

Tracing the policy implementation of commitments made by national governments and other entities at the Third Global Forum on Human Resources for Health

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ABSTRACT

We conducted a follow-up analysis of the implementation of the Human Resources for Health (HRH) commitments made by country governments and other actors at the Third Global Forum on HRH in 2013. Since then member states of the WHO endorsed Universal Health Coverage as the main policy objective whereby health systems strengthening, including reinforcement of the health workforce, can contribute to several Sustainable Development Goals. Now is the right time to trace the implementation of these commitments and to assess their contribution to broader global health objectives. The baseline data for this policy tracing study consist of the categorisation and analysis of the HRH commitments conducted in 2014. This analysis was complemented in application of the health policy triangle as its main analytical framework. An online survey and a guideline for semistructured interviews were developed to collect data. Information on the implementation of the commitments is available in 49 countries (86%). The need for multi-actor approaches for HRH policy development is universally recognised. A suitable political window and socioeconomic situation emerge as crucial factors for sustainable HRH development. However, complex crises in different parts of the world have diverted attention from investment in HRH development. The analysis indicates that investment in the health workforce and corresponding policy development relies on political leadership, coherent government strategies, institutional capacity and intersectoral governance mechanisms. The institutional capacity to shoulder such complex tasks varies widely across countries. For several countries, the commitment process provided an opportunity to invest in, develop and reform the health workforce. Nevertheless, the quality of HRH monitoring mechanisms requires more attention. In conclusion, HRH challenges, their different pathways and the intersectorality of the required responses are a concern for all the countries analysed. There is hence a need for national governments and stakeholders across the globe to share responsibilities and invest in this vital issue in a co-ordinated manner.

Key questions

What is already known about this topic?

- Several country studies on advancing Human Resources for Health (HRH) commitments and national governance models have been published.
- An overview study comparing different countries and tracing the implementation of this international health policy priority has not been conducted yet.

What are the new findings?

- The study indicates that considerable progress has been made in several countries in implementing multiple HRH policies.
- It also determines the contextual conditions and actors required to make this happen.
- Moreover, it identifies gaps and issues that deserve attention in health workforce development.

Recommendations for policy

- The HRH commitment process has engaged national governments and other actors in identifying, developing and implementing HRH policies.
- This mechanism of action could be applied to other global health issues but attention is required to monitoring, accountability and financial aspects.

INTRODUCTION

In the lead-up to the Third Global Forum (3GF) on Human Resources for Health (HRH) held in Brazil (2013), countries and other entities were invited to make new HRH commitments to advance the HRH agenda. 57 countries and 27 other entities made commitments, which were announced at the 3GF.¹ These commitments were made when countries had to handle the repercussions of the global financial crisis, and several countries were acutely or prospectively facing conflict situations or public health emergencies such

as the Ebola viral disease outbreak. Since then national governments have agreed on the Sustainable Development Agenda and the member states of the WHO endorsed Universal Health Coverage (UHC) as the main policy objective through which health systems strengthening, including the development of an adequate, skilled, well-trained and motivated health workforce, contributes to several Sustainable Development Goals (SDG).² The adoption of additional significant international policy frameworks supporting health workforce development and the completion of the Global Health Workforce Alliance's (GHWA) mandate in 2016 presents a good moment to trace the implementation of the HRH commitments at the 3GF and to assess their contributions to broader global health objectives.

In preparation for the 3GF, the GHWA and WHO provided countries and other entities with a template for the identification of interconnected pathways and actions for systemic solutions to HRH challenges. This template recommended the inclusion of measurable targets to assess progress, and requested countries and other entities to be available for follow-up inquiries.

An initial analysis of the HRH commitments made by countries was conducted by the GHWA Secretariat in 2014. Commitments were categorised according to the UHC framework of Availability, Accessibility, Acceptability and Quality and five areas of health workforce action.³ A clear demand from countries and international partners to follow-up on the commitments in order to ensure accountability and stimulate action for their implementation emerged.

Between February and June 2016, governments and other entities were approached in order to assess the implementation status of their HRH commitments and analyse the activities, policy mechanisms and drivers that facilitate HRH development at the national level. The objective of this tracing study is to analyse the implementation of the commitments by holding policy makers to account and by generating insights and evidence on relevance, effectiveness and results of the HRH commitment process to date. The study provides insights into the pathways accelerating progress on the global HRH agenda, as well as an understanding of its main challenges.

First, this paper describes the execution of the study and the data collection. Then it looks at the factual outcome of the actions, including their monitoring, as implemented by countries. An overview of this is presented in [boxes 1 and 2](#). Third, it provides a qualitative analysis of the contextual factors, the contributions by the different actors and the stages of the policy processes relevant for the implementation of health workforce measures in a sustainable manner. Lastly, lessons learnt and governance mechanisms and reforms required at the national and international level to sustain the global HRH momentum are discussed. Exemplarily, several statements from the survey are presented in [boxes 3–7](#) in order to enrich the analysis by illustrating the diversity of HRH actions

taken by national governments and non governmental organisations (NGOs).

The baseline data for the policy tracing consisted of the HRH commitments analysis conducted by the GHWA secretariat in 2014.³ Initially, a desk-based analysis consisting of a scoping review of the existing literature on HRH activities in each country was conducted. This review provided the reference against which subsequently the implementation status of the commitments, where available, could be verified. In the second part of the policy tracing study, the assessment of the outcome of the HRH actions was complemented by applying Walt and Gilson's health policy triangle as analytical framework.⁴ The health policy triangle analyses policy development in terms of the interaction of actors, context and processes. In our study, the interaction between different actors, policy processes and contextual factors driving the HRH activities was traced and provided insight into potential policy options for HRH investments and reforms. In addition, institutionalised and informal governance mechanisms as well as the policy impact of international agencies on national HRH development were assessed.

An online survey and a guideline for semistructured interviews were developed to collect data to be provided by the representatives from the governments and other entities (see online supplementary annex I). Triangulation of research data was performed via cross-checking available literature, policy documents and grey literature and through verification of the collected data by WHO country staff.

The implementation and monitoring of HRH commitments

46 countries completed an online survey and/or interview explaining the status of HRH actions and related policy processes. For seven countries, detailed case studies on the implementation of the commitments have been published.^{5,6} Information on the implementation of the HRH commitments made at the 3GF is available for a total of 49 countries. No such information is available for eight countries (see online supplementary annex II).

For the 49 countries for which data are available, three countries responded being unable to implement the commitments due to a conflict situation and the impact of the 2014–2015 Ebola epidemic which also severely affected the health workforce. 25 countries reported completion of the implementation for all commitments made or being in the process of doing so. 21 countries reported having partly implemented their HRH commitments, with conflicts or political instability listed as reasons hindering HRH actions. The categories and HRH pathways of the implemented commitments are generally in line with those of the baseline assessment from 2014. An overview of the implementation by country governments of their respective commitments is found in [box 1](#) and online supplementary annex II.

Although HRH plans and strategies do exist for many countries, the availability of overview reports that monitor progress and evaluate these strategic plans as well as

Box 1 Results of the implementation of Human Resources for Health (HRH) actions

- ▶ 43 countries approached HRH challenges in a cross-sectoral way by implementing multiple commitments, such as investing in educational facilities for required cadres, accrediting training institutes, incentivising practice in remote areas, developing institutional competencies in HRH management, strategic governance and information systems and labour market analysis (eg, Panama, [box 3](#)).
- ▶ 36 countries' actions targeted improving the availability and accessibility of HRH. 27 countries have been working on quality improvement via the regulation of educational and professional performance (eg, Cambodia, [box 3](#)).
- ▶ 17 countries have been working on the acceptability of HRH services, focusing on enhancing professional attitude and ethics via continuous professional development.
- ▶ 38 countries reported actions in the educational and training sector. Countries did not reform medical and nursing training curricula and introduced postgraduate and management training for HRH strategic planning, governance and monitoring, although progress regarding the latter shows considerable variation across countries (eg, Bangladesh, [box 3](#)).
- ▶ 36 countries included labour market interventions, such as expanding the recruitment of different health cadres, regulating the qualifications of medical staff and quality of private clinics, increasing the budget for HRH investments, contracting private service providers, eliminating ghost workers from HRH registries and addressing absenteeism.
- ▶ Improving the skills mix, working conditions and professional autonomy in health services were prioritised in 20 countries, mainly in the WHO-AFRO and EMRO regions. These countries addressed this pathway by diversifying the education and recruitment of different cadres and investing more in community health workers and midwifery and in some cases nurse practitioners or clinical officers (cadres that provide first-line medical consultations and treatment).
- ▶ Systematic policy interventions at central governmental level represent other areas of focus in 43 countries. 26 countries have also implemented actions at the local/peripheral level, for example, providing policy space at district level to contract health workers, or to plan/manage the workforce according to local needs.
- ▶ 16 countries, mainly in WHO-AFRO and EMRO regions, work on implementing community health workforce policies as a means to enhance the outreach and impact of health services.
- ▶ In 15 countries, mainly in the WHO-AFRO and PAHO region, Maternal, Neonatal and Child Health strategic objectives are important drivers for workforce development, especially by strengthening midwifery services.
- ▶ International migration of health workers and performance-based financing (PBF) have not been identified as important drivers for policy makers, with only three and two countries working on mitigating international mobility and PBF, respectively.
- ▶ According to the original commitments, 17 countries had included HRH plans into a national health sector strategy or adopted an HRH plan. In 2016, more countries mentioned the (ongoing) development of a national strategic plan, the verification of which was difficult, as government approval was in some cases pending.
- ▶ Six countries had included a financial component in the original commitments and 23 countries defined measurable indicators to monitor their achievements. While tracing the use of indicators, these six countries did report on the progress in financing their workforce development while 20 countries used indicators to measure progress.
- ▶ In the African context, nine countries have improved their workforce register so that occupancy rates of posts, mobility of different cadre, as well as educational, recruitment and attrition data are regularly updated. The health labour market is covered only partially as these normally do not capture the workforce trends in private educational and health services.

HRH commitments is limited. Several countries have shared annual and ad hoc reports of different formats. While absolute indicators are sometimes provided, such as '1000 additional midwives have been recruited in 2015' denominators and baseline data frequently remain unclear. Likewise, the analysis of HRH policies as part of demographic and labour market trends is often neither available nor quantified by indicators. In the WHO-PAHO region (eg, Costa Rica, [box 4](#)) and in several countries in the WHO-South-East Asia Region (SEARO) region, these reports are more structured. Online HRH information and monitoring platforms have been created (eg, Ghana, Republic of Moldova, [box 4](#)) and are sometimes linked to national or regional HRH observatories.

Policy mechanisms and HRH governance

Some broader trends regarding policy mechanisms (the interaction of actors, context and processes) relevant for the implementation of the commitments as well as HRH governance modalities were assessed by a qualitative analysis, complementing the quantitative analysis of the HRH actions. In all responding countries, there was

recognition of the need for multistakeholder approaches for HRH policy development. In most of the countries, scaling up the numbers of employed health workers was considered a priority over education. Their retention and equitable distribution were also considered important. Many countries recognised the need to adopt diverse skills mix models and increase the training of mid-level cadres, such as village midwives. Moreover, the need for investments in capacity building for HRH policy development and management was prioritised in several countries.

In 32 countries, basic HRH governance mechanisms such as technical working groups or HRH strategic committees exist—mostly under the management of the ministry of health. In countries with a strong presence of external agencies, HRH meetings regularly take place as part of donor co-ordination programmes. Particularly in those countries, in which health and labour market development is a government priority, HRH governance bodies are broad in scope and formally backed by a high-level institution. In other countries, the approach

Box 2 Results of the initiated policy and governance mechanisms

- ▶ The respondents of 40 countries mentioned the importance of having a department within the Ministry of Health that is in charge of harmonising activities across the remit of different ministries, such as the ministries of education and finance (eg, Burkina Faso, [box 5](#)). Respondents mentioned that often co-ordination exists with the ministries of social, labour and internal affairs (eg, Indonesia, [box 5](#)).
- ▶ In five countries, health workforce developments have attained sufficient importance for general cabinet and senior ministers to be involved in policy deliberations, decision making and follow-up of implementation (eg, Sudan, [box 5](#)).
- ▶ Universities and other training institutions, professional associations and, to a lesser extent, community-based organisations are important actors in national Human Resources for Health (HRH) governance. In 27 countries, multilateral agencies (WHO, Unicef, United Nations Population Fund (UNFPA)) and development banks play an important (technical) role. NGOs and bilateral donors can thus play a substantial role, reflecting the relevance of international assistance particularly in countries of the WHO-AFRO region and fragile states (eg, Intra-Health International, African Medical Research Foundation (AMREF) Health Africa, [box 7](#)).
- ▶ The interviews indicate that upper-middle income countries exhibit stronger HRH departments and government ownership of the HRH strategic agenda, while lower-middle and low-income countries rely more on the interest and financing of external actors. In 13 countries within the WHO-AFRO region, HRH development is a combined priority for the government, NGOs and funding agencies. In other regions, the picture is different, with a comparatively more limited role for international actors in the WHO-PAHO, SEARO and EMRO regions.
- ▶ 22 respondents support the role of international agencies, global health initiatives and NGOs in HRH development. However, several countries have highlighted declining interest in health systems strengthening due to the global recession and its impact on funding, particularly from European donors. Moreover, competing activities by global health initiatives, such as the Global Fund, Global Vaccine Alliance (GAVI) and U.S. President's Emergency Plan for AIDS Relief (PEPFAR), and international NGOs are sometimes considered a problem.
- ▶ According to respondents, neither labour unions nor private commercial health service providers have a noteworthy role in HRH governance in most settings.

involves fewer actors and is more technical. A few international NGOs have played an important role in strengthening technical and governance capacity. GHWA's Country Coordination and Facilitation model has been used to develop and manage the HRH governance mechanisms of Indonesia, South-Sudan and other countries in the recent past.⁷⁻⁹ An overview of the initiated policy and governance mechanisms can be found in [box 2](#).

Respondents noted the momentum that the 3GF commitment process provided, contributing to domestic and international recognition and, sometimes, investments in workforce development. Some stated that the HRH plans were already part of an existing government

Box 3 Examples of actions according to the Availability, Accessibility, Acceptability and Quality dimensions and policy pathways

- ▶ The Ministry of Health succeeded in improving the quality of preservice education, developing a licensing and registration system for the health workforce in order to improve the quality of care services. The development of a new health workforce development plan, including strategic objectives and interventions, has been defined as part of the government's strong political commitment to strengthen the competency and regulation of the health workforce. 'The HRH commitment process helped provide additional political support towards this end' (Cambodia).
- ▶ The government implemented several Human Resources for Health (HRH) actions couched within a comprehensive HRH plan. For example, updating the recruitment rules for different cadres and institutions. Continuing medical education is undertaken by the Centre for Medical Education, the capacity and content of nursing training and education was expanded, and an accreditation system was institutionalised within the Ministry of Health. 'The initiatives ... which were undertaken for developing the commitments and implementing them create[d] momentum to put emphasis on the HRH agenda at all levels' (Bangladesh).
- ▶ The government has worked progressively on the formation of regional teaching units, created as a means for strengthening health services and development of human resources by implementing processes of health education, identifying training needs and co-ordinating national HRH development in broader processes. Training workshops were held, in which multiple actions were identified in order to strengthen regional teaching units, such as the development of a training programme of Primary Health Care for rural areas in Panama (Panama).

strategy while in other cases commitments initially developed for the 3GF were subsequently adopted and incorporated into national planning and strategic frameworks (eg, Ethiopia, [box 6](#)). The examples in [boxes 3–7](#) (but not exclusively) indicate that in a range of countries considerable advancements in scaling up a workforce fit-for purpose have been made. Also, the Western-African countries affected by the Ebola viral disease outbreak in 2014–2015 have used this moment of crisis to rapidly scale up the workforce with the aim to strengthen the resilience of their health systems. (eg, Guinea, [box 6](#)) Generally, respondents found the commitment process and subsequent follow-up to be a useful mechanism and encouraged such model to be repeated in the future.

The importance of engaging with non-governmental actors

16 (59%) of the other entities—NGOs, professional associations and (regional) institutions providing technical assistance responded. Their commitments differed considerably and were sometimes highly specific. Several entities have funded and initiated integrated HRH policies and activities in partnership with governments. Only a few international NGOs have the resources, skills and competency to cooperate on HRH development in multiple countries. These NGOs have played a key role in the development of the original country commitments

Box 4 Examples of monitoring mechanisms being initiated

- The Ministry of Health (MoH) committed to strengthening management in the Human Resources for Health (HRH) department by 2020. They have developed and presented a proposal aimed at improving HRH management. Staff members were trained to improve their capacities to manage HRH policies. A national HRH observatory where data on health professionals are collected and updated annually related to general information, training and employment has been functional since 2012. The actions and commitments have been successful due to strong and sustained political commitment and institutional capacity (Costa Rica).
- In addition to the original commitment to develop and implement an HRH Commitment Action Plan, the state has made a lot of progress towards HRH development. To overcome inadequate numbers and maldistribution of health workers, a staffing norm was designed and implemented. A Human Resources Management Information System has been piloted and will be launched with the objective of managing and tracking the health workforce (Ghana).
- The government has initiated a functional national monitoring mechanism for HRH information and evaluation; this monitors among other aspects employment of newly graduated health workers in the health labour market, incentive structures, accreditation and curriculum standards, competence of nurses authorised for core health service tasks, and the number of bilateral and multilateral agreements in force (Republic of Moldova).

as well as their implementation in partnership with governments. Other NGOs have used the commitments for their advocacy for sustained health workforce investment. Some NGOs focused on digital innovation and skills transfer to strengthen nursing and midwifery. Seven NGOs have focused on investing in community health workers (CHW) development. Professional associations provided technical support to develop plans and strategies, while regional institutions and observatories

Box 6 Examples of the Human Resources for Health (HRH) political momentum

- As part of the revival of the health system (after Ebola), the state undertook to recruit 2000 health workers who will be transferred in priority to disadvantaged areas. During the process of recruiting these 2000 health workers, each candidate signed a commitment to serve at least 3 years in rural areas. 'Due to political will as well as reflecting on the socio-economic impact of the Ebola epidemic, we have agreed on a new national health policy and health development plan that incorporates strong participation of Community Health Workers' (Guinea).
- 'Following the Recife declaration a situational analysis was made and strategic documents were prepared. This created a real momentum to employ new graduates and to an expansion of medical and health science colleges. Also, the ministry has recently started an international institute for Primary Health Care (PHC) for south-south cooperation between African countries on PHC development' (Ethiopia).

Box 5 Examples of Human Resources for Health (HRH) governance mechanisms being initiated

- The HRH thematic committee under the auspice of the Directorate of Human Resources engaged in a multistakeholder approach involving all actors relevant for HR management. Among other actors, the Ministries of Health, Finance, Labour and Social Security and Public Service cooperated to improve the quality and availability of Maternal, Neonatal, Child Health (MNCH) cadres particularly in underserved regions. The '... [(commitment)] process has shown that concrete and operational actions could be identified and implemented to improve the distribution of and the quality of care of MNCH HRH in a concerted manner by seeking consensus of all stakeholders' (Burkina Faso).
- The HRH governance mechanism is part of a national Health-In-All-Policies strategy. This is managed by a National Council for the co-ordination of health services that is directly headed by the President of the Republic, who is committed to health development. HRH is a subtheme for which there is a special committee. There is governmental willingness, multi-actor dialogue and international assistance to develop the workforce. 'The issue of governance is very important. One has to ensure that there are strong governance tools' (Sudan).
- 'We expect to include almost all population by 2019 in a Universal Health Coverage scheme. This is a strong political commitment in this country to ensure everyone has equal access to quality health service. Yet, we still face various challenges including shortage of health workforce especially in remote areas. Main priority should be addressed to overcome those challenges by working with the local government. HRH actions, including the Coordination and Facilitation governance mechanism, should receive strong commitment from all stakeholders to support the fully functioning of the health system in every areas of the country' (Indonesia).

provided a platform for the harmonisation and standardisation of HRH actions among countries (eg, Health Schools network of the Union of South American nations, International Council of Nurses, [box 7](#)). Other organisations have used the commitment framework to highlight their own HRH work and to effectively guide HRH activities, monitoring, advocacy and accountability towards donors and partners (eg, the Health Workers 4 All project, [box 7](#)).

Lessons emerging from the HRH commitment process

It is important to acknowledge some of the limitations of this analysis by contextualising the findings: data collection took place only two and half years after the 3GF while intersectoral HRH policy implementation and workforce development require time. Countries have set goals for their activities, but a timeframe and related milestones were missing for most commitments. This affected the possibility to systematically assess and compare progress in commitment implementation.

Notwithstanding the aforementioned caveats, the results indicate that 46 countries are progressing towards their commitments. Countries have mainly focused on the implementation of policies to incentivise retention in rural areas, investing in and regulating education,

Box 7 Examples of Human Resources for Health (HRH) actions by other entities

- ▶ 'We committed to contributing to strengthening the network of national HRH leaders around the globe. Over the last two years, we have actively engaged senior HRH leaders in more than 15 countries in provision of technical support, training, and leadership development regionally, nationally, and sub-nationally. Further, we continue to maintain the HRH Global Resource Center as a go-to reference site for information on the field of HRH' (IntraHealth International).
- ▶ 'The Executive Secretary develops a series of meetings with training institutions to identify the possibility of conducting more regional or (sub)-regional courses on HRH management and governance' (Health Schools network of the Union of South American nations).
- ▶ 'In multiple countries the HRH priority is to match the community needs for health workers with the skills and competencies that are being taught at the health training institutions. A key priority is getting a mono-technic midwife in rural Africa a priority as compared to ensuring access to a multi skilled nurse midwife' (AMREF Health Africa).
- ▶ 'We have been active in advocacy, clinical practice, international migration, career development, leadership roles in health systems and a wider range of other workforce issues' (International Council of Nurses).
- ▶ 'We have been advising and urging policymakers at EU and Member State level to develop and maintain strong health systems and sustainable health workforces both within Europe and elsewhere. A main lesson learnt is the confirmation that the multi-stakeholder approach promoted by the Global Code of Practice on the International Recruitment of Health Personnel is key to its implementation' (Health Workers 4 All).

professional accreditation and the development of a CHW cadre, and capacity building on management, monitoring and governance. Gender mainstreaming, skills-mix reforms and international migration received limited attention.

An enabling context for HRH actions

Investment in the health workforce and policy development was enabled by strong political leadership and coherent government strategies. The actors involved benefitted from sufficient institutional capacity and collaborated coherently within functioning intersectoral governance mechanisms. The 57 countries vary substantially regarding their institutional capacity to conduct these complex tasks. Some countries used the momentum of the 3GF to accelerate HRH policies previously agreed on as part of national strategic plans, while others have used the commitments as key principles guiding HRH policy development.

In these countries, the problem, policy and politics streams converged to create a window of opportunity for countries to invest, develop and reform the health workforce.

A suitable political window and socioeconomic situation emerge as crucial factors for sustainable HRH

development. A stable sociopolitical situation and economy are required for the government to create demand and expand its investments in the workforce. Several LMICs throughout all regions have over the last years been able to harness such momentum. Most of these countries experienced considerable economic growth, while no examples of (countercyclical) government investments in workforce development during an economic downturn can be provided. Moreover, complex crises (armed conflicts, climate disasters, displaced populations, financial crises and epidemics) divert attention from HRH development and investments. Nevertheless, over the last years, several transnational viral disease epidemics have also raised awareness of the need to strengthen global health security—including the health workforce as a crucial component.¹⁰

Key actors for HRH development

Our findings indicate that international agencies and international NGOs play a considerable role in advancing HRH processes at both the global and national level in some nations. Countries in the PAHO region have benefitted from strong political support and intercountry technical cooperation for HRH policy development at the (sub-) regional level, including by the PAHO office itself.^{11 12} In the Western African Region, funding provided by France in the context of the G8 Muskoka initiative provided important financial support to develop and implement HRH actions in the field of maternal and child healthcare.¹³ In multiple African countries, close cooperation with key international NGOs contributed momentum and funding for HRH actions.^{6 14} Reliance on external funding and support for HRH raises questions about sustainability and domestic ownership of the HRH agenda. However, our assessment indicates that HRH governance and development have been awarded higher priority by governments in the countries analysed following the 3GF.

Intersectoral policy development to expand fiscal space for workforce investments remains a challenge. Financial targets have only been included in the commitments of a few countries and it is unclear whether this has led to corresponding budgetary adjustments by governments. As the public sector's fiscal space is closely aligned to broader governmental strategies and political choices, progress in expanding and financing the wage bill is slow in most places. However, when there is political support from government leaders for the crucial role of the health workforce in contributing to broader health, economic and employment objectives in society (this has been the case in Ethiopia, Ecuador, Indonesia, Sudan, Ghana and the Republic of Moldova), a rapid scale-up of HRH investments is possible.

The other entities, notably some international NGOs, have been instrumental in developing and implementing HRH actions in partnership with country governments, especially in a range of Sub-Saharan African countries. These partnerships have enabled funding and

momentum to put policies and innovative solutions such as E-Health training modules and mobile health applications in place. A number of organisations have developed (and want to harmonise) CHW programme. Although some countries have developed CHW strategies, the work of NGOs is often complementary to that of the government when it comes to the training and remuneration of this cadre. This could create some tension regarding the sustainability, prioritisation and integration of these programme. (International) professional associations and networks have been relevant for strengthening norms in competences and training. However, their role in the governance of national HRH mechanisms seems limited. Lastly, it can be noted that labour unions and the commercial private sector have rarely been mentioned as key actors in governance mechanisms.

The commitment process demonstrated that HRH observatories do play an important role in monitoring and evaluation of HRH development and policies. There are positive examples of regional cooperation in HRH observatories and integrated HRH information systems, especially in Latin America, Europe and South-East Asia. It is recommended for all countries to establish institutional mechanisms and processes, such as an HRH observatory, working groups and/or HRH co-ordination committees in order to expand the evidence base and to promote policy dialogue on health workforce issues as well as holding all actors accountable concerning HRH policies and actions initiated.

Advancing the international health workforce policy process

The commitment process generated political support and momentum to invest in the health workforce. Most of the 57 countries that had made commitments at the 3GF faced severe HRH challenges. The multipronged, cross-thematic approach chosen by many countries indicates deepened knowledge of the governance mechanisms required to deal with this complex issue.

Notwithstanding, some caution is warranted: HRH planning and management require a long-term perspective. The momentum that has been generated by the 3GF must not be lost. Political instability and 'shocks' such as epidemics, financial crises and environmental disasters could disrupt those earlier investments but could also raise political awareness of the need to support countercyclical economic investments to strengthen public health systems and public services employment.

The commitments were generally lacking appropriate financial planning and indicators to sustain HRH developments and to monitor success in the long run. This likely is the case due to a fear of cost escalation. However, the commitment process and the Recife Political Declaration on HRH¹⁵ provided the space to give HRH development and UHC priorities due consideration in discussions on the Sustainable Development Agenda. Consecutively, high-level political attention by the United Nations High Level Commission on Health Employment and Economic Growth (UNHEEG commission) has highlighted the

potential contribution of health employment to equitable economic growth and may add political momentum to sustained investments in the future workforce.¹⁶ The tracing of the HRH commitments also highlighted the continued need to develop strong monitoring and evaluation (M&E) mechanisms at the national, regional and global level for greater accountability.

The SDGs include a specific target 3c for Health Workforce Development, and the health workforce can contribute to the attainment of other SDGs.^{17,18} In 2016, the World Health Assembly adopted the Global Strategy on HRH: Workforce 2030.¹⁹ The UNHEEG commission has invited policy makers to commit to its agenda and the 10 recommendations it has put forward.²⁰ The SDGs, the global strategy on HRH and the UNHEEG commission provide the policy guidance and political framework on how to further the ongoing national and global HRH commitments.

The HRH commitment process provides national and regional examples of intersectoral and multiple actor governance, including its policy dialogue, accountability, monitoring and observatory functions. It demonstrates that similar functions need to be secured at the global level. Global HRH development has become an international public good that is required to improve universal health outcomes, facilitates decent employment and represents a crucial pillar for health security. HRH development demands sharing responsibilities and political commitment as well as investment by countries and other actors to overcome the global gap in workforce shortages.

These factors merit policy proposals and dialogue on the initiation of a governance mechanism at the global level that monitors HRH investments, overviews country progress in the different HRH policy pathways linked to the WHO Global Strategy on HRH and the UNHEEG commission, monitors the WHO's Code of Practice on the international recruitment of health personnel and provides a forum for policy dialogue on managing transnational workforce mobility. Such a global platform would facilitate exchange, communication, best practice and mutual accountability between countries and other actors regarding HRH developments, and would act as a nexus for intersectoral and structured dialogue with other global mechanisms such as the UHC 2030 alliance, the High Level Political Forum on Sustainable Development, G7/G20, Multilateral and regional trade agreements, the International Financial Institutions, International Labor Organization (ILO)'s decent work agenda, the International Health Regulations and the Global Health Security Agenda. The Global Health Workforce Network is an excellent place to discuss the potential of such a mechanism, linked with and contributing to the SDG monitoring and accountability framework.²¹

CONCLUSION

The findings and analysis from the HRH commitments implementation indicate that intersectoral action,

dedicated political support, a partnership approach and sustained funding are of crucial importance to further advance the HRH development agenda towards the three objectives of equitable health outcomes, inclusive and sustainable economic growth and improved health security. HRH challenges, their different pathways and the intersectorality of the required response are increasingly recognised as an issue of common concern; hence, there is a need for national governments to continue to share responsibilities and cooperate on this vital issue in a co-ordinated matter with all relevant actors.

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REFERENCES

1. Third Global Forum on Human Resources for Health. HRH commitments. 2013 www.who.int/workforcealliance/forum/2013/hrh_commitments/en/index.html (accessed 15 Jun 2017).
2. Kienny MP, Bekedam H, Dovlo D, *et al.* Strengthening health systems for universal health coverage and sustainable development. *Bull World Health Organ* 2017;95:537–9.
3. Global Health Workforce Alliance / World Health Organization. Analysis of the commitments made by national governments of 57 countries at the Third Global Forum on human resources for health. 2014 www.who.int/workforcealliance/knowledge/resources/Analysis_HRH_commitments_13Mar2015_c_SR_LAST.pdf (accessed 15 Jun 2017).
4. Walt G, Gilson L. Reforming the health sector in developing countries: the central role of policy analysis. *Health Policy Plan* 1994;9:353–70.
5. Dussault G, Badr E, Haroen H, *et al.* Follow-up on commitments at the third Global forum on human resources for health: Indonesia, Sudan, Tanzania. *Hum Resour Health* 2016;14:1.
6. Human Resources for Health Country Commitments. *Case studies from the Dominican Republic, Kenya, Mali and Uganda*: IntraHealth International, 2015. http://www.intrahealth.org/files/media/hrhcountrycommitmentscasestudies/HRH_Commitments_Case_Studies.pdf (accessed 25 Nov 2016).
7. Kurniati A, Roskam E, Afzal MM, *et al.* Strengthening Indonesia's health workforce through partnerships. *Public Health* 2015;129:1138–49.
8. Global Health Workforce Alliance. Country coordination and facilitation: South Sudan. 2013 <http://www.who.int/workforcealliance/countries/ssd/en/> (accessed 15 Jun 2017).
9. Global Health Workforce Alliance. Country Coordination and Facilitation (CCF)-resources. 2012 <http://www.who.int/workforcealliance/knowledge/resources/ccfresources/en/> (accessed 15 Jun 2017).
10. The Lancet. No health workforce, no global health security. *Lancet* 2016;387:2063.
11. Dal Poz MR, Sepulveda HR, Costa Couto MH, *et al.* Assessment of human resources for health programme implementation in 15 Latin American and Caribbean countries. *Hum Resour Health* 2015;13:24.
12. Pan American Health Organisation. Toronto Call to Action. 2006–2015. towards a decade of human resources in health for the Americas. Regional meeting of the observatory of human resources in health, 2005. http://www.bvsde.paho.org/bvsdeescuelas/fulltext/CallAction_eng1.pdf (accessed 15 Jun 2017).
13. G8 Communiqué. *Annex I: the G8 muskoka initiative: maternal, newborn and under-five child health: The Partnership for Maternal, Newborn & Child health and World Health Organization*, 2010. http://www.who.int/pmnch/media/g8watch_2010/en/ (accessed 15 Jun 2017).
14. AMREF. Position statement on community health workers. 2014 <http://amref.org/amref/en/info-hub/amref-position-statement-on-community-health-workers/> (accessed 15 Jun 2017).
15. The Recife Political Declaration on Human Resources for Health. *Renewed commitments towards universal health coverage. 3rd global forum on human resources for health*: WHO, 2013. http://www.who.int/workforcealliance/forum/2013/recife_declaration_17nov.pdf?ua=1 (accessed 15 Jun 2017).
16. UN High-Level Commission on Health Employment and Economic Growth. 2016 <http://www.who.int/hrh/com-heeg/en/> (accessed 15 Jun 2017).
17. WHO. Workforce 2030 and the sustainable development goals. 2015 http://www.who.int/hrh/HRH-SDG_infographic_Jan2016.png?ua=1 (accessed 15 Jun 2017).
18. Evans T, Araujo EC, Herbst CH, *et al.* *Addressing the challenges of health professional education: opportunities to accelerate progress towards universal health coverage*. Doha, Qatar: World Innovation Summit for Health, 2016. <http://www.wish-qatar.org/app/media/download/2747> (accessed 15 Jun 2017).
19. World Health Assembly. 16.1 Global strategy on human resources for health: workforce 2030, 2016. http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_BCONF4-en.pdf (accessed 15 Jun 2017).
20. WHO. Working for health and growth: investing in the health workforce. Report of the High-Level Commission on Health Employment and Economic Growth. 2016 <http://apps.who.int/iris/bitstream/10665/250047/1/9789241511308-eng.pdf?ua=1> (accessed 15 Jun 2017).
21. Berland A, Best A, Noel K, *et al.* *Assessing the legacy of the Global Health Workforce Alliance through the lens of Complex Adaptive Systems*: InSource Research Group, 2016. http://www.who.int/workforcealliance/media/news/2016/GHWA_LegacyReport.pdf?ua=1 (accessed 15 Jun 2017).