

WORKING FOR HEALTH

Stimulating investments and action to
expand and transform
the health and social workforce
for the 2030 Agenda

Terms of Reference
for the
ILO-OECD-WHO
Multi-Partner
Trust Fund
(MPTF)

‘Working for Health’ is a strategic, intersectoral, multi-stakeholder programme that leverages the convening power and mandates of the United Nations and the OECD, our rights-based approaches and standards, and the expertise, resources and support from our diverse constituents and partners to expand and transform the health and social workforce.

Contents

I. Introduction	4
1.1. Rationale	6
1.2. Making the case: the report and recommendations of the Commission	7
1.3. Working for Health: The Five-Year Action Plan on Health Employment and Inclusive Economic Growth	10
II. Functions of the Working for Health Multi-Partner Trust Fund	11
2.1. Other key functions.....	13
3.1. Priority and pathfinder countries.....	14
III. Theory of Change	15
3.2. Global public goods.....	17
3.3. Key principles	18
3.4. Key cross-cutting considerations	18
IV. Governance Arrangements.....	21
4.1. Steering Committee	21
4.2. Technical Secretariat.....	22
4.3. The Administrative Agent	23
4.4. Country Coordination Committees	23
4.5. Strategic Advisory Board	24
4.6. Donor Coordination Group	24
4.7. Policy Support Network	25
4.8. Participating Organizations.....	25
V. Fund Implementation	26
5.1. Contributions to the MPTF.....	27
5.2. Project Approval Cycle	27
5.3. Financial Viability	28
5.4. Risk Management	28
VI. Reporting	31
6.1. Reporting to governance structures of the ILO, OECD and WHO.....	31
6.2. Reporting to donors of the Working for Health Multi-Partner Trust Fund	31
6.3. Reporting by the ILO, OECD and WHO to the administrative agent.....	31
VII. Monitoring and Evaluation	34

VIII. Audit.....	34
IX. Public Disclosure	34
Annex 1. Five-year action plan deliverables	35
Annex 2. Results matrix.....	40

I. Introduction

1. The vision of the Working for Health programme is a world in which everyone has equal access to health services provided by skilled and empowered health and social workers in strengthened health systems.
2. The goals of the Working for Health programme are the *expansion* and *transformation* of the global health and social service workforce in order to accelerate progress towards universal health coverage and global health security. By providing state-of-the-art policy advice, technical assistance and capacity strengthening support to achieve these twin goals, the International Labour Organization (ILO), the Organisation for Economic Co-operation and Development (OECD), and the World Health Organization (WHO) will jointly assist their constituents and partners from governments, the private sector and civil society to achieve the following Sustainable Development Goals (SDGs):
 - Good health and well-being (SDG 3)
 - Quality education (SDG 4)
 - Gender equality (SDG 5)
 - Decent work and economic growth (SDG 8)
3. The mission of the Working for Health programme has been elaborated by the High-Level Commission on Health Employment and Economic Growth (“Commission” – see Box 1):
 - To stimulate and guide the creation of at least 40 million new jobs in the health and social sectors, and
 - To avert the projected shortfall of 18 million health workers, primarily in low- and lower-middle income countries, by 2030.
4. The Five-Year Action Plan on Health Employment and Inclusive Economic Growth (2017-21), adopted by the World Health Assembly in May 2017, is the overarching framework for the Working for Health Programme. It sets out how the ILO, OECD and WHO will support Member States to translate the Commission’s ten recommendations into action and create urgently needed health and social sector jobs. (Table 1). The list of deliverables under each recommendation are described in detail in Annex 1.
5. Guided by the Commission’s recommendations and the Five-Year Action Plan, the Working for Health programme will coordinate, enhance and extend the policy advice, technical assistance and capacity support that the ILO, OECD and WHO will provide to their constituents and partners. The purpose of the action plan is to catalyse the expansion and transformation of the health and social workforce in all countries through the development of global public goods and targeted technical

Box 1. The High-Level Commission on Health Employment and Economic Growth

was established by the United Nations Secretary-General on 2 March 2016 in response to United Nations General Assembly resolution 70/183 on Global Health and Foreign Policy: Strengthening the Management of International Health Crises adopted on 17 December 2015.

The Commission was chaired by H.E. President of France, Mr François Hollande, and H.E. President of South Africa, Mr Jacob Zuma; and co-chaired by the Director-General of the WHO, the Secretary General of the OECD and the Director-General of the ILO.

assistance in priority and pathfinder countries. Technical assistance will support Member States and stakeholders to develop social dialogue and evidence-based national strategies, improve accountability structures, achieve efficiencies in existing and future investments. This will make it easier for domestic and international partners to invest in a health and social workforce for the future.

6. Priority will be given to the 15-20 countries across different regions that are furthest from achieving universal health coverage, have the greatest disease burdens and are most at risk of emerging and re-emerging epidemics.
7. Priority will also be given to ‘pathfinder countries’ in any region and at every level of socio-economic development. These are countries that have demonstrated high level commitment to bold action and investments in the health workforce. Pathfinder countries have already requested urgent, improved and better coordinated support from the ILO, OECD and WHO to transform and expand their health workforce. These include but are not limited to:
 - Member States of the West African Economic and Monetary Union: Benin, Burkina Faso, Cote d'Ivoire, Guinea-Bissau, Mali, Niger, Senegal, and Togo;
 - Member States of the Southern African Development Community: Angola, Botswana, Democratic Republic of Congo, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, United Republic of Tanzania, Zambia, Zimbabwe; and
 - Iraq, the Philippines and Tunisia.
8. The targets of the Working for Health programme¹ are as ambitious as they are critical to global health security and to advancing the 2030 Agenda for Sustainable Development:
 - **By 2018, an interagency global data exchange on the health labour market is established:** harmonized interagency definitions and methodologies for the collection and analysis of health labour market metrics are critical to developing coherent, evidence-based policy advice and enhanced national health workforce strategies and investments.
 - **By 2018, an international platform on health worker mobility is established:** this platform will assist Member States to better monitor and manage health worker migration flows to maximize the mutual benefits of health worker mobility whilst mitigating its adverse effects. .
 - **By 2020, 20 countries have inclusive mechanisms in place to coordinate an intersectoral health workforce agenda supported by the Working for Health programme:** The ILO, OECD and WHO will facilitate concerted tripartite social dialogue with the engagement of governments, employers, workers’ organizations across sectors of education, health, labour, finance and foreign affairs. The purpose is to agree on a vision for the health

¹ Aligned to the milestones of the WHO Global Strategy on Human resources for Health

workforce and on concrete steps to invest in and transform current health workforce models to be sustainable and fit-for-purpose.

- **By 2020, 20 countries have developed enhanced national health workforce plans:** with the support of the ILO, OECD and WHO, these enhanced national intersectoral plans will contain strategies to maximize efficiencies, scale up transformative education, skills and decent job creation and mobilize the domestic and international resources needed to achieve this.
- **By 2020, 20 countries are making progress on sharing data through national health workforce accounts:** with the direct technical assistance of the ILO, OECD and WHO, the progressive implementation of these accounts will inform policy-making, enhance accountability and be used to monitor progress.
- **By 2021, 20 countries have secured financing to implement national health workforce plans:** with the catalytic support of ILO, OECD and WHO to achieve expanded sustainable financing to effectively implement national plans and maximize socio-economic returns on investments.
- **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:** with the support of ILO, OECD and WHO Member States maximize the mutuality of benefits from labour mobility and avert projected shortfalls towards achieving universal health coverage and the SDGs.

9. The impact of the Working for Health programme will be monitored using the interagency global data exchange and national health workforce accounts described above. Indicators and targets of the relevant SDGs will also be used to measure the impact and how it contributes to the attainment of the 2030 Agenda. (See Box 4).

1.1. Rationale

10. The world's population is growing, changing and facing an increasingly challenging employment outlook with a need for over 670 million new jobs by 2030. Four hundred million people lack access to healthcare. Universal health coverage, improved access to safe and quality health and social care, decent work and full employment are critical to eradicating poverty, enhancing social cohesion and stability and achieving prosperity for all. The health and social sector is a major and growing employer, offering rare opportunities for young women and men to find a decent job. In many countries, the health sector is the leading sector for job creation. Employment in the health and social sectors in OECD countries grew by 48 per cent between 2000 and 2014, compared to 14 per cent across all sectors. An ILO study of employment during the period 2005-2013 found that the annual average global growth in health employment was double that of total employment growth (2.8 per cent versus 1.3 per cent). In Asia and the Pacific, health employment growth outpaced total employment growth five-fold.
11. In 2013 43.5 million health workers were directly engaged in the provision of health services (WHO data), with over 234 million workers in the broader health economy in 2015 (ILO data). ILO

estimates that each health occupation job generates two additional jobs for workers in other occupations. It is expected that the demand for health care will rise steeply, leading to a need for more than 40 million new health worker jobs, primarily in high- and upper-middle-income countries. At the same time, the world is faced with a projected shortfall of 18 million health workers to achieve and sustain universal health coverage, in mostly low- and lower-middle income countries. Inaction and chronic underinvestment in the workforce have compromised health and security, and have also led to new global risks and serious economic and social setbacks (e.g., Ebola virus disease, Zika virus, Avian Influenza).

12. A study assessing the costs of achieving the health SDGs (Stenberg K et al, Lancet Global Health, 2017) found that the bulk of investment required to achieve better health and well-being by 2030 needs to be spent on training, paying and supporting the health and social service workforce. Although a vibrant and well-functioning health sector is a strong economic driver, the prevailing view has been that the health and social workforce is a cost to be contained and a drag on the economy, leading to decades of underinvestment. This entrenched pattern of financing is at odds with evidence put forward by the Commission that the health and social workforce is a force multiplier for inclusive growth.
13. As the Commission concluded unequivocally, business as usual is untenable. The international community and all Member States must urgently change the way we invest in the health and social workforce for better health, decent work and inclusive growth.

1.2. Making the case: the report and recommendations of the Commission

14. In its report, *Working for health and growth: investing in the health workforce*, the Commission proposed ten recommendations and five immediate actions to transform the health and social workforce for the achievement of the 2030 Agenda for Sustainable Development. Implementation of these will require game-changing interventions and action by Member States, led by ministries of health, education, employment and finance, as well as the international community.
15. Dismantling the long-held belief that investment in the health workforce is a drag on the economy, the Commission found that health workforce investments coupled with the right policy action could unleash enormous socioeconomic gains in

Box 2. Global support

The Commission's recommendations have been endorsed and supported by the:

- United Nations General Assembly;
- ILO, OECD and WHO High-Level Ministerial Meeting on Health Employment and Economic Growth;
- OECD Health Ministerial Meeting;
- France-Africa Bamako Summit;
- United Nations 61st Commission on the Status of Women;
- West African Economic and Monetary Union health and labour ministers meeting;
- ILO tripartite meeting on improving employment and working conditions in health services;
- G20 Health Ministers meeting;
- World Health Assembly; and
- High-Level Political Forum

quality education, gender equality, decent work, inclusive economic growth, and health and well-being. This paradigm shift provides new political impetus for Member States to implement the WHO global strategy on human resources for health: *Workforce 2030*, adopted by the Sixty-ninth World Health Assembly in May 2016 (WHA69.19).

16. The Commission identified the health and social sectors as major, growing sources of employment. The Commission also found these sectors are ideal for strategic investments that translate into more decent work opportunities, particularly for women and young people, than most other industries and sectors. Few economic sectors present such opportunities for steady growth in decent work. It is particularly important to recognize this, given the large job losses expected in other economic sectors due to rapid technological advances and the changing organization of production and work.
17. Without targeted interventions, the situation in resource-constrained settings may be further exacerbated by increased labour mobility towards countries with greater demands, thereby undermining already vulnerable health systems. Investing in the quality of jobs in terms of working conditions, labour protection and rights at work is key to retaining health workers where they are needed most.
18. The Commission called for immediate, bold and game-changing interventions to challenge the status quo and alter the projected trends in the health and social workforce. Achieving a sustainable health and social workforce is an intersectoral pursuit that requires coordinated leadership and action across the sectors of government responsible for 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. The ten recommendations and five immediate actions are listed in Table 1.
19. There is no single path to effective implementation of the Commission's recommendations and immediate actions. To be effective, the implementation of the Commission's recommendations must be driven by Member States and be aligned and integrated with national and regional priorities and related agendas on health, social protection, employment and economic growth across sectors. Policies and action must be implemented through continuous social dialogue with representatives of employers and of health and social workers. Current and future trends and needs must be anticipated and taken into account to ensure equity and inclusivity. These include demographic and epidemiological changes, migration flows, climate change, inequities in access to health services, technological advancements and socioeconomic transitions. Investments must be coupled with a transformative agenda and the right policies to ensure that they result in achieving decent jobs with the right skills and in the right places.

Table 1. Recommendations and immediate actions from the High-Level Commission on Health Employment and Economic Growth

10 Recommendations	
Transforming the health workforce	<ol style="list-style-type: none"> 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	<ol style="list-style-type: none"> 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	
	<ol style="list-style-type: none"> 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

1.3. Working for Health: The Five-Year Action Plan on Health Employment and Inclusive Economic Growth

20. The Five-Year Action Plan on Health Employment and inclusive Economic Growth (“action plan”) was unanimously adopted by the Seventieth World Health Assembly on 25 May 2017. There was broad consultative input from 67 submissions and 26 statements of commitment from Member States and other stakeholders, and contributions from over 200 participants at the High-Level Ministerial Meeting on Health Employment and Economic Growth in December 2016.
21. The action plan aims to support and facilitate country-driven implementation. It sets out how the ILO, OECD and WHO will work with Member States and key stakeholders to translate the Commission’s recommendations into action in line with national, regional and global plans and strategies. As such the ILO-OECD-WHO Working for Health programme exemplifies collaborative partnerships between international agencies needed to support Member States to realize the 2030 Agenda.
22. The specific objectives of the five-year action plan are to:
 - Facilitate Member States’ implementation of intersectoral, collaborative and integrated approaches and country-driven action to advance the Commission’s recommendations and immediate actions in line with the WHO global strategy on human resources for health.
 - Catalyse and stimulate predictable and sustainable investments, institutional capacity-building, and transformative policy action and practice in the health and social workforce, with special consideration to priority countries where universal health coverage and the Commission’s recommendations are least likely to be attained.
23. The action plan does not prescribe what Member States or key stakeholders are required to do to implement the Commission’s recommendations. Rather, it sets out the deliverables that ILO, OECD and WHO will generate in order to respond to the expected demands and requests of Member States, employers’ and workers’ organizations and other key stakeholders. Where applicable and requested by Member States, the organizations will engage in analysis and research, advise on norms and international labour standards, provide technical cooperation, convening and coordination, knowledge management and sharing, institutional capacity development, and the facilitation of investments and financing.
24. These deliverables are grouped in five interrelated workstreams:
 - **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;
 - **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;

- **Education, skills and jobs:** accelerating the implementation of intersectoral national health workforce strategies designed to achieve a sustainable health workforce;
- **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
- **International labour mobility:** facilitating policy dialogue, analysis and institutional capacity-building to maximize mutual benefits from international labour mobility.

II. Functions of the Working for Health Multi-Partner Trust Fund

25. The global health arena is characterized by a number of large financing facilities and multi-partner trust funds. These have mainly been established to raise funds and finance *inter alia*:
 - Action against specific diseases (e.g., The Global Fund to Fight AIDS, Tuberculosis and Malaria);
 - Specific health interventions (e.g., Global Alliance for Vaccines and Immunization); and
 - Interventions with specific target groups in mind (e.g., the Global Financing Facility to improve the health of women, children and adolescents).
26. Together, the global facilities, funds or bilateral donor programmes account for most official development assistance (ODA) for global health. They have yielded impressive results in their areas of operation and in the countries in which they operate or invest. However, all these facilities and funds rely on having a skilled and empowered health workforce to achieve their ambitious goals and targets. The sustainability of these considerable investments is undermined by a lack of investment in the women and men that ensure that health systems function and that essential health services are provided every day.
27. Although the health workforce comprises the largest subcomponent of health sector investments required to achieve the health-related SDGs in low and middle income countries, less than ten per cent of ODA is spent on strengthening health systems. Even less is spent on programmes investing in the health workforce. Investments to support the provision of skilled, trained and empowered women and men in the health workforce are an urgent and essential requirement for Member States to provide better health care. This includes providing preventive care, reforming health services, distributing vaccines, detecting, preventing and responding to emerging epidemic and providing long-term care for the increasing population with chronic illness.
28. Given the existence of the above-mentioned multibillion dollar facilities and funds – as well as many related initiatives financed by bilateral donors (e.g. the US President’s Emergency Plan for AIDS Relief - PEPFAR) or leading foundations (e.g. the Bill & Melinda Gates Foundation) – the Working for Health Multi-Partner Trust Fund (MPTF) has been designed to serve a different scope and purpose.
29. The Working for Health MPTF is not another, competing facility to finance action by governments, private sector or civil society actors themselves. As described above, it has instead been created to finance catalytic, coordinated policy advice, technical assistance and capacity strengthening

programmes that Member States have requested from the ILO, OECD and WHO as they set out to prepare new, enhanced, national health workforce plans and investments in line with the Commission's recommendations.

30. As described in the theory of change outlined in Section III below, the Working for Health MPTF will finance the ILO, OECD and WHO's joint policy advice, technical assistance and capacity strengthening support during the next five years to develop:
 - A set of catalytic global public goods; and
 - Enhanced national health workforce plans and investments.
31. The global public goods include the interagency data exchange and the international platform on health worker mobility. 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 massive scaling up of investments in transformative education, skills and job creation.
32. The enhanced national health workforce plans are critical for Member States to make an 'investment case' for increased investments in strengthening health systems and expanding the health workforce and will have the following three essential characteristics:
 - First, the national health workforce plans will be informed by social dialogue, national health workforce accounts and labour market analyses to provide the intersectoral data, transparency and accountability needed for investors to tailor, target and monitor the effectiveness of their investments.
 - Second, by better anticipating future skills needs, the impact of labour mobility, and other current and future challenges of reformed health delivery models, the national health workforce plans will set out credible and efficient strategies for why and how increased domestic resources, both public and private, should be allocated to the transformation and expansion of the health workforce.
 - Third, the enhanced national health workforce plans will be a critical component of the ILO, OECD and WHO's work to assist low- and lower-middle income countries to mobilize domestic resources as well as international financing from the above-mentioned global health facilities and funds and from the international and regional development banks.
33. In this regard, the ILO, OECD and WHO have had several consultations with the Global Fund, GAVI and the Global Financing Facility, as well as with the International Monetary Fund (IMF), the World Bank Group, the International Finance Corporation (IFC) and with leading bilateral donors and foundations. Along with the Global Fund, GAVI and the Global Financing Facility, the World Bank Group, IMF and IFC have been financing, investing and monitoring domestic resources allocated to the health sector in their Member States for decades. These organizations have all signaled their strong interest in supporting the Working for Health mission to invest in health workers, recognizing that the collaboration will take a different form in each priority- and pathfinder country.

34. In general, there is broad and increasing agreement that large-scale expansion of investments in transformative education, skills and job creation is essential for tackling existing health emergencies, future health threats and to ensure the long-term sustainability of health systems. Such investments are also needed to preserve and build on the progress made due to the significant investments that the international community has made in advancing global health and well-being to date (Box 3). Through collaborating closely with the Global Fund, GAVI and the Global Financing Facility, the World Bank Group, IMF and IFC, and by leveraging their resources and financing mechanisms, the Working for Health programme will be able to work with priority and pathfinder countries to make the strongest possible investment case and implement the most effective strategies to expand and transform the workforce.

Box 3. The case for investing in the transformation and expansion of the health workforce

We must expand and transform the global health workforce. This is not a cost. It is an investment that should be nurtured. The fact is, investing in health workers creates jobs, drives growth and increases productivity by getting sick people out of care and back to work.”

WHO Director-General, Tedros A. Ghebreyesus

“Good health matters for well-being and our economies. We must ensure we have health and social care workers in the right jobs, with the right skills, in the right places”

OECD Secretary General, Angel Gurría

“Employment opportunities and the quality of those jobs are equally critical in order to attract and retain qualified and motivated health workforce. This means paying attention to working conditions, including good training and career prospects, fair remuneration, adequate social protection, occupational safety, and participation in planning and decision making through social dialogue”

2.1. Other key functions

35. The Working for Health programme is fully aligned with the 2016 decision of the Quadrennial Comprehensive Policy Review’s (QCPR) to ‘support countries in their efforts to implement the 2030 Agenda for Sustainable Development in a coherent and integrated manner.’ It provides integrated normative support both at the global and country levels leveraging the expertise of the UN development system and the OECD.
36. As an interagency pooled fund seeking to mobilize resources from multiple sources in order to provide integrated policy support to Member States, other key functions of the Working for Health MPTF include:
- **Foster coordinated policy advice and assistance:** The Working for Health MPTF will provide Member States with the combined policy expertise and technical assistance of the ILO, OECD and WHO to address challenges to health and well-being, gender equality, decent work and

inclusive economic growth, through the provision of integrated multidisciplinary policy support, tailored to each Member States' needs and demands.

- **Harmonized and aligned support of development partners:** The MPTF will align and harmonize financing from donors and development partners with national development priorities, as expressed in a new generation of national health workforce plans.
- **Maximize UN and international organization efficiency:** The MPTF will finance the joint products and results from the pooled efforts, mandates and expertise of the ILO, OECD and WHO, thereby achieving greater efficiencies and synergies as compared with separate efforts by each organization.
- **Promote policy coherence:** The MPTF will finance joint interventions by the ILO, OECD and WHO improving policy coherence, both among and within governments and with employers' organizations, professional associations and workers' organizations.
- **Facilitate innovation and experimentation:** The Working for Health MPTF will allow the ILO, OECD and WHO to jointly develop new, innovative policy solutions for sustainable development.
- **Deepen normative-policy operational links:** Improved risk management and greater fund predictability will allow the three agencies to extend their policy support beyond the normative level and engage in the policymaking cycle as well as in operational activities, thus generating synergies between these core functions for the benefit of Member States.
- **Manage risks:** The Working for Health MPTF offers a way for donors to share and manage risks. It does so by pooling funds from different sources, enabling a diversified project portfolio, across different types of interventions and recipient countries. Projects implemented through the MPTF also benefit from a comprehensive and robust risk and results-based management system.

3.1. Priority and pathfinder countries

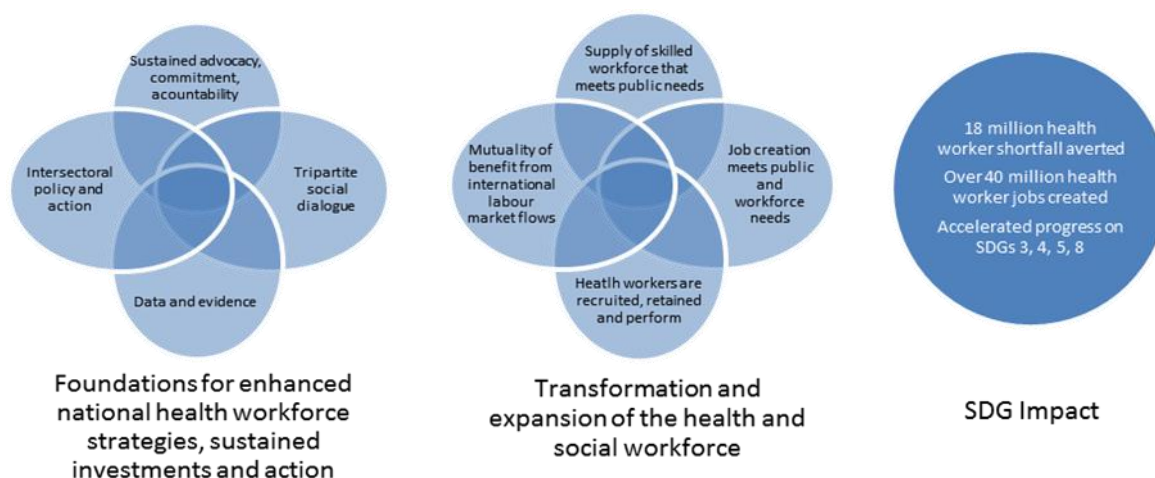
37. The Commission proposed that the international community prioritize 15-20 countries across regions where universal health coverage and the Commission's recommendations are least likely to be attained. A list of priority countries will be identified based on a careful analysis of existing health workforce, universal health coverage and socio-economic indicators and indices, and following further consultation with Member States.
38. Inspired by the Commission's report, many pathfinder Member States have already translated the Commission's recommendation into their own plans, and have requested the assistance of the ILO-OECD and WHO to implement their plans and help mobilize the considerable investments required. These countries include Member States of the West Africa Monetary and Economic Union (UEMOA) and the Southern African Development Community (SADC) but are not limited to:
 - UEMOA: Benin, Burkina Faso, Cote d'Ivoire, Guinea-Bissau, Mali, Niger, Senegal, Togo;
 - SADC: Angola, Botswana, Democratic Republic of Congo, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, United Republic of Tanzania, Zambia, Zimbabwe; and
 - Others: Iraq, The Philippines, Tunisia

39. In addition to the 15-20 priority countries and the pathfinder countries that have requested support, the ILO, OECD and WHO will provide assistance and advice to any Member State that requests it, subject to available resources and the amounts mobilized through the MPTF.
40. Transformation and expansion of the health workforce is a truly global and universal agenda. The ILO, OECD and WHO have joined forces to assist all countries to step up their education and training of health workers, and facilitate bilateral, multilateral, regional and international agreements on the international recruitment of health personnel to ensure mutuality of benefits and mitigate negative effects.

III. Theory of Change

41. 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).
42. 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.
43. 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.

Figure 1. Working for Health programme impact



44. By joining forces, the ILO, OECD and WHO will assist Member States in the formulation, financing and implementation of comprehensive, intersectoral and integrated national health workforce plans. The programme impact is illustrated in Figure 1:

- **First**, using their convening power and drawing on their data and analytical work, the ILO, OECD and WHO will facilitate sustained advocacy, political commitment, concerted tripartite social dialogue at the national level to share knowledge and enhance accountability. The leadership and stewardship roles of Member States and other key stakeholders are critical to implementation of the Commission's recommendations. Involvement of all stakeholders is essential for formulation of the national health workforce plan. Governments, employers and workers' organizations must work together across education, health, labour, finance and foreign affairs to agree on a vision for the health workforce. They must also agree on concrete steps for investing in and transforming current health workforce models to ensure they are sustainable and fit-for-purpose.

Target: 20 countries with inclusive mechanisms in place to coordinate an intersectoral health workforce agenda supported by the Working for Health programme by 2020.

- **Second**, the Working for Health programme will support Member States with progressive implementation and reporting of National Health Workforce Accounts. The purpose of these accounts is to facilitate the standardization of a health workforce information system to improve data quality, and support tracking of health workforce policy performance towards universal health coverage. This will be coupled with investments in developing individual and institutional skills and capacities in health workforce governance, science and research. Building institutional and individual capacity to perform robust analyses of health labour market dynamics will ensure the availability of the reliable and up-to-date data needed to develop national health workforce plans and to monitor and report on progress.

Target: 20 countries are making progress on sharing data through National Health Workforce Accounts by 2020.

- **Third**, the formulation of national health workforce plans is the cornerstone of sustained and transformative action to strengthen health systems and achieve universal health coverage. However, most of the existing health workforce strategies that the ILO, OECD and WHO have reviewed are narrow in scope and timid in ambition. Few are informed by robust labour market analysis to take into account the anticipated skills need, gender inequities in the labour market, the impact of health worker mobility and migration, and the need to reform the delivery of health services to be sustainable in the long term. Accounts of how investments in the health workforce will contribute to inclusive economic growth, gender equality, decent work and employment are lacking. Guided by the Commission's report and the Five-Year Action Plan, the Working for Health programme – together with other partners and global initiatives working on relevant goals of the 2030 Agenda (for example, for quality education, youth employment, gender equality, and sustainable business) – the

ILO, OECD and WHO will support countries to develop comprehensive, intersectoral and integrated health workforce plans.

Target: 20 enhanced health workforce plans supported by the Working for Health programme by 2020

- **Fourth**, based on the national health workforce plans, the ILO, OECD and WHO will assist Member States to develop an investment case, improving governance and analyzing the fiscal and financial space, identifying and committing domestic resources and implementing the financing reforms required for expanding the health workforce in line with national priorities and in a realistic and feasible manner. Priority investments in education include infrastructure, institutional capacity, training programmes and accreditation. These must be coupled with plans for investments to stimulate decent job creation, particularly where there is insufficient economic demand to employ the health workers needed to achieve universal health coverage. In addition, the ILO, OECD and WHO will support low- or lower-middle income countries to mobilize financing from the global health initiatives and funds as well as from the international and regional development banks.

Target: 20 countries with financing secured to implement national health workforce plans by 2021.

- **Fifth**, the ILO, OECD and WHO will assist Member States to implement financed national health workforce plans when requested to do so, in order to accelerate progress towards averting the global health workforce shortfall and achieving a sustainable global health workforce. The Working for Health programme will support Member States to strengthen the health worker education, training and lifelong learning market to produce the required skills; align job creation to meet public and health and social workforce needs; strengthen the institutional capacity to regulate and ensure accountability; improve the quality of jobs, working environment and equity of prospects for health worker employment; and maximize the mutuality of benefits from international health worker mobility through the effective governance of international health worker mobility, negotiation of international cooperation and co-investments and uphold migrant worker rights.

Target: 20 countries are making progress towards halving inequalities in access to a health worker and reducing their dependency on foreign-trained health professionals by 2030.

- **Finally**, the investments in the transformation and expansion of education, skills and decent job creation across the 20 countries directly supported by the Working for Health programme, and the other countries indirectly supported through global public goods generated by the Working for Health programme, will contribute towards a sustainable health workforce. This will, achieve socio-economic dividends across SDG 3, 4, 5 and 8. The overall impact of the Working for Health programme and MPTF will be measured and tracked via the interagency data exchange using the indicators and targets of the relevant SDGs as set by the United Nations Statistical Commission (Box 4).

3.2. Global public goods

45. **Interagency data exchange and online knowledge platform:** a more comprehensive understanding of the health labour market, policies, effective practices, evidence, monitoring and analysis of labour market developments against SDG targets is critical to expanding and transforming the health and social workforce. An openly accessible, interagency data exchange and online knowledge platform hosted by the ILO, OECD and WHO will pool available labour market data from the three organizations and yield a deeper understanding of the health labour market. The interagency data exchange will also help coordinate future streamlined and harmonized approaches to further advance labour market data and evidence towards achieving the vision of including all health and health-related social occupations. This will accelerate progressive implementation of national health workforce accounts labour market indicators, while minimizing the data collection burden on countries. The online knowledge platform will serve as a global resource to strengthen intersectoral knowledge management, coordination, analysis and dissemination of evidence and best practice to inform health and social workforce plans, actions and investments. Innovations, lessons and experiences will be rapidly disseminated via the online knowledge platform.
46. **International health worker labour mobility platform:** to tackle the challenges associated with increasing international mobility of health workers, the Commission called for the immediate establishment of an international platform on health worker mobility. The aim is to optimize the benefits of increasing international mobility of health workers while counteracting any adverse effects. The platform will serve as a mechanism to facilitate evidence-based policy dialogue and action towards achieving a sustainable global health and social workforce. It will offer a global data hub on international mobility of health workers by country of origin and training, as well as by countries of destination. It will also organize international meetings to promote consultation and dialogue between countries on key policy issues, including innovative and effective policy practices for assessing and recognizing foreign qualifications. The platform will also disseminate policy papers produced by OECD, WHO and ILO on topics of regional and international interest to inform and encourage these country consultations. Such topics include trends in regional and international mobility of health workers, and examples of good practices in bilateral and regional agreements to co-invest in the education, training and employment of the health and social workforce. This will contribute to the discussion and negotiation on the Global Compact for Safe, Regular and Orderly Migration.
47. **Normative guidance and tools:** other global public goods generated by the Working for Health programme will include normative guidance, tools and evidence that can be adapted and utilized globally. This will harness the expertise of the ILO, OECD and WHO with their constituents' expertise to efficiently and effectively address currently unmet priority health and social workforce needs. Specific tools include: skills assessment tools and approaches to evaluate the skills of the health and social workforce; guidance for the provision of inter-professional education and organization of multidisciplinary care; guidance for practices to ensure adequate distribution of the workforce for equitable primary care services; a review of information and communication

tools to enhance health worker education and performance; guidance to improve the security and protection of health workers; tools and methodologies to analyze productivity, performance and wages; the advancement of research methodologies and evidence for decent work in the health and social sector; and effective labour market interventions to optimize the socioeconomic return on health and social workforce investments.

3.3. Key principles

48. The implementation of the Working for Health programme will follow these key principles:

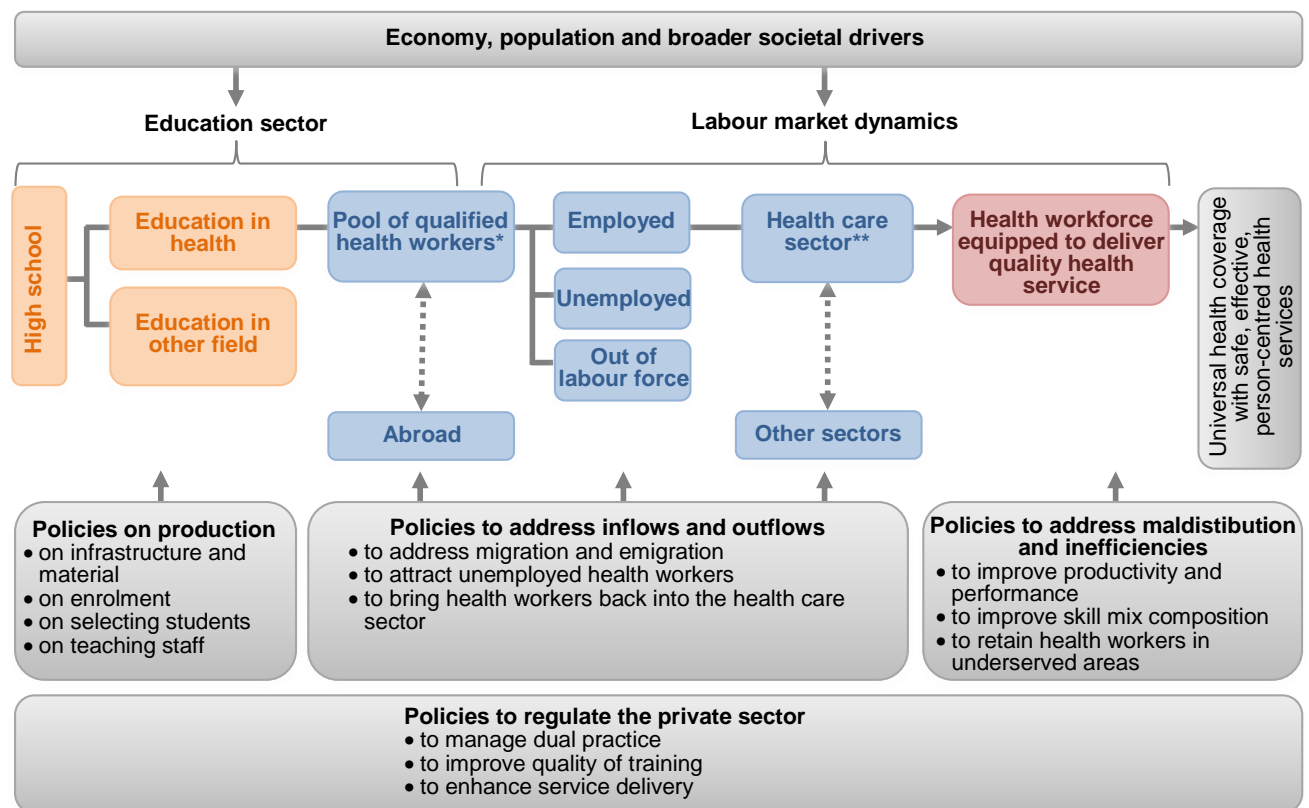
- supporting the achievement of universal health coverage and the 2030 Agenda for Sustainable Development;
- being guided by United Nations General Assembly resolutions, World Health Assembly resolutions, normative frameworks and instruments, and international labour standards;
- being country-led and driven, with the agencies working in close consultation with governments, employers and workers' organizations as well as other key partners at the country, regional and global levels;
- focusing on making an impact and achieving tangible results at the country level and in key sectors;
- combining immediate action and longer-term strengthening of laws, policies and institutions;
- making full use of institutional mandates, strengths and value-added activities across the three agencies without duplication; utilizing existing initiatives, knowledge platforms, networks and lessons learned, particularly those related to education and skills, gender equality, youth employment and decent work, health emergencies amongst others; and
- harnessing and building on credible data and analysis to monitor progress and impact at the national, regional and global levels.

3.4. Key cross-cutting considerations

49. Key cross-cutting considerations that underpin the Working for Health programme include the following:

- **Labour market approach:** A labour market approach will be applied to health and social workforce analyses, action and investments, taking full consideration of the dynamics and drivers across sectors (Figure 2). This approach utilizes the National Health Workforce Accounts indicators and includes analysis of the education sector, pre-service education systems, available workforce pool (for example, demographics, skills and distribution), life-long learning systems (for example, continuing professional development and continuing education), employment, and workforce investments against current and future population health and social care needs. A suite of appropriate policies, reforms, regulatory frameworks and incentives may be required to address labour market failures identified through labour market analyses.

Figure 2. Public policy levers to shape health labour markets



Adapted from Sousa et al., 2013.

* Supply of qualified health and social workforce willing to work

** Health and social workforce job creation (or demand) in the health and health-related social care sectors

- **Coherence and coordinated action across sectors:** Coordinated intersectoral analysis, action and investments across education, health, social, labour, finance, and foreign affairs sectors are critical to effective progress. Policy coherence and alignment across sectors are also essential.
- **Decent work:** Health and social workforce investments and interventions must strive towards ensuring decent work for all available and future jobs across the health economy. Attention must be paid to improving working conditions, including job security and occupational health and safety as well as the effective recognition and application of labour rights.
- **Gender equality:** Gender equality will be mainstreamed as a cross-cutting goal in gender-transformative investments and actions for the health and social workforces. Gender inequalities, for example women’s provision of unpaid care in the absence of social protection and skilled care workers, must be analysed and redressed. Other essential gender equity actions include: ensuring that women are appropriately represented in social

dialogue mechanisms; strengthening and using sex-disaggregated data; undertaking gender analysis as an integral part of labour market analysis; and developing and strengthening national health workforce strategies, policies and investments that address identified gender biases and inequalities, including gender-sensitive considerations regarding women's security, working conditions and mobility.

- **Youth empowerment:** Opportunities to improve the quality of education, educational opportunities, human capital, decent work and career pathways for youth will be maximized. Young people and people from vulnerable and disadvantaged communities, including indigenous communities will be empowered.
- **Social dialogue:** Social dialogue between governments, employers and workers as well as other relevant stakeholders will be strengthened as a fundamental process in health and social workforce policy development. Social dialogue facilitates consensus building and contributes positively to health sector reforms and is particularly important in times of structural change.
- **Needs-based, fit-for-purpose health and social workforce:** Health and social workforce investments and actions must respond to the current and future needs of populations not only for universal health coverage, but also to ensure global health security. Policies should take into account the national context, demographic changes, technological changes, inequities in access to health and social services, and socioeconomic transitions. The workforce should be geared towards the social determinants of health, health promotion, disease prevention, primary care and integrated people-centred services that are community-based. This includes all types of health and social sector workers. Coherent public action in partnership with stakeholders is urgently required to develop labour market policies conducive to stimulating demand for a sustainable health workforce, particularly in underserved areas.
- **Maximize available opportunities and reinforce linkages with existing initiatives:** Existing opportunities and mechanisms across agencies and economic fora will be utilized to the greatest extent possible through available projects, collaborations and initiatives, and SSTC partnerships (better-targeted and solidarity-driven cooperation between countries) to streamline efforts towards the implementation of the Working for Health programme.
- **Sustainability:** Reforms and improved use and management of existing financing opportunities will be advocated for and supported. Sustainable financing strategies for health workforce investments must be expanded, including use of general budget, progressive taxation, social health protection, earmarked funds, and the private sector.
- **Acute and protracted health emergencies, and humanitarian settings:** Special consideration must be taken of the specificities of the health labour market and challenges in the education and training of health workers, decent work, and the protection and

security of health workers in acute and protracted health emergencies and humanitarian settings.

IV. Governance Arrangements

50. The ILO, OECD and WHO will oversee and coordinate the implementation of the five-year action plan (Figure 3) through regular decision-making meetings at the senior management level; a senior level Steering Committee of the three organizations is being established for that purpose (see below). Working under the direction of the Steering Committee, a joint Technical Secretariat will be responsible for developing annual operational plans, ensuring effective implementation, communications and knowledge management, stakeholder management, consultative processes, monitoring and reporting. A high-level Strategic Advisory Board will provide strategic input and political support.
51. Effective implementation of the five-year action plan will require intersectoral and multi-stakeholder engagement and collaboration. Regular consultative processes with Member States and key stakeholders will be embedded into the implementation process of the five-year action plan to facilitate input and technical exchange. ILO, OECD and WHO will explore engagement with key stakeholders across sectors at global, regional and national levels as an integral part of conducting their work and drawing on available institutional capacities to derive added value in implementing the action plan in the most effective and efficient way. A website will be established as an online knowledge platform to strengthen intersectoral knowledge management, coordination, analysis, and dissemination of evidence and best practice to inform intersectoral plans, actions and investments.

4.1. Steering Committee

52. As the principal governing and decision-making body, the Steering Committee will be responsible for approving the strategy and overall work plan and providing oversight of the Working for Health programme. Decisions are taken by consensus. Working closely with the secretariat (see below), the Steering Committee will support and guide the programme to ensure an effective impact. It will serve as the Steering Committee for the Working for Health programme and the Working for Health MPTF.
53. The main functions of the Steering Committee are as follows:
 - provide general oversight and exercise overall accountability of the Working for Health programme and the MPTF;
 - approve the strategic direction of the Working for Health programme and the MPTF and its overall results framework;
 - approve MPTF risk management strategy and review risk monitoring regularly;
 - review and approve proposals submitted for funding, ensuring their conformity with the requirements of the fund terms of reference (TOR) and those of other donors;
 - decide the allocation of funds within the Working for Health programme MPTF;
 - request fund transfers from the administrative agent (signed off by UN member of the

Steering Committee);

- review MPTF status and oversee the overall progress against the results framework through monitoring, reporting and evaluation;
- review and approve the periodic progress reports consolidated by the administrative agent and the secretariat based on the progress reports submitted by the implementing entities;
- commission mid-term and final independent evaluations on the overall performance of the Working for Health Programme and the MPTF;
- approve direct costs related to MPTF operations supported by the Secretariat;
- approve MPTF extensions and updates to the terms of reference of the MPTF, as required; and
- develop and implement resource mobilization strategies to capitalize the MPTF.

54. The Steering Committee will include two high-level representatives, or their nominated deputies, from each of the three agencies (ILO, OECD, WHO). The first at the level of Deputy or Assistant Director-General / Deputy Secretary General and the second at the level of Department Director.

The full composition of the Steering Committee will be:

- Deputy Director-General for Field Operations and Partnerships, ILO
- Director, Sectoral Policies Department, ILO
- Assistant Director-General, Health Systems and Innovation, WHO
- Director, Health Workforce Department, WHO
- Chief of Staff and Sherpa to the G20, OECD
- Director for Employment, Labour and Social Affairs, OECD
- Coordinator of the Secretariat, ex officio (see below)
- Executive Coordinator of the UN MPTF Office, UNDP, ex officio
- Up to two Donor Coordination Group representatives (see below)

55. The Steering Committee will meet twice a year for one day, preferably in person, with the option of scheduling additional meetings as and when needed. The Steering Committee will be chaired by a representative from one of the three agencies on a rotating basis for one year at a time.

56. From time to time, the three agencies will invite the Directors-General of WHO and the ILO or the Secretary-General of OECD to represent their respective agencies at Steering Committee meetings. The Steering Committee may also invite observers on a case by case basis.

4.2. Technical Secretariat

57. The technical secretariat for the Working for Health programme will also serve as the secretariat of the MPTF. Its support functions include: advising the Steering Committee on strategic priorities, programmatic and financial allocations; providing logistical and operational support to the Steering Committee; organizing calls for proposals and appraisal processes; supporting resource mobilization; and monitoring operational risks and MPTF performance. The secretariat will also provide programme support, including but not limited to: reviewing proposals; providing monitoring and evaluation guidance; quality assurance of reports; supporting partnership

management; collating and sharing knowledge, including lessons learned and good practices; and additional policy and programmatic support.

58. The secretariat will be composed of four professional staff members from WHO and will be housed by WHO in Geneva, Switzerland:

- Coordinator, Working for Health
- Programme Officer, Support to Country-Level Action
- Communications Officer
- Partnerships and Resource Mobilization Officer

59. The secretariat will also comprise one staff member from each of the OECD and the ILO. They will act as focal points for the programme and will support the work of the secretariat on a regular basis to ensure that contributions and inputs from departments across the ILO and OECD are well coordinated and delivered on time. Although part of the secretariat, these focal points will be working in their respective organizations.

4.3. The Administrative Agent

60. The Working for Health MPTF will be administered by the UN MPTF Office, which will act as the MPTF's administrative agent. As such, it will be responsible for fund design and administration. Key administrative functions include receiving and administering contributions and transferring them to the participating UN organizations and participating non-UN organizations (as per the Working for Health MPTF Steering Committee decisions) as well as consolidating financial reports with narrative reports prepared by the fund secretariat. The UN MPTF Office is well-placed to take on the administrative agent role for the Working for Health MPTF, given its inter-agency nature and the UN MPTF Office's proven experience in carrying out this function for other pooled funds.

4.4. Country Coordination Committees

61. In countries where the three organizations will provide significant support and assistance, country coordination mechanisms will be strengthened or established if they do not exist, pending discussion with representatives of the government in these countries. These committees will play an important role in ensuring country ownership, policy coherence and coordination at the national level.

62. The country coordination committees should consist of representatives from ministries of health, labour, education and preferably finance, national statistics institutions, employers' associations, trade unions, professional associations, think tanks, academia and civil society organizations. The UN Resident Coordinator, representatives from the United Nations Country Team (including from UNFPA and UNICEF), international and regional financial institutions, leading bilateral development partners working in health, education and decent work, and leading global health initiatives will also be invited in order to leverage the support of the WHO Country Coordination Strategies, the ILO Decent Work Country Programmes, UN Development Assistance Frameworks, and existing health and sustainable development initiatives.

63. The country coordination committees will be supported by dedicated WHO and ILO country office staff, and, where possible, OECD in close coordination with the UN Resident Coordinator. In countries where neither the ILO, OECD nor WHO have offices or staff, the three agencies will make arrangements with the Resident Coordinator to chair these committees and with the United Nations Country Team to assist with coordination of policy advice and technical assistance to the Member State in question.

4.5. Strategic Advisory Board

64. It is also proposed that a strategic Advisory Board (“the Board”) be established. The Board would offer strategic advice and guidance for the Working for Health programme. This involves providing advice on strategic directions for the programme, strategic partnerships to pursue, as well as advice on key health and social sector developments and trends.
65. The Board will be comprised of constituents from the three agencies. These will be drawn from the High-Level Commission on Health Employment and Economic Growth, which helped pave the way for the Working for Health programme, as well as from donors, from Member States that have led the global health workforce agenda, from international employers’ associations and unions, professional health associations, other global health initiatives, and academia, research organizations, civil society organizations and think-tanks. Special attention will be given to ensuring that the Board is gender-balanced.

4.6. Donor Coordination Group

66. Development partners contributing to the Working for Health programme will be engaged actively in the Working for Health programme as key partners for advancing and shaping the health workforce agenda. Development partners that contribute funds to the Working for Health programme can participate in the donor coordination which will:
- review and discuss the reports the three agencies provide on progress against agreed outcomes and indicators;
 - review, suggest and discuss future direction, work plan priorities as well as pipeline country-level projects and budgets on a no-objection basis; and
 - discuss lessons and potential policy issues arising from the experience and results of the programme.
67. The ILO, OECD and WHO will organize two face-to-face meetings a year for the Donor Coordination Group. These will be held, wherever possible, as back to back meetings with those of the strategic Advisory Board. In addition to the objectives set out above, these meetings will furthermore allow the three agencies to understand development partners’ specific interests and goals and how these can be advanced through the Working for Health programme.
68. The Donor Coordination Group may nominate up to two representatives to reflect their views on the Steering Committee.

4.7. Policy Support Network

69. The newly established Global Health Workforce Network will act as the policy support network for the Working for Health programme. The network will bring together all key stakeholders, including, but not limited to, representatives from the health workforce. These will be professional associations and trade unions; the private sector and health sector employers; and representatives from the civil society, academia, and foundations.
70. The aims of the network are closely linked to the goals of the Working for Health programme, namely to:
- maintain high-level political commitment;
 - promote inter-sectoral and multilateral policy dialogue, including, as appropriate, through public–private collaboration;
 - facilitate the alignment of domestic financing, global health initiatives and donors to the HRH investment priorities outlined in the Global Strategy; and
 - foster global coordination and mutual accountability.
71. The operations of the network will be supported by a core team within the WHO Health Workforce Department that will engage with a broad range of actors through technical work streams and thematic hubs. This team will help ensure that knowledge generated, shared and discussed by the network will inform the implementation of the Working for Health programme on a continuous basis.
72. In addition, the Working for Health programme will liaise closely with other relevant global alliances, coalitions and networks, including but not limited to:
- UHC 2030;
 - The Global Initiative on Decent Work for Youth;
 - The Future of Work Commission;
 - The UN High-Level Panel on Women’s Economic Empowerment;
 - The Equal Pay International Coalition;
 - The Business and Sustainable Development Commission;
 - The International Commission on Financing Global Education Opportunity; and
 - The UN Secretary-General’s High-Level Panel on Humanitarian Financing.

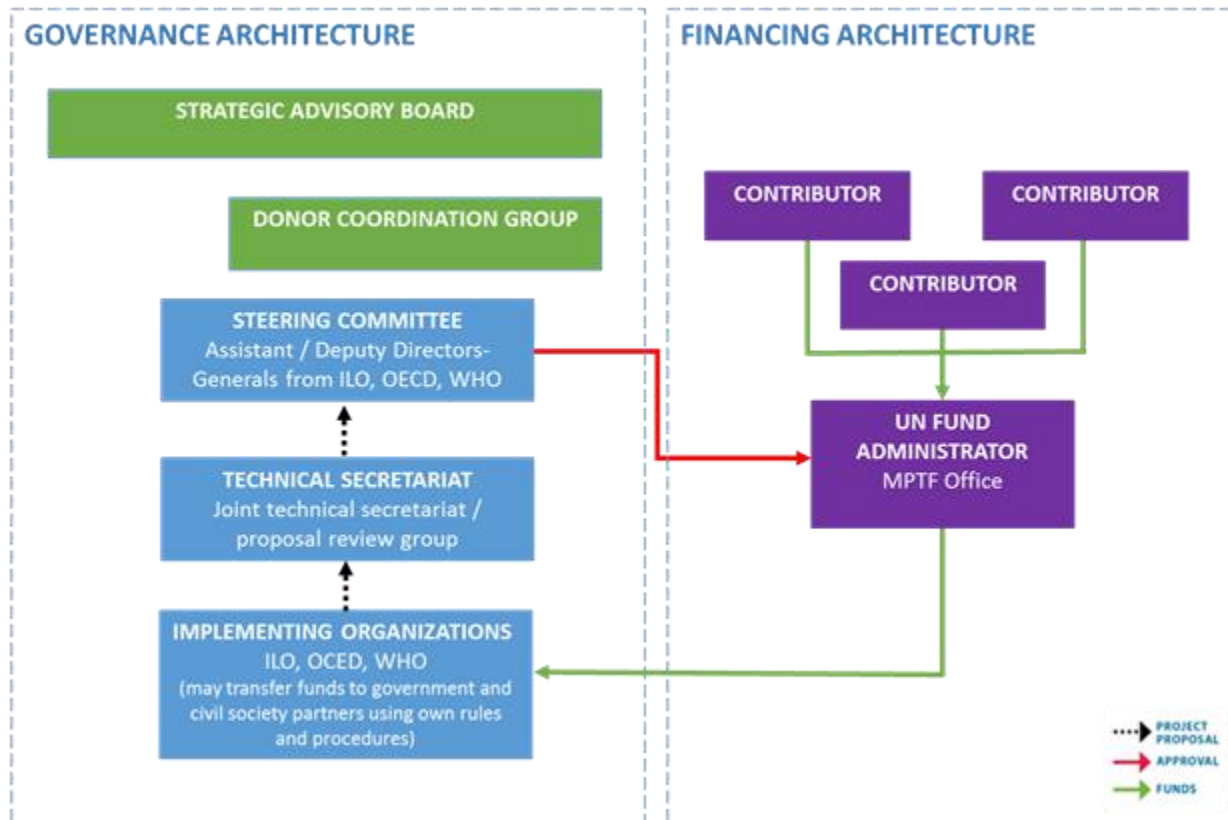
4.8. Participating Organizations

73. The ILO, OECD and WHO will be the participating organizations of the Working for Health MPTF. The three agencies will be responsible for implementing projects approved by the Steering Committee. The ILO, OECD and WHO will actively explore opportunities to establish synergies and linkages between the projects financed by the MPTF and new and existing projects in related fields(e.g. skills, social protection, universal health coverage, migration) being financed by donors outside the MPTF or by the organizations’ regular budgets. The three agencies will encourage other development organizations to provide parallel financing as well.

V. Fund Implementation

74. As described in Section II (“Functions of the Working for Health Multi-Partner Trust Fund”), the MPTF has been created to finance the joint and coordinated policy advice, technical assistance and capacity strengthening programmes that Member States have requested and will be requesting from the ILO, OECD and WHO.
75. The Fund will be administered by the UNDP MPTF office. As UNDP’s financial regulations and rules only allow them to provide services to UN organisations and Member countries, the ILO and WHO will assume overall responsibility for the actions and activities funded by the trust fund and undertaken by the OECD. Whilst recognising the need for this accountability arrangement to comply with UNDP rules, the ILO, OECD and WHO regard each other as equal partners in delivering the programme of work.
76. The OECD has entered into privileges and immunities agreements with its member countries and a limited number of other countries (Bulgaria, Lithuania, Peru, Romania, Russian Federation, Ukraine and Indonesia). It has therefore agreed with WHO and ILO that for activities under the Trust Fund in countries where the OECD has not entered into agreements on privileges and immunities, OECD staff will be loaned to or considered as experts on mission for the Participating UN Organizations and the OECD staff will enjoy the Privileges and Immunities of these organisations.
77. The ILO, OECD and WHO will work closely with, and coordinate all actions with, the global health initiatives or funds, other United Nations agencies, the World Bank Group, Regional Development Banks, bilateral donors and foundations, as well as governments, employers’ associations and health workers’ associations or unions. However, pending any future decision of the Steering Committee, the Working for Health MPTF will not finance the activities of these institutions or organizations directly.
78. In the event that financing is provided to governments, employers’ associations, health workers’ associations or unions, academia, think tanks, consultants, non-governmental or civil society organizations, such funds will be provided through, and overseen by, either the ILO, OECD or WHO.

Figure 3. Working for Health MPTF governance and financing architecture



5.1. Contributions to the MPTF

79. Contributions to the Working for Health MPTF can be made by bilateral donors, international financial institutions, foundations and other non-state actors. The receipt of funds from private sector companies is subject to UNDP's risk assessment tool for the assessment and approval of funding from non-state actors.
80. To ensure maximum flexibility and adaptation to national priorities, donors are strongly encouraged to contribute multi-year, non-earmarked resources.
81. However, if this is not possible, earmarking by donors will be allowed to the level of the global public goods described above or to activities in a specific country. Earmarking to a participating organization is not permitted. It is expected that the percentage of earmarked resources will diminish over time.

5.2. Project Approval Cycle

82. The WHO, ILO and OECD will develop proposals for specific projects or activities that will achieve the deliverables of the five-year action plan. These proposals can be country specific, regional or global in scope, but must follow the project proposal template developed by the technical secretariat.
83. These proposals will be submitted to the technical secretariat where they will be reviewed by experts from the ILO, OECD and WHO. Preference will be given to proposals in which two or all

three agencies set out how they will jointly develop global public goods or respond to specific requests from Member States together.

84. Eligible projects will be forwarded by the technical secretariat to the Steering Committee. The Steering Committee will discuss the proposals based on comments from the technical secretariat and make decisions for the allocation of available MPTF resources. The decisions will be recorded in minutes of Steering Committee meetings.
85. The Steering Committee of the Working for Health programme will meet twice a year and, amongst other agenda items, review proposals and allocate resources. The dates for the Steering Committee meetings and deadlines for the submission of proposals will be communicated to the three agencies by the technical secretariat.
86. In case any of the three agencies receive an urgent and sufficiently important demand for assistance from a Member State, the technical secretariat will review the proposal put forward by the agency and determine whether it should be sent to the Steering Committee for review and approval by email under a fast-track procedure.

5.3. Financial Viability

87. Whilst aiming for a fund of US\$70 million, in line with established MPTF thresholds, the anticipated minimum contributions necessary to make the MPTF financially viable is US\$5 million per year during the first five years that the MPTF will be operational.
88. The administrative agent fee will be one per cent of total contributions.

5.4. Risk Management

89. A risk management strategy has been developed by the ILO, OECD and WHO, taking into account the nature of risks in relation to the implementation of the five-year action plan. It defines the MPTF's risk tolerance, establishes policies in relation to identified risks, and determines the risk treatment through mitigation measures or adaptation. The key risks and mitigation measures are summarized in Table 2:

Table 2. Risk matrix for the Working for Health MPTF

#	Description	Outcome	Impact / Likelihood	Mitigation Measures	Owner
1	Donor response lower than anticipated	Unable to set up MPTF, action plan not deliverable	15 Extreme (5)/ Possible (3)	Ensure sufficient resources is allocated to resource mobilization.	Steering Committee, secretariat

#	Description	Outcome	Impact / Likelihood	Mitigation Measures	Owner
				<p>Steering Committee members to commit own time and engage their donor contacts. Implement the resource mobilization strategy, which covers both traditional donors as well as foundations and PPPs, with full support from the corporate resource mobilization units of the three agencies. Finalize and implement communication strategy to convince donors to contribute. Apply the funding to financing approach in selected focus countries to map the health financing landscape and identify innovative financing opportunities.</p> <p>If fewer resources are received than anticipated, activities will be scaled back. If no, or very few, resources are mobilized within 18 months, other organizations will be asked if they would be willing to take the initiative forward.</p>	
2	Lack of engagement by countries supported by Working for Health	Unable to fully implement action plan	10 Extreme (5)/ Unlikely (2)	Engage with constituents through country coordination committees (CCCs)	Steering Committee
3	Lack of capacity in countries supported by	Incomplete country level monitoring	12 Major (4)/ Possible (3)	Provide additional technical assistance to the high risk countries	Steering Committee

#	Description	Outcome	Impact / Likelihood	Mitigation Measures	Owner
	Working for Health				
4	Delay in implementation	Donors less inclined to fund future years	8 Minor (2)/ Likely (4)	Ensure all activities are properly project-managed and that donors are adequately informed of progress and any delays in a timely manner	secretariat, Steering Committee
5	Capacity issues in host organizations	Action plan delayed or scaled back	12 Major (4)/ Possible (3)	Ensure resources are made available or contract-out work	Steering Committee
6	Funds mismanaged	Work programme compromised	5 Extreme (5)/ Rare (1)	Ensure all activities are properly project-managed	Steering Committee
7	Anticipated outcomes not delivered	Recommendations not delivered, funding cut	12 Major (4)/ Possible (3)	Review progress on regular basis	Steering Committee
8	Security situation deteriorates	Work in country in question postponed	9 Moderate (3) Possible (3)	Keep under review and suspend work if necessary	secretariat, Steering Committee
9	Overlap with work of other organizations	Funds wasted; synergies not realized	6 Minor (2)/ Possible (3)	Monitor through CCCs, collaborate closely with the UN Resident Coordinator, and reach out to the Global Fund, World Bank and other key partners at the country, regional and global level	secretariat, Steering Committee, strategic Advisory Board

90. Risk monitoring will be done by the ILO, OECD and WHO as well as the technical secretariat as part of their regular reporting. Key mitigation or adaptation measures taken in accordance with the risk management strategy and their direct influence on achieving the expected results will be highlighted.
91. Particular attention will be given to risks arising from the three agencies' work in relation to the recommendation to strengthen global preparedness and capacity to respond to health crises and to ensure the protection and security of all health workers and all health facilities in conflict situations and humanitarian emergencies.

VI. Reporting

92. As described above and in the Commission's report, the impact of the Working for Health programme will be measured by the extent to which progress is achieved on the relevant targets and indicators for SDG 3, 4, 5 and 8 (Box 4).

93. These targets and indicators will be included in the interagency data exchange that the three agencies will establish under the five-year action plan and also form part of the national health workforce accounts that the ILO, OECD and WHO will support Member States to establish.

6.1. Reporting to governance structures of the ILO, OECD and WHO

94. The first report on operationalization of the five immediate actions, including the five-year action plan, has been submitted for consideration by the United Nations General Assembly at its seventy-second session, as requested in its resolution 71/159.

95. Annual progress reports, with formal reporting on performance against the five-year action plan, will be submitted to the World Health Assembly, aligned with reporting on the implementation of WHO's global strategy on human resources for health.

96. The ILO and OECD will also report on progress to their governance structures at regular intervals.

6.2. Reporting to donors of the Working for Health Multi-Partner Trust Fund

97. The MPTF administrative agent will provide the following statements and reports to the donors and the Steering Committee, as described in the memorandum of understanding:

- annual consolidated narrative progress reports;
- annual consolidated financial reports;
- a final consolidated narrative report with a summary of the results and achievements compared to the goals and objectives of the Working for Health programme.

98. These reports will be based on submissions provided to the technical secretariat and administrative agent by the ILO, OECD and WHO (see below).

6.3. Reporting by the ILO, OECD and WHO to the administrative agent

99. For each project approved for funding, the participating organization(s) will provide the technical secretariat and the administrative agent with annual narrative progress reports and final reports. They will also provide annual and final financial reports and statements prepared in accordance with their accounting and reporting procedures, as agreed upon in the memorandum of understanding signed with the administrative agent.

100. These annual and final reports will be results-oriented and evidence-based. The reports will give a summary of results and achievements and a comparison with projected results provided in the approved project document.

101. Both programmatic and financial performance indicators will be monitored at the outcome and output level (programme and project level). Every project will monitor its contribution to the key

outcome indicators of the Working for Health programme. The output indicators will be specific for each project.

102. The final report will also contain an analysis of how the outcomes and outputs have contributed to the overall impact.

103. The prime responsibility for collecting data lies with the implementing organizations and will be one of the key elements reflected in their annual report. The technical secretariat will be responsible for coordinating the data collection and ensuring the proper use of the standard reporting format.

Box 4. Targets and indicators aligned with the Sustainable Development Goals

SDG 3: Good health and well-being

Target 3.c: Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small-island developing States

Indicator 3.c.1: Health worker density and distribution

SDG 4: Quality education

Target 4.3: By 2030, ensure equal access for all women and men to affordable and quality technical, vocational and tertiary education, including university

Indicator 4.3.1: Participation rate of youth and adults in formal and non-formal education and training in the last 12 months, by sex (for health and social sector-related programmes)

Target 4.b: By 2020, substantially expand globally the number of scholarships available to developing countries, in particular least developed countries, small-island developing States and African countries, for enrolment in higher education, including vocational training and information and communications technology, technical, engineering and scientific programmes, in developed countries and other developing countries

Indicator 4.b.1: Volume of official development assistance flows for scholarships by sector and type of study (for health and social sectors)

SDG 5: Gender equality

SDG target 5.1: End all forms of discrimination against all women and girls everywhere

Indicator 5.1.1: Whether or not legal frameworks are in place to promote, enforce and monitor equality and non-discrimination on the basis of sex

SDG target 5.4: Recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate

Indicator 5.4.1: Percentage of time spent on unpaid domestic and care work, by sex, age and location

SDG 8: Decent work and economic growth

SDG target 8.5: By 2030, achieve full and productive employment and decent work for all women and men, including for young people and persons with disabilities, and equal pay for work of equal value

Indicator 8.5.1: Average hourly earnings of female and male employees, by occupation, age and persons with disabilities (for health workers)

SDG target 8.b: By 2020, develop and operationalize a global strategy for youth employment and implement the Global Jobs Pact of the International Labour Organization

Indicator 8.b.1: Total government spending in social protection and employment programmes as a proportion of the national budgets and GDP

VII. Monitoring and Evaluation

104. The secretariat will be responsible for consolidating the data reported by the ILO, OECD, WHO and other implementing organizations together with the financial reported expenditure into a single monitoring and evaluation scorecard. This tool will be used by the steering committee to review the overall progress against expected results and assess the achievement of performance targets.
105. Similarly, country-level implementation will be monitored and reviewed by the country coordination committees (see above).
106. In addition, the Steering Committee will commission two independent reviews/evaluations on the overall performance of the MPTF. These evaluations will take place at mid-term (2019) and at the closure of the MPTF (2021) respectively. The aim of these evaluations, to be described in further detail in the evaluation terms of reference, will be to assess the performance of the MPTF against agreed objectives and impact against the theory of change. The mid-term evaluation will make specific recommendations to the Steering Committee for the revision of the objectives and the underlying theory of change, if necessary.

VIII. Audit

107. The administrative agent and participating organizations will be audited in accordance with their organizational financial regulations and rules and, in the case of UN participating organizations, with the Framework for Joint Internal Audits of UN Joint Activities, which has been agreed to by the Internal Audit Services of Participating UN Organizations and endorsed by the UN Development Group in 2014.

IX. Public Disclosure

108. The secretariat and the administrative agent will ensure that the MPTF's operations are disseminated on the administrative agent's website (mptf.undp.org). Information posted on the website will include: contributions received stating from whom contributions are received, funds transferred, annual expenditures, summaries of proposed and approved projects, the work plan and MPTF progress reports.
109. The ILO, OECD and WHO will take appropriate measures to promote the Working for Health MPTF. Information shared with the press regarding fund beneficiaries, official notices, reports and publications will acknowledge the MPTF's role. More specifically, the administrative agent will ensure that the role of the contributors is fully acknowledged in all external communications related to the MPTF.

Annex 1. Five-year action plan deliverables

Cross-cutting immediate actions (2017–March 2018)	Deliverables	Lead ^a	Partner
	1. Commitments and expressions of support by the governing bodies of ILO, OECD, WHO, partner organizations and international decision-making forums secured	ILO, OECD, WHO	
	2. Recommendations of the Commission adopted in regional and national forums	ILO, OECD, WHO	
	3. Conclusions of the ILO Tripartite Sectoral Meeting on Improving Employment and Working Conditions in Health Services (Geneva, 24–28 April 2017) and the 4th Global Forum on Human Resources for Health (Dublin, 13–17 November 2017) support implementation of the Commission’s recommendations in line with WHO’s global strategy on human resources for health	ILO, WHO	OECD
	4. An online knowledge platform established to strengthen intersectoral knowledge management, coordination, analysis, and dissemination of evidence and best practice to inform health and social workforce plans, actions and investments	ILO, OECD, WHO	

Recommendations	Deliverables	Lead ^a	Partner
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	1.1 Capacity of governments, employers’ associations and trade unions and other key stakeholders in the health and social sectors strengthened to establish dialogue mechanisms and engage in social dialogue processes	ILO	
	1.2 Development of international, regional and national tripartite dialogue across health, education, finance and labour sectors supported as a step towards strengthening or producing national health workforce strategies	ILO	OECD, WHO
	1.3 Labour market, gender and fiscal space analysis supported and institutional capacity strengthened for the development of policy options to inform national health workforce strategies, financing reforms and investments	WHO	ILO, OECD
	1.4 Development and implementation of national health workforce strategies, medium-term fiscal frameworks and investments supported with technical assistance and institutional capacity-building to ensure decent work, gender-transformative approaches, and current and future sustainable health workforce	WHO	ILO, OECD
	1.5 Alignment of domestic resources and official development assistance with national health workforce strategies and investments facilitated	WHO	

Recommendations	Deliverables	Lead ^a	Partner
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	2.1 Gender-transformative ² global policy guidance developed and regional and national initiatives accelerated to analyse and overcome gender biases and inequalities in education and the health labour market across the health and social workforce (for example, increasing opportunities for formal education, transforming unpaid care and informal work into decent jobs, equal pay for work of equal value, decent working conditions and occupational safety and health, promoting employment free from harassment, discrimination and violence, equal representation in management and leadership positions, social protection/child care, and elderly care)	ILO, OECD, WHO	
	2.2 Gender-transformative policy development and implementation capacity to overcome gender biases and inequalities in education and the health labour market supported	ILO, WHO	
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	3.1 Transform and expand education and lifelong learning and intersectoral coordination integrated in the development and implementation of health workforce strategies	WHO	ILO, OECD
	3.2 Massive scale-up of socially accountable and transformative professional, technical and vocational education and training supported with technical cooperation, institutional capacity-building and financing	WHO	ILO
	3.3 Professional, technical and vocational education, training and lifelong learning systems strengthened for health and social occupations (including community-based health workers) to achieve integrated people-centred care	WHO	ILO, OECD
	3.4 Develop skills assessment tools and approaches to evaluate the skills of the health and social workforce, including assessment of skills mix, shortages and mismatches to support greater alignment of skills with jobs and integrated people-centred care	OECD	ILO, WHO
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,	4.1 Governance, regulation, accreditation and quality-improvement mechanisms improved and supported with guidance and institutional capacity-building to ensure safe, ethical, effective and people-centred practice that protects the public’s interests and rights	WHO, ILO	
	4.2 Guidance developed for provision of interprofessional education and organization of multidisciplinary care, including recommendations on skills mix and competencies to achieve integrated people-centred care	WHO	OECD

² Gender-transformative approaches seek to re-define women’s and men’s gender roles and relations to promote gender equality and achieve positive development outcomes by transforming unequal gender relations in order to promote shared power, control of resources, decision-making, and support for women’s empowerment.

Recommendations	Deliverables	Lead ^a	Partner
people-centred primary and ambulatory care, paying special attention to underserved areas	4.3 Evidence and guidance developed on practices to ensure an adequate proportion of the workforce in primary health care is appropriately distributed to achieve equitable access in underserved areas and for marginalized groups (for example, recruitment practices, education methods, professional development opportunities, and incentive structures).	ILO, WHO	OECD
5. Harness the power of cost-effective information and communication technologies to enhance health education, people-centred health services and health information systems	5.1 Efficacy and efficiency of information and communication tools with a target product profile that could enhance health worker education, people-centred health services and health information systems mapped, reviewed and disseminated for national adoption	WHO	
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	6.1 Workforce strategies for full implementation of the International Health Regulations (2005), emergency and disaster risk management and response capacity integrated into national health workforce and emergency strategies and supported	WHO	ILO
	6.2 Evidence and guidance on metrics, methodologies, practices, reporting and information systems that improve the security and protection of health workers in all settings strengthened, including humanitarian and emergency settings	WHO	
	6.3 Capacities of high-risk countries to protect occupational health and safety of health and emergency aid workers strengthened	WHO	ILO
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	7.1 National health workforce strategies and global, regional and national institutional financing reforms that identify and commit adequate budgetary resources for investments in transformative education, skills and job creation developed and supported	WHO	ILO
	7.2 Sustainable financing for expanding and transforming the health and social workforce expanded, particularly for countries where universal health coverage and the Commission's recommendations are least likely to be attained	WHO	ILO
	7.3 Mechanisms to track the alignment of official development assistance for education, employment, gender, health and skills development with national health workforce strategies strengthened	WHO	OECD

Recommendations	Deliverables	Lead ^a	Partner
appropriate number of health workers	7.4 Tools and methodologies to analyse health and social workforce productivity, performance and wages reviewed and advanced	WHO	ILO, OECD
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	8.1 The Global Health Workforce Network engaged to support coordination, alignment and accountability for WHO's global strategy on human resources for health and implementation of the Commission's recommendations with international, regional and national stakeholders	WHO	ILO, OECD
	8.2 Intersectoral collaboration and coordination for the implementation of national health workforce strategies strengthened and capacity developed among relevant ministries (for instance, health, social, labour, education, finance, and gender), professional associations, labour unions, civil society including women's civil society organizations, employers, the private sector, local government authorities, education and training providers and other constituencies	ILO, WHO	
	8.3 Global health initiatives ensure that all grants and loans include an assessment of health workforce implications and align contributions with implementation of national health workforce strategies beyond disease-specific in-service training and incentives	WHO	
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	9.1 Platform established to maximize benefits from international health worker mobility through: <ul style="list-style-type: none"> (a) improved monitoring of labour mobility; building on the success of the OECD/WHO EURO/Eurostat collaborative work and with a progressive international scale-up and implementation of the National Health Workforce Accounts; (b) strengthened evidence analysis, knowledge exchange and global public goods on mobility, recognition of qualifications, remittances, resource transfers, good practices and policies 	ILO, OECD, WHO	
	9.2 Existing instruments, such as the WHO Global Code of Practice on the International Recruitment of Health Personnel and ILO Conventions on Migrant Workers, strengthened and implementation supported; and policy dialogue facilitated for new innovations and voluntary commitments that maximize mutual benefits informed by lessons from other international instruments	ILO, OECD, WHO	
	9.3 Management of health worker migration improved to ensure mutuality of benefits through institutional capacity-building to governments, employers, workers and other relevant stakeholders in countries of both source and destination	ILO, WHO	OECD

Recommendations	Deliverables	Lead ^a	Partner
10. Undertake robust research and analysis of health labour markets, using harmonized metrics and methodologies, to strengthen evidence, accountability and action	10.1 Health workforce monitoring, financing and accountability reports produced	WHO	ILO, OECD
	10.2 Implementation of national health workforce accounts and disaggregated reporting supported and institutional capacity for implementation strengthened	WHO	ILO, OECD
	10.3 An interagency global data exchange on the health labour market with harmonized metrics and definitions established and maintained	WHO	ILO, OECD
	10.4 A health workforce research agenda established, research methodologies advanced, and evidence base expanded for decent work and effective health labour market interventions that optimize the socioeconomic returns on health workforce investments	WHO	ILO, OECD

^a The agency or agencies designated as the lead in the action plan will hold or share responsibility for leading the coordination and implementation of the deliverable. The agency or agencies designated as partners will take a supportive role in contributing specific inputs towards the deliverable.

Annex 2. Results matrix

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