plans. This fund, similar of others[2], administered from Africa and open to application from each country. It could be established as an one-off instrument to address the short and medium term investment requirements,

[2] For instance, in PAHO/AMRO, there is the PAHEF (Pan-american Health and Education Foundation), that is a U.S. not-for-profit philanthropic organization that enjoys a unique partnership with the Pan American Health Organization based on a shared vision of health for all and promotes health through the provision of grant support for public health projects, the training of physicians and allied health workers, the publication of medical textbooks, pharmacological bulletins and continuing education materials, while maintaining low administrative costs.

thus avoiding the complexities of a new continuous funding mechanism. Such a fund could also be seen as a means of attracting financial investments for further training initiatives in Africa from those countries what have benefited from the migration of Africa's health workforce.

Alternatively, partners at the country level may be able to set up a common financing mechanism for short and medium term measures.

Such funds/financing mechanisms could enable countries to develop investment plans for:

- Strengthening capacity of training institutions in terms of equipment and teachers/ lecturers.
- Increasing the production of health workers in a way that equitably meets the needs of the country;
- Developing innovative new programmes to better address the health priorities of the country;
- Increasing the health workforce in both the short and long terms.

Action Four: Technical cooperation

Technical assistance

Such an initiative will require intensive efforts and accelerated inputs. Taking into account that most countries also face shortages of management and planning capacity at both national and lower levels. Technical assistance would, therefore, be important to facilitate the attempts. This will be one of the areas where global responsibility lies and the international and bilateral agencies need to be prepared to mobilize technical assistance rapidly.

However, the technical assistance need should emerge from country level and country strategies and plans need to identify the requirements quickly.

A technical cooperation network

The comprehensive national and global policies that need to be developed and implemented to succeed in workforce strengthening are complex. In developing countries the capacity to do this is often limited. Consequently the pressure globally to assist developing countries in addressing their substantial health workforce shortcomings is rapidly rising.

At present the group of experts and institutions assisting countries in strengthening their health workforce is relatively small and fragmented. Having recognized the potential increase in demand and incoherent response, a global Technical Cooperation Network of experts in HRH is proposed. The aim is

- to boost the global HRH expert field,

- to establish a mechanism for access to HRH expertise on country demand, and
- to upgrade HRH expertise within developing countries.

To develop an HRH network that responds to requests for support, requires overview and analysis of country needs, conceptual thinking, and identification of the available HRH experts. This should strongly target investing in strengthening national capacities individually and institutionally. The efforts needs to be built on ongoing efforts such as the Regional Expert Network in Africa.

Developing the size and breadth of the expert field can also be achieved by engaging adjacent, untapped pools. An inventory of institutions (academia, ministries of health, education, finance) that house potential HRH experts, willing to follow teaching and training and to engage in country support, is worthwhile. Teaching and training require a shared knowledge base and suitable material.

Guidelines for country support in health workforce strengthening are of key value here. An inventory of existing guidelines and tools could be made, and the coherence of the field and the growth of its knowledge base are served by agreement concerning overarching guidelines, that define what information is needed and what steps must to be taken to develop a national plan for health workforce strengthening. This would add to the identity and coherence of the global HRH expert field, as well as to the impact of country support. Network could be facilitated with a virtual facility that:

- Has on line overview of the expertise countries require;
- Can constantly oversee the (availability of the) expanding HRH expert field
- Can effectively link supply to demand
- Can capture best practices
- Does facilitate (virtual) learning
- Oversees emerging HR issues
- Generates an HRH research agenda

International volunteers

A number of initiatives have been proposed, involving the use of international volunteers to reverse the flow of skilled health workforce and meet some of the critical needs. There is a growing interest and intention in increasing the magnitude of the support through volunteers. When considering their use in coping with the health workforce crisis, concerns include

- overall cost (i.e. full cost of bringing in a volunteer) compared to the cost of retention measures and the risk of postponing critical decisions on pay and incentives for the national workforce;
- maintaining the continuity and sustainability in service delivery;
- responsiveness to the communities to the coping skills and support potential of local communities.

Thus, a clear code of conduct for the use of international volunteers in managing the HRH crisis in countries under severe stress should be agreed by the various stakeholders as part of international recruitment policies. Unless this is accompanied by transition strategies and local capacity building objectives, the value of the input will be limited.

International volunteers can be considered for the following purposes:

- International short to medium term volunteers can be used in peripheral service delivery by systems and places with the absorptive capacity to maximize their use. The use of southern international volunteers may be particularly appropriate in this context.
- International volunteers may be used for both service delivery and capacity building of NGOs/civil society working in health service delivery.
- Strengthening training institutions through support by skilled trainers as international volunteers can support motivation and retention through skill upgrading and additional opportunities for the regular staff.

Some caution is required in using volunteers:

- Planning for use of international volunteers in the health sector needs to build in the overall national action plan for personnel in the health sector (all provider systems, public, private and NGO, and academic sector) avoiding duplication and inefficiencies caused by individual partners and agencies when they do their own assessments in isolation, avoiding that volunteers should not become a prescription or conditionality for support being offered for HRH.
- Gap filling through international volunteers should be a last resort measure, *or supplementary measure* where other measures fail to create the necessary response to the crisis. The potential role of international volunteers should always be considered in

terms of their capacity to catalyze and/or facilitate local volunteers who are mobilized through the efforts of the public, private and voluntary sectors.

- International volunteers must comply with the agreed national health strategies and action plans, and not create solutions to provision of care, which are dependent on the individual and cannot be sustained over time.
- Some form of mechanism within government to assist in the coordination of volunteer action is desirable. Similarly, a mechanism to coordinate volunteer inputs on the part of international volunteer coordinating agencies should also be sought.

Action Five: Better intelligence for HRH

Evidence base for further development and monitoring of country specific policies and strategies is critical. There is a need for more evidence as well as further research on education, skill-mix, retention and incentives, availability to improve need based planning and strategy development.

Monitoring of the progress and fine tuning the activities would also require operational intelligence function. This function needs to be developed at both country level and global/regional level. This would include further development of strategies, elements of monitoring and evaluation process and mechanisms.

Building inter-country collaboration and regional coordination mechanisms for the development and management of information and knowledge relevant to human resources policies will allow to regional and country level trends, to develop common definitions, etc. It will also help evaluate and monitor the human resource situation and trends for health systems strengthening. A database and collaborative mechanisms can be is an important mechanism for evaluating human resources for health in the improvement of the performance of health systems.

Health systems and HRH research have long been neglected: much emphasis has been given to more technical areas of research, such as clinical management or drug delivery, and not so much to service provision. If, historically there has been little interest from donors in funding HRH research, the recent worsening of the crisis has raised the need. The neglect includes lack of national and international capacity to carry out the research, lack of an international champion for this HRH research and its political nature. Appropriate resources and mechanisms including capacity building in health systems and HRH research needs to be put in place to solve the issue.

4: The way forward

Advocacy and strategic communication

The immediate response depends very much on the commitment at political level, including both in countries and other stakeholder, multilateral and bilateral agencies. Continuing efforts are required to ensure and maintain the commitment and interest.

It is essential to promote advocacy for the importance of human resources for effective health services delivery, tackling the HRH crisis and the need for urgent action. The initial activities to ensure advocacy, commitment and support for the initiative aims to:

- Ensure commitment and incorporate different stakeholders
- Mobilize regional constituencies
- Assure that workforce considerations are a central feature of disease specific global initiatives, global funds
- Develop a strategy to mobilize additional long-term commitments of donor resources for mobilizing health workforce and capacity building

Elaborating the strategy

This document outlines the main thrusts and strategic framework for response. This needs to be detailed into strategy and action plan with required investments. Through the discussion of this strategic framework at HLF, the following are expected:

- Endorsement of the avenue of action
- Invitation to return with highly developed action plans
- Willingness to support

With the endorsement of HLF, this work will be taken forward. Following the HLF, *working groups* will be established and start to work intensively on elaborating the strategies and plans of action.

The strategies indicate two dimensions: *Country level strategies and global alignment to support country strategies.*

The coordinators of each working group will be identified and are expected to ensure products of working groups which are made up of members from countries, different agencies and experts in relevant areas.

Working groups will be formed in relevant technical domains which will contribute to the action agenda. The domains working groups will be around the action areas.
A group also will work on what could be the country actions and how they could build on country specific contexts.

The working groups will elaborate each action area in terms of detailing strategies, timelines, technical assistance requirements, costs and investment plans. The work is also expected to highlight the short-, medium-, and long-term strategies and actions.

Following the intensive work of the working groups, a *consultation* focused on HRH crisis and strategies will allow further discussion and refinement of the strategies with broader participation. The consultation is expected to ensure agreement on the action plan, commitment and partnership.

Forthcoming events can also provide opportunities for further communication and discussion at high political level such as:

- African Union Summit on Human Resources, with special emphasis on health workers
- G8 summit
- World Health Assembly 2005
- UN Summit to review progress since 2000 Millennium Declaration
- Next HLF

The World Health Report 2006 and the World Health Day 2006 will be on HRH and they will also contribute to further analysis, global advocacy and communication on progress.

Making it happen

Besides detailing the strategy, some work in the following areas can start immediately to accelerate and facilitate the process.

Coordinated efforts
Solid partnership is key for such an ambitious action. This would mean attempting to harmonize actions and tools, mobilizing resources, tackling with macroeconomic constraints jointly. In recognition of their shortfalls, the institutions need to reorganize, reequip and reorient themselves for more effective response.

For example, scaling up HRH needs to play a major role in increasing availability of ARVs in Africa, requiring close interaction with PEPFAR and the Global Fund. Regional organizations and networks, such as The African Union and NEPAD, can play an important role in the mobilization of stakeholders and resources.

Cooperation and collaboration with/among countries

Networking countries that are sharing the same crisis can support technical cooperation between countries. Other activities to foster cooperation and collaboration may include establishing expert networks, facilitating policy dialogue and process management in countries, and improving resources availability.

Institutional arrangements

There is a need for a substantive effort, working together, and unlocking institutional boundaries. An interagency secretariat will take the work further in operational terms for detailing action plan and implementation. The HRH working group can maintain this function with a review of the participants after HLF.

Resourcing the action agenda

The action agenda will require both in kind and financial resources. The resource requirements will be detailed during the action plan development.

It is expected to mobilize some resources through:

- Better use of national resources
- Ensuring appropriate allocations to HRH from existing flow of external funds such as PRSC, HIPC, Global Fund resources
- Mobilizing additional resources from multilateral, bilateral agencies, funds

Mobilizing resources for this initiative will require creative thinking, new ways of working. The countries will be in the driving seat to change the behaviour of donors directing the resources to the areas of need.

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