Independent review of the Working for Health programme and its Multi-Partner Trust Fund 2017–2022

Opportunities for future programming
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## Abbreviations

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<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>CHW</td>
<td>community health worker</td>
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<tr>
<td>DWT</td>
<td>Decent Work Technical Support Teams (ILO)</td>
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<tr>
<td>ELS</td>
<td>Employment, Labour and Social Affairs (OECD)</td>
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<td>GHW4</td>
<td>Global Health Watch (fourth edition)</td>
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<td>HLMA</td>
<td>health labour market analysis</td>
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<td>HRH</td>
<td>human resources for health</td>
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<td>IADEx</td>
<td>Interagency Data Exchange Platform</td>
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<td>ILO</td>
<td>International Labour Organization</td>
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<td>MPTF</td>
<td>Multi-Partner Trust Fund</td>
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<td>MoV</td>
<td>means of verification</td>
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<td>NHA</td>
<td>national health account</td>
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<td>NHWA</td>
<td>National Health Workforce Accounts</td>
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<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
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<td>OSH</td>
<td>occupational safety and health</td>
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<td>SADC</td>
<td>Southern African Development Community</td>
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<td>SDGs</td>
<td>Sustainable Development Goals</td>
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<tr>
<td>SWOT</td>
<td>strengths, weaknesses, opportunities, threats</td>
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<tr>
<td>UHC</td>
<td>universal health coverage</td>
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<td>W4H</td>
<td>Working for Health</td>
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<tr>
<td>WAEMU</td>
<td>West African Economic and Monetary Union</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Executive summary

The Working for Health five-year action plan for health employment and inclusive economic growth (2017–2021) draws on the recommendations of the report of the United Nations High-level Commission on Health Employment and Economic Growth. It is delivered principally through the joint intersectoral W4H programme and its Multi-Partner Trust Fund (MPTF) in partnership with WHO, ILO and OECD. A major part of its objectives is to stimulate workforce actions in alignment with national, regional and global strategies and plans. These actions are delivered at country and regional level through multisectoral Member State-led collaboration and catalytic technical and financial support. Other joint W4H work includes developing and adapting key global public goods, including an international platform for health worker mobility, an interagency data exchange platform, an ILO and OECD approach to anticipating the skills needs of health workers, and a methodology for measuring employment impact.

This document presents the findings of an independent end-of-project review and covers the experience of implementing the projects funded and supported under the W4H MPTF over the first action plan period (2017–2021), which included direct support to 13 countries, two economic regions and three global projects. The review is based on the evaluation criteria of relevance, efficiency, effectiveness, impact and sustainability.

The review also looks to the future of sustaining investment and support for implementation of subsequent projects under the new Working for Health 2022–2030 Action Plan and its MPTF, which was extended by Member States at the Seventy-fifth World Health Assembly in May 2022.

A review of documents and interviews with 36 respondents demonstrated that the W4H programme and its 2017–2021 5-year action plan have continued to be highly relevant and have contributed to countries’ efforts to address challenges in relation to the health and care workforce and health systems strengthening.

Since 2018, the W4H MPTF has mobilized US$ 4.8 million in contributions from the Norwegian Agency for Development Cooperation and Silatech. This is less than the anticipated US$ 70 million, although the United Nations Peace and Trust Development Fund provided an additional US$ 2.9 million funds through the Government of China in a bilateral agreement with WHO to implement the W4H approach in an additional four countries over the 3-year period 2018–2021.

Countries and regions have been supported through the W4H MPTF via short, 1-year catalytic funding of US$ 100 000–300 000 per country, which has been used to mobilize additional resources in support of workforce investments. Although the catalytic model is considered effective by respondents and stakeholders, the considerable underfunding of the W4H programme has affected its expansion and limited the programme’s scope in supported countries.

The W4H programme has delivered results in a cost efficient and timely way by providing targeted catalytic funding and technical assistance. However, respondents indicate that there was limited funding per country, which was “more thinly spread” than initially intended, putting pressure on existing capacity and raising some uncertainties in terms of continuity, scope and sustainability.
The W4H multisectoral approach starts with understanding the context, inclusive and evidence-based policy dialogue, bottom-up planning, adaptation and adoption of tailored implementation methods based on national priorities. This takes time but ensures that it is sustained by enabling and supporting national counterparts, social partners, partners and implementers with context-specific tools, guidance and facilitation.

Countries have strengthened capacities and put systems in place to sustain the programme’s interventions and results over time. In all countries and economic regions, the W4H programme has resulted in evidence-informed and data-driven changes concerning national health and care workforce strategies, inclusive policy dialogue and decisions. Respondents commended the W4H programme and MPTF for its flexibility to adjust to evolving needs and priorities related to country context, especially fuelled by the COVID-19 pandemic. This flexibility is considered a success factor in the effective and sustainable impact of the W4H programme, though it is observed that the decision-making and approval timeframe needs to be significantly streamlined and shortened in the future.

As part of the W4H MPTF, WHO, ILO and OECD have created and developed a set of catalytic global public goods, including the Interagency Data Exchange Platform (IADEx) and the International Platform on Health Worker Mobility. Stakeholders from the three agencies consider the new knowledge products that have been developed through these platforms valuable. More support, and hence capacity, is needed to ensure the uptake and application of these global public goods.

Observations from this review of the implementation of the W4H programme and an analysis of development actors’ investments in health and care workforce programmes and job creation indicate available donor commitments to the MPTF as well as the broader health workforce agenda have so far remained modest. Factors that may have hindered the emergence of a well-funded long-term health and care workforce agenda include the relative complexity of securing sustained workforce investment across sectors, an unfavourable macroeconomic policy environment, and the issue itself receiving little traction despite significant recognition of its importance – which was also noted in the independent mid-term review. Thus, 20 years after the Joint Learning Initiative on the health workforce, there is still an urgent need for shared responsibility for international cooperation to eliminate and address the persistent underinvestment in the health workforce. Three considerations are provided for moving forward.

- **From competition to collaboration and joint advocacy:** Current developments show a global architecture that prioritizes (financing) pandemic preparedness and response. While this could be considered increased competition, the W4H programme could learn from a recent initiative exploring the role of universal health coverage (UHC) within the global health security architecture. The W4H programme could connect with such new initiatives, position itself as a partner enabling collective action at a time when political energy is mostly spent on health security, pandemic preparedness and combating transnational health threats, and advocate against the false dichotomies between global health security and UHC – as both require sustained investments in the health and care workforce. The joint advocacy should emphasize the importance of investing in the health and care workforce at the very time when many countries are maintaining inadequate levels of health spending and austerity measures have returned.

- **Financing the global health and care workforce:** International platforms, financial institutions and multilateral organizations now clearly speak out on the need for social health and care spending, which provides opportunities for W4H and its partners to engage in a constructive dialogue with these economic governance bodies. The W4H programme could lead by example: offering beneficiaries and donors the prospect of a sound, longer term W4H programme and structure managed in an inclusive manner, aligned with new emerging health workforce initiatives to address shortages, and sustain essential services and health systems preparedness as opportunities for joint investment, collaboration and action. It should do so from a global health equity point of view.

- **From “tragedy of the commons” to investing in global public health goods:** W4H has generated global public goods such as IADEx and the International Platform on Health Workforce Mobility. In several countries, the W4H programme has contributed to laying the foundation for investments and actions in the workforce, including through the facilitation of more granular data collection via the National Health Workforce Accounts (NHWA), and through the lens of health labour market analysis (HLMA). These fundamental global public goods, namely knowledge synthesis and dissemination that provide a basis for global policy guidance, should be prioritized and financed through a global collective financing mechanism. These investments must be needs based and focus on local capacity strengthening and move away from the fragmented plethora of global initiatives.
1. Introduction

Background

The Working for health five-year action plan for health employment and inclusive economic growth (2017–2021) (1) draws on the recommendations of the report of the United Nations High-Level Commission on Health Employment and Economic Growth (“the Commission”) (2). It is delivered through the joint intersectoral W4H programme and its MPTF in partnership with ILO, OECD and WHO. Its objective is to stimulate workforce actions in alignment with national, regional and global strategies and plans. These actions are delivered at country and regional level through multisectoral Member State-led collaboration and catalytic technical and financial support.

The W4H programme has successfully mobilized and leveraged workforce investments in evidence-based policy, education, skills, occupational safety and health (OSH), employment and institutional capacity-building in 13 countries, and two subregional economic zones.1 It directly supports those countries with significant workforce gaps, and where UHC is least likely to be achieved.

The 2017–2021 action plan’s MPTF implementation and funding mechanism was operationalized in 2018 as set out in its terms of reference and operations manual. The MPTF is administered by the United Nations MPTF Office within the United Nations Development Programme which serves as the management and administrative interface between the donors and the participating United Nations organizations.

The implementation of the W4H programme and MPTF is overseen by ILO, OECD and WHO through twice annual decision-making meetings of a senior-level steering committee supported by a joint technical secretariat responsible for developing annual operational plans and ensuring effective implementation, including communications and knowledge management, stakeholder engagement, consultative processes, and monitoring and reporting.

The programme aims to provide direct assistance to governments, social partners and key stakeholders to strengthen institutional capacity, analytics and intersectoral policy dialogue in order to develop, finance and implement enhanced national health workforce strategies that:

- develop the supply of appropriately skilled workforce to meet public needs;
- create decent jobs that meet both public and workforce needs;
- optimize the retention, recruitment and performance of the workforce; and
- achieve mutuality of benefits from the international labour mobility of health workers.

1 These include country and area programmes in Benin, Chad, Guinea, Kenya, Mali, Mauritania, Niger, Pakistan, occupied Palestinian territory, including east Jerusalem, Rwanda, Somalia, South Africa, Sudan (MPTF supported); Cambodia, Kyrgyzstan, Nepal, Sri Lanka (supported by the United Nations Peace and Development Trust Fund); and regional programme work focused on the Southern African Development Community (SADC) and West African Economic and Monetary Union (WAEMU).
The 2017–2021 W4H 5-year action plan does not prescribe what Member States or key stakeholders are required to do to implement the Commission’s recommendations. Instead, it sets out the deliverables that ILO, OECD and WHO would generate to respond to the demands and requests by Member States, employers’ and workers’ organizations, and other key stakeholders. Where applicable, and at the request of Member States, the organizations would conduct analysis and research, advise on norms and international labour standards, provide technical cooperation, convene and coordinate, manage and exchange knowledge, develop institutional capacity, and facilitate investment and financing.

The deliverables have been grouped in five interrelated work streams (Fig. 1). The initial plan was to prioritize 15–20 countries across regions where UHC and the Commission’s recommendations are least likely to be attained. These countries included Member States of SADC and WAEMU and beyond. Moreover, W4H chose to specifically support these regional economic integration organizations to establish coherent intersectoral human resources for health (HRH) development strategies and investment plans. Countries and regions have been supported via short, 1-year catalytic funding of US$ 100 000–300 000 per country, which could be used to mobilize additional resources in support of workforce investments. Also, W4H developed and adapted key global goods, including the International Platform on Health Worker Mobility, IADEx, an approach by ILO and OECD for anticipating skill needs in the health workforce, and a methodology for measuring employment impact.

1. Advocacy, social dialogue and policy dialogue: galvanizing political support and momentum and building intersectoral commitment at the global, regional and national levels; strengthening social dialogue and policy dialogue for investments and action;

2. Data, evidence and accountability: strengthening data and evidence through implementation of the NHWA and the global health labour market data exchange; enhancing accountability through monitoring, review and action; and strengthening knowledge management;

3. Education, skills and jobs: accelerating the implementation of intersectoral national health workforce strategies designed to achieve a sustainable health workforce;

4. Financing and investments: supporting Member States in catalysing sustainable financing for increased investments in health and care workforces through financing reforms and increased domestic and international resources; and

5. International labour mobility: facilitating policy dialogue, analysis and institutional capacity building to maximize mutual benefits from international labour mobility.

Fig. 2. Deliverables of the Working for Health five-year action plan for health employment and inclusive economic growth (2017–2021) programme grouped in five interrelated work streams

Scope and purpose of the review

In 2020 an independent mid-term review was commissioned to evaluate the progress of the 2017–2021 W4H 5-year action plan programme and its MPTF; it was conducted by an independent research team, through the Antwerp Institute of Tropical Medicine. The review found that the W4H programme effectively enabled the International Platform on Health Worker Mobility and IADex, contributed to the establishment of health sector investment plans in regions, and facilitated intersectoral health and care workforce development and capacity strengthening in beneficiary countries. This overall programme evaluation will build on these findings, which demonstrated a near-unanimous confirmation of the relevance of the W4H programme.8

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This independent end-of-programme review assesses the experience of implementing the first W4H 5-year action plan (2017–2021) and its MPTF, with a continuation of project activities to the end of 2022 due to the no-cost extension as a result of the barriers faced by the COVID-19 pandemic and other emergencies in several countries. This independent review looks to the future of sustaining investment and support for the next W4H programme action plan (2022–2030). In 2022, at the Seventy-fifth World Health Assembly, Resolution 75.17: Human resources for health (3), was co-sponsored by over 100 Member States, which called for the adoption and implementation of the 2022–2030 W4H action plan (4) and utilization of the related Global health and care worker compact (5).

In line with the WHO evaluation policy, the review focuses on five key criteria: relevance, efficiency, effectiveness, impact and sustainability. It also assesses the potential for sustainability of the programme beyond its end date. Its findings, recommendations and lessons learned will feed into decision-making processes of the MPTF and key stakeholders.

Specific objectives of this review

The specific objectives of this review are:

• To conduct a review of implementation and achievements of the W4H programme and its MPTF according to the MPTF’s terms of reference and results matrix – to describe challenges and lessons learned.

• To provide a description and analysis of findings, taking into consideration the relevance, efficiency, effectiveness, impact and sustainability in terms of the programme’s design, delivery, governance, operational and financial structures, and reporting modalities.

• To undertake a brief impact and sustainability assessment of the programme with respect to its contribution to the targets set out in the 2017–2021 W4H 5-year action plan.

• To advise WHO and partner organizations on leveraging the lessons learned from the W4H programme in order to meet the targets of the new 2022–2030 W4H action plan.

Evaluation methodology

The end-of-project review is based on a desk review of strategic documents, implementation and reporting documents, meeting reports, and communication and visibility materials relating to all the MPTF-supported projects under review (2017–2022) (Annex 1):

• Phase 1: Guinea, Niger, Rwanda, South Africa, SADC, WAEMU, International Platform on Health Worker Mobility, IADEx

• Phase 2: Benin, Chad, Mali, Mauritania, occupied Palestinian territory, including east Jerusalem (hereafter referred to as occupied Palestinian territory), and Sudan

• Phase 3: Pakistan, Somalia and Kenya

• Phase 4: Anticipating skill needs in the health workforce.

In addition, key informant interviews with stakeholders were conducted with direct beneficiaries such as ministry of health representatives, staff involved in the management, coordination and implementation of the programme at country and area, regional and global levels, as well as the MPTF Secretariat, and members of the Steering Committee (see Acknowledgements). In total, individual interviews took place with 12 persons and eight interviews covered between two and four participants. In total 36 participants provided their input, covering 12 country and two regional perspectives (Annex 2 covers the key evaluation criteria and questions).

2. Implementation and achievements, including tangible results at country and area, regional and global levels

This section provides an overview of key findings from the documents reviewed and from the interviews. This section makes no claim to completeness as not all results were published and available at the time of the review.

Key findings from the documents reviewed

Country- and area-level achievements

Implementation of the first approved W4H project in 2019 supported four countries to initiate and implement health workforce strategies and investment plans to achieve UHC (Guinea, Niger, Rwanda, South Africa).

In 2020 W4H expanded its operations to a total of 10 countries and areas (Benin, Chad, Guinea, Mali, Mauritania, Niger, occupied Palestinian territory, Rwanda, South Africa and Sudan). It facilitated multisectoral policy engagement; evidence-based planning and decisions; guidance on investment choices to expand education, skills and jobs; and the building of core capabilities for robust health system strengthening.

In 2021, W4H facilitated multisectoral policy engagement and evidence-based planning and decisions in 13 directly supported countries and areas (including Pakistan and Somalia), which in Chad led to the recruitment and deployment of 1652 health workers. However, in Chad the planned recruitment of an estimated 5000 health workers was not realized due to the political instability. In Somalia, multisectoral policy engagement and evidence-based planning and decisions facilitated by W4H led to the deployment of over 3000 community health workers (CHWs). In addition, the programme built core capabilities for robust health system strengthening in the 13 supported countries and areas, which enabled skills development of over 1500 health workers at the hospital and primary health care level in occupied Palestinian territory, and improved capacities to strengthen OSH for health workers in eight countries and areas (Benin, Chad, Guinea, Mali, Mauritania, South Africa, occupied Palestinian territory, Pakistan). At least 900 constituents in the health sector were trained in OSH and COVID-19 response (using HealthWISE and the COVID-19 checklist for health facilities). In Mauritania and Chad, workshops combined training on social dialogue in the health sector with OSH training.
The country achievements of Niger, Rwanda and South Africa for the years 2019, 2020 and 2021, as examples, show in more detail the progress made in those years (see Annex 3). For Rwanda, the HLMA provided evidence for policy dialogue, development and implementation. In addition, the World Bank used the findings of the HLMA in dialogue with the Government of Rwanda to support health workforce policy reforms and investment in HRH. In Niger, by the end of 2021, out of a projected total of 6000 health workers to be recruited as part of the national action plan, W4H, together with funding from other sources, had facilitated the creation of 1005 jobs for health workers (doctors, midwives, nurses, laboratory technicians and hygiene technicians) in 2019, 100 jobs in 2020 and 1540 jobs in 2021. It was also noted that 3355 additional jobs in the health sector have yet to be created due to insufficient domestic resources dedicated to HRH initial progress. In South Africa, upon request from the Eastern Cape Department of Health, progress towards strengthening OSH has been made in close collaboration with the tripartite Technical Working Group, established to coordinate all the work related to COVID-19, OSH and HIV/TB in the world of work. Through the W4H programme, ILO provided technical guidance and support on OSH and COVID-19 response.

Regional-level achievements

In 2019 W4H enabled two regional economic communities to develop and implement harmonized health workforce strategies to expand education, skills and jobs (SADC and WAEMU). The continued support and funding throughout 2020 and 2021 enabled the development of workforce strategies and investment plans in those two regions. Political engagement at the regional level, through developing HRH strategies, took some time to involve all relevant stakeholders and political cycles. It effectively generated regional coherence and commitment (e.g. by agreeing on fiscal space levels) to investment in health employment, including in providing for flexible adjustments during the COVID-19 pandemic.

After the successful development and endorsement of the new SADC Health workforce strategic plan 2020–2030: investing in skills and job creation for health (6), which calls for an additional 40% in workforce investments over the next 10 years, W4H supported the dissemination of the detailed, costed, model implementation plan and monitoring framework, including key milestones and indicators, for the SADC strategic plan. Furthermore, the W4H facilitated preparatory work for the launch and dissemination of the HRH strategy, and for the establishment of an “accountability mechanism” for the SADC Secretariat, which was launched in 2022.

Following the recommendations of the High-Level Commission on Health Employment and Economic Growth (2), WAEMU has been the first subregional economic group to engage in developing a subregional health workforce investment plan, which is committed to the creation of 40 000 new jobs by 2022 and intensified regional cooperation to boost health employment. However, the WAEMU region faced severe challenges from the COVID-19 pandemic that triggered a triple crisis impacting the health, economic and security situations. Both fiscal and monetary policies were relaxed significantly in 2020 to contain the pandemic and support the economy.

In 2021, ILO led a study to examine the long-term quantitative employment impacts of WAEMU’s investments in the health sector. Results confirmed that public health and related spending have important long-term impacts on economic growth, the health and care workforce and employment. The results of the study aim to inform WAEMU’s ministries of health, labour and employment, finance, education, higher education and civil service broader consideration of an investment allocation framework in support of future subregional health care investment decisions.

In 2022 a high-level regional health workforce investment policy dialogue was attended by 26 Member States, development partners and international financing institutions in Accra, Ghana, with technical and financial support provided through W4H’s portfolio of subregional support to WAEMU for the development, resourcing and implementation of subregional health workforce investment plans (7). The outcome of the policy dialogue will be the development of the Regional Health Workforce Investment Charter in 2023 that will align all stakeholders and partners around one common investment approach and agenda for the region.

Global-level achievements

W4H developed and established the International Platform on Health Worker Mobility and IADEx as major global initiatives for driving evidence-based health workforce policy, reform and investments in 2019. In 2020 the International Platform on Health Worker Mobility advanced knowledge and cooperation on health worker mobility through the 10-year review of the relevance and effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel (8). Further, IADEx consolidated workforce data and information exchange between partner organizations of 193 countries through NHWAs. In addition, in 2021, a multiagency technical working group on job creation developed a methodology to measure employment impact and job creation in the health sector, an approach for anticipating skill needs in the health workforce, and a methodology for measuring employment impact.

Observations from the independent mid-term review included that both the International Platform on Health Worker Mobility and IADex would need to be more visible and tested against country-level activities and achievements. Between the independent mid-term review and this end-of-project review both global public goods have expanded the evidence base (including what is measured and how it is measured) regarding adherence to the WHO Code. Further institutionalization of the International Platform on Health Worker Mobility was recommended, given the pressures and growth of labour mobility, which have also been noted in recent W4H-supported OECD papers on doctors (9) and nurses (10). A joint report by the OECD and ILO that has recently been published with W4H support aimed to enable more resilient health workforces by helping countries to assess future demand in terms of both numbers of health workers and skills needs, and to prepare appropriate policy responses (11). Observations from these current publications agree with those from the independent mid-term review that various actors (besides Member States) should continue to be involved in the International Platform on Health Worker Mobility, including employers’ and workers’ organizations, and civil society, in order to discuss and ensure win-win outcomes of migration flows for both origin and destination countries.
Interviews with stakeholders provided the following key findings regarding the W4H programme benefits and impact and its constraints/limitations:

Benefits and impact of the W4H programme

• Respondents consider a benefit of W4H is that it raised the profile of health and care workforce issues. It has contributed to putting the health and care workforce on the global, regional and national agenda, which was reinforced by the COVID-19 pandemic. Taking the regional agenda as a case in point, SADC comprises 16 African countries that form an economic zone and collaborate on health, among other issues. Jacob Zuma co-chaired the United Nations High-Level Commission on Health Employment and Economic Growth and was at that time part of the SADC troika which includes past, current and future chairs of SADC to ensure continuation. This facilitated the successful development and endorsement of the new SADC Health workforce strategic plan 2020–2030, with technical and financial support from W4H (in following up on the Commission’s recommendations).

• Respondents found the establishment of multistakeholder dynamics and committees with representatives from ministries, including labour, health, finance, higher education etc., to be very important (both at national and decentralized levels), as these often did not previously exist around the topic of HRH. In Sudan, for example, 28 stakeholders worked with the Ministry of Health regarding the health workforce. The Sudanese National Taskforce increased collaboration with the Ministry of Higher Education which helped improve education of the health workforce. In the occupied Palestinian territory, W4H activities facilitated a collaboration between government and private sector health facilities on HRH, and that relationship is still ongoing. In Benin, W4H facilitated good collaboration between the Ministry of Health and the Ministry of Education. It has helped identify HRH priorities with a focus on underserved rural areas; the National Medical and Health Institute has strengthened and increased HRH training programmes.

• W4H’s catalytic funds have been used to support the development of longer term HRH strategic development plans in beneficiary countries and at regional level. For instance, the Sudanese Government, with support from the W4H programme, adopted the National human resources for health strategic framework 2030 (12), which provided impetus for investment and implementation to strengthen the health and care workforce.

• In supported countries W4H has helped mobilize other partners and funding for additional HRH activities and policies. In Benin, for example, the World Bank has committed to the recruitment of 2384 young doctors, midwives and nurses as a result of resource mobilization. Mali, too, has been successful in mobilizing international resources and finding synergies with the Muskoka Fund, i.e. to support HealthWISE trainings in OSH in several regions. In Chad, W4H has helped to mobilize other funds during COVID-19 and funding through the Muskoka Fund for developing health and care workforce policies and strategies.

• WHO and ILO are specialized agencies that have different roles and perspectives, and it is challenging yet valuable to bring these health and labour perspectives together. In Chad, for example, the programme made it possible to create a true multisectoral committee involving key ministries, employers and unions in the health sector. This multisectoral committee manages the implementation of the W4H programme in Chad. This has led to further training of the health and care workforce in OSH. In Pakistan, similar to Mali and Chad, W4H supported capacity building to improve working conditions and OSH for health and care workers. WHO and ILO worked together to jointly prepare plans and activities to support workers’ rights in the health and care sector.

Constraints/limitations of the W4H programme

• As a result of the pandemic, initially identified priorities for W4H were overtaken by more pressing issues such as immediate support for the response to COVID-19. As a case in point, in Benin, W4H supported efforts to strengthen the effectiveness of the national COVID-19 response – including enhanced community surveillance, and capacity of frontline professionals (psychologists, social workers and health workers) to provide care and psychosocial support interventions for individuals and families affected or infected by COVID-19.

• Despite all the achievements, respondents from several beneficiary countries considered the unstable sociopolitical and economic situations in their contexts as limiting the W4H programme. In Niger, for instance, security is a particular issue in three regions (Diffa, Tahoua and Tillabéry) and impacted on the activities that could be implemented throughout the duration of the programme. This might also have an impact on the sustainability of the activities and possibilities for follow-up actions.

• Some respondents indicated that finding additional resources is time consuming and that the duration of W4H projects is too short to implement all activities.

Additional key findings from the interviews regarding challenges and lessons learned can be found in Section 4.
3. An analysis of the relevance, effectiveness, efficiency, impact and sustainability of the programme

Relevance

A review of documents and interviews with respondents demonstrated that the W4H programme and its 2017–2021 5-year action plan have continued to be highly relevant and have contributed to countries’ efforts to address challenges in relation to the health and care workforce and health systems strengthening. It is seen as a strategic mechanism for addressing the health and care workforce’s essential role and the impact of the COVID-19 pandemic in exposing investment needs in the workforce. The information confirms the relevance of intersectoral dialogue on the health workforce and policy advocacy. In the 13 countries and two regions supported through the MPTF, there is interest and a clear willingness to continue this approach – for instance in Mauritania, on the joint development and implementation of its national HRH development plan (2022–2026). It is also reflected in the recruitment and investment plans that several countries have committed to, such as Somalia and Niger.

W4H is also considered relevant due to its focus on responding to pressures and failures in the international health labour market, and on health and care workforce mobility. These results confirm the earlier findings of the independent mid-term review from 2020. For example, SADC set an objective of creating a multilateral framework on health workforce mobility. In addition to the previously mentioned W4H supported ILO/OECD papers (9–11), a recent brief with a focus on the nursing workforce emphasizes that the pandemic has heightened the risks associated with international recruitment: cutting across international supply to some high-income “destination” countries, in the short term, whilst driving up “push factors” and likely outflow from low-income “source” countries. Therefore, it is important that country-led projects link with the International Platform on Health Worker Mobility established by W4H. A newly developed dataset and report enabled cross reference of migrant health workers by country of birth and training in the OECD, leading to a more granular understanding of international health worker mobility patterns. An HLMA in Kenya, supported by the W4H programme, provided data showing that 30,000 Kenyan nurses had moved to the United Kingdom of Great Britain and Northern Ireland. It evidenced that a migration policy was needed as part of the new national policy on the health workforce. The International Platform on Health Worker Mobility has also served to monitor policy changes in crucial destination countries regarding entry, stay and recognition of foreign health professional foreign qualifications during the COVID-19 pandemic.

Effectiveness

Since 2018, the W4H MPTF has mobilized US$ 4 813 814 in contributions from the Norwegian Agency for Development Cooperation and Silatech. This is less than the anticipated US$ 70 million, although the United Nations Peace and Development Trust Fund provided an additional US$ 2.9 million funds via the Government of China in a bilateral agreement with WHO to implement the W4H approach in four countries over the 3-year period 2018–2021.

An anticipated, additional contributions from the Swiss Development Cooperation will be committed to implementation of the 2022–2030 W4H action plan in phase two, to comply with the Swiss Development Cooperation’s financial cycle.

There was insufficient funding to deliver the full programme as intended (initial targets set). With its limited funding, however, the W4H MPTF has programmed funding across the phases of implementation, which has facilitated:

- intersectoral health and care workforce development and capacity strengthening in 16 countries;
- supported two regional economic areas (SADC and WEAMU), informed and guided by detailed HLMA and NHWAs;
- developed and adapted key global goods, including the International Platform on Health Worker Mobility, IADEx, an approach for anticipating skill needs in the health workforce, and a methodology for measuring employment impact.

Countries and regions have been supported via short, 1-year catalytic funding of US$ 100 000–300 000 per country, which has been used to mobilize additional resources in support of workforce investments. Although the catalytic model is considered effective by respondents and stakeholders, the considerable underfunding of the W4H programme has affected its expansion and limited its scope in countries.

Effective implementation was enabled due to multisectional collaboration, for example in Chad. As part of the joint WHO-ILO inception mission in February 2020, technical discussions contributed to the capacity building of stakeholders engaged in the development of a social health protection strategy for UHC. This included a multisectional tripartite dialogue about creating decent work with the appropriate compensation for health and care workers at primary health care level, involving stakeholders from different ministries – health, economic planning and development, higher education, research and vocational training; and ministers for the civil service, labour, employment, decentralization, economy, planning, and cooperation.

### Efficiency

The W4H programme has delivered results in an economic and timely way by providing targeted catalytic funding and technical assistance. In some instances, for example South Africa, this enabled the programme to contribute towards a range of “additional deliverables” without any additional funds (e.g. a strategic directions for nursing document, and a rollout of OSH capacity building initiatives at provincial level). However, respondents indicate that there was limited funding per country as it was “more thinly spread” than initially intended, putting pressure on existing capacity and raising some uncertainties in terms of continuity, scope and sustainability.

The programme’s governance, partnership, operational and institutional arrangements including funds allocation, management and transfer; staff time used to develop, manage and implement the project; as well as reporting modalities, worked well but were perceived as quite heavy in relation to the level of available funding. Respondents indicated that sustainability of funding was preferable to fragmentation. This would improve clarity on the scope and length of W4H funding, timely disbursement and reporting requirements.

### Impact

Countries have built capacities and put systems in place to sustain the programme’s results over time. In all countries and economic regions, the W4H programme has resulted in evidence-informed and data-driven changes concerning national health and care workforce strategies, inclusive policy dialogue and decisions. For Rwanda, as a case in point, the HLMA provided evidence for policy dialogue, policy development and implementation. In addition, the World Bank used the findings of the HLMA in the dialogue with the Government of Rwanda to support HRH reforms.

Other examples confirm the W4H programme’s impact. W4H facilitated multisectional policy engagement and evidence-based planning and decisions in 13 supported countries and areas, which, in Chad led to the recruitment and deployment of 1652 health workers. It also facilitated guidance on investment choices to expand education, skills and jobs enabling the creation of 1540 personnel in Niger in 2021. Further, the programme has built core capabilities for robust health system strengthening in 13 supported countries and areas, which enabled skills development of over 1500 health workers at the hospital and primary health care level in the occupied Palestinian territory. WAEMU countries committed to create 40 000 new jobs by 2022, and SADC’s new regional strategy and investment plan calls for an additional 40% in workforce investments over the next 10 years.

Respondents commended the W4H programme and MPTF for its flexibility to adjust to changing needs related to country context, especially fuelled by the COVID-19 pandemic. This flexibility is considered a success factor for the effective and sustainable impact of the W4H programme, though it is observed that the decision-making and approval timeframe needs to be significantly streamlined and shortened for the future. The pandemic challenged health systems at all economic levels and tested the strength of the W4H partnership within country systems leaving WHO and ILO sometimes taking separate routes, though in many ways the W4H programme has planted the seed of the interagency approach.

### Sustainability

The W4H multisectional approach starts with understanding the context, inclusive policy dialogue, evidence-based bottom-up planning, adaptation and adoption of tailored implementation methods based on national priorities. This takes time but ensures that programme achievements are sustained by enabling and supporting national counterparts, social partners and consultants with context-specific tools, guidance and facilitation. W4H has supported countries to establish intersectoral collaboration and coordination mechanisms, such as in Chad and Sudan, often strengthening and/or making existing mechanisms and partnerships more strategic and functional, which helps stakeholders to lead and drive efforts to strengthen the health workforce and care personnel and align them with immediate and peripheral policies, institutions, actions, approaches and instruments in the health and care sector so that they all work together toward the same goal.

Health and care workforce development requires a long-term commitment from partner countries and funders alike to enable sustainable impact. This review shows that the W4H approach has been able to contribute to UHC and to SDGs 3, 4, 5 and 8, through multisectional interventions to expand and transform health and care workforce education, skills and jobs.
4. Results of the impact and sustainability assessment

This section presents a strengths, weaknesses, opportunities and threats (SWOT) analysis, challenges and lessons learned. The SWOT analysis opposite has been updated from that presented in the independent mid-term review of the 2017–2021 W4H 5-year action plan programme and its MPTF.

Updated SWOT analysis

Challenges and lessons learned

W4H Program

The W4H programme has been ambitious in bringing together all stakeholders to work jointly on all SDGs related to the health and care workforce. Both the W4H programme and its MPTF have demonstrated the high value and effectiveness of applying catalytic flexible funding and technical assistance where it is most needed, and to address immediate country-defined priorities.

In response to direct country support requests to the MPTF, WHO prepared project concept notes through its country and regional offices, but not all these countries had ILO country offices, which sometimes prevented joint collaboration and cooperation on these projects. ILO had to involve different constituents, such as health sector workers and employers’ representatives, and could have benefited from more time to consult them. The new W4H action plan programme would benefit from allowing for enough time for WHO and ILO to facilitate the joint preparation of concept notes and implementation trajectories in response to country requests, which requires involving all relevant partners at national level. Additionally, time is needed to enable all planned activities, deliverables and interventions to be implemented and supported through multisectoral engagement, collaboration and partnership.

Maintaining a relevant agenda for health and care workforce investment throughout different political cycles remains a complex challenge. This requires a long-term commitment, translated into strengthened institutions and long-term health and care workforce plans and policies – both at country and regional level. Political engagement at regional level (e.g. SADC and WAEMU), through developing RH strategies, took some time to involve all relevant stakeholders and political cycles. It effectively generates regional coherence and commitment (e.g. by agreeing on fiscal space levels) to investments in health employment, including in providing for flexible adjustments (e.g. during the COVID-19 pandemic).

The regional role has proven to be important due to its support with technical capacity for coordinating and liaising between countries, which has increased the impact of the W4H programme beyond the target countries and regions (e.g. Lesotho and Kenya). Although the focus must remain on direct country support, additional capacity for the implementing partners could reduce some pressure on the current capacities and allow additional countries to benefit from the W4H programme through linking and learning with stakeholders.
As part of the W4H MPTF, ILO, OECD and WHO have created and developed a set of catalytic global public goods, including the International Platform on Health Worker Mobility and IADEx. Support from the W4H programme to the International Platform on Health Worker Mobility has resulted in developing new knowledge products which provide a significantly more comprehensive understanding of international health worker mobility than previously available. IADEx has consolidated and maximized the value of existing health workforce data and information to ensure greater consistency and reduce the data collection burden on countries. The global public goods also included the normative guidance, tools, evidence, global advocacy and awareness-raising required to accelerate plans and investments, foster greater policy coherence, develop innovative partnerships and disseminate new knowledge to support scaling up investments in transformative education, skills and job creation. Stakeholders from the three agencies consider these public goods valuable. More support, and hence capacity, would be needed to ensure the uptake and application of these global public goods, linking low- and middle-income countries and high-income countries through the health and care workforce agenda (i.e. migration and mobility flows of health workers).

**MPTF**

The structure and governance of the MPTF are considered strong and appropriate for multistakeholder engagement, according to stakeholders. One of its strengths is that donors co-share potential risks compared with bilateral funding. Also, the W4H and its MPTF support the normative side of investing in the health and care workforce, such as the global public goods. The MPTF could benefit from more branding to raise its identity and better showcase the technical work done through joint work.

Both the COVID-19 pandemic and political and social instability in countries where the W4H programme was implemented (e.g. Benin, Niger, Mali, Sudan) imposed challenges and caused delays to implementing activities. Stakeholders confirm that the flexibility of the W4H programme and its MPTF to adjust to the changing needs of constituents according to their context should be seen as a success factor for its effective and sustainable impact. This was effectively demonstrated in multiple instances where rapid reprogramming was carried out in order to accommodate country requests during the pandemic response.

This would improve even further if this could be supported with a decision-taking mechanism that is up to speed for (very often) ad hoc guidance and approval for reprogramming of activities so as not to lose momentum at country level.

Cooperation between the three agencies has proven its added value in promoting investment in the health and care workforce. The joint ILO-OECD-WHO W4H programme has provided country-led support to several countries, facilitated the application of HLMAs, and the utilization of data and NHWA for evidence-based policy, planning and decision-making, which attracted further investments from the World Bank. Similarly, catalytic activities of WHO and ILO in the occupied Palestinian territory contributed to further investments from other donors, including in nursing education and regulation.

This collaboration of ILO, OECD and WHO requires long-term commitment, continuous engagement, transparency and communication as it cannot be taken for granted. All three organizations have different mandates and different decision-making mechanisms. It remains important for all three to internally advocate for (investing in) the health and care workforce and keep it high on the agenda of the senior leadership.

**Limitations of the programme evaluation**

The review had several limitations.

- Firstly, this review is based on internal reports as primary sources. Other sources, such as the independent mid-term review (2020) and Review of the Working for Health: Cambodia, Kyrgyzstan, Nepal, Sri Lanka project (2022) and academic publications have been used to provide a contextualization of the findings.

- Time limitations restricted the independent reviewer from contacting a larger number of individual external stakeholders at local level that could have shed light on the benefits and challenges/limitations of this project.

- Due to the timeframe for submission of this review it cannot capture the final overview of the results matrix (Annex 5), nor the longer term impact such as coverage of essential health services and total expenditure on health workforce.
5. Opportunities for future programming and leveraging achievements of the programme

The Joint Learning Initiative on HRH and development, in its analysis of the global health workforce published in 2004 (13), called for mobilizing and strengthening HRH as an essential strategy to combat health crises in the world’s poorest countries and build sustainable health systems everywhere. The fourth Global Health Watch (GHW4) (14) noted that this was the beginning of several “good years for HRH” in global health policy, including the 2006 World health report 2006: working together for health (15) and the first Global Forum on Human Resources for Health in 2008 with its Kampala Declaration and Agenda for Health. According to GWH4, those “good years” culminated in 2010, when the World Health Assembly unanimously adopted the WHO Global Code of Practice on the International Recruitment of Health Personnel. Some years later, however, the United Nations High-Level Commission on Health Employment and Economic Growth presented its recommendations and the 2017–2021 W4H 5-year action plan. The renewed mandate given by Member States through Resolution 75.17 at the Seventy-fifth World Health Assembly extended the W4H programme and its agenda to 2030 (3,4).

Observations from this review of the implementation of the W4H programme and an analysis of development actors’ investments in health workforce programmes and job creation are that available donor resources have so far remained modest. Concerns also remain about the short-term nature of activities supported by donor funding and their viability in creating sustainable health systems (16). Factors that may have hindered the emergence of a well-funded long-term health and care workforce agenda include the relative complexity of securing sustained workforce investment across sectors, an unfavourable macroeconomic policy environment, and the issue itself not getting much traction despite significant recognition of its importance – which was also noted in the independent mid-term review, i.e. 20 years after the Joint Learning Initiative on the health workforce, there is still an urgent need for shared responsibility for international cooperation to eliminate and address the persistent underinvestment in health workforce. There are three interrelated considerations for moving forward.

From competition to collaboration and joint advocacy

The W4H programme aims at the expansion and transformation of the global health and care workforce in order to accelerate progress towards UHC and global health security. The independent mid-term review was hopeful, noting that “the COVID-19 pandemic may prove an opportunity and transformational moment for political will to invest in the health workforce”. Current developments, however, show a global architecture that prioritizes (financing) pandemic preparedness and response. Examples include the World Bank approved US$ 100 million support programme for the Africa Centres for Disease Control and Prevention (17), the launch of the Gulf Center for Disease Control and Prevention (18) and the European Commission State of health preparedness report (19) presented in parallel to the European Union’s Global Health Strategy (20).
While this could be considered increased competition, the W4H programme could learn from a recent initiative exploring the role of UHC within the global health security architecture. Lal et al. propose solutions to equitably meet the needs of all communities while ensuring resilience to future pandemics threats (21). This includes dedicated investments in a robust health workforce, including in its working conditions and sustained essential health services that prove most vulnerable during health emergencies. The W4H programme could connect with such new initiatives, position itself as a partner enabling collective action at a time when political energy is mostly spent on health security, pandemic preparedness and combating transnational health threats, and advocate against the false dichotomies between global health security and UHC: “the international community should not repeat the mistakes of past health security efforts that ultimately contributed to the rapid spread of the COVID-19 pandemic and disproportionately affected vulnerable and marginalised populations, especially by overlooking the importance of coherent, multisectoral approach to sustainably strengthening health systems” (22).

The joint advocacy should emphasize the importance of investing in the health and care workforce, at a time when many countries are maintaining inadequate levels of health spending and austerity measures have returned – both in low- and middle-income countries and high-income countries (22, 23, 24). The added value of the joint forces of ILO, OECD and WHO in addressing human resource issues in health offers a unique opportunity to combat these structural barriers. W4H’s great strength (and challenge) is that it supports intersectoral cooperation and coordination between the finance, labour, education, health, social affairs and external affairs sectors, as well as close collaboration with health employers’ and workers’ organizations, professional associations and other key stakeholders.

Financing the global health and care workforce

It remains critical that development assistance and other forms of financing for the health and care workforce target the full range of activities that are necessary for deployment, retention, protection and management of a sustainable skilled health workforce that can deliver on the global health goals. International platforms, financial institutions and multilateral organizations now clearly speak out on the need for social spending, which provides opportunities for W4H and its partners to engage in a constructive dialogue with these economic governance bodies. The WHO Council on the Economics of Health For All suggests three pathways for action:

- creation of fiscal space;
- direction of investment; and
- governance of public and private finance (25).

Close collaboration between WHO and ILO on investing in decent work, gender equality, labour migration and the care economy must be continued and deepened, as also indicated in the independent mid-term review. The same goes for the work with OECD, focusing on financing, official development assistance and taxation benefitting health and care workforce employment. Teaming up around HRH leadership, capacity and global health diplomacy should be strengthened and supported in national, regional and global political fora. Likewise, at the G7, G20 and United National General Assembly, it is crucial to argue for (and prioritize) the fiscal and financial space to invest in health employment, even more so in the aftermath of the COVID-19 pandemic. For this, leadership must be secured through alliances between countries, health workers, civil society and prominent leaders. This will be no easy task and past experience has shown that strategies can quickly be forgotten – languishing on bookshelves. And change of political leadership often leads to discussion of new priorities.

As addressed in the independent mid-term review, the W4H programme and MPTF could play an important catalytic and facilitating role to operationalize an investment fund for the global health and care workforce. The W4H programme could lead by example: offering beneficiaries and donors the prospect of a sound, longer term programme and structure managed in an inclusive manner, aligned with new emerging health and care workforce initiatives to address shortages, sustain essential services and health systems preparedness as opportunities for joint investment, collaboration and action. It should do so from a global health equity point of view (26).

- Such investments require a broad coalition of financing actors to de-risk and back domestic financial efforts (27). The MTPF is considered (both during the independent mid-term review and this end-of-programme review) a solid mechanism to implement the W4H programme, and as such, it should be maintained. Also, investments made and activities implemented so far through the W4H programme and its MPTF would benefit from continued support to current implementing partners, with sustained impact as a result.
- Donors may hesitate to invest in HRH because they find it difficult to track and trace their investments or lack evidence of how they contribute to strengthening health systems. The establishment of a global observatory and independent panel to track workforce employment, financing and labour market outcomes could strengthen global transparency and accountability for investment in human resources. The IADEx, the International Platform on Health Worker Mobility and the jointly developed framework to assess employment effects in the health sector could provide the basic mechanisms for such an observatory.

From “tragedy of the commons” to investing in global public health goods

The implementation of W4H has been country-led and provided catalytic support to health and care workforce policies. Its catalytic finance approach has led to further sustained investments and measures to transform and expand the health and care workforce within already existing initiatives and policies. This has not been nearly enough, but W4H has also generated global public goods such as the International Platform on Health Workforce Mobility and IADEx.

In several countries, the W4H programme has contributed to laying the foundation for investments and actions in the workforce, including through the facilitation of more granular data collection via NHWA and HLMA. The next W4H programmatic period should also include improving measurement and analysis of its impact on country health systems and labour markets. The IADEx could provide a mechanism for this aim. In addition, it would be important to monitor and, perhaps, encourage the wider uptake of these global public health goods, as observed through the example of the recently released report by the Federation of Indian Chambers and Commerce & Industry and KPMG (28). This would contribute to evidence-based policy, planning and decision-making based on common data and/or a common approach to these data.

These fundamental global public goods, namely knowledge synthesis and dissemination that provide a basis for global policy guidance, should be prioritized and financed through a global collective purse (29). An investment agenda that prioritizes institutional, human and physical capital for health services – which are to a large extent home grown – will have to be developed. These investments must be needs based and focus on local capacity strengthening and need to move away from the fragmented plethora of global initiatives. Instead, it should unite to strengthen public health and UHC institutions at the country level. This is a “global common” which W4H can be part of and that requires global leaders to commit themselves to fostering collaboration between all international financial institutions (27).
References


Annex 1. List of documentary evidence reviewed


- Relevant products (governing bodies documents from ILO, OECD, WHO, technical documents and other meeting reports).

- Documents from Benin, Chad, Guinea, Mali, Mauritania, Niger, Pakistan, occupied Palestinian territory, Rwanda, Somalia, South Africa, Sudan (workplans, progress reports, documents resulting from technical assistance provided by the W4H programme, MPTF supported).

- Cambodia, Kyrgyzstan, Nepal, Sri Lanka (workplans, progress reports, documents resulting from technical assistance provided by the W4H programme; United Nations Peace and Development Trust Fund/China grant supported).

- Regional programme work focused on SADC and WAEMU regions (workplans, progress reports, documents resulting from technical assistance provided by the W4H programme, MPTF supported).

- Communication and visibility materials.

Annex 2. Key evaluation criteria and questions

**Relevance: did the W4H programme do the right things?**

- To what extent did the objectives and design of the project respond to:
  - the health and care workforce-related needs, policies and priorities of the beneficiaries, as well as other stakeholders involved (public and/or private sector, regional, international partners, etc.); and
  - the W4H goal to accelerate implementation of the 2030 Agenda and strengthen national policy capacity in the country and/or region to expand and transform the health and care workforce for the 2030 Agenda for Sustainable Development?
- To what extent were there differences and/or trade-offs between different priorities or needs?
- To what extent did the project remain relevant, even if the circumstances changed over the course of implementation?

**Effectiveness: did the W4H programme and related MPTF achieve its objectives?**

- To what extent were the W4H objectives achieved or are likely to be achieved (based on the indicators for expected outputs and outcomes identified in the W4H matrix) including any differential results across countries?
- What were the major factors influencing the achievement (delivery) or non-achievement of the project objectives, outcomes and outputs?

**Efficiency: how well were resources used?**

- To what extent did the W4H programme deliver results in an economic, efficient and timely way, based on the project document?
- What changes and risks, if any, occurred during W4H programme implementation, and how was the W4H programme able to adapt to these changes and manage risks?
- Was the W4H programme a cost-effective contribution to addressing the needs of the beneficiaries?
- How well was the project managed (and how did its governance, operational and financial structures, and reporting modalities fit)?

**Impact: what difference did the W4H programme make?**

- To what extent did W4H generate, or is expected to generate, significant positive or negative, intended or unintended, higher level effects linked to its theory of change?
- What real difference (expected and/or unexpected) has W4H made, or is likely to have, on the final beneficiaries including generating much needed new decent work opportunities and addressing the health and care workforce mismatches to drive UHC?
- How did W4H catalyse any other action or change, for instance raising awareness on health and care workforce challenges and/or mobilizing additional resources for health and care workforce capacity development?
Sustainability: will the benefits last?

- To what extent are the benefits of the project continuing, or likely to continue over the longer term, after the end of W4H programme funding?
- To what extent was sustainability addressed at the design stage and during the project, and what are the major factors (including risks) influencing sustainability?
- Are the necessary capacities and systems (financial, social, institutional, etc.) in place to sustain the project results over time?
- What follow-up activities, if any, are planned and/or required to sustain these results over time?

Lessons learned

- What lessons can be learned from the W4H programme regarding the process of its design and implementation?
- What lessons can be learned from the W4H programme and its financing mechanism, which may be of importance to the broader donor community and which should be disseminated more widely?
- What actions have been taken by the beneficiary, W4H programme partnership or others to disseminate, learn and follow-up on the outcomes of the project?

Key questions for the interviews

- How would you assess the benefits of the W4H programme for your country and (how) will they last after the end date of the W4H programme?
- How would you assess the W4H programme has impacted on your working relations with stakeholders within your country’s government and outside?
- What would you assess as constraints/limitations of the W4H programme (and MPTF) and/or factors impacting the W4H programme in the wider landscape?
- How would you assess W4H has contributed to domestic resource mobilization and/or international resource mobilization for the health and care workforce?
- What is your take on challenges of and lessons learned from the implementation of the current W4H programme and MPTF (to leverage engagement and investment in the new action plan)?

Annex 3. Selected country achievements – Niger, Rwanda and South Africa

Box 1: Country achievements 2019

**Niger**

The W4H programme supported the implementation of Niger’s rural pipeline programme aimed at accelerating rural development through the creation of jobs for rural women and youth. The rural pipeline approach aims at translating the demographic dividend into social and economic development by improving labour force participation for women and youth in rural and remote areas to reduce health inequities in access to care. As a result, this contributes toward limiting migration to cities or abroad, generates local economic development and reinforces social cohesion.

The “national action plan for investment in health and social sector employment and growth in economic health 2018–2021” aims for 11 500 permanent and temporary jobs to be created in the health and care sector, including 216 doctors, 1400 nurses, 864 midwives and 1440 other health professionals; and 1.8 million additional people in underserved areas (9% of the total population) to be closer than 5 km to a health facility, to increase health coverage from 48–58%. In 2019, the programme created 2500 CHW jobs and 5000 indirect jobs in three regions (Diffa, Tahoua and Tillabéri).

**Rwanda**

Under the guidance of the Ministry of Health-led HRH technical working group, an HLMA survey was conducted, to be followed by a comprehensive HRH situation analysis and to initiate the development and costing of a new HRH strategic plan.

W4H is helping to further strengthen collaboration across sectors, government agencies and partners to address the health workforce shortfall through a roadmap to improve workforce planning capacity, capability and increased investment and resource mobilization for skills development, job creation and employment opportunities for women.

**South Africa**

The W4H programme supports the creation of jobs in the health sector through the development of a national 2030 HRH strategy framework and 5-year HRH strategic plan. The project supported the National Department of Health-led multistakeholder process for developing the HRH strategy, including direct technical assistance to an assigned ministerial task team and a rapid health labour market and political economy analysis to inform the process. The strategy also supports the role of national health insurance, through which South Africa aims to create 97 000 additional jobs in the health sector by 2025, the majority of which are for primary health care expansion. These new jobs will contribute to improved access and coverage of health services.

Towards meeting these needs, in 2019 the Government of South Africa recruited and deployed an additional 5000 newly trained health workers, including 2329 medical interns, 1723 community service medics (medical doctors) and 650 medical officers, as well as an additional number of nurses and CHWs.
Niger
Within the framework of “Niger’s Renaissance Programme”, the Niger Government is working to implement essential reforms. These reforms are reflected in Niger’s economic and social development plan. These reforms aim to “strengthen the resilience of the economic and social development system” and achieve the SDGs. In this context, a national action plan for investment in health and social sector jobs for economic growth in Niger was adopted by presidential decree. The government has been supported in this process, by WHO and ILO. ILO provided technical support by developing an econometric model to evaluate the impact of the rural pipeline programme as a contribution to the WHO baseline study on employment and professional insertion in the three target regions (Diffa, Tahoua and Tillabéri) of the rural pipeline programme.

The revitalization of primary health care and the achievement of UHC requires 4.5 health workers per 1000 inhabitants; Niger has only 0.3 health workers per 1000 inhabitants, which is 8 to 15 times lower than expected thresholds. The national action plan interventions aim to significantly improve the availability, accessibility and quality of health personnel while acting effectively on the other pillars of the health system, within a framework of person-centred health care and services.

The W4H programme supported the rural pipeline programme through a foundational baseline survey studying the impact indicators and stakeholders’ expectations to determine the value chain of decent jobs for women and youth and develop mechanisms for effective and efficient implementation. Further, the W4H programme supported the establishment of a resource mobilization roundtable event.

Rwanda
Building on the previous reporting period, and following completion of the HLMA in 2019, the Ministry of Health embarked on a comprehensive HRH situation analysis and initiated the development and costing of the new HRH roadmap and 2-year implementation plan, under the guidance of a Ministry of Health-led HRH technical working group. Despite delays in this process as a result of the COVID-19 response, the programme’s catalytic funding contributed towards the Ministry of Health-led development of a 10-year government programme (National Strategy for Health Professions Development 2020–2030) and the establishment of a multisectoral technical HRH secretariat within the Ministry of Health to coordinate, guide and support its implementation. The 17th National Leadership Retreat (18–19 February 2020), resolved to shift the mandate of health professional education from the Ministry of Education to the Ministry of Health to harmonize the HRH production with the need, and also to harness health sector perspectives to improve the quality of education and synergize efforts in health professional development.

The W4H programme facilitated the application of the HLMA approach and utilization of data and NHWA for evidence-based policy, planning and decision-making in Rwanda. The comprehensive HLMA is already showing signs of strengthening political momentum, attracting investments to address health workforce gaps, and leading to action which should ultimately strengthen health care systems and UHC in Rwanda. The HLMA identifies current and projected potential labour failures, which guides stakeholder prioritization and investment. In addition, the HLMA provides evidence for policy dialogue, policy development and implementation.

South Africa

Detailed work on the costing and financing for implementing the national HRH strategy and preparing an investment case for submission to the national treasury is ongoing. Building on these two strategies, the Presidential Employment Stimulus Programme created 5531 new nurse jobs in the public sector in 2020 by bridging 1045 enrolled nurses, 1236 auxiliary nurses and 3205 CHWs and outreach team leaders from training into employment. This is in follow-up to the 2018 Presidential Jobs Summit which agreed a target of 275 000 new jobs annually, including jobs within the health and care economy. Similarly, the finalization of these two strategic documents contributed towards the rollout of the Presidential Health Compact 2019, specifically pillar 1 on “augmenting human resources for health”.

Niger
Niger is experiencing a multidimensional crisis (environmental, security, humanitarian, migration and economic), which is exacerbating the challenges of poverty reduction and sustainable development in the country. Within the framework of the implementation of its economic and social development plan and health development plan, Niger received technical and financial support from W4H to support the implementation of the national action plan, including organizing a resource mobilization roundtable, and implementation of the rural pipeline programme and its baseline study.

By the end of 2021, W4H, together with funding from other sources, had facilitated the creation of 1005 jobs for health workers (doctors, midwives, nurses, laboratory technicians and hygiene technicians) in 2019; 100 jobs in 2020; and 1540 jobs in 2021. This is in addition to the 2500 CHW jobs and 5000 indirect jobs in 2019 (see page 31). Related to these workforce expansion efforts, access to and the use of health services and care by the population have increased in the regions, with health coverage increasing from 48.31% in 2018 to 53.6% in 2021 (an increase of 5%).

Finally, training was provided to 564 youth and women based on the training needs identified in the annual action plans and the national health workforce strategy/plan in the health sector.

Within this context, the W4H programme provided technical support to develop an econometric model that evaluates the impact of the rural pipeline programme and its contribution to the baseline study on employment and professional insertion in the three target regions (Diffa, Tahoua and Tillabéri). The methodological contribution developed an impact assessment model specific to the rural pipeline project, including its potential to create decent jobs and its contribution to absorbing the job offers attributable to its implementation, depending on the regions and areas of intervention as well as a framework for optimizing the results (effects and impact) predicted by the model.

Rwanda
The W4H programme facilitated the application of the HLMA approach and utilization of data and NHWA for evidence-based policy, planning and decision-making in Rwanda. The comprehensive HLMA is already showing signs of strengthening political momentum, attracting investments to address health workforce gaps, and leading to action which should ultimately strengthen health care systems and UHC in Rwanda. The HLMA identifies current and projected potential labour failures, which guides stakeholder prioritization and investment. In addition, the HLMA provides evidence for policy dialogue, policy development and implementation.

In 2020, the World Bank used the findings of the HLMA in the dialogue with the Government of Rwanda to support HRH reforms. The Human Capital Development Program Financing to the Government of Rwanda spans 3 years and includes support for health workforce reforms.

South Africa
Upon request from the Eastern Cape Department of Health, the W4H programme provided technical guidance and support on OSH and COVID-19 in close collaboration with the tripartite technical working group, established to coordinate all the work related to COVID-19, OSH and HIV/TB in the world of work. In October 2021, ILO organized and facilitated a 2-day training on the ILO/WHO HealthWISE methodology, including the COVID-19 checklist. As an immediate impact of the training, the Head of the Eastern Cape Department of Health approved the rollout of HealthWISE implementation in 10 health facilities in the Eastern Cape Province through continued technical support from ILO.

Box 2: Country achievements 2020

Box 3: Country achievements 2021
Annex 4. Working for Health Results matrix

**Impact: Accelerated progress towards UHC and relevant SDGs through an expanded and transformed health workforce**

<table>
<thead>
<tr>
<th>Outcome indicators</th>
<th>Baseline</th>
<th>2021 target</th>
<th>Means of verification (MoV)</th>
</tr>
</thead>
<tbody>
<tr>
<td>II1: Coverage of essential health services* (SDG Indicator 3.8.1)</td>
<td>SDG Index – based on country-level assessments</td>
<td>SDG Index</td>
<td>SDG Index</td>
</tr>
<tr>
<td>II2: Total expenditure on health workforcec (NHWA Indicator 7 – 01)</td>
<td>Based on country-level assessments</td>
<td>Projected increase of at least 15%</td>
<td>Data from annual reports, national health accounts (NHA) and NHWA</td>
</tr>
</tbody>
</table>

**Outcome 1: The supply of skilled health workers meets assessed country needs**

<table>
<thead>
<tr>
<th>Outcome indicators</th>
<th>Baseline</th>
<th>2021 target</th>
<th>Means of verification (MoV)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total public sector expenditure on health workforce pre-service education (NHWA 04 – 02)</td>
<td>Based on country-level assessments</td>
<td>% increase to be determined based on country-level assessment</td>
<td>Data from annual reports, NHA, NHWA and Global Health Expenditure Database</td>
</tr>
<tr>
<td>2. Ratio of newly active domestic trained health workers to total stock of active health workersd (NHWA 5 – 02)</td>
<td>Based on country-level assessments</td>
<td>Extent of change to be determined based on country-level assessment – threshold to be defined at national level</td>
<td>Data from annual reports, NHWA and labour force surveys</td>
</tr>
</tbody>
</table>

**Output 1.1**

- Strengthened country accreditation mechanisms to align types of education and training with health labour market demand and population needs
- **Indicator:** Existence of national and/or subnational mechanisms for accreditation of health workforce education and training institutions and their programmes (Yes/No/Partly) (NHWA 3 – 02)
- **MoV:** Data from annual reports and NHWA
- **Baseline:** Based on in-country assessment
- **Target:** 20 countries supported: extent of change to be determined based on country-level assessment

**Output 1.2**

- Models developed for assessing staffing needs for health services delivery
- **Indicator:** Existence of institutional models for assessing and monitoring staffing needs for health service delivery (Yes/No/Partly) (NHWA 9 – 05)
- **MoV:** Data from annual reports and NHWA
- **Baseline:** Based on in-country assessment
- **Target:** 20 countries

**Output 1.3**

- Strengthened institutional capacity to align skills and competencies with health labour market and population needs
- **Indicator:** Existence of national education plans for the health workforce, aligned with the national health plan and the national health workforce strategy/plan* (Yes/No/Partly) (NHWA 9 – 04)
- **MoV:** Data from annual reports and NHWA
- **Baseline:** Based on in-country assessment
- **Target:** 20 countries
### Outcome 2: Health sector jobs created to match labour market and public health needs

<table>
<thead>
<tr>
<th>Outcome indicators</th>
<th>Baseline</th>
<th>2021 target</th>
<th>Means of verification (MoV)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Density of active health workers employed by type of facility ownership (NHWA 1 – 05)</td>
<td>Based on country assessment</td>
<td>Extent of change based on country assessment</td>
<td>Data from end of project assessments, NHWA and/or workforce registry</td>
</tr>
<tr>
<td>2. Density of health workers per 10 000 population (NHWA 1 – 02)</td>
<td>Based on country assessment</td>
<td>% change based on country assessment</td>
<td>Data from end of project assessments and NHWA</td>
</tr>
<tr>
<td>3. Ratio of previous year graduates who started practice to total number of previous year graduates (NHWA 5 – 01)</td>
<td>Based on country assessment</td>
<td>% change based on country assessment</td>
<td>Data from annual reports and NHWA</td>
</tr>
</tbody>
</table>

#### Output 2.1

**Indicator:** Number of W4H-supported countries where HLMA has been applied to inform health workforce planning  
**Baseline:** Based on in-country assessment  
**Target:** 20 countries

#### Output 2.2

**Indicator:** Number of W4H-supported countries with investment case for job creation in the health sector (public and private)  
**Baseline:** 0  
**Target:** 20 countries

#### Output 2.3

**Indicator:** Number of W4H-supported countries with investment case for job creation in the health sector (public and private)  
**Baseline:** 0  
**Target:** 20 countries

#### Output 2.4

**Indicator:** Number of W4H-supported countries producing annual monitoring and accountability reports for health workforce strategies  
**Baseline:** 0  
**Target:** 20 countries

#### Output 2.5

**Indicator:** Number of W4H-supported countries producing annual monitoring and accountability reports for health workforce strategies  
**Baseline:** 0  
**Target:** 20 countries

### Outcome 3: Health workers are recruited and retained according to country needs

<table>
<thead>
<tr>
<th>Outcome indicators</th>
<th>Baseline</th>
<th>2021 target</th>
<th>Means of verification (MoV)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Density and distribution of active health workers (SDG Indicator 3.C.1), by occupation and subnational level</td>
<td>SDG Index, based on country assessment</td>
<td>15% increase</td>
<td>NHWA 1 – 01; 1 – 02</td>
</tr>
<tr>
<td>2. Ratio of unfilled posts to total number of posts (NHWA 05 – 07)</td>
<td>Based on country assessment</td>
<td>10% decrease</td>
<td>Data from annual reports, labour force survey and NHWA</td>
</tr>
<tr>
<td>3. Ratio of active health workers voluntarily leaving the health sector labour market to total stock of active health workers (NHWA 5 – 04)</td>
<td>Based on country assessment</td>
<td>% change based on country assessment</td>
<td>Data from annual reports and NHWA</td>
</tr>
</tbody>
</table>

#### Output 3.1

**Indicator:** Health workforce deployment and distribution mechanisms strengthened for primary health care in rural and underserved areas  
**Baseline:** Based on in-country assessment  
**Target:** Density change to be determined based on country-level assessment

#### Output 3.2

**Indicator:** Strengthened capacity to address gender bias and inequalities in health workforce policy and practice  
**Baseline:** Based on in-country assessment  
**Target:** % change to be determined based on country-level assessment

#### Output 3.3

**Indicator:** Improved OSH of health workers in all settings at national level  
**Baseline:** Based on in-country assessment  
**Target:** 10 countries

#### Output 3.4

**Indicator:** Strengthened health workforce social protection coverage  
**Baseline:** Based on country assessment  
**Target:** 10 countries

#### Output 3.5

**Indicator:** Improved policies and regulatory framework for decent work in the health sector  
**Baseline:** Based on country assessment  
**Target:** 10 countries
### Outcome 4: Health workforce data inform effective policy, planning, monitoring and international mobility

<table>
<thead>
<tr>
<th>Outcome indicators</th>
<th>Baseline</th>
<th>2021 target</th>
<th>Means of verification (MoV)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Number of countries that have developed health workforce policy, planning and monitoring, including on mobility, based on harmonized metrics and definitions</td>
<td>Number of countries using harmonized metrics and definitions</td>
<td>Data from end of project assessments NHWA</td>
<td></td>
</tr>
<tr>
<td><strong>Output 4.1</strong></td>
<td>An international health labour mobility platform established to advance knowledge and international cooperation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicator: Number of countries participating in the platform</td>
<td>MoV: Project monitoring data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline: 0</td>
<td>Target: 50 countries</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Output 4.2</strong></td>
<td>Strengthened country capacity to understand and manage health worker flows, in order to inform the development of national policies and bilateral agreements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicator: Number of national policies and bilateral agreements supported</td>
<td>MoV: Project monitoring data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline: Based on country assessment</td>
<td>Target: 10 countries</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Output 4.3</strong></td>
<td>Increased monitoring of health worker mobility through the WHO Global Code reporting system</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicator: Number of countries supported by WHO which report on the WHO Global Code</td>
<td>MoV: Project monitoring data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline: Third round of WHO Global Code reporting</td>
<td>Target: 20 countries</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Output 4.4</strong></td>
<td>New harmonized metrics and definitions established through an interagency global data exchange on the health labour markets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicator: Number of countries using the data exchange platform</td>
<td>MoV: Project monitoring data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline: 0</td>
<td>Target: 50 countries</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Output 4.5</strong></td>
<td>Improved quality and reporting of health workforce data through NHWA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicator: Number of W4H-supported countries that report NHWA core indicators to WHO annually</td>
<td>MoV: NHWA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline: Based on country assessment</td>
<td>Target: 20 countries</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**

* Baseline country assessments are overarching outputs for all outcomes and will be costed during the implementation stage.
* Defined as the average coverage of essential services based on 16 tracer indicators that include reproductive, maternal, newborn and child health, infectious diseases, noncommunicable diseases and service capacity and access, among the general and the most disadvantaged population. In terms of service capacity and access, SDG 3.8.1 uses hospital access and health worker density as the two key proxy indicators for coverage (http://apps.who.int/gho/portal/uhc-overview.jsp).
* Disaggregation by facility ownership: public and private sectors.
* Considers the number of newly active health workers, defined in headcounts, by occupation and sex.
* Considers the health workforce competency match with population, health systems and labour market needs; scale up of transformative education and training; workforce market needs and absorptive capacity.
* Total number of active health workers, disaggregated by public, private and not for profit ownership.
* Corresponds with SDG Indicator 3.c: Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States – 3.c.1. Health worker density and distribution. Note that in terms of labour market needs, coverage will be dependent on nationally defined staffing norms and projections.
* Aligned with SDG. No SDG target defined.