

2024



# Africa Health Workforce Investment Charter

*Enabling sustainable health workforce investments for universal health coverage  
and health security for the Africa we want*

**PRIORITISE • ALIGN • INVEST • SUSTAIN**

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**ISBN: 9789290314998**

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**Designed in Kampala, Uganda**

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## Contents

Glossary	iv
Process for Development of the Africa Health Workforce Investment Charter	vi
Abbreviations	viii
1. Context of the Health Workforce Investment Charter	1
1.1 Global socioeconomic downturn: consequences for Africa	2
1.2 Health system status and performance in the Africa Region: the role of health workers	2
1.3 Accelerated investments in the health workforce	3
2. Rationale of the Africa Health Workforce Investment Charter	4
3. The Goal of the Africa Health Workforce Investment Charter	8
4. Expected outcomes of the Africa Health Workforce Investment Charter	10
5. Health Workforce Investment Principles	12
6. Theory of Change	14
7. Commitments	16
8. Coordination and Accountability Mechanism	22
Partners and collaborators	24

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## Glossary

→ **Investment Charter:**

A formal commitment to adhere to agreed principles in investment and to pursue a common purpose through investment actions.

→ **Health workforce investment plan:**

Evidence-informed investment priorities that are costed and appraised against the expected benefits, with the funding sources for implementation clearly identified with the funding parties making formal commitments on the volume, duration, and flow of the funds. It has clear accountability mechanisms in terms of financial management and expected deliverables.

→ **Social Partners:**

The social partners in health services are in principle public authorities as regulators or as employers, private employers' and workers' organizations in the health sector that cooperate in working relationships to achieve a mutually agreed-upon goal, typically for the benefit of all involved groups.

→ **Health workforce (HWF):**

All people engaged in actions whose primary intent is to enhance health. They may be paid staff or volunteers working full-time or part-time in the public and private sectors. They may be delivering health services, managing the services offered by the system, or addressing social determinants of health. That means that the health workforce includes: all personnel trained in health occupations delivering clinical work in health facilities (such as medical doctors, nurses, or dentists); all non-health professionals employed in the health sector, public and private, regardless of their occupation (such as managers, ambulance drivers or teachers of health education); and all those whose work supports the delivery of health services, even if they are employed by other sectors or industries (such as cleaning, catering, security or agency staff working in the health sector).

→ **Health Labour Market (HLM):**

The structure that allows the services of health workers to be sought (demanded) and offered (supplied). The health labour market can be characterized according to geographical area (local, national or international); occupation (by occupation title or category, specialized or unspecialized); and sector (private or public, formal or informal). The dynamic between the number and the kind of jobs offered on the market and the number of health workers is central in determining the configuration of the health labour market.

→ **Population health needs:**

Interventions required to promote, maintain, and secure the health and well-being of the population along their life course. This typically covers the range of disease burden and risk factors, stratified by the population's demographics, taking into account effective health interventions and professional standards and competence for delivering those interventions.

→ **Alignment:**

Ensuring a clear policy and investment intent that all parties have discussed and agreed to, ensuring policy coherence, promoting mutually reinforcing policy actions between government, the private sector, development partners, and across health, labour, education, financing sectors.

→ **Investment:**

Channelling financial resources into a health workforce-related course of action in line with identified priorities in which its expected return is clearly understood.

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→ **Stimulating investment:**

Committing new financial resources or unlocking unused funding towards a health workforce-related course of action aligned with identified priorities.

→ **Innovative financing:**

A range of non-traditional mechanisms to raise additional funds for health through “innovative” projects to fill identified financial gaps such as micro-contributions, taxes, public-private partnerships, and market-based financial transactions, among others. An innovative financing mechanism complements existing funding and does not substitute them or have a “crowding-out effect” on pre-existing budgetary commitments (**additionality or *raison d’être***); ensures the right and better use of the additional funds (**effectiveness**); and ensures value for the use of the additional funding (**efficiency**).

→ **Sustainability:**

Ensuring that health workforce investment decisions are focused on the long term, addressing mechanisms for integration and continuity and taking future generations into account.

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## Process for Development of the Africa Health Workforce Investment Charter

### 1. Regional Policy Dialogue for Building Consensus to Develop the Health Workforce Investment Charter:

In 2022, the WHO Regional Office for Africa, with support from the ILO-OECD-WHO Working for Health Programme, convened a Regional Policy dialogue on health workforce investment and protection from November 15 to 17, hosted by the Government of Ghana in Accra. policy dialogue was attended by twenty-six member states<sup>1</sup>, the International Labour Organization (ILO), USAID, the Global Fund to Fight TB, HIV and Malaria (Global Fund), the World Bank, AFREHealth, African Centre for Health and Social Transformation (ACHEST), the East Central and Southern African (ECSA) Health Commission, and the Southern African Development Commission (SADC). The dialogue recommended the development of an Africa Health Workforce Investment Charter laying time-tested principles to align efforts and stimulate investments in countries to address the root causes of health challenges.

### 2. Expert Working Group (EWG) Drafting of the Charter:

WHO AFRO convened health workforce experts with key member states from December 19 to 22, 2022, at the WHO Regional Office in Brazzaville, Republic of Congo, to draft the Investment Charter. The Expert Working Group is made up of independent health workforce experts, member states, key partners, academic institutions, and WHO.

### 3. Consultation with partners:

In January 2023, WHO engaged partners bilaterally to brief them about the Charter and to get feedback on the draft charter. Such bilateral meetings were held with the World Bank, USAID, Global Fund, and the Harmonization for Health in Africa (HHA) partners - attended by the Japanese International Corporation Agency (JICA), the Global Financing Facility (GFF), UNICEF, the Africa Development Bank (AfDB), Frontline Health Workers Coalition, and the Africa Frontline First (AFF).

### 4. Written feedback from Partners:

In January 2023, the Draft Charter was shared with partners through the WHO Liaison Office in Addis Ababa for their review, input, and feedback. Written feedback was received from COMESA, the International Federation of the Red Cross (IFRC), JICA, USAID, and the Global Fund.

### 5. Resolution by Ministers of Health of ECSA-Health Community:

During the 71st Conference of Health Ministers held in Lesotho in February 2023, discussed the draft Charter and made a resolution (ECSA/HMC71/R2) to noting “***the ongoing efforts of WHO AFRO in developing the African Health Workforce Investment Charter***” and urged the Member States to “***support the development of the WHO AFRO African Health Workforce Investment Charter***”.

### 6. Member States consultation:

On March 28 2023, after officially sharing the draft charter and requesting their participation in the consultation to provide feedback and input, a virtual consultative session with Member States was held. Fifty-five participants from 35 Member States and selected experts attended and provided feedback and input, which were used to revise the draft charter.

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<sup>1</sup> Benin, Central African Republic, Chad, Congo, Cote D'Ivoire, Ethiopia, Gabon, Ghana, Guinea, Guinea Bissau, Kenya, Liberia, Malawi, Mali, Mozambique, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Tanzania, Togo, Uganda, Zambia, and Zimbabwe

**7. Global discussion and support for the Charter:**

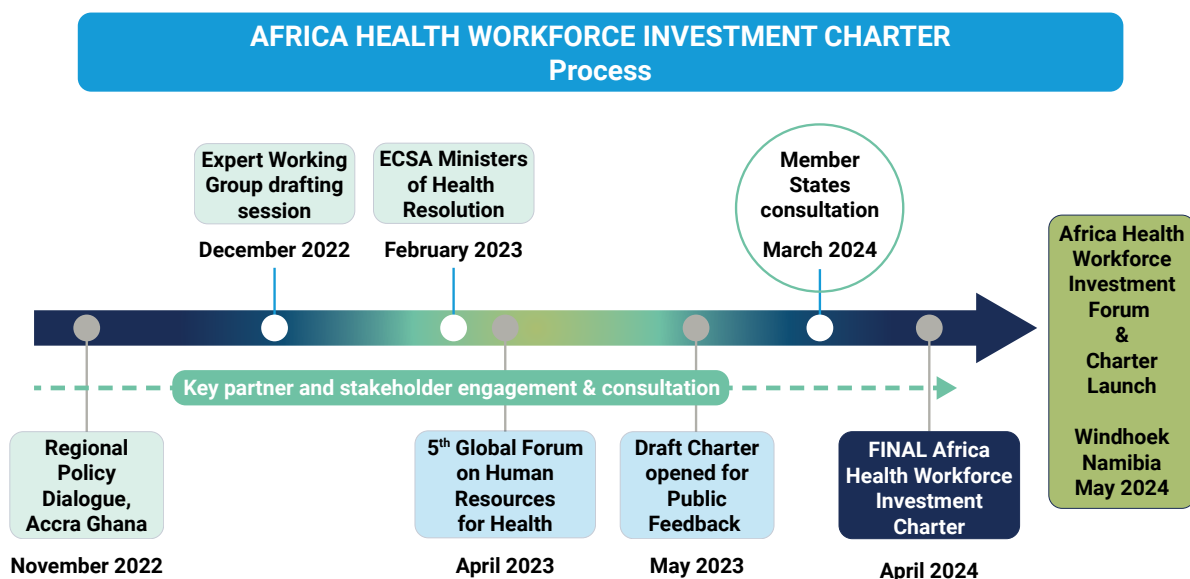
During the 5<sup>th</sup> Global Forum on Human Resources for Health, held from 3<sup>rd</sup> to 5<sup>th</sup> April 2023 in Geneva, the principles of the Charter were the basis of a roundtable on health workforce investment. This roundtable was attended by about 40 global health leaders and Ministers. The global leaders reflected on the Charter’s principles and affirmed support, noting that it was timely and needed.

**8. WHO African Region opened the Charter for Public Feedback:**

The Charter was published and opened for public feedback for six months. Twenty-five (25) entries were received from organizations and individuals, which were reviewed, synthesized, and incorporated by the Expert Working Group before the Charter was finalized.

**9. Global discussion and support for the Charter:**

The Expert Working Group was expanded and re-convened in April 2024 to finalize the text of the Charter.





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## Abbreviations

<b>COVID-19</b>	Coronavirus Disease 2019
<b>GDP</b>	Gross Domestic Product
<b>HLM</b>	Health Labour Market
<b>HRH</b>	Human Resource for Health
<b>HWF</b>	Health workforce
<b>HWIC</b>	Health Workforce Investment Charter
<b>IHR</b>	International health regulations
<b>IMF</b>	International Monetary Fund
<b>SADC</b>	Southern African Development Community
<b>SDG</b>	Sustainable Development Goals
<b>UEMOA</b>	Union Economique et Monétaire Ouest Africaine
<b>UHC</b>	Universal Health Coverage
<b>WHO</b>	World Health Organization



# 1. Context of the Health Workforce Investment Charter

Smart and sustained investments in the health workforce are crucial for improving health, economic and social outcomes. The Africa Health Workforce Investment Charter materializes the joint commitment of investment partners – including governments, key stakeholders, and development and financing partners – to align their priorities with population health needs. Together, investment partners can secure and deliver strategic investments in the health workforce and achieve lasting impact.

### 1.1 Global socioeconomic downturn: consequences for Africa

According to the International Monetary Fund (IMF)<sup>2</sup> and the World Bank<sup>3</sup>, global economic activity is experiencing a broad-based and sharper-than-expected slowdown, with the highest inflation rates in several decades. Public debt sustainability has become a concern; the cost of living has risen in many African countries, thus increasing the risk of many people falling into poverty with constrained access to health services, especially where adequate financial risk protection is not available. This has affected the availability of social protection measures for the health workforce.

The IMF has projected gradual economic recovery in sub-Saharan Africa as from 2023, but it may take several years to reach its pre-pandemic prospects.<sup>4</sup> African countries may not have the needed budgetary space to invest more in the health sector, especially in the health workforce, given the adoption of tighter fiscal policies/strategies by governments, increasing inflation and associated difficulties in getting funding from the international markets. Armed conflict and other humanitarian crises have further complicated the economic prospects of the Region.

Nonetheless, the COVID-19 pandemic and previous health emergencies have demonstrated that health workers primarily save lives and restore opportunities for economic activities and to revive businesses. Thus, these challenges are a clarion call for solidarity, alignment, and synergistic efforts to innovatively invest in cost-effective priorities to build back better health systems and economies

### 1.2 Health system status and performance in the Africa Region: the role of health workers

**The African Region has recorded increased service coverage over the decades but at a slower-than-needed pace.** The Sustainable Development Goal (SDG) indicator 3.8.1 on service coverage, as measured by the universal health coverage (UHC) service coverage index, increased in the African Region from 24% to 44% from 2000 to 2017, and from 44% to 46% from 2017 to 2019.<sup>5</sup> However, there are disparities between countries, ranging from 28% in Chad and 75% in Algeria, and the overall trend is not fast enough to reach the UHC target of 80% by 2030. Also, among 40 countries in the African Region that had completed independent joint external evaluations, none was found to have the required capacities to fully implement the International Health Regulations (IHR (2005)) to address health security<sup>6</sup>.

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2 International Monetary Fund, 'World Economic Outlook: Countering the Cost-of-Living Crisis', International Monetary Fund (IMF), October 2022. (<https://www.elibrary.imf.org/downloadpdf/books/081/460116-9781513577524-en/460116-9781513577524-en-book.pdf>.)

3 World Bank, 'World Development Report 2022: Finance for an Equitable Recovery' The World Bank, 2022.

4 International Monetary Fund, 'World Economic Outlook: Countering the Cost-of-Living Crisis.'

5 World Health Organization and World Bank, 'Tracking Universal Health Coverage: 2021 Global Monitoring Report' Washington, DC: World Bank, 13 December 2021. (<https://openknowledge.worldbank.org/handle/10986/36724>).

6 Ambrose Talisuna et al., 'Joint External Evaluation of the International Health Regulation (2005) Capacities: Current Status and Lessons Learnt in the WHO African Region', *BMJ Global Health* 4, no. 6 (1 November 2019): e001312, (<https://doi.org/10.1136/bmjgh-2018-001312>).

Life expectancy increased from 51 years in 2000 to 64 years in 2019. Healthy life expectancy, which shows the number of years one is expected to live in good health, increased from 45 years in 2000 to 55 years in 2019.<sup>7</sup> Neonatal mortality declined from 40.90 per 1000 live births in 2000 to 26.68 per 1000 live births in 2020, and under-five mortality declined from 154 per 1000 live births in 2000 to 71.86 per 1000 live births in 2020.<sup>8</sup> Nonetheless, the Region still faces multiple health threats, including changing patterns of communicable diseases, a growing burden of noncommunicable diseases, a disproportionate share of global health emergencies and a rising burden of injuries. The health workforce shortfall puts a severe strain on the system.

Before the COVID-19 pandemic, Africa was not on track to achieve the health-related SDG targets, and the pandemic set the Region even further back.<sup>9</sup> However, the COVID-19 pandemic illuminated the essential role and impact of the workforce in delivering essential public health functions; these considerations had largely been overlooked or taken for granted, and led to disparities within and across countries, as well as fragmented approaches to public health workforce development in terms of policies, planning, implementation and monitoring. Health workforce challenges have been a critical barrier to maintaining essential health services and delivering COVID-19 response activities. Increasing and optimizing investment in the health workforce is therefore required to improve health security and achieve the UHC target.

### 1.3 Accelerated investments in the health workforce

The challenges posed by COVID-19 generated added impetus and new opportunities to invest in the health workforce, and triggered a trend of investment interest following decades of chronic underinvestment. Governments have launched new initiatives to develop, employ and retain health workers. Major development partners have announced large health workforce investment initiatives, and international financial institutions have expanded their health and infrastructure investments, which will impact the health workforce. To ensure that all these investments respond to population health needs, there is need for better alignment with concrete priorities and stimulation of additional investments.

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7 World Health Organization Regional Office for WHO/AFRO, 'People Are Living Longer, but Are They Living Healthier? Analytical Factsheet' (Data Analytics and Knowledge Management (DAK), 2022), (<https://aho.afro.who.int/ind/af?ind=2&dim=62&dom=Life%20Expectancy&c=af&ci=1&cn=Afro%20Region>).

8 World Health Organization Regional Office for WHO/AFRO, 'Integrated African Health Observatory (IAHO) - Database of Indicators', accessed 13 January 2023, <https://aho.afro.who.int/ind/>.

9 WHO, 'Tracking Universal Health Coverage: 2023 Global Monitoring Report' Geneva, Switzerland: World Health Organization, 2023 (<https://www.who.int/publications-detail-redirect/9789240080379>).



## 2. Rationale of the Africa Health Workforce Investment Charter

**The health workforce has been and remains even more critical in health and socioeconomic development.** The attainment of the health-related SDGs and guaranteeing health security are intricately linked to equitable access to health workers within resilient health systems that are built to prevent, predict, timeously detect, and promptly and effectively respond to all public health emergencies while maintaining the optimal provision of routine health services. In recognition of this reality, more than 50% of the investments required to achieve SDG 3 are estimated to be spent on health workforce employment (wages and salaries)<sup>10</sup> and could reach 80% if the investment needed for their training is considered. Additionally, it is estimated that addressing future pandemics requires additional spending of at least US\$ 5 per capita per year,<sup>11</sup> of which 66% must be spent on workforce capacities for prevention, detection and response.<sup>12</sup> From the health workforce perspective, it is imperative for UHC and health security to be pursued as a joint investment objective.

**Over the years, health workforce investment has made a difference, but remains woefully inadequate to close the gaps.** Past investment in the health workforce contributed to improved health workforce stock by one million workers between 2013 and 2020, culminating in a 32% increase after adjusting for population growth.<sup>13,14</sup> However, despite these additional health workers being needed on the frontlines of service delivery, one in every three graduates risks failing to get decent employment after graduating due to inadequate investments in the recruitment of trained health workers. Despite the progress in health workforce density, more than 70% of African countries still face critical shortages – with needs-based estimates showing that the African Region will need between 5.3 and 6.1 million additional health workers by 2030.<sup>15,16</sup> Country-level and geographical maldistribution, deficits in working conditions, and migration of health workers remain longstanding challenges globally, but they are higher in African countries compared to the rest of the world.<sup>17</sup> Within countries, primary health care facilities, especially in rural areas, are understaffed and underresourced, and unless investment is expanded to recruit and retain health workers in these areas, merely training more will not improve the situation because the trained health workers will simply leave to work elsewhere.<sup>18</sup> For every 10 doctors or nurses working in Africa, at least one other is working in another country.<sup>19</sup> Retaining health workers in national health systems is challenging due to decent work deficits, low salaries and inadequate career development opportunities. Addressing these challenges will require aligned priorities for new and sustained investments in the health workforce, particularly for the primary health care level where the needs are greater and the returns are higher. While most countries have elaborate health workforce strategies to address

10 Karin Stenberg et al., 'Financing Transformative Health Systems towards Achievement of the Health Sustainable Development Goals: A Model for Projected Resource Needs in 67 Low-Income and Middle-Income Countries', *The Lancet Global Health* 5, no. 9 (1 September 2017): e875–87, [https://doi.org/10.1016/S2214-109X\(17\)30263-2](https://doi.org/10.1016/S2214-109X(17)30263-2).

11 Craven M, Sabow A, Van der Veken L, Wilson M. Not the last pandemic: Investing now to reimagine public-health systems. McKinsey and Company; (<https://www.mckinsey.com/industries/public-and-social-sector/our-insights/not-the-last-pandemic-investing-now-to-reimagine-public-health-systems#>, accessed 9 December 2022).

12 Stephanie Eaneff et al., 'Investing in Global Health Security: Estimating Cost Requirements for Country-Level Capacity Building', *PLOS Global Public Health* 2, no. 12 (<https://doi.org/10.1371/journal.pgph.0000880>, accessed 5 December 2022).

13 Mathieu Boniol et al., 'The Global Health Workforce Stock and Distribution in 2020 and 2030: A Threat to Equity and 'Universal' Health Coverage?', *BMJ Global Health* 7, no. 6 (2022): e009316.

14 WHO/AFRO, 'The State of the Health Workforce in the WHO African Region, 2021', World Health Organization (WHO) Regional Office for Africa (AFRO), 2021, (<https://apps.who.int/iris/bitstream/handle/10665/348855/9789290234555-eng.pdf?sequence=1>).

15 Boniol et al., 'The Global Health Workforce Stock and Distribution in 2020 and 2030'.

16 WHO, 'Global Strategy on Human Resources for Health: Workforce 2030', World Health Organization, 2016, (<https://apps.who.int/iris/handle/10665/250368>).

17 Mathieu Boniol et al., 'Inequal Distribution of Nursing Personnel: A Subnational Analysis of the Distribution of Nurses across 58 Countries', *Human Resources for Health* 20, no. 1 (2022): 1–10.

18 Merlin L. Willcox et al., 'Human Resources for Primary Health Care in Sub-Saharan Africa: Progress or Stagnation?', *Human Resources for Health* 13, no. 1 (10 September 2015): 76, (<https://doi.org/10.1186/s12960-015-0073-8>).

19 WHO/AFRO, *State of the Health Workforce in Africa: A Decade Review of Progress and Emerging Priorities for Investments* (Brazzaville, Republic of Congo: World Health Organization, Regional Office for Africa, 2024).

the challenges, their rate of implementation is less than 35%, particularly due to underinvestment and lack of investment plans to mobilize resources for education, decent employment and management and retention<sup>20,21</sup>.

**Inadequate health investment and limited prioritization of the health workforce have critically exposed health systems.** Investment in health, especially from domestic sources, is still low and inadequate for many countries to meet the UHC target and ensure health security. For example, 21 countries in the African Region spent less than 5% of their gross domestic product on health. Also, 36 countries spent less than the minimum of US\$ 112 per capita per annum required to ensure access to essential health services in 2019. Due to the underinvestment in health, many aspects of the health system remain underfunded and unable to deliver services to their full potential. For example, one study<sup>22</sup> found that between 2010 and 2018 the **proportion of** public health expenditure allocated to the health workforce in East and Southern Africa was, on average, 49%, compared to 57% globally. At these levels of workforce spending, a financing gap of 37–43% needs to be filled if all current health workers are to be employed. Official development assistance, a critical part of health investment in Africa, has plateaued at an average of 22% of government health expenditure since 2011, with much of it (44–55%) usually spent on in-service training.<sup>23</sup> The impact of this is a mismatch in investment between training and employment, and this can be addressed depending on the country context.

Informal work in the health and social care sectors persists and tends to be larger than comparable sectors, like education.<sup>24</sup> Unpaid care work is a significant barrier to gender equality and women's progression in the health and social care sectors which, in some contexts, is exacerbated by overreliance on unremunerated community health workers. This unpaid, informal and volunteer work is a hidden subsidy to health systems. Addressing this undervaluation requires progressive integration of health workers in informal employment, including community health workers into national health systems and establishing mechanisms for regulating, accrediting and integrating the informal workforce with varying skill levels into the formally employed health workforce, ensuring decent jobs, social protection, rights at work and equal pay for equal work for all.

Addressing the gaps in the health workforce would require spending almost an additional 2% of gross domestic product on health, of which at least 57% is dedicated to health workforce investments.<sup>25</sup> However, health systems in Africa are only 77% efficient,<sup>26</sup> implying that one in every five dollars spent on health is lost to technical inefficiency, to which health workforce mismanagement significantly contributes in the form of ghost workers on payrolls, absenteeism and suboptimal performance. Nonetheless, African countries are becoming more efficient, improving efficiency by 13% between 2014 and 2019.

**The health workforce is a worthwhile investment for governments and all investors.** Investment in the health workforce has multiple returns for both health and the economy,<sup>27</sup> in that it increases life expectancy and job creation respectively, especially for young people and women and also enhances

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20 Adam Ahmat et al., 'Health Workforce Policy and Plan Implementation in the Context of Universal Health Coverage in the Africa Region', *BMJ Global Health* 7, no. Suppl 1 (1 May 2022): e008319, (<https://doi.org/10.1136/bmjgh-2021-008319>).

21 Doris Osei Afriyie, Jennifer Nyoni, and Adam Ahmat, 'The State of Strategic Plans for the Health Workforce in Africa', *BMJ Global Health* 4, no. Suppl 9 (1 October 2019): e001115, (<https://doi.org/10.1136/bmjgh-2018-001115>).

22 James Avoka Asamani et al., 'Investing in the Health Workforce: Fiscal Space Analysis of 20 Countries in East and Southern Africa, 2021–2026', *BMJ Global Health* 7, no. Suppl 1 (1 June 2022): e008416, (<https://doi.org/10.1136/bmjgh-2021-008416>).

23 Pascal Zurn, 'Official Development Assistance (ODA) Investment Trends and Economic Perspectives', in *Regional Policy Dialogue on Investment and Protection of Health and Care Workers in Africa: Towards a Health Workforce Investment Charter 15- 17 November 2022*, Accra (Accra: World Health Organization, 2022).

24 Umberto Cattaneo and Emanuela Pozzan Valentina Beghini, 'A Quantum Leap for Gender Equality: For a Better Future of Work for All', Report, 7 March 2019, ([http://www.ilo.org/global/publications/books/WCMS\\_674831/lang-en/index.htm](http://www.ilo.org/global/publications/books/WCMS_674831/lang-en/index.htm)).

25 Asamani et al., 'Investing in the Health Workforce'.

26 WHO/AFRO, *State of the Health Workforce in Africa: A Decade Review of Progress and Emerging Priorities for Investments*.

27 WHO, 'Working for Health and Growth: Investing in the Health Workforce', 2016.

education and drives progress towards the achievement of the SDGs and UHC. The health sector holds potential for generating more decent jobs through increasing demand for its services and through its contribution to stimulating growth in other economic sectors, such as infrastructure, equipment, supplies and technology production, administrative and other services. Estimates by the International Labour Organization (ILO) suggest that increasing spending to achieve the SDG targets for health would result in the creation of approximately 173 million jobs globally in the health and social work sector as well as in other sectors through backward linkages.<sup>28</sup>

For every dollar invested in health and creating decent employment for health workers, the potential return is about nine dollars.<sup>29</sup> It has also been demonstrated that half of the global economic growth over the last decade resulted from improvements in health, and that for every added year of life expectancy, the economic growth rate is boosted by 4%.

A number of commitments have been made by governments and partners to improve the health workforce situation in Africa, including the African Union's Agenda 2063 (2013), the Addis Ababa Call to Action (2015), the Declaration of Astana (2018), the WHO Global strategy on human resources for health: Workforce 2030 (2016), the WHO African regional road map for scaling up human resources for health for improved health service delivery in the African Region 2012–2025 (2012), the West African Economic and Monetary Union (WAEMU) Action Plan (2018), the Southern African Development Community (SADC) Health workforce strategic plan 2020–2030 (2020), the Global health and care worker compact (2022), the Working for health 2022–2030 action plan (2022), the New Public Health Order (2022) and the Regional strategy for health security and emergencies 2022–2023 (2022).

Following a policy dialogue between Member States and partners held in November 2022 in Accra, Ghana, a consensus was reached to develop an investment charter. The rationale of the charter is to facilitate the alignment and stimulation of investments in the health workforce to implement regional and continental commitments. It is intended to serve as an instrument that will guide the implementation of Regional Committee resolution AFR/RC67/11 (2017) to have “... *reduced at least by half inequalities in access to a health worker*”<sup>30</sup> by 2030, through its capacity to “***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 the health workforce.

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28 ILO, World Employment and Social Outlook 2023: The Value of Essential Work. (Geneva, Switzerland: International Labour Organization, 2023), ([https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms\\_871016.pdf](https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms_871016.pdf)).

29 Dean T. Jamison et al., 'Global Health 2035: A World Converging within a Generation', *The Lancet* 382, no. 9908 (7 December 2013): 1898–1955, ([https://doi.org/10.1016/S0140-6736\(13\)62105-4](https://doi.org/10.1016/S0140-6736(13)62105-4)).

30 World Health Organization Regional Office for WHO/AFRO, The African Regional Framework for the Implementation of the Global Strategy on Human Resources for Health: Workforce 2030 World Health Organization. Regional Office for Africa, 2017 (<https://apps.who.int/iris/handle/10665/332179>).



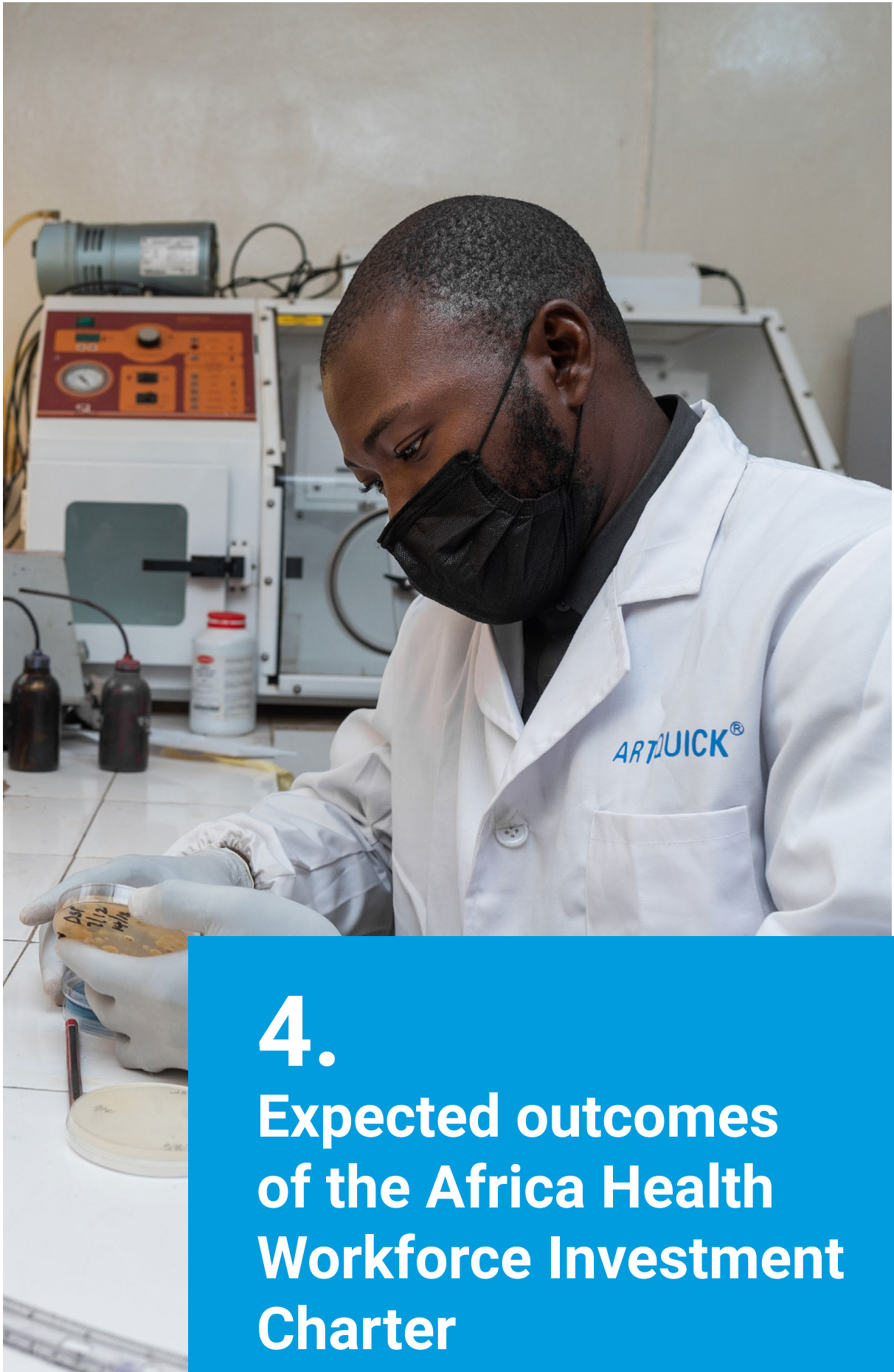


### 3. The Goal of the Africa Health Workforce Investment Charter

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The goal of the Africa Health Workforce Investment Charter is to align and stimulate investments in health worker education, employment, retention and mobility, in order to contribute to halving inequalities in access to health workers, especially in rural and primary health care settings, thereby creating decent employment, particularly for women and youth, strengthening health systems and accelerating progress towards UHC, health security and the SDGs in Africa.



# 4.

## Expected outcomes of the Africa Health Workforce Investment Charter

#### 4. Expected outcomes of the Africa Health Workforce Investment Charter

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The Health Workforce Investment Charter seeks to facilitate the alignment and stimulation of greater, smarter and sustainable investments in the health workforce, accelerating the implementation of national strategies and regional and global commitments. The Charter brings together the health workforce investment efforts of all stakeholders, including national governments, the private health sector, civil society, external financing institutions and development partners in Africa.

The expected outcomes are:

**01**

Governments, development partners, social partners and other key stakeholders align on health workforce priorities and formalize their commitments through a national health workforce investment compact.

**02**

Increased funding mobilized to ensure the availability of the required health workforce that enjoys decent working conditions and rights at work, to address health priorities, health security and contribute to inclusive growth.

**03**

New health workforce investments channelled into developing, recruiting and equitably distributing the health workforce towards halving inequalities in access to health workers, especially in rural settings and at the primary health care level.

**04**

The quality of jobs improved, including greater retention of health workers, with respect for the fundamental rights of the health workforce to freedom of association and collective bargaining.



# 5.

## Health Workforce Investment Principles

Informed by evidence and existing commitments, the Charter defines and elaborates on the five key health workforce investment principles that will reinforce and support the goal of aligning and stimulating health workforce investments to halve inequalities in access to health workers in Africa. The key principles are: (1) government leadership and stewardship; (2) evidence-driven prioritization; (3) alignment and synergy (partnership and collaboration); (4) stimulating new and accelerated investments; and (5) fostering sustainability in health workforce investment.

### **1. Principle 1: Government leadership and stewardship:**

Government leadership and stewardship are the most important elements that ensure alignment between investment and national development aspirations. Raising the health workforce agenda to the highest level of political and technical leadership is critical for all of society, all government dialogues and the commitment to break down barriers associated with working in silos.

### **2. Principle 2: Prioritization of health workforce investment is evidence-informed and linked to conducive conditions for delivery of better health outcomes and impact:**

Financial resources are limited, and evidence-informed priority-setting is essential to inform cost-effective and innovative investment decisions. Governments, in collaboration with social partners and development partners, need to develop long-term, costed health workforce plans that are evidence-driven and reflect priority population health needs and are aligned with international labour standards and integrated into national development, employment and health sector strategies.

### **3. Principle 3: Aligning and synergizing health workforce investments through partnership and collaboration:**

Returns on health workforce investments will be maximized through full implementation of the concept of 'one plan, one monitoring and evaluation framework'. Ensuring alignment and synergy, which will improve efficiency across health workforce investments coordinated through government leadership, will avert the current loss of time and waste of resources due to duplicative efforts, misalignment, missed opportunities and poor coordination.

### **4. Principle 4: Stimulating more and better investments in the health workforce:**

Longstanding underinvestment in the health workforce now requires urgent actions to meet health financing commitments and better prioritize health workforce investments. Intersectoral investments to address the health workforce challenge will generate dividends in education, employment for women and young people, while addressing gender inequalities and rural development. Additionally, stimulating investment efforts will contribute towards countries' sustained efforts to attract and generate more and better investments.

### **5. Principle 5: Fostering sustainability of health workforce investments:**

The principle of fostering sustainability encourages governments and international and local investment partners to ensure that decisions are intended for the long term, address mechanisms for integration and continuity and take future generations into account.



## 6. Theory of Change

The Africa Health Workforce Investment Charter views investment as a process that applies the five key health workforce investment principles to achieve the greatest impact (figure 1). Throughout the investment process, clear **government leadership and stewardship** are critical for prioritization, aligning actions, leading the way in stimulating multi-sectoral investments and ensuring sustainability in collaboration with social partners. Such integrated investment planning and mobilization provides a joint approach for joint action and accountability, monitored and strengthened through an investor/joint investor forum, building on existing structures and systems wherever possible.

The investment process begins with evidence-driven identification and **prioritization** of investment options. Once the investment priorities are identified, appraised, and prioritized, **alignment and synergy** across the investors are needed to enable investment actions. This can be achieved through a purposeful investment dialogue and negotiations with the investors, where consensus and negotiated commitments (“investment decisions”) are made and used to inform an investment plan, signed by all the partners involved as an instrument of agreement (investment compact).

Based on the investment plan and compact, governments and investors can jointly **stimulate investments**, direct their financial and technical resources to meet their commitments and hold each other accountable for meeting them. Once investments are made, growing and protecting their value and **sustainability** are key to realizing their full returns. This is addressed by ensuring that all investments are clearly linked to measurable health outcomes in the medium- to long-term horizons to deliver impacts on health and inclusive growth while ensuring decent work and rights at work for health workers.

Investments in the health workforce must, thus, shift from ad-hoc in-service training, education and capacity-building to strategic strengthening of the education sector (quality, scale, skills mix to match needs). Investments must also shift from ad-hoc health worker incentives to sustainable employment and retention investments and sustainable management of migration of health workers for health impacts.

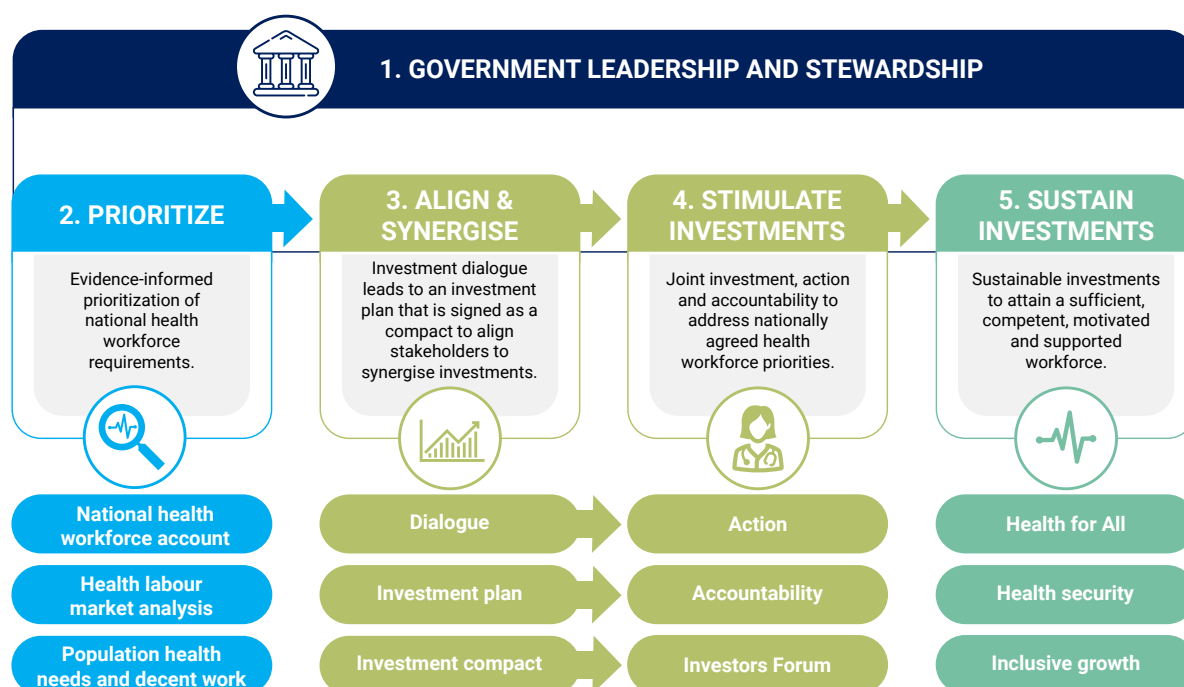


Fig. 1. Theory of change





# 7. Commitments

In pursuing the health worker investment principles, we affirm our commitment to the following:

## Principle 1: Government Leadership and Stewardship

1.1

We support the role of governments in leading a multistakeholder inclusive process of contextualizing and using the best available evidence, tools and models to establish nationally-defined and costed needs-based health workforce requirements and the investments needed to fulfil them.

1.2

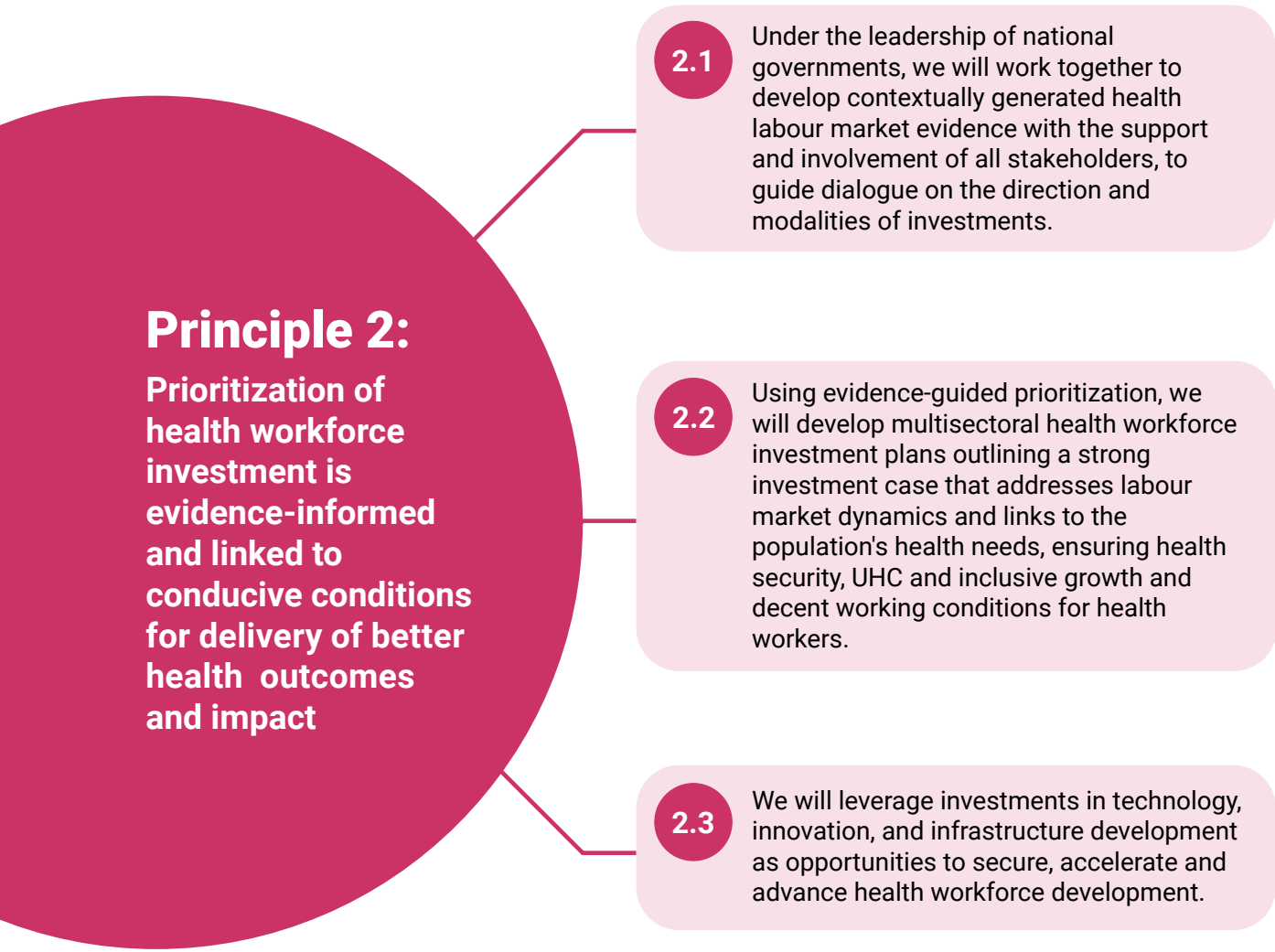
We affirm the leadership role of governments in developing coherent and aligned policies and strategies as a central point for investment coordination and actions.

1.3

We affirm the role of governments in leading investments in education and employment.

1.4

We will champion the establishment of mechanisms to allow the free and coordinated movement of health workers between countries to address critical gaps and health emergencies through the adoption of bilateral and multilateral agreements on health workforce migration in line with international labour standards.



**Principle 2:**  
Prioritization of health workforce investment is evidence-informed and linked to conducive conditions for delivery of better health outcomes and impact

2.1

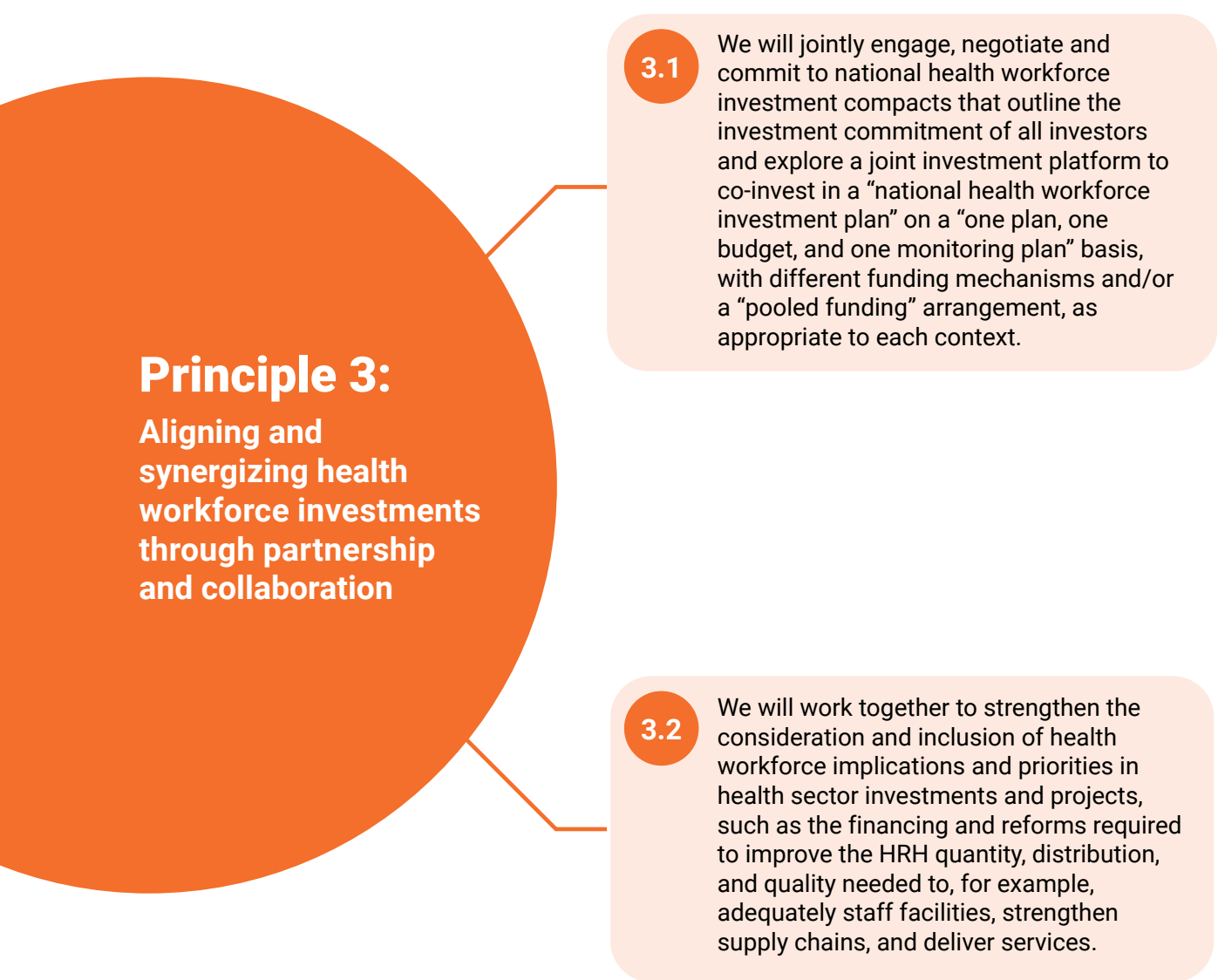
Under the leadership of national governments, we will work together to develop contextually generated health labour market evidence with the support and involvement of all stakeholders, to guide dialogue on the direction and modalities of investments.

2.2

Using evidence-guided prioritization, we will develop multisectoral health workforce investment plans outlining a strong investment case that addresses labour market dynamics and links to the population's health needs, ensuring health security, UHC and inclusive growth and decent working conditions for health workers.

2.3

We will leverage investments in technology, innovation, and infrastructure development as opportunities to secure, accelerate and advance health workforce development.



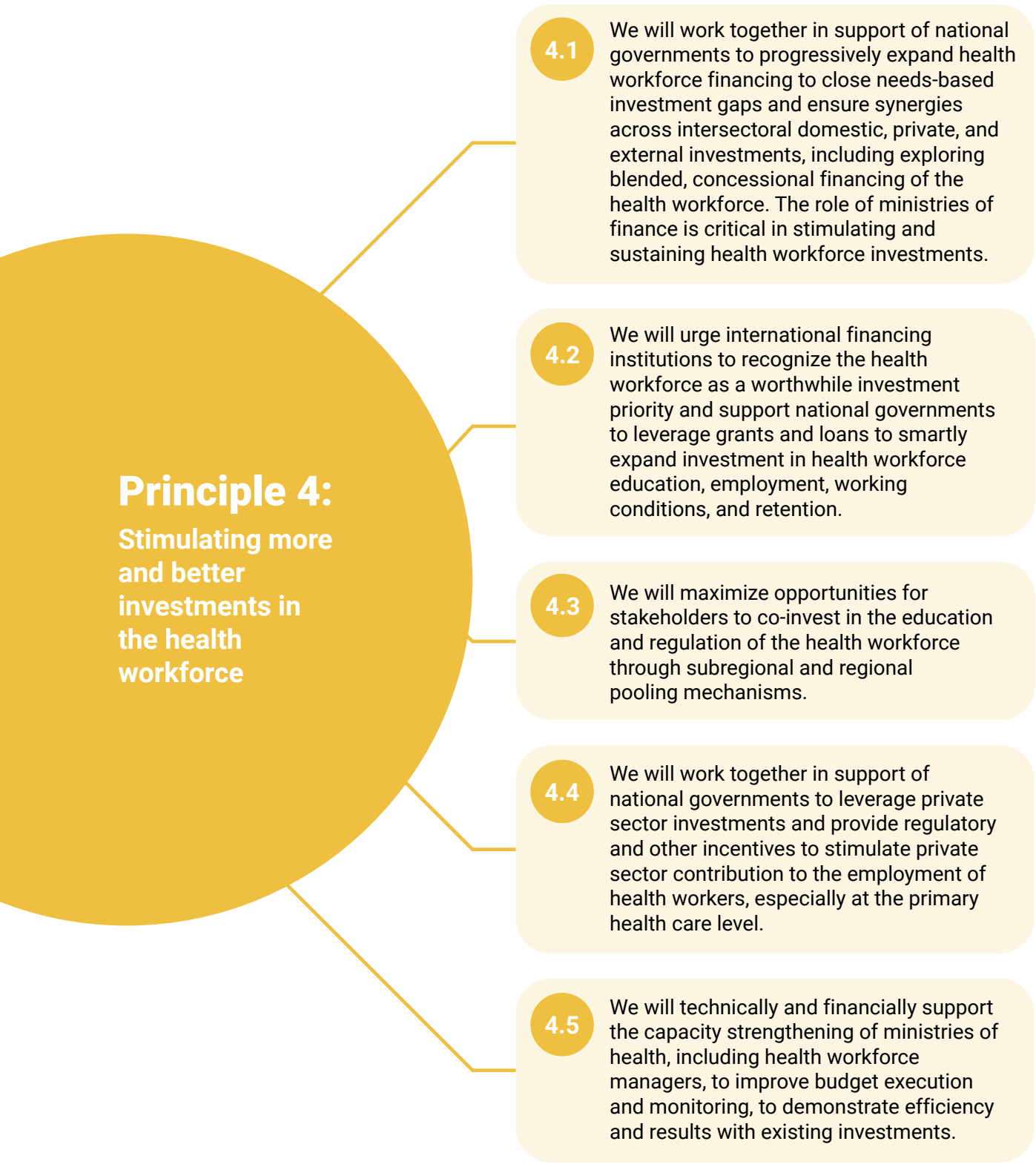
**Principle 3:**  
Aligning and synergizing health workforce investments through partnership and collaboration

3.1

We will jointly engage, negotiate and commit to national health workforce investment compacts that outline the investment commitment of all investors and explore a joint investment platform to co-invest in a “national health workforce investment plan” on a “one plan, one budget, and one monitoring plan” basis, with different funding mechanisms and/or a “pooled funding” arrangement, as appropriate to each context.

3.2

We will work together to strengthen the consideration and inclusion of health workforce implications and priorities in health sector investments and projects, such as the financing and reforms required to improve the HRH quantity, distribution, and quality needed to, for example, adequately staff facilities, strengthen supply chains, and deliver services.



**Principle 4:**  
Stimulating more  
and better  
investments in  
the health  
workforce

4.1

We will work together in support of national governments to progressively expand health workforce financing to close needs-based investment gaps and ensure synergies across intersectoral domestic, private, and external investments, including exploring blended, concessional financing of the health workforce. The role of ministries of finance is critical in stimulating and sustaining health workforce investments.

4.2

We will urge international financing institutions to recognize the health workforce as a worthwhile investment priority and support national governments to leverage grants and loans to smartly expand investment in health workforce education, employment, working conditions, and retention.

4.3

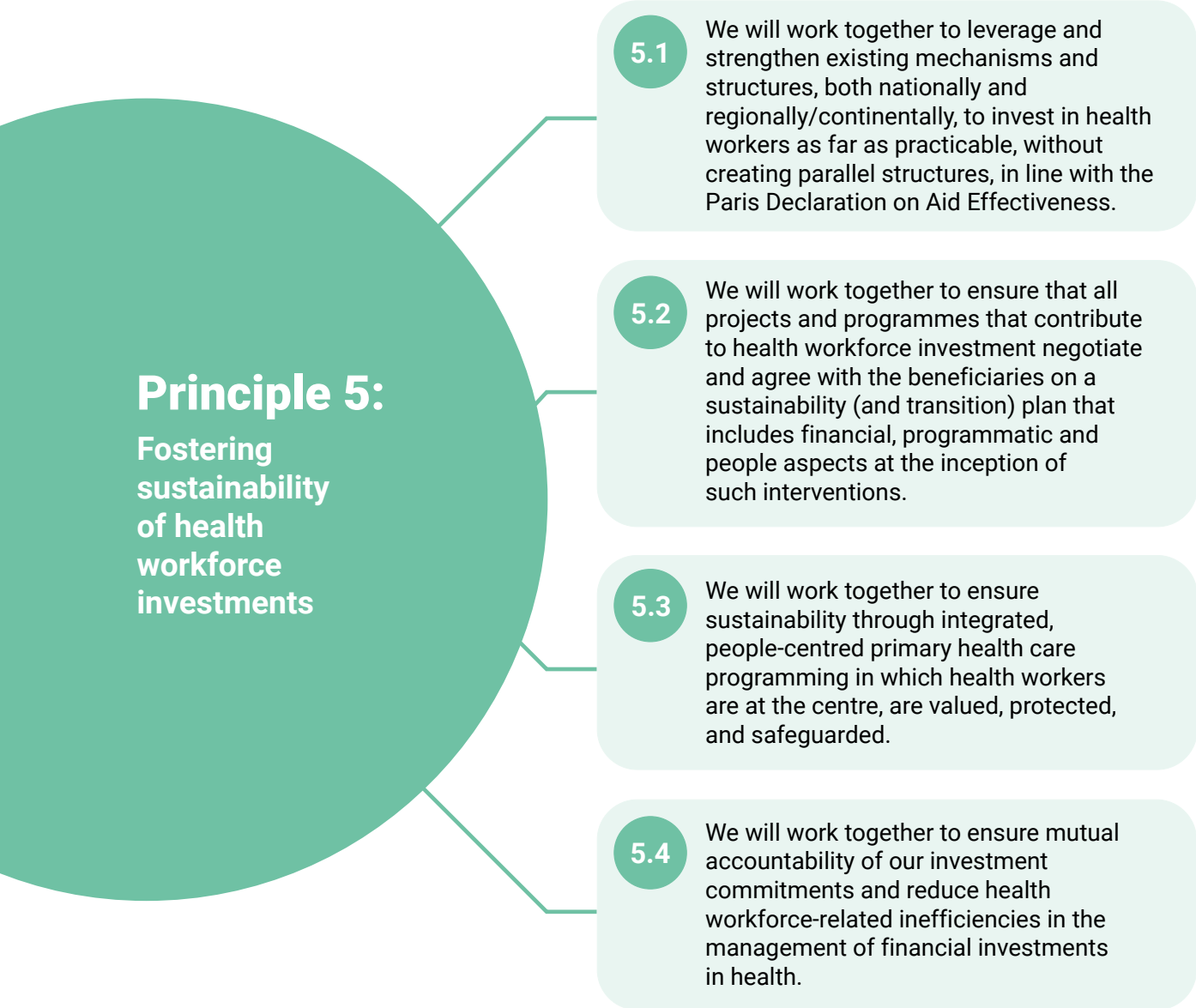
We will maximize opportunities for stakeholders to co-invest in the education and regulation of the health workforce through subregional and regional pooling mechanisms.

4.4

We will work together in support of national governments to leverage private sector investments and provide regulatory and other incentives to stimulate private sector contribution to the employment of health workers, especially at the primary health care level.

4.5

We will technically and financially support the capacity strengthening of ministries of health, including health workforce managers, to improve budget execution and monitoring, to demonstrate efficiency and results with existing investments.



**Principle 5:**  
Fostering  
sustainability  
of health  
workforce  
investments

5.1

We will work together to leverage and strengthen existing mechanisms and structures, both nationally and regionally/continentally, to invest in health workers as far as practicable, without creating parallel structures, in line with the Paris Declaration on Aid Effectiveness.

5.2

We will work together to ensure that all projects and programmes that contribute to health workforce investment negotiate and agree with the beneficiaries on a sustainability (and transition) plan that includes financial, programmatic and people aspects at the inception of such interventions.

5.3

We will work together to ensure sustainability through integrated, people-centred primary health care programming in which health workers are at the centre, are valued, protected, and safeguarded.

5.4

We will work together to ensure mutual accountability of our investment commitments and reduce health workforce-related inefficiencies in the management of financial investments in health.



# 8.

## Coordination and Accountability Mechanism

A Health Workforce Investment Advisory Committee (HWIAC) is established to advocate for the implementation of the Charter, monitor the indicators for progress and prepare a biennial state of the health workforce investment scorecard. The HWIAC shall be chaired by a minister of health of a Member State (who may be represented by the Permanent Secretary or equivalent) and co-chaired by a development partner with substantial investment and/or expertise in health workforce in the Region, with WHO serving as the secretariat. The HWIAC will meet at least once a year. The Chair, Co-chair and members of the HWIAC will serve for three years, after which it will be reconstituted.

The HWIAC will develop appropriate tools and methodologies to track, measure and report on the progress of expanded funding from all investors (domestic, external, private sector), and inform the workforce investment scorecard. Reporting on the domestication and implementation of the Charter will be incorporated by countries into their existing monitoring frameworks and processes, and reports will be submitted to WHO through the National Health Workforce Account (NHWA) annual reporting process. In addition to other metrics that may be considered relevant at a given time, the following areas will be monitored and reported upon every two years:

- 1** Number of countries that have used a multisectoral approach to conduct health labour market analyses to inform policy reforms and/or development of health workforce investment plans.
- 2** Number of countries that have used a multisectoral approach to sign health workforce investment compacts between governments and partners at the national level.
- 3** The volume, mix and flows of additional investments in health workforce education (including digital technologies for learning), employment, working conditions and retention mechanisms in line with the nationally agreed investment plan.
- 4** Increase in the headcount stock and density of health workers, disaggregated by rural and urban setting, sex and occupational group.
- 5** Number of new graduates and number of new graduates employed and starting work within one year of graduation.

The World Health Organization working with all partners, will organize a regional/continental regular workforce investment forum to foster advocacy, alignment and negotiation between governments, health worker unions or associations, the private sector and social and development partners.

At the country level, governments will promote, organize and facilitate annual national investment dialogues with investment and social partners within existing mechanisms and platforms.



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## Partners and collaborators

The development of the Africa Health Workforce Investment Charter received technical support, feedback, and inputs from Member States of the WHO African Region, the public and several partners and stakeholders including the United States Agency for International Development (USAID), the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the World Bank, the International Labour Organization (ILO), the Southern African Development Community (SADC), the East, Central and Southern Africa Health Community (ECSA-HC), the African Centre for Health and Social Transformation (ACHEST), the African Foundation for Research and Education in Health (AFREHealth), the Harmonization for Health in Africa (HHA) partners, the Japanese International Cooperation Agency (JICA), the Common Market for Eastern and Southern Africa (COMESA), and the International Federation of the Red Cross and Red Crescent.

The development of the Africa Health Workforce Investment Charter was funded through the ILO-OECD-WHO Working for Health Programme and its Multi-Partner Trust Fund.



## The WHO Regional Office for Africa

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Africa is one of the six regional offices throughout the world, each with its own programme geared to the particular health conditions of the Member States it serves.

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Algeria	Lesotho
Angola	Liberia
Benin	Madagascar
Botswana	Malawi
Burkina Faso	Mali
Burundi	Mauritania
Cabo Verde	Mauritius
Cameroon	Mozambique
Central African Republic	Namibia
Chad	Niger
Comoros	Nigeria
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Côte d'Ivoire	Sao Tome and Principe
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Equatorial Guinea	Seychelles
Eritrea	Sierra Leone
Eswatini	South Africa
Ethiopia	South Sudan
Gabon	Togo
Gambia	Uganda
Ghana	United Republic of Tanzania
Guinea	Zambia
Guinea-Bissau	Zimbabwe
Kenya	

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