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THE AFRICAN REGIONAL FRAMEWORK FOR THE IMPLEMENTATION OF THE GLOBAL STRATEGY ON HUMAN RESOURCES FOR HEALTH: WORKFORCE 2030

Report of the Secretariat

EXECUTIVE SUMMARY

1. Efforts have been made to reduce the human resources for health (HRH) crisis in the African Region after the World Health Report 2006 declared the Region to have the most severe shortage of health workforce. Member States adopted the Regional Roadmap on Human Resources for Health in 2012 to use various strategies to increase production, performance and retention of health workers. However, minimal improvement has occurred since the publication of the report and 36 Member States out of the 57 facing health workforce crisis globally that are from the Region are still under the recommended minimum threshold of 2.3 doctors, nurses, and midwives per 1000 population.

2. The development of human resources for health is critical to achieving Sustainable Development Goals in health. However, Health Workforce remains an important challenge in the African Region due to continued poor coverage and inequity in access to health workers. A multisectoral response is needed. Such a response should be of value to all stakeholders in the health workforce area, including public and private sector employers. Strong governance and leadership, effective use of available resources, innovative education strategies and health workforce deployment are also recognized as critical factors to reduce the crisis. The vision that by 2030, all communities have universal access to health workers requires more investment in health workforce production, recruitment and deployment.

3. The Global Strategy on Human Resources for Health: Workforce 2030 (GSHRH) aims at ensuring equitable access to qualified health workers to help Member States accelerate progress towards achieving universal health coverage and Sustainable Development Goal 3. Its objectives are to: (a) Optimize the performance, quality and impact of the health workforce to accelerate progress towards UHC and SDG; (b) Align investment in HRH with the current and future needs of the population and health systems to maximize job creation and economic growth; (c) Strengthen the capacity of institutions at regional and national levels for effective public policy stewardship, leadership and governance on HRH; and (d) Strengthen data and information systems on HRH for monitoring and ensuring accountability for the implementation of national and regional strategies.

4. The strategy has specific indicators and milestones for 2020 and 2030 and this framework includes regional targets for 2022 and proposes specific priority interventions, targets and milestones of the Global HRH Strategy: Workforce 2030 to be implemented by Member States.

5. The Regional Committee is requested to examine and adopt the priority interventions and actions proposed in this framework.

CONTENTS

ANNEXES

ABBREVIATIONS

CHW	Community Health Worker
GSHRH	Global Strategy on Human Resources for Health: Workforce 2030
HRH	Human resources for health
HW	Health worker
HW	Health workforce
ICT	Information and Communication Technology
NHWA	National Health Workforce Accounts
SDGs	Sustainable Development Goals
WHO	World Health Organization
UN	United Nations

INTRODUCTION

1. According to the World Health Report 2006,[1] the African Region has the most severe health workforce[2] (HWF) shortage in the world. (Of the 57 countries facing HWF crisis globally, 36 are in the African Region). Since 2006, Member States have made more efforts to tackle the HRH challenges even though the number of Member States under HRH crisis remains unchanged.[3]

2. In 2012, Resolution AFR/RC62/R3 was adopted to endorse a roadmap for scaling up the Human Resources for Health for Improved Health Service Delivery in the African Region from 2012–2025. It urged Member States to make efforts to strengthen the capacity of the health workforce in the Region.

3. In May 2014, resolution WHA67.24 on *Follow-up of the Recife Political Declaration on Human Resources for Health*: renewed commitments towards universal health coverage called on WHO to develop a global strategy for human resources for health. In May 2016, resolution WHA69.19 on the *Global Strategy on Human Resources for Health: Workforce 2030* (GSHRH) was adopted. The GSHRH is fully aligned with Sustainable Development Goal 3. Implementation of the GSHRH by Member States will be instrumental in contributing to the achievement of this goal and its targets, especially Universal Health Coverage (UHC). The UN Secretary-General established the High-Level Commission on Health Employment and Economic Growth which produced a report in September 2016 on health employment titled *Working for health and growth: investing in the health workforce* which is aligned with the GSHRH. The report recognized that investing in new health workforce employment opportunities may also add broader socioeconomic value to the economy and contribute to the implementation of the SDGs. In April 2017, the International Labour Organization Tripartite Meeting adopted a resolution on Improving Employment and Working Conditions in Health Services. In May 2017, resolution WHA70.6 adopted a five-year action plan for health employment and inclusive economic growth (2017-2021).

4. The proposed framework is intended to guide Member States in the African Region in the implementation of the GSHRH.

CURRENT SITUATION

5. In the last decade, there have been minimal positive changes in addressing the HRH crisis in the African Region. By 2015, only 11 Member States[4] in the Region had met the minimum threshold of 2.3 doctors, nurses and midwives per 1000 population. There has been a general increase in the total number of doctors, nurses and midwives in more than half (54%) of the Member States but, in terms of density of health workers, only 23% have reached the minimum threshold. However, the needs-based shortage of health workers in Africa is estimated to reach 6.1 million by 2030, out of 14.5 globally.[5]

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1 WHO, World Health Report 2006, Geneva, World Health Organization, 2016 http://www.who.int/whr/2006/en/.

2 Health workforce is all people engaged in actions whose primary intent is to enhance health (World Health Report 2006) whereas Human Resources for Health can be defined as the different kinds of clinical and non-clinical staff responsible for public and individual health intervention (World Health Report 2000). Human Resources is also the organizational function that deals with the people and issues related to people such as compensation, hiring, performance management, and training.

3 WHO AFRO: Equitable access to a functional health workforce,http://www.afro.who.int/en/downloads/cat_view/1501-english/2298-regional-forum-on-strengthening-health-systems-for-the-sdgs-and-uhc.html

4 Algeria, Botswana, Equatorial Guinea, Gabon, Ghana, Mauritius, Namibia, Sao Tome and Principes, Seychelles, South Africa and Swaziland.

5 WHO, Global strategy on human resources for health: Workforce 2030, Geneva, World Health Organization, 2016.

6. The Global Burden of Disease Study 2015 showed that the Region still bears a huge disease burden.[6] In 2015, the Region accounted for 26% of the estimated 10.4 million new cases of tuberculosis[7] and 88% of the 214 million malaria cases.[8] Noncommunicable diseases are also on the increase in the Region. Moreover, the rising number of disease outbreaks in Africa has significantly impacted the few existing health workers (HWs) as clearly highlighted during the EVD outbreak in 2014-2015 in West Africa.

7. In 2015, thirty-three Member States had costed and validated Strategic Plans for Health Workforce.[9] Since the establishment of the Africa Health Workforce Observatory in 2007, fourteen Member States in the Region had established Workforce Observatories to produce and utilize HRH information to support evidence-based policies.[10] Various approaches have been implemented to reduce the effects of the HRH crisis. For example, Cameroon, Ethiopia, Malawi, Mali and Rwanda have adopted community-based approaches using community health workers especially in rural areas for health promotion and preventive care. In addition, task-shifting and task-sharing have been adopted and implemented in more than fifteen Member States to increase the delivery of quality essential services such as emergency obstetric and HIV care.

ISSUES AND CHALLENGES

8. **Weak leadership and governance of health workforce**: Persistent weak leadership and governance of HRH is a major threat in achieving UHC in the African Region. Sustained political will and policy champions are necessary to coordinate the various aspects of HRH. Furthermore, the weak capacity of HRH departments in the ministries of health should be strengthened to improve the quality and implementation of HRH strategic plans.

9. **Poor retention of health workers:** Retaining the available HWs is critical to improving coverage and equity of access to health services. Furthermore, poor working conditions, unattractive remuneration, inadequate protection and little incentives play a role in demotivating HWs. Migration of HWs poses a challenge for Member States. There is inequitable distribution between urban and rural areas. It is a challenge getting HWs to serve in remote and rural areas, hence they are underserved.

10. **Inadequate and inefficient use of financial and human resources**: In 2014, only Liberia, Rwanda, Swaziland and Zambia met the Abuja Declaration target of allocating 15% of annual budget for health.[11] Although most Member States have national HRH plans, their implementation has been a challenge. For example, some Member States cannot afford to absorb all HWs produced, leading to the paradox of HW unemployment amidst shortages in the health system.

11. **Inadequate HRH education and training capacity:** Some training schools are not accredited which implies that the quality of education provided is not assured.[12] There are only 168 medical schools in the Region, with 11 of the Member States having no medical school and 24 only one

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6 Vos T, et al. Global, regional, national incidence, prevalence, and years lived with disability for 310 diseases and injuries 1990–2015: a systematic analysis for the Global Burden of Disease Study 2015. *Lancet*, 388 (10053):1545-602, 2016.

7 WHO, Global Tuberculosis Report 2016: Geneva, World Health Organization, 2016.

8 WHO, World Malaria Report 2015, Geneva, World Health Organization, 2015.

9 All Member States except Algeria, Angola, Central African Republic, Equatorial Guinea, Gabon, Ghana, Namibia, Madagascar, Mauritius, Congo, Seychelles, South Sudan and Zimbabwe.

10 Angola, Benin, Burundi, Cameroon, Central African Republic, Chad, Comoros, Democratic Republic of the Congo, Ghana, Madagascar, Malawi, Mauritania, Mozambique and Togo.

11 WHO. WHO Global Health Expenditure Atlas, Geneva, Switzerland, World Health Organization, 2014.

12 WHO, Transforming and Scaling up Health Professional Education and Training: Policy brief on Accreditations of Institutions for Health Professional Education, Geneva, World Health Organization, 2013.

medical school.[13] However, there is a significant increase in the number of health science training schools for other categories of health workers, partly due to increasing involvement of the private sector in education.

12. **Limited availability of health workforce information:** In 2015, thirty-four Member States had not yet established a workforce observatory.[14] Availability of accurate health worker data is crucial in informing evidence-based policies. However, the capacity to collect, analyse and use HRH information is weak in the Region. In addition, HRH research and dissemination of best practices have been limited.

THE REGIONAL IMPLEMENTATION FRAMEWORK

Vision, goal, objectives, targets and milestones

13. **The vision** is to accelerate progress towards achieving UHC in Member States by ensuring universal access to skilled and motivated health workers.

14. **The goal** is to guide the efforts of Member States in making adequate investments to enable implementation of effective policies that ensure universal availability and accessibility and quality of HWF.

15. **The objectives are:**

(a) To optimize the performance, quality and impact of the health workforce through evidence-informed policies and strategies.
(b) To align investment in HRH with the current and future needs of the population and health systems.
(c) To strengthen the capacity of institutions for effective public policy stewardship, leadership and governance on HRH.
(d) To strengthen data on HWF for monitoring and accountability.

16. **Regional targets[14]**

By 2022,

(a) All Members States have institutional mechanisms in place to coordinate HWF agenda.
(b) 50% of Member States have regulatory mechanisms in place to promote HWF safety and adequate oversight of the private sector.
(c) At least 50% of Member States have established accreditation mechanisms for health training institutions.
(d) At least 50% of Member States have an HRH investment plan.
(e) At least 50% of Member States have developed National Health Workforce Accounts (NHWA), and HWF observatories and registries.

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[13] Global health workforce shortage to reach 12.9 million in coming decades, Geneva, Washington, 2013. http://www.who.int/mediacentre/news/releases/2013/health-workforce-shortage/en accessed on 22 November 2016.

[14] Algeria, Burkina Faso, Botswana, Cabo Verde, Congo, Côte d'Ivoire, Eritrea, Ethiopia, Equatorial Guinea, Gabon, Gambia , Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Mali, Mauritius, Namibia, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, South Sudan, Swaziland, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

[14] The GSHRH has no targets. It has only milestones for 2020 and 2030 which are rephrased as targets in this regional implementation framework. Baseline indictors for 2017 are provided in Annex1 for measurement of progress.

By 2030,

(a) All Member States have reduced at least by half inequalities in access to a health worker.
(b) All Member States have reached at least 80% of the course completion rates in health training institutions.
(c) All Member States have developed an HRH investment plan.
(d) All Member States have established accreditation mechanisms for health training institutions.
(e) All Member States have regulatory mechanisms to promote HWF safety and adequate oversight of the private sector.
(f) All Member States have established NHWA, and HWF registries and observatories.

Guiding principles

17. The following principles will guide the implementation of the Global Strategy in the Region:

(a) Ensure **alignment and conformity** with the Regional roadmap for scaling up HRH regarding the priority interventions and strategic directions.
(b) Promote the **right to the enjoyment of the highest attainable standard of health** by improving universal access to quality and motivated HWF.
(c) Provide integrated, **people-centred health services** devoid of stigma and discrimination.
(d) Foster empowered and engaged **communities** as active contributors to service delivery.
(e) Uphold the personal, employment and professional **rights of all health workers**, including gender-sensitive, safe and decent working environments and freedom from all kinds of discrimination, coercion and violence.
(f) Promote **international collaboration and solidarity** in alignment with national priorities.
(g) Mobilize and sustain **political and financial commitment** and **foster inclusiveness** and collaboration across sectors as part of investment in the development, performance and retention of HWF.
(h) Promote **innovation and the use of evidence** for planning and implementation of HWF strategies**.**

PRIORITY INTERVENTIONS AND ACTIONS

Objective 1: Optimize the performance, quality and impact of HWF through evidence-informed policies and strategies

18. **Strengthening the quality and implementation of HRH plans:** HRH should be an integral part of national development planning and be aligned with relevant government sectors, professional associations and the private sector. HRH plans should consider population and health system needs in addressing shortages and maldistribution of and inequity in access to health workers.

19. **Ensuring effective use of available resources**: Effective accountability systems should be implemented to improve efficiency of health and HRH spending. Member States need to adopt appropriate and cost-effective health-care delivery models aligned with market forces that will inform appropriate and sustainable skills-mix to meet population needs equitably.

20. **Adopting transformative strategies in the scale-up of health worker education, including training of HRH planners, managers, health economists among others:** Transformative strategies should focus on investment in trainers to cater for a variety of populations such as children, refugees and other vulnerable populations. Trainees should be adequately equipped with knowledge of social determinants of health and public health issues including epidemic

preparedness. Member States should strengthen public-private partnership due to increasing involvement of the private sector in education. The capacity and quality of educational institutions should also be strengthened through accreditation and certification of trainees. Member States should increase investment in faculty members of training schools to ensure adequate numbers and quality.

21. **Scaling up and/or improving the effectiveness of Community Health Workers (CHWs) programmes:** Member States should, when deploying large-scale CHW programmes in deprived regions, provide promotive, preventive and defined curative health care services consistent with national regulations and needs. CHWs should be integrated into the health system and Member States should consider providing them with financial compensation. Evidence-based assessments should be conducted on the role of CHWs.

22. **Optimizing health worker retention, equitable distribution and performance:** An integrated package of gender-sensitive attraction and retention policies should be considered. Evidence-based mechanisms for retention as well as for attracting back health workers from the diaspora need to be developed. In addition, an enabling working and living environment should be created through gender-sensitive employment conditions, merit-based career development opportunities and fairness. These should include manageable workloads, HWF safety, supportive supervision, continuing education and professional development opportunities, family and lifestyle incentives, hardship, housing and education allowances, as well as adequate facilities and working tools.

23. **Harnessing information and communication technology (ICT) opportunities**: Member States should strive to incorporate appropriate ICT tools such as e-learning, electronic health records and telemedicine to improve education and efficiency of health service delivery. Equally important are the accreditation procedures and regulation of mobile health services and ICT tools as well as mechanisms to protect the confidentiality of workforce data.

24. **Strengthening the capacities of the domestic health workforce in emergency and disaster risk management for greater resilience and health-care response:** Health workers, including community health workers, need to be trained and equipped for the implementation of operations in emergencies at all levels of the health system. This should include enhancing and promoting the safety and protection of all health personnel by adopting and implementing appropriate measures for physical protection and safety and legal frameworks to address violence against health personnel.

25. **Collaborating with professional bodies:** Member States should collaborate with professional councils and other regulatory authorities in developing and enforcing standards and regulation. This should be done through appropriate measures, including separation of roles of regulatory bodies, government and professional associations. There is need to facilitate establishment of HW regulatory bodies and to strengthen those already existing to ensure their active engagement.

Objective 2: Align investment in HRH with the current and future needs of the population and health systems

26. **Building planning capacity to develop or improve HRH policy and strategies that quantify health workforce needs, demand and supply**: Member States should build the capacity of HRH units to develop HRH plans that include long-term forecasting of different cadres of health workers. These strategies should provide for the production, recruitment and retention of sufficient numbers of health workers.

27. **Mobilizing resources for HRH from both traditional and innovative sources:** Member States should make efforts to increase the HRH budget through progressive taxation, social health insurance and increase in the general budget. The allocation of resources to the health sector should

be consistent with and aligned to the broader national health policies and the social protection agenda.

28. **Establishing an investment case for HRH as a vital component of the SDGs/UHC:** Member States should engage relevant ministries and the private sector to support the development and implementation of a national workforce agenda in collaboration with professional associations, labour unions and civil societies so as to broaden ownership and sustainability of HRH plans and policies.

Objective 3: Strengthen the capacity of institutions for effective public policy stewardship, leadership and governance on HRH

29. **Ensuring that all Member States have an HRH unit or department in the MoH**: Member States should ensure that HRH units within the ministries of health have a standard set of core functions. These functions must include HRH policy, planning and governance, and data management and reporting. The HRH units should also have the capacity to analyse HRH data and labour economics, track mobility of health workers, and monitor and evaluate HRH interventions and trends.

30. **Strengthening technical and management capacities to translate political will and decisions into effective implementation**: Member States should invest in strengthening the capacity of health managers, HRH planners and policy-makers for quality health workforce planning and management.

Objective 4: Strengthen data on HWF for monitoring and accountability

31. **Investing in the analytical capacity of Member States for HRH and health system data:** Member States should have policies and guidelines for standardization and interoperability of HRH data using tools such as the WHO minimum data sets and national health workforce accounts. These include establishment of national HWF observatories as platforms for generating and sharing HRH data and best practices. Investing resources in building capacity to analyse data is also critical.

32. **Establishing national registries of practising health workforce**: Member States should have workforce registries which encompass a comprehensive set of key performance indicators on health worker stock, distribution, flow, demand, supply and remuneration in both the private and public sector. Establishing a register of practising workforce linked to payroll can facilitate the removal of ghost workers.

33. **Implementing incentives and policies for collecting, reporting, analysing and using reliable and impartial workforce data**: Member States should strengthen the standardized, national and subnational collection and reporting of health workforce data for local decision-making and sharing with the WHO Global Health Observatory annually.

34. **Embedding in HRH strategies the relevant policy options and the corresponding monitoring and accountability requirements**: Ensure that national HRH strategic plans are aligned with the necessary interventions in this implementation framework and that mechanisms for accountability are established. The monitoring of the framework is presented in Annex 1.

35. **Strengthening HRH information systems and building the human capital required to manage the systems:** This should be in alignment with broader health management information systems, including the ability to utilize such systems during emergencies and disasters. The capacity to use data effectively for dialogue with policy-makers and civil society should also be strengthened.

36. The Regional Committee is invited to adopt the actions proposed in this framework.

ANNEX 1: MONITORING AND ACCOUNTABILITY FRAMEWORK TO ASSESS PROGRESS ON HUMAN RESOURCES FOR HEALTH IN THE AFRICAN REGION. MAINLY USING THE NHWA AS SOURCE OF INFORMATION AND DATA

Baseline Indicator (2017)	**Regional targets (by 2022)**
1. The percentage of Member States with institutional mechanisms in place to coordinate an intersectional health workforce agenda	2. All Member States have inclusive institutional mechanisms in place to coordinate an intersectoral health workforce agenda
3. The percentage of Member States with HRH investment plan based on the current and future needs of the population	4. At least half of the Member States have HRH investment plan based on the current and future needs of the population
5. The percentage of Member States with accreditation mechanism for health training institutions	6. At least half of the Member States have established accreditation mechanisms for health training institutions.
7. The percentage of Member States with regulatory mechanisms to promote HWF safety and adequate oversight of the private sector	8. 50% of the Members States have regulatory mechanisms in place to promote HWF safety and adequate oversight of the private sector
9. The percentage of Member States with a health workforce observatory including HWF registry	10. At least 50% of the Member States have made progress in establishing HRH observatory including HWF registry
11. The percentage of Member States with established national health workforce accounts and that share annually with WHO Secretariat	12. Half of the Member States have made progress in establishing national health workforce accounts and sharing annually HRH data with WHO Secretariat
Baseline Indicator (2017)	**Regional targets (by 2030)**
1. Density of health workers (dentist, midwife, nurse, pharmacist, physician) per 1000 population by district level distribution	1. All Member States have reduced at least by half inequalities in access to health workers (dentist, midwife, nurse, pharmacist, physician)
2. Percentage of Member States that have achieved at least 80% student graduation rate across medical, nursing and allied health professional training institutions	2. All Member States have reached at least 80% of the course completion rates in medical, nursing and allied health professional training institutions
3. The percentage of Member States with HRH investment plan based on the current and future needs of the population	3. All Member States have developed HRH investment plan
4. The percentage of Member States with accreditation mechanisms for health training institutions	4. All Member States have established accreditation mechanisms for health training institutions
5. The percentage of Member States with regulatory mechanisms to promote HWF safety and adequate oversight of the private sector	5. All Member States have regulatory mechanisms to promote HWF safety and adequate oversight of the private sector
6. The percentage of Member States with established national health workforce accounts and that share annually with WHO Secretariat	6. All Member States have established national health workforce accounts and are sharing HRH data annually with WHO Secretariat
7. The percentage of Member States with a health workforce observatory including HWF registry	7. All Member States have established national HRH observatory including HWF registry

ANNEX 2: GLOBAL STRATEGY ON HRH: WORKFORCE 2030–AT A GLANCE

VISION

Accelerate progress towards universal health coverage and the UN Sustainable Development Goals by ensuring equitable access to health workers within strengthened health systems.

OVERALL GOAL

To improve health, social and economic development outcomes by ensuring universal availability, accessibility, acceptability, coverage and quality of the health workforce through adequate investments to strengthen health systems, and the implementation of effective policies at national, regional and global levels.

PRINCIPLES

(a) Promote the **right to the enjoyment of the highest attainable standard of health.**

(b) Provide integrated, **people-centered health services** devoid of stigma and discrimination.

(c) Foster empowered and engaged **communities.**

(d) Uphold the personal, employment and professional **rights of all health workers,** including safe and decent working environments and freedom from all kinds of discrimination, coercion and violence.

(e) Eliminate **gender-based violence,** discrimination and harassment.

(f) Promote **international collaboration and solidarity** in alignment with national priorities.

(g) Ensure **ethical recruitment practices** in conformity with the provisions of the WHO Global Code of Practice on the International Recruitment of Health Personnel.

(h) Mobilize and sustain **political and financial commitment** and foster **inclusiveness** and collaboration across sectors and constituencies.

(i) Promote **innovation and the use of evidence.**

OBJECTIVE 1:	**OBJECTIVE 2**	**OBJECTIVE 3**	**OBJECTIVE 4**
Optimize the performance quality and impact of the HWF through evidence-informed policies and strategies.	Align investment in HRH with the current and future needs of the population and health systems.	Strengthen capacity of institutions for effective public policy stewardship, leadership and governance on HRH.	Strengthen data on HWF for monitoring and accountability.

GLOBAL MILESTONES BY 2020

(a) All countries have inclusive institutional mechanisms in place to coordinate an intersectoral health workforce agenda.

(b) All countries have a human resources for health unit with responsibility for development and monitoring of policies and plans.

(c) All countries have regulatory mechanisms to promote patient safety and adequate oversight of the private sector.

(d) All countries have established accreditation mechanisms for health training institutions.

(e) All countries are making progress on health workforce registries to track health workforce stock, education, distribution, flows, demand, capacity and remuneration.

(f) All countries are making progress on sharing data on human resources for health through national health workforce accounts and submit core indicators to the WHO Secretariat annually.

(g) All bilateral and multilateral agencies are strengthening health workforce assessment and information exchange.

GLOBAL MILESTONES BY 2030

(a) All countries are making progress towards halving inequalities in access to a health worker.

(b) All countries are making progress towards improving the course completion rates in medical, nursing and allied health professionals training institutions.

(c) All countries are making progress towards halving their dependency on foreign-trained health professionals, and implementing the WHO Global Code of Practice.

(d) All bilateral and multilateral agencies are increasing synergies in official development assistance for education, employment, gender and health, in support of national health employment and economic growth priorities.

(e) As partners in the United Nations Sustainable Development Goals, to reduce barriers in access to health services by working to create, fill and sustain at least 10 million additional full-time jobs in health and social care sectors to address the needs of underserved populations.

(f) As partners in the United Nations Sustainable Development Goals, to make progress on Goal 3c to increase health financing and the recruitment, development, training and retention of the health workforce.