HEALTH WORKFORCE STRATEGIC PLAN

2020–2030

Investing in Skills and Job Creation for Health

SADC Health Workforce Strategic Plan 2020–2030

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About SADC

The Southern African Development Community is an organisation founded and maintained by countries in Southern Africa that aims to further socio-economic, political, and security cooperation among its Member States and foster regional integration, in order to achieve peace, stability, and wealth. The Member States are: Angola, Botswana, Union of the Comoros, Democratic Republic of the Congo, Eswatini, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, United Republic of Tanzania, Zambia, and Zimbabwe.

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November 2020

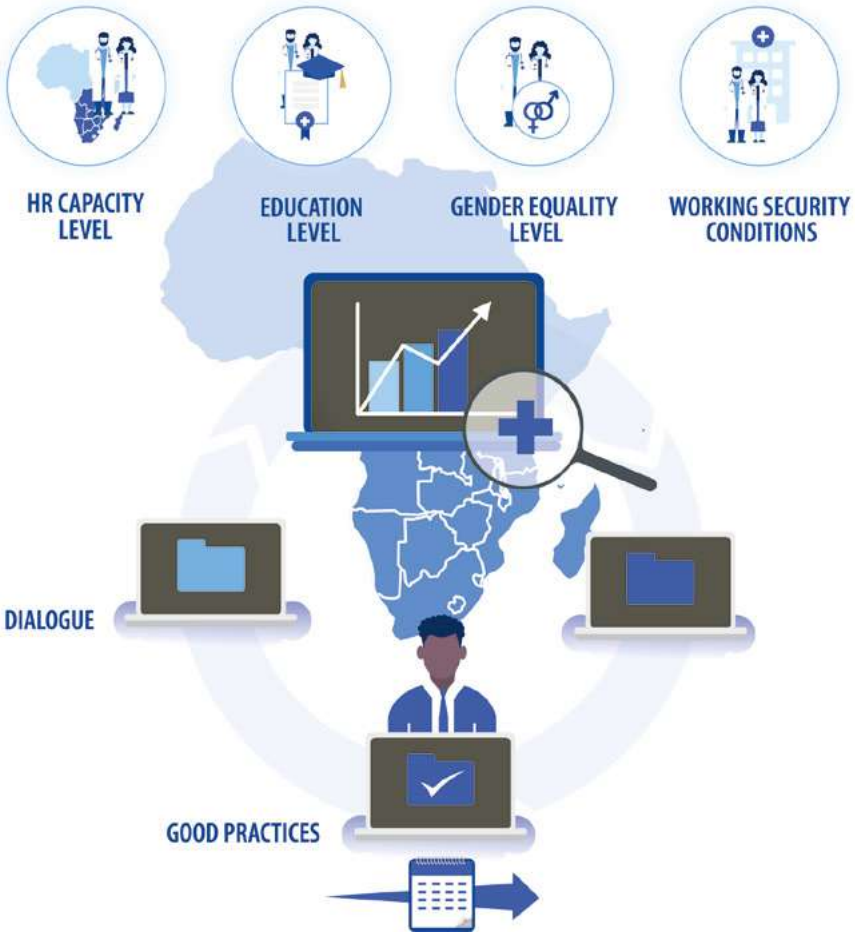
United Nations MPTF Office

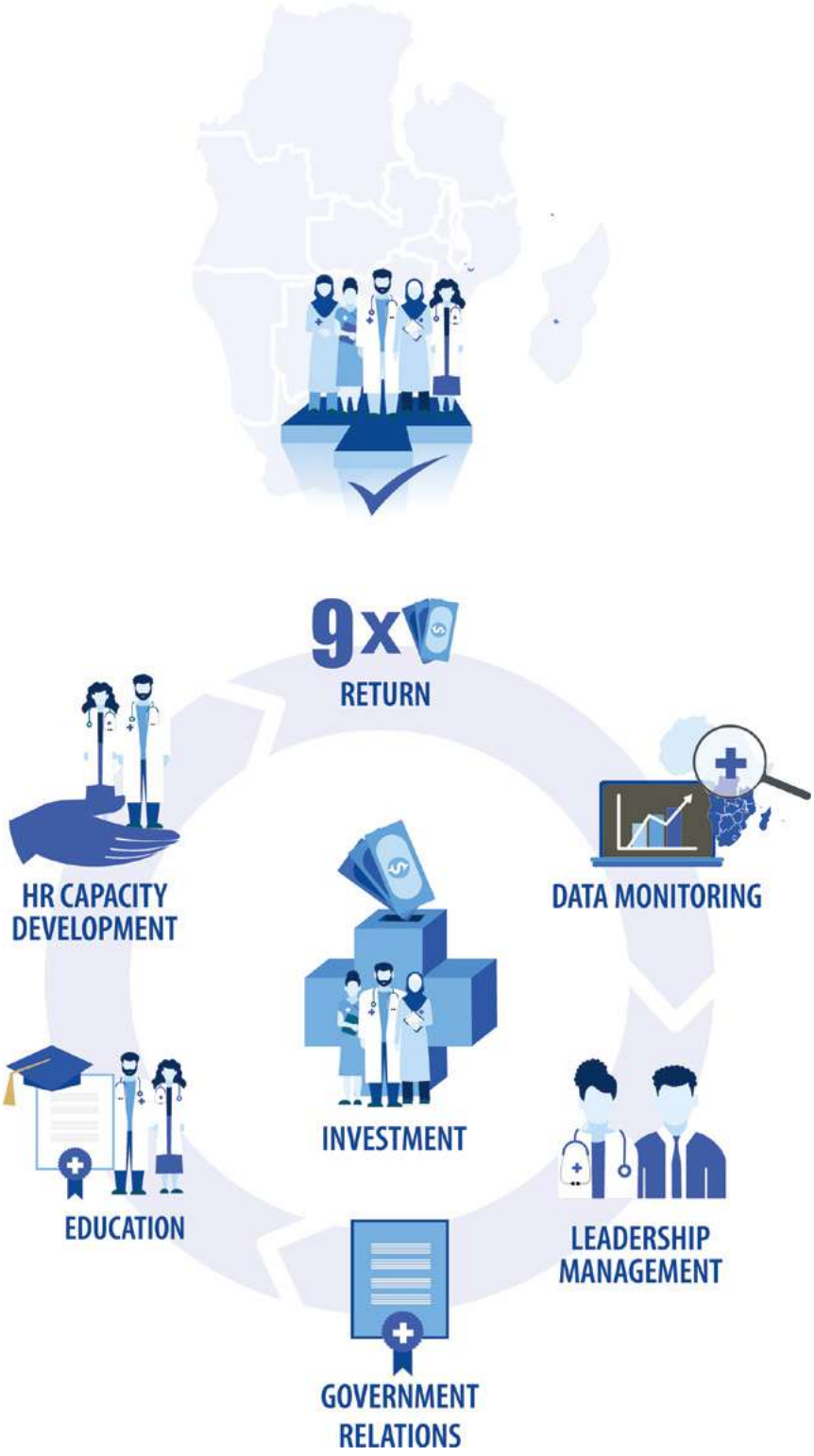
International Labour Organization

OECD
BETTER POLICIES FOR BETTER LIVES

World Health Organization

SOUTHERN AFRICAN DEVELOPMENT COMMUNITY
TOWARDS A COMMON FUTURE

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RETURN
HR CAPACITY DEVELOPMENT
DATA MONITORING
INVESTMENT
EDUCATION
LEADERSHIP MANAGEMENT
GOVERNMENT RELATIONS

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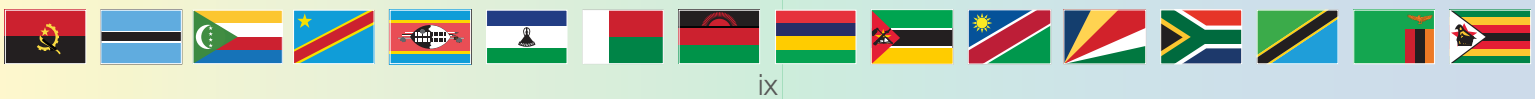
ABBREVIATIONS AND ACRONYMS

AFRO	Africa Region Office
AU	African Union
CCP	Commonwealth Code of Practice
CPI	Consumer Price Index
COVID-19	Coronavirus Disease
CPD	Continuing Professional Development
CSO	Civil Society Organization
DRC	Democratic Republic of Congo
ELS	Employment & Labour and Social Partners
FBO	Faith-Based Organization
GDP	Gross Domestic Product
GGHE	General Government Health Expenditure
GHED	Global Health Expenditure Database
GSHRH	Global Strategy on Human Resources for Health
HEEG	UN High-Level Commission on Health Employment and Economic Growth
HesDA	Health Service Development and Analysis
HMIS	Health Management Information Systems
HR	Human Resources
HRH	Human Resources for Health
HRIS	Human Resources Information Systems
HO	Health Occupation
HWSC	Health Worker Safety Charter
ICT	Information and Communication Technology
ILO	International Labour Organization

KPI	Key Performance Indicator
M&E	Monitoring and Evaluation
NGO	Non-Governmental Organization
NHO	Non-Health Occupation
NHWA	National Health Workforce Account
OECD	Organization for Economic Co-operation and Development
OSH	Occupational Safety and Health
PHC	Primary Health Care
RC	Regional Committee
SADC	Southern African Development Community
SDG	Sustainable Development Goals
SD	Strategic Direction
TWG	Technical Working Group
UEMOA	Member States of the West-African Economic and Monetary Union
UHC	Universal Health Coverage
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
USD	US Dollars
WDI	World Development Indicators
WEO	World Economic Outlook
WFO	World Food Organization
WHO	World Health Organization
WISN	Workload Indicators of Staffing Need



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ACKNOWLEDGEMENTS

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EXECUTIVE SUMMARY

SADC Member States have made significant progress towards the attainment of their key health indicators over the last decade, however, the biggest challenge for ensuring equitable access to health for all is the persistent shortage and availability of skilled health and social care workers across the region, and the sub-optimal utilization and efficiency of the existing workforce. SADC Member States' total population of 345.2 million as of 2018 is estimated to be growing at an average rate of 2.5% annually, placing extra demands on the health systems. Additionally, fewer people are attracted to health and social care professions due to low wages, long working hours, violence and harassment at the workplace and occupational safety and health risks. Access into employment plays a significant role, with some Member States reporting challenges regarding the available fiscal space for government to employ and absorb the additional health workers that are needed to fill the already existing workforce gaps, in particular, new graduates. A new dynamic introduced by the coronavirus pandemic (COVID–19) is its devastating health and economic impact, with lower and middle-income countries (LMIC), and those experiencing fragility, violence, and conflict (FCV), affected the most. This has highlighted the need for countries to develop robust health systems, strengthen primary health care capacity, and build public health preparedness and response capability. The occupational health, safety, and protection of the workforce, especially those directly exposed who are working in high-risk settings has been brought into sharp focus, as health systems globally were affected by high levels of health and social care worker infection rates, and deaths.

The COVID–19 pandemic, whilst its impact has not been fully evaluated, is cause for concern for the SADC region. As the numbers of COVID–19 cases and deaths in the WHO Africa Region has continued to show a downward trend, SADC must factor in its long-term effects. It is the health and care workers that face a substantially higher risk due to excessive exposure to COVID–19. This also has major psycho-social impact on individual health workers as fear of taking the disease to their families is realistic.

The UN High-level Commission on Health Employment and Economic Growth emphasises the importance of the health and care sector in providing growing opportunities for employment and the economy, particularly by empowering women and young people with skills, jobs and economic participation. Although existing training capacity within the SADC region could potentially meet almost 66% of this need in aggregate terms, given the prevailing trends in HRH underinvestment, reduced budgets and cost containment across the region, only around 33% of the needed numbers may be funded positions by 2030.

The perennial challenge is that health workforce gaps across the region are generally determined based on existing staff establishments and/or funded posts. These approaches to workforce planning misrepresent the true picture for SADC member states when measured against their need-based projections for delivering universal health coverage (UHC) and meeting their 2030 SDG targets. This strategy advances a practice where its application serves as a mechanism to challenge traditional views on health workforce gaps, determining demand and investment needed, and how governments can unlock additional domestic and other resources. This situation necessitates a regional response and comprehensive strategy to address the key human resources challenges across SADC.

Among the main objectives of SADC, the achievement of economic development, growth, enhancement of the standard and quality of life of the peoples of Southern Africa. This envisages actions through regional integration and harmonisation of development approaches. To achieve these objectives in the health sector requires a strategic leadership that utilises a multisectoral framework to build and resource comprehensive plans for effective health workforce planning, development, and management. However, without accurate, current data for human resource policies, planning and management meaningful development in the region is difficult. Thus, the need for a regional health workforce strategic plan.

In developing this strategic plan, two critical engagements took place in Johannesburg, South Africa: (i) the SADC human resources for health technical consultations from 26–29 August 2019, and (ii) the tripartite technical workshop for the SADC region organised by ILO on 10–12 September 2019. Both engagements were highly participatory with Member States represented at senior leadership of the HRH divisions of the Ministries of Health Ministries of Labour and Employment and employers' and workers' representatives who had converged on the need to: align the SADC HRH strategy with the SADC Employment and Labour Policy Framework (2020–2030); enhance collaboration and social dialogue between all relevant stakeholders at national and regional level; strengthen coordination mechanisms among governments, workers, employers and other relevant stakeholders to promote decent work in the health sector; and ensure a strategic plan that guides and compliments individual Member States' policies and strategic plans on the health workforce.

The SADC Health Workforce Strategic Plan, 2020–2030 presents five (5) evidence-based strategic directions to inform member states' health workforce policy, planning and implementation:

1. Invest in health worker jobs and decent work.

2. Harmonise Education, Training and Development.

3. Establish best practices in strategic HRH Leadership and Management.

4. Enhance Health Workforce Governance and Regulation.

5. Develop and Use Reliable Data, Monitoring and Evaluation Systems.

The following are the key milestones targeted to be achieved by both the SADC Secretariat and Member States during the plan period:

2021–2025 MILESTONES

SD 1: Investment, Jobs & Decent Work

1.2 By 2023 Member States will commence expansion by at least 40% of the fiscal space to enable increase investments in skilled health workforce

1.3 By 2023 Member States will be continuously protecting health workers from occupational hazards and risks

1.4 By 2023 Member States will be continuously improving the working conditions and remuneration of health workers

1.5 By 2025 Member States will have developed and implemented strategies to mainstream gender equality in the health sector workforce improving the working conditions and remuneration of health workers

SD 2: Education, Training & Development

2.4 By 2025 regional training centres of excellence will have been designated

2.5 By 2025 SADC Secretariat will have initiated the health workforce development scheme

SD 3: Leadership & Management

3.1 By 2023 Member States will champion the mainstreaming of health workforce issues in all health policies and interventions

3.3 By 2024 SADC will have established a mechanism for peer-to-peer support and accountability mechanism

SD 4: Governance & Regulation

4.1 By 2021 Member States will enforce the upholding of professional standards and safeguard public safety

SD 5: Data, Monitoring & Evaluation

5.1 By 2021 Member States will have HRIS with ability to generate information to track end-to-end health workforce life cycle (production – active stock – exit)

5.2 By 2023 Member States will have a health workforce registry to track health workforce stock, distribution, flows, exits, demand and supply

5.3 By 2021 Member States will have improved multi-sectoral dialogue for improved management of the health workforce

5.4 By 2022 Member States will have institutionalised national health workforce accounts (NHWA) and reporting annually

2026–2030 MILESTONES

SD 1: Investment, Jobs & Decent Work

1.1 By 2030 Member States will have improved the density of health workers from the current SADC median of 1.02 to 4.45 per 1,000 population

SD 2: Education, Training & Development

2.1 By 2026 Member States will have harmonised training and development

2.2 By 2027 Member States will be conducting specialist health professions training in line with current and emerging population health needs

2.3 By 2027 Member States will have policies that promote access to education opportunities in health based on principles of equality and affordability, inclusive of youth and women

SD 3: Leadership & Management

3.2 By 2026 Member States will have strengthened their capacity in health labour market analysis, HRH planning, development, and management

3.4 By 2027 Member States will have institutionalised social dialogue mechanisms among governments, workers, employers and other relevant stakeholders

SD 4: Governance & Regulation

4.2 By 2027 SADC Secretariat will have developed a framework with strict compliance criteria for mutual and reciprocal recognition of health professions education and qualification

4.3 By 2026 Member States will be promoting exchange programmes between the Member States especially for skills transfer

4.4 By 2026 Member States will have created multi-sectoral collaboration/partnerships (PPP) to facilitate sharing of HRH resources

SD 5: Data, Monitoring & Evaluation

5.5 By 2026 Member States will have integrated health worker safety indicators with health information system

The overall estimated cost of implementing the strategic plan is roughly **US$15.7 million** over the 10-year period. Of this amount, about 35% (US$5.6 million) would be needed at both the SADC secretariat and Member States to generate evidence, facilitate policy dialogue, and mobilize resources to increase investments substantially to approximately expand health workforce employment by 40% over the 10-year period (strategic direction 1). This cost, however, excludes the cost of training and remuneration for health workers at the Members States which a country-by-country analysis is highly recommended as part of the investment case development at the level of Member States.

It is envisaged that multisectoral policy advice and technical guidance may be required in some instances during the development of Member States' national health workforce policies and strategies – in particular, to focus on adopting investment planning for employment creation and decent work, inter alia through their decent work country programmes and regional decent work programmes; drawing on the collaborative multi-sectoral approaches and strategies to expand and transform the health and social care workforce that are guided by the ILO–OECD–WHO Working for Health programme and its 5-year Action Plan on health employment and growth: 2017–2021.

CHAPTER 01

INTRODUCTION

1.1 Background

The Southern Africa Development Community (SADC) adopted a Protocol on Health in 1999 which followed the SADC Health Policy Framework in 1998 setting out a framework "to attain an acceptable standard of health for all citizens by promoting, coordinating and supporting the individual and collective efforts of Member States" (SADC, 1999). The Protocol is based on the principles of:

- Equality of Member States.
- Co-ordination, sharing and support.
- Health for All through Primary Health Care (PHC).
- Health Care for All through better access.
- Promoting equity to achieve better health.

Various efforts guided by the principles enshrined in the Protocol provided an enormous impetus for accelerating progress towards the attainment of key health targets in tandem with global efforts during the era of the Millennium Development Goals (MDGs) (International Council for Local Environmental Initiatives, 2015). Efforts are continuing to maintain the momentum of progress across the SADC Members States. For instance, healthy life expectancy has improved from an average of 52 years in 2008 to 60 years in 2018 across the SADC Member States (SADC, 2018). Also, data from the UNAIDS Global HIV & AIDS statistics show that the number of new HIV infections have declined from an average of 1,202,759 in 2008 to 820,689 in 2018 (UNAIDS, 2019).

These among other gains made in health status indicators have provided optimism and impetus for the attainment of the health-related targets of the Sustainable Development Goals (SDGs) which were adopted by United Nations Member States in 2015 (UNDP, 2016).

In operationalizing aspects of the SADC Protocol on Health (SADC, 1999), SADC in 2006 developed a Human Resources Strategic Plan (2007–2019) with an ultimate goal "to ensure adequate production, recruitment and retention of the required Human Resource for Health in the region by 2019". The strategic plan guided complementation of individual Member States policies and strategic plans on the health workforce; and promoted close cooperation and collaboration for enhanced capacity to design and implement health programmes to respond to the dynamic and changing population health needs.

As the horizon of the SADC HRH Strategic (2007–2019) ended in 2019, and in light of global developments, including the WHO Global Strategy on Human Resources for Health and the UN High-Level Commission on Health Employment and Economic Growth (HEEG) (World Health Organisation, 2016a), a review of the SADC Human Resources for Health (HRH) Strategic Plan became necessary. At the SADC Health Ministers' Meeting in March 2018, the revival of the SADC Human Resources for Health Technical Committee was approved and tasked with leading the development of the HRH strategy for the SADC region based on current HRH situation and taking into account the recommendations of the HEEG Commission. This document is a result of extensive consultation and dialogue with the technical and social partners of SADC Member States, and review of relevant evidence relating to the health workforce.

1.2 Global and Regional Health Workforce Context

The Astana Declaration on Primary Health Care global leaders calls on countries to scale up efforts towards the attainment of Universal Health Coverage (UHC) and the SDGs through a renewed Primary Health Care (PHC) focus (World Health Organisation, 2018). It centres on the pivotal role of responsive and resilient health systems underpinned by adequate, motivated and equitably distributed health workforce. It has been recognised that the health workforce contribution to the SDGs goes beyond the attainment of optimal health (SDG 3), being intricately connected to SDGs 4 (quality education), 5 (gender equality), and 8 (decent work and economic growth).

The World Health Assembly (WHA) in 2016 also adopted the Global Strategy on Human Resources for Health: Workforce 2030 (GSHRH) (World Health Organisation, 2016b) which aims at ensuring equitable access to qualified health workforce towards achieving UHC and SDGs. Its specific objectives are to:

a. Optimize the performance, quality, and impact of the health workforce to accelerate progress towards UHC and SDG

b. Align investment in HRH with the current and future needs of the population and health systems to maximize job creation and economic growth

c. Strengthen the capacity of institutions at regional and national levels for effective public policy stewardship, leadership, and governance on HRH

d. Strengthen data, evidence, and knowledge for cost-effective policy decisions.

The GSHRH also implores countries to "build planning capacity to develop or improve HRH policy and strategies that quantify health workforce needs, demands and supply under different future scenarios in order to manage health workforce labour markets and devise effective and efficient policies that respond to today's population needs while anticipating tomorrow's expectations" (p.25). Thus, countries and regional bodies such SADC are urged to ensure that their plans are continually updated to address:

a. The estimated number, category, and qualification of health workers required to meet public health and population health needs;

b. The capacity to produce a sufficient, and adequately distributed health workforce (education and effective regulatory policies); and

c. The government and labour market capacity to attract, recruit, deploy and retain health workers (economic and fiscal capacity, and workforce deployment, remuneration, and retention through financial and non-financial strategies).

The UN High Commission on Health Employment and Economic Growth (HEEG) provides a wealth of evidence for the health workforce investments that are needed to meet a projected needs-based shortage of 6.1 million in the Africa region.[1] In the context of the Africa Region, the Regional Committee (RC) of the World Health Organisation (WHO) adopted a roadmap for scaling up health workforce interventions in the Region (2012–2025) and also approved a regional implementation framework of the global strategy on HRH in 2018. These global and regional initiatives have provided blueprints for evidence-informed health workforce policy and investment in the context of SADC.

1.3 Recommendations of the Commission on Health Employment and Economic Growth (HEEG) and the SADC Context

The report of the UN High Commission on Health Employment and Economic Growth (HEEG) demonstrated that investing in the health workforce yielded a nine (9) fold return on investment (World Health Organisation, 2016a). It also demonstrated that half of the global economic growth over the last decade resulted from improvements in health, noting that for every added year of life expectancy, the economic growth rate is boosted by 4%. While this sector is an important driver of economic growth, it is estimated that globally, about 40 million health workers would be needed, primarily in upper-middle- and high-income countries (Liu, et al., 2017). It is however projected that the growth in jobs will take place alongside a potential shortfall of 18 million health workers if universal health coverage is to be achieved and sustained by 2030 (World Health Organisation, 2016b).

Against this background, the high-level commission made ten (10) recommendations (see box 1) and proposed these five immediate actions:

1. Encouraging commitments; fostering intersectoral engagement and develop an implementation plan

2. Galvanizing accountability, commitment, and advocacy

3. Advancing health market labour data, analysis and tracking in all countries

4. Accelerating investment in transformative education, skills, and job creation

5. Establishing an international platform for health worker mobility

[1] Health workforce needs, demand and shortage to 2030, an overview of forecasted trends in the global labour market, Cometto, Scheffler, et al, in 'Health Employment and Economic Growth: an evidence base, Buchan, Dhillon and Campbell, WHO, 2017

Box 1: Recommendations of UN High-Level Commission on HEEG

1. ***Job Creation:*** *Stimulate investments in creating decent health sector jobs, particularly for women and youth, with the right skills, in the right numbers and the right places.*
2. ***Gender and Women's Rights:*** *Maximize women's economic participation and foster their empowerment through institutionalizing their leadership, addressing gender biases and inequities in education and the health labour market, and tackling gender concerns in health reform processes.*
3. ***Education, Training and Skills:*** *Scale-up transformative, high-quality education and lifelong learning so that all health workers have skills that match the health needs of populations and can work to their full potential.*
4. ***Health Service Delivery and Organization:*** *Reform service models concentrated on hospital care and focus instead on prevention and the efficient provision of high-quality, affordable, integrated, community-based, people-centred primary and ambulatory care, paying special attention to underserved areas.*
5. ***Technology:*** *Harness the power of cost-effective information and communication technologies to enhance health education, people-centred health services and health information systems.*
6. ***Crises and Humanitarian Settings:*** *Ensure investment in the International Health Regulations core capacities, including skills development of national and international health workers in humanitarian settings and public health emergencies, both acute and protracted. Ensure the protection and security of all health workers and health facilities in all settings.*
7. ***Financing and Fiscal Space:*** *Raise adequate funding from domestic and international sources, public and private where appropriate, and consider broad-based health financing reform where needed, to invest in the right skills, decent working conditions and an appropriate number of health workers.*
8. ***Partnership and Cooperation:*** *Promote intersectoral collaboration at national, regional and international levels; engage civil society, unions and other health workers' organizations and the private sector; and align international cooperation to support investments in the health workforce, as part of national health and education strategies and plans.*
9. ***International Migration:*** *Advance international recognition of health workers' qualifications to optimize skills use, increase the benefits from and reduce the negative effects of health worker migration, and safeguard migrants' rights.*
10. ***Data, Information and Accountability:*** *Undertake robust research and analysis of health labour markets, using harmonized metrics and methodologies, to strengthen the evidence, accountability and action.*

To accelerate global action on the recommendations of the Commission on HEEG, particularly to avert the potential shortage of 18 million health workers by 2030, ILO, OECD and WHO jointly established the Working for Health programme to support the expansion and transformation of the global health and social service workforce in order to accelerate progress towards universal health coverage and global health security. Guided by the Commission's recommendations and the Five-Year Action Plan for Health Employment and Inclusive Growth (2017–2021), the Working for Health programme will coordinate, enhance and extend the policy advice, technical assistance and capacity support that the ILO, OECD and WHO will provide to their constituents and partners (World Health Organisation, 2016a).

In November 2017, the South African Ministry of Health, as the incumbent SADC chair, took the initiative to propose to the SADC Health Ministers' meeting to develop a SADC action plan on health employment and economic growth. This was inspired by the Member States of the West-African Economic and Monetary Union (UEMOA) that has developed a UEMOA action plan which was endorsed by an inter-ministerial meeting in March 2017. The SADC health ministers noted that by taking immediate action and making strategic investments across the SADC region, Member States could potentially avert serious health workforce shortfalls to better position health systems to achieve the health-SDGs as well as create much-needed jobs to address youth unemployment and enhance women's labour participation.

The SADC Health Ministers' Meeting considered that in light of global developments, including the WHO Global Strategy on Human Resources for Health and the Commission HEEG, the existing SADC Human Resources for Health Strategic Plan and its Business Plan needed to be updated. They approved the revival of the SADC Human Resources for Health Technical Committee and considered that a sub-committee of the SADC HRH technical committee should develop a costed SADC five-year action plan to implement the outcomes of the Commission HEEG, and that the action plan should be guided by principles of collaboration and partnership.

Furthermore, the meeting of the SADC Ministers of Employment & Labour and Social Partners (ELS) held their meeting in Cape Town on 2nd March 2018. Ministers agreed to include an item titled 'Health employment and economic growth' under the section on issues for noting as one of the inter-sectoral issues of priority to the Employment and Labour Sector.

SADC HRH technical committee needs to build a framework for translating the Global Strategy on Human Resources for Health and the recommendations of the Commission HEEG to the regional context. Recognising this, SADC aims to attain an acceptable standard of health for all citizens and to reach specific targets within the objective of "Health for All" by 2030. Therefore, the Framework should support accelerating progress towards achieving the population health objectives of Health 2020 and the longer-term health goals for the Member States in the SADC region. The Framework should help build sustainable transformed and effective health workforce within strengthened health systems and supports Global Strategy objectives.

Lastly, the Framework should provide vital support to the SADC Member States by identifying policy options and guidance on investment. It is within this context that ILO, OECD and WHO should provide technical support to capacitate the development of broader strategic objectives and policy options for the SADC region. The SADC Member States will then, based on their context, develop, review, and prioritise actions from the broader strategic objectives and policy options that are set out in the regional health workforce strategic plan.

1.4 Approach to the Health Workforce Strategic Plan Development

The consultative process and methodology were applied to engage the Member States and social partners. A mixed-method approach was used to ensure robust qualitative and quantitative data were obtained to inform a comprehensive sub-regional strategy. Member States were requested to complete a rapid self-evaluation of their level of readiness using thematic areas adopted from an HRH Effort Index Tool (Fort, et al., 2017). The tool covers 50 items distributed over seven recognized HRH dimensions: (1) Leadership and Advocacy, (2) Policy and Governance, (3) Finance, (4) Education and Training, (5) Recruitment, Distribution, and Retention, (6) Human Resources Management, and (7) Monitoring, Evaluation, and Information Systems. Also, quantitative data on the health workforce production, densities, staffing establishments/norms and spending was submitted to SADC by nine (9) Member States and which guided technical consultations from 26–29 August 2019 in Johannesburg, South Africa, and supplemented with additional data drawn from the WHO National Health Workforce Accounts (NHWA) platform.

During the technical consultative meeting, Member States presented the outcomes of the various HRH self-evaluations and were then further supported to complete Health Service Development and Analysis (HesDA) Model (Asamani et al. 2018) using their country data. Each Member State in attendance presented their health workforce forecasts, projected supply, labour market gaps, including economic feasibility analysis and there were extensive discussions on the policy priority of their own countries as well as the implications for the broader SADC sub-region. The outcome of this technical consultation, which was facilitated by WHO and ILO, was presented to a tripartite technical workshop for the SADC region in Johannesburg on 10–12 September 2019 for consideration.

The recommendations from the ILO tripartite technical workshop for the SADC region were incorporated and a draft SADC HRH Strategy Framework was developed, supported by a team of consultants, with technical backstopping from experts in WHO and ILO and coordinated by the SADC Secretariat. The draft HRH Strategy Framework was reviewed by technical experts of the SADC and taken note of by the SADC Ministers of Health on 7th November 2019 in Dar Es Salaam, Tanzania. Feedback from the SADC Ministers informed further analysis and refinement of the framework into this HRH Strategic Plan 2020–2030, which was endorsed by the Member States on 15 November 2020 during the meeting of SADC Ministers in charge of Health and HIV/AIDS in Maputo, Mozambique and further endorsed by the SADC Ministers of Labour and Employment.

CHAPTER 02

SITUATION ANALYSIS

2.1 Population and Socio-Economic Background

2.1.1 Population

The SADC Member States is estimated to have a total population of 345.2 million as of 2018 which grows at an average rate of 2.5% annually. The Democratic Republic of Congo (DRC) has the largest share of the SADC population with approximately 27%, followed by South Africa and Tanzania at 16.7% and 15.7% respectively. Seven Member States (namely Seychelles, Namibia, Mauritius, Lesotho, Eswatini, Comoros and Botswana) together constitute slightly less than 3% of the SADC population (see figure 1). Thus, the principle of sharing and interdependence as espoused in the various SADC protocols is essential to benefit from the economic dividends of the population (SADC, 2018).

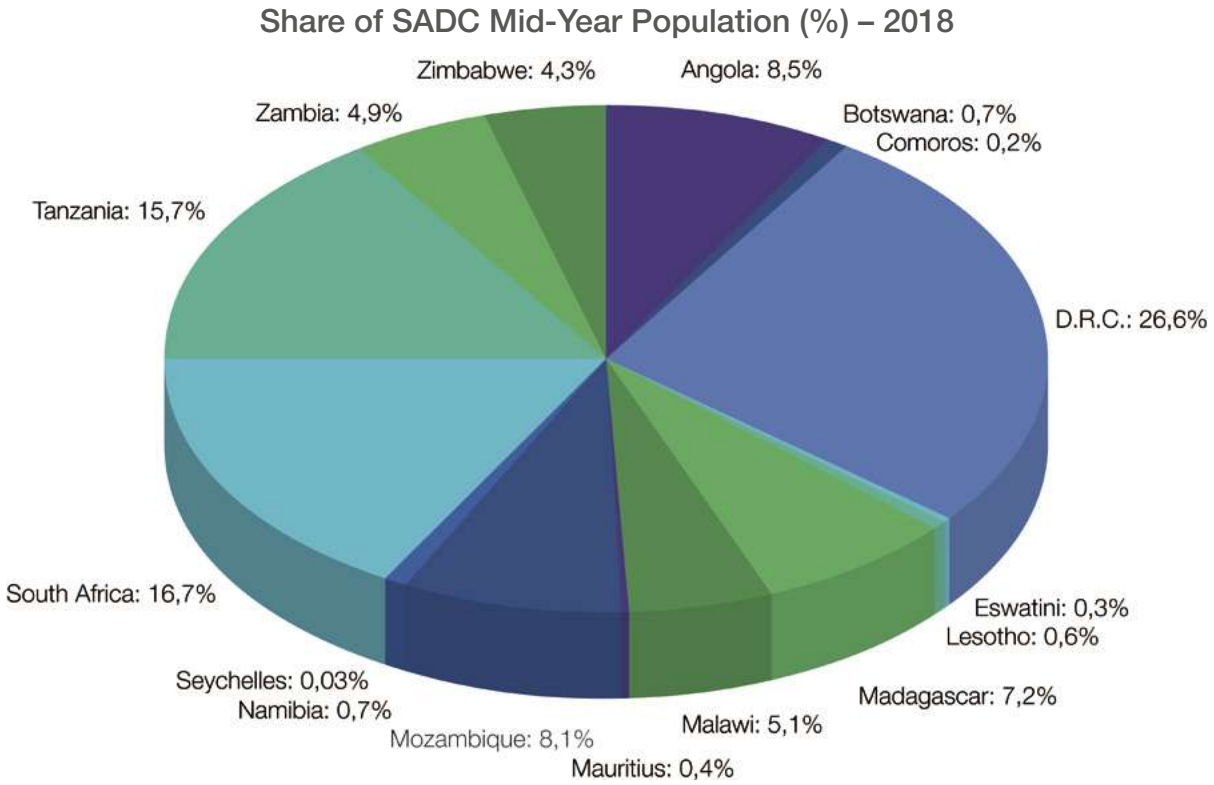

Figure 1: SADC mid-year population, 2018

Source: SADC selected economic and social indicators, 2018

2.2 Socio-economic background

Together, the SADC sub-region has a Gross Domestic Product (GDP) of US$721.3 billion in 2018 which has grown by nearly 42% from US$508.7 billion in 2008. The sub-region's GDP is growing at a declining rate – an average of 1.8% in 2018 which is an average 6.4% decline in annual economic growth rate since 2008 (see table 1 for GDP of SADC Members States and figure 2 for the trend of aggregate GDP growth rate). As evident from figure 2, the effects of global economic downturn adversely impacted the economic growth in the sub-region. However, the anticipated economic downturn resulting from COVID–19 may further hamper economic growth.

Table 1: Gross Domestic Product in SADC at Current Market Prices, (US $ million), 2008–2018

SADC Member States	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Angola	88 539	70 415	83 799	111 943	128 138	136 725	145 668	116 164	101 124	122 121	107 970
Botswana	10 945	10 267	12 787	15 438	14 420	14 902	16 251	14 421	15 662	17 486	18 596
Comoros	524	531	906	1 022	1 016	1 116	1 148	988	1 021	1 082	1 241
DRC	19 144	16 004	21 567	25 841	29 308	32 686	35 909	37 918	37 135	37 981	47 228
Eswatini	3 279	3 612	4 436	4 821	4 830	4 587	4 440	4 023	3 815	4 440	4 362
Lesotho	1 867	1 886	2 384	2 787	2 727	2 553	2 616	2 463	2 305	2 592	2 519
Madagascar	9 413	8 544	9 983	11 552	11 579	12 424	12 523	10 371	11 805	13 177	13 904
Malawi	5 322	6 185	6 960	8 003	5 721	5 290	5 918	6 431	5 310	6 348	7 197
Mauritius	9 984	9 135	10 002	11 517	11 669	12 122	12 804	11 671	12 127	13 146	14 129
Mozambique	11 557	11 242	10 456	13 135	15 343	16 123	17 327	15 457	10 902	12 647	14 428
Namibia	8 346	8 954	10 911	12 602	13 032	12 659	12 848	11 725	11 293	13 579	14 446
Seychelles	969	849	970	1 019	1 060	1 328	1 343	1 377	1 428	1 503	1 589
South Africa	287 100	297 217	375 298	416 878	396 811	366 837	351 047	317 638	296 333	349 630	368 398
Tanzania	27 389	28 574	31 704	34 452	39 643	45 668	49 969	47 522	49 763	53 281	57 347
Zambia	17 909	15 329	20 266	23 461	25 528	28 076	27 163	21 274	21 031	25 590	25 177
Zimbabwe	6 451	8 157	12 042	14 102	17 115	19 091	19 495	19 963	20 549	22 041	22 790
SADC region	**508 737**	**496 902**	**614 470**	**708 572**	**717 940**	**712 186**	**716 470**	**639 406**	**601 602**	**696 643**	**721 321**

Source: SADC Selected Economic and Social Indicators, 2018

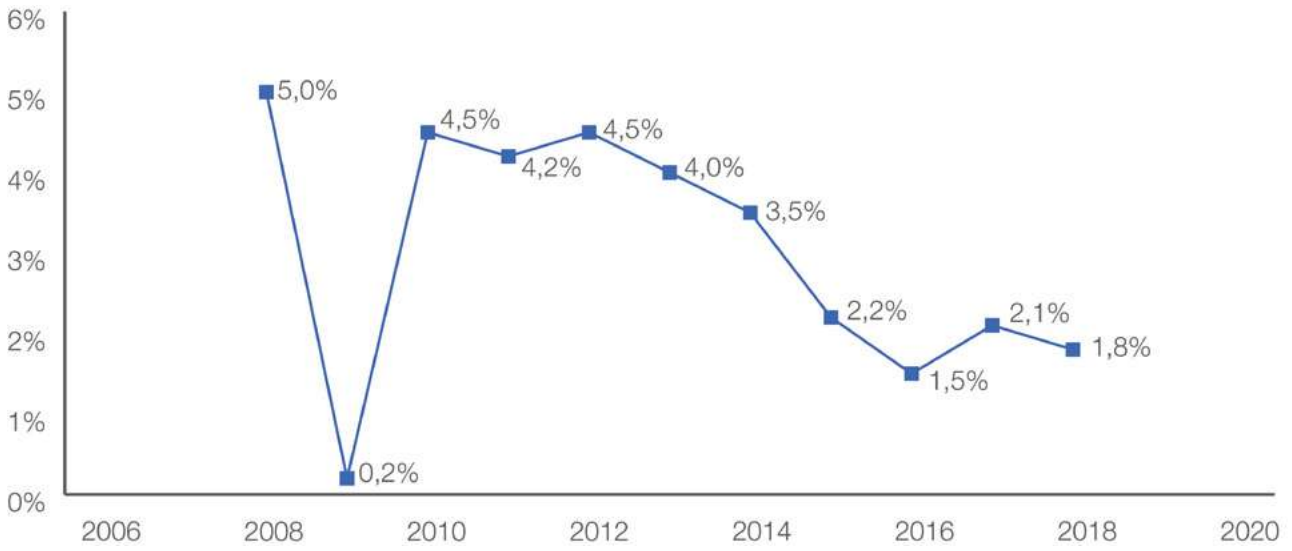

Figure 2: GDP Growth rate for the SADC Region

Source: SADC Selected Economic and Social Indicators, 2018

Youth unemployment in the sub-region varies significantly with figures of less than 10% recorded for countries such as DRC, Madagascar, Malawi and Tanzania in contrast to countries as high as 57% such as South Africa (57.4%), Eswatini (54.8%), Mozambique (42.7%) and Namibia (45.5%) (SADC, 2018).

Table 2: Unemployment, youth (% ages 15–24) (%) in SADC, 2008–2017

SADC Member States	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Angola	33.7	28.1	22.8	16.9	17.0	17.0	17.0	16.9	18.0	19.1
Botswana	32.5	32.6	35.3	35.3	35.4	35.6	35.4	35.3	35.7	35.7
Comoros	9.9	9.9	9.9	9.9	9.9	9.9	9.9	9.9	9.9	10.0
DRC	7.3	7.3	7.3	7.3	7.3	7.3	7.3	7.3	7.3	7.3
Eswatini	53.0	53.1	53.1	53.1	53.3	53.4	53.5	53.5	54.1	54.8
Lesotho	47.7	46.2	36.3	38.9	32.9	34.5	34.9	38.0	39.0	38.5
Madagascar	5.5	5.9	6.4	3.8	1.0	1.5	2.0	3.0	3.0	3.0
Malawi	9.6	9.2	8.9	8.6	8.2	7.8	7.9	7.8	7.9	8.0
Mauritius	18.9	21.8	23.2	22.1	24.4	23.4	24.6	26.0	23.6	23.3
Mozambique	38.5	38.5	38.5	38.5	38.6	39.8	43.2	43.2	43.0	42.7
Namibia	46.1	46.6	45.3	42.6	34.3	40.8	38.7	40.1	45.2	45.5
Seychelles	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
South Africa	45.6	48.4	51.2	50.3	51.7	51.4	51.3	50.1	53.4	57.4
Tanzania	6.9	4.9	5.9	7.1	6.5	5.8	3.7	3.7	3.8	3.9
Zambia	15.5	20.9	26.8	20.1	15.3	15.3	15.3	15.2	15.3	15.4
Zimbabwe	7.9	8.2	8.4	8.5	11.5	11.5	11.4	11.4	11.4	11.4

Source: SADC Selected Economic and Social Indicators, 2018

2.3 Economics of COVID–19 Pandemic in SADC Region

At the beginning of 2020, the SADC region reported its first case of the COVID–19 infection. The disease has since spread rapidly across many countries in the region, impacting severely on their economies and health systems. The impact of COVID–19 is changing the economic landscape around the world including SADC region. The SADC regional economy, which was forecasted to recover in 2020 according to the October 2019 WEO has seen significant downward revision due to the adverse impact of COVID–19. Resultantly, SADC regional 2020 economic growth initially forecasted at 3.3 per cent in October 2019, has been revised downwards to a contraction of about 3 per cent. Disruptions of economic activity and the elevated expenditures by Governments coupled with economic packages in response to the pandemic is expected to affect economic growth of SADC Member States. Consequently, scale deficit is forecasted to widen to 5.7 per cent of GDP in 2020 compared to the previous estimate of 3.0 per cent of GDP. Additionally, debt levels are forecasted to increase beyond the regional threshold of 60 per cent of GDP to 69.8 per cent of GDP in 2020.[2]

Economic sectors that have been severely impacted by COVID–19 include the tourism and leisure, aviation and maritime, automotive, construction and real estate, manufacturing, education and the oil industry. There were initial concerns that the COVID–19 pandemic would also disrupt the global food processing and retail business. However, these have remained stable. The food processing and retail business largely benefited from the announcement by WHO and World Food Programme that, it is highly unlikely that people can contract COVID–19 from food or food packaging.

[2] https://www.sadc.int/files/6915/8758/8533/BULLETIN_2-SADC_Response_to_COVID19_ENGLISH.pdf

SADC Member States have instituted several socio-economic policies and measures to minimize the impact of COVID–19 to the economy. These policies and measures include suspension of non-essential economic activities; increased spending in health sector and in social safety nets; accommodative tax measures; economic stimulus packages, accommodative monetary policies and establishment of emergency/solidarity funds. These policies and measures have far-reaching implications on Member States including availability to invest in health workforce post the pandemic (SADC, 2020).

2.4 Overview of Health Status and Health Systems

Many African countries made significant progress towards the attainment of key health indicators over the last decade. For instance, 43 countries in Africa observed much more significant declines in child mortality during the 2000–2013 period than during the 1990–2000 period. Also, the continent recorded a massive decline in under-five mortality rate by nearly 56% between 1990 and 2012; infant mortality declined by 40% (UNICEF, 2018).

In the context of the SADC region, in the last decade from 2008 to 2018, the average life expectancy improved by about 8 years, from 52.4 years in 2008 to 61 years in 2018. This represents an average improvement of 16% across the SADC Members States. However, wide variations have also been observed in the accrued improvements in life expectancy. The largest gains were recorded in Zimbabwe (30%), Botswana (29), Democratic Republic of Congo (26%), Angola (24%) and Malawi (23%); and on the other hand, other Member States such as Namibia, Lesotho and Madagascar recorded less than a percentage point improvement in life expectancy over the last decade (see table 3).

Table 3: Life Expectancy in the SADC Region

SADC Member States	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	Percent change since 2008
Angola	49.9	48.2	48.4	48.6	48.7	48.9	60.3	61.2	61.5	61.7	62.0	24%
Botswana	52.8	53.2	53.3	68.0	68.0	68.0	68.0	68.0	69.0	67.0	68.0	29%
Comoros	66.2	66.5	66.8	67.1	67.4	67.6	67.9	68.1	68.3	68.5	68.7	4%
DRC	47.6	47.8	48.1	48.4	48.7	56.0	56.0	59.1	59.1	59.1	60.0	26%
Eswatini	45.2	45.1	45.1	45.2	45.3	45.5	45.6	45.7	45.8	61.2	58.0	28%
Lesotho	46.1	46.9	47.6	42.5	43.1	43.6	44.0	45.0	45.5	45.7	46.3	0%
Madagascar	65.9	66.2	66.5	66.7	66.9	64.7	65.2	65.5	65.7	65.8	66.0	0%
Malawi	47.6	51.7	52.5	53.4	54.3	55.1	56.0	56.8	57.6	58.4	58.6	23%
Mauritius	73.2	73.3	73.7	73.9	74.1	74.2	74.4	74.4	74.6	74.5	75.0	2%
Mozambique	51.3	51.7	52.1	52.4	52.8	53.1	53.5	53.8	54.1	53.7	55.0	7%
Namibia	61.1	61.7	62.2	56.9	56.9	56.9	56.9	57.5	59.0	60.0	60.2	-1%
Seychelles	72.9	72.9	73.2	72.6	74.2	73.1	73.2	74.2	74.0	74.0	74.0	2%
South Africa	56.0	57.4	58.9	59.9	61.2	61.8	62.5	62.8	63.2	63.9	64.2	15%
Tanzania	54.0	54.0	55.0	55.0	61.8	61.8	61.8	61.8	61.8	61.8	61.8	14%
Zambia	51.3	51.2	51.2	52.7	52.8	53.0	53.2	53.3	53.7	54.9	54.6	6%
Zimbabwe	47.2	48.6	50.0	51.4	60.7	60.7	60.7	60.7	60.7	59.7	61.4	30%
SADC Total	**52.4**	**52.9**	**53.5**	**54.0**	**55.9**	**57.8**	**59.0**	**60.0**	**60.2**	**60.4**	**61.0**	**16%**

Source: SADC selected economic and social indicators, 2018

Other population health indicators such maternal mortality also recorded some improvements from an average of 443 per 100,000 live births in 2008 to 367 per 100,000 live births in 2017. This represents 14% reduction in maternal mortality over the last decade (see table 4). However, in some Member States (example Malawi and Zimbabwe), no or just marginal improvements were recorded as compared to Botswana (24%) and Tanzania (23%) where the most gains were made in the SADC region. Related health indicators such skilled birth attendance rate, infant mortality and crude death rate per 1,000 people all recorded aggregate improvements over last decade but significant disparities are inherent across Member States owing to varying degrees of service coverage.

Table 4: Maternal mortality ratio (deaths per 100,000 live births) in SADC, 2010–2015

SADC Member States	2010	2011	2012	2013	2014	2015	Percent reduction between 2010 and 2015
Angola	561.0	546.0	526.0	509.0	493.0	477.0	15%
Botswana	169.0	159.0	153.0	139.0	134.0	129.0	24%
Comoros	388.0	376.0	365.0	354.0	344.0	335.0	14%
DRC	794.0	777.0	771.0	746.0	717.0	693.0	13%
Eswatini	436.0	418.0	400.0	413.0	400.0	389.0	11%
Lesotho	587.0	555.0	549.0	532.0	513.0	487.0	17%
Madagascar	436.0	420.0	402.0	384.0	369.0	353.0	19%
Malawi	629.0	618.0	624.0	636.0	638.0	634.0	-1%
Mauritius	59.0	51.0	54.0	54.0	54.0	53.0	10%
Mozambique	619.0	596.0	563.0	528.0	506.0	489.0	21%
Namibia	319.0	315.0	299.0	283.0	273.0	265.0	17%
Seychelles	N/A	N/A	N/A	N/A	N/A	N/A	N/A
South Africa	154.0	154.0	152.0	145.0	140.0	138.0	10%
Tanzania	514.0	483.0	464.0	438.0	418.0	398.0	23%
Zambia	262.0	251.0	243.0	237.0	231.0	224.0	15%
Zimbabwe	446.0	409.0	379.0	369.0	401.0	443.0	1%
SADC Region	**424.9**	**408.5**	**396.3**	**384.5**	**375.4**	**367.1**	**14%**

Source: Adapted from SADC selected economic and social indicators, 2018

Universal Health Coverage (SDG 3 target 3.8), generally defined as all persons receiving the health services that they require, ranging from health promotion through prevention, curative, to rehabilitative and palliative care which is effective and of good quality; delivered to the population without imposing the risk of catastrophic financial expenditure to people at the point of care (WHO, 2015). Globally, UHC is monitored using a defined index based on tracer indicators across four dimensions: reproductive, maternal, new-born and child health; infectious disease; non-communicable diseases; and service capacity and access (WHO and World Bank, 2015, 2019).

In the 2019 monitoring report, the UHC index for the SADC Member States ranged from as low as 28% in Madagascar to as high as 71% in Seychelles, the average being 48%. Thus, on average, only 48% of the population in the SADC region can reliably obtain the services they need which are of good quality and without pushing them into poverty. About 33% of SADC Member States are below the regional average whereas 67% of Member States are above the regional average. Thus, it is evident that there are still some gains to be realised for Member States to achieve UHC by 2030.

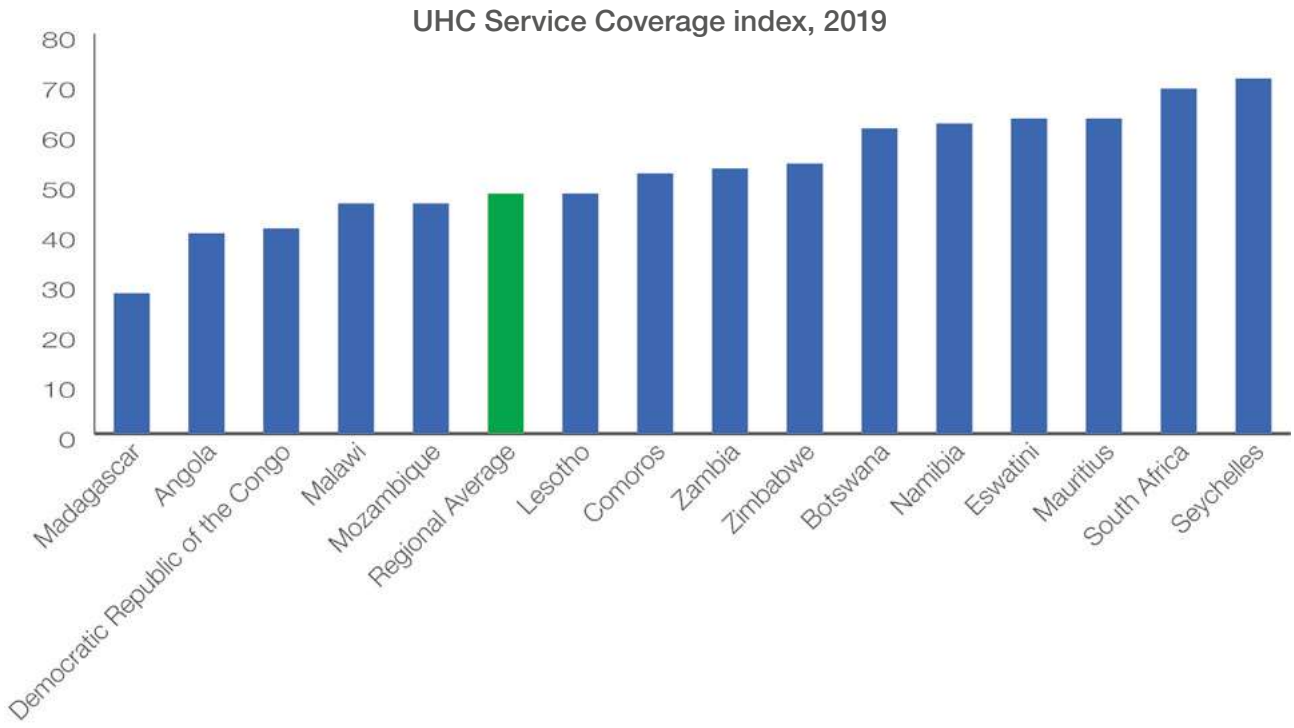

Figure 3: SADC UHC Service Coverage Index

Source: WHO/World Bank 2019 UHC Monitoring report

2.5 Health Workforce Situation across the SADC Member States

The Africa Region of the WHO which has 47 countries including all the SADC Member States has recorded a 13% increase in the numbers of nurses, doctors and midwives between 2005 and 2015. However, the Region continues to face a critical shortage of health workers as just 11 (23%) of the countries had at least 2.3 doctors, nurses and midwives per 1000 population by the end of 2015.

Globally, the Region bears about 25% of the disease burden but with less than 5% of the global health workforce (World Health Organisation, 2016a). It is estimated that this current shortage of health workers may not be significantly bridged if much-concerted efforts to tackle underinvestment in the workforce are not made. Africa's shortage of health workers is projected to be around 6.1 million by 2030 – including 1.1 million physicians, 2.8 million nurses and midwives, and 2.2 million of other cadres (Cometto et al, 2017). Whereas some 3.1 million health workers are projected to be produced, absorption capacity (economic demand) could limit employment to only 2.4 million, leaving around 700,000 health workers who are trained and "needed" but unemployed/underemployed by 2030, because governments may not have the funding required to absorb and deploy them. This raises the issue of "paradoxical surplus", which occurs where health workers are trained and needed but governments lack the fiscal capacity to absorb them into the service delivery structures (Asamani, et al., 2019). The following sections explore this phenomenon and its contributory factors in the context of the SADC region, and sets out the evidence base for a set of proposed strategy and policy interventions to address these challenges.

2.5.1 Health Workforce Stock in the SADC Region

Based on data obtained from the WHO/AFRO Survey 2018, it is estimated that the SADC region has about 689,342 doctors, nurses, midwives and associates. Across the Member States, there are wide variations in the density of medical doctors, dentists, midwives, and nurses, ranging from 0.9 to 120 per 10,000 population (see table 5). The average density of medical doctors, dentists, midwives, and nurses per 10,000 population is about 19.3 as compared to the global threshold of 45 per 10,000 deemed necessary to make sustainable progress towards universal health coverage (UHC) by 2030.

Considerable uncertainty is inherent in the aforesaid estimates given that the quality of the is not satisfactory. Nonetheless, the data is similar to those reported in various regional and global reports and in some cases was supplied by the Member States. The data, despite its quality concerns with a resulting imprecise estimate, is indicative of several challenges for example unequal production capacities, unharmonized conditions of employment including remuneration, poorly managed migration of health personnel and less than optimal funding of the health systems in Member States.

Table 5: Selected Health Workforce Stock and Densities in the SADC Member States – 2018 – a

Member State	No. Dentists & Associates	No. Medical Doctors	Total No. Doctors, Dentist & Associates	No. Nurses & Associates	No. Midwives & Associates	Total No. Nurses, Midwives & Associates	No. of Pharmacists, Technicians & Associates	Year	Grand Total No. Nurses, Midwives, Pharmacists, Dentists and Doctors	Population	Density: Per 10,000 Population	Data Source
Angola	856	6593	7449	46082	1438	47520	2302	2018	57271	32 866 000,00	17.4	WHO/AFRO
Botswana	94	853	947	6935	n.a.	6935	487	2018	8369	2 352 000,00	35.6	WHO/AFRO
Comoros	32	220	252	747	487	1234	55	2018	1541	16 426 000,00	0.9	WHO/AFRO
DRC	404	31546	31950	103785	3642	107427	1687	2018	141064	89 561 000,00	15.8	WHO/AFRO
Eswatini	74	278	352	2204	14	2218	281	2018	2851	1 160 000,00	24.6	WHO/AFRO
Lesotho	159	998	1157	8245	496	8741	398	2018	10296	2 142 000,00	48.1	WHO/AFRO
Madagascar	556	5230	5786	4560	3164	7724	329	2018	13839	27 691 000,00	5.0	WHO/AFRO
Malawi	112	2760	2872	6025	n.a.	6025	387	2018	9284	19 130 000,00	4.9	WHO/AFRO
Mauritius	466	2395	2861	4419	567	4986	748	2018	8595	1 270 000,00	67.7	WHO/AFRO
Mozambique	545	2180	2725	7961	5820	13781	2310	2018	18816	31 255 000,00	6.0	WHO/AFRO
Namibia	289	1445	1734	12956	n.a.	12956	907	2018	15597	2 541 000,00	61.2	WHO/AFRO
Seychelles	152	240	392	645	4	649	135	2018	1176	98 000,00	120.0	WHO/AFRO
South Africa	6816	43503	50319	287458	n.a.	287458	16195	2018	353972	59 309 000,00	59.7	WHO/AFRO
Tanzania	682	2885	3567	31940	n.a.	31940	1845	2018	37352	59 734 000,00	6.3	WHO/AFRO
Zambia	455	2026	2481	14516	3432	17948	1708	2018	22137	18 384 000,00	12.0	WHO/AFRO
Zimbabwe	347	1959	2306	25835	854	26689	776	2018	29771	14 863 000,00	20.0	WHO/AFRO
SADC Region	**12039**	**105111**	**117150**	**564313**	**19918**	**584231**	**30550**	**2018**	**731931**	**378 782 000**	**19.3**	

Table 6: Selected Health Workforce Stock and Densities in the SADC Member States – 2018 – b

Member State	Environmental and occupational health & hygiene workers	Community health workers	Medical assistants – clinical officers	Paramedical practitioners	Dieticians and nutritionists	Health care assistants and other personal care workers	Health service managers	Medical and dental prosthetic technicians	Medical and pathology laboratory technicians	Medical imaging and therapeutic equipment operators	Year	Data Source
Angola	657	1 680	134	56	n.a.	n.a.	328	75	98	789	2018	WHO/AFRO
Botswana	99	n.a.	n.a.	58	n.a.	1 622	n.a.	n.a.	460	78	2018	WHO/AFRO
Comoros	389	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	8	498	2018	WHO/AFRO
DRC	167	n.a.	n.a.	n.a.	535	n.a.	2 651	n.a.	2 934	338	2018	WHO/AFRO
Eswatini	187	6 324	28	29	n.a.	927	195	n.a.	370	47	2018	WHO/AFRO
Lesotho	144	14 508	71	4	29	849	110	10	205	41	2018	WHO/AFRO
Madagascar	15	35 000	n.a.	n.a.	414	311	411	52	306	214	2018	WHO/AFRO
Malawi	35	10 016	2 804	98	25	178	178	n.a.	542	44	2018	WHO/AFRO
Mauritius	48	180	9	24	n.a.	1 153	315	12	291	213	2018	WHO/AFRO
Mozambique	n.a.	2 205	n.a.	n.a.	n.a.	n.a.	2 466	29	1 951	206	2018	WHO/AFRO
Namibia	218	2 292	21	1 053	33	n.a.	313	470	510	303	2018	WHO/AFRO
Seychelles	69	n.a.	n.a.	36	5	258	0	11	54	3	2018	WHO/AFRO
South Africa	3 585	54 180	577	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	8 072	2018	WHO/AFRO
Tanzania	578	n.a.	9 250	1 963	148	25 803	633	73	4 361	681	2018	WHO/AFRO
Zambia	2 016	1 262	2 617	n.a.	404	n.a.	n.a.	n.a.	1 602	602	2018	WHO/AFRO
Zimbabwe	1 644	2 143	76	1 094	n.a.	2 115	327	10	648	412	2018	WHO/AFRO
SADC Region												

Table 7: Selected Health Workforce Stock and Densities in the SADC Member States – 2018 – c

Member State	Optometrists and opticians	Physiotherapists and physiotherapy assistants	Other health management and support workers	Other health service providers	Other science professionals and technicians	Social workers	Traditional and complementary medicine practitioners	Year	Data Source
Angola	56	1 156	28 324	n.a.	468	n.a.	16 380	2018	WHO/AFRO
Botswana	1	38	n.a.	20	n.a.	n.a.	n.a.	2018	WHO/AFRO
Comoros	n.a.	n.a.	44	115	161	n.a.	n.a.	2018	WHO/AFRO
DRC	n.a.	395	74 310	1 608	n.a.	n.a.	n.a.	2018	WHO/AFRO
Eswatini	12	29	1 215	85	84	n.a.	7	2018	WHO/AFRO
Lesotho	8	22	2 130	58	416	n.a.	6 097	2018	WHO/AFRO
Madagascar	56	99	6 355	n.a.	n.a.	n.a.	602	2018	WHO/AFRO
Malawi	13	52	n.a.	n.a.	n.a.	n.a.	n.a.	2018	WHO/AFRO
Mauritius	n.a.	64	3 295	n.a.	274	n.a.	5	2018	WHO/AFRO
Mozambique	147	377	26 735	n.a.	5 726	n.a.	n.a.	2018	WHO/AFRO
Namibia	147	233	2 157	n.a.	1 739	509	8	2018	WHO/AFRO
Seychelles	25	33	n.a.	31	4	n.a.	n.a.	2018	WHO/AFRO
South Africa	n.a.	11 975	n.a.	15 266	8 415	n.a.	n.a.	2018	WHO/AFRO
Tanzania	213	103	n.a.	3 630	3 028	n.a.	15 200	2018	WHO/AFRO
Zambia	61	606	17 801	n.a.	n.a.	n.a.	n.a.	2018	WHO/AFRO
Zimbabwe	n.a.	459	9 502	1 122	368	n.a.	5	2018	WHO/AFRO
SADC Region									

2.5.2 Health Workforce Needs and Supply Gaps

Using the trend of the density of doctors, nurses and midwives (which are based on data availability), a linear extension was conducted to provide a rough estimate of the future supply of doctors, nurses and midwives if current levels of production continue. The observed trend in the SADC region was consistent with the overall trend of 13% increase between 2005 and 2015 in the African Region.

As shown in table 5a, it is estimated that in 2018 the SADC region had about 689,342 doctors, nurses, midwives and associates which may reach 728,698 by 2020 and 975,791 by 2030 as a result of scale-up programmes in health workforce production. However, there are expected cross-country variations in the level of production in that some countries are likely to train more than the projected numbers while others may train less.

Using the HWF SDG-index which is a threshold density of 4.45 doctors, nurses and midwives per 1,000 population established in the Global Strategy on Human Resource for Health by WHO as the minimum requirement towards UHC, it is estimated that the SADC region collectively required at least 1.6 million doctors, nurses and midwives by 2020, which it is estimated to increase to at least 2 million by 2030.

Compared with the potential supply, SADC will, by 2020, supply only 51% of its needs. It has the potential to improve its supply capacity to 56% by 2024 and 66% by 2030. Although existing training capacity could potentially meet almost 66% of need (in aggregate terms), given the prevailing trends in HRH investments, reduced budgets, and cost containment across the region, those that are likely to be employed from the supply be around 33% of the number needed by 2030 using the SDG-index benchmark.

Table 8: SADC Needs and Supply gaps for Doctors, Nurses and Midwives

SADC Member States	2020			2024			2030		
	Minimum Need	Estimated Supply	Workforce Ratio	Minimum Need	Estimated Supply	Workforce Ratio	Minimum Need	Estimated Supply	Workforce Ratio
Angola	136,599	59,240	✗ 43%	151,054	70,999	✗ 47%	172,454	93,153	! 54%
Botswana	13,213	8,761	! 66%	14,052	11,086	✓ 79%	15,321	15,782	✓ 103%
Comoros	4,933	1,587	✗ 32%	5,395	1,891	✗ 35%	6,077	2,460	✗ 40%
DRC	429,300	144,380	✗ 34%	469,312	155,834	✗ 33%	531,130	174,741	✗ 33%
Eswatini	6,473	2,714	✗ 42%	6,690	3,209	✗ 48%	7,040	4,125	! 59%
Lesotho	11,510	10,590	✓ 92%	12,196	12,520	✓ 103%	13,073	16,096	✓ 123%
Madagascar	115,840	14,085	✗ 12%	126,612	16,653	✗ 13%	142,560	21,410	✗ 15%
Malawi	82,937	9,552	✗ 12%	91,334	11,294	✗ 12%	103,815	14,519	✗ 14%
Mauritius	7,074	8,004	✓ 113%	7,113	9,411	✓ 132%	7,181	11,999	✓ 167%
Mozambique	130,824	17,001	✗ 13%	143,880	19,289	✗ 13%	162,926	23,311	✗ 14%
Namibia	14,038	15,659	✓ 112%	14,553	18,514	✓ 127%	15,462	23,801	✓ 154%
Seychelles	3,142	947	✗ 30%	3,333	1,074	✗ 32%	3,588	1,298	✗ 36%
South Africa	264,388	343,704	✓ 130%	280,061	370,681	✓ 132%	303,403	415,167	✓ 137%
Tanzania	250,679	40,308	✗ 16%	276,771	54,000	✗ 20%	313,985	83,734	✗ 27%
Zambia	79,299	21,276	✗ 27%	87,426	24,139	✗ 28%	99,765	29,172	✗ 29%
Zimbabwe	68,575	30,890	✗ 45%	73,796	35,913	✗ 49%	81,687	45,021	! 55%
SADC Total	**1,618,825**	**728,698**	**! 51%**	**1,763,579**	**816,508**	**! 56%**	**1,979,469**	**975,791**	**! 66%**

The foregoing presents an emerging challenge where in some SADC Member States where there are inadequate funded positions to absorb trained health workforce even though there are substantial normative staffing gaps – the paradox of surplus health workers within a country with a critical need-based shortage. In the self-assessment and consultative process, Member States indicated that in some instances, trained health workers have remained unemployed for periods between one and three years before being absorbed. This also raises an additional concern of how to keep the practical skills of health professionals up to date when they remain unemployed for such a considerable period.

During the technical consultations, most Member States indicated that delayed and limited absorption of newly trained health workers had become pressing policy issues in their context, which was mainly attributed to limited post establishments (funded positions) as a result of budgetary constraints and sometimes restrictive and outdated staffing norms/standards. Some countries were mitigating this delay by offering internships to new graduates and would employ as and when vacancies and funding become available. The participants of the ILO tripartite technical workshop for the SADC region pointed towards the general mismatch between demand for and supply of health workers (ILO, 2019). To compensate for workforce gaps, sometimes excessive overtimes are used which may at the same time constitute a constraint for job creation in the health sector. The foregoing therefore calls for country-specific robust labour market analysis and investment cases for enhanced policy and social dialogue to prioritise health workforce employment across the sector as a whole, including the NGO and private sectors.

2.5.3 Health Workforce Leadership, Governance and Policy

This section covers the areas of leadership, advocacy, policy, and governance. The leadership and advocacy dimension covered five items which include human resources for health (HRH) prominence within respective Ministries of Health; political support for HRH; the influence of HRH leaders or champions; strength of an HRH observatory, stakeholder or technical working group and media coverage for HRH.

Strengthening leadership and governance capacity entails improving policy dialogue and establishing clear mechanisms for coordination between line ministries, the private sector and other stakeholders (Afriyie et al., 2019). The WHO Regional Roadmap for scaling up human resources for health in Africa (WHO, 2012) identifies weak governance and leadership for HRH as a priority area for intervention. A well-functioning health system with equitably distributed healthcare infrastructure underpinned by transparent and accountable leadership and governance has been shown to influence staff motivation and acceptance of postings to district and sub-district levels (Lehmann et al., 2008). Appropriate and sustained leadership skills have been linked to increasing staff productivity and retention (Asamani et al., 2016).

During technical consultations, SADC Member States who responded to the self-assessment indicated an HRH prominence in their respective Ministries of Health where a permanent HRH office or post within the Ministry of Health develops and monitors HRH policies and strategies. However, some Member States indicated challenges with high mobility of HRH leaders within the public service (i.e. frequent changes to administrative leadership) which has an adverse impact on continuity and capacity. It was also gathered that Member States make use of Technical Working Groups / Observatory / HRH Committees (however named) as a mechanism for stakeholder coordination and policy dialogue. However, while some countries mentioned that these bodies are vibrant, have sub-committees and have regular meetings, others indicated that these bodies may have the inadequate capacity and not optimally institutionalised. Additionally, countries had various degrees of engagement with other sectors including non-governmental organisations.

A recent analysis by the WHO Regional Office Africa demonstrated that by 2014, only 14 out of 47 countries (about 30%) in the Africa Region had comprehensive and costed HRH plans in place, the majority had some drafts many of which remained for long (Afriyie et al., 2019). Consistent with this finding, a considerable number of SADC Most Member States during the consultations indicated that they had no current, comprehensive and costed HRH strategic plans in place. In most SADC Member States, the plans were either in draft form or processes were being initiated to develop/review the HRH plan. Member States indicated that while their HRH strategy is informed by analysis of country-level data, the implementation of these plans is often constrained due to limited funding available.

2.5.4 Education and Training Efforts

Over the last decade, there has been 4% to 13% scale-up in the training of health workers which is similar to the overall African average. Indeed, all Member States who participated in the technical consultation indicated that there have been efforts to scale-up their supply pipelines through the training and deployment of health workers, which has led to improvements in health workforce density. Two-thirds of Member States who responded indicated the existence of a comprehensive approach to health workforce education through existing training plans which are gender-responsive in terms of equal access to training.

In terms of quality of health workforce training, Member States indicated the availability of quality curricula that align with national health priorities, but inadequate faculty, infrastructure, equipment, and practice sites tend to pose a challenge in translating the curricula into an acquired skill for the students/trainees. Across the Member States, various regulatory bodies conduct monitoring exercises to ensure quality assurance standards related to training are met. Nevertheless, Member States indicated and registered concern regarding the variations in the quality of training; and requirements for professional recognition / registration for similar health worker categories across the SADC region. Some regulatory bodies, under the auspices of SADC, have therefore begun to work towards harmonizing their regulatory frameworks for the licensing of health professionals.

Owing to inadequate faculty as well as limited capacity to train adequate health workers, especially for the highly skilled and specialized medical professionals, some Member States (especially small population countries) rely on training abroad (from which some of the trainees do not return upon completion of their studies) and also in recruiting health workers from other countries. None or extremely limited information was immediately available on training slots (theoretical capacity) per programme by country as well as graduation and certification rates. However, in one-third of SADC Member States, it was indicated that student drop-out rates were low, between 3% and 6% - the most cited reasons for the drop-outs was lack of financial resources.

To mitigate cases of extreme financial barrier to health workforce training, it was gathered that most governments of SADC Member States allocate some funding for both pre-service and in-service education, including Continuing Professional Development (CPD). Member states further asserted that the allocation of funding is based on training needs assessments to identify training gaps. These are, however, mostly focused on clinical areas while managerial and administrative related training appears neglected.

2.5.5 Absorption, Distribution and Retention

Member States self-reported based on their country contexts, issues and challenges relating to how the analysis of shortages and labour market dynamics are undertaken; absorption of pre-service education graduates; effectiveness (and transparency) of health workforce recruitment strategies; effectiveness of health worker deployment and distribution strategies and the effectiveness of health worker retention strategies.

Seventy-seven per cent (77%) of Member States indicated that their national recruitment and distribution of the health workforce is based on HRH planning and is linked to public service statutes. However, most Member States underscored significant financial constraints in rapidly employing / absorbing health workers soon after graduation, an observation that corroborates empirical analysis in the previous section. Member States believed that their recruitment processes are transparent albeit linked to the broader public service policies and procedures which has inherent layers of bureaucracies that inhibit the speed of recruitment.

Globally, equity in the distribution of health workers is a lingering thorny issue which is influenced by political decisions, wages/salaries, social living conditions and individual health worker factors, among others. In the context of Africa, it was previously estimated that 29-53% of all health workers are not equitably distributed whilst over 90% of pharmacists, 86% of medical specialists, 63% of general physicians and 51% of nurses/midwives work mainly in urban areas (WHO/AFRO, 2006). During the technical consultations for this strategic plan, Member States acknowledged worrying levels of inequities in health workforce distribution, especially in underserved areas. In addition, 55% of SADC Member States indicated a need for evidence-based deployment and distribution strategies in their respective countries. Only a few countries have used evidence-based tools such as Workload Indicators of Staffing Need (WISN) as a guideline for the equitable redistribution and deployment of health workers.

All Member States indicated that retention and staff turnover in underserved and hard to reach areas remains a problem, and while countries have some form of rural and remote incentive scheme, there is a need for the strategy to be reviewed. Further emphasis was placed on the migration of higher-skilled health professionals to other countries and the private sector which continues to deplete the existing workforce stock.

2.5.6 Human Resources Management

The dimension for Human Resources Management includes: human resources management (HRM) leadership capacity and availability; existence and availability of human resource manuals/guidelines; performance management practices; performance evaluation and results; career development; health workforce occupational safety and health (OSH) strategy; non-discrimination, equal opportunity, and gender equality in the workplace and enabling health workforce performance and productivity.

All Member States indicated the existence and availability of human resource functions, processes, manuals and/or guidelines, albeit linked principally to public service rules and regulations. However, most countries expressed concerns over the insufficient numbers of HRM leaders across the sector and inadequate capacity and training of HRM practitioners and managers, especially at sub-national and district levels. Most countries indicated that issues with performance management and health worker productivity levels were regarded as suboptimal and associated measures, rewards and sanctions were applied ineffectively. In terms of career development, some Member States indicated a need to develop and strengthen career pathways for various professional cadres. Additionally, some countries indicated that career development is based on merit, health facility needs and individual healthcare workers' preferences.

All Member States indicated the existence of a national occupational health and safety (OSH) strategy that covers the broader public service, under the responsibility of the Ministries of Labour. However, there are few OHS programmes and strategies that are specific to the unique context and operational environment of the health sector. This is an area requiring attention is given to the emerging occupational health and safety risks of COVID–19 International Health Regulations (IHR), international labour standards, such as the Occupational Safety and Health Convention, 1981(No. 155), and the Violence and Harassment Convention, 2019 (No. 190), and related public health emergency measures.

2.4.7 Gender

Member States indicated that they aim to ensure equitable and fair practices with respect to the gender of the health workers. Nevertheless, gender disparities in the health workforce remain an issue for many countries. A key theme of the SADC health workforce strategic plan will be to guide member states to identify, address and eliminate gender inequities, notably as they relate to participation, occupational segregation by gender, leadership, decent and safe work including bias and discrimination in the workforce, as well as the working environment, and gender pay gaps. A first step in addressing this is by mainstreaming gender equality, equity, rights, protection and economic participation throughout this strategic plan. In some instances, where pervasive gender gaps exist an explicit gender analysis may be necessary to inform the needed policy measures to achieve gender balance – with measurable targets and indicators.

Additionally, to advocate member states to collate and use workforce profile data disaggregated by gender/sex and other aspects of personal identity (i.e. ethnicity, language) in all policy, decision making and reporting processes. Proposed investment in the health workforce should be cognizant of the need to promote gender-responsive policy across and opportunities for gender transformative change. Including, but not limited to key areas, such as: equal pay and the recognition of unpaid and underpaid work in the health and social sector; decent work – with respect to the work environment, safety and protection; equal access and opportunities in training, education recruitment and promotion; and eliminating harassment, violence, and sex discrimination in the workplace, all of which have an important gender component.

2.5.7 Accreditation and Regulation

All Member States indicated the existence of professional councils that regulate licensing and certification. These professional bodies also ensure that health worker classifications and their related scopes of practice are recognized and defined. Most Member States who responded indicated that health workers need to demonstrate CPD credits to ensure certification and re-licensure and that this is done through the various professional bodies in their countries. However, countries indicated a need to strengthen this process or a specific coordination programme to be developed to ensure that the criteria are applied to all health workers consistently.

Member States also expressed concerns about lack of uniformity and inconsistencies in the standards of training health professionals and requirement for professional licensing across and between member states. It was noted that efforts to establish a harmonized health professions regulatory mechanism are being initiated by SADC, which is timely and hopefully will be expanded to cover all health professions. This is an important initiative by SADC which will be used as a foundation for the regional recruitment pool.

2.5.8 Monitoring, Evaluation, and Information Systems

Some Member States indicated various degrees of efforts aimed at improving the availability and use of health workforce data, information, and evidence. The main challenge in this area has been weak technical capacity and lack of or poorly implemented Human Resources Information Systems (HRIS). Unfortunately, there no comprehensive data on the sector as a whole; incomplete data; limited integration and interoperability of data sets. Many countries indicated that monitoring and evaluation relating to the health workforce is not fully institutionalised. In line with the various World Health Assembly resolutions to strengthen health workforce data and evidence, most Member States were at various initial stages of implementing National Health Workforce Accounts (NHWA).

2.5.9 The Impact of COVID–19 Pandemic on Health Workers

Health workers face several occupational risks in their daily work. These include, for example, risks associated with biological, chemical, physical, ergonomic, and psychosocial hazards thus increasing the risk of occupational disease and injury on them, patients, quality of care and the overall resilience of health systems at risk. The COVID–19 pandemic exacerbated these risks and highlighted the need for strong occupational safety and health measures and policies in addition to infection prevention and control measures. At the beginning of 2020, the SADC region reported its first case of the COVID–19 disease. The pandemic has since spread rapidly across many countries in the region, impacting severely on their economies, health systems, and society. As of 1 September 2020, accumulative total of 1 056 448 COVID–19 cases was reported in the region of which 860 927 (82%) have recovered from the disease. The SADC region has the highest number of registered cases 66% (701,146) in Africa. South Africa has registered more than half, 59% (628,259) of all reported confirmed cases in the region. Furthermore, there is an increase in infections among health workers. About 27,736 health worker infections have been reported in 14 countries in SADC region since the beginning of the outbreak. Overall, South Africa has been the most affected, with 25,841 of its health workers infected as of 2nd September 2020.

Although the impact of COVID–19 on health workers has not been fully evaluated, is cause for concern for the SADC region. It is the frontline healthcare workers that face a substantially higher risk of infection and death due to excessive COVID–19 exposure (Shaukat et al, 2020). The pandemic has also highlighted the extent to which protecting health workers is key to ensuring patient safety as well as a functioning health system and a functioning society (WHO, 2020). This therefore emphasizes the critical need to ensure they have access to personal protective equipment, the latest infection prevention and control protocols, regular testing, and ultimately are prioritized as a key group for accessing COVID–19 therapeutics, treatments and vaccines through the Access to COVID–19 Tools (ACT) Accelerator and COVAX initiatives when initial supplies are readily available. Their high risk of exposure causes considerable mental stress, resulting in high levels of anxiety and post-traumatic stress disorders with nurses being the most affected (Chersich et al, 2020). Other envisaged implications include increased workload leading to potential burnout, declined enrollment in health training programmes, among others. Figure 4 shows the number of health workers infected in the SADC region.[3]

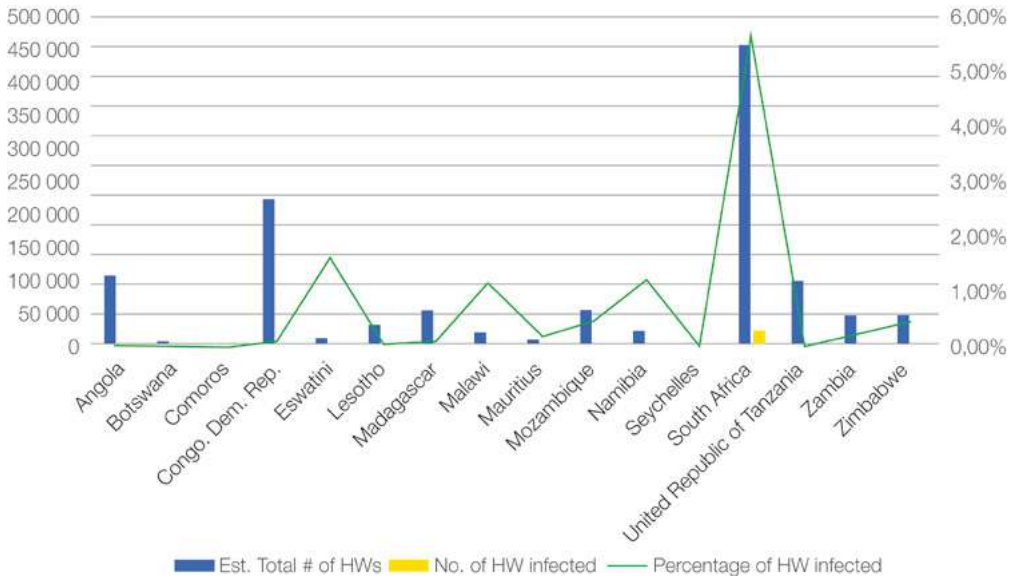

Figure 4: Health Worker COVID–19 infections in SADC region

Source: WHO COVID–19 External Situation Report 27

[3] Source: WHO COVID–19 External Situation Report 27

In September 2020, WHO released Health Worker Safety Charter that provides guidelines on how to ensure that health workers have the safe working conditions, the training, the pay and the respect they deserve. The Charter calls on governments and other actors providing health services at local levels to take five actions to better protect health workers. These include steps to protect health workers from violence; to improve their mental health; to protect them from physical and biological hazards; to advance national programmes for health worker safety, and to connect health worker safety policies to existing patient safety policies.[4] In light of the above emerging implications of COVID–19 on the health workforce, it is recommended that SADC prioritizes a rapid assessment on the impact of COVID–19 on health workers by mid-2021 and adopt additional interventions to address the impact of COVID–19 on the health workforce in the region.

2.6 Framework for the SADC Health Workforce Resource Pool

Rationale for a SADC Resource pool: Whilst Member States of SADC continues to train a significant number of health professionals, the challenge of excessive health workforce migration is also a challenge where some health workers seek employment in better resourced health systems outside their countries of origin. However, despite the importance of health worker migration, estimates remain imprecise, hampered by poor administrative data collection (Azose, 2019). Also, some Member States do not have adequate domestic capacity to train certain cadres of health workers at graduate and post-graduate level especially medical specialists (SADC 2019). They thus depend on external recruitment to fill critical health workforce gaps health service delivery. This has led to a decision by SADC Member States to develop a mechanism for a health workforce pool where countries that cannot produce locally can recruit from others. It is envisaged to be applicable for both specialist and non-specialist health professionals.

There are existing guiding protocols which relate to the recruitment of health personnel e.g. Commonwealth Code of Practice for the International Recruitment of Health Workers (2003), Kampala Declaration (2008), and the WHO Code of Practice on the International Recruitment of Health Personnel (2010). The WHO Code was influenced by the uncontrolled health personnel migration experiences of developing countries and provides a backdrop for a SADC regional framework on intercountry recruitment. Relevant international labour standards on labour migration also apply, including the Migration for Employment Convention (Revised), 1949 (No. 97) and Migration for Employment Recommendation (Revised), 1949 (No. 86); the Migrant Workers (Supplementary Provisions) Convention, 1975 (No. 143) and Migrant Workers Recommendation, 1975 (No. 151); the Private Employment Agencies Convention, 1997 (No. 181), and the Maternity Protection Convention, 2000 (No. 183).

The Africa Health Strategy 2007 – 2015 identified, inter alia, the following workforce related challenges as contributing to the efforts to reduce the disease burden being undermined: a shortage of appropriately trained and motivated health workers, capacity of the private sector including non-governmental organisations not fully mobilised; lack of intersectoral action and coordination; and gaps in governance and effective leadership of the health sector. These factors will play a role in the applicability and relevance of the envisaged SADC health workforce recruitment pool.

[4] Source: WHO's Health Worker Safety Charter, September 2020

A likelihood exists that the establishment of a regional recruitment tool may have an impact on health worker migration patterns. There is no existing evidence which points to any SADC country having developed a monitoring system for health worker migration (Mahlathi & Dlamini, 2015). This therefore necessitates that the SADC Secretariat becomes the best placed organisational unit to develop, manage, and monitor a regional recruitment pool. Whilst implementation and actual activity will be at country level, the integrity of the system will be the responsibility of the SADC Secretariat.

Guiding Principles: Whilst the AU Protocol to the Treaty Establishing the African Economic Community Relating to Free Movement of Persons, Right of Residence and Right of Residence objective is to facilitate the progressive implementation of free movement of persons, there is currently inhibitions regarding the ability of health workers to cross borders in search of work. The establishment of a regional health workforce recruitment pool will be guided by the following principles.

a. The SADC Secretariat is the custodian of the recruitment pool
b. In operationalising the recruitment pool, consideration is given to the WHO Code international labour standards and similar policy instruments that impact on SADC
c. The pool is established based on voluntary structured cooperation between two or more countries
d. The recruitment pool is developed and organised based on the underlying SADC and national legal frameworks, diplomatic and policy instruments
e. It allows for wide participation by various stakeholders e.g. health agencies, health care providers, education institutions, research institutions, regulatory / statutory bodies, or other relevant health sector actors
f. Each Member State must establish / strengthen and maintain an updated database of laws and regulations relating to the recruitment of health personnel including migration
g. Each SADC Member State must submit to the SADC Secretariat data relating to its health needs that justify the need to recruit from other Member States

Success Factors: This framework is an overarching mechanism, and its principles take precedence. Bilateral or multilateral arrangements predating this mechanism must be reviewed and harmonised with this framework. Voluntary bi- or multilateral cooperation agreements can help address the health workforce challenges that often force patients to travel outside their countries to find appropriate care (Kroezen et al, 2017).

Accreditation: relates to the recognition of education and training which leads to the accreditation of the health practitioner qualifications.

Diplomatic: relates to political relations between countries and within the region that create an enabling environment for cooperation to thrive.

Economic: relates to intercountry trade and economic relations that impact on health goods and services which in turn have considerable financial implications in areas like specialist care.

Legislative: relates to the institutional frameworks including legislative requirements of registered practitioners including policies on employment of non-resident health practitioners.

Social: encompasses several factors including organisational culture, language and socio-cultural practices that impact on communication and health seeking behaviours of the population.

Leadership: relates to the way the national health system and relevant organizational divisions are led influences staff attitudes and can act as either an attraction or repellent to health professionals, thus affecting the stability of the health workforce.

CHAPTER 03

STRATEGIC DIRECTIONS FOR THE HEALTH WORKFORCE IN THE SADC REGION

3.1 Introduction

SADC Member States have experienced a shortfall and continued underinvestment in the number, availability, and quality of their human resources for health. The causes for these have ranged from interrelated factors such as limitations in the coordination, integration and use of workforce planning and projection models to inform the delivery of essential services, and limited strategic management and development of the workforce; all of which contribute to persistent imbalances in skills mix, urban versus rural deployment, distribution, retention, and the effective utilisation of the workforce across member countries. These issues are further exacerbated by the impact of unregulated and uncoordinated health worker mobility and external migration – both between member states and beyond the SADC region. Against this background, and building on the previous SADC HRH Strategy with the view to deliver on the SADC region's collective future health and developmental priorities, and related SDG targets, this consolidated, evidence-based and costed SADC Health Workforce Strategic Plan provides the basis to implement investment to impact on health, skills, jobs and economic growth.

3.2 Theory of Change

SADC Health Workforce Strategic Plan's overarching goal is to ***enable investments by Member States in health workforce development and decent employment as a catalyst to achieving universal health coverage***. The achievement of this goal will be driven by interventions informed by a theory of change (TOC) anchored on three (3) key strategic catalysts namely ***accountability and data; partnership and dialogue***; and ***learning and decision making***. Figure 5 depicts interrelationship of facets of this Theory of Change. Below is operational description of these catalysts drawn from the recommendations of the Commission on Health Employment and Economic Growth (HEEG).

- **Accountability and Data:** Through the SADC Human Resources for Health Technical Committee, initiate and adopt a mechanism to inform evidence-based policy and decisions related to investments and efficient management of health workforce. Accountability would be achieved through robust data, research, and analysis of health labour markets, using harmonized metrics and methodologies to strengthen the evidence, accountability and action.

- **Partnership and Dialogue:** Denotes collaboration and dialogue with various sectors and stakeholders at national, regional, and international levels to support investments in the health workforce. For example, Member States are expected to institute a mechanism to enhance collaboration between ministries of health and labour to create an investment case for health worker skills, education, and jobs. Additionally, through enhanced collaboration between health sciences faculties in the region – including the designation of regional training centres of excellence where dedicated slots for specialised trainings will be reserved for Member States without such training capacity, standardised competency frameworks and professional regulatory mechanisms across the region among other interventions.

- **Learning and Decision-making:** This implies creating a policy and social dialogue platform under the SADC Human Resources for Health Technical Committee, where health workforce managers and social partners have the opportunity to shape the agenda, make collective decisions, and address key challenges by implementing priority workforce actions and interventions. This multi-stakeholder consultative and learning platform will also serve as a peer-to-peer support network and a key accountability mechanism for the strategy's implementation.

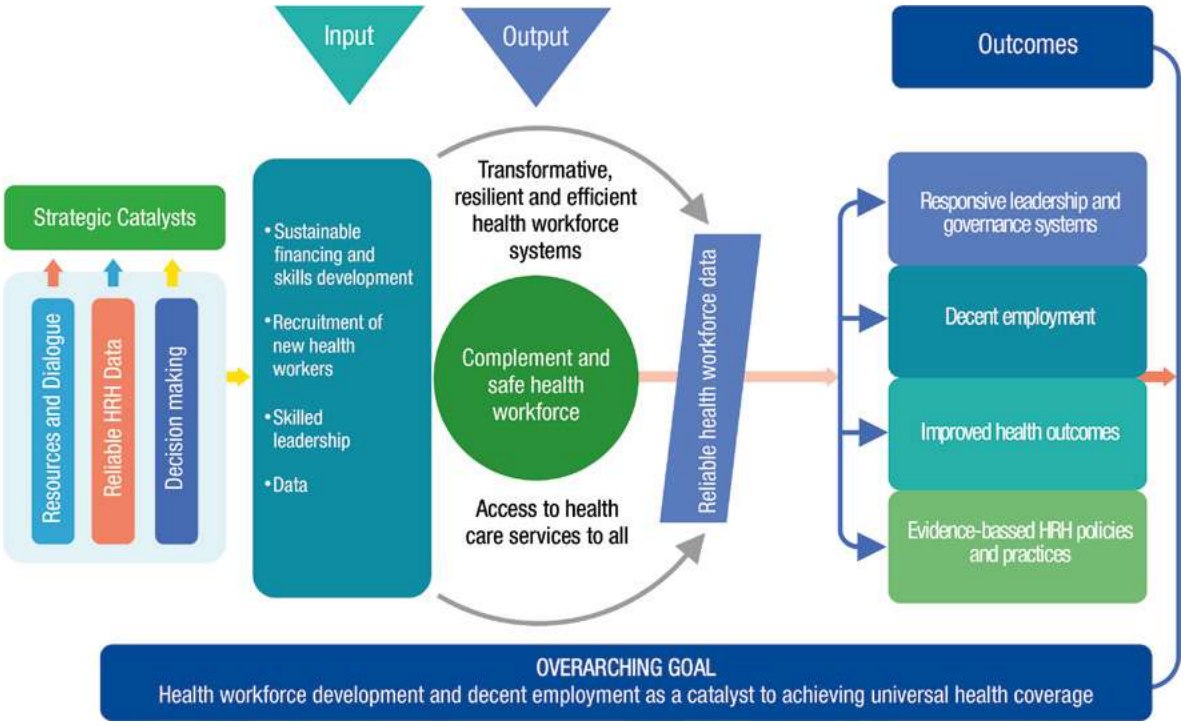

Figure 5: Theory of Change

3.3 Strategic Directions and Interventions

The SADC Health Workforce Strategic Plan 2020-2030 has five (5) strategic directions (SDs) namely (1) Invest in health worker jobs and decent employment, (2) Harmonise Education, Training and Development, (3) Establish best practices in strategic HRH Leadership and Management, (4) Enhance Health Workforce Governance and Regulation, and (5) Develop and Use Reliable Data, Monitoring and Evaluation Systems. Each strategic direction has a set of interventions that will inform resource allocation to actualize the plan. An implementation framework (chapter 4) details the steps, with timelines, that need to be taken by SADC Member States and partners.

3.3.1 Strategic Direction (SD) 1: Investment in health workforce jobs and decent employment

Employment and decent work in the health sector are fundamental for ensuring the effective functioning of resilient health systems; a prerequisite for addressing health workforce shortages and achieving equity in access to high-quality health services for all. This should include the planning, production and absorption of trained health workers and new graduates. Of equal importance is ensuring that these health workers are attracted, deployed, appropriately supported, enabled, retained, and adequately protected in community and facility settings where the need is greatest. It is equally important that the financing of HRH programmes and interventions for increasing jobs and skills are driven through significant investments that guarantee health, economic and developmental impact, and sustainability. The objective is to ensure adequate budget allocations by the Ministries of Finance and appropriate investments by Ministries of Health, labour, education, and other social sectors in programmes that will ensure the sustainability of HRH availability and investment to catalyse creation of decent jobs and improving skills, aligned to the country's National Human Resource for Health Strategy. This is premised on astute utilisation of existing resources through efficient investment in HRH. The following are key interventions to drive investments in health workforce jobs and decent employment.

SD1.1 Develop health workforce investment plans based on robust evidence that quantify health workforce needs, demands and supply that respond to the population's needs and economic realities.

SD1.2 Expanding the fiscal space for the health sector to enable increase investments in skilled health workforce, decent employment, and retention of health workers in line with the national health workforce investment plan.

SD1.3 Develop occupational health and safety policies and programmes that protect health workers from occupational hazards and risks in accordance with national legislation and backed by effective enforcement mechanisms in line with the relevant international labour standards, as well as the ILO–WHO Joint Global Framework for National Occupational Health Programmes for Health Workers.

SD1.4 Improve the working conditions and remuneration of health workers including competitive and gender-equitable salaries, guided by a SADC reference remuneration package, to improve retention and reduce turnover.

SD1.5 Mainstream gender equality in strategies and approaches to the health sector workforce. This includes strengthening policies and strategies to promote and ensure equal opportunities, participation and treatment of women and men, including equal remuneration for work of equal value, and the development of gender-responsive legislation, policies, and measures for a health sector workplace free from violence and harassment.

3.3.2 Strategic Direction (SD) 2: Harmonisation of Education, Training and Development

Quality education, training and continuing development are key ingredients of a functional health system. Member states should develop effective policies, aimed at facilitating the transition from education and training to work, with emphasis on the effective integration of young people into the health workforce. Ongoing improvements to ensure that the health workforce obtains and applies the relevant competencies and skills to meet current and future needs will assist in the provision of quality health care and services. It is, therefore, essential to develop and continuously improve the quality of education and training programmes to produce and enhance the future skills base and competencies of the workforce. The Member States will prioritise the following interventions for harmonisation of education, training, and development:

SD2.1 Harmonised accreditation of training programmes and health training institutions.

SD2.2 Scale-up the training of specialist health professionals in line with current and emerging population health needs in all Members States.

SD2.3 Ensure access to education opportunities in health based on principles of equality and affordability, inclusive of youth and women.

SD2.4 Strengthen cooperation and collaboration between health sciences faculties in the region – including the designation of regional training centres of excellence where dedicated slots for specialised trainings will be reserved for Member States without such training capacity.

SD2.5 Establish a SADC health workforce development scheme that will provide or facilitate the acquisition of competitive scholarships and research grants for health workforce research.

3.3.3 Strategic Direction (SD) 3: Develop and adopt best practices in strategic HRH Leadership and Management

A major reason for the prolonged and persistent health workforce shortages and underinvestment across the Member States is the lack of evidence-based planning, policy, and decision-making capability. To drive reforms and investment in the health workforce, a critical mass of enabled, competent, and skilled HRH managers, analysts and planners are needed to ensure that the Member States have the capacity for strategic human resource management, planning and development. This is to enable informed and evidence-based policy choices that translate into actionable implementation and investment plans for the health workforce. Efforts in this strategic direction are aimed at ensuring the development of systems and tools for improved systemic HRH leadership and management; as well as improving the capability and capacity of HR practitioners in planning, resourcing, developing, and managing the health workforce. Priority Interventions under this strategic direction include:

SD3.1 Establish (for Member States that do not currently have) HRH Departments/Directorates in MOH/Service delivery agencies to champion the mainstreaming of health workforce issues in all health policies and interventions at all levels of the health system.

SD3.2 Strengthen Member States capacity in health labour market analysis, HRH planning, development, and management through the application of evidence-based tools.

SD3.3 Institute a health workforce leadership capacity development training for HRH managers within the region.

SD3.4 Institute an annual SADC forum of health workforce managers and social partners dialogue to discuss progress and challenges in the implementation of priority interventions and also serve as peer-to-peer support and accountability mechanism.

SD3.5 Enhance collaboration and social dialogue between all relevant stakeholders and strengthen, at the national and regional level, coordination mechanisms among governments, workers, employers and other relevant stakeholders to promote decent work in the health sector.

3.3.4 Strategic Direction (SD) 4: Enhanced Health Workforce Governance and Regulation

Most health practitioner classifications are regulated. Thus, the way that the health professions are governed and regulated provides a major reflection on the influence they wield beyond formal structures. Profession-specific governance systems are partly where practitioners derive the associated professional authority through licensure and being guided by Codes of Ethics. The leadership of health workers must be immersed in improving governance systems and mechanisms in line with societal expectations and the application of best practices. SADC Member States have a responsibility to establish and enable regulatory mechanisms that provide oversight of all aspects of HRH, especially education, training, practice, and migration. The attainment of this strategic direction will be hinged on enabling health worker leaders to address the contextual challenges of evolving health priorities and systems by ensuring fair regulatory environments, development of competencies in policy development, management, and evidence generation. Member States will implement the following priority interventions to enhance health workforce governance and regulation:

SD4.1 Establish (for Member States that do not currently have) health workforce regulatory bodies for all health professions to uphold professional standards and safeguard public safety.

SD4.2 Develop a SADC framework with compliance criteria for mutual and reciprocal recognition of health professions education and qualification through the adoption of minimum curricula content and harmonisation of regulatory mechanisms.

SD4.3 Strengthen the health workforce governance structures through sharing of good practice and relevant WHO guidelines.

SD4.4 Institute mechanism to foster multisectoral collaboration and cooperation between the public and private sector to create synergies by sharing HRH resources.

3.3.5 Strategic Direction (SD) 5: Develop Reliable Data, Monitoring and Evaluation Systems

Member States continue to experience challenges with data collection, analysis, use, monitoring and evaluation. This is ascribed to a variety of factors including limited ICT, data inoperability capacity and reliance on manual systems. There are also challenges posed by the lack of advanced Human Resources Information Systems (HRIS) including systems that are inadequate to cater to their information requirements and demands. The SADC Member States should aim to apply robust evidence and data for guiding health workforce policy, planning and investment. In addition, they must regularly monitor and report on key HRH indicators and metrics across the region. This strategic direction seeks to guide the development of Human Resource Information Systems and capabilities across member states, with appropriate tools and guidelines for the efficient management of the health workforce. Member States will strengthen data, monitoring and evaluations systems through the following interventions:

SD5.1 Develop and/or strengthen human resource information system that is scalable and interoperable with routine health information systems.

SD5.2 Strengthen the implementation of National Health Workforce Accounts (NHWA) and Human Resources Observatories to improve data availability, quality and use for policy and decision making.

SD5.3 Improve multi-sectoral dialogue for improved management of the health workforce through the NHWA and HRH Observatories.

SD5.4 Develop the competencies of HRH staff through reliable tools and guidelines for monitoring and reporting on standard key HRH indicators and scorecards (country-specific and regional) across SADC member states.

SD5.5 Develop integrated metrics of health worker safety indicators and integrate with health information system.

CHAPTER 04

IMPLEMENTATION ARRANGEMENTS

The combined efforts of the Member States are required to adapt and implement this SADC Health Workforce Strategic Plan within their respective HRH, health, and broader national development strategies. The SADC secretariat will provide the accountability platform and mechanism for coordinating, monitoring, and reporting on the implementation of the strategy across member states.

4.1 Implementation Mechanism

The strategic plan implementation process should adopt a consultative multisectoral approach, involving different stakeholders including non-state actors (CSOs, FBOs/NGOs, private sector, development and Implementing partners), and state actors (government Ministries, Departments and Agencies) at the Member State level. The Health Workforce Strategic Plan will be implemented through member states' work plans, which set out and operationalise more detailed activities for priority interventions. Several structures and stakeholders will be key for ensuring accountability and implementation of the strategic plan. Collaboration between member states in terms of operationalising and implementing the strategic plan will be carried out through the SADC Human Resources for Health Technical Committee, with the SADC Secretariat playing and overall coordination role.

Political level: The SADC Ministers of Health will provide overall high-level policy guidance to inform the implementation of the strategic plan. This is expected to be particularly important because of the need to engage inter-sectoral collaboration with health and other key partners sectors/ministries such as education, labour, social welfare, finance, and foreign affairs, among others. The Ministers in charge of Health provide policy guidance, leadership, and accountability for implementation at Member State level.

Operational and technical level: The *SADC Secretariat*, through the SADC HRH Technical Committee will coordinate the implementation of the strategic plan. The Secretariat will also be responsible for implementing integrated interventions such as formulation of the regional protocol on health worker resource pool, and coordination of monitoring and evaluation activities. The Secretariat will provide regular progress reports and plans to the Ministers for decision-making and approval.

4.2 Role of the SADC HRH Technical Committee

The SADC HRH Technical Committee (SADC HRH Managers' Forum) will be the implementation arm of the SADC Secretariat for the purposes of operationalising this strategic plan. The Technical Committee has a key role in operationalizing the strategy and mobilizing resources and technical support as well as facilitate information sharing, mutual support, and multisectoral coordination between partners implementing HRH initiatives at a national level and between member states. The SADC Secretariat will ensure coordination and accountability for implementation through member states and will expedite the ratification of regional-specific protocols, development of enforcement mechanisms and appropriate institutional framework to facilitate implementation of the strategic plan.

The key responsibilities of the HRH Managers' Forum are provision of guidance and technical support. These are listed below:

- Act as a key link between Member States and the SADC Secretariat.
- Set a regional agenda for adoption and implementation of the workforce strategic plan.
- Monitor and evaluate the implementation of the strategic plan.
- Advise on operations research to identify evidence-based policy options.
- Promote the sharing of best practices across member states.
- Advance technical cooperation between countries on areas such as health workforce education especially curricula, regulation of the health professions, advice on evidence-based deployment and retention strategies.
- Promote gender mainstreaming in all aspects of health workforce including promotion of intersectoral collaboration at both regional and country level.
- Support Member States with training on health workforce modelling, planning, costing of national strategies on human resources for health and conducting health labour market analyses.

4.3 Role of the SADC Secretariat

The SADC Secretariat will develop a technical assistance (TA) plan to guide support to Member States requiring additional expertise to implement certain interventions. Its key responsibilities are advocacy and promotion of compliance by member states. These are highlighted below:

- Facilitate annual reporting by countries utilising a minimum set of core indicators of human resources for health, for monitoring and accountability for the Regional Strategy.
- Support Member States to establish and strengthen the quality and completeness of national health workforce data.
- Develop a SADC multilateral framework on health workforce mobility (or health workforce pool) as a mechanism for ethical cross-country recruitment of trained health workers within the SADC region.
- Adapt, integrate, and link the monitoring of targets in the Regional Strategy to the accountability framework of the UN Sustainable Development Goals.
- Present recommendations for regional action to be taken by Member States and relevant stakeholders.
- Promote the role of multisectoral partnerships at country level by encouraging regular formal engagement with sectors like education, social welfare, treasury, labour, donors whilst at regional level this would include for example bodies like WHO, International Labour Organisation, and others.

Member State (MS) level: The Ministries or Departments of Health will coordinate with key sectors including the labour, employment, education and other social sectors on the implementation of this strategic plan, with a specific focus on securing domestic and donor resources and investments for its implementation; with an emphasis on mobilizing additional funds to drive investments in skills, education and jobs, and to empower the economic participation of women and youth in employment and decent work in the health sector. Through its HRH Technical Committee, the SADC Secretariat will work closely with Member States including designated institutions or centres of excellence, as well as with regional and international partners to coordinate the integration country-specific strategies and policy interventions into their national health workforce strategies and implementation plans. Through the guidance of the SADC HRH Technical Committee, member states will ensure that the regional health workforce initiatives are integrated into their health plans, monitor implementation of programmes at MS level and provide feedback to the SADC Secretariat. To ensure wider collaboration and engagement on the plan, Member States should seek to establish and/or further strengthen existing multisectoral and multi-stakeholder HRH coordination mechanisms and platforms, including regional or country-level HRH Observatories.

4.4 Implementation Plan

The following is provided as a basic implementation framework that aligns country to the SADC Health Workforce Strategic Plan and can be adapted at country level. It is acknowledged that a Member State may have additional strategic goals/objectives than expressed in the SADC Strategic Plan.

However, these should as much as possible link and relate to the broad strategic objectives as espoused by the Strategic Plan. It should be noted that the key to a successful implementation of this strategic includes the Ministries of Health possessing staff that has the appropriate knowledge and skills in the various fields to enable its operationalization.

Since many of the interventions expressed under each Strategic Direction are essentially part of a process, it is expected that Member States will ensure harmonisation to fit in their operational systems. Activities and/or interventions are therefore not limited to those mentioned in this document. In the course of implementing this strategic plan there are several activities that responsible authorities/departments/divisions at Member State level will undertake. These will vary in intensity, period of application and even nature depending on contextual issues. In the following implementation matrices, the words “maintain activity” appear to denote the need to ensure maintenance of the activity which will lead towards achievement of the goal/objective.

Strategic Direction 1: Investment in health worker jobs and decent employment Milestones, Activities, Resources and Timelines

SD1: Strategic Intervention Baseline	Priority Member State(s)	Key Activities	Resources Needed	Timelines									
				2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
SD1.1 Improve the density of doctors, nurses, and midwives from an average of 1.02 to a minimum of 4.45 per 1,000 population (SADC median) by 2030	All Member States	Health labour market analysis/need-based projections Establish staffing needs and gap using evidence-based tools	HWF team trained to use of WISN for staff distribution	Establish staffing needs/ develop staffing plan	Review organisational structures	Review staff deployments	Monitor progress of implementation	Maintain activity	Maintain activity	Assess impact in line with needs	Read just if necessary	Maintain activity	Maintain activity
		Recruit additional health workers as per Member State projected staffing needs	Post provisioning at country level	Identify critical posts	Resource mobilisation	Incremental hiring of health workers	Maintain activity	Maintain activity	Assess and readjust accordingly	Maintain activity	Maintain activity	Assess and readjust accordingly	Maintain activity
SD1.2 By 2023 Member States will commence expansion by at least 40%[5] (or 57% of health budget) of the fiscal space to enable increase investments in skilled health workforce	All Member States	Engage Ministries of Finance and Labour to secure sustainable health financing from domestic sources complemented by international sources	HRH planners, data analysts, education, and training institutions	Capacity building on health labour market analysis and needs-based HWF planning	Comprehensive health labour market analysis including investment case		Policy dialogue on HWF investment	Integration with health sector strategic plans and national development framework/plan for expansion of HWF investment					
			Annual budgets	SADC HWF investment forum (health, finance, labour, public services, private sector, partners)	Country-level consensus building on expansion of fiscal space for HWF investments and employment		Implementation of agreed expansion of fiscal space (budget ceilings)	Implementation of agreed expansion of fiscal space (budget ceilings)	Implementation of agreed expansion of fiscal space (budget ceilings)	Follow-up SADC HWF investment forum	Country-level consensus building on expansion of fiscal space for HWF investments	Implementation of agreed expansion of fiscal space (budget ceilings)	Implementation of agreed expansion of fiscal space (budget ceilings)
SD1.3 By 2023 Member States will be continuously protecting health workers from occupational hazards and risks	All Member States	Develop and apply occupational health and safety policies and programmes	Occupational Health and Safety Legislation	Review existing OHS policies in including impact of COVID-19	Review/develop SADC HWF OHS protocol.	SADC consensus workshop on the new HWF OHS protocol	Member States to adapt and operationalise	Maintain activity	Early impact assessment	Adjustment if necessary	Maintain activity	Maintain activity	Assessment and adjustment
SD1.4 By 2023 Member States will be continuously improving the working conditions and remuneration of health workers	All Member States	Review and provide competitive and gender-equitable salaries	National and SADC reference remuneration package	Conduct a review of working conditions across the SADC region	Develop a draft SADC reference renumeration package	SADC consensus on reference remuneration and working conditions for health workers	Development of national implementation framework/ action plans	Integration with national systems and processes	Incorporate into multi-year negotiations	Maintain activity	Maintain activity	Assessment and review	Maintain activity
SD1.5 By 2025 Member States will have developed and implemented strategies to mainstream gender equality in the health sector workforce	All Member States	Develop/update and implement gender mainstreaming strategies and policies in the health workforce	HRH planners, data analysts, education, and training institutions	Analyse gender mainstreaming in the health workforce	Develop or update relevant policies and strategies	Implement gender mainstreaming interventions	Implement gender mainstreaming interventions	Implement gender mainstreaming interventions	Implement gender mainstreaming interventions	Implement gender mainstreaming interventions	Implement gender mainstreaming interventions	Implement gender mainstreaming interventions	Implement gender mainstreaming interventions

5 It is anticipated that 40% will not find employment so increase by 40%

Strategic Direction 2: Harmonisation of Education, Training and Development Milestones, Activities, Resources and Timelines

SD2: Strategic Intervention	Priority Member State(s)	Key Activities	Resources Needed	Timelines									
				2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
SD2.1 By 2026 Member States will have harmonised training and development	All Member States	Conduct a needs-based training requirements and capacity assessment	HRH planners, data analysts	Planning and capacity assessment training	Engage partners	Reach agreement and implement	Consolidate and implement programmes	Ongoing assessment	Re-evaluate	Maintain activity	Maintain activity	Maintain activity	Assess and adjust
	SADC Secretariat / SADC HRH Technical Committee	Develop regional prototype standardized competency-based curricula Consolidate country competency frameworks into regional frameworks	Curriculum experts in health sciences education	Assemble a team of experts and adopt Terms of Reference	Assess / review existing frameworks including regulatory mechanisms	Prepare for implementation	Implement	Implement	Assess early impact	Adjust and maintain activity	Maintain activity	Conduct in-depth review	Adjust and maintain implementation
SD2.2 By 2027 Member States will be conducting specialist health professions training in line with current and emerging population health needs	All Member States	Conduct specialist need and production capacity assessment	Ministry of Health / Universities / Colleges joint forums	Establish expert team and conduct production capacity assessment	Develop and negotiate multi-year budgets	Approve budgets, implement and monitor	Monitoring	Monitoring	Mid-term review	Adjust where necessary	Maintain activity	Conduct major review	Adjust and maintain implementation
SD2.3 By 2027 Member States will have policies that promote access to education opportunities in health based on principles of equality and affordability, inclusive of youth and women	All Member States	Conduct gap analysis on inclusivity	Ministry of Health / Universities / Colleges joint forums	Establish the gap in youth and women inclusivity	Develop strategies and interventions to close the gap	Implement the interventions	Monitoring	Monitoring	Mid-term review	Adjust where necessary	Maintain activity	Conduct major review	Adjust and maintain implementation
SD2.4 By 2025 regional training centres of excellence will have been designated	SADC Secretariat and Member States	Strengthen cooperation and collaboration between health sciences faculties in the region Develop a framework for mutual recognition of titles and health worker categories in SADC region	Ministries of Health / Universities / Colleges joint forums	Develop collaboration framework	Negotiate with partners	Conclude and apply agreement	Maintain activity	Maintain activity	Reassess and adjust	Maintain activity	Conduct regional evaluation	Maintain activity	Maintain activity
SD2.5 By 2025 SADC Secretariat will have initiated the health workforce development scheme	SADC and Member States	Facilitate the acquisition of competitive scholarships and research grants for health workforce research	SADC Technical Team, Ministries of Health / Universities / Colleges joint forums	Review existing programme/s	Identify qualifying programmes	Advertise and award grants	Maintain activity	Maintain activity	Evaluate impact on development	Maintain activity	Maintain activity	Conduct major regional review	Maintain activity

Strategic Direction 3: Develop and adopt best practices in strategic HRH Leadership and Management Milestones, Activities, Resources and Timelines

SD3: Strategic Intervention	Priority Member State(s)	Key Activities	Resources Needed	Timelines									
				2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
SD3.1 By 2023 Member States will champion the mainstreaming of health workforce issues in all health policies and interventions	All Member States	Establish (for Member States that do not currently have) HRH Departments/ Directorates in MOH/ Service delivery agencies	Appropriately funded organizational structures	Conduct policy review	Implement approved policies	Review organizational structures and do budget adjustments	Implement approved policies	Maintain activity	Maintain activity	Conduct mid-term review	Maintain activity	Maintain activity	Conduct in-depth review / evaluation
SD3.2 By 2026 Member States will have strengthened their capacity in health labour market analysis, HRH planning, development, and management	SADC and Member States	Intensive training in the application of evidence-based tools	Expert trainers in health labour market analysis	Mobilise / organise funding and training resources	Commence regional and country training		Maintain activity	Maintain activity	Mid-term review	Maintain activity	Maintain activity	Conduct in-depth assessment	
SD3.3 By 2024 SADC will have established a mechanism for peer-to-peer support and accountability mechanism	SADC HRH Technical Team	Institute an annual SADC meeting or forum of health workforce managers and social partners dialogue	Funded platform	Develop terms of reference	Mobilise funding and establish platform		Maintain activity	Maintain activity	Conduct mid-term review	Maintain activity	Maintain activity	Maintain activity	Conduct in-depth review / evaluation
SD3.4 By 2027 Member States will have institutionalised social dialogue mechanisms among governments, workers, employers and other relevant stakeholders	All Member States	Institute a health workforce social dialogue mechanism at Member State and regional levels	Capacity development programmes and HRH trainers	Review existing dialogue mechanisms		Rollout new social dialogue mechanism		Maintain activity	Maintain activity	Maintain activity	Conduct mid-term review	Maintain activity	Maintain activity

Strategic Direction 4: Enhanced Health Workforce Governance and Regulation Milestones, Activities, Resources and Timelines

SD4: Strategic Intervention	Priority Member State(s)	Key Activities	Resources Needed	Timelines									
				2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
SD4.1 By 2021 Member States will enforce the upholding of professional standards and safeguard public safety	All Member States	Establish (for Member States that do not currently have) health workforce regulatory bodies for all health professions	Relevant legislation and enforcement mechanisms	Commence the process of legislative review (where necessary)			Popularize role of health professions regulation	Ensure appropriate regulation	Maintain activity	Maintain activity	Maintain activity	Maintain activity	Review legislation (if necessary)
SD 4.2 By 2027 SADC Secretariat will have developed a framework with strict compliance criteria for mutual and reciprocal recognition of health professions education and qualification	SADC Secretariat	Development and adoption of minimum curricula content and harmonisation of regulatory mechanisms	Curricula experts	Assemble experts			Develop framework and test for applicability	Run limited pilot	Negotiate for regional implementation	Monitor implementation	Monitor implementation	Monitor implementation	Conduct regional impact assessment
SD4.3 By 2026 Member States will be promoting exchange programmes between the Member States especially for skills transfer	Member States and SADC Secretariat	Coordination of databases for health professionals and other relevant stakeholders	HRH Databases	-			Develop & design concept	Address cross-country IP ownership issues	Run pilot	Maintain activity	Assess early impact	Assess and adjust	Maintain activity
SD4.4 By 2026 Member States will have created multi-sectoral collaboration/partnerships (PPP) to facilitate sharing of HRH resources	Member States and SADC Secretariat	Introduce well-regulated multisectoral collaboration and cooperation between the public and private sector	Legislation and regulatory mechanisms	Review, compare and create synergies across countries		Harmonise with other global instruments	Implement programme	Monitor and assess impact			Conduct review	Maintain activity	Maintain activity

Strategic Direction 5: Develop Reliable Data, Monitoring and Evaluation Systems Milestones, Activities, Resources and Timelines

SD5: Strategic Intervention	Priority Member State(s)	Key Activities	Resources Needed	Timelines									
				2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
SD5.1 By 2021 Member States will have HRIS with ability to generate information to track end-to-end health workforce life cycle (production-active stock – exit)	All Member States	Introduce scalable and interoperable with routine health information systems	ICT and data experts	Assess existing systems	Adjust accordingly			Regular use and reporting	Assess impact	Maintain activity	Maintain activity	Assess impact	Assess existing systems
SD5.2 By 2023 Member States will have a health workforce registry to track health workforce stock, distribution, flows, exits, demand and supply	All Member States	Regular use of NHWA and HRH Observatories	NHWA and HRH Observatories data	Access to observatories	Assess use and impact on workforce management			Regular reporting	Regular reporting	Regular reporting	Regular reporting	Regular reporting	Regular reporting
SD5.3 By 2021 Member States will have improved multi-sectoral dialogue for improved management of the health workforce	All Member States	Regular use of NHWA and HRH Observatories	NHWA and HRH Observatories data	Access to observatories	Assess use and impact on workforce management			Regular reporting	Regular reporting	Regular reporting	Regular reporting	Regular reporting	Regular reporting
SD5.4 By 2022 Member States will have institutionalised national health workforce accounts (NHWA) and reporting annually	All Member States	Strengthen the implementation of National Health Workforce Accounts (NHWA) and Human Resources Observatories	Trained personnel managing health workforce accounts	Assess skills base	Training and/or skills updating		Regular use and reporting	Regular use and reporting	Assessment and review	Regular use and reporting	Regular use and reporting	Regular use and reporting	Impact assessment
SD5.5 By 2026 Member States will have integrated health worker safety indicators with health information system	All Member States	Develop integrated metrics of health worker safety indicators	Occupational Health and Safety experts	Develop metrics and integrate into HIS		Apply and monitor	Maintain activity	Maintain activity	Assess, review and adjust	Maintain activity	Maintain activity	Maintain activity	Impact assessment

4.5 Implementation Framework for a SADC Recruitment Pool

The SADC Recruitment Pool will be designed such that it confers certain duties and benefits on all that will seek to utilise the system. The system will also provide the following guarantees:

- Subscribe to the ethical principles that are applicable to international recruitment of health personnel
- Alignment with international labour standards
- Protection of the rights of the health worker (job seeker)
- Guarantee the health worker so recruited labour rights that are commensurate with those of its own health workers
- Health workers so recruited shall not be used to replace existing citizens who may be in dispute with relevant authority

Some countries may already have reciprocity mechanisms for exchange of skills. However, where reciprocity of recognition of licensure to practice does not exist, the recruiting country takes responsibility to inform the prospective candidates of specific requirements for successful registration / licensure. It will remain the responsibility of the recruit to understand and comply with the jurisdictional requirements around registration and education.

Table 9: Key actions to implement Recruitment Pool mechanism

Action	Envisaged Benefit	Implementing Agent	Timeframe
Establish and electronic database	• Harmonised hub of individual health professionals that seek employment • Information exchange between countries and health sector actors	SADC Secretariat Member States	By 2025
Design system according to categories of the health professions, specialist, and non-specialist	• Comprehensive list including all relevant biographical information	SADC Secretariat / HRH Technical Committee	By 2025
Design and develop a formal registration form and process	• Uniform endorsement by a designated Member States authority	SADC Secretariat / HRH Technical Committee	By 2024
Establish mechanisms for verification of qualifications	• Authentication of education qualifications	SADC Secretariat / HRH Technical Committee	By 2023
Establish a mechanism for reciprocal recognition of licensure and registration	• Ability to practise in any Member State that participates in the recruitment pool	SADC Secretariat / HRH Technical Committee	By 2024

CHAPTER 05

COSTING OF IMPLEMENTATION PLAN AND INVESTMENT CASE

The chapter describes in detail the level of resource requirements for the SADC health workforce strategic plan period, including an indicative budget estimate of funds required per strategic direction/priority, financing gap and strategies that the Member States and SADC Secretariat will seek to mobilize.

5.1 Methodology for costing the implementation plan

The detailed costing component of the Strategic Plan helps prepare the foundation for applying a health workforce investment case across the SADC region, by supporting member states to apply investment choices and approaches into their respective specific health workforce strategies and implementation plans. Additionally, it quantifies the investment options that are required to put in place common regional initiative that are identified in the HRH strategic plan – for example the SADC regional health workforce resource pool. It is intended to facilitate more regional and member state engagement on the strategic use of resources and make choices for increased fiscal space and added investment in the workforce that also build on and maximise efficiencies across the existing workforce. A macro-costing approach (Drummond et al., 2015) was adopted for the cost estimation of the strategic plan implementation. As a guiding principle, a conservative approach to resource use identification was used to estimate the cost from the perspective of the SADC secretariat and Ministries of Health of the Member States. A standard costing process (Culyer and Newhouse, 2000; Drummond et al., 2015; Morris et al., 2012) was followed with some adaption to standardise the unit costs across countries. The process included resource need identification, assigning of a standardised unit cost, and estimating aggregate cost.

1. **Resource needs identification:** The resources required as inputs in the implementation of the different activities of the strategic interventions were obtained directly from the implementation plan (chapter 4) SADC strategic plan. These inputs/cost drivers were broadly grouped as:

    - Conference package (residential and non-residential) for meetings, training etc.
    - Technical Assistance (consultants)
    - Daily Subsistence Allowance (DSA)/Per Diem
    - Printing and dissemination of documents
    - Computers, Servers
    - Staff cost (Salaries of new staff recruitment and existing wage bill)

2. **Assigning standard unit costs:** There is limited comparable data on the prices of goods and services across the SADC Member States; hence unit costs were triangulated from prevailing strategic plans from the Member States and standardised to the equivalent international dollars in Purchasing Power Parity (PPP). To the convert country-specific unit costs to a standardised cost in PPP international dollars, which will be applicable in any of the Member States, the following was undertaken:

   a. The unit costs of the resources needed/cost drivers (explained in 1 above) were taken from costed HRH strategic plans from the Member States that had recent (2018 or later) plans developed, which has been costed and approved. For each item that unit cost was taken from a country, that country became the reference for that specific item. The identified unit cost(s) were in the in Local Currency Unit (LCU) of the reference country.

   b. The official exchange rate of the reference country was obtained from the World Bank database and used to convert the unit cost from LCU to USD (World Bank, 2019).

   c. The Consumer Price Index (CPI), a marker of inflation rate was taken from the World Bank to adjust the unit cost to its current USD value in the reference country.

   d. Converted the unit cost in current USD in the reference country by applying price level ratio of a purchasing power parity (PPP) conversion factor to bring the value to PPP international dollars. The unit cost in PPP international dollars was then deemed as the standardised unit cost for any cost element subsequently used in the costing. This implies that if a Member State wishes to convert the cost estimates into their local currency unit, the estimated cost in PPP international dollars should be multiplied by the country-specific conversion factor which will give the current USD equivalence in the country. The currency USD equivalence should then be converted to the local currency using the official exchange rate.[6]

3. **Estimating the cost of strategic directions and interventions:** Using the resources identified (step 1) and unit costs in PPP int. $ (step 2), the quantity and frequency of the resource need (in the implementation plan) were combined to compute the cost estimates using the following formula.

$$\textit{Total cost of Strategic Direction } i = \sum_j (\textit{Resource}_{i,j,k,m} \times \textit{Unit cost}_j \times \textit{frequency},_k)$$

… equation 1

Where

- Resource_{ijkl} is the amount of resource, (j) needed during activity, (k) for strategic intervention, (m) towards the attainment of strategic direction, (i) strategic direction.
- Unit cost_j is the unit cost for resource_j in PPP international dollars.
- $\text{frequency},_k$ is the number of occurrences (or frequency) of activity k during the time horizon of the strategic plan.

[6] Source: https://data.worldbank.org/indicator/PA.NUS.PPPC.RF

5.2 Limitations of the costing

The main limitations of the cost estimations relate to data paucity and quality. There was no contemporaneous data on the unit costs of goods and services from different member states that could be directly compared to enhance the precision of the estimates. Hence, the outcome of the costing is regarded as ordered indicative estimates, which provide useful reference points for advocacy and resource mobilisation that can be refined during member states' operational budgeting for the activities.

The estimate of workforce related costs to train and compensate health workers by individual Member States for their interpretation and implementation of the strategic plan are difficult to benchmark. There is no comparative cross-country data and analysis of overall health workforce budgets, the compensation of the workforce, and related costs to train, deploy and retain health workers across the region. The costing therefore assume that these costs will be determined by each Member States, based on their context-specific needs and gap analysis, domestic financing mechanisms, health sector budgets, and health workforce expenditure – including the direct cost of training new health workers, and the recurrent wage and compensation costs needed to sustain the workforce. In this regard, each Member States will need to undertake a comprehensive analysis of investment requirements to develop a national health workforce investment case.

From a methodological perspective, the approach adopted in this costing exercise well documented but stack variability between the economic fundamental of the SADC Member States reduces the applicability of using standard cost across countries. Added to this, the ongoing and anticipated economic downturn occasioned by the COVID-19 pandemic is likely to distort the economic fundamentals further, and hence the data relied upon for this analysis could soon be outdated. Therefore, a revision of the cost estimates with improved data when the COVID-19 pandemic and its economic impact eases will be imperative.

5.3 Estimated cost of operationalising the Strategic Plan

The overall estimated cost of implementing the strategic plan is roughly US$15.7 million over the 10-year period. Of this amount, about 35% (US$5.6 million) would be needed at both the SADC secretariat and Member States to generate evidence, facilitate policy dialogue, and mobilize resources to increase investments substantially to approximately expand health workforce employment by 40% over the 10-year period (strategic direction 1). This cost, however, excludes the cost of training and remuneration for health workers at the Members States which a country-by-country analysis is highly recommended as part of the investment case development at the level of Member States.

In addition, about 32% of the estimated cost or approximately US$5.1 million will be needed at both SADC secretariat and Member States level to develop and institutionalize systems, mechanisms and capacity for reliable data and evidence generation that will support evidence-based policies, strategies, and operational management of the health workforce across Member States (strategic direction 5). Harmonization of education and training of the health workforce across Member States will cost approximately US$1.8 million dollars or 12% of the total cost whilst US$2.3 million (15% of the total cost) is required to strengthen health workforce leadership at the Ministries of Health and enhance best practices in human resource management towards better retention and improved motivation of health workers. About 6% of the total cost (US$947,422) will be needed to strengthen health workforce governance and regulatory mechanisms. The detailed breakdown across each of the Strategic Directions and proposed interventions is summarized in table 10 below. The estimated cost of operationalising the Strategic Plan at country level and the main cost drivers summarised in annex 2.

Table 10: Estimated cost of implementing the Strategic Plan

Strategic Direction	Strategic Interventions	Estimated Cost Per Year (1,000 Int. $ PPP)										
		2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	Total
SD 1. Investment in health workforce jobs and decent employment	SD1.1 Strategies to improve the density of doctors, nurses, and midwives from an average of 1.02 to a minimum of 4.45 per 1,000 population (SADC median) by 2030	156.4	591.2	1,940.9								2,688.4
	SD1.2 By 2023 Member States will commence expansion by at least 40% of the fiscal space to enable increase investments in skilled health workforce	626.8		136.0	262.5	544.5		200.9				1,770.6
	SD1.3 By 2023 Member States will be continuously protecting health workers from occupational hazards and risks	20.9	163.0	170.0								353.9
	SD1.4 By 2023 Member States will be continuously improving the working conditions and remuneration of health workers	95.0	21.7		184.0							300.6
	SD1.5 2024 Member States will have developed and implemented strategies to mainstream gender equality in the health sector workforce	95.0	353.8	42.2								491.0
Sub-Total		**994.0**	**1,129.8**	**2,289.1**	**446.4**	**544.5**		**200.9**				**5,604.6**
SD 2. Harmonisation of Education Training and Development	SD2.1 By 2025 Member States will have harmonised training and development		473.4	170.0								643.4
	SD2.2 By 2027 Member States will be conducting specialist health professions training in line with current and emerging population health needs			531.6								531.6
	SD2.3 By 2027 Member States will have policies that promote access to education opportunities in health based on principles of equality and affordability, inclusive of youth and women			253.1								253.1
	SD2.4 By 2025 regional training centres of excellence will have been designated			385.3								385.3
	SD2.5 By 2025 SADC Secretariat will have initiated the health workforce development scheme			0.0								0.0
Sub-Total			**473.4**	**1,340.0**								**1,813.4**
SD 3. Develop and adopt best practices in strategic HRH Leadership and Management	SD3.1 By 2023 Member States will champion the mainstreaming of health workforce issues in all health policies and interventions		128.6									128.6
	SD3.2 By 2025 Member States will have strengthened their capacity in health labour market analysis, HRH planning, development, and management			170.0								170.0
	SD3.3 By 2024 SADC will have established a mechanism for peer-to-peer support and accountability mechanism	156.4	163.0	170.0	177.2	184.8	192.6	200.9	209.4	218.3	227.6	1,900.3
	SD3.4 By 2025 Member States will have institutionalised social dialogue mechanisms among governments, workers, employers and other relevant stakeholders		0.0			45.4					54.6	100.0
Sub-Total		**156.4**	**291.7**	**340.0**	**177.2**	**230.2**	**192.6**	**200.9**	**209.4**	**218.3**	**282.2**	**2,298.9**
Estimated Overall Cost		**1,720.0**	**3,038.0**	**4,802.7**	**1,169.0**	**1,308.8**	**913.4**	**945.5**	**565.2**	**587.3**	**664.9**	**15,714.8**

Strategic Direction	Strategic Interventions	Estimated Cost Per Year (1,000 Int. $ PPP)										
		2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	Total
SD 4. Enhanced Health Workforce Governance and Regulation	SD 4.2 By 2025 SADC Secretariat will have developed a framework with strict compliance criteria for mutual and reciprocal recognition of health professions education and qualification			297.7								297.7
	SD4.1 By 2021 Member States will enforce the upholding of professional standards and safeguard public safety			206.4								206.4
	SD4.3 By 2025 Member States will be promoting exchange programmes between the Member States especially for skills transfer											
	SD4.4 By 2025 Member States will have created multi-sectoral collaboration/partnerships (PPP) to facilitate sharing of HRH resources	41.7				203.9	193.6	1.0	1.0	1.0	1.1	443.3
Sub-Total		**41.7**		**504.2**		**203.9**	**193.6**	**1.0**	**1.0**	**1.0**	**1.1**	**947.4**
SD 5. Develop Reliable Data Monitoring and Evaluation Systems	SD5.1 By 2021 Member States will have HRIS with ability to generate information to track end-to-end health workforce life cycle (production-active stock – exit)	135.7	684.4	34.0								854.1
	SD5.2 By 2023 Member States will have a health workforce registry to track health workforce stock, distribution, flows, exits, demand and supply	157.1	162.9	169.0	175.3	181.8	188.5	195.6	202.8	210.4	218.2	1,861.5
	SD5.3 By 2021 Member States will have improved multi-sectoral dialogue for improved management of the health workforce				107.6	12.3	197.4					317.3
	SD5.4 By 2022 Member States will have institutionalised national health workforce accounts (NHWA) and reporting annually	235.2	122.0	126.5	262.5	136.1	141.2	347.3	151.9	157.6	163.4	1,843.7
	SD5.5 By 2022 Member States will have integrated health worker safety indicators with health information system		173.9									173.9
Sub-Total		**528.0**	**1,143.2**	**329.5**	**545.3**	**330.2**	**527.1**	**542.9**	**354.7**	**367.9**	**381.6**	**5,050.5**
Estimated Overall Cost		**1,720.0**	**3,038.0**	**4,802.7**	**1,169.0**	**1,308.8**	**913.4**	**945.5**	**565.2**	**587.3**	**664.9**	**15,714.8**

5.4 Financial space potential for health workforce investments in the SADC region

Preliminary analysis using data of SADC Member States supports the global evidence that investing in the right type of health workforce interventions and policy measures could yield a 9:1 return on investment. This section highlights the fiscal space analysis for the SADC region and for each of the Member States for which data were submitted. While eight countries submitted data, these data sets were not complete, and two countries did not provide any data on their projected supply of HRH. Thus, data mining from the World Bank's World Development Indicators, WHO's Global Health Expenditure Database, SADC website and NHWA database to augment where needed for the modelling which followed the health labour market approach and using the Health Service Development and Analysis (HeSDA) Model (Asamani, et al., 2018).

The economic demand for health workers is reflected in a country's ability and willingness to pay for health workers. This estimates the joint interest of the government and the private market in purchasing health care, a large part of which includes the cost of health worker wages. The logic underlying this approach is that countries will not spend more than they can afford on health care even if their level of health or level of health care utilization is suboptimal relative to an internationally established benchmark (Scheffler et al., 2016). Therefore, it is recommended that demand-based forecast uses indicators of overall economic growth or specific health sector indicators that represent spending within the health care sector.

A previous approach for linearly estimating the financial space was adopted (see Box 2). In applying the formulae in Box 2 to estimate public sector fiscal space (demand) for employment of health workers, the projected GDP growth of Member States ; general government health expenditure (GGHE) as a percentage of GDP ; proportion of the GGHE spent on wages and salaries of health workers were taken from the World Development Indicators of the World Bank and WHO Global Health Expenditure Database (GHED). Where data on the private sector contribution to health workforce employment was not available, the private out-of-pocket health expenditure (as a proportion of current health expenditure) was used as a proxy.

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Box 2: Financial Space Assumptions

- **Public Sector Fiscal Space for the year, i** = (GGHE as % GDP_i * Nominal GDP $Values_i$) * HRH Expenditure as % $GGHE_i$ **…** **(1)**
- **Cumulative Economic Capacity for the year, i** = Public Sector Fiscal $Space_i$ * (1 + proportion of private sector HRH employment) **…** **(2)**

Where:

- **i = target year**
- **GGHE = General Government Health Expenditure**
- **GDP = Gross Domestic Product**

Notes: *There are elaborate and recommended econometric equations for estimating the demand for health workers from macroeconomic indicators and health spending patterns in countries. With data constraints, these concepts guided the use of the above formulae in which conservatively, it was assumed that if the government continue to spend similar proportion of GDP on health and similar proportion of GGHE on HRH, all things being equal, the fiscal space for HRH would be proportional to the size of the GDP. It was further assumed that the private sector would not contract and that conservatively, a similar proportion of private-sector employment would continue.*

As shown in table 7, it is estimated that across the SADC Member States, the cumulative economic space for the employment of health workers is about 2.5 billion US dollars which is likely to expand to 2.8 billion USD by 2024 and 3.45 billion USD by 2030. Using the minimum normative need for health workers (using WHO's threshold of 4.45 per 1,000 population), the cost of need is about 13.3 billion US dollars which will increase to about 14.4 billion US dollars by 2024 and 16.3 billion US dollars by 2030.

The current and anticipated levels of supply of health workers are estimated to cost 7.5 billion US dollars in health workforce employment in 2020 which will increase to at least 8.8 billion US dollars in 2030 if the current trend continues. Thus, while potential supply could meet nearly 89 % of minimum normative need, only 33 % of the number needed may be funded. The foregoing suggests a significant future financing gap for the health workforce if concerted efforts are not pursued to making the case for increased investments including harnessing and maximizing the private sector's potential. One key limitation in this quick and rough estimate is that the contribution of development partners in health wage bill has not been fully accounted for.

The analysis of eight Member States that participated in the technical consultative meeting shows that in most cases, the current production or supply of health workers falls short of the countries' aggregate HRH needs. Only three Member States may be able to meet their estimated need before 2030. Furthermore, the cumulative demand or ability to pay (in both public and private sectors) is higher than the supply of HRH. This is evident in the number of expatriate workers that are employed in those Member States (see figures 5–12).

Table 11: Estimated Financial Space and Economic feasibility analysis – SADC Region (Million US Dollars)

Variable	Estimation		
	2020	2024	2030
Public Sector Fiscal Space for HRH	1,752.48	1,969.01	2,344.98
Private Sector Economic Demand for HRH	747.82	840.22	1,000.66
Cumulative Financial Space (Economic Demand) for HRH	2,500.31	2,809.23	3,345.64
Estimated Cost of HRH Stock/Supply	7,496.97	8,770.39	11,097.34
Estimated Cost of Minimum Need (WHO Threshold)	13,293.67	14,408.09	16,257.30

5.5 The Health Workforce Investment Case for the SADC Region

Global evidence has shown that the contribution of the health workforce transcends its critical role in the attainment of health (SDG 3) as a clear nexus has been established between health workforce investment and other SDGs such as goals 4 (quality education), 5 (gender equality), and 8 (decent work and economic growth) among others. However, the health workforce has been one of the most affected areas of health care cost containment measures to free up resources for investment in other competing areas. Recent evidence (Lauer et al., 2017) - as shown in figure 7 has demonstrated at least six (6) causal pathways through health workforce investments that (as part of health system inputs) can stimulate inclusive economic growth beyond the health sector.

Box 3: Health Pathway to economic growth

(a) the health pathway - the intrinsic (non-market-valued) health benefits of the health system;

(b) the economic output pathway which concerns the intrinsic (market-valued) economic benefits of the health system;

(c) the social protection pathway, addressing sickness, disability, unemployment and old-age benefits, as well as financial protection against loss of income and catastrophic health payments;

(d) the social cohesion pathway, addressing the role of a health system in promoting equity and fostering redistribution and growth;

(e) the innovation and diversification pathway, addressing the role of the health system in driving technological development and in offering protection against macroeconomic shocks; and

(f) the health security pathway, addressing the role of the health system in protecting against epidemic outbreaks and potential pandemics.

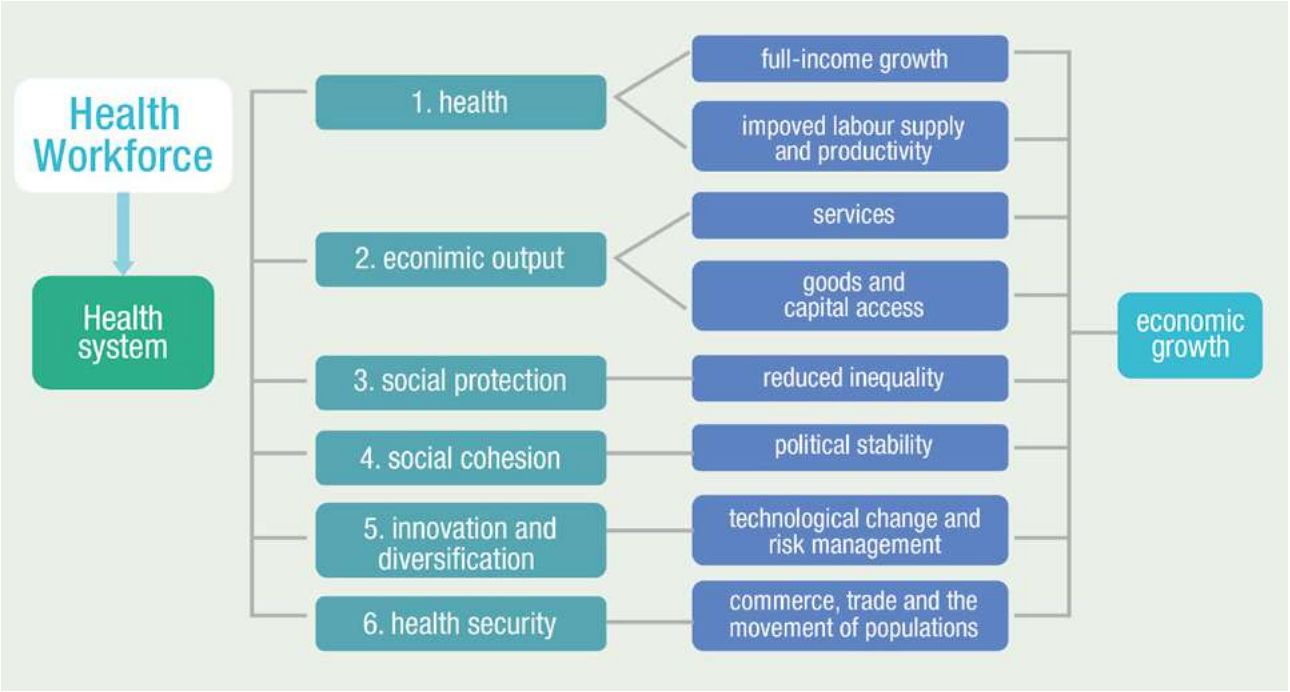

Figure 6: Health pathway to economic growth

Source: Adapted from (Lauer, et al., 2017)

The International Labour Organisation (ILO) also analysed the contribution of the health workforce (health occupations) on employment within the wider health economy, which revealed that, a broad range of workers and potential multiplier effects in industries providing goods and services for health, the potential for job creation is even higher, including for low skilled workers. With regard to paid employment, ILO estimates suggest that globally, for each health occupation job (such as physician, nurse, physiotherapist), 1.5 additional jobs are generated for workers in non-health support occupations (administration, cleaning, manufacturing) both in the health sector and the broader health-related economy. Taking into consideration additional unpaid long-term elderly care work, this would raise this ratio to 2.3 non-health jobs per 1 health occupation job. This approach considers all workers producing health-related products and providing services regardless of their occupation, employment status or economic sectors. Accordingly, the workforce has been estimated to be 234 million workers in the entire health-related economies globally, consisting of 71 million workers in health occupations, 106 million paid workers in non-health occupations and 57 million unpaid non-health occupation workers, mostly persons who left paid employment to provide care to relatives. Figure 8 summarizes the impact of health occupations employment on job creation across different income groups of countries.

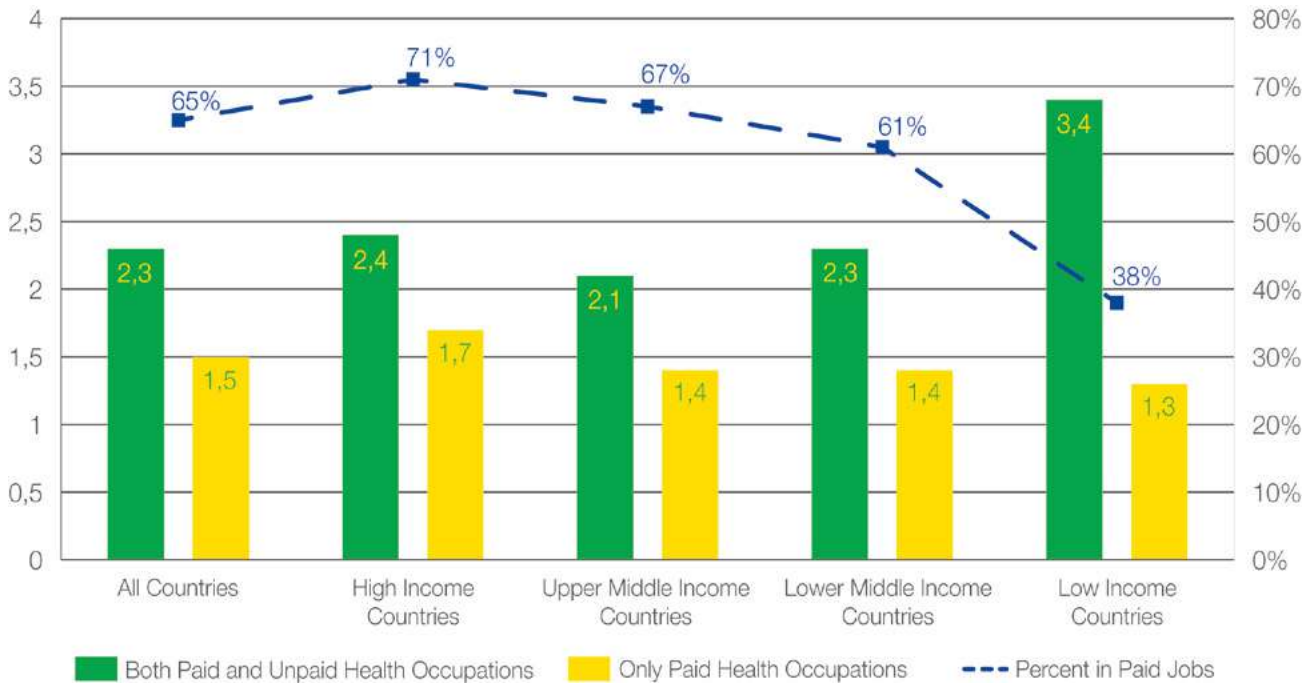

Figure 7: Ratio of Non-Health Occupation (NHO) workers to Health Occupation (HO) workers, by income group, 2015

Source: Adapted from ILO calculations, 2016

By investing in the 9.2 million health workers needed in Africa by 2030 (which includes 3.1 million supply and 6.1 shortage), there is the potential to create over 20 million new jobs in the region equivalent to a 40% boost to current rates of job creation (World Health Organisation, 2016). In representing around a third of the population in the Africa region, efforts in SADC would contribute substantially to addressing the labour market failures in the region.

A rapid analysis was undertaken with limited data to examine the influence of health workforce investments on some economic indicators to augment global evidence to make a case for increased investments, as well as strengthening social dialogue with employers, worker representatives and engaging other key stakeholders. Due to challenges with data quality and completeness, limited estimations were applied to explore the relationships between health workforce density and some health and economic indicators. The emerging correlations reinforces known global evidence that investing in the health workforce provides a significant return on investment. The simulation showed that in the context of the SADC region, if the employed health workforce density is collectively increased by one unit per 1,000 population (i.e. by approximately 277,000) it could boost the rate of growth in GDP per capita by economic growth by some 39% up to 2030 (adding about US$ 1,340 GDP per capita over 10 years).[7] The economic return on investment ranges between 1:6 and 1:11.

[7] At individual country level, the analysis is valid in at least 50% of SADC Member States. When Adjusted net national income per capita (current US$) is used for the analysis instead of GDP per capita, the return is about a 41% increase over 10 years.
The analysis was based on data submitted by countries (for those that participated in the meeting) augmented with the latest available data from global databases of SADC, WHO and the World Bank.

In terms of impact on health outcomes, an investment increase of 1 per 1,000 population is also likely to be associated with an additional 4 to 8 years of life expectancy at birth; and a reduction in the incidence of HIV (% of uninfected population ages 15-49) by 2.3%. Unlocking these returns would require at least a 9% increase in total health expenditure, of which 60% to 72% must be invested in health workforce employment and job creation.

Box 4: Summary of health workforce investment case

- The cumulative fiscal space or economic demand for HRH is below the WHO-determined threshold of workforce density necessary for achieving UHC.
- From the available data, the modelling projected that should employment of health workforce be increased by one unit per 1,000 population, it would add 39% to the sub-regional economic growth in terms of GDP per capita. This represents an additional US$1,340 in GDP per capita over ten years and a return of investment that ranges between 6:1 and 11:1.
- These investments also relate to positive health outcomes in it would add eight additional years to the life expectancy at birth for citizens of Member States and a reduction in HIV prevalence of 2.3% (in the age group 15–49).
- However, to realize these returns would require an investment of at least 9% increase in total health expenditure across Member States. Additionally, between 60%–72% of the increased investment must be geared towards decent job creation for health workforce.

CHAPTER 06

MONITORING AND EVALUATION

6.1 Introduction

The chapter details the monitoring and evaluation (M&E) framework to guide the implementation of the strategic plan. The M&E framework aims to have a coordinated and effective mechanism that supports evidence-based HRH decision-making and accountability. The framework will facilitate tracking implementation of key strategic interventions, generate information to support decision-making and make recommendations on improvement areas. The SADC Secretariat and Member States, including partners, will be involved in the process of strategic monitoring, harmonising at regional level through the SADC HRH Technical Committee made up of HRH managers. Each Member State will carry out its own monitoring and evaluation process based on their respective health workforce strategic plans.

6.2 Monitoring

Monitoring of the key regional milestones of this plan will be done on quarterly basis by SADC HRH Technical Committee. The HRH units of Member States (at the national and sub-national level) will be responsible for the day to day implementation and coordination of HRH activities to monitor implementation this strategic plan. Performance reviews will be jointly conducted by stakeholders at national and sub-national level (both government and non-government actors). The purpose of the joint assessment is to review performance and inform investment on key priorities with highest impact.

6.3 Evaluation

The SADC Secretariat through the HRH Technical Committee will analyse and report key performance indicators annually while a mid-term review of the plan will be done in 2025 and an end evaluation in 2030 to determine the extent to which the objectives of this strategic plan are met across the different key targets. The mid-term review will focus on assessing implementation status, document alignment of key strategic interventions at Member State level and improvement opportunities, among others. The results will be used to adjust key strategies, priorities, and objectives.

6.4 Mechanism for collaboration and Accountability

At Member State level, monitoring and evaluation of the plan will be the responsibility of the Ministries of Health through the HRH divisions / departments. All relevant stakeholders and institutions are required to report the relevant data periodically within the framework of the national health workforce observatory. The following will be undertaken to ensure accountability:

- **Stakeholder collaboration and accountability:** The Ministries of Health shall engage its stakeholders through the HRH division / department forum at least twice a year. Stakeholders (state and non-state) and institutions shall submit relevant reports and data through available HRH information system or using an agreed reporting template.

- **Timely, reliable and accurate data:** The stakeholder shall be requested to submit reports on implementation of planned activities, program and project arising from this plan using a standardised format. All stakeholders shall ensure that all data submitted is reliable. Specific attention should be made to ensure the mainstreaming of gender analysis and sex disaggregation into health workforce data and reporting.

- **Feedback and dissemination:** The ministries of health shall review the HRH data, provide feedback to the reporting institutions about the quality of the data and reports (completeness, accuracy, and timeliness) and periodically disseminate updated information on HRH situation through HRHICC and other relevant fora.

6.5 Key Performance Indicators and Targets

The strategic plan has key performance indicators (KPIs) to guide monitoring and evaluation. These indicators will be used by the SADC Secretariat and Member States to facilitate implementation of the strategic plan. Most KPIs are linked to ***Global strategy on human resources for health: health workforce 2030, WHO African regional framework for the implementation of the global strategy on human Resources for health and NHWA*** indicators.

Table 12 lists baseline, mid-term, and end-term key indicator targets.

Table 12: Monitoring and Evaluation Plan

Strategic Direction (SD)	Code	Key Performance Indicators (KPIs)	Baseline (2020)	Mid-Term Target (2025)	End-Term Target (2030)	Source of Data	Periodicity of reporting	Reporting Responsibility
SD 1: Investment in health worker jobs and decent employment	SD1.1	Density of health workers (doctors, nurses and midwives) per 1,000 population (SADC mean)	1.02	2.3	4.45	Labour force surveys/ NHWA reports/population census	Annual	Member States & SADC Secretariat
	SD1.2	Percentage increase in funds allocated to health workforce priorities	(establish baseline)	25%	40%	National Health Accounts/ National budgets	Annual	Member States (MOH, MOF)
	SD1.3	Number of Member States with updated occupational health and safety policies and programmes (WHO HW Safety Charter)	(establish baseline)	12	16	Policy papers	Annual	Member States & SADC Secretariat
	SD1.4	Percentage improvement of staff attrition (turnover) rate through better working conditions and remuneration	(establish baseline)	25% reduction from baseline	50% reduction from baseline	HRIS, Health workforce registry/ observatory	Annual	Member States, SADC Secretariat
	SD1.5	Number of Member States implementing strategies to mainstream gender equality in the health sector workforce	(establish baseline)	8	16	NHWA reports	Annual	Member States & SADC Secretariat
SD 2: Harmonisation of Education, Training and Development	SD2.1	Percentage of Member States with harmonised accreditation mechanisms for health worker training and development programmes	(establish baseline)	30%	50%	Accreditation authorities/professional bodies /HTIs reports	Annual	Member States (MOH, MOE)
	SD2.2	Minimum ratio of trained Specialist cadres to total stock of active health workers (regulated cadres)	(establish baseline)	20%	40%	Professional council/ NHWA reports	Annual	Member States (MOH)
	SD2.3	Number of Member States with policies that promote access to education opportunities in health based on principles of equality and affordability, inclusive of youth and women	(establish baseline)	16	16	Accreditation authorities/professional bodies	Every three (3) years	Member States (MOH, MOE)
	SD2.4	Number of established regional health training institutions (Centres of Excellence)	(establish baseline)	5	10	SADC annual reports	Every three (3) years	Member States (MOH, MOE)
	SD2.5	Percentage of Member States with health workforce development schemes that promote health workforce research	(establish baseline)	30%	80%	SADC annual reports	Every three (3) years	Member States (MOH, MOE)

Strategic Direction (SD)	Code	Key Performance Indicators (KPIs)	Baseline (2020)	Mid-Term Target (2025)	End-Term Target (2030)	Source of Data	Periodicity of reporting	Reporting Responsibility
SD 3: Develop and adopt best practices in strategic HRH Leadership and Management	SD3.1	Number of Member States with HRH Departments/Directorates in MOH/Service delivery agencies	(establish baseline)	16	16	HRH strategic plans	Annual	Member States (MOH)
	SD3.2	Number of Member States with capacity in health labour market analysis, HRH planning, development, and management	(establish baseline)	16	16	HRH strategic plans	Annual	Member States (MOH)
	SD3.3	Number of Member States with operational Inter-agency HRH (intersectoral) mechanism for peer-to-peer support, accountability and learning	N/A	2	16	HRH reports	Annual	Member States, SADC Secretariat
	SD3.4	Number of Member States with institutionalised social dialogue mechanisms among governments, workers, employers and other relevant stakeholders	N/A	8	16	HRH strategic plans	Annual	Member States (MOH)
SD 4: Enhanced Health Workforce Governance and Regulation	SD4.1	Number of Member States with health workforce regulatory bodies for all health professions	(establish baseline)	11	16	Government/ legislative records/treaties	Every three (3) years	Member States
	SD4.2	Ratified protocol/framework with strict compliance criteria for mutual and reciprocal recognition of health professions education and qualification	N/A	1	1	Policy papers/ approved protocol		SADC Secretariat
	SD4.3	Number of Member States with exchange programmes for skills transfer	N/A	4	16	Training/skills transfer reports		SADC Secretariat
	SD4.4	Number of Member States with multi-sectoral collaboration/partnerships (PPP) sharing of HRH resources	N/A	16	16	Bilateral treaties/ mobility reports	Every three (3) years	SADC Secretariat & Member States
SD 5: Develop Reliable Data, Monitoring and Evaluation Systems	SD5.1	Number of Member States with HRIS with ability to generate information to track end-to-end health workforce life cycle (production- active stock – exit)	(establish baseline)	16	16	Ministries of health, education, labour reports	Annual	Member States (MOH)
	SD5.2	Number of Member States with a health workforce registry to track health workforce stock, distribution, flows, exits, demand and supply	(establish baseline)	16	16	Ministries of health, education, labour reports	Annual	Member States (MOH)
	SD5.3	Number of Member States with multi-sectoral dialogue platforms	N/A	16	16	Ministries of health	Annual	Member States (MOH)
	SD5.4	Number of Member States with institutionalised national health workforce accounts (NHWA) and reporting annually	N/A	16	16	Ministries of health, education, heath training institutions	Annual	Member States (MOH)
	SD5.5	Number of Member States with integrated health worker safety indicators with health information system	(establish baseline)	8	16	National NHWA reports	Every three (3) years	Member States (MOH)

6.6 Overview of Potential Risks and Mitigation Measures

Implementation of the SADC Health Workforce Strategic plan 2020-2030 may be affected by several factors beyond its influence. These will be documented as risks and assumptions to be considered during the annual planning and in the next strategic review and planning cycle. The major risk is securing and sustaining domestic and development financing the strategic plan, particularly considering the COVID-19 pandemic and its impact on immediate to long-term economic growth and fiscal space across the SADC region.

However, it is expected that Member States will endeavour to mitigate these factors through evidence-based advocacy, to make a clear investment case for HRH financing, as well as instituting innovative financing mechanisms through other stakeholders such as the private sector and development partners in health including local non-governmental partners where applicable. Each Member State has a responsibility to develop a risk management plan for the implementation of this SADC HRH Strategic Plan. For illustrative purposes, the risk management framework will address, as a minimum, three broad risk areas summarized in the table 13 below.

Table 13: Summary of key Risks and Mitigation measures

Type of Potential Risk	Potential Mitigating Measure
Strategy related	Member States should build the capability of responsible ministries/departments to manage or contain the identified risk events should they occur and address factors that associate this strategy with uncertainty e.g. capacity at country level for data collection and policy implementation
Policy related	Member States should regularly revisit the non-health policy levers which shape health labour markets e.g. policies that relate to the education and training sector and those impacted by the labour market dynamics
External risks	Member States should institute mechanisms to anticipate and develop mitigation strategies e.g. workforce responses to risks like epidemics, pandemics, and the ability to maintain a functional health system and sustain essential health services amid political and major macroeconomic shifts
Preventable risks	Member States should align their health workforce strategies with the SADC strategic plan and provide adequate funding for implementation of the strategy

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ANNEXURES

Annex 1: Economic Feasibility Analysis

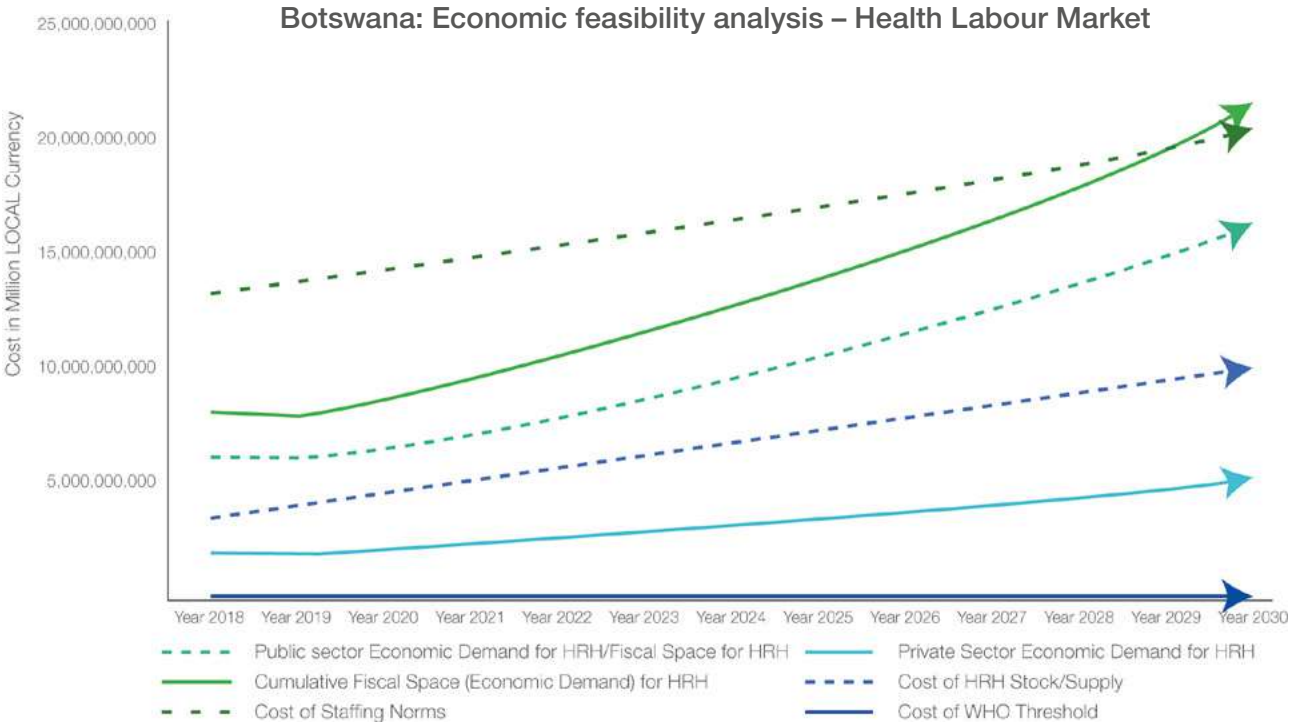

Figure 8: Economic feasibility analysis – Botswana

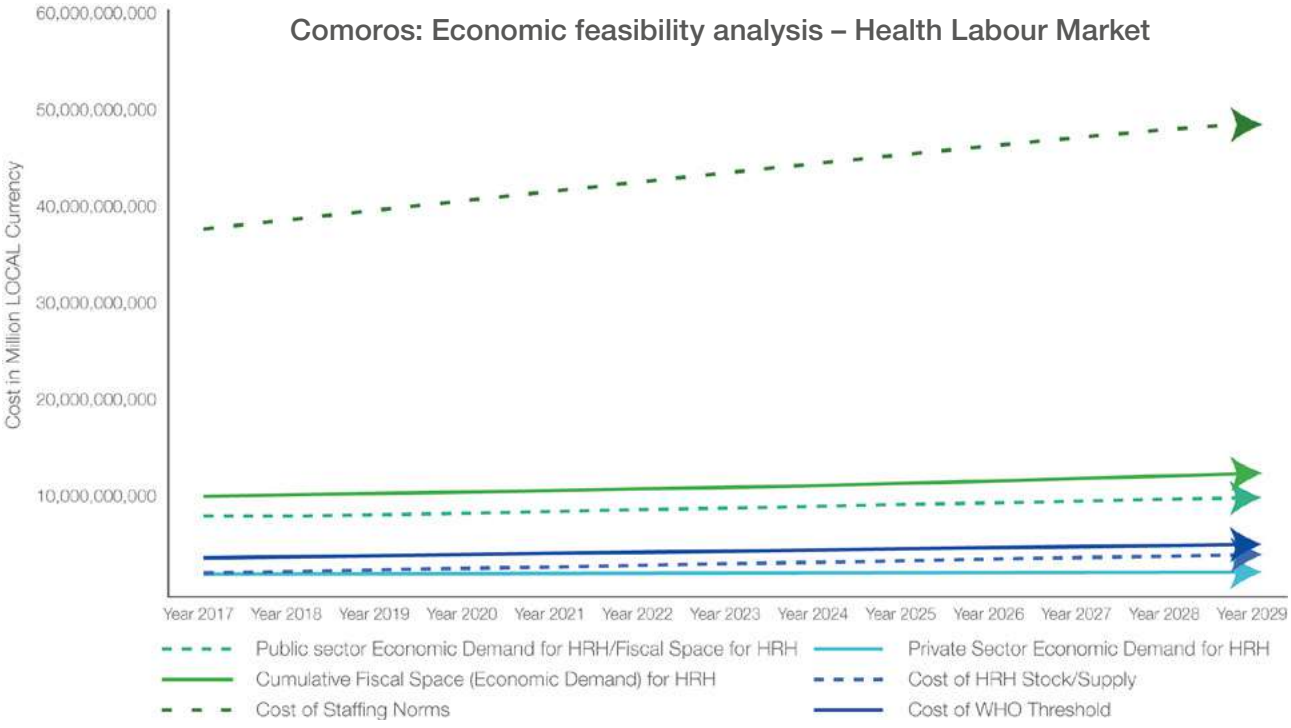

Figure 9: Economic feasibility analysis – Comoros

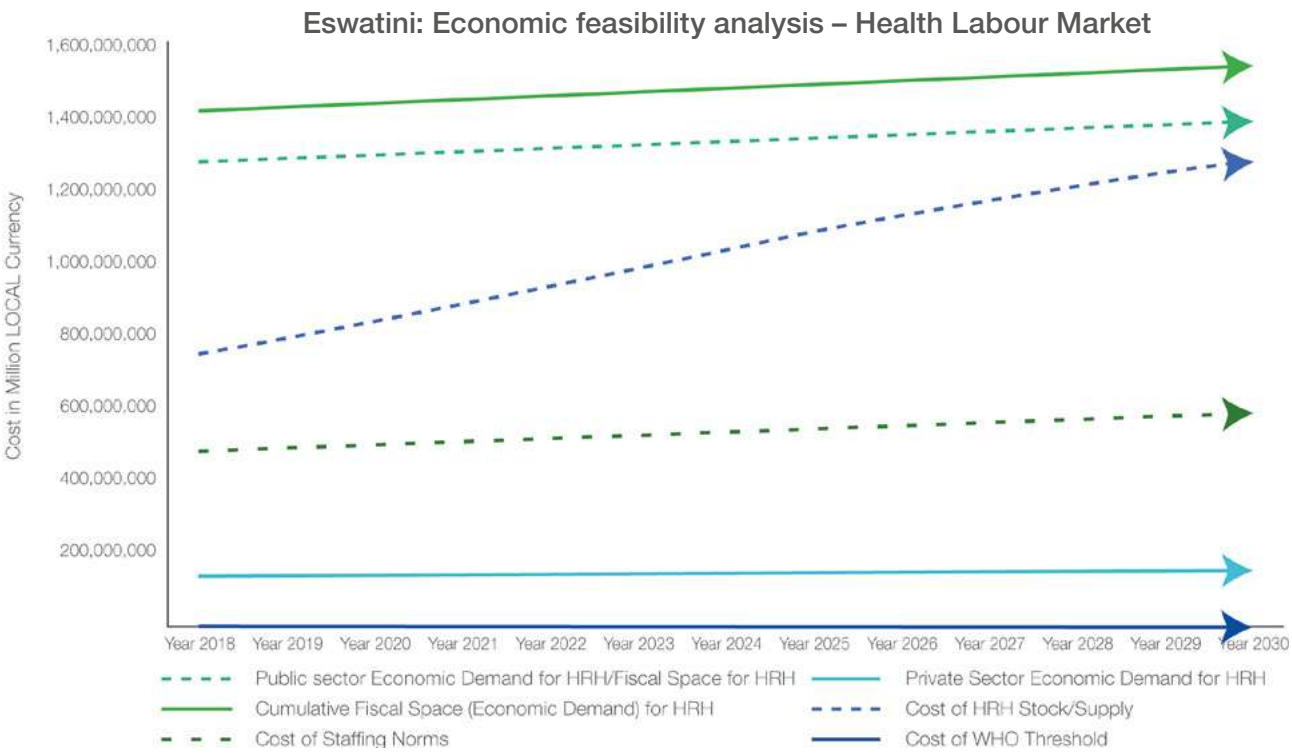

Figure 10: Economic feasibility analysis – Eswatini

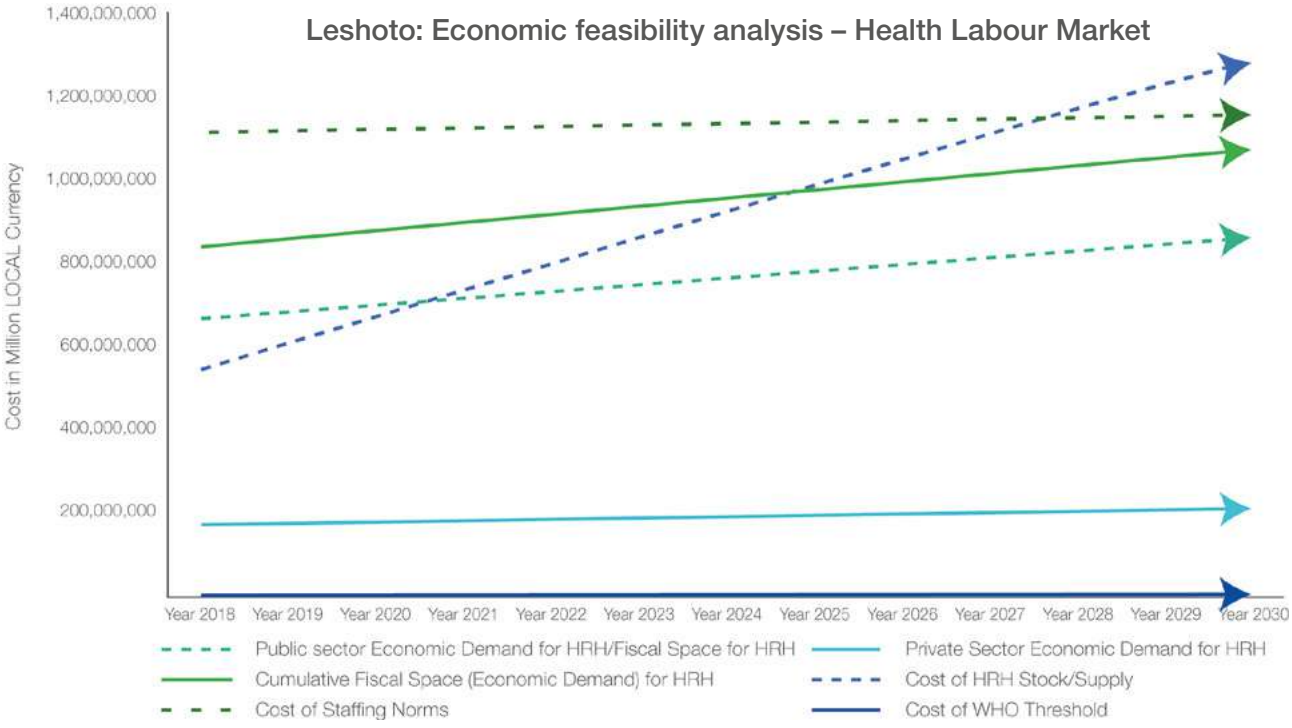

Figure 11: Economic feasibility analysis – Leshoto

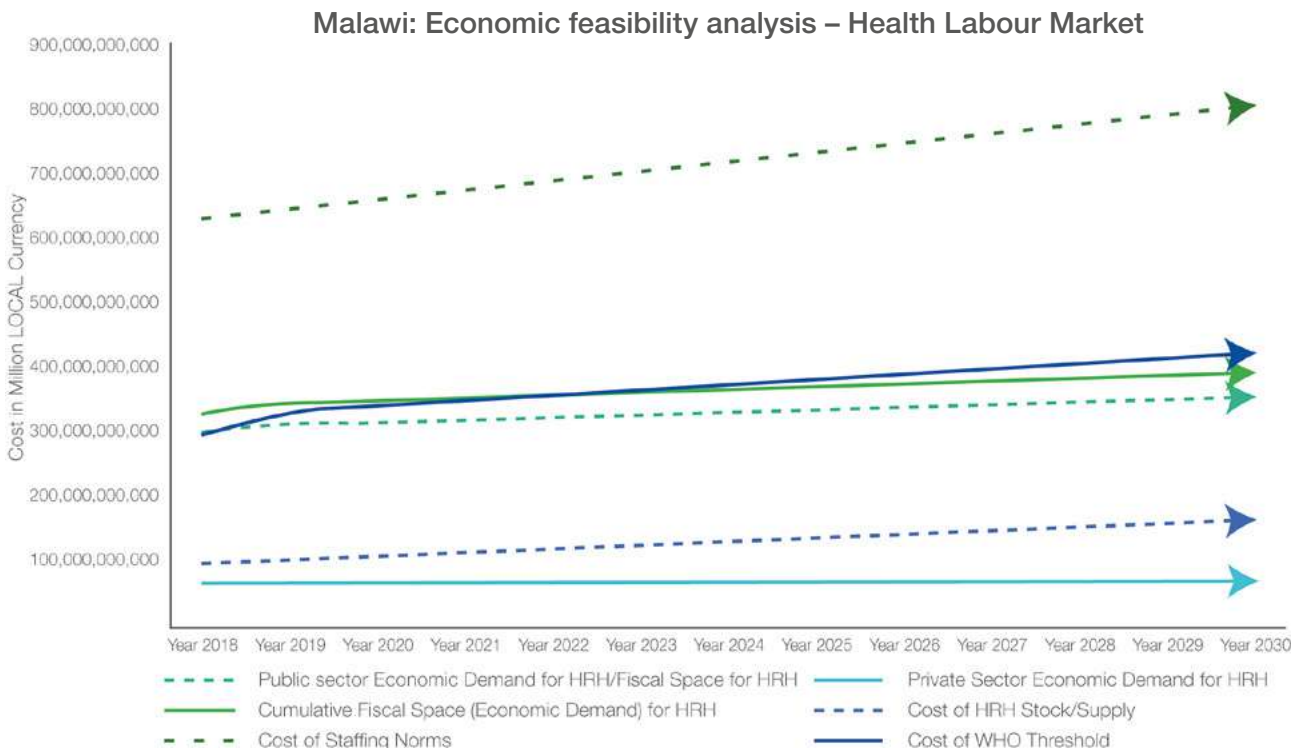

Figure 12: Economic feasibility analysis – Malawi

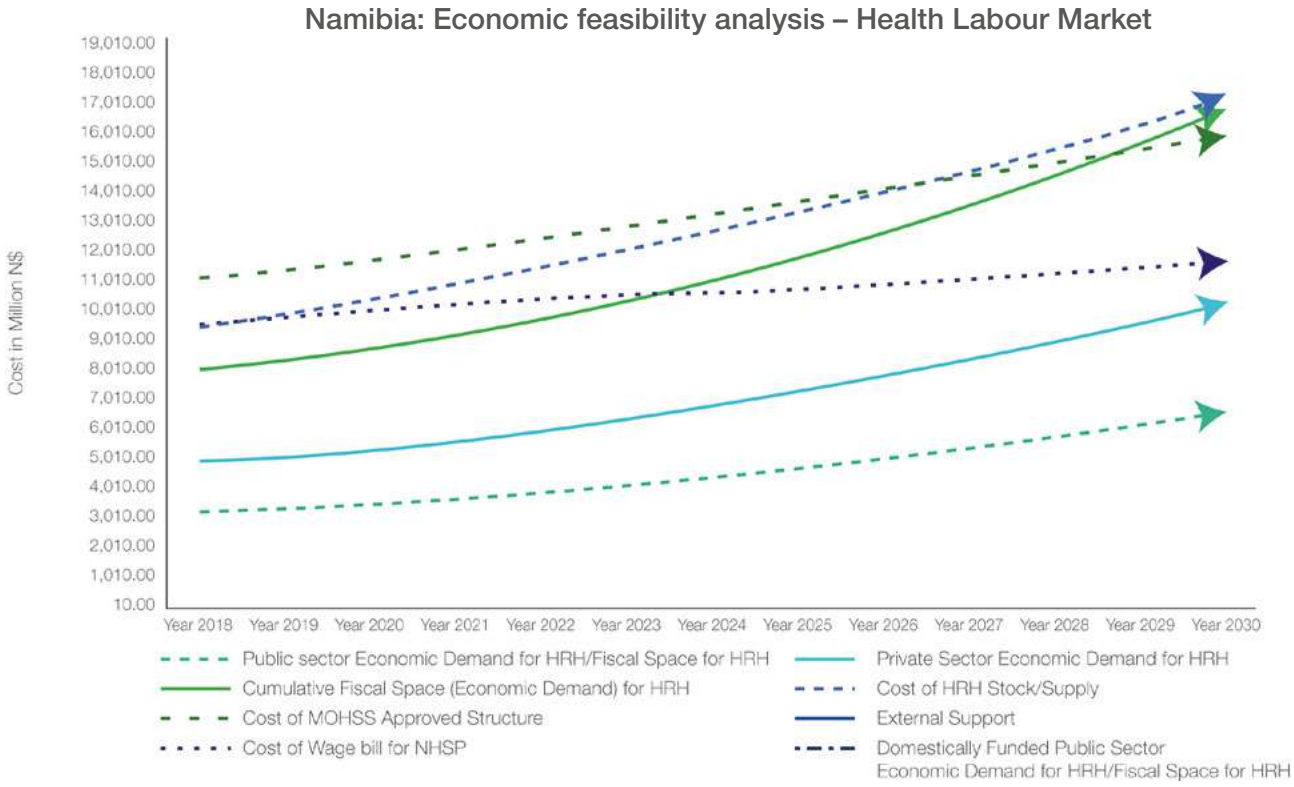

Figure 13: Economic feasibility analysis – Namibia

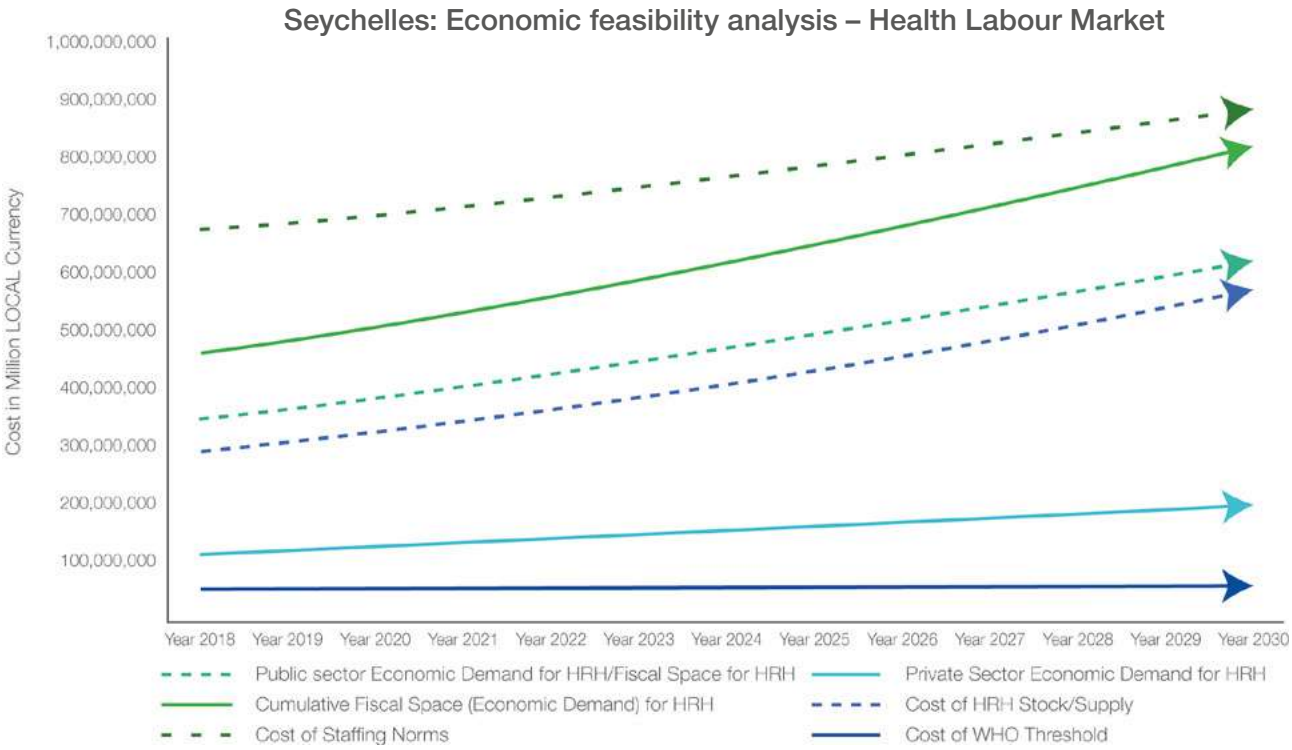

Figure 14: Economic feasibility analysis – Seychelles

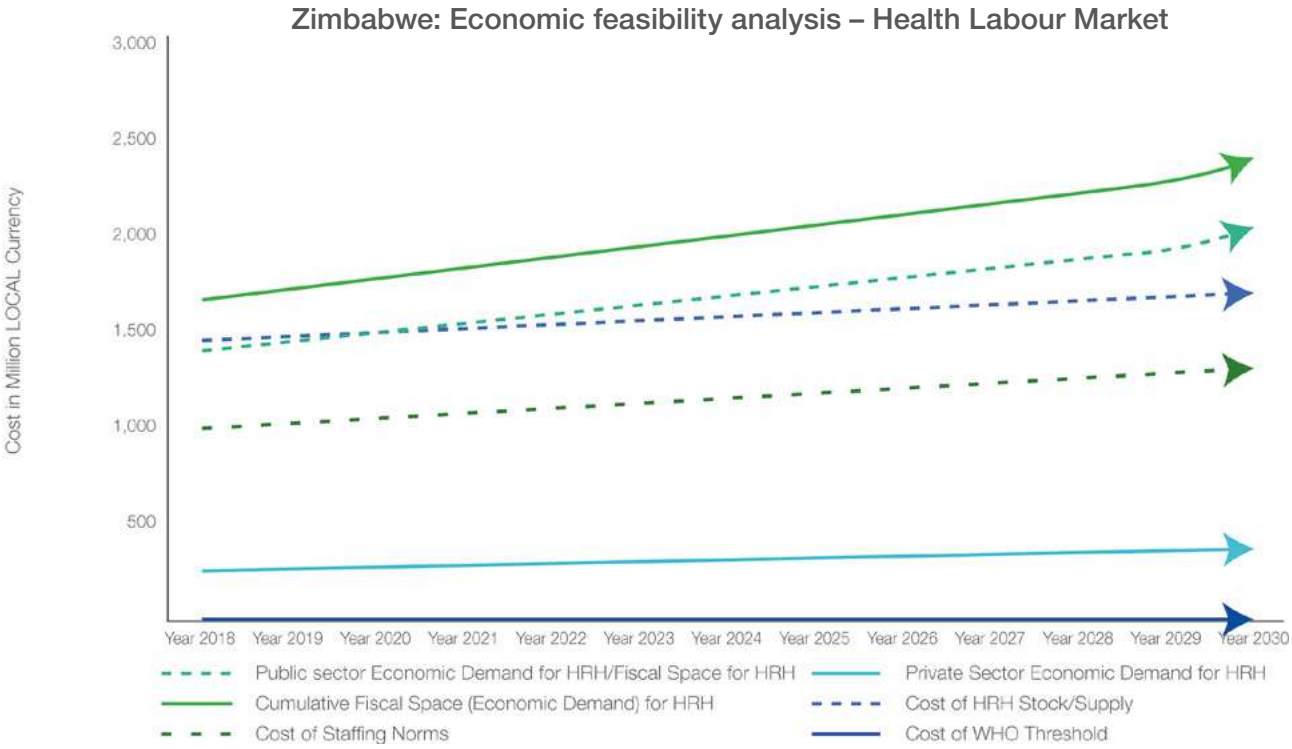

Figure 15: Economic feasibility analysis – Zimbabwe

Annex 2: Estimated cost of implementing the strategic plan by type of resource needs at the level

Strategic Direction	Resource Needs	Total (1,000 Int. $ PPP)	Estimated Cost at Country Level (per Country) [1,000 Int $ PPP]
SD 1. Investment in health workforce jobs and decent employment	International conference package including travel	$1,023.9	$0.0
	International Consultant	$506.8	$34.0
	National/Local Consultant	$295.6	$18.1
	Non-Residential Conference package/person	$79.2	$5.3
	Printing	$57.5	$4.1
	Residential Conference package/person	$2,055.1	$133.2
	WISN studies	$1,586.6	$113.3
Sub-Total		**$5,604.6**	**$308.0**
SD 2. Harmonisation of Education Training and Development	International conference package including travel	$510.0	$0.0
	International Consultant	$538.4	$22.7
	National/Local Consultant	$99.0	$6.2
	Non cost item	$0.0	$0.0
	Non-Residential Conference package/person	$169.0	$10.6
	Residential Conference package/person	$497.0	$31.1
	Specialist training	$0.0	$0.0
Sub-Total		**$1,813.4**	**$70.5**
SD 3. Develop and adopt best practices in strategic HRH Leadership and Management	International conference package including travel	$2,070.3	$0.0
	Leverage on other activities	$0.0	$0.0
	National/Local Consultant	$37.1	$12.4
	Non cost item	$0.0	$0.0
	Non-Residential Conference package/person	$100.0	$6.2
	Residential Conference package/person	$91.5	$30.5
Sub-Total		**$2,298.9**	**$49.1**
Grand Total		**$15,714.8**	**$781.1**

Strategic Direction	Resource Needs	Total (1,000 Int. $ PPP)	Estimated Cost at Country Level (per Country) [1,000 Int $ PPP]
SD 4. Enhanced Health Workforce Governance and Regulation	Computers	$5.9	$2.0
	International conference package including travel	$192.6	$0.0
	International Consultant	$183.6	$47.3
	Leverage on other activities	$0.0	$0.0
	National/Local Consultant	$309.6	$19.4
	Other hosting-related charges	$5.9	$0.0
	Procurement/development of software	$123.2	$0.0
	Residential Conference package/person	$126.5	$7.9
	(blank)	$0.0	$0.0
Sub-Total		**$947.4**	**$76.5**
SD 5. Develop Reliable Data Monitoring and Evaluation Systems	Computers	$135.7	$8.5
	International conference package including travel	$556.5	$0.0
	International Consultant	$231.1	$10.9
	National/Local Consultant	$107.6	$6.7
	Non-Residential Conference package/person	$1,861.5	$116.3
	Printing	$4.8	$0.0
	Residential Conference package/person	$1,642.8	$102.7
	Server	$510.5	$31.9
Sub-Total		**$5,050.5**	**$277.0**
Grand Total		**$15,714.8**	**$781.1**

Annex 3: Reporting Framework Tool by Member States to the SADC Secretariat

SADC HRH Strategic Goal (SD)	Summary of Outcome/s	Activities utilised to achieve the outcomes	Over what period was this achieved?	Impact on Health Workforce
SD 1: Investment in health worker jobs and decent employment				
SD 2: Harmonisation of Education, Training and Development				
SD 3: Develop and adopt best practices in strategic HRH Leadership and Management				
SD 4: Enhanced Health Workforce Governance and Regulation				
SD 5: Develop Reliable Data, Monitoring and Evaluation Systems				


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