Technical Brief

# Strategic Support for Human Resources for Health

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The Global Fund

# Contents

# Abbreviations and acronyms

AIDS = acquired immune deficiency syndrome
CDC = Centers for Disease Control and Prevention
CHAI = Clinton Health Access Initiative
CHW = community health worker
COE = challenging operating environment
CSO = civil society organization
DHIS = district health information system
GAVI = Global Vaccine Alliance
HIV = human immunodeficiency virus
HMIS = health management information system
HRH = human resources for health
HRIS = human resources information system
HSS = health system strengthening
iCCM = integrated community case management
ICT = information and communications technology
LFA = local funding agent
MDR = multiple drug resistant
MoH = ministry of health
NGO = non-governmental organization
OVC = orphans and vulnerable children
PBF = performance-based financing
PHC = primary health care
PR = principal recipient
RAMP = rapid mobile phone data collection
RSSH = resilient and sustainable systems for health
SRMNCAH = sexual, reproductive, maternal, newborn, child and adolescent health
SDG = sustainable development goal
TB = tuberculosis
UNDP = United Nations Development Program
UNFPA = United Nations Population Fund
UNICEF = United Nations Children's Emergency Fund
USAID = United States Agency for International Development
VCT = voluntary counselling and testing
WHO = World Health Organization

# I. Introduction

Human resources for health (HRH) challenges have been recognized as a critical bottleneck to the scale-up and quality improvement of health services, including for HIV/AIDS, tuberculosis (TB) and malaria services.[1] The links between the availability and accessibility of HRH and subsequent service coverage and health outcomes are well established.[2,3,4,5] Most countries supported by the Global Fund face HRH challenges, including shortages and inequitable distribution of HRH, high turnover, inadequate education and training, poor working conditions and lack of reliable health workforce data. HRH are, therefore, a fundamental part of the effort to achieve the health-related sustainable development goals (SDGs)[6] and to build resilient and sustainable systems for health (RSSH).[a] This is a key objective of the Global Fund's new Strategy for 2017-2022.[7] One sub-objective critical to achieving this aim is ensuring that the Global Fund leverages critical resources for HRH.

The Global Fund, together with ministries of health and technical partners, also has the responsibility to assess the HRH implications of its investments and to ensure that HRH are strengthened in a sustainable way. This responsibility has been formalized in the World Health Organization (WHO) Global Strategy on HRH,[8] which was approved at the 69th World Health Assembly in May 2016.

For the purposes of this document, the terms 'HRH' and 'health workforce' include both health workers with clinical responsibilities (e.g. doctors, nurses, midwives, pharmacists and community health workers), as well as those who support their work (e.g. health service managers, program staff, administrative workers, laboratory technicians, social workers, environmental health workers, and community health workers such as peer educators and community treatment and testing workers). Thus, all human resources supported through Global Fund financing are included. Annex 1 provides a list of useful HRH resources and tools.

The Global Fund aims to make ethical and sustainable investments in HRH, which necessarily places limitations on the types of support that will be offered, especially in countries without relevant national policies and strategies to guide HRH investments. This briefing note aims to clarify the Global Fund's approach to HRH investments by outlining the following:

1. general principles which underpin Global Fund's HRH investments (section 2),
2. different types of HRH investments that may be supported by the Global Fund (section 3), and
3. how the HRH support offered by the Global Fund may vary according to the country context (section 4).

The purpose of this note is to guide countries preparing funding requests to the Global Fund. It should be used as a basis for discussion and negotiation with stakeholders when developing applications. Applicants should familiarize themselves with the entire briefing note, but the following points are fundamental:

- Funding requests which include HRH investments should demonstrate an understanding of the underlying conditions of the HRH labor market (see section 2.3), and should clearly state how the investments will be sustainable and strategic within the context of the labor market and the broader primary health care (PHC) system (see sections 2.1 to 2.6).
- Where national HRH policies, plans and strategies exist, requests for HRH investments must be aligned with these policies, plans and strategies. If they do not exist, the Global Fund will prioritize support to develop them. Similarly, support for building or strengthening capacities for HRH management and planning will be relevant in most countries (see section 3.1).
- For maximum sustainability, investment in HRH education and training should focus on pre-service education and continuing professional development for PHC providers, rather than short-term disease-specific, in-service training (see section 3.2). In-service training will, however, continue to be funded if it can be demonstrated that this support is needed.

[a] For more information about the RSSH approach see here. Also see the Global Fund's 2016 Paper on Resilient and Sustainable Systems for Health.

- In line with the WHO Global Strategy on HRH, the Global Fund will invest in both capital and recurrent expenditure (including salaries), where appropriate. Investment in salaries should be compliant with current Global Fund budgeting guidelines, and must be informed by evidence that it is necessary for the delivery of TB, malaria and/or HIV services (see section 3.3).
- Salary top-ups and incentives should be avoided unless they are the only way to pay HRH a living wage and/or are essential for the achievement of Global Fund objectives, and will only be funded if they can be shown to be essential. Other types of retention and motivation mechanisms should be considered first (see section 3.4).
- The Global Fund's approach may differ from one country to another, because an intervention that is appropriate in one context may not be appropriate in a different context (see section 4).

# II. General principles for applications including HRH support

HRH investments will be prioritized if health workforce challenges represent a barrier to the availability, accessibility, acceptability or quality of evidence-based interventions for prevention, diagnosis, treatment and care of HIV, TB and malaria (and broader health goals), especially in countries with high disease burden and low economic capacity.

General principles to consider when developing funding requests for HRH are:

- consider sustainability
- ensure investments are supported by evidence
- invest according to the country's HRH labor market
- invest in more integrated HRH approaches
- engage in strategic partnerships, and
- consider investments in information and communications technology.

## 01 Consider sustainability

The Global Fund defines the sustainability of its programs in relation to their capacity to maintain service coverage at a level that will provide continuing control of a disease even after the removal of external funding. The focus should be on the sustainability of improved epidemiological outcomes through a sustained commitment to fighting AIDS, TB and malaria, and not necessarily on the sustainability of specific programs. For more information, refer to the Global Fund's policy and guidance note on Sustainability, Transition and Co-financing.[bc]

A key element of programmatic sustainability is to embed the HRH interventions within a sound, costed, national strategic plan which is budgeted on a yearly basis and has legal standing. Funding applications should clearly demonstrate how the proposed interventions align with national policies, strategies and plans.

Where HRH policies, strategies and plans do not exist or are weak, Global Fund support should be offered to develop and implement them, in collaboration with other development partners when appropriate and feasible. Sound HRH governance and management however, require more than a plan, so Global Fund support may include activities to establish or strengthen the capacity of relevant institutions at national or sub-national level capable of carrying out core functions and tasks related to HRH and health labor market analysis, planning, policy setting, monitoring and evaluation (see also section 3.1).

[b] See the Global Fund's Sustainability, Transition and Co-financing policy
[c] See the Global Fund's Sustainability, Transition and Co-financing technical brief found here

Countries can work towards the sustainability of HRH investments by prioritizing interventions and approaches that lead to cost savings or to cost-effective use of resources. Examples include:

- improved transparency and efficiency in payroll and other HRH financial management systems (see section 3.1);
- incentives and subsidies to reduce attrition rates from health education institutions (see section 3.2);
- investment in pre-service education of HRH which is often a more cost-effective and sustainable solution than a focus on short-term, disease-specific, in-service training.[9],[10] (see section 3.2).
- priority focus on PHC-oriented health workers including community health workers;
- non-financial incentives to improve health worker motivation, performance and retention (see section 3.4).

Sustainability depends on increased domestic financial investments in health. The Global Fund will incentivize this financial commitment through co-financing requirements.[d] The Global Fund will also support and coordinate the provision of technical assistance with partners to ensure that countries have robust and comprehensive national health financing strategies underlying their strategic plans, which include the private sector where appropriate. See Box 1 for examples of HRH investments which included a firm commitment to demonstrating that sustainability was considered from an early stage.

**Box 1: Examples of sustainable HRH investments**

In **South Africa** the Global Fund is paying salaries for human resources working to develop and implement a new system for supply chain management for a range of drugs and essential supplies. It will take two years for the recurrent costs to be embedded in the government budgeting cycle, but this process has begun.

In **Bulgaria**, the HIV grant helped to fund the opening and maintenance of 19 voluntary counselling and testing (VCT) centers over the period 2004-2015, and 4 methadone centers which provided opioid substitution therapy to 400 intravenous drug users. Of these, 13 VCT centers and 3 methadone centers (including staff salaries) have been absorbed by government and continue to operate.

The **Bangladeshi** economy is growing to the extent that it has recently been classed as a lower-middle income country, and the government has recently announced plans to increase its spending on health. The strategy for enhancing sustainability for HRH in Bangladesh is to focus initially on the government absorbing salaries of government employees currently funded by the Global Fund. This process will be facilitated by the fact that the government's strategic investment plan identifies the health workforce as a priority.

## 02 Ensure investments are supported by robust evidence

The presentation of robust and reliable evidence and data which clearly demonstrate why an investment is needed will strengthen any application for Global Fund support for HRH. In countries with effective health management information systems (HMIS) and human resources information systems (HRIS), obtaining the necessary data should be relatively straightforward. However, many countries supported by the Global Fund either do not have such information systems, or have systems that are not working effectively. In such cases, the Global Fund will consider funding initiatives to create or strengthen the HMIS and/or HRIS (see section 3.1).

[d] Global Fund's Sustainability, Transition and Co-financing policy. See also the Global Fund's Sustainability, Transition and Co-financing technical brief found here.

Improved systems for the collection, collation, analysis and dissemination of HRH data will also contribute towards effective monitoring and evaluation of the Global Fund's HRH investments, in line with the Global Fund's Monitoring and Evaluation Framework.[e]

## 03 Invest according to the country's HRH labor market

A strong and effective health workforce which is able to respond to current priorities can only be achieved by effectively matching the supply and skills of professional and lay health workers to population needs, both now and in the future. Applications should demonstrate an understanding of the underlying conditions of the HRH labor market (both public and private sector). For example, if there is a shortage of HRH, the appropriate response will depend on whether the shortage is supply-based or demand-based, or both. A supply-based shortage occurs when insufficient HRH are being produced/imported and retained. A demand-based shortage occurs when a country would not be able to meet the recurrent costs of meeting the demand for HRH. Considerations for Global Fund support within this context include the following:

- If there is a labor shortage (i.e., more funded positions or economic demand than can be met by the current supply of health workers), the Global Fund will consider supporting pre-service education to increase the number of health workers to the level required to meet population needs.
- Conversely, if there are more health workers than public-sector funded positions (i.e., under- or unemployment of health workers), the Global Fund will consider funding additional positions if there is evidence to show that this is sustainable and/or necessary to increase service coverage for the three diseases.
- In most low-income countries, both supply of health workers and economic demand fall short of population needs. In such situations a combined approach is required, investing both in funding additional positions and in scaling up pre-service education of health workers.
- In settings where labor market analysis indicates that health worker remuneration is too low to achieve the delivery of services, the Global Fund will consider providing support to improve remuneration to achieve better retention and geographical distribution of health workers.

If a suitable labor market analysis does not already exist, the Global Fund may support its development (e.g, by funding technical assistance to collate and analyze the necessary data). This analysis will lead to investment decisions that are informed by understanding of financing gaps, fiscal space and capacity to absorb HRH in the future.

## 04 Invest in integrated HRH approaches

A lack of coordination between different disease programs can result in fragmented service delivery, and uncoordinated tasks and approaches for health workers. Sustainability and effectiveness can be enhanced through better integration of services and HRH at the PHC and community levels, as appropriate, in a way that aligns with government strategies (where these exist) and existing service delivery structures. Note that moving towards more integrated service delivery does not mean that everything must be integrated into a single package; nor does an integrated HRH approach mean that a single health worker is responsible for the provision of all services. Instead, it could mean working towards ensuring that professional and lay health workers have coordinated education, training, supervision, remuneration and career development prospects.

There are many opportunities for integration across a variety of contexts to ensure that patients' multiple needs are addressed at once. Applicants should therefore attempt to maximize synergies between disease-specific and other PHC and community HRH investments, particularly sexual,

[e] See the Global Fund monitoring and evaluation framework

reproductive, maternal, newborn, child and adolescent health (SRMNCAH) services (see Box 2 below for country examples). For more information on integrated approaches, refer to the RSSH Information Note and the supporting technical brief on SRMNCAH.[f]

**Box 2: Examples of integrated HRH investments that aim to build resilient and sustainable systems for health**

In **Mauritania** the government has recently approved a program of integrated training of 500 community health workers (CHWs), to be co-funded by the government, UNICEF and the Global Fund. Initially it was designed as an integrated community case management (iCCM) program only, but the MoH saw it as an important opportunity to train CHWs to provide a full package of community health services for adults as well as children, including - but not limited to - AIDS, TB and reproductive health.

Similarly, in **Namibia** CHWs used to provide only support and palliative care for AIDS, but some have received six months' training as extension workers which also qualifies them to provide chronic care and door-to-door testing. The end goal is for these extension workers to be integrated across all three disease programs.

## 05 Engage in strategic partnerships

Because its mandate is to fight AIDS, TB and malaria, the Global Fund is not expected to take the lead on initiatives to grow or improve a country's health workforce. Rather, its strategy in relation to HRH is to work with countries to identify gaps in HRH that affect efforts to tackle the three diseases and related services (e.g. integrated SRMNCAH services). Funding applications should explain how the proposed interventions will support countries to fill those gaps until this can be done using domestic funding.

Many organizations and agencies have responsibilities in relation to HRH and the Global Fund is committed to working in partnership with them. WHO facilitates the development of global policies on HRH;[g] other international agencies also have an important role to play on certain specific issues, such as the International Labor Organization (on employment conditions), UNICEF and UNFPA (who are particularly active in issues concerning maternal and child health, including on some workforce aspects). National governments are responsible for ensuring that national HRH policies, strategies and plans respond to population needs and citizens' expectations, informed by evidence-based global policies and strategies as relevant and appropriate. The World Bank and UNDP can also be engaged in a policy dialogue about creating fiscal space to absorb recurrent HRH costs. WHO has a technical support role in HRH, so WHO country offices, if requested by countries, can support HRH policy dialogue and the development or strengthening of HRH plans. It may be appropriate to enter into dialogue with these and/or other partners to support the development of funding applications. It may also be appropriate to coordinate with other donors to identify synergies, align strategies and avoid duplication of effort.

It is, however, part of the Global Fund's role to negotiate and agree on specific grant-related issues such as HRH remuneration levels (see section 3.3). Dialogue with ministries of health (MoH) is an essential part of this process, but in some contexts it will also be appropriate to engage with other parts of government, e.g. HRH and planning directorates of other ministries (education, finance, labor), civil service, and/or other donors funding HRH and/or the private sector, to ensure that efforts are harmonized.

[f] The RSSH information note and SRMNCAH technical brief can be found under applicant resources.

[g] For example, the Global Strategy on HRH and the Global Code of Practice on International Recruitment.

### 06 Consider investments in information and communications technology

Making good use of information and communications technology (ICT) is one way to make investments in HRH more strategic and catalytic. Catalytic interventions are those which will make things happen more quickly and/or with greater impact than would otherwise be the case. In the context of HRH, ICT investments should focus on harnessing the power of software and systems to contribute to issues such as workforce planning, professional development and improving the working environment.

ICT can be of particular relevance in relation to: health worker deployment, e-learning, electronic health records, telemedicine, clinical decision-making tools, links among health workers and between health workers and patients, supply chain management, payroll management, performance management and feedback loops, patient safety,[11] service quality control, and the promotion of patient autonomy.[12] ICT creates opportunities to enhance HRH support across all the interventions described above, from education to deployment, incentives and performance management. The adoption of ICT elements in the context of Global Fund grants are potentially relevant in all settings, but should be accompanied by justification that this represents both a feasible and cost-effective approach in the national context.

# III. Types of HRH investments supported by the Global Fund

There are evidence-based interventions and strategies to overcome HRH challenges. For example, radical improvements to the quality of the workforce are possible if the education and health sectors collaborate to implement a transformative education agenda.[13] Improvements to health worker motivation, satisfaction, retention, equitable distribution and performance can be achieved through an integrated package of recruitment and retention policies (e.g., financial and non-financial incentives), regulatory measures, and service delivery reorganization.[14] Efficiency can be improved by working towards a user-centered PHC delivery model. This involves adopting a diverse, sustainable skill mix, and harnessing the potential of community-based and mid-level health workers as part of multi-disciplinary primary care teams.[15,16]

Depending on the country context, relevant HRH interventions may focus on one or more different elements of the health labor market, including:

1. **strengthening capacity** for effective policy-making, governance and workforce planning/management;
2. increasing the supply and competencies of HRH through **education and training**;
3. supporting demand through **funding positions** in the health sector; and
4. improving **motivation and retention** through monetary or non-monetary incentives that contribute to the objectives of the grants, consistent with Global Fund budgeting guidelines.[h]

The successful implementation of all of the above types of intervention, but especially remuneration, motivation and retention, is highly dependent on the existence of a national platform which facilitates the alignment of all HRH-related activities in the country. If no such platform exists, the Global Fund will consider supporting its development under country ownership.

The relevance of these interventions will be determined by the country context, including both disease burden and the type of support currently provided by the Global Fund and other donors, as well as the existing HRH situation and economic capacity. More detailed guidance differentiated by context is provided in each section below and is summarized in Table 1 in section 4.

[h] Global Fund Guidelines for Grant Budgeting and Annual Financial Reporting 2014

## 01 HRH policies, governance and workforce planning/management

Effective governance and management are required for the successful implementation of all types of HRH interventions, so this type of support is potentially relevant in all countries supported by the Global Fund (see Table 1 in section 4).

Relevant interventions may include building or strengthening capacities to:

- lead short- and long-term health workforce planning and development;
- mobilize and use resources effectively, efficiently and accountably;
- create better working conditions, performance management systems,[i] reward systems and career structures for professional and lay health workers;
- strengthen in-service training systems to improve links and alignment between in-service training, continuing professional development and pre-service education;
- set policies on regulation, service provision and education/training of health workers;
- identify suitable strategies to engage in a collaborative manner and enter into contractual relations with civil society organizations (CSOs) and the private sector;
- manage the HRH payroll and other financial management mechanisms to enhance efficiency, accountability, and transparency in monitoring and reporting of HRH spending; and/or
- analyze workforce data and labor economics; improve human resource management capacity, including the effective usage of human resource information systems (HRIS) and the development of national health workforce accounts (see section 2.2).[17] Under the WHO global strategy for HRH,[18] there is a call for harmonization of HRH data in terms of definitions, analysis and dissemination, and for the creation of national health workforce accounts. There is global guidance on a minimum data set for a health workforce registry,[19] and on collecting HRH data for workforce planning.[20] Countries requesting support for the creation or strengthening of a HRIS should familiarize themselves with these concepts and ensure that requests for funding for this activity are aligned with these global recommendations.

In some settings, interventions to scale up the education or employment of the health workforce may be more effective if they target a decentralized level or are effected through non-state actors, where results and lessons for scale-up can be seen more quickly (see Box 5 for an example of scale-up being effective through an NGO in Bangladesh). In these settings, capacity will need to be built or strengthened at the relevant administrative level(s) and in the relevant organizations (e.g., public sector, NGO, private sector and/or CSO).

In challenging operating environments (COEs), building management capacity is absolutely necessary to ensure that HRH support is effective, so these types of interventions should be prioritized, in collaboration with other stakeholders. See Box 3 below for country examples of HRH investments in capacity building for HRH management in different types of contexts.

**Box 3: Examples of Global Fund investments in building capacity for HRH management**

In **Liberia**, the Global Fund is supporting a new HRH training unit. CHAI, supported by the World Bank, will provide long-term technical assistance by sending HRH professionals to build capacity in the new training unit. The Global Fund has supported several countries (e.g. **Mali, Sierra Leone**) to carry out a 'payroll clean-up', which has resulted in better HRH retention rates, lower rates of absenteeism, and fewer ghost workers.

In **Djibouti** and **Morocco**, the Global Fund has supported the development of database systems to keep track of information about HRH training and career moves. The system in Djibouti is used to record health worker attendance and performance at in-service training events. In Morocco, it is planned to develop a system which will keep track of career moves as well as training, to improve the effectiveness and efficiency of HRH planning and deployment. The Global Fund grant also includes funds to evaluate the effectiveness of the system.

[i] Performance management is a process of ongoing communication between a worker and a supervisor, which aims to ensure that the worker understands and is motivated to achieve the employer's objectives.

## 02 Education and training

Increasing the supply and/or competencies of health workers is essential for the delivery of ambitious health goals including those related to HIV, TB and malaria. Therefore, education and training interventions are potentially relevant in all countries supported by the Global Fund, although the focus of such action will vary depending on country typology and context (see Table 1 in section 4).

The education of PHC workers (e.g. primary care doctors, nurses and midwives, community health workers and outreach workers for key population groups) is particularly important because these cadres most commonly deliver integrated services related to the three diseases, as well as SRMNCAH.

**Pre-service education**

Priority should be given to investments in pre-service education, depending on context. It is important to improve the quality of education/training and ensure curricula are up to date, especially in countries which do not produce graduates with all the necessary competencies for the prevention, diagnosis and treatment of the three diseases. Pre-service training should also be prioritized where there is a need to scale up production of health workers in countries where there are insufficient health workers to meet the need for health services, and where lack of capacity in health worker training schools is a barrier to scaling up production. Relevant interventions may include:

- revising curricula or instruction modalities (e.g. to facilitate task-sharing[j] initiatives or to include education on human rights issues and specialties such as multiple drug resistant (MDR)-TB);
- training health educators;
- enhancing the capacity and improving the quality of training institutions;
- updating systems for accreditation and quality control of health worker education; and/or
- supporting governments to ensure that quality standards are aligned across the public and private sectors.

Pre-service education also represents an opportunity to address gender and ethnic imbalances and increase gender- and ethnicity-sensitivity in the health workforce. All countries supported by the Global Fund should ensure that gender and ethnicity balance and sensitivity are included in all health workforce policies. Relevant interventions may include:

- creating a sufficient supply of female and ethnic minority health care providers in countries where there are cultural barriers to women consulting male health workers or those from a different ethnic group;
- building the capacities of health and community workforces to deliver gender- and ethnicity-sensitive services; and
- introducing mechanisms to ensure gender and ethnic equality in access to education and training programs.

Similarly, pre-service education presents an opportunity to recruit students from underserved parts of the country, in the anticipation that are more likely to practice in these areas once they are qualified (see also section 3.4).

Whereas most middle-income countries have the potential to finance the required investment in health worker education through domestic resources, in the short and medium term many low-income countries and many COEs will require additional support. Funding applications must show clearly how the proposed intervention(s) will contribute to national health system and HRH strategies, and explain

[j] Task sharing involves a more rational allocation of roles, e.g. by moving some specific tasks from high-qualified health workers to health workers with shorter training durations who can deliver them with equal effectiveness and quality. See http://www.who.int/healthsystems/task_shifting/en/

how the additional/more competent health workers will be employed within the health system (public or private sector).

**In-service training**

In-service training programs can be necessary to update health workers on new procedures and guidelines, or in COEs where the pre-service education system is not functioning adequately. However, requests for support must be justified and clearly articulated. In-service training activities should be designed and organized so as to minimize health workers' absence from their duty stations and avoid disruption of service delivery. Whenever possible, in-service training should also be integrated within broader training packages, which include at least one of the three diseases, but ideally also go beyond the three diseases (e.g. integrated management of childhood illnesses, integrated community case management (iCCM), provision of family planning, detection and treatment of common non-communicable diseases).

Requests for support for in-service training must provide justification in terms of identified needs and gaps, and should indicate: (a) how the proposed training activities align with national training strategies, plans and systems,[21] and (b) plans for embedding the relevant competencies in pre-service training so that in the future it will not be necessary to conduct in-service training on this subject. See Box 4 below for examples of investments in education and training.

**Box 4: Examples of Global Fund investments in education and training**

In the 15 most impoverished provinces in **Viet Nam** with the lowest doctor-to-population ratios, the Global Fund is supporting an initiative to train 3000 assistant medical doctors to become fully-fledged doctors. These doctors have been recruited from rural and remote populations, in the anticipation that they will be more likely to stay and practise in these underserved communities. At the same time, in-service training has been limited by (a) alignment of costs for training sessions (food, accommodation, *per diems*) with government cost norms, and (b) funding in-service training only if necessary.

In **Namibia,** the Global Fund has worked in partnership with CDC to support the opening of a new medical school, and provides bursaries for pre-service training of doctors and nurses. The bursaries are conditional on agreement to serve in Namibia for at least two years after graduation.

## 03 Salaries and remuneration

In countries facing a demand-based shortage of health workers, simply producing more workers may not be effective. This is because the national budgets of low-income countries and COEs may not be sufficient to cover basic recurrent costs such as salaries in the short- to medium-term, resulting in increased rates of unemployment or international migration, which represents a waste of scarce resources. Where there is evidence that fiscal space and economic demand for health workers is insufficient, but there is great need for more health workers, Global Fund resources may be allocated for salaries (full salaries or contributions to salaries) for relevant health workers, but only with strong justification.

Funding requests for scaling up the health workforce must comply with current Global Fund budgeting guidelines[k] and should include a short- to medium-term plan to transition salaries to government payrolls. The plan should explain how the health system will maintain a larger health workforce over the long term, and specify how salary support will be taken over by domestic funding (e.g. by describing the mechanism(s) to be used to increase health funding, and supporting fiscal space and health workforce analyses).

[k] Global Fund Guidelines for Grant Budgeting and Annual Financial Reporting 2014

Funding applications must show how requests for support with salaries are in line with national human resources procedures and salary scales (both government[1] and non-government), or how the request is part of a deliberate HRH strategy adopted by the government to change the *status quo*. Where no national strategy or pay scale exists (or exceptional circumstances do not permit alignment to it), justification for the proposed remuneration level should be provided (e.g. benchmarking against the most efficient and cost-effective costing structures of countries at a similar level of socio-economic development).

In many countries, the process of setting salaries is complicated by the presence of other donors whose aims overlap with the Global Fund's but whose HRH policy and practice may not be aligned with the country's and the Global Fund's. In these situations, unilateral decisions (e.g. to limit health worker remuneration) are likely to have undesirable consequences, and applicants are encouraged to enter into dialogue with government, other donors, UN agencies and other relevant actors. If the country has a HRH plan (either stand-alone or as part of a broader health or public sector strategy), this can be used to facilitate country-led harmonization between partners. If not, technical assistance can be offered by one or more partners to develop such a plan. Ideally, the government should take the lead on harmonization initiatives to ensure country ownership of the issue, while taking into account that health workers need decent terms and conditions.

**Community health workers**

Deployment of community health workers (CHWs) can be a cost-effective strategy to improve access to and coverage of basic health services, especially if they provide a range of services across an integrated program. The term 'community health workers' includes a very wide variety of roles, from formally trained providers of health care and education to less formal roles such as peer educators and community treatment and testing workers. They are considered by WHO and the Global Fund to be part of the health workforce, even if they are volunteers and/or not providing clinical care services (e.g. outreach workers or peer educators).

If a country has a specific policy framework on CHWs support by the health system, proposed investments in CHWs should be in alignment with that policy or strategy, whether the CHWs are employed directly by the government or by NGOs. In countries without such policies/strategies, it may be appropriate for the Global Fund to support their development, especially if there is evidence that investment in CHWs would be a cost-effective way to improve outcomes across one or more disease programs. CHW plans and policies should be linked to broader HRH plans and policies, supported by labour market analyses.

For CHWs to be fully effective they must be carefully selected, appropriately trained and adequately supported within the wider PHC system.[22],[23] As part of the health workforce, it is good practice for CHWs to be paid for their work if this is consistent with the national policy framework. It may, therefore, be appropriate for Global Fund to support CHW remuneration, provided that this can be achieved within the national policy guidance on HRH remuneration more generally, as set out above.

In some countries, the Global Fund will consider funding salaries for CHWs who are NGO or CSO employees rather than government employees. This may occur for a number of reasons, such as if the work they do is unacceptable in the current political climate or if NGOs/CSOs are important providers of health services but the government does not have a mechanism under which it can contract out health services. CHW remuneration should be aligned with government pay scales, even if the CHWs are not employed directly by the government (taking into account that other benefits such as pensions may not be directly comparable). In such cases, applications should include a plan for the government to absorb the costs, either directly or via the introduction of a mechanism for contracting out to NGOs, even if it is expected to take many years to achieve this plan.

[1] Alignment with government salary scales is one of the enabling factors that should be in place before a country can begin the process of planning for transition away from Global Fund support. See the Global Fund's Sustainability, Transition and Co-financing policy

Box 5 presents some illustrative examples of Global Fund's investments in salaries.

**Box 5: Examples of Global Fund investments in salaries**

In **Bangladesh**, the Global Fund pays full salaries for over 200 TB leprosy community assistants, which has contributed towards the establishment of community clinics in line with the government policy of focusing resources on primary health care. It is expected that the government will absorb these salaries at the next funding allocation. The Global Fund has also worked to align salaries with government and/or other development partners by conducting a salary survey across different UN offices and international NGOs. The results of the survey were used during negotiations as a benchmark for salary levels under the new grant.

Also in **Bangladesh**, CHWs employed by the NGO PR are paid salaries that are higher than government pay scales to compensate for the lower level of employment benefits offered by the NGO. The NGO has its own salary scales, so its employees receive the same salary regardless of who is funding the program.

In **Liberia**, the MoH and UNICEF collaborated to produce a comprehensive community health strategy which includes salary costs and a modular training package for community health assistants. Together with UNICEF, USAID and the World Bank, the Global Fund will finance monthly salaries of community health assistants and their supervisors, who will implement iCCM as part of this strategy.

## 04 Retention and motivation

### Retention packages

Many countries supported by the Global Fund experience challenges relating to retention and motivation of HRH. To ensure that investments in education are not wasted and to ensure that disease programs can be implemented successfully, the Global Fund will consider funding interventions to improve retention and motivation, especially in rural and remote areas of low-income countries and COEs.

Evidence shows that retention schemes are more effective when different interventions are implemented together as a package, as opposed to being pursued disjointedly.[24] Relevant interventions may include:

- educational interventions that promote the enrolment of students with rural backgrounds (see section 3.2) and support the expansion of education infrastructure in peripheral areas, including rural internships in training programs;
- regulatory interventions such as implementing task-sharing reforms, introducing new professional and/or lay cadres with specific rural oriented professional profiles, introducing voluntary/incentivized rural postings for new employees;
- financial and non-financial incentives, e.g. professional development opportunities, hardship allowances, grants for housing, extra holidays, family support, professional support, improved communication; and/or
- improved working conditions and career development opportunities, e.g. safe and supportive working environment, outreach support, career development programs, professional networks, public recognition measures, etc.

Strengthening of human resource management capacity (see section 3.1) is also likely to improve HRH retention.

### Motivation through salary top-ups and incentives

Salary top-ups and incentives can have distortionary effects, such as demotivating workers who do not receive them and unduly shifting priorities. As a general rule, therefore, salary top-ups and incentive

payments should be avoided in favor of more comprehensive strategies for public sector reform to improve working conditions (including remuneration) of the existing health workforce.

In some circumstances, however, top-ups or incentives may be necessary for successful delivery of disease programs in the short term. For example, if health workers are not motivated to provide outreach services to remote areas, it may be appropriate to pay travel and accommodation expenses to ensure that crucial services such as case detection are provided throughout the country. Requests for funding for salary top-ups and incentives must comply with current Global Fund budgeting guidelines,[25] and where possible should be aligned with the payments made by other donors. Applicants should provide a strong justification for such interventions, an assessment of the implications of these interventions and include a plan to phase them out.

**Motivation through performance-based financing/incentives**

Performance-based financing (PBF) is a specific type of salary top-up, commonly used to provide additional remuneration which is conditional on the achievement of performance targets. It can be applied to individuals as well as organizations or health entities (e.g. health clinics). While this can greatly incentivize performance, care needs to be taken to avoid: (a) a focus on certain interventions to the detriment of others, (b) supplier-induced increases in demand for services, increasing both the supply of particular health services and the cost of these services, (c) the possibility of false/inflated reporting in contexts with weaker monitoring and contract enforcement capacity, and (d) fraud in settings characterized by weak financial management capacity. In countries where the national health system has a functioning PBF policy and system in place, Global Fund support may be provided to ensure that the incentives include an appropriate level of focus on the three diseases as part of a broader and balanced package of PHC services. Box 6 gives illustrative examples of how countries have used Global Fund support for salary top-ups and incentives.

**Box 6: Examples of Global Fund investments in retention and motivation**

Under **Mali**'s HIV grant, health workers are entitled to incentive payments that are conditional on performance. To quality, they are required to provide documentary evidence of their base salary, to ensure that the incentive does not exceed 20% of base salary. In **Central African Republic**, the CCM devised a scheme whereby the Global Fund would pay 20% of the cost of salary top-ups on condition that the government first paid its 80% share.

While some countries have made the payment of incentives/top-ups conditional on performance, others (e.g. Mauritania) have found it difficult to monitor performance in remote areas due to the difficulty in making supervisory visits to these areas. Innovative solutions to this issue are being developed. For example, in **Central African Republic**, a stock control system known as RAMP (rapid mobile phone data collection) has been used to support performance-based payments by making incentive payments conditional on the submission of regular and complete reports.

In **Viet Nam**, top-ups have been phased out. This was achieved with no major effect on retention, because (a) those formerly in receipt of top-ups are all government employees who are motivated to remain in post due to their pension and other employment benefits, and (b) there is very limited external funding for HRH in the country. This set of circumstances presented an opportunity to make the disease programs more sustainable over the long term.

In the **Democratic Republic of Congo**, partners are working together under national leadership to expand performance-based financing (PBF) programs to cover larger geographical areas, and to ensure that an effective supply chain for essential health commodities is in place for populations most in need, particularly women and children. The Global Fund supports the provision of essential malaria test kits and drugs as well as HIV-TB commodities to health facilities. UNICEF and GAVI complement this support by focusing on child health services and critical commodities. The World Bank supports the design and management of the PBF program and the verification of results.

# IV. HRH investments in different country contexts

Table 1 provides high-level, illustrative examples of the types of HRH investments that can be considered in different country contexts. It is divided into four main areas of intervention: cross-cutting interventions for HRH policies, governance and management; education and training; support for demand for health workers through the creation of funded positions; and retention, motivation and performance management of health workers. A '+++' sign in the box indicates that type of investment is highly relevant in that context, a '++' sign indicates relevance, and a '+' sign indicates potential relevance with justification.

It is important to note that the principles and guidance outlined in Table 1, as well as the rest of this briefing note, needs to be interpreted and adapted depending on country context. Ultimately, it is the HRH situation in a country that should inform HRH investments, supported by underlying analyses, such as labor market and health workforce assessments. When there is evidence to support deviation from these principles, the Global Fund will be receptive to well-justified funding requests for HRH. Specific considerations for COEs and countries preparing for transition are outlined below.

**Challenging operating environments**

COEs may be found in countries with chronic weaknesses in capacity and governance as well as countries facing crises such as conflict, disease epidemics or natural disasters. They therefore may occur in countries from across the development continuum. In many COEs, there are severe deficiencies in the availability of HRH and in the quality of services that they are able to provide. There will be a need to support a wide range of activities relevant to HRH, so it is important to be strategic. Priority will be given to interventions aimed at building and strengthening capacity for HRH education, management and planning (see section 3.1). In many COEs, salaries are low and/or payroll systems not functioning properly, with obvious implications for HRH retention and motivation (see Box 6). Many will also require support with scaling up of pre-service education (see section 3.2), which may include support for students being educated outside of the country if the country's own education system is not functioning adequately.

Where national budgets are insufficient to cover basic recurrent costs such as salaries, Global Fund resources may be allocated for salaries (see section 3.3), especially if the Global Fund is the only partner with this mandate in a country. In principle, the Global Fund aims to avoid the payment of salary top-ups, but recognizes that in some contexts they may be the only viable strategy to pay health workers a decent wage (see section 3.4).

**Countries preparing for transition**

There are also specific considerations for countries focusing on transition preparedness and preparing for transition. For all upper-middle income (UMI) countries and for low-middle income (LMI) countries with low and moderate disease burden, strengthening sustainability and transition preparedness should be an integral part of planning and developing funding requests to the Global Fund. In some cases, reductions in allocations may result in countries needing to progressively assume greater roles in the financing of HRH interventions, even multiple allocation periods before the country becomes fully ineligible for Global Fund support. Annex 2 provides country examples of how countries have approached transition preparedness, as well as sustainability of HRH interventions more broadly.

Once a country becomes ineligible, they may be eligible for "transition funding" under the Global Fund's Sustainability, Transition, and Co-Financing policy. In general, it is expected that countries submitting funding applications for "transition funding" grants (expected to be the final grant from the Global Fund) will in most cases have secured adequate domestic funding for all HRH support that focuses on service provision (with the exception of support for civil society organizations and or temporary human resources engaged new functions that need to be put in specific place for transition preparedness activities). Therefore, it is unlikely, although possible, that these countries will need to request support for core HRH interventions. Where and when the "transition funding" does include support to HRH

education, remuneration and other recurrent costs, the country should include within the overall transition plan details outlining how the production and employment of health workers will be transferred to national systems funded by domestic resources by the end of the grant.

**Conclusion**

Investments in HRH are fundamental to the successful delivery of HIV, TB and malaria initiatives and to achieve related health goals. Countries are encouraged to ensure that their requests for HRH support are strategic and aligned with national policy. Applicants should make full use of the information in this information note and other relevant Global Fund documents to ensure that investments in HRH contribute to the building of resilient and sustainable systems for health.

Table 1: Prioritizing strategic investments in human resources for health – illustrative examples

| Type of HRH intervention | Low income countries and COE | Middle Income |
|---|---|---|
| **Cross-cutting interventions for HRH policies, governance and management** | | |
| Strengthen governance: HRH policies and strategies, legal frameworks, management systems, effective payroll administration, information systems, national health workforce accounts | +++ | ++ |
| Harness ICT for improved HRH education, management, support | + | + |
| **Education and training** | | |
| Pre-service education to scale up production of PHC workforce* | +++ | + |
| Mainstream/ integrate competencies related to 3 diseases in pre-service education of health workers (e.g. by revising curricula and instruction modalities, training educators etc.) | +++ | +++ |
| Ensure a gender-balanced and gender-sensitive workforce | +++ | +++ |
| In-service training to enhance competencies of existing health workers | + | + |
| **Supporting demand through the creation of funded positions** | | |
| Support, in alignment with national systems, health sector employment through salaries/remuneration of PHC workers* | ++ | + |
| **Retention, motivation and performance management** | | |
| Salary top-ups | + | + |
| Incentives for retention schemes in rural and under-served areas aligned with national systems | ++ | + |
| Performance-based incentives | ++ | + |

*Legend: +++ highly relevant; ++ relevant; + potentially relevant under certain circumstances, but requires adequate justification;* in countries facing a shortage of health workers in relation to population needs.*

# Annex 1 – Annotated List of HRH Resources

The following is a list of key resources and tools for HRH. They are drawn from 'Annex 2 - Annotated list of selected WHO tools and guidelines for human resources for health', from the *Global Strategy on Human Resources for Health: Workforce 2030*, WHO, 2016.

**Workload indicators for staff need**

The Workload Indicators for Staff Need (WISN) use business and industry planning principles for the health sector. This tool provides guidance for health managers on how to analyse and calculate the health workers' workload to derive health worker requirements in health-care facilities. The program software is simple to run and is supported by an easy-to-follow instruction manual and WISN case studies.

http://www.who.int/hrh/resources/wisn_user_manual/en/.

**Task shifting for HIV and optimizing health workers' roles for maternal and newborn health**

The guidelines for task sharing and delegation provide countries with guidance on how to use a more diverse skills mix, most efficiently and rationally, for the delivery of essential HIV/AIDS and reproductive, maternal, newborn, child health services. The guidelines highlight evidence-based, effective and cost-effective interventions to delegate service delivery tasks to other cadres of health workers. http://www.who.int/healthsystems/TTR-TaskShifting.pdf and http://www.optimizemnh.org/.

**Transforming and scaling up health professionals' education and training**

These guidelines set out a vision of transforming education for health professions, and offer recommendations on how best to achieve the goal of producing graduates that are responsive to the health needs of the populations they serve. The guidelines encourage educational and training institutions to foster institutional and instructional reforms, and to enhance the interaction and planning between education, health and other sectors. http://www.who.int/hrh/education/en/ and http://whoeducationguidelines.org./content/guidelines-order-and-download.

**Increasing access to health workers in remote and rural areas through improved retention**

These policy recommendations examine the evidence base and outline policy options for maximizing retention of health workers in rural and underserved areas. They can be used in conjunction with other WHO resources, such as the WHO Global Code of Practice on the International Recruitment of Health Personnel. To ensure better health worker retention outcomes in countries, the best results will be achieved by choosing and implementing a bundle of contextually relevant recommendations, encompassing interventions on education, regulation, financial incentives, and personal and professional support. http://www.who.int/hrh/retention/guidelines/en/.

**WHO Global code of practice on the international recruitment of health personnel**

In May 2010, the Sixty-third World Health Assembly (WHA63.16) endorsed the Code aiming to establish and promote a comprehensive framework that promotes principles and practices for the ethical management of international migration of health personnel. It also outlines strategies to facilitate the strengthening of the health workforce within national health systems, and the evidence and data requirements for tracking and reporting on international mobility of health personnel. The Code was designed by Member States to serve as a continuous and dynamic framework for global

dialogue and cooperation. http://www.who.int/hrh/migration/code/practice/en/ and http://www.who.int/hrh/migration/code/code_en.pdf?ua=1. 49

**National health workforce accounts**

The purpose of a national health workforce account (NHWA) is to standardize the health workforce information architecture and interoperability as well as track HRH policy performance towards universal health coverage. The implementation of NHWAs facilitates a harmonized, integrated approach for regular collection, analysis and use of standardized health workforce information to inform evidence-based policy decisions. http://www.who.int/hrh/documents/15376_WHOBrief_NHWFA_0605.pdf

**Minimum data set for health workforce registry**

This tool provides guidance on the minimum information fields required to develop or modify an electronic system for health workers at national or subnational levels. The minimum data set for health workforce registry (MDS) provided in this document can be used by ministries of health to support the development of standardized health workforce information systems. http://www.who.int/hrh/statistics/minimun_data_set/en/.

**Monitoring and evaluation of human resources for health with special applications for low- and middle-income countries**

The handbook offers health managers, researchers and policy-makers a comprehensive, standardized and user friendly reference for monitoring and evaluating human resources for health, including approaches to strengthen relevant technical capacities. It brings together an analytical framework with strategy options for improving the health workforce information and evidence base, as well as country experiences that highlight successful approaches. http://www.who.int/workforcealliance/knowledge/toolkit/25/en/.

**Analysing disrupted health sectors**

This modular manual supports policy-makers in settings characterized by complex humanitarian emergencies to analyse and plan for their health systems. Module 10 of the tool reviews aspects to be considered in the study of a health workforce in these settings. In these irregular contexts, tailored strategies for planning, education, deployment, retention and staff performance management are required.

http://www.who.int/hac/techguidance/tools/disrupted_sectors/en/

Module 10 – Analysing human resources for health:

http://www.who.int/hac/techguidance/tools/disrupted_sectors/adhsm_mod10_en.pdf?ua1

# Annex 2: Country experiences of working towards sustainability and strengthening transition preparedness of HRH

In many countries where the Global Fund is currently paying salaries and other recurrent costs, governments have begun work towards taking up key program costs to strengthen sustainability, transition preparedness, and prepare for eventual transition from external donor financing. Political will to invest in HRH for the three diseases and broader health priorities is a pre-requisite for countries to successfully absorb HRH interventions that are fundamental to the national disease response. In **Namibia**, the government is investing in pre-service education for HRH, has developed HRH guidelines and is thinking beyond Global Fund support.

In countries with robust and transparent HRH systems and salary scales, and available fiscal space, it has been relatively straightforward for governments to absorb recurrent HRH costs. For example, In **South Africa**, the Global Fund used to support an orphans and vulnerable children (OVC) program which included salaries for social workers. The Global Fund no longer supports this program, but the program is still running in several provinces because the government absorbed the recurrent costs in provinces where the need was greatest.

Similarly, in **Peru**, sustainability is facilitated by the country's well-established system of payment by results. Under this system, if an initiative can be shown to be cost-effective, an application can be made to the Ministry of Finance to fund it from domestic resources. Global Fund support, therefore, only needs to be in place until effectiveness has been demonstrated.

Other countries are facing sustainability challenges due to the creation of large numbers of HRH positions under Global Fund support. Their experiences emphasise the importance of building sustainability into grants from the outset, even in low income countries. In **Mali**, for example, the Global Fund used to pay salaries for over 800 health workers at rates higher than the government pay scale. To reduce this number, targets were set for the PR to reduce the number of people being paid salaries or incentives. This led to the MoH identifying significant numbers of workers as 'non-essential' (mainly those providing support services).

The issue of sustainability applies to training costs as well as to salaries and other recurrent costs. For example, there are plans for the Government of **Namibia** to absorb the costs of bursaries for student doctors and nurses (see Box 4), but this process is complicated by the fact that the existing system of government bursaries is not integrated with the Global Fund bursary system. This makes it difficult to establish exactly how many students are being supported and which courses they are doing. On the other hand, in **Viet Nam**, the alignment of in-service training costs with government cost norms means that it is much more likely that the government will be able to absorb these costs when Global Fund support ends.

# References


[1] Dräger S, Gedik G, Dal Poz MR. Health workforce issues and the Global Fund to fight AIDS, Tuberculosis and Malaria: An analytical review. *Hum Resour Health* 2006; **4**: DOI: 10.1186/1478–4491 – 4–23.

[2] Anand S, Bärnighausen T. Human resources and health outcomes: Cross-country econometric study. *Lancet* 2004; **364**: 1603–9.

[3] Anand S, Bärnighausen T. Health workers and vaccination coverage in developing countries: An economometric analysis. *Lancet* 2007; **369**: 1277–85.

[4] Campbell J, Buchan J, Cometto G, *et al.* Human resources for health and universal health coverage: fostering equity and effective coverage. *Bull World Heal Organ* 2013.

[5] Van Lerberghe W, Matthews Z, Achadi E, *et al.* Country experience with strengthening of health systems and deployment of midwives in countries with high maternal mortality. *Lancet* 2014; **384**: 1215–25.

[6] United Nations Department of Economic and Social Affairs. Sustainable Development Goals. 2015. https://sustainabledevelopment.un.org/?menu=1300 (accessed Oct 19, 2015).

[7] The Global Fund. The Global Fund strategy 2017-2022: Investing to end epidemics (draft). Geneva: The Global Fund, 2016.

[8] World Health Organization. Global strategy on human resources for health: Workforce 2030 (draft 1.0 submitted to the Executive Board (138th session). Geneva: World Health Organization, 2016 http://www.who.int/hrh/resources/global_strategyHRH.pdf?ua=1 (accessed Sep 14, 2016).

[9] Vujicic M, Weber SE, Nikolic IA, Atun R, Kumar R. An analysis of GAVI, the Global Fund and World Bank support for human resources for health in developing countries. *Health Policy Plan* 2012; **27**: 649–57.

[10] Bowser D, Sparkes SP, Mitchell A, *et al.* Global Fund investments in human resources for health: Innovation and missed opportunities for health systems strengthening. *Health Policy Plan* 2014; **29**: 986–97.

[11] Bates DW, Gawande AA. Improving safety with information technology. *N Engl J Med* 2003; **348**: 2526–34.

[12] Weakliam D. Information technology (IT) in the new Global Strategy on Human Resources for Health. GETHealth Summit, Dublin, Repub. Irel. 2014. http://www.who.int/workforcealliance/media/news/2014/4HSE_GlobalHealthProgrammeIreland.pdf?ua=1 (accessed June 13, 2016).

[13] Frenk J, Chen L, Bhutta ZA, *et al.* Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. *Lancet* 2010; **376**: 1923–58.

[14] World Health Organization. Increasing access to health workers in remote and rural areas through improved retention: Global policy recommendations. Geneva: World Health Organization, 2010.

[15] Lewin S, Munabi-Babiqumira S, Glenton C, *et al.* Lay health workers in primary and community health care for maternal and child health and the management of infectious diseases: S. *Cochrane Database Syst Rev* 2010; : doi: 10.1002/14651858.CD004015.pub3.

[16] Lassi ZS, Cometto G, Huicho L, Bhutta ZA. Quality of care provided by mid-level health workers: Systematic review and meta-analysis. *Bull World Health Organ* 2013; **91**: 824–33.

[17] World Health Organization. Policy brief: National health workforce accounts. 2015. http://www.who.int/hrh/documents/brief_nhwfa/en/ (accessed Aug 30, 2016).

[18] World Health Organization. Global strategy on human resources for health: Workforce 2030 (draft 1.0 submitted to the Executive Board (138th session). Geneva: World Health Organization, 2016 http://www.who.int/hrh/resources/global_strategyHRH.pdf?ua=1 (accessed Sep 14, 2016).

[19] World Health Organization. Human resources for health information system: Minimum data set for health workforce registry. Geneva: World Health Organization, 2015 http://www.who.int/hrh/statistics/minimun_data_set.pdf?ua=1 (accessed Sep 14, 2016).

[20] UNFPA, WHO, ICM. The state of the world's midwifery 2014: A universal pathway. A woman's right to health. New York: United Nations Population Fund, 2014.

[21] USAID. A global improvement framework for health worker in-service training: Guidance for improved effectiveness, efficiency and sustainability. 2013. https://www.usaidassist.org/sites/assist/files/inservicetraining_july2013.11x17spreads.pdf (accessed Aug 30, 2016).

[22] Third Global Forum on Human Resources for Health. Joint commitment to harmonized partners action for community health workers and frontline health workers (Recife commitment). 2013. http://www.who.int/workforcealliance/knowledge/resources/chw_outcomedocument01052014.pdf (accessed Aug 30, 2016).

[23] Lehmann U, Sanders D. Community health workers: What do we know about them? 2007. http://www.who.int/hrh/documents/community_health_workers.pdf (accessed June 28, 2016).

[24] World Health Organization. Increasing access to health workers in remote and rural areas through improved retention: Global policy recommendations. Geneva: World Health Organization, 2010.

[25] The Global Fund. Global Fund guidelines for grant budgeting and annual financial reporting. Geneva: The Global Fund, 2014.