

**Working for Health**  
**3<sup>RD</sup> ANNUAL PROGRAMME NARRATIVE PROGRESS REPORT**  
**REPORTING PERIOD: 1 JANUARY 2021 – 31 DECEMBER 2021**

<b>Programme Title &amp; Project Number</b>	<b>Country, Locality(s), Priority Area(s) / Strategic Results<sup>1</sup></b>
<ul style="list-style-type: none"> <li>Programme Title: <b>Working for Health MPTF</b></li> <li>Programme Number (if applicable)</li> <li>MPTF Office Project Reference Number:<sup>2</sup> 00125249, 00118644, 00116408</li> </ul>	<p>(if applicable) Country/Region/Global</p>
<b>Participating Organization(s)</b>	<b>Implementing Partners</b>
<ul style="list-style-type: none"> <li>Organizations that have received direct funding from the MPTF Office under this programme</li> <li>World Health Organization (WHO)</li> <li>International Labour Organization (ILO)</li> <li>Organisation for Economic Cooperation &amp; Development (OECD)</li> </ul>	<p>Priority area/ strategic results <b>Health workforce, employment &amp; economic growth</b></p> <ul style="list-style-type: none"> <li>National counterparts (government, private, NGOs &amp; others) and other International Organizations <ul style="list-style-type: none"> <li>Social enterprise</li> <li>National counterparts (government, private, nongovernmental organizations and others) and</li> <li>other international organizations</li> </ul> </li> </ul>
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<p>Total approved budget as per project document: MPTF /JP Contribution<sup>3</sup>:</p> <ul style="list-style-type: none"> <li>OECD: 556,842</li> <li>ILO: 877,690</li> <li>WHO: 3,369,329</li> </ul> <p>Agency Contribution</p> <ul style="list-style-type: none"> <li>by Agency (if applicable)</li> </ul> <p>Government Contribution (if applicable)</p> <p>Other Contributions (donors) (if applicable)</p>	<p>Overall Duration (55 months)</p> <p>Start Date<sup>4</sup> (23.05.2018)</p> <p>Original End Date<sup>5</sup> (31.12.2022)</p> <p>Current End date<sup>6</sup>(31.12.2022)</p>

<sup>1</sup> Strategic Results, as formulated in the Strategic UN Planning Framework (e.g. UNDAF) or project document;

<sup>2</sup> The MPTF Office Project Reference Number is the same number as the one on the Notification message. It is also referred to as “Project ID” on the project’s factsheet page the [MPTF Office GATEWAY](#)

<sup>3</sup> The MPTF or JP Contribution, refers to the amount transferred to the Participating UN Organizations, which is available on the [MPTF Office GATEWAY](#)

<sup>4</sup> The start date is the date of the first transfer of the funds from the MPTF Office as Administrative Agent. Transfer date is available on the [MPTF Office GATEWAY](#)

<sup>5</sup> As per approval of the original project document by the relevant decision-making body/Steering Committee.

<sup>6</sup> If there has been an extension, then the revised, approved end date should be reflected here. If there has been no extension approved, then the current end date is the same as the original end date. The end date is the same as the operational closure date which is when all activities for which a Participating Organization is responsible under an approved MPTF / JP have been completed. As per the MOU, agencies are to notify the MPTF Office when a programme completes its operational activities.

<b>TOTAL:</b>
<b>Programme Assessment/Review/Mid-Term Eval.</b>
Assessment/Review - if applicable <i>please attach</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No Date: <i>dd.mm.yyyy</i>
Mid-Term Evaluation Report – if applicable <i>please attach</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No Date: <i>dd.mm.yyyy</i>

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## Abbreviations

APPB	Association of Practicing Psychologists of Benin
BLS	Basic Life Support
ECOWAS	Economic Community of West African States
EMT	emergency medical technician
ECDoH	Eastern Cape Department of Health
HIS	health information system
HLMA	health and labour market analysis
HRH	Human Resources for Health
HWF	health workforce
IADEx	Inter-Agency Data Exchange
IDSR	Integrated Disease Surveillance and Response
ILO	International Labour Organization
IPC	infection prevention and control
IPUMS	Integrated Public Use Microdata Series
LFS	Labour Force Surveys
MoH	Ministry of Health
MOU	memorandum of understanding
MPTF	Multi-Partner Trust Fund
NHWA	national health workforce account
OECD	Organization for Economic Co-operation and Development
OSH	occupational safety and health
PN4P	private not for profit
PPE	personal protective equipment
P4P	private for profit
RPP	Rural Pipeline Programme
SAA	standard administrative arrangement
SADC	Southern African Development Community
SDGs	Sustainable Development Goals
TOR	terms of reference
UHC	universal health coverage
UNDG	United Nations Development Group
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UOE	UNESCO/OECD/Eurostat
WAEMU	West African Economic and Monetary Union
WHO	World Health Organization
WISN	Workload Indicators Staffing Needs Tool
W4H	Working for Health

## Executive Summary

The findings and recommendations of the High-Level Commission on Health Employment and Economic Growth in 2016 brings a new level of understanding of how health sector jobs drive inclusive economic development. Implementation of its recommendations through the Working for Health (W4H) Action Plan (2017-2021) and its Multi-partner Trust Fund mechanism (MPTF) has stimulated action for sustained investment in the health and care workforce over the reporting period. At the beginning of 2021 an independent evaluation of the W4H programme's five-year action plan (2017-2021) and its MPTF produced recommendations substantiating its continued relevance and effectiveness as a mechanism for enabling country-led action. The corresponding resolution 74.14, and a report by the Director General on W4H to the 74<sup>th</sup> World Health Assembly (WHA) in May 2021, resulted in a mandate to develop a renewed W4H action plan through a member states-led process, which will be presented to the 75<sup>th</sup> WHA in 2022

W4H has contributed to universal health coverage (UHC) and to the Sustainable Development Goals (SDGs) 3, 4, 5 and 8, through multisectoral interventions to expand and transform health workforce (HWF) education, skills, and jobs. Over the reporting period the Working for Health Programme (W4H) operated in 12 countries, continued to support two regional economic areas Southern African Development Community (SADC) and West African and Monetary Union (WEAMU), and further developed key global goods, including an *International Platform on Health Worker Mobility*, an *Interagency Data Exchange* platform, an approach for *Anticipating Skill Needs* in the health workforce, and a methodology for *Measuring Employment Impact*. The W4H MPTF key achievements for 2021:

- **Country impact:** Facilitated multisectoral policy engagement and evidence-based planning and decisions in 12 supported countries, which in Chad has led to the recruitment and deployment of 1,652 health workers and the deployment of over 3,000 community health workers (CHWs) in Somalia. W4H also facilitated guidance on investment choices to expand education, skills and jobs enabling the creation of 1,540 in 2021 in Niger. In addition, the programme has built core capabilities for robust health system strengthening in 12 supported countries, which enabled skills development of over 1,500 health workers at the Hospital and PHC level in West Bank and Gaza, and improved capacities to strengthen occupational protection of health workers in seven countries.
- **Regional integration:** West African Economic Monetary Union (WAEMU) countries have committed to create 40,000 new jobs by 2022, and a Southern African Development Community (SADC) new regional strategy and investment plan calls for an additional 40% in workforce investments over the next 10 years.
- **Global public goods:** The International Platform on Health Worker Mobility advanced knowledge and cooperation on health worker mobility through the 10-year review of the WHO Global Code's relevance and effectiveness. A multi-agency technical working group on job creation developed a methodology to measure employment impact and job creation in the health sector. Furthermore, the Inter-Agency Data Exchange (IADEX) consolidated workforce data and information exchange between partner organizations of 193 countries through national health workforce accounts (NHWAs).

## **W4H programme outcomes**

Over the past three years the W4H programme and MPTF has supported the development of catalytic global public health goods and provided funding, policy advice, direct technical assistance and capacity strengthening support to Member States. At regional and country level, the programme supported a range of inter-sectoral collaboration, action, and capacity-building efforts, which have enabled the development, financing and implementation of multisectoral workforce policies, strategies and plans, and enhanced institutional capacity to achieve the following outcomes:

1. The supply of skilled health workers meets assessed country needs.
2. Health sector jobs created to match public health and labour market needs.
3. Health workers are recruited and retained according to country needs.
4. Health workforce data inform effective policy, planning, monitoring and international mobility.

The outcomes of the programme over the reporting period are outlined in the W4H results matrix, including detailed indicators and targets (see Results Matrix section).

### **Country level**

#### **South Africa**

Upon request from the Eastern Cape Department of Health (ECDoH), the W4H program provided technical guidance and support on occupational safety and health (OSH) and COVID-19 in close collaboration with the tripartite Technical Working Group, established to coordinate all the work related to COVID-19, OSH and HIV/TB in the world of work. In October 2021, the ILO organized and facilitated a two-day training on the ILO/WHO HealthWISE methodology, including the COVID-19 checklist. As immediate impact of the training the Head of Department of the ECDoH approved the roll-out of HealthWISE implementation in ten (10) Health Facilities in the Eastern Cape Province, through continued technical support from ILO.

#### **Benin**

Through the requested reprogramming of project activities, W4H supported efforts to strengthen the effectiveness of the national COVID-19 response – including enhanced community surveillance, and capacity of frontline professionals (psychologists, social workers, and health workers) to provide care and psychosocial support interventions for individuals and families affected or infected by COVID-19. Collaborative partnership was facilitated between the National Agency for Primary Health Care, and the Association of Practicing Psychologists of Benin (APPB) to implement these interventions. Additionally, the programme helped to further strengthen existing initiatives already underway in the region, including Integrated Disease Surveillance and Response (IDSR). Considering lessons learned from earlier episodes of epidemic (Lassa, Cholera, Meningitis) and the health challenges associated with COVID-19, capacity building of key actors at the community level, including community relays, was implemented, to significantly enhance surveillance and response capabilities, including for COVID-19. The main recipients of this capacity building and training are community relays, health workers, social workers, and psychologists.

The pandemic has further revealed decent work deficits, including the absence of appropriate occupational safety and health management systems to protect health workers and staff. The prevention of occupational accidents and diseases in the health sector is one of the challenges of the national occupational safety and health policy validated by the tripartite constitutions and is being adopted by the government of Benin. This prevention involves strengthening the capacity of the system and the health workforce in terms of occupational

safety and health. Two training workshops were provided applying the ILO-WHO HealthWISE tool, with a focus on the COVID-19 checklist for health facilities.

## **Niger**

Niger is experiencing a multidimensional crisis (environmental, security, humanitarian, migration, and economic) that is exacerbating the challenges of poverty reduction and sustainable development in the country. Within the framework of the implementation of the Economic and Social Development Plan (PDES) and the Health Development Plan (PDS), Niger received technical and financial support from W4H, to support the implementation of the National Action Plan (NAP) including organizing a resource mobilization roundtable, and the implementation of the "Rural Pipeline Programme" (RPP) and its baseline study. The National Health Workforce Investment Plan and the subsequent National Strategic Plan for Community Health are expected to create approximately 40,000 additional jobs in the health sector and contribute to a 10% increase in rural health coverage, to reach 58%. By the end of 2021, out of a projected total of 6,000 health workers recruited as part of the NAP, the W4H together with funding from other sources, facilitated to the creation of **1,005 jobs** for health workers (doctors, midwives, nurses, laboratory technicians and hygiene technicians) in 2019, **100 jobs** in 2020 and **1,540 jobs** in 2021. Related to these workforce expansion efforts, access to and the use of health services and care by the population have increased in the regions, with health coverage increasing from 48.31% in 2018 to 53.6% in 2021, i.e., an increase of 5%. Finally, training was provided to **564 youth and women** based on the training needs identified in the annual action plans and the national HWF strategy/plan in the health sector.

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

## **Chad**

The program provided technical support to mitigate the COVID 19 impact on the health workforce, by facilitating training on Infection prevention and Control: 136 trained (in two provincial health delegations, 4 tertiary hospitals and public and private health schools) on Occupational Health and Safety: 206 agents (three University Hospitals including 2 public and 1 private, a district hospital, a military training hospital, 10 health centers and the provincial health delegation of N'Djamena). Furthermore, W4H supported the production of strategy documents – including a models of care document, a benefits package, and a competencies framework - for the implementation of UHC. Additionally, a health workforce recruitment plan was developed, which led to the recruitment and deployment **1,652 new health workers**.

Furthermore, a 4-day training workshop has enhanced the capacity of **40 participants**, including members of the Occupational Safety and Health Committees in health facilities on the management of occupational safety and health in health facilities, including the training of health workers on protection during COVID-19 as well as establishing occupational safety and health committees in selected hospitals. To ensure that the objectives of the training are met, a follow-up programme was developed and will be implemented in 2022.

## **Mali**

The density of health personnel is low in all regions of the country (6 health professionals per 10,000 population). There is further geographical imbalance and disparity from one region to another, with urban



areas favored over rural such as Bamako 17 health workers per 10,000 in comparison to Taoudénit 2 and Mopti 3 per 10,000 respectively (2019 health HR statistics directory). Furthermore, the gender disparities are even more striking, where men are more favored than women. The W4H program strengthened workforce planning and governance through better coordination among stakeholders and contributed to the improvement of working and employment conditions in the health and social sector and address the health workforce disparities. Accordingly, the program facilitated the development of National Plans for Recruitment, Training, Career and Motivation of Human Resources and Mapping of HWF in Public Hospital Establishments (EPH) and Hospitals Health Districts. The Covid-19 pandemic and political instability, embargo and economic sanctions against the country delayed the program implementation.

The prevention of occupational accidents and diseases in the health sector is one of the priorities of the national occupational safety and health policy being developed by the Ministry of Labour. Therefore, in the context of the W4H COVID-19 response, two training workshops for **48 participants**, were held to improve the Occupational Safety and Health (OSH) capacities of health services for a better protection of health workers. The workshops used the HealthWISE methodology and provided guidance on the application of the COVID-19 Checklist for health facilities. The participants, covering **42 health facilities** throughout the country, developed action plans for the application of the tools for improving the prevention of occupational injuries and diseases, and the implementation will be evaluated in a follow-up workshop.

## **Mauritania**

Between January and December 2021 and under the leadership of the HR Directorate of the Ministry of Health, W4H provided support for the development of the National HRH Development Plan, 2022-2026. The W4H programme has enabled and strengthened coordination, collaboration and commitment of multi-sectoral partners and key stakeholders around the importance of HRH for achieving UHC, and on the joint development and implementation of the National HRH Development Plan, 2022-2026. Within the framework of reforms initiated by the Ministry of Health, notably the decentralization of the functions of the Human Resources Department (HRD), a multi-sectoral steering committee composed of the Ministries of Health; Public Service; Finance and the legal department, other stakeholders and various labour unions was set up as a key mechanism to improve coordination and strengthen governance within decentralization.

Furthermore, the W4H program facilitated a tripartite meeting 18 February 2020 in Nouakchott in the presence of national stakeholders, technical and financial external partners and proposed the establishment of a national committee for social dialogue. The tripartite meeting considered that the creation of regional social dialogue committees of community leaders, youth networks, women's cooperatives, and other local organizations as well as regional representatives of trade unions, professional associations and employers in the health sector. It was an opportunity to initiate the first discussions on strengthening coordination with a view to promoting access and decent employments, mostly for young people and women. These discussions led to the creation of the multisectoral platform for coordination and collaboration to enable youth and women's decent employment in the health sector.

Delayed by the COVID-19 pandemic, in 2021, the activities for the development of an ongoing stakeholder strategic dialogue mechanism were initiated at regional levels in four regions, namely Guidimakha, Tagant, Assaba and Brakna. Altogether 92 participants (13 women and 79 men) were trained in the workshops in December 2021. As an immediate outcome, action plans for the implementation of social dialogue mechanisms and for the improvement of occupational safety and health protection were developed and agreed.

## **Sudan**

In 2021, the W4H programme continued to support inter-sectoral collaboration within the FMOH and other HRH stakeholders and partners to develop the indicators of the National Health Workforce Account that aims at improving the availability, quality, and use of health workforce data to support achievement of Universal Health Coverage and other SDGs targets in Sudan. The programme enabled the development and finalization

of the national Human Resources for Health Strategic Framework 2030 in line with the national priorities of the transitional period. WHO supported establishment of E-Learning platform and website for the Academy of Health Sciences (training institution responsible for pre-service training of nurses and other health professions). The purpose of this platform is to ensure continuity of the training programmes during COVID-19 pandemic and lockdown.

### **West Bank and Gaza Strip**

The W4H programme supported and enabled reprogramming of implementation due to COVID-19 pandemic to emergency response activity with national counterparts specifically the Ministry of Health, to conduct capacity building activities for health workers serving as front liners including training **1,500 emergency medical technician (EMTs), nurses and doctors** working in emergency rooms and COVID ICU wards on Basic Life Support (BLS) and 30 of them as BLS trainers. The program enabled investment in the PHC workforce and pre-service training quality through review of two essential training curricula for EMTs and paramedics and institutional strengthening of HWF planning and regulation through Workload Indicators Staffing Needs Tool (WISN) training and application.

Furthermore, a priority concern was the need to improve the protection of health workers in the fight against COVID-19. To respond to this need, activities were partially reprogrammed to enhance capacity building on occupational health and safety for health workers through the adaptation and application of the COVID-19 Checklist of measures to be taken in health facilities. The requested support included the translation of the Checklist into Arabic, training on the practical application of the checklist and technical assistance in the implementation of action plans resulting from the workplace assessment.

The application of the HealthWISE approach was a bottom-up process in line with national occupational health and safety measures and programmes. Two Trainings of Trainers were conducted: a two-day workshop in West Bank (August 2021) and a three-day workshop in Gaza (November 2021) for piloting the COVID-19 Checklist in health facilities. The objectives were to build the capacity of participants to understand the HealthWISE approach, to apply the COVID-19 checklist in health facilities to improve protection of health workers and to build a network of trainers who will take the training and implementation of the checklist to other health facilities in their area or district.

### **Somalia**

Decades of conflict, political instability and underinvestment have weakened and fragmented the health system in Somalia and led to migration of skilled health workers. Workforce density in Somalia is among the lowest in the world, the UHC service index is only 27 out of 100 against the global average of 60.2. The government, with the support of WHO, developed a revised Essential Package of Health Services (EPHS 2020). Linked to this, the W4H programme supported a rapid landscape analysis of the existing health workforce in both the public and private sector, which also provided meaningful insights into existing regulatory pathways, HRH legislation, and the accreditation of the workforce.

During COVID-19, WHO with the support of W4H enabled the deployment of over **3,000 community health workers (CHWs)**. The programme also supported the setting of standards and policies, and the development of a business case for sustainable investment on CHWs with a view to harnessing the community health services. The W4H programme also collaborated to collect information on availability and type of HWF at different levels of health system in the country using the harmonized health facility assessment (HHFA) survey tool.

Befitting the world universal health coverage day in 2020 and 2021, the catalytic work of W4H contributed to finalization of National Midwifery Curriculum for Somalia which will ensure that all academic institutions for nurses and midwives teach standard concepts in midwifery in alignment with international standards. The programme, towards the end of 2021, continued its technical and funding support for the revision of National

Human Resources for Health (NHRH) strategy of Somalia in line with the EPHS 2020 and other capacity building activities for Human Resources Department of Federal Ministry of Health for effective roll out of NHRH strategy. The W4H programme also supported the development of training programme for its frontline health workers on field epidemiology as part of newly established National Institute of Health's (NIH) plan to build its public health workforce for national health security.

## **Pakistan**

Pakistan faces a critical shortage of health workers, mainly nurses, a skill mix imbalance with a doctor nurse ratio of 1 to 0.5. To overcome this, more than 900,000 nurses need to be produced, absorbed, and retained by 2030. The W4H program supported the implementation of the Universal Health Coverage (UHC) benefit package through HWF strengthening initiatives. The programme is also helping to accelerate development at local level by ensuring that the nursing workforce (nurse educators) are trained and capacitated with the basic 'know how' of educational psychology, teaching and learning principles and methods, assessment, curriculum and leadership, and professionalism.

Through W4H support, the Ministry of National Health Services, Regulations & Coordination developed a roadmap to strengthen Pakistan Nursing Council (PNC) based on a 2018 assessment. Accordingly, a comprehensive implementation plan for nursing (PC-1) was developed to expand nursing and midwifery education, skills, and employment.

Furthermore, the country's health system faces many challenges including low financial allocation for health, and high out of pocket expenditure; economic, social, and geographical constraints to access health services. To strengthen the health system the W4H program is supporting (i) Comparative assessment study on ILO Nursing Personnel Convention (No. 149) and working conditions of nursing personnel; (ii) Gender Equality in Health (Women in Health Leadership) Study; and (iii) implementing HealthWISE in Pakistan health institutions. The results will be available in 2022.

## **Regional level**

### **Southern African Development Community (SADC)**

After the successful development, and endorsement of the new SADC Health Workforce Strategic Plan (2020–2030): Investing in Skills and Job Creation for Health that calls for an additional 40% in workforce investments over the next 10 years, the program supported the dissemination of the detailed, costed, model implementation plan and monitoring framework, including key milestones and indicators for the SADC Health Workforce Strategic Plan (2020–2030). Furthermore, the W4H facilitated preparatory work for the launch and dissemination of the HRH strategy, and for the establishment of an 'accountability mechanism' for the SADC secretariat, to be launched in 2022.

### **West African Economic and Monetary Union (WAEMU)**

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

In 2021, the ILO led a study to examine the long-term quantitative employment impacts of WAEMU's investments in the health sector. Results confirmed that public health and related spending have important long-run impacts on economic growth, the HWF and employment. The results of the study aim to inform the WAEMU's Ministries of Health, Labour and Employment, Finance, Education, Higher Education and Civil

Service broader consideration of an investment allocation framework in support of future sub-regional healthcare investment decisions.

## **Global level**

### **International Platform on Health Workforce Mobility**

The pandemic continued to present challenges for health workers worldwide, notably for migrant health workers who often have been in the frontline for ensuring the continuity of service at all levels in care homes, public hospitals, and private practice. Over the reporting period the mobility platform has continued to generate and improve the evidence base that informs both the public debate in this area and the review of the relevance and effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel. This in turn led to the publication of WHO's recommended approach of "health workforce support and safeguards" for 47 countries with the most pressing UHC-related health workforce challenges. The approach is informing global and national policy dialogue and collaboration across WHO Member States, including leading destination nations such as the United Kingdom of Great Britain and Northern Ireland and Germany.

A newly developed dataset and report is enabling cross reference of migrant health workers by country of birth and training in the OECD, leading to a more granular understanding of international health worker mobility patterns. The platform has also served to monitor policy changes in crucial destination countries regarding entry, stay and recognition of foreign health professional foreign qualifications during the COVID-19 pandemic. The work on the mobility platform concluded this year with the publication of two working papers on the international migration of doctors and nurses. It also includes new work on "how to do" bilateral labour migration agreements for health workers which aims at producing a joint WHO-OECD-ILO practical guide for policy makers and relevant stakeholders.

### **Inter-Agency Data Exchange (IADEX)**

The IADEX mechanism aims at consolidating and maximizing the value of existing health workforce data and information, ensuring greater consistency and synergies as well as reducing the data collection burden on countries. In the context of NHWA implementation over 160 countries have nominated focal points to report HWF data in the NHWA platform. Data on health workforce stock is available for 175 Member States for the top 5 occupations – medical doctors, nursing and/or midwifery personnel, dentists, and pharmacists – including 193 Member States for medical doctors and 194 Member States for nursing personnel<sup>7</sup>.

Migration data is also available for 120 countries in the NHWA platform. In 2021, the OECD continued to provide data on health employment, health education and health workforce migration in OECD countries in the context of the joint data collection questionnaire with EURO STAT and WHO. The purpose of this work is to avoid duplication of data collections and increase data consistency at the international level. These new robust data allow a continuous monitoring of recent health workforce trends in OECD countries (as shown for example in the health workforce chapter of Health at a Glance 2021: OECD Indicators).

Building on work undertaken in 2019 and 2020 the ILO has produced a draft report on the use of labour force survey (LFS) data to monitor variables related to the health workforce and working conditions. The report summarizes the analysis of LFS microdata from 56 countries which provided data about health and social care workers in sufficient detail to distinguish between different occupation groups within the workforce and puts it into the global health context. Further, it reflects on the strengths and limitations of the use of LFS compared

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<sup>7</sup> Based on data reported on the National Health Workforce Accounts by Member States for the period 2011-2020

with other data sources. A meeting of the inter-agency technical working group discussed and further informed the report results.

### **Measuring employment impact and job creation**

A multi-agency technical working group on job creation (WHO, ILO, OECD – with additional input from German Technical Cooperation: GTZ) developed an evidence-based methodology and working paper on assessing employment impact in the health sector. This paper presents a summary of methods and approaches to assess employment impact from across different sectors. It proposes a guiding framework to assess employment impact in the health sector. Additionally, the paper outlines guiding elements that can be used for the measurement and monitoring employment effects, which can be applied in countries which are being supported through the W4H programme, as well as in similar contexts.

### **Anticipating skill needs in the Health Workforce**

The project started in November 2021, and so far, has been preparing the groundwork. A draft joint questionnaire was developed and shared for feedback. Background research to link the project with the WHO competency framework for health professionals was completed, and an initial virtual interview, with an institution carrying out a skill anticipation exercise for the health workforce (Capaciteitsorgaan, based in the Netherlands). Further work planned for 2022 will ensure a timely completion of the project.

## **Outputs**

### **Health workforce strategies improved at national level through a multisectoral approach**

#### **South Africa**

Conducted HealthWISE training of 40 representatives from the Department of Employment and Labour, Eastern Cape Department of Health Provincial Officials, District Coordinators, facility-based OSH Coordinators, CEOs of Health Facilities (Hospitals) as well as from the main Health Sector Unions in the Eastern Cape, such as the Health and Other Services Personnel Trade Union of South Africa (HOSPERSA), National Education, Health and Allied Workers' Union (NEHAWU), Public Service Association of South Africa (PSA), and Democratic Nursing Organization of South Africa (DENOSA).

#### **Benin**

1. Six training modules were developed including the trainer's guide for community health workers for the surveillance of COVID-19 other diseases with epidemic potential; the training support for health workers and social workers for the psychosocial support / care of individuals and families infected and / or affected by the coronavirus disease.
2. Fifty professionals from the country's 12 health departments trained on psychosocial interventions.
3. An expert mobilized to develop a mobile application capable of generating basic statistical data (number of cases taken care of, locality, gender, age, etc.) of people cared for by front-line professionals.
4. Trained 145 trainers (77 Majors, 34 Social Action and Mobilization Research and 34 Heads of Epidemiological Surveillance Centre from health zones on the use of COVID-19 community surveillance tools.
5. Trained 57 health workers and their managers in two 5-day HealthWISE in Bohicon and in Parakou, organized in collaboration with the Ministry of Labour and Ministry of Health. Participants were trained on the basic concepts of occupational health and safety; the fundamental principles of occupational risk management; the use of the HealthWISE approach as a practical tool for prevention and improvement of work practices in health services and the use and application of the COVID-19 checklist in health care facilities.

## **Niger**

1. Baseline study on employment and professional integration in the three target regions (Diffa, Tahoua and Tillabéry) of the Rural Pipeline Programme (RPP). The implementation of this activity involved several steps, including:

- Finalised the data collection tools- WHO contributed to the review process.
- Recruited and trained supervisors and interviewers.
- Completed a pilot survey and adjustment of tools and impact analysis protocol.
- Data collection: in progress

2. Organization of a resource mobilisation roundtable for the implementation of the National Action Plan (NAP) and the RPP: was delayed due to the country's electoral context. The NAP Coordination and Monitoring Committee held a series of meetings to brief the new authorities after the election, which led to the Prime Minister signing a letter instructing the relevant ministers to get involved in the organization of the roundtable. As part of the implementation of this activity, several sub-activities were carried out, including:

- Capitalization - at the level of each ministerial department - of the Government's efforts in the implementation of the NAP and the Regional Action Plans, through a situational analysis, an evaluation of the achievements of 2018- 2020 and an estimate of the Government's contribution for the coming years.
  - Revision of the NAP and RPP documents and translation from French into English and Arabic.
  - Assessment of the funding needs/gaps of the NAP.
  - Development of the concept note for the roundtable.
- Revision of the technical documents (project sheets) to readjust them according to what has been previously achieved by the government in the framework of the implementation of the NAP.

## **Chad**

1. Supported the development of PHC models to implement UHC strategy, including national consultation workshops and HRH stakeholders.
2. Supported the development of the HWF Competency Framework developed for PHC/UHC.
3. Provided technical support for the HWF projection exercise to estimate the number of HWF needed per year to achieve UHC goals.
4. Facilitated the recruitment of 1652 new health workers to support the implementation and delivery of the PHC/UHC strategy.
5. Supported the development of the NHWA platform.
6. Strengthened the HWF capacity in the fight against Covid-19 by providing training on Infection and Prevention Control in healthcare establishments responsible for case management
7. Strengthened the capacity of health workers in Occupational Health and Safety, knowledge and practical implementation, including the application of the ILO-WHO HealthWISE tool, with a focus on the COVID-19 checklist for health facilities.
8. Assisted in the establishment of the Health and Safety Committees in healthcare.
9. Supported the Human Resources and Training Department to carry out a study of the impact of Covid-19 on HRH for the consideration of the convincing results in the strategic planning of human resources development.

## **Mali**

1. Supported in the development of the human resources development policy and the National Strategic Plan for HRH development (PSNDRH 2019-2023)
  - Conducted an HRH situation analysis and logical framework
  - Supported the finalization of the investment plan
  - Facilitated the establishment and functioning of a human resources thematic group, which was created to serve as a resource mobilization catalyzer for the implementation of the national investment action plan.
2. Supported the development of National Plans for the recruitment, training, career and motivation of Human Resources in Mali in 5 regions of the country (out of a total of 11).
3. Supported the mapping of health personnel in Public Hospital Establishments (EPH) and Health District Hospitals in 4 regions of the country (out of a total of 11).
4. Finalization of the National Recruitment, Training, Career and Motivation Plans to take place after workshops have been organized in all regions.
5. Conducted two 5-day training workshops on occupational safety and health for a total of 48 participants from 42 health facilities. The workshops took place in November and December 2021 in Bamako and Ségou. The participants included doctors, nurses, hospital managers, human resources managers, and those in charge of hospital hygiene in the health services.

## **Mauritania**

1. Strengthened Health Workforce planning
  - Health labour market analysis (HLMA): addressed the situation and dynamics of the HLM training (initial and ongoing), recruitment, deployment and retention.
  - Develop and implement an HRH strategy: informed by HLMA evidence an HRH situation analysis was developed and validated by HRH stakeholders. Furthermore, it addressed HWF profile, retirements, migration, absenteeism, financing with a fiscal space analysis and assessment of HRH needs according to the national standards.
2. HWF governance is strengthened through better coordination among stakeholders
  - Established a coordination and consultation framework to promote the access of women and youth to the decent employments in the health sector
  - Held a tripartite consultative meeting to discuss HWF challenges: The objective of the tripartite meeting was to introduce the ILO-OECD-WHO' program "Working for Health" to key stakeholders; identify key priorities to facilitate the creation of decent employment for youth and women in the health sector; to facilitate and discuss the future national HWF plan with emphasis on decent employment and strengthen consultation and collaboration of HRH stakeholder
3. Established a functional multisectoral platform for coordination and collaboration on youth and women's employment in the health sector and alignment and management of interventions for health workforce.
4. Conducted four regional workshops aimed at contributing to the effective participation of stakeholders in the establishment and ownership of the sectoral social dialogue framework of the health sector

## **West Bank and Gaza Strip**

1. Increased investment in the Primary Health Care workforce and pre-service training quality:

- Review of pre-service curriculums for EMTs two-year program and newly started 4-year paramedic programme. Dialogue started between the MoH and the universities on the curriculums to ensure technical skills match the skills needed to perform.
  - BLS national curriculum developed and adopted.
  - BLS trainer's curriculum developed and adopted.
2. Institutional strengthening of HWF planning and regulation
    - WISN tool implementation started. Two technical trainings were conducted for technical teams on how to implement the WISN tool. A Steering Committee Meeting was conducted, headed by the Minister of Health to set priorities for WISN implementation. Expert groups were formed to support the implementation of WISN.
    - Licensing of EMTs officially approved by MoH and published in the newspaper for public knowledge.
    - Data collection started with the health association to capture data on unemployment and emigration rates among health workers
  3. Skills development for the HWF at the Hospital and PHC level
    - Over 1,500 EMTs, nurses and physicians were trained on BLS
    - Around 30 select EMTs, nurses and physicians were trained as trainers on BLS
  4. Conducted HealthWISE training on occupational safety and health with focus on protection during COVID-19: two Trainings of Trainers: a two-day workshop in West Bank (August 2021) and a three-day workshop in Gaza (November 2021) for piloting the COVID-19 Checklist in health facilities. The objectives were to build the capacity of participants to understand the HealthWISE approach, to apply the COVID-19 checklist in health facilities to improve protection of health workers and to build a network of trainers who will take the training and implementation of the checklist to other health facilities in their area or district.

## **Sudan**

1. Provided specialist support to finalize the National HRH Strategic Framework 2030.
2. Supported drafting HRH list of indicators for the National Health Workforce Account.
3. Conducted data collection (pre-test) for the NHWA supported by Community Medicine registrars in Sudan Medical Specialization Board.
4. Conducted capacity building/orientation for HRH Observatory staff in data analysis and interpretation
5. WHO supported development of E-Learning Platform and website for the Academy of Health Sciences (training institution responsible for pre-service training of nurses and other health professions).

## **Pakistan**

1. Enhanced health workforce production and retention
  - Supported the development of the HRH strategy for the Health Department Sindh and Balochistan which sets policies on the production and retention of HWF and manages the impact of dual practice on reducing access to and availability of quality care at all healthcare level as well as underserved areas.
  - Conducted national level assessment of the strengthening and up-gradation of the nursing and midwifery within the health sector.
  - Technical assistance to review the UHC health strategy on PHC level for the HWF strategy development.



2. Improved nursing education and leadership capacities.
  - Provided technical support for the HWF projection exercise to estimate the number of health care workers needed per year to achieve UHC goals.
  - Organized consensus building meeting on the development of certified course for nursing educators.
  - Stakeholder consultative engagement on the finalization of certified course for nursing educators.
  - Provided catalytic and technical support on 10 days Training of the Trainer (ToT) workshop of Certificate Course for Nurse Educators.
  - Supported to Refurbish one nursing institute's building Turbat, Balochistan.
  - Procured nursing hostel's furniture, IT equipment focusing on underserved areas with a view of decent living atmosphere for nursing trainee.
  - Technical assistance to oversee the implementation of UHC benefit package through strengthened nursing HWF
3. Strengthen HWF Information System and HWF Observatory for Nursing
  - Provided support to M/oNHSR&C to organized back-to-back consultative meetings on UHC DHIS 2 "Health Work force Registry system".
4. Strengthened Regulation of HWF Practice and Education
  - Developed roadmap of PNC based on the need assessment 2018
  - Provided technical support to M/oNHSR&C on the development of Nursing PC implementation plan.
5. Comparative assessment study on the ILO Nursing Personnel Convention, 1977 (No. 149) and working conditions of nursing personnel:
  - Tripartite validation meeting brought together 25 participants from various government agencies, health workers, including nursing personnel, research organizations, I/NGOs
  - Report to be submitted to the Government of Pakistan to support the ratification process of C149 and strengthen the provision of a decent work environment for nursing personnel in line UHC
6. Conducted Gender Equality in Health (Women in Health Leadership) Study to assess the gender situation in health leadership – particularly, women's leadership role in health system at institutional, structural, policy and service delivery level and provides recommendations
7. Implementation of HealthWISE in health facilities to improve the occupational safety by conducting a 3-day Training of Trainers workshop in collaboration with the Directorate of Workers Education. In a second step, two 'HealthWISE Introductory Workshops' with 62 participants were held in Islamabad (26<sup>th</sup> October 2021) with 33 health workers and management representatives from 13 health facilities and Gilgit (28<sup>th</sup> October 2021) and in **Gilgit**, 28 representatives from 12 Health Institutions.

## **Somalia**

1. Provided technical and catalytic funding support for rapid landscape analysis of HWF.
2. Conducted analysis of health services providers in the private sector with the overarching view of engaging the private sector in the delivery of essential package of health services (EPHS 2020) to achieve UHC.
3. Developed a policy and business case for sustainable funding and investment for recruitment, deployment, and sustenance of community health force in the country to harness their services for basic health care at the community and primary level of care through task shifting.
4. Trained over 3000 community health workers on providing basic essential health services at the community level including COVID-19 case detection during the COVID-19 pandemic to offset the disruption of essential health services.

5. Reprogrammed part of the catalytic support for the health and care workforce through strengthened infection prevention control (IPC) and OSH measures and addressed issues of stress and psychosocial support for health workers especially those in the informal health workforce category.
6. Provided technical guidance and support to the Federal Ministry of Health for revision of National Human Resources for Health (NHRH) strategy

## **Health workforce data inform effective policy, planning, monitoring and international mobility**

### **International Platform on Health Workforce Mobility**

1. Published two working papers on international migration and movement of doctors to and within OECD countries - 2000 to 2018<sup>8</sup>; and international migration and movement of nursing personnel to and within OECD countries - 2000 to 2018<sup>9</sup>.
2. WHO led the development of a guidance on bilateral agreement with international health worker migration and mobility with support from OECD and ILO and facilitated by the consultation and validation from the WHO Technical Expert Group on Bilateral Agreements.
3. Supported evidence generation for the guidance on bilateral agreement through rapid literature review, textual analysis of bilateral agreements including categorization by focus area (trade, labour, health, education, migration), and key stakeholder interviews led by WHO.
4. Elaboration of the linkages between the WHO Global Code and the Global Compact for Safe, Orderly and Regular Migration, including exploring the potential of new skill partnerships in the health sector.
5. Conducted research on compendium on skills recognition processes for migrant health workers to analyze the existing modalities of qualification and skills recognition requirements for migrant health workers, and any obstacles and challenges faced by them, with a particular reference to women migrant workers in destination countries. In the initial phase of the research case studies of several origin and destination countries were conducted, namely the Philippines, Egypt, Italy and Germany. Based on the national reports, the ILO is in the process of preparing a comparative analysis that draws on the national policy lessons and experiences to provide general guidance on how access to qualification and skills recognition for migrant health workers
6. Developed a manual on participatory assessment of policy coherence on labour migration in the health sector. ILO targets assessing coherence among labour migration, employment, education/training and health policies with the aim to support constituents and stakeholders at country level in developing more coherent health worker migration governance. The manual is currently under final review and will be published in 2022.

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<sup>8</sup> <https://doi.org/10.1787/7ca8643e-en>

<sup>9</sup> <https://doi.org/10.1787/b286a957-en>

## **Inter-Agency Data Exchange (IADEx)**

1. Revitalization of data collection in eastern part of Europe as part of the joint data questionnaire.
2. WHO organized a global seminar NHWA during November 2021, in which all partners contributed with aim of strengthening HRH planning and service delivery and (HLM)
3. The University of Minnesota- Integrated Public Use Microdata Series (IPUMS) Programs fully active in the IADEx- meeting held in November 2021 with ILO and WHO to provide update on the latest availability on census and survey data.
4. IPUMS organized a session on how data availability impacts policy and used population census for strengthening health workforce programs as an example
5. IPUMS is now gathering LFS data in addition to population census data set working with national statistical office
6. ILO led joint work on LFS in continuation of foundational piece on use of LFS on HWF analysis. The analysis showed that some health and social care workers work outside of the health and social care sector This piece speaks to relevant HWF planning areas. IADEx technical working group meeting was convened to discuss the findings and the way forward. The final report will be published in 2022
7. WHO technical and financial supported NHWA implementation in six African countries namely, Burundi, Cameroon, Cape Verde, Senegal, Sierra Leone and Chad.

## **Achievements, challenges, lessons learned and Next steps**

The High-Level Commission on Health Employment and Economic Growth in 2016 brought a new level of understanding of how health sector jobs drive inclusive economic development. Implementation of its recommendations through the Working for Health Action Plan (2017-2021) has provided further stimulus towards sustained investment in the health and care workforce. With operations in over 12 countries, continued support for two regional economic areas Southern African Development Community (SADC) a new regional strategy and investment plan calls for an additional 40% in workforce investments over the next 10 years and West African and Monetary Fund (WEAMU) countries have committed to create 40 000 new jobs by 2022 and; established three global goods International Platform on Health Worker Mobility and Interagency data exchange platform and Anticipating skill need in the health workforce. In addition to the W4H Technical Working Group on Job Creation assessment of employment impact in the health sector. The W4H has contributed to universal health coverage (UHC) and to Sustainable Development Goals (SDGs) 3, 4, 5 and 8, through multisectoral investments and interventions to expand and transform health workforce (HWF) education, skills and jobs.

The COVID-19 pandemic has drawn attention on how chronic underinvestment in our health systems compromises human health and leads to serious economic and social setbacks. We witnessed the most vulnerable countries falling further behind as they lack the fiscal space to make the necessary investments in

the workforce to build more resilient health systems. Consequently, the pandemic has impacted the implementation of the W4H-supported activities with national restriction measures causing delay and re-programming to respond to country needs. Furthermore, the political and social instability in many countries (Benin, Niger, Mali and Sudan) imposed as a challenge causing delays due to the insecurity, high turnover and restructure of national counterpart turnover at middle and senior management due to the political situation among others.

Overall, flexibility to adjust to changing needs of constituents according to their context should be seen as a success factor for effective and sustainable impact of the Working for Health Programme. The pandemic challenged the health systems at large and tested the strength of the W4H partnership within country systems. W4H country focal points built stronger partnerships with national implementers mainly Ministries of Health and was committed and provided support to implement the W4H interventions. Additionally, effective implementation was enabled due to multi-sectoral collaboration and led to attracting additional funds.

An independent review of the relevance and effectiveness of the W4H 5-Year Action Plan for Health Employment and Inclusive Economic Growth (2017–2021) was conducted in 2021 validating and reinforcing the continued high relevance of the W4H Programme and its MPTF. The corresponding WHO Director-General report to the 74th World Health Assembly on the final year of the 5-year action plan presented a pathway for its continuity and recommended a renewed W4H action plan and agenda. In May 2021, Resolution WHA 74.14 on “protecting, safeguarding and investing in the health and care workforce” was adopted by the WHA, calling for a new set of actions and 2030 agenda to be developed through a Member States-led process. Building on the experience and lessons learned of the past five years, the current action plan, 2022–2030 is aligned with, enables and supports health systems strengthening and financing for universal health coverage, essential public health functions, and emergency preparedness and response, as well as the core programmes that support them. It is guided by target 3.c of the Sustainable Development Goals, as well as by the specific needs and priorities of each country and the best available evidence and data to leverage sustainable multisectoral country-driven action aimed at driving policy, implementation and investment.

## Indicator Based Performance Assessment

Using the **Programme Results Framework from the Project Document / AWP** - provide an update on the achievement of indicators at both the output and outcome level in the table below. Where it has not been possible to collect data on indicators, clear explanation should be given explaining why, as well as plans on how and when this data will be collected.

	Achieved indicator targets (at country level)	Achieved indicator targets (across countries)	Reasons for variance with planned targets (if any)	Source of verification
<b>Outcome 1: The supply of appropriately skilled health workers meets assessed country needs</b>				
<p><b>Indicator 1:</b> Total public sector expenditure on health workforce pre-service education</p> <p><b>Baseline:</b> Based on country level assessments</p> <p><b>Planned target:</b> % increase to be determined based on country level assessment</p>	N/A	N/A	No data for Guinea and Niger on NHWA portal	Data from annual reports NHA, WHO NHWA portal
<p><b>Indicator 2:</b> Ratio of newly active domestic trained health workers to total stock of active health workers</p> <p><b>Baseline:</b> Based on country level assessments</p> <p><b>Planned target:</b> Extent of change to be determined based on country level assessment – threshold to be defined at national level</p>	<p><b>Benin:</b> 1050 health workers have strengthened capacity to manage the COVID-19 pandemic. 145 trainers [77 Majors, 34 Social Action and Mobilization Research Fellows (CRAMS) and 34 Heads of Epidemiological Surveillance Centre (RCSE)] from health zones were trained on the use of COVID-19 community surveillance tools (<i>ongoing</i>). 1000 community health workers trained to identify, track and trace potential cases within the community. 50 health workers trained on psychosocial care and support interventions.</p> <p><b>Somalia:</b> Trained and deployed 3126 Community Health Workers to support the COVID-19 response efforts who have been retained for</p>	N/A	<b>Chad:</b> planned to recruit an estimated 5000 health workers but this was not realized due to the political instability	Data from annual reports, WHO NHWA portal

	providing essential health services at the community level.			
<b>Output 1.1:</b> Strengthened country accreditation mechanisms to align types of education and training with health labour market demand and population needs				
<p><b>Indicator 1.1.1:</b> Existence of national and/or subnational mechanisms for accreditation of health workforce education and training institutions and their programmes (Yes/No/Partly)</p> <p><b>Baseline:</b> 0</p> <p><b>Planned target:</b> 20 countries supported</p>	<p><b>West Bank and Gaza Strip:</b> Led by the MoH, international standards and best practices were reviewed for licensing requirements for EMTs and paramedics; licensing criteria drafted for paramedics and advanced EMTs in order to initiate the process of regulating these professions</p> <p><b>Somalia:</b> Conducted a rapid landscape analysis of existing health workforce, regulatory pathways for recruitment and retention and accreditation system for health workforce in the country.</p>	N/A	N/A	Data from annual reports
<b>Output 1.2:</b> Models developed for assessing staffing needs for health services delivery				
<p><b>Indicator 1.2.1:</b> Existence of institutional models for assessing and monitoring staffing needs for health service delivery (Yes/No/Partly)</p> <p><b>Baseline:</b> 0</p> <p><b>Planned target:</b> 20 countries supported</p>	Three countries Benin, Guinea and Niger have fully implemented the workload indicators staffing needs (WISN) methodology	Three countries ( <b>Guinea and Niger</b> partially, and <b>Benin</b> )	Currently, there is only funding to support 12 countries not 20 Targets should be revised to 12	Data from annual reports
<b>Output 1.3:</b> Strengthened institutional capacity to align skills and competencies with health labour market and population needs				
<p><b>Indicator 1.3.1:</b> Existence of national education plans for the HWF, aligned with the national health plan and the national health workforce strategy/plan (Yes/No/Partly)</p> <p><b>Baseline:</b> 0</p> <p><b>Planned target:</b> 20 countries</p>	<p><b>Chad:</b> Models of care developed for the implementation of the UHC strategy; Competencies framework for PHC developed.</p> <p><b>Mauritania:</b> A comprehensive analysis was developed that addressed all issues related to the situation and dynamics of the</p>	Five countries reported ( <b>Chad, Niger, Sudan, West Bank and Gaza Strip, Somalia</b> )	Currently, there is only funding to support 12 countries not 20 Targets should be revised to 12	Data from annual reports

	<p>health care labour market: training (initial and ongoing), recruitment, deployment and retention. A separate stakeholder analysis was conducted on: health workforce profile, retirements, migration, absenteeism, financing with a fiscal space analysis and assessment of Human Resources for Health needs according to the national standards.</p> <p><b>Niger:</b> Continued training youth and women in health jobs to provide them with permanent employment opportunities and improve their skills.</p> <p><b>Somalia:</b> Supported the revision of national human resources for health strategy and its effective roll out by building institutional capacity of federal ministry of health.</p> <p>Also supported the establishment of National Institute of Health to support building public health workforce, especially for the front-line health workers.</p> <p><b>Sudan:</b> established an e-learning platform for training of nurses and other allied health professionals.</p> <p><b>West Bank and Gaza Strip:</b> Developed curriculum and ensured adoption for two core courses in support of a national emergency training center: basic life support (delivered to over 200 workers and 15 trainers); advanced life support (delivered to 80-100 health workers); critical care and infection</p>			
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	prevention and control courses (50-70 health care workers).			
<b>Outcome 2: Health sector jobs created to match labour market and public health needs</b>				
<p><b>Indicator 1:</b> Percentage of active health workers employed by type of facility ownership</p> <p><b>Baseline:</b> Based on country assessment</p> <p><b>Planned target:</b> Extent of change based on country assessment</p>	<p><b>Baseline data for the WAEMU countries:</b></p> <p><b>Benin in 2018:</b> Medical doctors: 71.0% in public, 18.4% in P4P, 10.6% in PN4P; nurses: 94.3% in public, 1.5% in P4P, 4.2% in PN4P</p> <p><b>Burkina Faso in 2017:</b> Medical doctors: 100% in public; nurses: 100% in public</p> <p><b>Chad in 2020:</b> Medical doctors 12.5% in private not for profit (PN4P), 87.5% in private for profit (P4P).</p> <p><b>Côte d'Ivoire in 2018:</b> Nurses: 100% in public</p> <p><b>Guinea-Bissau in 2018:</b> Nurses: 100% in public</p> <p><b>Mali in 2018:</b> N/A</p> <p><b>Niger in 2016:</b> Medical doctors: 84.1% in public, 15.9% in P4P, 0% in PN4P; nurses: 86.8% in public, 13.2% in P4P, 0% in PN4P.</p> <p><b>Senegal:</b> No data</p> <p><b>Togo in 2018:</b> Medical doctors: 75.5% in public, 24.5% in P4P, 0% in PN4P; nurses: 78.5% in public, 21.6% in P4P, 0% in PN4P</p> <p><b>Somalia:</b> The rapid landscaping analysis of health workforce and regulatory framework revealed the following findings: Of the 13 236 current health work force in Somalia, 7073 (53.4%) are</p>	87.5% (seven WAEMU countries)	N/A	Data from the WHO NHWA portal and country reports



	physicians, nurses and midwives. 70% of these health workforce work in the private sector (NGOs and for-profit sector)			
<p><b>Indicator 2:</b> Density of health workers per 10 000 population</p> <p><b>Baseline:</b> Based on country assessment</p> <p><b>Planned target:</b> % change based on country assessment</p>	<p><b>Change in comparison to the baseline:</b></p> <p><b>Benin 2018–2019:</b> - 0.14 for medical doctors; - 0.71 for nurses; - 0.15 for midwives; no change for pharmacists</p> <p><b>Burkina Faso 2017–2019:</b> +0.09 for medical doctors; +0.18 for nurses; +0.26 for midwifery; -0.01 for dentists; no change for pharmacists</p> <p><b>Chad 2018-2020:</b> +0.09 for medical doctors; no change for nurses; +0.43 for midwifery; no change for pharmacists; dentists N/A. The density is 2.67 per 10 000 inhabitants in 2020. An additional 1652 new health workers have been deployed in 2021.</p> <p><b>Côte d'Ivoire 2018–2019:</b> +0.01 for medical doctors; -1.67 for nurses; +2.18 for midwifery; +0.01 for dentists; no change for pharmacists</p> <p><b>Guinea-Bissau 2018–2020:</b> +0.69 for medical doctors; -1.62 for nurses; no change for midwifery; - 0.09 for dentists; no change for pharmacists (2016)</p> <p><b>Mali in 2018:</b> +1.29 for medical doctors; +2.71 for nurses; 1.70 for midwifery; 0.01 for dentists; 0.1 for pharmacists. 6 health professionals per 10 000 inhabitants in 2021.</p> <p><b>Niger 2018-2020:</b> +0.18 medical doctors;</p>	N/A	<p>Densities in the eight WAEMU countries</p> <p><b>Niger:</b> 3355 additional jobs in the health sector have yet to be created due to insufficient domestic resources dedicated to HHR</p>	WHO NHWA portal

	<p><b>2016-2018:</b> -0.45 nurses; -0.01 midwives; no change for dentists; +0.02 pharmacists.</p> <p>The density is: 4 per 10 000 inhabitants in 2021.</p> <p>2645 additional jobs created in the health sector (1540 in 2021 including physicians, nurses, midwives, laboratory technicians, hygiene technicians).</p> <p><b>Senegal 2017–2019:</b> + 0.19 for medical doctors; + 1.94 for nurses; + 0.33 for midwifery; +0.05 for dentists; and + 0.01 for pharmacists</p> <p><b>Togo in 2018–2020:</b> +0.06 for medical doctors; +0.5 for nurses; +0.48 for midwifery; no change for dentists; +0.01 for pharmacists</p> <p><b>Somalia:</b> In 2014-2015, less than 1 doctor/nurse/midwife per 1000 population; No change has been observed pending the detailed assessment to be done through the harmonized health facility assessment survey.</p>			
<p><b>Indicator 3:</b> Ratio of previous year graduates who started practice to total number of previous year graduates</p> <p><b>Baseline:</b> Based on country assessment</p> <p><b>Planned target:</b> % change based on country assessment</p>	N/A	N/A	N/A	N/A
<p><b>Output 2.1:</b> Strengthened country capacity on gender-responsive health labour market analysis, to inform and feed into the development of workforce policies, strategies and reforms</p>				

<p><b>Indicator 2.1.1:</b> Number of W4H-supported countries where health labour market analysis has been applied to inform health workforce planning</p> <p><b>Baseline:</b> 0</p> <p><b>Planned target:</b> 20 countries</p>	<p><b>Mauritania:</b> Existence of a functional multisectoral platform for coordination and collaboration on youth and women’s employment in the health workforce.</p> <p><b>Somalia:</b> Revised the national human resources for health strategy to meet the need and requirement of EPHS 2020.</p>	<p>10% (two countries – <b>South Africa:</b> National Health Workforce Strategic Framework: 2019–2030 and HRH Strategic Plan Sector: 2019/20–2024/25 based on intersectoral and tripartite dialogue and health labour market analysis; <b>Rwanda:</b> Comprehensive HRH situation analysis; initiated the development and costing of the new HRH roadmap and 2-year implementation plan)</p>	<p>Currently, there is only funding to support 12 countries not 20</p> <p>Targets should be revised to 12</p> <p>Achieved targets should be then 16.67%</p>	<p>Data from annual reports</p>
<p><b>Output 2.2:</b> Improved capacity to develop enhanced multisectoral national health workforce strategies and plans</p>				
<p><b>Indicator 2.2.1:</b> Existence of mechanisms and models for health workforce planning (yes/no/partly)</p> <p><b>Baseline:</b> Eight WAEMU countries</p> <p><b>Planned target:</b> 20 countries</p>	<p><b>Mauritania:</b> A multi-sectoral steering committee was established as a key mechanism to improve coordination and strengthen governance.</p> <p>The National Human Resources for Health Development Plan was developed with the involvement of key stakeholders. The strategic components of this plan were defined from the rapid assessment of the previous plan and the priority challenges and associated recommendations resulting from the analysis on the situation and stakeholders of the health workforce. Validation is ongoing.</p> <p><b>Sudan:</b> developed and finalized the national Human Resources for Health Strategic Framework 2030.</p>	<p>50% (10 countries: eight countries of <b>WAEMU</b> have elaborated investment plans with situation analysis, HRH projections and scenarios with estimated costing and health service coverage, plus <b>South Africa and Rwanda)</b></p>	<p>N/A</p>	<p>Data from annual reports</p>
<p><b>Output 2.3:</b> Strengthened countries’ capacity to secure sustainable funding for health workforce strategies and plans</p>				

<p><b>Indicator 2.3.1:</b> Number of W4H-supported countries with investment case for job creation in the health sector (public and private)</p> <p><b>Baseline:</b> 0</p> <p><b>Planned target:</b> 20 countries</p>	<p><b>South Africa:</b> 100% Catalytic funding support toward the development and endorsement of three national HRH strategies.</p>	<p>All eight <b>WAEMU</b> countries did return on investment studies – 100% case studies on job creation potential of health sector planned in three countries; <b>Mali</b> conducted situational analysis for the development of the investment case; <b>Somalia</b> developed a business case for sustainable investment on CHWs with a view to harnessing the community health services.</p>	<p>Currently, there is only funding to support 12 countries not 20</p> <p>Targets should be revised to 12</p> <p>Achieved targets should be then 100%</p>	<p>Data from annual reports</p>
<p><b>Output 2.4:</b> Strengthened tripartite intersectoral mechanisms to coordinate the development and implementation of health workforce policies and strategies</p>				
<p><b>Indicator 2.4.1:</b> Existence of institutional mechanisms or bodies to coordinate an intersectoral health workforce agenda (Yes/No/Partly)</p> <p><b>Baseline:</b> 0</p> <p><b>Planned target:</b> 20 countries</p>	<p><b>Benin &amp; Chad:</b> Established OSH committees in selected hospitals.</p> <p><b>Sudan:</b> Nursing and Midwifery Working Group established to enhance coordination with different stakeholders.</p> <p><b>Mali:</b> Workshops organized in four regions to prepare for the finalization of national health workforce plans.</p> <p><b>Mauritania:</b> Held a tripartite consultative meeting to discuss HWF challenges. Social dialogue platform for health workforce development initiated through training in four pilot regions.</p>	<p>All eight <b>WAEMU</b> countries have either a national committee on HRH or a HRH Observatory or a HRH working group</p> <p>ILO provided support for multisectoral tripartite dialogue to four countries (<b>Benin, Chad, Mauritania, South Africa</b>) plus <b>SADC</b> region</p>	<p>N/A</p>	<p>Data from annual reports</p>
<p><b>Output 2.5:</b> Improved systems and processes for monitoring of and accountability for health workforce strategies at country level</p>				
<p><b>Indicator 2.5.1:</b> Number of W4H-supported countries producing annual monitoring and accountability reports for health workforce strategies</p> <p><b>Baseline:</b> 0</p>	<p>All W4H countries</p>	<p><b>SADC countries:</b> Updated and revised data and baseline; implementation plan, costing model and M&amp;E framework initiated</p>		<p>Data from annual reports</p>

<b>Planned target:</b> 20 countries		<b>WAEMU countries:</b> Monitoring framework developed and pilot is ongoing in two countries		
<b>Outcome 3: Health workers are recruited and retained according to country needs</b>				
<b>Indicator 3.1:</b> Density and distribution of active health workers, by occupation and subnational level <b>Baseline:</b> SDG – based on country assessment <b>Planned target:</b> 15% increase	All W4H countries	<b>SADC:</b> As of 2020, the SADC density of health workers median of 1.02 to 4.45 per 1000 population; across the SADC countries there are wide variations in the density of medical doctors, dentists, midwives and nurses, ranging from 0.9 to 120 per 10 000 population ( <i>country-specific data is in Table 5 of the strategy document</i> )	N/A	SADC Health Workforce Strategic Plan (2020–2030): Investing in Skills and Job Creation for Health
<b>Indicator 3.2:</b> Ratio of unfilled posts to total number of posts <b>Baseline:</b> Based on country assessment <b>Planned target:</b> 10% increase	No baseline data to compare with, because there were no data on the NHWA portal	N/A	N/A	N/A
<b>Indicator 3.3:</b> Ratio of active health workers voluntarily leaving the health sector labour market to total stock of active health workers <b>Baseline:</b> Based on country assessment <b>Planned target:</b> % change based on country assessment	No baseline data to compare with because there were no data on the NHWA portal	N/A	N/A	N/A
<b>Output 3.1: Health workforce deployment and distribution mechanisms strengthened for primary health care in rural and underserved areas</b>				
<b>Indicator 3.1.1:</b> Density of active health workers per 10 000 population by occupation at subnational level <b>Baseline:</b> Based on in country assessment	<b>Change in comparison to the baseline:</b> <b>Benin 2018–2019:</b> - 0.14 for medical doctors; - 0.71 for nurses; - 0.15 for midwives; no change for pharmacists	<b>SADC:</b> As of 2020, the SADC density of health workers median of 1.02 to 4.45 per 1000 population; across the SADC countries there are wide variations in the density of medical doctors, dentists,	N/A	SADC Health Workforce Strategic Plan (2020–2030): Investing in Skills and Job Creation for Health; WHO NHWA portal

<p><b>Planned target:</b> Density change to be determined based on country level assessment</p>	<p><b>Guinea-Bissau 2016–2018:</b> No change in medical doctors; + 1.7 nurses; no change for midwifery; no change for dentists; no change for pharmacists (2016)</p> <p><b>Burkina Faso 2017–2019:</b> + 0.09 for medical doctors; + 0.18 for nurses; + 0.26 for midwifery; - 0.01 for dentists; no change for pharmacists</p> <p><b>Côte d'Ivoire 2018–2019:</b> + 0.01 for medical doctors; - 1.67 for nurses; + 2.18 for midwifery; + 0.01 for dentists; no change for pharmacists</p> <p><b>Mali in 2018:</b> +1.29 for medical doctors; +2.71 for nurses; 1.70 for midwifery; 0.01 for dentists; 0.1 for pharmacists</p> <p><b>Niger 2021:</b> physicians 0.5; nurses 2.5; midwives 2.3. Rural Pipeline Project was evaluated in three target regions; an economic model was used for forecasting and a framework for optimizing the results was predicted by the model.</p> <p><b>Senegal 2017–2019:</b> + 0.19 for medical doctors; + 1.94 for nurses; + 0.33 for midwifery; +0.05 for dentists; + 0.01 for pharmacists.</p> <p><b>Togo in 2018–2019:</b> + 0.01 for medical doctors; + 0.17 for nurses; + 0.37 for midwifery; + 0.02 for dentists; no change for pharmacists</p>	<p>midwives and nurses, ranging from 0.9 to 120 per 10 000 population (<i>country-specific data is in table 5 of the strategy document</i>)</p> <p><b>WAEMU:</b> planned but due to COVID-19 not executed</p>		
<p><b>Output 3.2:</b> Strengthened capacity to address gender bias and inequalities in health workforce policy and practice</p>				
<p><b>Indicator 3.2.1:</b> Gender wage gap <b>Baseline:</b> Based on in country assessment</p>	<p>W4H advocates gender equality in all the countries.</p>	<p><b>SADC:</b> Set an objective of developing and implementing strategies to mainstream gender equality in the health</p>	<p>N/A</p>	

<p><b>Planned target:</b> % change to be determined based on country level assessment</p>	<p><b>Pakistan:</b> Research to assess gender equality in health leadership was initiated.</p>	<p>sector workforce; two-thirds of SADC countries indicated the existence of a comprehensive approach to health workforce education which is gender-responsive; the strategy will guide countries in addressing and eliminate gender inequities; workforce profile data will be disaggregated by gender</p>		
<p><b>Output 3.3:</b> Improved occupational health and safety of health workers in all settings at national level</p>				
<p><b>Indicator 3.3.1:</b> Existence of national occupational health and safety plans or programmes integrated in health workforce strategies</p> <p><b>Baseline:</b> Based on in country assessment</p> <p><b>Planned target:</b> 10 countries</p>	<p>The HealthWISE approach and the COVID-19 checklist for health facilities were implemented with ILO support in 15 workshops conducted in three regions (Africa: Benin, Chad, Mali, Mauritania, Somalia, South Africa; Arab States: Occupied Palestinian Territories; Asia: Pakistan).</p>		<p>N/A</p>	<p>Data from annual reports</p>
<p><b>Output 3.4:</b> Strengthened health workforce social protection coverage</p>				
<p><b>Indicator 3.4.1:</b> Existence of national/subnational policies/laws regulating social protection (Yes/No/Partly)</p> <p><b>Baseline:</b> based on in country assessment</p> <p><b>Planned target:</b> 10 countries</p>	<p><b>Chad:</b> Developed models of care the implementation of UHC strategy, which included social health protection strategy .</p>	<p>N/A</p>	<p>N/A</p>	<p>Data from annual reports; SADC Health Workforce Strategic Plan (2020–2030): Investing in Skills and Job Creation for Health</p>
<p><b>Output 3.5:</b> Improved occupational health and safety of health workers in all settings at national level</p>				
<p><b>Indicator 3.5.1:</b> Existence of national/subnational policies/laws regulating working hours and conditions (Yes/No/Partly)</p> <p><b>Baseline:</b> Based on in country assessment</p> <p><b>Planned target:</b> 10 countries</p>	<p>HealthWISE training in 7 countries addressed questions of working hours and workload</p>	<p>N/A</p>	<p>N/A</p>	<p>N/A</p>

<b>Outcome 4: Health workforce data inform effective policy, planning, monitoring and international mobility</b>				
<b>Indicator:</b> Number of countries that have developed health workforce policy, planning and monitoring, including on mobility, based on harmonized metrics and definitions <b>Baseline:</b> 0 <b>Planned target:</b> 20 countries	N/A	N/A	N/A	N/A
<b>Output 4.1:</b> An international health labour mobility platform established to advance knowledge and international cooperation				
<b>Indicator 4.1.1:</b> Number of countries participating in the platform <b>Baseline:</b> 0 <b>Planned target:</b> 50	Seven W4H countries ( <b>Benin, Chad, Rwanda, Pakistan, Sudan, South Africa, Somalia</b> ): have a designated national authority, and/or submitted a national report	<b>SADC:</b> Set an objective of creating a multilateral framework on health workforce mobility	N/A	SADC Health Workforce Strategic Plan (2020–2030): Investing in Skills and Job Creation for Health; WHO Global Code of Practice on the International Recruitment of Health Personnel: report of the WHO Expert Advisory Group (May 2020)
<b>Output 4.2:</b> Strengthened country capacity to understand and manage health worker flows, in order to inform the development of national policies and bilateral agreements				
<b>Indicator 4.1.2:</b> Platform established to maximize benefits from international health worker mobility <b>Indicator 4.2.1:</b> Number of national policies and bilateral agreements supported <b>Baseline:</b> 0 <b>Planned target:</b> 10 countries	N/A	Platform established; one bilateral agreement signed	The OECD started a consultation process with its Member States on the bilateral agreements ILO co-facilitated development of the UN Network on Migration guidelines on Bilateral Labour Agreements (adopted in 2021 publication 2022)	
<b>Output 4.3:</b> Increased monitoring of health worker mobility through the WHO Global Code of Practice reporting system				



<p><b>Indicator 4.3.1:</b> Number of countries supported by W4H which report on the WHO Global Code</p> <p><b>Baseline:</b> 0</p> <p><b>Planned target:</b> 20 countries</p>	<p>17 countries appointed a DNA of which 3 countries submitted their report</p>	<p>N/A</p>	<p>Fourth round of code reporting took place</p>	<p>Secretariat report to the World Health Assembly; meeting notes</p>
<p><b>Output 4.4:</b> New harmonized metrics and definitions established through an interagency global data exchange on the health labour markets</p>				
<p><b>Indicator 4.4.1:</b> Number of countries using the data exchange platform</p> <p><b>Baseline:</b> 0</p> <p><b>Planned target:</b> 50 countries</p>	<p>Eight W4H countries reported nursing workforce data for 2016–2019 in the WHO NHWA portal; Eight W4H countries reported medical doctor workforce data for 2016–2019 in the WHO NHWA portal; 11 W4H countries reported workforce data to the Global Health Observatory data repository</p> <p>ILO extended analysis of LFS micro-data on health workforce for 56 countries</p>	<p>N/A</p>	<p>Currently, there is only funding to support 12 countries, not 50</p>	<p>WHO NHWA portal; Global Health Observatory data repository</p>
<p><b>Output 4.5:</b> Improved quality and reporting of health workforce data through national health workforce accounts</p>				
<p><b>Indicator 4.4.1:</b> Number of W4H-supported countries that report NHWA core indicators to WHO annually</p> <p><b>Baseline:</b> 0 countries</p> <p><b>Planned target:</b> 20 countries</p>	<p>Eight countries (<b>Benin, Chad, Guinea, Niger, Mali, Mauritania, Rwanda, South Africa</b>): 2016–2020</p>	<p>N/A</p>	<p>Currently, there is only funding to support 12 countries, not 20</p> <p>Targets should be revised to 12</p> <p>Achieved targets should be then 66.7%</p>	<p>WHO NHWA portal</p>

## **Annex (1) Country case studies**

### **Mauritania- Strengthened Health Workforce Planning & National Human Resources for Health Strategy Development**

In 2020, the Working for Health (W4H) Programme expanded its support' to ten countries, including Benin, Chad, Guinea, Mali, Mauritania, Niger, Rwanda, South Africa, Sudan and the West Bank and Gaza Strip. Key successes include, the establishment of a multi-sectoral platform focusing on youth and women's employment as well as a Health Labour Market Analysis (HLMA) guiding the development of the National Health Workforce Development Plan of Mauritania.

Building on this strong foundation, progress is made towards developing the National Human Resources for Health Development Plan (NHRHDP, 2022-2026). Mauritania reports that the HLMA conducted continues to contribute to strengthened and sound health workforce planning, specifically, guiding training, recruitment and retention. The HLMA is considered to be an essential national tool providing insights into health worker absenteeism, migration as well as drawing attention to the fiscal space. Such strategic and evidence-based planning are the cornerstones of stronger healthcare systems and universal health coverage (UHC).

Mauritania is at the forefront of ensuring the prioritization of decent work among women and youth in the health sector among key stakeholders. The W4H programme supports the ongoing multi-sectoral dialogues among stakeholders (tripartite meetings), establishing a coordination and consultation framework to promote and work towards developing interventions targeting women and youth yielding the following outcomes -

- The increase in the number of young women in the Faculty of Medicine (40-45 percent of students).
- The gradual absorption of the stock of unemployed youth from medical schools (1,000 recruitments made out of 3,000 unemployed young people).
- The commitment of the Ministry of Finance to open 700 positions each year for the benefit of the health sector.

The COVID-19 pandemic affected health workforce programming in Mauritania, a high-priority issue to guide the country's health workforce efforts is the validation of the National Human Resources for Health Development Plan (NHRHDP, 2022-2026).

## **Mali - Challenging Humanitarian and Socio-Political Context - Human Resources for Health Interventions & Investments**

There is a low density of health personnel across all regions of Mali – 6 health professionals per 10 000 inhabitants (Health HR Statistics Directory, 2019). The Working for Health (W4H) Programme has supported Mali for the past three years (2019- 2021). Initially, a human resources for health (HRH) situational analysis was carried out leading to the Human Resources Development Policy as well as the National Strategic Plan for Human Resources for Health Development (PSNDRH 2019–2023). Since 2019, there has been a concerted effort and interest to finalize a national investment plan and to improve employment conditions in the health and care sector.

Mali's HRH priority interventions are –

- The development of a National Recruitment-Training-Career-Motivation Plan stemming from the PSNDRH 2019-2023 to improve employment and working conditions in the health and social sector in 5 of 11 regions in the country.
- Mapping of health personnel in Public Hospital Establishments (EPH) and Health District Hospitals in 4 out of 11 regions of the country.
- Finalization of the National Recruitment, Training, Career and Motivation Plans

The implementation of HRH interventions in the country are severely hampered by a long-standing humanitarian crises (2012), ongoing socio-political instability, exacerbated by the onset of the COVID-19 pandemic. The Ministry of Labour through the National Occupational Safety and Health Policy prioritizes the prevention of occupational accidents and diseases in the health sector. Within this framework the W4H COVID-19 response supported two training workshops (HealthWISE<sup>10</sup>) to improve the Occupational Safety and Health (OSH) capacities for better protection of health workers. Despite challenges, Mali is committed to implementation and the upscale of HRH intervention across all regions.

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<sup>10</sup> HealthWISE is a practical, participatory quality improvement tool for health facilities. The HealthWISE package consists of an Action Manual and a Trainers' Guide to combine action and learning. Topics include occupational safety and health, personnel management and environmental health.

## **West Bank and Gaza Strip – Catalytic Funding Supports COVID-19 Emergency Response**

Daily, health care workers lives are at risk as they attempt to provide services in humanitarian settings such as the West Bank and Gaza Strip. More so, health systems in conflict settings require strong emergency and disaster management, the rapid coordination and response including financing, technical support and human resources for health (HRH). In 2019, the Working for Health (W4H) Programme supported national plans aimed at building an Ambulance and Emergency and Disaster Management Unit as well as roll out training among 800 emergency medical technicians (EMTs), and 100 nurses and doctors working in emergency rooms. In the West Bank and Gaza, attention is drawn to the fact that staff outside of hospitals are under-trained and often under-regulated, impacting the quality of healthcare services provided.

The onset of the COVID-19 pandemic compounded the HRH challenges the West Bank and Gaza. W4H technical and financial support was re-oriented to respond immediately to an intensified emergency landscape. The W4H project worked in close partnership with the Ministry of Health, conducted capacity building activities for health workers serving as frontline staff, also enabling investment in the primary healthcare (PHC) workforce and pre-service training quality through review of two essential training curricula for EMTs. Basic Life Support (BLS) Training was conducted among 1500 EMTs, nurses and doctors working in emergency rooms and COVID-19 Intensive Care Unit (ICU) wards in Hospitals and at the PHC level. In addition, selected staff (30 nurses and physicians) transitioned to BLS trainer roles. The BLS national curriculum as well as the BLS trainer's curriculum was developed and adopted in 2021.

With the aim to improve health worker occupational safety and health protection, the International Labour Organization (ILO), piloted a COVID-19 checklist for health facilities as well as conducted two HealthWISE<sup>11</sup> Trainings of Trainers in the West Bank and Gaza. The specific objectives include - building the capacity of participants to understand the HealthWISE approach; the application the COVID-19 checklist in health facilities to improve the protection of health workers during the pandemic and to build a network of trainers.

To some extent, other W4H programming continued e.g. strengthening health workforce planning. In particular, the Workload Indicators of Staffing Need (**WISN**) tool trainings was rolled out. As an initial step, a Steering Committee meeting was conducted, led by the Minister of Health to set priorities for WISN implementation. Further expert groups were also formed to support the implementation of WISN. Other strides include that there are attempts to capture data on unemployment and emigrations rates.

Overall, these measures are immediate and imperative steps to building and supporting a resilient health workforce amidst emergency responses. A key lesson learnt from programming in humanitarian responses is that funding must be flexible in order to be tailored to rapidly changing situations/ emergencies.

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<sup>11</sup> HealthWISE is a practical, participatory quality improvement tool for health facilities. The HealthWISE package consists of an Action Manual and a Trainers' Guide to combine action and learning. Topics include occupational safety and health, personnel management and environmental health.

## **West Bank and Gaza Strip – Investments in Nursing Education and Regulation**

Pakistan has a total population of approximately 223 million people, with a severely constrained health system characterized by low investments in human resources for health (HRH), high out-of-pocket expenditure, poor quality of services and an inequitable distribution of the health workforce.

At present, there is a severe shortage of health workers, specifically nurses in Pakistan. There is a skills imbalance of more physicians than nurses with a ratio of 1 to 0.5 against the recommended threshold of 1 to 3. To address these HRH challenges, it is estimated that Pakistan requires up to 900 000 nurses to be produced, absorbed and retained by 2030.

Since 2019, the Working for Health (W4H) programme provides support across different levels of the healthcare system (federal, provincial and district level). The W4H Programme supports the Ministry of National Health Services Regulations & Coordination (M/oNHSR&C) as well as provincial counterparts. Programmatic focus includes the implementation of Pakistan's universal health coverage (UHC) benefit packages through various health workforce strengthening initiatives, enhancing the institutional capacity, policy advice, technical assistance to M/oNHSR&C and building capacity of health workforce. The International Labour Organization (ILO) works together with several partners to roll-out three main activities, namely; a comparative assessment study on ILO Nursing Personnel Convention (No. 149) and working conditions of nursing personnel ; Gender Equality in Health (Women in Health Leadership) Study and implementing HealthWISE<sup>12</sup> in Pakistan health institutions. Pakistan's HRH priority areas include –

1. Enhanced health workforce production and retention
2. Improved nursing education and leadership capacities
3. Strengthen health workforce information systems and a health workforce observatory for nursing
4. Strengthened regulation of health workforce practice and education.

Interventions range from supporting the development of HRH Strategy for the Health Department Sindh and Balochistan; conducting national level assessments to strengthen nursing and midwifery; technical assistance to review the UHC Strategy on primary healthcare (PHC) for health workforce strategy development and through expert consultations supporting the District Health Information System (DHIS), Health Workforce Registry System.

There has been a significant focus on strengthening nursing education and regulation. The MoNHSRC, the Pakistan Nursing Council (PNC) and World Health Organization Pakistan developed a certificate nursing course to build capacity of nurse educators on teaching methodologies. The course was launched in October 2021 with a 10-day Training of Trainers. Through this course, 21 master trainers have been trained from all provinces and areas to build their capacities on an evidence-driven approach to teach undergraduate students as per the current requirement. The W4H Programme provided financial support for infrastructure and technology at a Nursing Institute, Turbat, Balochistan as well as in other underserved areas. Within the W4H Programme support, M/oNHSR&C developed the roadmap to strengthen the PNC. Further, implementation plan of nursing PC-1 was developed to guide the nursing and midwifery education sector.

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<sup>12</sup> HealthWISE is a practical, participatory quality improvement tool for health facilities. The HealthWISE package consists of an Action Manual and a Trainers' Guide to combine action and learning. Topics include occupational safety and health, personnel management and environmental health.

Previously, a Diploma in General Nursing was offered at the majority of public and private institutions, however the PNC phased this out and prioritized a Bachelor of Science in Nursing Education. Teaching Bachelors of Science in Nursing Education requires experts with the 'know how' of educational psychology, teaching and learning principles and methods, assessment, curriculum and leadership, professionalism, and educational ethos. However, there has not been any parallel capacity building for nurse educators, this poses a significant challenge to addressing the nursing shortfall the country faces.

# Rwanda’s multi-sectoral Health Labour Market Analysis attracts investments

## KEY MESSAGES

- Rwanda’s Vision 2050 and the Fourth Health Sector Strategic Plan (HSSP4) have increased skilled health workers (physicians, nurses and midwives) to population density by more than 60% over a 10-year period (2005-2015).
- The skewed geographic distribution, availability, and under-employment of the health workforce, including a 6.6% unemployment rate among the nurses and midwives and a 46% unemployment rate for Allied Health Professionals, continues to impact on the healthcare system.
- Adapting and applying a Health Labour Market Analysis (HLMA) has helped to inform policy actions, decisions, and investments for strengthening the health workforce.
- In 2020, informed by the findings of the HLMA, the implementation of health workforce reforms have been supported under the World Bank Human Capital Development Program Financing (DPF) which provides budget support to the government.
- So far, the two main actions introduced under the health workforce priority area of the World Bank DPF program are (1) increase the number of positions and staffing arrangements in health facilities within 5 years, and (2) credentialing of health professionals to ensure the qualification requirements of staff working in health facilities. The World Bank is currently negotiating an additional Human Resources for Health (HRH) measure with the Ministry of Health to facilitate the recruitment process of health professionals.

## 1.0 BACKGROUND

### RWANDA’S HUMAN RESOURCES FOR HEALTH (HRH) POLICY LANDSCAPE

Rwanda has a total population of approximately 12 million people, a high life expectancy of (69.1 years) and a Gross Domestic Product (GDP) of US\$ 9.14 billion, the country is one of the fastest growing economies in the world (NHWA, 2022: Rwanda Ministry of Health, 2019). Rwanda’s Vision 2050 sets out health related targets aligned to universal health coverage (UHC) and the Sustainable Development Goals (SDGs). Efforts centred on the seven-year National Strategy for the Transformation, Rwanda’s Vision 2050 and the Fourth Health Sector Strategic Plan (HSSP4) have resulted in significantly increasing skilled health workers (physicians, nurses and midwives) to population density by more than 60% within a 10-year period (Rwanda Ministry of Health, 2019). This increase translates from 0.48 personnel per 1,000 population in 2005 to 0.79 personnel per 1,000 population by 2015 in Rwanda (Rwanda Ministry of Health, 2019).

### OVERVIEW OF THE HEALTHCARE SYSTEM AND SPECIFIC HUMAN RESOURCES FOR HEALTH TARGETS

The Rwanda healthcare system is structured according to a central level (national referral and teaching hospitals), intermediary level (provincial referral hospitals) and primary level (district hospitals, health centres and health posts). According to the Ministry of Health (MOH), Master Facility List (MFL) there are 1,248 health facilities, (53%) are publicly owned and 30% are private health facilities. The remaining 17% of facilities are faith-based but co-owned with Government. Most facilities are concentrated at the primary healthcare (PHC) level, 40.5% of health centres and 33.8% are health posts (Rwanda Ministry of Health, 2019). The HSSP4 health workforce targets are –

Table 1: Rwanda’s Fourth Health Sector Strategic Plan (HSSP4) Health Workforce Targets 2016 -2024

Inputs/ process indicators	Baseline 2016	Targets 2020 (mid-term)	Targets 2024
Doctor/ population ratio (General Practitioner & Specialists)	1/10 055	1/ 9 000	1/ 7 000
Nurse/ population ratio	1/ 1094	1/ 900	1/800
Midwife/ pop ratio (women aged 15-49 years)	1/4 064	1/3 500	1/2 500
Pharmacist/ population ratio	1/ 16 871	1/16 000	1/15 500
Laboratory technician/ population ratio	1/ 10 500	1/ 9 000	1/ 7500
Doctor attrition rate	NA	>10%	>5%

## **2.0 WORKING FOR HEALTH SUPPORT TO**

### **RWANDA**

The World Health Organization (WHO) Global Strategy on Human Resources for Health: Workforce 2030 (GSHRH) prioritises the Health Labour Market Analysis (HLMA) to enable countries to quantify health workforce needs, demands and supply, and to inform effective HRH policies, strategies, planning, and implementation. Under the guidance of a MOH-led HRH technical working group, a HLMA survey was conducted, including a comprehensive HRH situation analysis, as part of process to develop and cost a new HRH Strategic Plan. In support of this, the joint ILO-OECD-WHO Working for Health Programme (W4H) facilitated the application of the HLMA, and the utilization of data and National Health Workforce Accounts (NHWA) for evidence-based policy, planning and decision making.

Since 2019, the W4H Programme has provided country-level support to Rwanda, to strengthen collaboration and coordination across sectors, government agencies and partners to address the health workforce shortfall through a roadmap to improve workforce planning capacity, capability and increase investment and resource mobilisation for skills development, job creation and employment opportunities for women (Working for Health Annual Report, 2019). The W4H programme's catalytic funding contributed towards the MoH-led development of the 10-Year Government Programme: National Strategy for Health Professions Development 2020–2030, as well as contributed to the establishment of a multisectoral technical HRH secretariat within the MoH to coordinate, guide and support its implementation.

### **IMPORTANCE OF A HEALTH LABOUR MARKET ANALYSIS**

It is essential to achieve a better understanding of the forces that drive health worker shortages and surpluses, skills mix and geographical imbalances, and suboptimal performance, and to develop effective policies to address these issues. A well conducted HLMA across all sectors of the market (public and private) provides reliable information on the main dimensions of the performance of the health workforce, for example, its availability, accessibility, acceptability, and quality (*WHO, 2021*)

### **IMPLEMENTING THE HLMA IN RWANDA**

There is a mix of HRH progress e.g., increased production of health workers and persistent health workforce challenges in Rwanda. Health workforce issues in Rwanda include skewed intra and inter-provincial distribution, unemployment rates e.g. 46% among Allied Health Professionals and training institutions with inadequate infrastructure. The main objective of the HLMA is to generate evidence that supports key policy decisions to improve health workforce availability, distribution, and efficient use, with a view to enable Rwanda to achieve its health sector and broader development targets.

The HLMA report was a collaborative effort between the Ministry of Health stakeholders - higher learning institutions, professional councils, the private sector, health facilities and relevant development partners. The HLMA in Rwanda is based on analysis of several data sources including, a desk review, qualitative data (key informant interviews and focus group discussions), several policy documents, reports and peer-reviewed articles. Two types of analysis were carried out, descriptive analysis (examine the size, composition, distribution, and trend of the health workforce) and a supply and demand analysis (health workforce supply forecast, forecasting need-based requirements for health workers and forecasting economic demand for health work.



### 3.0 RWANDA HLMA (2019): FINDINGS & RECOMMENDATIONS

<b>Health workforce situation analysis</b>
<p><b>What is the composition of the health workforce?</b></p> <p>The health workforce is comprised of 2.3% of medical specialists, 70% of the health workforce was composed of nurses and midwives. The density of doctors, nurses and midwives per 1,000 population is estimated to be 1.01, translating to a 108% increase since the year 2005.</p>
<p><b>What are the disparities in age and gender in the health workforce?</b></p> <p>The majority of General Practitioners (GPs) were between the ages 25 and 34 years (58%) and 43% of medical specialists were between the ages 35 and 44. In terms of the gender distribution of doctors, between 2013 and 2018, about 19% of doctors were females as compared with 81% males.</p>
<p><b>How is the health workforce distributed in public and private sectors as well as across and within provinces?</b></p> <p>Sixty-five percent of the health personnel worked in the public sector, 20% in the private-for-profit and 15% in the private-not-for-profit sector. Approximately 50% of medical specialists were employed in the private-for-profit sector with only 47% working with the public sector. Seventy-seven percent of pharmacists work in the private sector.</p> <p>Workforce distribution is skewed geographically between-provinces and within-provinces. Thirty-six percent of GPs are based in Kigali province, whereas only 12% are based in the Northern province. The distribution of medical specialists presents huge disparities across districts, in Gatsibo, Nyagatare, Gicumbi, Rutsiro and Nyamagabe, there are no medical specialists compared to Gasabo (41%) and Nyarugenge (20%).</p>
<p><b>What is the production capacity i.e., education outputs and training?</b></p> <p>The main public training institution in Rwanda underwent a series of policy reforms that lead to changes in its internal structures. Between 2010 and 2013, the country produced about 4,290 health workers across various categories. There are persistent gaps around infrastructure and high lecturer-to-student ratios which could compromise the quality to teaching and learning.</p>
<p><b>What are the unemployment rates among health workers?</b></p> <p>There was a 6.6% unemployment rate recorded among the nurses and midwives. The unemployment rate for Allied Health Professionals is the highest across all the staff categories with an average of 46%. The unemployment rate reflects a mismatch between the supply of health workers and the actual demand for health workers.</p>
<p><b>How is the health workforce financed i.e., domestic versus international financing?</b></p> <p>The public sector wage bill grew by 16% between 2013/14 to 2014/15. Close to 56% of the public health sector remuneration was domestically funded, the remaining 44% is funded through bilateral and multilateral support.</p>
<p><b>What are the trends in international migration of the health workforce?</b></p> <p>Rwanda is considered to be a net gainer of health worker migration in the East African region. Medical specialists who graduated from the University of Rwanda between 2000 and 2016, show that cumulatively about 22% left the country. By 2014, 33% of doctors are non-Rwandan nationals while only 1.7% of nurses are non-Rwandan nationals. The proportion of non-Rwandan doctors higher in rural districts.</p>
<b>Health labour market scenario/ projection</b>
<p><b>What gaps need to be addressed to reach the HSSP4 targets?</b></p> <p>Overall, the analysis shows that there is a structural shortage of the health workforce because the expected level of production is and will be inadequate to cater for the projected level of needs. In terms of the density of doctors, nurses and midwives per 1,000 population, the HSSP 4 target would yield 1.79 per 1,000 population in 2018 and 2.09 per 1,000 population by 2024 (the year when the HSSP 4 is due to be revised). When simulated up to 2030, the HSSP 4 target yields doctors, nurses and midwives' density of 2.37 per 1000 population which only meets the threshold used by the WHO for need-based estimates during the millennium development goal (MDG) era but falls short of the 4.45 per 1,000 population threshold used GSHRH.</p>
<b>HLMA recommendations informing key workforce policy actions and investment decisions for the Rwanda health system</b>

- Develop an investment case to advocate for increased domestic investment in health workforce towards the attainment of financial sustainability for HRH.
- Scale-up the training of health workers in short supply (as shown in the projections) to be able to respond to the epidemiological and demographical transition of the country.
- Address the unemployment rate of health workers (6%) with specific attention to the 46% unemployment among Allied Health Professionals. Recognise, employ and deploy health professionals who have been trained but are not on the Government approved structures (public and private).
- Improve private health sector engagement to invest in both production and recruitment of HRH.

### 3.0 RWANDA’S HLMA 2019- FURTHER IMPACT

#### ATTRACTING INVESTMENT, STRENGTHENING THE HEALTH WORKFORCE & THE RWANDAN HEALTHCARE SYSTEM

The utilization of the HLMA spans quite widely and is already showing signs of strengthening political momentum, attracting investments to address health workforce gaps, and leading to action which ultimately brings the potential of strengthening healthcare systems and UHC in Rwanda. The HLMA points out, current and projected potential labour failures which guides stakeholder prioritization and investment. In addition, the HLMA provides evidence for policy dialogue, policy development and implementation.

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

#### Health workforce specific reforms supported under the World Bank Loan to Rwanda

##### Development Program Financing (DPF) 1: Increase the number of positions and staffing arrangements within health facilities

On September 1, 2020, the Prime Minister’s Instructions 001/03 was issued with the support of the DPF1 to regulate an increase in the number of positions and staffing arrangements within health facilities over five years. In early 2020 (March- June), the Ministry of Health reported a minor net increase of 67 physicians, 60 nurses and 13 midwives, as fiscal pressure slowed down hiring during the COVID-19 pandemic. In July 2021, the Ministry of Health prioritized the hiring of new staff in health facilities to meet the staffing norms as outlined in the Prime Minister’s Instructions and approved implementation plan.

##### DPF2: Credentialing of health professionals to ensure the qualification requirements of staff working in health facilities

DPF2 supports the issuance of Ministerial Instructions No. 20/7018 on credentialing and privileging of health professionals to ensure the qualification requirements of staff working in health facilities. Following international best practice, these requirements go beyond the common licensing and registration of health professionals. Credentialing defines the verification process for health facilities to follow to ensure that health professionals have the required educational and professional qualifications for the position applied for (including license, registration with professional society, previous employer references, malpractice history etc.). Privileging defines the process of authorizing a physician’s specific scope of patient care based on their clinical experience.

##### DPF3: Strengthening health workforce data

Building on the reforms supported under DPF1 and DPF2, DPF3 will aim to improve transparency through quality health workforce data. The DPF3 supports reforms to improve transparency for the government and health facilities with the support of a central MOH human resource (HR) database and an online jobs portal for health professionals.

### 4.0 LESSONS LEARNT

Conducting a national HLMA helps facilitate an evidence-based understanding of health labour market dynamics and take action to address systemic health workforce challenges.

HLMA should be an integral part of national policy and planning processes for strengthening healthcare systems to achieve UHC – and be a key element for building existing workforce governance and leadership, capacity.

The HLMA is a powerful tool to engage stakeholders and to garner multisectoral support for the health workforce agenda. The HLMA in Rwanda supported the development of several health workforce policies/ strategic documents e.g., HRH Roadmap/ MoH-led development of the 10–Year Government Programme: National Strategy for Health Professions Development 2020–2030. The HLMA generates essential evidence to inform decision-making, planning and interventions on the health workforce. Importantly, to provide relevant information for development partners such as the World Bank Human Capital DPF budget support, which includes a focus on creating quality jobs for the health workforce.

Furthermore, studies conducted by the World Bank on the future of medical work in Lesotho have benefited from the HLMA conducted by the WHO in Lesotho (World Bank, 2022).

It is recommended that advocacy to ensure implementation of the HLMA recommendations is prioritized, through the communication, dissemination, and uptake of the HLMA findings and results.

## **5.0 FURTHER/ RECOMMENDED READINGS**

Health labour market analysis guidebook. Geneva: World Health Organization; 2021. Licence: CC BY-NC-SA 3.0 IGO.

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### **Acknowledgments**

This case-study is drafted based on documents/ information provided by the World Health Organization, World Bank and the Working for Health Programme.

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Referral Hospitals, Provincial Hospitals, District Hospitals, Specialised Hospitals, Medicalised Health Centres and Health Centres published in Official Gazette n° Special of 01/09/2020.

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Working for Health Multi-Partner Trust Fund, Annual Report 2020.

**III. Other Assessments or Evaluations (if applicable)**

- Report on any assessments, evaluations or studies undertaken.

**IV. Programmatic Revisions (if applicable)**

- Indicate any major adjustments in strategies, targets or key outcomes and outputs that took place.

**V. Resources (Optional)**

- Provide any information on financial management, procurement and human resources.
- Indicate if the Programme mobilized any additional resources or interventions from other partners.