A review of the relevance and effectiveness of the five-year action plan for health employment and inclusive economic growth (2017-2021) and ILO-OECD-WHO Working for Health programme

This independent review report was commissioned by WHO, through the joint ILO, OECD, and WHO Working for Health Programme, and conducted by an independent research team at the Institute of Tropical Medicine, Antwerp
WORKING FOR HEALTH

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April 2021
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<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACT</td>
<td>The Access to COVID-19 Tools (ACT) Accelerator</td>
</tr>
<tr>
<td>ASEAN</td>
<td>Association of Southeast Asian Nations</td>
</tr>
<tr>
<td>EIB</td>
<td>European Investment Bank</td>
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<tr>
<td>EU</td>
<td>European Union</td>
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<tr>
<td>EWEC</td>
<td>United Nations Secretary-General’s Every Woman Every Child (EWEC) Global Strategy for Women’s, Children’s and Adolescents’ Health</td>
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<tr>
<td>G7</td>
<td>The Group of Seven is an intergovernmental organization consisting of Canada, France, Germany, Italy, Japan, the United Kingdom of Great Britain and Northern Ireland and the United States of America</td>
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<tr>
<td>G20</td>
<td>The Group of Twenty is an international forum for the governments and central bank governors from 19 countries and the European Union (EU)</td>
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<tr>
<td>GAP</td>
<td>Global Action Plan</td>
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<tr>
<td>GAVI</td>
<td>The GAVI Alliance, formerly known as the Global Alliance for Vaccines and Immunization</td>
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<tr>
<td>GCM</td>
<td>Global Compact on Safe, Orderly and Regular Migration</td>
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<tr>
<td>GF</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<td>GFF</td>
<td>Global Financing Facility</td>
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<td>GHS</td>
<td>global health security</td>
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<td>GHWA</td>
<td>Global Health Workforce Alliance</td>
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<td>GHWN</td>
<td>Global Health Workforce Network</td>
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<td>HCIF</td>
<td>Health Care Investment Fund</td>
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<td>HIC</td>
<td>high-income countries</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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<tr>
<td>IADEx</td>
<td>Interagency data exchange mechanism</td>
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<tr>
<td>ILO</td>
<td>International Labour Organization</td>
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<tr>
<td>IMF</td>
<td>International Monetary Fund</td>
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<tr>
<td>IPHWM</td>
<td>International Platform on Health Worker Mobility</td>
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<td>LMIC</td>
<td>Low- and Middle-Income Countries</td>
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<td>MPTF</td>
<td>Multi-Partner Trust Fund</td>
</tr>
<tr>
<td>NHWA</td>
<td>National Health Workforce Accounts</td>
</tr>
<tr>
<td>ODA</td>
<td>Overseas Development Assistance</td>
</tr>
<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
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<tr>
<td>PHC</td>
<td>primary health care</td>
</tr>
<tr>
<td>REIO</td>
<td>regional economic integration organizations</td>
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<tr>
<td>SADC</td>
<td>Southern African Development Community</td>
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<tr>
<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>SDGs</td>
<td>Sustainable Development Goals</td>
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<tr>
<td>ToC</td>
<td>Theory of Change</td>
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<tr>
<td>UHC</td>
<td>universal health coverage</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
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<tr>
<td>UNGA</td>
<td>General Assembly of the United Nations</td>
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<tr>
<td>UNHEEG</td>
<td>United Nations Secretary General's High-Level Commission on Health Employment and Economic Growth</td>
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<tr>
<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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<tr>
<td>WB</td>
<td>World Bank</td>
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<td>WHA</td>
<td>World Health Assembly</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Executive Summary

The 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 and is delivered through the joint intersectoral Working for Health (W4H) programme in partnership with the World Health Organization (WHO), International Labour Organization (ILO) and Organisation for Economic Co-operation and Development (OECD). Its objectives are to deliver workforce actions in alignment with national, regional, and global strategies and plans through Member State collaboration and multisectoral action by stimulating investment through informed policy change and supporting those countries where universal health coverage (UHC) is least likely to be realized. The action plan’s governance structure was established in 2017, with a Multi-Partner Trust Fund (MPTF), operationalized in 2018, to facilitate initial funding for the two-year period 2019-2020.

This document presents the findings of an independent review of the joint WHO, ILO and OECD Working for Health (W4H) programme and five-year action plan to assess its relevance and effectiveness, as it enters its final year of implementation. The assessment considers the COVID-19 pandemic, the evolution of the health workforce agenda, and shifting economic policy priorities. It provides policy options for the continuation of the W4H programme agenda in 2022 and beyond. The review has been conducted by an independent research team, through the Antwerp Institute of Tropical Medicine. It includes a review of policy documents and articles and in-depth interviews with a range of actors relevant to the W4H programme.

The review indicates that the W4H programme remains highly relevant according to the respondents and based on a review of documents. It is a strategic mechanism for addressing the health workforce’s essential role and the impact of the COVID-19 pandemic exposing investment needs in the health workforce. W4H is also considered relevant due to pressures in the international health labour market and growing health workforce mobility.

Regarding its effectiveness, the review found that since 2018, the W4H programme has enabled the International Platform on Health Workforce Mobility, organized an interagency data exchange mechanism, contributed to the establishment of health sector investment plans in the Southern African Development Community (SADC) and West African Economic and Monetary Union (WAEMU) economic regions, and facilitated intersectoral health workforce development and capacity strengthening in about 16 countries, amongst others guided by detailed health labour market analyses. However, the effectiveness of the W4H programme has been limited as its Multi-Partner Trust Fund only raised about US$ 7 million in funding, with an additional US$ 3 million received through the United Nations Peace and Development Trust Fund, while the intended five-year action plan target was US$ 70 million. Although the catalytic model is considered effective by participants, the considerable underfunding of the W4H programme has affected its expansion and limited the programme’s scope in countries. Health workforce development requires a long-term commitment from partner countries and funders alike to enable sustainable impact.

Despite the relevance of the United Nations Secretary General’s High-Level Commission on Health Employment and Economic Growth (UNHEEG) recommendations, the five-year action plan and the W4H programme, a number of factors were identified that may have hindered the emergence of the health workforce agenda and related workforce network. These include the relative complexity of securing sustained workforce investment across sectors, an unfavourable macro-economic policy environment, and the issue itself didn’t get much traction despite significant recognition of its importance. The health workforce can be regarded as a modern ‘tragedy of the commons’ whereby national authorities and the international community expect health workers to provide the services required to attain global health security (GHS) and universal health coverage (UHC), with mutual expectations by both sides to provide sustainable health workforce finance. Overall, there is relative
neglect, underinvestment, and limited shared responsibility in the development and employment of this workforce, despite it being key to the social foundation of countries and achieving the expected health goals.

Analyses over the last 15 years indicate that integration of health workforce actions in other global health programmes and health systems strengthening initiatives has been far from sufficient to secure sustainable and scalable investments in the health workforce. Nevertheless, economic thinking is shifting, whereby international financial institutions and multilateral organizations now clearly speak out on the need for social spending. W4H and its partners must find entry points and engage in a constructive dialogue with these economic governance bodies. The COVID-19 pandemic is a wake-up call and provides a clear momentum. The Seventy-third World Health Assembly has designated 2021 as the International Year of Health and Care Workers. Countries can only advance towards global health security, UHC and decent work when education and jobs in the health sector are guaranteed, now and in the future.

Proposed policy options for moving forward are:

- The review shows near-unanimous confirmation of the relevance of the five-year action plan and the W4H programme. Hence, a working group should revisit the objectives of the W4H programme and develop a new five-year action plan with a clear level of ambition and matching resources and support. Given the current pandemic context, such a reorientation must include a greater focus on the health workforce as crucial in providing global health security and global public goods. The MTPF is considered a solid mechanism to implement the W4H programme, and as such, it should be maintained.

- The W4H programme should seek closer cooperation, including joint proposals, programming and monitoring with global health initiatives (the Global Financing Facility, the Global Fund, the Global Alliance for Vaccines and Immunization), primary health care and health systems initiatives such as the UHC Partnership, the SDG3 Global Action Plan programme and, importantly, the health sector response to the COVID-19 pandemic and its recovery via the Access to COVID-19 Tools (ACT) Accelerator. Investments in the health workforce could be made through a pooled global financial mechanism with a clear governance and accountability structure, funded through domestic and international finance.

- The network strengthening of W4H, the Global Health Workforce Network (GHWN) and the health and care worker community needs to expand and consolidate a vibrant global health workforce movement. Such a movement and advocacy are required to keep investing in the health workforce high upon the political agenda.
Accelerate progress towards universal health coverage and the SDGs by ensuring equitable access to health workers within strengthened health systems.

Expansion and transformation of the health and social workforce

International Labour Organization, Organisation for Economic Co-operation and Development and World Health Organization

An expanded, trained and supported health workforce is critical to achieving the health SDG 3 targets – almost fifty percent of resources needed to achieve SDG 3 involve workforce education and employment and training requirements. Working for Health will increase numbers and education and training catalyse investments and action needed to make the health workforce fit for purpose. Other SDGs—education (SDG 4), gender equality (SDG 5), decent work and economic growth (SDG 8) will also be advanced.

Facilitate country-driven intersectoral action:
1. Advocacy, social dialogue and policy dialogue
2. Data, evidence and accountability
3. Education, skills and jobs
4. Financing and investments
5. International labour mobility
Background

As populations grow and change, the global demand for health workers is estimated to almost double by 2030, creating around 40 million new health worker jobs, primarily in upper-middle- and high-income countries. However, the projected growth in jobs occurs alongside the potential shortfall of 18 million health workers to achieve and sustain access to essential health services by 2030, primarily in low- and middle-income countries. Left unaddressed against a backdrop of anticipated demographic, epidemiological, ecological and socioeconomic changes, projected workforce shortfalls and mismatches threaten to erode hard-won gains in health, well-being and global health security (GHS).

In September 2016, the United Nations Secretary General’s High-Level Commission on Health Employment and Economic Growth (UNHHEEG) proposed ten recommendations and five immediate actions to stimulate the creation of health and social sector jobs to support universal health coverage (UHC) and advance inclusive economic growth. (Box 1, Annex 1). The UNHHEEG report is based on more than two decades of existing evidence and policy recommendations on the need to develop strong health systems and decent employment for health workers.

The idea of setting up a United Nations high-level commission on health employment was inspired by the United Nations Secretary-General’s Every Woman Every Child (EWEC) Global Strategy for Women’s, Children’s and Adolescents’ Health. This EWEC approach to development that was launched in 2015 and particularly its Commission on Information and Accountability provided an example for a United Nations commission on health employment. The multi-partner funding for the implementation of the EWEC global strategy has for a considerable part been channelled via the Global Financing Facility (GFF), a trust and investment fund managed by the World Bank (WB) that currently supports 36 Low- and Middle-Income Countries (LMIC) in Africa.

Economic, social, health and security benefits from investment in the health workforce are manifold. The economic evidence for investing in health employment has been published by the World Health

Organization (WHO) as an accompaniment to the UNHEEG report.\textsuperscript{14} This led UNHEEG to argue that investing in the health workforce, locally and globally, could lead to gains across several Sustainable Development Goals (SDGs). United Nations General Assembly resolution 71/159 mandating WHO, the International Labour Organization (ILO) and other international organizations to operationalize the recommendations of the UNHEEG remains pertinent.\textsuperscript{15}

In 2017, the World Health Assembly (WHA) adopted the five-year action plan for health employment and inclusive economic growth (2017-2021) as a mechanism for coordinating and advancing the intersectoral implementation of the UNHEEG report. Similar resolutions were adopted by the OECD\textsuperscript{16}, and ILO\textsuperscript{17} and this mechanism became the joint intersectoral 'ILO-OECD-WHO Working for Health programme'. The governance structure for the action plan was established in 2017, and its Multi-Partner Trust Fund (MPTF) was operationalized in 2018 with an aspirational level of funding of US$ 70 million to initiate implementation over the two-year period 2019-2020 (Figure 1).

Figure 1. Global policy process W4H programme

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\textsuperscript{16} The OECD Health Ministerial Statement requested the organization to work with WHO and ILO on the implementation of the recommendations of the Commission’s recommendations (17 Jan 2017).

\textsuperscript{17} In its Conclusions, the ILO Tripartite Sectoral Meeting on Improving Employment and Working Conditions in Health Services (Geneva, 24-28 April 2017) endorsed the Commission’s report, requesting the Office to actively contribute to the implementation of its recommendations. At its 331st session, the ILO Governing Body endorsed the conclusions of the Tripartite Meeting and requested the Director-General “to work with the WHO and the OECD on the implementation of the recommendations of the High-Level Commission on Health Employment and Economic Growth and to take into account its guidance in the implementation of the Five-Year Action Plan for Health Employment and Economic Growth” (GB.331/POL/3; 31 October 2017).
By joining forces, the ILO, OECD and WHO assists Member States to accelerate the investments and actions needed to avert the projected 18 million health worker shortfalls and create over 40 million new health and social worker jobs (Figure 2).  

![Diagram of Working for Health Programme Impact - Theory of Change]

*Figure 2. Working for health programme impact - Theory of Change*

The action plan is coordinated through a joint WHO-led secretariat, managed through the United Nations Development Programme (UNDP) MPTF office, and delivered through country, regional and global collaboration. The MPTF has helped leverage development partners and United Nations agencies to promote policy shifts that drive workforce investments whilst deepening the reach, uptake and impact of health workforce normative tools and standards. A sustained three-year programme of parallel support to four countries is also being delivered, funded through the United Nations Peace and Development Trust Fund. In addition, the autonomous GHWN has been planned to act as the policy support network. The W4H programme works at the global, regional and country level.

By joining forces, the ILO, OECD, and WHO want to assist Member States in developing, financing, and implementing comprehensive, intersectoral and integrated national health workforce plans. This requires, at the country, regional and global level, supporting the foundations for sustained advocacy, political commitment and accountability; establishing tripartite social dialogues; promoting intersectoral approaches; and generating improved data and evidence. In W4H’s programmatic ToC, these foundations for enhanced national health workforce strategies, sustained investments and actions will lead to a transformation and expansion of the health and social workforce, hence creating impact in attaining the SDGs.

The 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 will generate to respond to Member States’ expected demands and requests, employers’ and workers’ organizations, and other key stakeholders. Where applicable and requested by Member States, the organizations engage in analysis and research, advise on norms and international labour  

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19 In the Terms of Reference of the W4H MPTF the following aims of the GHWN are listed:  
- to maintain high-level political commitment;  
- to promote intersectoral and multilateral policy dialogue, including, as appropriate, through public-private collaboration;  
- to facilitate the alignment of domestic financing, global health initiatives and donors to the HRH investment priorities outlined in the Global Strategy; and  
- to foster global coordination and mutual accountability.
standards, provide technical cooperation, convening and coordination, knowledge management and sharing, institutional capacity development, and the facilitation of investments and financing.

These deliverables are grouped in five interrelated work streams. The initial plan has been to prioritize 15-20 countries across regions where UHC and the UNHEEG recommendations are least likely to be attained. These countries include Member States of the West Africa Monetary and Economic Union (WAMEU) and the Southern African Development Community (SADC). Moreover, W4H chose to specifically support these regional economic integration organizations (REIO) in establishing coherent intersectoral human resources for health (HRH) development strategies and investment plans. Countries and regions have been supported via short, one-year catalytic funding of about US$ 100,000 to US$ 300,000 per country, which can be used to mobilize additional resources in support of workforce investments.

The targets of the Working for Health programme are:

➢ By 2018, an interagency global data exchange on the health labour market is established;
➢ By 2020, 20 countries have inclusive mechanisms in place to coordinate an intersectoral health workforce agenda supported by the Working for Health programme;
➢ By 2020, 20 countries have developed enhanced national health workforce plans;
➢ By 2020, 20 countries are making progress on sharing data through national health workforce accounts;
➢ By 2021, 20 countries have secured financing to implement national health workforce plans;
➢ By 2030, 20 countries are making progress towards halving inequalities in access to a health worker and reducing their dependency on foreign-trained health professionals.

Scope and overall objective

The review covers the relevance of the W4H programme in the year 2021, acknowledging the context of the COVID-19 pandemic and the effectiveness of the implementation of the action plan since its adoption. The review of W4H and its MPTF effectiveness covers the period 2018-2020. This review provides options for the continuation of the W4H programme in 2022 and beyond. The definitions of ‘relevance’ and ‘effectiveness’ have been adapted from the review of the WHO Global Code of Practice on the International Recruitment of Health Personnel.

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20 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 national health workforce accounts 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 catalyzing sustainable financing for increased investments in health and social 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

21 Including, but not limited to, WAEMU: Benin, Burkina Faso, Côte d’Ivoire, Guinea-Bissau, Mali, Niger, Senegal, Togo; SADC: Angola, Botswana, Democratic Republic of Congo, Eswatini, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, United Republic of Tanzania, Zambia, Zimbabwe; and Others: Iraq, The Philippines, Tunisia


23 The guiding definitions for ‘relevance’ and ‘effectiveness’ are:
Specific objectives

1. To conduct a review of the implementation and achievements of the W4H programme.
2. To undertake a brief SWOT analysis of the programme - with respect to its contribution to the targets set out in the five-year action plan and the MPTF terms of reference.
3. To provide a description and analysis of findings in terms of the programme’s design, structure, operational processes, delivery and results, and sustainability.
4. To advise WHO and the partner organizations on options for the future of the W4H programme.

Methodology

A research team led by the Institute of Tropical Medicine, Antwerp, conducted the review from November - December 2020. This included a rapid scoping review of the W4H documentation. A purposeful sampling strategy was used to identify the documents. The review included strategic documents, meeting reports, country-level documentation, and communication and resource mobilization material. In addition, academic literature was reviewed on the implementation of HRH actions in the respective countries and regions supported by W4H. Lastly, global, regional and country policy documents that are indirectly relevant to health workforce matters, including investment and governance matters, were included, especially concerning the ongoing COVID-19 pandemic and its momentum. 

A range of actors relevant to the W4H programme was selected and interviewed. These interviews followed a semi-structured questionnaire addressing the specific objectives of the review.

In total, 48 people responded to the request to participate; the four research consultants individually interviewed 39 persons, and 9 people participated in two focus-group discussions. Given the review’s time limitations, this was a good response rate, with about 75% of the contacted people participating.

Given the priorities of the W4H programme, the review focused on the implementation of the programme at country level, and through sub-regional communities in West Africa (UEMOA) and Southern-Africa (SADC). Implementation in the countries supported by a separate United Nations Peace and Development Trust Fund grant, notably Kyrgyzstan, Sri Lanka, Nepal and Cambodia, was also reviewed. The labour mobility aspect of the W4H programme was specifically reviewed, given it being one of the work streams and given labour market pressures on the international mobility of health workers.

The discussion of the findings on the relevance and effectiveness of the W4H programmes was informed by a conceptual framework analysing the emergence of global health networks, such as the W4H programme and its affiliated GWHN. This will be further explained in the discussion chapter.

- Relevance: the extent - noting the context of the COVID-19 pandemic - to which the W4H programme and its five-year action plan continue to be pertinent and can contribute to countries’ efforts to address challenges in relation to the health and social care workforce and health systems strengthening.
- Effectiveness: the extent to which the implementation of the Five-year Action Plan deliverables and immediate actions, via the W4H Programme, have resulted in evidence-informed changes concerning health workforce policy and strengthening at country, regional and global levels.

24 Taking into account the global health architecture and priorities since 2016 (e.g.: the United Nations High Level Meeting on Universal Health Coverage, the Global Action Plan on SDG3, the impact of Ebola and COVID-19 on health preparedness and health security, and the Access to Covid-19 Tools Accelerator) and how to respond to the rapidly unfolding public investment and economic stimulus measures arising from the COVID-19 pandemic.
25 See Annex 2 for an overview of the documents that have been included.
26 This sample includes interviewees representing the following categories; WHO/ ILO/ OECD staff (both direct and indirectly involved); Members from the GHWN network; UNHEEG experts and commissioners, former key WHO/ ILO/ OECD staff; persons involved in the International Platform on Health Worker mobility network; Health (workforce) and social policy academic experts, members of several professional and NGO networks, trade unions; key government officials from ECOWAS and SADC region.
27 See Annex 3 for the semi-structured questionnaire.
In addition, the analysis of economic policy space is informed by recent recommendations on how to spur massive economy-wide public investments in human capital (such as the health workforce) and institutions, whilst respecting the ecological and planetary boundaries.²⁹

**Findings**

The sections in the findings cover relevance and effectiveness and conclude with an overview of the strengths, weaknesses, opportunities and threats of the five-year action plan and W4H programme. The findings are informed by the respondent’s interviews and review of documents.

**Relevance**

*Relevance: the extent - in the context of the COVID-19 pandemic - to which the W4H programme and its five-year action plan continue to be pertinent and can contribute to countries’ efforts to address challenges in relation to the health and social care workforce and health systems strengthening.*

**The relevance of the W4H programme and its five-year action plan**

All 48 respondents and the review of the literature find the 10 recommendations of UNHEEG and the W4H programme, its objectives, partnership, and Theory of Change (Figure 2) relevant and pertinent. The expansion and transformation of the global health and social service workforce to accelerate progress towards UHC and GHS are even more urgent given the current economic and health impact of the COVID-19 pandemic.

Several factors have contributed to the continued and increasing relevance of the five-year action plan and its W4H programme. These include recognising the workforce’s central role in health systems’ functioning, the need for long-term investments in health and social sector employment, and an increasing trend of international health workforce mobility.

**The essential role of the health workforce**

The essential role of the health workforce, enabling the provision of global public health goods³⁰ by being prepared for and responding to health security risks, has become very visible during the COVID-19 pandemic. In many countries, health systems have become overwhelmed and medical and care workers find themselves on the frontline risking their health while containing the pandemic. At the Seventy-third World Health Assembly, Member States designated the year 2021 as the International Year of Health and Care Workers. Governments and non-State Actors emphasized the urgency and imperative to address persistent health worker challenges.³¹ HRH Princess Muna Al-Hussein of Jordan, WHO patron of nursing and midwifery in the Eastern Mediterranean Region, was outspoken in her keynote address: "Applause without action is no longer acceptable, recognition without rights and proper remuneration is not sufficient, a resolution without implementation is not governance, we must invest in health workers."³² Most respondents also expressed this sense of urgency. In addition to health and care systems being overstretched, billions of people now have to be vaccinated against COVID-19. This additional demand on the workforce needs to be considered seriously.

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³⁰ Definition of a Global public good: “a good which it is rational, from the perspective of a group of nations collectively, to produce for universal consumption, and for which it is irrational to exclude an individual nation from consuming, irrespective of whether that nation contributes to its financing”. In Smith, R. D., & MacKellar, L. (2007). Global public goods and the global health agenda: problems, priorities and potential. Globalization and Health, 3(1), 1-7.

³¹ Seventy-third World Health Assembly. (2020) 2021 designated as the International Year of Health and Care Workers.

Moreover, early evidence shows that countries with a robust health system and workforce responded more adequately and effectively to the pandemic. The COVID-19 pandemic provides the lessons that this is not only an agenda for LMIC but that a considerable number of high-income countries (HIC) should likewise transform and invest in their health systems and public health workforce. Some of the latest evidence from WHO talks about the absolute necessity to support and protect the health workforce in the context of the COVID-19 response.

**COVID-19 exposes investment needs**

The COVID-19 pandemic has exposed long-standing challenges in the health workforce, and, concerning this, respondents mentioned the increased relevance of the programme. The health workforce faces considerable ageing and attrition in many countries. Respondents worry about young professionals wanting to drop out due to negative COVID-19 experiences in overwhelmed health systems. Health workers have become exhausted, and in many regions, the attraction and retention of health workers are worrying; now and further down the line. Decent work will be important in the COVID-19 economic recovery, and the benefits from a gender-equity lens remain highly pertinent. Governments should much more clearly emphasize and remunerate the crucial role of health workers. Their services are essential for personal security and societal well-being and form the basis for a sustainable economy.

Respondents indicate that there appears to be a considerable mismatch between the pertinence of the health workforce agenda and the international political commitment and financial support of (most of) the major G20 economies. Domestic leadership and support are much needed to transform and expand the workforce. The W4H programme, with its global, regional and national commitments, may not automatically translate into domestic commitment and priority setting by government leaders and other relevant actors. Several of the countries supported by the W4H programme have committed to the actions, collaboration and long-term investment required. Others have, partly due to government changes, opted for other policy priorities. Respondents indicate that sustaining a relevant health workforce investment agenda over several domestic political cycles remains a complex challenge. It requires long-term commitment and solid institutions.

According to the respondents, health workforce development remains for many governments a narrative of recurrent costs, dependent on macroeconomic, fiscal policy frameworks, and a complex intersectoral matter. Despite their ubiquitous relevance, health workforce employment and development programmes are less suited to the cycles of overseas development assistance (ODA) funders and global health initiatives. Respondents observe that the health workforce’s services and availability are considered essential, but both international and domestic institutions structurally underinvest in them, having mutual expectations to take responsibility. The global health workforce could, therefore, be considered a modern ‘tragedy of the commons’.

**A change in the global context**

The global health policy environment has altered and hence influenced W4H programme implementation since the appointment of the UNHEEG. WHO has a new Director-General and has embarked on a transformative agenda as part of its thirteenth general programme of work 2019-2023.

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Intersectoral health workforce investment has its place in relation to the overall UHC agenda. WHO Director-General Tedros frequently speaks about the health workforce’s central role in reaching the GPW13 ‘Triple-Billion’ targets. Major global health policy declarations such as the Declaration of Astana on Primary Health Care and the United Nations Political Declaration of the High-level Meeting on Universal Health Coverage also refer to the need to invest in the health workforce and health jobs.

Just as the EWEC approach, channelling its funding through the GFF, inspired the development of the W4H programme and MPTF, interviewees argue for greater collaboration, and possible financing, between the W4H programme and GFF. This indicates the need for global health initiatives, such as the GFF and the Global Fund, to invest in health systems strengthening and sustainable workforce development. The Global Action Plan for Healthy lives and Well-being for All should ideally be the platform for cross-collaboration between different global institutions. It builds on seven accelerator themes to advance interagency cooperation toward reaching SDG 3. Unfortunately, and this indicates a pattern, the health workforce is overlooked in this plan.

Health workforce governance and dialogue

Respondents confirmed the relevance of intersectoral health workforce dialogue and policy facilitation. In the 12 countries and two regions supported via the MPTF, there is interest and a clear willingness to take this approach forward. The recruitment and investment plans that several countries have committed to shows this. Moreover, the interest in social spending for health that currently exists in regional economic integration organizations (REIO), not only SADC and WAEMU but also for instance at European Union (EU) and Association of Southeast Asian Nations (ASEAN) governance level, indicate that regional dialogue has its merits. There is a demand and need to strengthen health workforce governance, policy capacity, and dialogue at the sub regional level to facilitate an interface between global policy proposals and national implementation. Given the growing relevance of REIO in shaping labour markets and economic cooperation, it is of much importance that W4H continues the facilitation of policy dialogue and capacity at the regional level.

Respondents indicate that there is an evident role for inter-country and inter-agency data exchange and standardization. The establishment (and improvement) of National Health Workforce Accounts (NHWA) as well as the Health Labour Market Analyses (HLMAs) conducted and facilitated in several countries, including the guidebook that is to be published, are considered global public health goods. These provide the granular data for the governance of contextualised health systems with specific needs and policy environments. These actions fall obviously within the standard-setting and normative mandate of WHO (in coordination and collaboration with the partners ILO and OECD).

Accelerating international health workforce mobility

Another element that indicates the pertinence of the W4H programme, according to respondents, is the work of the International Platform on Health Worker Mobility (IPHWM, Box 2, Annex 1). IPHWM enables efforts towards mutual agreements and accreditation. International mobility in global education and labour markets continues and is even accelerating. The second review on the Relevance and Effectiveness of the WHO Global Code of Practice on the International Recruitment of Health

Personnel (the WHO Code) in 2020 notes that, due to ageing and demographic changes, there is an increased demand for health and care workers in high- and upper-middle-income countries.\footnote{Ibid. 22} The pertinence of the WHO Code and IPHWM is such that there needs to be a process of dialogue and governance between concerned actors to facilitate mutual benefits and shared responsibilities. Promoting policy coherence is important because recruiting health workers from other countries with a shortage of health personnel should be aligned with investing in the health workforce domestically and abroad.

Health workforce migration can be promoted but must be done fairly and sustainably. This includes the facilitation, financing and governance of future bilateral, regional and multilateral agreements on health workforce migration in line with international labour standards. The Global Compact on Safe, Orderly and Regular Migration (GCM) was adopted in 2018.\footnote{Ibid. 22} The GCM and related United Nations Network on Migration are of much importance to health workforce mobility. They provide guidance on the governance of labour mobility and matters such as Global Skills Partnerships. The IPHWM must interact with the Network on Migration and ensure that the principles of the WHO Code and relevant international labour standards are well considered in cooperation on skills development for the care sector, including the mutual strengthening of health systems.\footnote{Ibid.}

**A pandemic momentum**

Interviewees indicate that the immediate uptake of funding to support the UNHEEG recommendations and W4H programme has been below expectations. Health workforce investment has not been as high on leaders’ political agenda as was hoped and suggested in global political statements. Nevertheless, the current COVID-19 pandemic, by amplifying considerable health systems limitations and health workforce constraints, offers a unique momentum to have this agenda re-initiated. International Financial Institutions (IFI) such as the IMF, WB and European Investment Bank (EIB) recognize the centrality of social spending in health employment for economic recovery.\footnote{Ibid.} GHS and UHC are not possible without a skilled, prepared, motivated, supported and responsive health workforce. The COVID-19 pandemic may thus prove an opportunity and transformational moment for political will to invest in the health workforce.\footnote{Ibid.} 47-49 50

**Effectiveness**

*Effectiveness: the extent to which the implementation of the five-year action plan deliverables and immediate actions, via the W4H programme, have resulted in evidence-informed changes concerning health workforce policy and strengthening at country, regional and global levels.*

**Implementation of the W4H programme**

To date, 12 countries and two regional blocs are directly supported by the MPTF, via the W4H programme, with an additional four countries supported through the United Nations Peace and

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\footnote{Ibid. 22}


\footnote{Ibid. 22}


\footnote{The Lancet (2016). No health workforce, no global health security. Editorial | 387 issue 10033. 2063}


Development Trust Fund grant. The MPTF has also supported the establishment of an interagency data exchange mechanism (IADEx) and the international platform on health worker mobility (IPHWM). 51

**Multi-Partner Trust Fund**

The Working for Health Multi Partner Trust Fund (MPTF) was established to finance the ILO, OECD and WHO’s joint policy advice, technical assistance and capacity strengthening support. Due to the institutionalized complexity of working with multiple international agencies and donors, the MPTF started to fund country and regional initiatives from 2018. Since its creation, W4H has mobilized around US$ 7.5 million with contributions from Norad (The Norwegian Agency for Development Cooperation) and Silatech (and a contribution from the Swiss Development Cooperation from 2021). In addition, the United Nations Peace and Development Trust Fund grant provided funds in a bilateral agreement with WHO for the implementation of the W4H approach in four countries, amounting to US$ 2.9 million over three years. However, the effectiveness of the W4H programme has been limited since the intended five-year action plan target was US$ 70 million.

Regarding the MPTF, respondents mention that its structure and governance are strong and appropriate for multi-stakeholder engagement, but it has not reached the intended scale. The design phase took longer than anticipated because it was based on robust consultations between the three large agencies regarding the partnership’s objectives and expectations. For example, the agencies had to balance supporting LMIC while also having good agreements with regions that stimulate exchanges between countries. They also raised questions about what the Trust Fund was going to do with funding streams that did not run through this MPTF.

Interviewees indicate that the programme’s catalytic funding model is working, with achievements at the country and regional level as well as global public goods. This is elaborated below.

**Good programme collaboration**

Respondents describe programme cooperation between partners of the W4H programme and MPTF at the global level as a solid team. WHO, OECD and ILO have different perspectives regarding health sector development: ILO brings social partners to the table and collaborates with ministries of labour. At the same time, the OECD provides a forum and knowledge hub for economic data sharing and analysis. Collaboration between the agencies at the regional and country level requires further strengthening as ILO, for instance, does not have a presence in each country. Country concept notes, where WHO and ILO have collaborated well, include jointly negotiated deliverables linked to other existing projects and are a ‘win-win’ for all projects. In Cambodia, for example, WHO and ILO went on a joint mission. WHO’s country office supported collaboration with ILO and ILO participated actively in the preparation and the mission. This enabled health stakeholders to get to know labour stakeholders and the other way around, helping break down the silos and broaden the stakeholders’ views.

**Communication / awareness raising limited**

The MPTF has pursued an ever-evolving resource mobilization strategy, albeit with limited initial results. Some interviewees noted that communication, global advocacy and awareness raising about the W4H programme, the MPTF, and its results had been limited. This might have hampered getting new donors on board.

Respondents suggested that the agencies should be more explicit about the added value for donors to work on HRH by working with the W4H programme and MPTF. This could help donors to overcome barriers to investing in HRH. Barriers mentioned are, among others: salaries for the health workforce

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51 These include country programmes in Benin, Chad, Guinea, Mali, Mauritania, Niger, Pakistan, Palestine, Rwanda, Somalia, South-Africa, Sudan (MPTF supported); Cambodia, Kyrgyzstan, Nepal, , Sri Lanka (China grant supported), Regional programme work focused on SADC and WAEMU regions. The two global platforms referred to are the Inter-Agency Data Exchange and the International Platform on Health Worker Mobility.
as a recurring cost; HRH being too complicated; and HRH being solely a national responsibility. Although communication is included in the work plan, stakeholders have not been able to advocate on this due to the staff’s limited capacity amongst WHO, ILO, and OECD. This, in turn, was due to the underfunding of the W4H programme. Respondents assume that since there is an existing mechanism and programme that provides a relevant framework, donors can easily step in.

Country level achievements
The three agencies’ joint efforts over the implementation period 2018-2020 indicate that steps have been taken to strengthen health workforce governance across beneficiary countries. In several countries, this has provided an intersectoral and multi-stakeholder perspective and approach for building the evidence base, approach and investment choices to deliver UHC and the SDGs (examples in Box 3 - Box 5, Annex 1).

The HLMA (including the development of an HLMA guidebook) has been clear, tangible, effective outputs at the international and country level (Mauritania, Rwanda, Sri Lanka, Cambodia, Niger). Although partially co-funded by other funds, such as the French Muskoka Fund, respondents indicate valuable examples of the W4H programme outcome.

The W4H programme supported countries to set up intersectoral dialogues. Niger, for example, engaged with a range of sectors and ministries to translate the Commission’s recommendations to the national context. This resulted in the National Action Plan for investment in health and social sector employment and growth in economic health 2018-2021, endorsed by the Government and adopted through a Presidential decree. In 2019, the programme led to creating 2,500 community-based health worker jobs and 5,000 indirect jobs in three regions.52

In South Africa, the W4H programme supports the creation of jobs in the health sector through the development of a national 2030 HRH Strategy and a five-year Strategic Plan. The strategy supports, amongst others, the role of the National Health Insurance, through which South Africa aims to create 97,000 additional jobs in the health sector by 2025, with most of them for primary health care expansion. To meet these needs, in 2019, the Government of South Africa recruited and deployed an additional 5,000 newly trained health workers, including 2,329 medical interns, 1,723 community service medics (medical doctors) and 650 medical officers, as well as an additional number of nurses and community health workers. As part of the rural pipeline approach, Guinea anticipates creating 16,000 community-based health care jobs in rural areas by 2025, which would represent a national increase of 47%.53

According to respondents, a constraining factor for progress was the considerable turnover of government staff (e.g., in SADC countries and Kyrgyzstan). This resulted in gaps in institutional memories and fewer people being aware of the W4H programme and UNHEEG recommendations. Political instability and security issues also influenced the progress of the W4H programme.

Regional level achievements
The programme supported the development of a Southern African Development Community (SADC) HRH strategic framework 2020-2030 through Member State and tripartite consultation and policy dialogue. This framework provides a common approach for regional investment and harmonization of health workforce education, employment, governance and regulation. The framework is being further developed into a costed and prioritized implementation and investment plan.

The W4H programme enabled coordination across the eight West African Economic and Monetary Union (WAEMU) countries to implement the sub-regional health workforce-related investment plan. The WAEMU strategy and investment plan aim to harmonize health system regulation and governance mechanisms with a shared investment plan across all eight countries. Countries have committed, for example, to create a minimum of 40,000 decent health work jobs by 2022. Political engagement at the regional level (SADC and WAEMU), through developing HRH 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 during the COVID-19 pandemic.

**Global public health goods**

As part of the Working for Health MPTF, ILO, OECD and WHO have jointly developed a set of catalytic global public goods, including the inter-agency data exchange and the IPHWM. They also include the normative guidance, tools, evidence, global advocacy and awareness-raising required to accelerate plans and investments, foster greater policy coherence, innovative partnerships and new knowledge to support scaling up investments in transformative education, skills and job creation.

Support from the W4H programme to the IPHWM has resulted in developing new knowledge products that provide a significantly more comprehensive understanding of international health worker mobility than previously available. The updated information and evidence, including perspectives from diverse members of the IPHWM, informed the second Member State-led relevance and effectiveness review of the WHO Code.

The W4H Interagency Data Exchange (IADEx) consolidates and maximises the value of existing health workforce data and information to ensure greater consistency and reduce the data collection burden on countries. Labour Force Survey (LFS) data provide information that contributes to a better understanding of health labour market aspects such as the share of countries’ health sector overall employment, the occupational composition of the workforce, employment status, working conditions, gender issues and geographical distribution. Therefore, the identification and analysis of relevant datasets held in the ILO LFS microdata repository is an essential part of the IADEx work.

Respondents observe that both IPHWM and IADEx need to be more visible and tested against country-level activities and achievements. This is especially needed around expanding the evidence base (including what is measured and how it is measured) and the uptake of the WHO Code: respondents call for further institutionalisation of the IPHWM and an increased drive given the pressure of labour mobility and its impetus. Also, it remains important that several different actors (besides Member States) remain involved, including employers' and workers’ organizations, and civil society.

**Visibility of the W4H programme**

Respondents indicate that the W4H programme would benefit from more coherence between the programme’s activities and existing regional work by WHO (on health systems, workforce development, and GHS) and from engaging with contextualised, bottom-up approaches from countries. Respondents argue that the capacity of the W4H programme remains limited to drive and support intersectoral platforms in collaboration with government ministries and other actors. More regional capacity support would be welcome to facilitate countries with such a ‘complex’ agenda. Barriers at the country level are mentioned, such as governments prioritising other sectors, limitations in fiscal space, and limited advocacy for the health workforce agenda.

In the context of SADC and considering the COVID-19 pandemic, the interviewees felt that this creates opportunities for the W4H programme and its MPTF approach to be entrenched more, leading to the strengthening of community-based health services. However, there is a need to look at new strategies and methodologies for providing health services, including ushering in digital technologies and tools to support health services provision.
Communication, information flows, accountability and advocacy are considered weaknesses of the W4H programme. Interviewees indicate that currently, no 'champion' or related advocacy network is pushing this agenda forward. GHWN ought to have a role in this, but its relationship with W4H seems relatively weak. According to respondents, this might be due to, amongst others, a lack of funding for GHWN. This also hampered the visibility of the W4H programme and its results. Collaborating on communication and agenda setting with third actors on health workforce development and investments will thus be critical in the next phase to improve the effectiveness of the W4H programme.

**Championing the centrality of the health and care workforce**

There is a need for new champions of this strategy to increase its effectiveness. Respondents urge the involved organizations to step up their efforts at a higher level and involve civil society for increased advocacy and communication. The current resource mobilization has had limited success to date, but, according to respondents, now needs to be fully realigned around what will be more feasible and impactful for COVID-19 response and recovery. The programme's effectiveness can be improved with the COVID-19 pandemic showing how vital the health and care workforce is to emergency preparedness response and maintaining health services. This might lead to a refreshed debate in the global health community on the need to invest in the health workforce and improve the link between global, regional and country levels.

**SWOT analysis of the W4H programme and MPTF**

The table below gives an overview of the SWOT analysis based on the document review and participant interviews. It reflects the relevance and effectiveness of the five-year action plan being implemented via the W4H programme and MPTF.
<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
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| • W4H programme is embedded in the SDGs, and UHC agenda and its objectives are considered relevant and pertinent;  
• ToC underpinning the W4H programme is considered solid and relevant;  
• Joint forces of the ILO, OECD and WHO in support of an intersectoral and interagency approach;  
• Decent employment argument and underlying evidence-base;  
• MPTF established and solid mechanism, open for new donors and partners  
• Catalytic finance approach to further sustained investments and action to transform and expand the health workforce;  
• Generating global public goods such as IADEx and IPHWM | • Limited translation of global political commitments into national realities;  
• (S)low uptake of the MPTF, including funding commitments;  
• Limited capacity to support regional level intersectoral dialogue  
• Country commitment and absorption capacity translating into limited HRH actions;  
• Lack of awareness raising and advocacy;  
• W4H programme with diminishing interest across the leadership of three organizations (given HEEG in 2016) and developments since;  
• Difficulty to assess the upstream impact of the W4H programme; |

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Threats</th>
</tr>
</thead>
</table>
| • COVID-19 pandemic momentum  
• 2021 the International Year of Health and Care Workers;  
• GHS and health systems resilience drivers;  
• Relevance and effectiveness of WHO Code; acceleration of mobility trends and interests;  
• The growing relevance of regional integration policies in the social and economic domain;  
• Economic models supporting well-being and global public goods gain traction;  
• International Financial Institutions (IFI) recognise the need to invest in social spending and human capital; | • Health workforce development considered a cost for governments (persistent narrative);  
• Long-term investment in the health workforce interfered by political priorities, cycles and turnover of people;  
• Competition of global and domestic political priorities: health workforce investment agenda over several domestic political cycles requires long-term commitment and solid institutions;  
• A mismatch between the pertinence of the health workforce agenda and international political commitment and financial support;  
• Economic contraction post- COVID 19 and impact on fiscal space;  
• COVID-19 reprioritization (vaccine development, medicalization); |
Discussion

This review indicates a considerable gap between the high relevance of the W4H programme and the mixed picture of its effectiveness so far due to limited resources and the equally limited time-period since the establishment of the MPTF. Although the effectiveness of the W4H programme has been limited, the MPTF is now an operating mechanism that, according to respondents, deserves to be continued. However, a more dedicated involvement from international donors and domestic leadership at the country level is required. A conceptual framework on the emergence of global health networks provides analytical depth on the limited uptake of W4H. This framework builds on several components and considers the interrelation of network and actor features, the policy environment, and issue characteristics as key to take the agenda forward (see Figure 3).54

![Figure 3. Framework on the emergence and effectiveness of global health networks](image)

Based on the document review and interviews, succinct analysis of these factors is provided for the W4H programme and the global health workforce agenda. This is followed by a reflection on recent shifts in economic thinking on social spending to be pursued through international cooperation and investments in public health systems.55 This will provide input for suggested ways forward.

Network and actor features of the W4H programme

The leadership, i.e., the people who were central to UNHEEG and the initiation of the W4H programme, has altered considerably. The presidents of both countries that co-hosted the Commission left their position in the year after the UNHEEG report was released, and the Director-General of WHO who commissioned this report completed her term in office. While dedicated staff at WHO, ILO and OECD have pursued the programme, there is limited capacity to push these efforts given financial resources, hence staff, available for the programme. Outspoken leadership on the issue is required at all levels – from global to local. Well-respected health workforce ambassadors have been appointed, such as the former president of Liberia, Ellen Johnson. However, the W4H programme and health workforce movement could benefit from additional political and institutional leadership. WHO

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54 Ibid. 28 Shiffmann et. al.
55 Ibid. 29 Rodrik
recognises the importance of leadership as it has embarked on developing an HRH leadership capacity and capability course and creating the WHO Academy.56

The governance and composition of the W4H programme and the supporting GHWN require attention. Several groups feel ‘disconnected’ from WHO and the W4H programme since the Global Health Workforce Alliance (GHWA) transition to GHWN. The GHWN is an informal network and has only a small budget. Given the limited capacity for communication and outreach, several actors have not been aware of implementing the W4H programme and the activities of GHWN. There is hence limited ‘ownership’ of the issue. While the governance model and the focused approach, of WHO/ILO/OECD work within the MPTF, it is considered too small in terms of funding and actors involved and too narrow in its scope of supported activities. Most of this relates to intersectoral policy development and governance at the country and regional level. However, there also seems to be limited cross-reaction and engagement with other HRH activities, such as the campaign around the state of the world’s nursing 2020.57 One of the challenges ahead will be to create a shared and wider health workforce community at the global, regional and domestic level.

UNHEEG and W4H have focused on investing in health employment and inclusive economic growth in line with the SDG agenda. Respondents mentioned that this framing remains valid but is relatively narrow. The focus here is mainly on ministries of finance and labour, whilst this may resonate much less with others, such as the health workers themselves. Health workers and communities are affected by economic globalization that has been unequal, with income inequalities growing and precarious living conditions increasing in many parts of the world.58 59 Unless and until there is engagement by major economic powers towards fair globalization and a shared responsibility for generating health care jobs and a decent work agenda60, the framing of inclusive economic growth will not lead to long-term commitment and trust by major health workforce actors involved.

The policy environment

There are no evident opponents to the W4H programme and investment agenda. The question, however, is how many real allies the W4H programme has. In theory, there could be many, given the health workforce’s centrality to health systems, disease control, and labour markets. Nevertheless, an era of austerity led many governments, including HIC, to make choices about their investment priorities in public sectors. Several global (health) networks, such as the Global Fund (GF), the GAVI Alliance (GAVI), and GFF, have found themselves in competition for limited international funding and had to focus on a certain topic, thereby excluding finance for the complex, long-term, health workforce component. Multilateral cooperation in the United Nations and elsewhere has been under financial pressure for much of the last decade. This had an impact on workforce investment, which overall remains a public finance agenda.

Issue characteristics

The severity of the health workforce shortage, indicating the fragility of health systems vis-à-vis health security risks, has become more pertinent and urgent during the COVID-19 pandemic. The image of overwhelmed nurses in over-occupied intensive care units has contributed to this sense of urgency. Nevertheless, there is also a risk here. This has to do with the tractability of the issue. It is likely that staff will be redeployed during this pandemic period. They might receive incentives to

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59 “Many (if not most) developing nations are becoming service economies without having had a proper experience of industrialization, a process known as premature deindustrialization”. Rodrik, D. 2017. Straight Talk on Trade: Ideas for a Sane World Economy: Princeton University Press.
provide social and health services, including for the COVID-19 vaccination. However, as health workforce development requires a comprehensive approach, it could be more challenging to ensure that education and funding jobs get traction for a more extended period. A solid partnership of political parties and actors at the national, regional and global level is required to support this progressive agenda. The last issue then concerns the affected groups. Different health worker categories all have their professional associations and trade unions to defend their interests. These certainly deserve more involvement, at different levels, in social dialogues on workforce development. However, for the overall population, once the pandemic has been ‘managed’ and health workers continue their normal routine, the HRH issue may quickly become a less visible, salient and urgent policy issue.

While it deserves further analysis and dialogue, these factors above help identify policy actions to strengthen W4H, the health workforce network and increase participation from countries. To complete this analytical picture, the macroeconomic landscape also needs to be considered, as it affects policy space for health workforce investments. The health employment agenda cannot be separated from a macroeconomic policy discussion, the political choices involved, and its governance and institutional directions. It is of uttermost importance that health workforce jobs are being protected and supported in IFI policies and agreements with countries. Health employment financing is the priority resource need for achievement of the health SDGs. However, W4H and its partners must find entry points and engage in a constructive dialogue with these economic governance bodies. There has been justified criticism of the role of IFI in decreasing space for health systems investment during the last decades. However, thinking on (macro)economic policy approaches and social spending is shifting. This trend has accelerated due to the pandemic and its economic impact (and accompanying social unrest and unemployment) in a considerable number of countries and the increasingly visible impact of the climate crisis.

**Economic policy - building back better**

A sustainable economy is a means to the health and well-being of society and the planet. Economic growth is not an end in itself. Mainstream policy institutions, like the World Economic Forum, already think beyond Gross Domestic Product as the main indicator for economic progress, even more so in this fourth digital revolution. Sustainable economies should thrive, regardless of whether they grow or contract, and enable social foundations such as health care and other public services while respecting the planetary boundaries. This doughnut economics model provides an excellent guide towards a more equitable post-COVID-19 recovery. Economist Mariana Mazzucato, who chairs a new WHO Council on the Economics of Health for All that should guide a healthy post-Covid19 economic recovery, has written extensively about the need for investments in public services. She invites her public to think differently about ‘values’ in an economy and their implications in societies. The COVID-19 pandemic has forced governments to think differently about vital professions for a society. The most valuable, irreplaceable citizens have been recognized as those who work in health and social care, education, etc. Governments must protect and invest in them. This is, in essence, a policy and political choice.

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Several economic arguments have emerged that propose a more pluriform, flexible, longer-term approach to public health employment financing. The WHO-EIB partnership on health preparedness and primary health care aims to finance resilient health systems in LIC countries to face future pandemics. The above-mentioned economic arguments could provide health workforce investment space in this partnership, thereby securing decent public sector jobs to help address the considerable youth unemployment in several African and other regions.68 69

A reset of, and new framework for, the financing of global health in the wake of the COVID-19 pandemic has been proposed. To finance global public goods for health, three pathways have been suggested to overcome ‘the tragedy of the commons’. They are a global tax; pooling funds for unifying global financing; and strategic purchasing.70 It would be highly relevant to elaborate on what this would imply for health employment investments as the workforce delivers these global public health goods.

W4H, partners and political leaders should benefit from this clear economic policy momentum to re-articulate and shape the policy agenda for health employment, improving health and human security. It could enhance investment in health and social care jobs, transform the health and economic sector by creating real value and essential jobs, thereby contributing to global public goods and fairer economic globalization while also staying within planetary boundaries.

Policy options for moving forward

**W4H programme - the next five years and beyond**

Given the near-unanimous confirmation in this review of the relevance of the five-year action plan and the W4H programme, its steering committee, a few persons from the UNHEEG and a selected group of key (and representative) actors should form a working group that revisits the objectives and ToC of the W4H programme and develops a new five-year action plan. Given the current pandemic context, such a reorientation must include a more significant focus on the health workforce as crucial in providing GHS and global public goods. There is a clear demand and need to deepen the mandate and work of the IPHWM given the increasing international mobility of health workers and pressure in regional and global health labour markets. Likewise, there should be increased attention to the social care workforce’s role and contributions to the employment agenda. Moreover, advances in digital education and applications in the workplace require more reflection on the initial training and re-skilling of health workers.

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 NHWA and HLMA. The next phase of the W4H programme 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. More effort is needed to engage with and secure participation from ministries of health, labour and finance and other key actors to realize sustainable impact at the country level. This includes the initiation of relevant fora and contextualized dialogue to engage health professional associations and others in a more bottom-up approach. Both at the country and

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69 As proof of concept - in November 2019 a successful joint mission to Palestine took place with WHO and EIB, resulting in the establishment of a joint project and US$ 1.16 million grant to develop and fund a human capital for primary health care strategy and investment plan

regional levels, there should be a focus on capacity strengthening and identifying a core group of people who have the competences, leadership skills and dedication to commit for a longer time to this agenda.

The MTPF is considered a solid mechanism to implement the W4H programme, and as such, it should be maintained. For the programme's cost-effectiveness, it would be advisable for new donors, potential partners and other relevant actors to scale-up and engage via this - now fully operational - mechanism. The mechanism itself could also be strengthened via enhanced information and feedback provision to generate greater coherence between activities and outcomes at country, regional and global levels. Communication, advocacy, and resource mobilization for W4H require close attention and design as the programme is relatively unknown beyond those closely involved (see also network strengthening below). From a governance perspective, it is recommended to strengthen and formalize the links between W4H, GHWN, and broader health systems actors and partnerships (both within and external to WHO), thereby enhancing engagement with the W4H programme. In general, W4H, in relation to GHWN or by itself, should seek to engage new actors and funders that take issues forward. Employers and workers organizations, civil society, and professional associations have an important participatory role as their extensive networks could also facilitate active engagement at the regional and national levels. However, this requires a strengthening of the capacity of the W4H programme across all three involved organizations and across all levels (global, regional and national) to deliver an ambitious agenda.

Health workforce investment fund

The W4H programme should seek closer cooperation, including joint proposals, programming and monitoring with global health initiatives (GFF, GF, GAVI), PHC and health systems initiatives such as the UHC Partnership, the SDG3 GAP programme and, notably, the health sector response to the COVID-19 pandemic and its recovery via the Access to COVID-19 Tools (ACT) Accelerator. However, analyses from the last 15 years indicate that integration in and cooperation with other global health initiatives has been far from sufficient to secure sustainable and scalable investments in the health workforce.

Hence, countries should seriously consider a pooled global financial mechanism specifically for the health workforce with a clear governance and accountability structure, funded through domestic and international finance. Such a new structure is required to meet the ambitious workforce agenda. A US$ 1 billion health care investment fund (HCIF) has been proposed by WHO, WB and EIB, aimed at increasing access to PHC through investing in infrastructure (health facilities and educational institutions) and job creation (human capital). The proposal was presented by the WHO Director, Universal Health Coverage / Life Course, at the United Nations high-level meeting on universal health coverage in 2019. However, it did not materialize, amongst others, due to the COVID-19 pandemic and Dr Peter Salama’s sudden death. The joint WHO-EIB partnership on health preparedness and primary health care could provide new momentum and an initial mechanism to establish such an HCIF. The W4H programme and MPTF could play an important catalytic and facilitating role to operationalise such an investment fund when there are sufficient resources and expansion of the partnership guaranteeing international and institutional commitment.

Donors may be reluctant to invest in human resources for health because they may find it difficult to track and trace their investments or not have the evidence on how it contributes to strengthening health systems. Initiating a global observatory and independent panel to trace HRH employment, financing and labour market outcomes should strengthen global transparency and accountability for HRH investments. The IADEx and IPHWM could provide the basic mechanisms for such an observatory.

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71 The HCIF will combine health, education, and skills investments - with a financing mechanism in place to support grants for operational expenditure for human capital investments and recurrent costs, and training; and loans to support infrastructure costs. The fund will initially target 30 LMCs to implement health and social care job creation programmes.

Collaboration should be continued and deepened with initiatives outside the health sector, such as addressing youth unemployment with the WB and ILO and the global skills partnership programmes following the principles set out in the GCM. Likewise, cooperation with China on international health employment should be pursued, including a second round of finance via the United Nations Peace and Development Trust Fund grant.

Close collaboration with ILO on investing in decent work, gender equality, labour migration and the care economy must be continued and deepened. The same goes for the work with the OECD, focusing on financing, ODA and taxation benefiting health 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 UNGA, 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.

Network strengthening

The biggest challenge for W4H, GHWN and the health workforce community is expanding and consolidating a vibrant global health workforce movement. Such a movement is required to put and keep making investments into the health workforce high upon the political agenda. The current COVID-19 pandemic provides a unique momentum for this, even more so as the WHA has labelled 2021 as the International Year of Health and Care Workers. This could become an important year for re-initiating an international health workforce movement by involving youth groups, professional associations, workers’ and employers’ organizations, civil society, celebrities, societal and political leaders. These networks should consider amending the frame and narrative, focusing more on the essential role of health workers for societies’ functioning. Well-being and decent employment of health workers also require attention. A large international campaign, part of a WHO-coordinated health systems and COVID-19 recovery effort, should be orchestrated to drive this agenda forward. Simultaneously, the health workforce’s plight (and employment) should be emphasized in more prominent international fora at regional and global levels, e.g., during the global health (G20) summit in Italy in 2021 as well as later in the year at the UNGA. This agenda, including a continuation of W4H, should be taken forward at an ambitious fifth global forum on HRH. It will be crucial to ensure diverse country participation from the different WHO regions and perhaps identify one health workforce ambassador or champion per region. The advocacy should emphasize the importance of the joint W4H programme and its intersectoral work. ILO, OECD and WHO joining forces to address health workforce issues is a unique opportunity to overcome structural barriers. Its major strength (and challenge) is that it supports intersectoral collaboration and coordination across the sectors of finance, labour, education, health, social affairs and foreign affairs, as well as close collaboration with employers’ and health workers’ organizations, professional associations and other key stakeholders.

Countries can only advance towards GHS, UHC, Gender equality, and the Decent Work agenda when education and jobs in the health sector are guaranteed, now and in the future. Therefore, it is recommended that Member States approve the continuation of the W4H programme and provide the leadership and support required to meet the aspirational funding needs for the next five years.
Annex 1: Boxes

Box 1. Ten recommendations and five immediate actions

10 Recommendations

Transforming the health workforce:
1. Stimulate investments in creating decent health sector jobs, particularly for women and youth, with the right skills, in the right numbers and in the right places.
2. 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. Scale up transformative, high-quality education and life-long learning so that all health workers have skills that match the health needs of populations and can work to their full potential.
4. Reform service models concentrated on hospital care and focus instead on prevention and on the efficient provision of high-quality, affordable, integrated, community-based, people-centred primary and ambulatory care, paying special attention to underserved areas.
5. Harness the power of cost-effective information and communication technologies to enhance health education, people-centred health services and health information systems.
6. Ensure investment in the International Health Regulations (2005) 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.

Enabling change:
7. 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. 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. 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. Undertake robust research and analysis of health labour markets, using harmonized metrics and methodologies, to strengthen evidence, accountability and action.

5 Immediate Actions by March 2018

A. Secure commitments, foster intersectoral engagement and develop an action plan
B. Galvanize accountability, commitment and advocacy
C. Advance health labour market data, analysis and tracking in all countries
D. Accelerate investment in transformative education, skills and job creation
E. Establish an international platform on health worker mobility
Box. 2 Health Workforce Mobility

Support from the W4H Programme to the ILO, OECD and WHO International Platform on Health Worker Mobility (IPHWM), has resulted in the development of new knowledge products that provide a significantly more comprehensive understanding of international health worker mobility than previously available. The updated information and evidence, including perspectives from members of the International Platform on Health Worker Mobility (representing national governments, international organizations, national professional regulatory bodies, employers organizations, trade unions, international credential verification organizations, academia and civil society), informed the Member State-led 2nd Review of Relevance and Effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel. The knowledge products developed have informed deliberations among Member State governments. Emerging topics for discussion for the International Platform are the Global Skills Partnerships (GSP). With GSP industrialized countries want to co-finance the training of health workers in low and middle-income countries - for the domestic and foreign labour market. The International Platform is well placed to discuss benefits and negative side effects distributed and governed in these new forms of skills mobility partnership.

Box 3. Kyrgyzstan

The project, “Working for Health: 2030 Agenda for Sustainable Development” funded through the United Nations Peace and Development Trust Fund is a multi-country project that includes Kyrgyzstan. It strengthens national policy, planning and investment to expand and transform the health and social workforce to achieve the Sustainable Development Goals (SDGs). In Kyrgyzstan a pre-intervention HRH assessment mission in support of the national health programme “Healthy Person - Prosperous Country” took place in March 2020. A joint mission team from the WHO Country Office in Kyrgyzstan and the WHO Regional Office for Europe supported the Human Resources for Health (HRH) Department of the Ministry of Health to identify and prioritize HRH planning and management strengthening interventions. Multi stakeholder dialogue processes were established and initiated inclusive of the Ministry of Health, the national e-Health centre, the Ministry of Education and Science, and the Ministry of Labour and Social Development, as well as with key development partners in the health systems arena, including GIZ (Germany) and the Swiss Development Cooperation. The Ministry of Health and programme technical team have conducted a joint review, re-programming and budget revision process of Kyrgyzstan’s HRH activities and interventions. This was done in parallel with the approved COVID-19 national preparedness and planning submission to the United Nations COVID-19 Response and Recovery Fund.
Box 4. Southern African Development Community (SADC)

The W4H programme supported the development of a SADC HRH Strategic Framework 2020-2030 that was approved in November 2020, through a process of member state, tripartite consultation and policy dialogue. This framework provides a common approach for regional investment and harmonization of health workforce education, employment, governance and regulation. The framework is being further developed into a costed plan and prioritized implementation and investment plan.

Box 5. 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 National Health Workforce investment plan and the subsequent National Strategic Plan for Community Health are driving the creation of approximately 11,500 additional health and social sector jobs by 2021 in underserved areas. Furthermore, contributing to an increase of 10% rural health coverage to reach a total of 58% by 2021. The programme created 2,500 community-based health worker jobs and 5,000 indirect jobs in 2019 in three regions (Diffa, Tillabéri and Tahoua).

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. It also coincides with national priorities to fight insecurity and its underlying causes such as poverty. As a result, this contributes toward limiting migration to cities or abroad, generates local economic development and reinforces social cohesion.
Annex 2: Document review

W4H Founding Documents
- 2017-06-29 Working for Health - proposals for governing structure
- Global Health and Foreign Policy - Report_v4Sept17
- ILO-OECD-WHO-Working for Health-SDG-partnership-report_1112217
- UNGA 1 year progress report
- UNSG report on human resources development
- W4H_5YR_Action_Plan_Annex_EB_Doc_A70-18
- WHA70

W4H Key Documents
- High-Level Commission on HEEG Report
- WHO 13th General Programme of Work
- ToR Working for Health MPTF
- Working for Health Operations Manual

W4H MPTF Steering Committee Meetings
- 1st MPTF SC meeting 23 May 2018 (Agenda, documents, meeting minutes)
- 2nd MPTF SC meeting 23 November 2018 (Agenda, documents, meeting minutes)
- 3rd MPTF SC Meeting 26 April 2019 (Agenda, documents, meeting minutes)
- 4th MPTF SC Meeting 09 October 2019 (Agenda, documents, meeting minutes)
- 5th MPTF SC Meeting 09 March 2020 (Agenda, documents, meeting minutes)
- 6th MPTF SC Meeting 28 October 2020 (Agenda, documents, meeting minutes)

W4H Programme Implementation

Phase 1:
April 2019 Project Documents
- W4H_MPTF-Proposal and concept notes_2019
- W4H_MPTF-project-document_Annex1_programme-overview
- W4H_MPTF-project-document_signed-ALL_2019-06-11

Country Support (Guinea, Niger, Rwanda, South Africa)

Global Support (Inter-Agency Data Exchange, International Platform on Health Workforce Mobility)

Regional Support (SADC, WAEMU)

Phase 2:
Country Support (Benin, Chad, Mali, Mauritania, Palestine, Sudan)

Phase 3:
Country Support (Pakistan_TBC, Somalia_TBC)
W4H Annual MPTF Report:
- 1st Annual MPTF Report
- Synopsis of 1st Annual MPTF Report
- Financial Report

W4H China Grant:
- Agreement
- Interim and Annual Reports of years 1-

Reviewed Literature


Stenberg, K., Hanssen, O., Edejer, T. T. T., Bertram, M., Brindley, C., Meshrekya, A., ... Soucat, A.


Annex 3: Semi-structured questionnaire

1. Interview Guide SO2-SO3 combined

Targeted actors: External persons and experts involved (indirectly) in the development and implementation of W4H

(Interviewers’ guide, not for respondents)

SO 2: To conduct a SWOT analysis of the MPTF and Theory of Change (Figure 1 in the MPTF ToC)

(See also below under 2. for details) but most important is whether the Theory of Change is still relevant and effective. Has it been transformative? Theory of Change of Working 4 Health is described as:

- By joining forces, the ILO, OECD and WHO will assist Member States to accelerate the investments and actions needed to avert the projected 18 million health worker shortfalls and create over 40 million new health and social worker jobs (Figure 1. P.15).
- In strengthening sustained advocacy, political commitment and accountability, tripartite social dialogue, intersectoral approaches and data and evidence, the Working for Health programme will work with Member States and stakeholders to bolster the national foundations for health and social workforce action and investment.
- Building on these foundations, the Working for Health programme will develop catalytic global public goods and provide direct assistance to Member States to enhance institutional capacity, analytics and facilitate intersectoral policy dialogue to: develop the supply of appropriately skilled workers 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.

Question to respondents: Has this ToC worked at the country/regional/ and national level? What are its strengths and weaknesses? Are their current opportunities and threats? (Note for interviewer: make the link with broader relevance and effectiveness discussions of the UNHEEG recommendations and action plan, see below)

SO3: To provide a description and analysis of findings, taking into consideration the relevance and effectiveness.

- Please provide insights to what extent the “Health employment and Economic growth” Frame/ Agenda (with Working 4 health as executive programme) has been relevant (pertinence) and effective (results in evidence-informed changes), given the current policy environment (UN HLM Universal Health Coverage 2019, the GAP on SDG3, the impact of Ebola and COVID-19 on health preparedness and health security, and the Access to COVID-19 Tools Accelerator?)
- How would you describe the implementation of this Agenda so far vis-à-vis the original strategic objectives, recommendations and action plan from the HLC on HEEG?
Could you respond on the following related aspects of the UNHEEG recommendations and Agenda?

- To what extent has the policy environment (international norms and policies, the domestic and international funding landscape; affiliated or actors) shaped the W4H programme and outcome?
- To what extent has the composition of the UNHEEG W4H network (leadership, governance, composition and framing) influenced its programme shaping and outcome?
- To what extent has the issue characteristic (severity, tractability, affected groups) of “investing in workforce” frame influenced the W4H programme and outcome?
- To what extent has this led to an emergence of the W4H/ GHWN network and has it been effective?
- Could you reflect on external economic factors influencing health workforce investment? To what extend have debts, fiscal space limitations and its flexibilities enabled or hindered investment in the health workforce at the national and global level? How to improve fiscal space for investing in the workforce? If and how could economic recovery plans for the COVID-19 pandemic enable investments in the health workforce at national and regional levels?
- What would be your recommendations to continue or amend the investing in health workers/W4H programme beyond 2021? What would be needed to have communities, professional associations countries and international agencies on board? Could the COVID-19 pandemic be a transformative momentum? (Anticipation So4)

2. Interview Guide SO1-SO2 combined

Targeted actors: Persons (closely) involved in the implementation of W4H

(Interviewers guide, not for respondents)

SO 1: To conduct a review of implementation and achievements of the W4H programme

- Please explain your position and role in the W4H programme?
- To what extent has the five-year working plan of W4H been successful in its implementation and why (not)?
- Could you specify this for the part of the five-year action plan that you have been involved in, whether at the country/regional or global level? What did it change in the respective countries? Could you give an example?
- The Multi-Partner Trust Fund (MPTF) is the mechanism to put W4H in action. To what extent has the MPTF fulfilled its objectives? Did it succeed in the resource mobilization required to start actions in the 20 designated countries?
- Has the governance and institutional set-up of the MPTF been effective in catalyzing action?
- How have the programme features, such as administration, finance, and communications, worked out according to you?
- Overall, has the programme been effective in catalysing the actions for investing in the health workforce at nation, regional and/or global level?

SO 2: To conduct a SWOT analysis of the MPTF and its Theory of Change (Figure 1 in the MPTF ToC)

- What are, in your opinion the strengths, of the W4 health programme and the MPTF ToC (E.g. Intersectoral/interagency approach; link with UHC/SDG agenda; focus on inclusive economic growth; catalysing function?)
- Likewise, could you identify weaknesses of the W4H programme and its implementation?
(E.g. engagement from donors, country commitment and absorption, bureaucracy/governance of a MPTF)

- What could be current and future opportunities of the MPTF and the W4H programme? (E.g. the COVID-19 pandemic momentum; attention to relevance + effectiveness of the Code, Call for health systems resilience; Economics of Health and Well-being (Mazzucato); Global common goods financing (Soucat/Kickbusch); Pan-European Commission on Health and Sustainable Development; European Investment Bank plans)
- What could be the current and future threats for the MPTF and the W4H programme? (E.g. much focus on vaccine development and GHS; not workforce; austerity, fiscal space and debt challenges in many countries).
- In summary; how would you reflect on the relevance (pertinence) and effectiveness (results in evidence-informed changes) of the MPTF and the W4H programme?
- What would you recommend WHO and partner organizations as options for the future of the W4H programme? (Anticipation S04)