Working for Health Multi-Partner Trust Fund
Annual report 2020

Accelerated progress towards UHC and SDGs through a transformed health workforce

United Nations MPTF Office

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BETTER POLICIES FOR BETTER LIVES

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Abbreviations

ECOWAS	Economic Community of West African States
EMT	emergency medical technician
HIS	health information system
HLMA	health and labour market analysis
HRH	Human Resources for Health (strategy)
HWF	health workforce
IADEx	Inter-Agency Data Exchange
ILO	International Labour Organization
IPC	infection prevention and control
IPUMS	Integrated Public Use Microdata Series
LFS	Labour Force Surveys
MOU	memorandum of understanding
MPTF	Multi-Partner Trust Fund
NHWA	national health workforce account
OECD	Organisation for Economic Co-operation and Development
OSH	occupational safety and health
PN4P	private not for profit
PPE	personal protective equipment
P4P	private for profit
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

Definitions

Allocation: Amount approved by the Steering Committee for a project/programme.

Approved project/programme: A project/programme, including budget, etc., approved by the Steering Committee for fund allocation purposes.

Contributor commitment: Amount(s) committed by a donor to a fund in a signed standard administrative arrangement (SAA) with the United Nations Development Programme Multi-Partner Trust Fund Office (MPTF Office), in its capacity as the administrative agent. A commitment may be paid or pending payment.

Contributor deposit: Cash deposit received by the MPTF Office for the fund from a contributor in accordance with a signed SAA.

Delivery rate: The percentage of funds that have been utilized, calculated by comparing expenditures reported by a participating organization against the "net funded amount".

Indirect support costs: A general cost that cannot be directly related to any particular programme or activity of the participating organizations. United Nations Development Group (UNDG) policy establishes a fixed indirect cost rate of 7% of programmable costs.

Net funded amount: Amount transferred to a participating organization less any refunds transferred back to the MPTF Office by a participating organization.

Participating organization: A UN organization or other intergovernmental organization that is an implementing partner in a fund, as represented by signing a memorandum of understanding (MOU) with the MPTF Office for a particular fund.

Project expenditure: The sum of expenses and/or expenditure reported by all participating organizations for a fund irrespective of which basis of accounting each participating organization follows for donor reporting.

Project financial closure: A project or programme is considered financially closed when all financial obligations of an operationally completed project or programme have been settled, and no further financial charges may be incurred.

Project operational closure: A project or programme is considered operationally closed when all programmatic activities for which participating organization(s) received funding have been completed.

Project start date: Date of transfer of first instalment from the MPTF Office to the participating organization.

Total approved budget: This represents the cumulative amount of allocations approved by the Steering Committee.

US dollar amount: The financial data in the report are recorded in US dollars (US$); due to rounding off of numbers the totals may not add up.

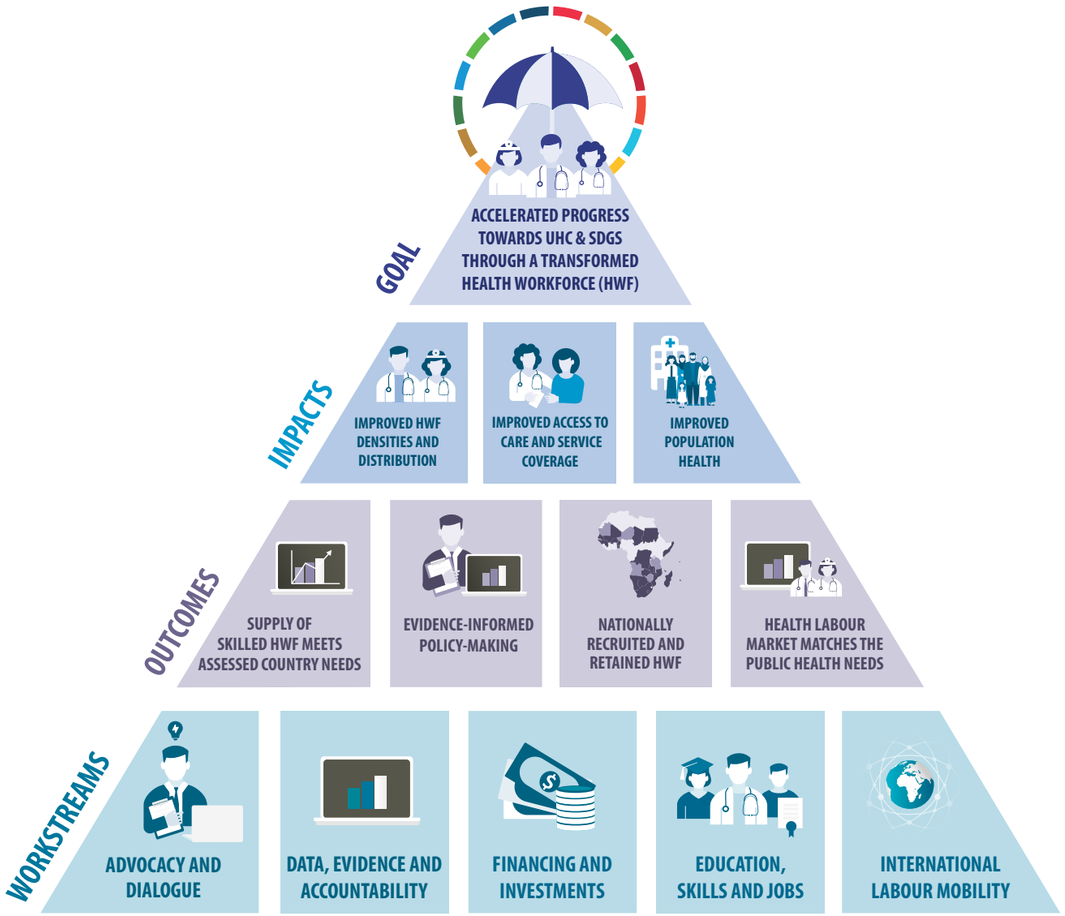


Figure 1 – Working for Health Programme vision and mission

Executive summary

The joint International Labour Organization (ILO), Organisation for Economic Co-operation and Development (OECD) and World Health Organization (WHO) Working for Health (W4H) Programme was established in 2017 to operationalize the 5–Year Action Plan (2017–2021) for Health Employment and Inclusive Economic Growth, adopted by the World Health Assembly, and welcomed by the ILO Governing Bodies, and the OECD Health Committee.

Since its initiation, 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. This report summarizes the operational activities, results, achievements, challenges and lessons learned through its interventions, technical assistance and policy advice at country, regional and global levels for the second annual reporting period of the programme's Multi-Partner Trust Fund (MPTF): January to December 2020.

In 2020, W4H expanded its operations in 10 countries and areas (Benin, Chad, Guinea, Mali, Mauritania, Niger, Rwanda, South Africa, occupied Palestinian territory, including east Jerusalem, hereinafter referred to as "occupied Palestinian territory"); continued to work in two regional economic areas (Southern African Development Community [SADC] and West African Economic and Monetary Union [WAEMU]; and supported development of two global goods (International Platform on Health Worker Mobility and Inter-Agency Data Exchange [IADEx]).

The COVID-19 pandemic has impacted the implementation of the W4H-supported activities, and the programme has responded accordingly. Many of the W4H-supported countries applied lockdown measures for extended periods throughout 2020, resulting in several planned activities being cancelled or delayed. These cancellations or delays were mainly due to countries repurposing and prioritizing for COVID-19 response and preparedness efforts, and the temporary reassignment of core counterpart staff. Responding to this, the W4H Programme has incorporated a series of reprogramming requests from supported countries,[1] which demonstrates the high value and effectiveness of applying catalytic flexible funding and technical assistance where it is most needed, and to address immediate country-defined priorities.

While the impact of the pandemic caused unanticipated delays in implementation and expenditure over the reporting period, January, to December 2020, the rate of implementation significantly increased towards the end of the year, and the rate of implementation at the time of reporting is approximately 54%, as of April 2021.

[1] Due to the impact of COVID-19, delays and disruptions to project implementation were experienced during the majority of the period up to 31 December 2020. However, in the following period to April 2021 implementation has rapidly scaled up to just above 50%; and this will be reflected in the third consolidated annual narrative and financial report in 2022.

The W4H MPTF key achievements for 2020

- **Country and area impact:** Facilitated multisectoral policy engagement; evidence-based planning and decisions; guidance on investment choices to expand education, skills and jobs; and the building of core capabilities for robust health system strengthening in 10 supported countries.

- **Regional integration:** Enabled the development of harmonized workforce strategies and investment plans in two regional socioeconomic cooperation and integration organizations in West Africa (WAEMU) and Southern Africa (SADC). WAEMU countries have committed to creating 40 000 new jobs by 2022; a 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 advances knowledge and cooperation on health worker mobility through the 10-year review of the WHO Global Code's relevance and effectiveness. Furthermore, the Inter-Agency Data Exchange (IADEx) consolidates workforce data and information exchange between partner organizations of 193 countries through national health workforce accounts (NHWAs).

The COVID-19 pandemic has had a devastating impact on public health, livelihoods, employment, economies and communities. The limitations of persistent underinvestment in health systems, workforce and core public health functions have been magnified. Essential health services have been disrupted in over 90% of countries,[1] and our already overstretched HWF has been pushed to its limits. As of May 2021, it has been reported that about 2.02 million health and care workers have been infected in the past year.[2] Health and care workers experience burnout, stress, anxiety, insomnia, depression and are coping with a lack of personal protective equipment (PPE). The pandemic hit when the HWF landscape lacks investments in the essential policies and practices needed to curb the pandemic's adverse effects: the shortfall of HWF globally, with the most critical shortages in 47 countries;[3] skill-mix imbalances; geographical maldistribution; lack of decent working conditions; and challenges with retention, gender inequity and discrimination, and migration. Furthermore, challenges remain, maximizing the utilization of the current HWF to deliver a high standard of care while maintaining an enabling environment, despite amendments and advances in HWF regulation in more than 70 countries.

W4H programme outcomes

The W4H Programme develops catalytic global public health goods and provides policy advice, direct technical assistance and capacity strengthening support to Member States. At regional and country and area level, the programme supported intersectoral collaboration, action and capacity-building efforts. These efforts enabled the development, financing and implementation of multisectoral workforce policies, strategies and plans while enhancing institutional capacity and analytics to achieve the following expected 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 this programme are outlined in the W4H results matrix, including detailed indicators and targets (see the results matrix in Annex 1).

[1] https://www.who.int/publications/i/item/WHO-2019-nCoV-EHS-continuity-survey-2021.1
[2] https://covid19.who.int/
[3] https://cdn.who.int/media/docs/default-source/health-workforce/hwf-support-and-safeguards-list8jan.pdf?sfvrsn=1a16bc6f_10

Key highlights

Countries and areas level

South Africa

The programme continued technical and catalytic funding support towards the development and endorsement of the national Human Resources for Health (HRH) Strategy (2030 Human Resources for Health Strategy: Investing in the Health Workforce for Universal Health Coverage) and the HRH Strategic Plan 2020/21–2024/25 and the National Strategic Direction for Nursing and Midwifery Education and Practice: Roadmap for Strengthening Nursing and Midwifery in South Africa (2020/21–2024/25).

Detailed work on the costing and financing for implementing the national HRH strategy and preparing an investment case for submission to the National Treasury is ongoing. Building on these two strategies, the Presidential Employment Stimulus Programme created 5531 new nurse jobs in the public sector in 2020 by bridging 1045 enrolled nurses, 1236 auxiliary nurses and 3205 community health workers and outreach team leaders from training into employment.[1] This is in follow-up to the 2018 Presidential Jobs Summit that agreed a target of 275 000 new jobs annually, including jobs within the health and care economy. Similarly, the finalization of these two strategic documents contributed towards the roll-out of the Presidential Health Compact 2019,[2] specifically pillar 1 on "augmenting human resources for health".

Guinea

The W4H Programme continues to strongly support the Rural Pipeline Programme, which was adopted in 2019 by the government. This programme is one of the mechanisms to accelerate development at local level by ensuring that youth and women have access to training and employment in the health, education and agriculture sectors in the locality where they live. In 2019, the training and employment needs of youth and women were assessed. Curricula were developed for the community health schools. A new category of health workers has been created – community health workers – who follow a 2–year training programme deployed in the rural health facilities. The Rural Pipeline Programme has been integrated into the local development plans of 20 convergence municipalities. The HealthWISE approach has been used to strengthen the providers' work environment (security and safety environment) in the health centres that will receive the community health workers for their internship.

Rwanda

Building on the previous reporting period, and following completion of the health and labour market analysis (HLMA) in 2019, the Ministry of Health embarked on a comprehensive HRH situation analysis and initiated the development and costing of the new HRH roadmap and 2–year implementation plan, under the guidance of a Ministry of Health-led HRH technical working group. Despite delays in this process as a result of the COVID-19 response, the programme's catalytic funding contributed towards the Ministry of Health-led development of the 10–Year Government Programme: National Strategy for Health Professions Development 2020–2030, as well as the establishment of a multisectoral technical HRH secretariat within the Ministry of Health to coordinate, guide and support its implementation. The 17th National Leadership Retreat (16–19 February 2020), resolved to shift the mandate of health professional education from the Ministry of Education to the Ministry of Health to harmonize the HRH production with the need, and also to harness health sector perspectives to improve the quality of education and synergize efforts in health professional development.

1 http://www.thepresidency.gov.za/download/file/fid/1910
2 http://www.thepresidency.gov.za/download/file/fid/1650

Niger

Within the framework of "Niger's Renaissance Programme", the government is working to implement essential reforms. These reforms are reflected in Niger's Economic and Social Development Plan. These reforms aim to "strengthen the resilience of the economic and social development system" and achieve the SDGs. In this context, a National Action Plan for investment in health and social sector jobs for economic growth in Niger was adopted by presidential decree. The government has been supported in this process, by WHO and ILO. While the revitalization of primary health care and the achievement of UHC require 4.5 health workers per 1000 inhabitants, Niger has only 0.3 health workers per 1000 inhabitants, which is 8 to 15 times lower than expected thresholds. The National Action Plan interventions aim to significantly improve the availability, accessibility and quality of health personnel while acting effectively on the other pillars of the health system, within a framework of person-centred health care and services. The W4H Programme supported the Rural Pipeline Programme through a foundational baseline survey studying the impact indicators, and stakeholders' expectations to determine the value chain of decent jobs for women and youth and develop mechanisms for effective and efficient implementation. Furthermore, the W4H Programme supported the establishment of a resource-mobilization roundtable event.

Benin

The health reforms undertaken since 2016, with contributions from WHO and other development partners, have helped improve HRH. Indeed, the number of health care workers recruited since 2018 has increased from 12 003 to 14 670 (an increase of 16%). The country has been able to improve the production, recruitment and retention of health workers. The ongoing health reforms propose the recruitment of 20 946 health workers up until 2025 (1727 medical staff, 13 821 paramedics, 5398 administrative and logistics personnel). Various measures have been taken during the last 3 years to better regulate the HWF, such as the elimination of dual practice, performance-based incentives and accountability measures. The W4H Programme supported the development of the NHWA, Workload Indicators of Staffing Needs (WISN) verification and a HWF investment plan. That facilitated the recruitment of 331 health workforce (78 medical doctors, 228 paramedics, 25 administrative staff). In addition, catalytic support enabled health facilities to recruit 1701 health workers (67 medical doctors, 1159 paramedics, 475 administrative staff).

Chad

One of the Government of Chad's objectives is "to move a large segment of the population from the status of 'vulnerable people' to that of 'real development actors'". Thus, the government has decided to prioritize policies and development strategies, particularly UHC, which emphasize access to health care for the most vulnerable populations. In 2020, W4H funds made it possible to develop models of care at the primary level and analyse the skills needed to implement these models. The human resources information system has been strengthened to better monitor the availability, recruitment and distribution of the health workers needed to implement the UHC strategy. As part of the joint WHO-ILO inception mission in February 2020, technical discussions contributed to the capacity building of stakeholders engaged in the development of a social health protection strategy for UHC.

Mali

Within the W4H Programme support to establish the National Health Workforce Investment Plan, a situational analysis was carried out, with a special focus on both the human resources development policy as well as the National Strategic Plan for Human Resources for Health Development (2019–2023). The finalization of the investment plan will take into account the logical framework and the situation analysis already available. The "human resources thematic group", created under the Programme de développement socio-sanitaire, will serve as a resource mobilization catalyst for the implementation of the national investment plan. The programme also aims to improve employment and working conditions in the health and social sector. To initiate the process, workshops were organized in four regions to finalize preparations for the national plan. The development of national recruitment, training, career and motivation plans stemming from the National Strategic Plan for Human Resources for Health Development (2019–2023) is a key intermediate step for improving employment and working conditions in the health and social sector.

Mauritania

The W4H Programme supported the establishment of a multisectoral platform promoting coordination and collaboration regarding youth and women's employment. This platform played a key role in the execution and validation of the HLMA completed in November 2020. The HLMA identified critical issues, led to concrete decisions, and provided a solid basis for developing the National Health Workforce Development Plan of Mauritania. In particular, the health labour market absorption capacity remains relatively low. The HLMA highlighted the paradox that while Mauritania suffers from critical health workforce shortages, around 3000 paramedics are unemployed. Unemployment affects young people who have completed paramedic education in particular. As a result of the HLMA, measures to facilitate the participation of youth and women in the health labour market included: 1) a target of recruiting 600 additional health workers; 2) an increase in financial benefits to improve attraction and retention in remote and rural regions; and 3) a target of recruiting approximately 60 additional teaching staff.

Sudan

The catalytic role of the W4H Programme facilitated the development of the National Human Resources for Health Strategic Framework 2030 to guide the country towards attaining UHC and the SDG agenda. The programme also supports the Ministry of Health and other HRH stakeholders and partners to strengthen Sudan's HRH Observatory and strengthen HWF information and the NHWA based on an assessment and improvement plan. In Sudan, W4H supported the establishment of the Nursing and Midwifery Coordination Council. The programme also supported the development of several curricula review exercises to improve the content and quality of the training programmes to respond to health system needs, focusing on family medicine, nursing, midwifery and paediatric medicine as a first phase.

occupied Palestinian territory

In support of local plans to build the capacity of the Ambulance and Emergency and Disaster Management Unit, a review of international standards for licensing and re-licensing of paramedics, advanced emergency responders and basic emergency responders was undertaken. A total of 800 emergency medical technicians (EMTs), and 100 nurses and doctors working in emergency rooms and COVID-19 intensive care unit wards were trained in basic/advanced life support. Additionally, in the context of increasing the effectiveness and efficiency of inspection operations in OPT, a virtual training on HealthWISE (a practical tool to assess and improve workplaces in health services) was conducted for labour inspectors.

Regional level

Southern African Development Community (SADC)

The W4H Programme facilitated the development, and endorsement by SADC Health Ministers, of the new SADC Health Workforce Strategic Plan (2020–2030): Investing in Skills and Job Creation for Health; and additionally, the decision to establish a HWF investment forum, led by the SADC Health Secretariat. Furthermore, a detailed and costed strategy under development estimates that the SADC region is on course to meet 66% of its aggregate health and care worker needs by 2030. Based on minimum UHC requirements, the strategy estimates that the SADC region collectively required at least 1.6 million doctors, nurses and midwives by 2020, which will increase to at least 2 million by 2030. Adapting to the pandemic context, the African Union Development Agency and ILO established an Expert Advisory Group to develop a series of guidelines to facilitate webinars on occupational safety and health (OSH) and COVID-19 with a focus on the health sector, delivering 12 online courses, with more than 1000 individuals participating from all 55 Member States. A further review of the HRH requirements may be needed in 2 years' time to reflect the impact of COVID-19, which cannot be fully estimated at this time.

West African Economic and Monetary Union (WAEMU)

As a result of the COVID-19 crisis, the planned subregional WAEMU/Economic Community of West African States (ECOWAS) meeting aimed at sharing experiences from WAEMU subregional and country health workforce investments plans, and obtaining consensus to extend a similar approach to ECOWAS countries, was postponed. In consultation with national stakeholders, the time was used instead for preparing background papers to inform a future meeting and, based on country priorities, focus on research on the impacts of COVID-19 on the HWF in select countries and review the policy responses implemented to address the challenges. A standard methodology was undertaken in all eight WAEMU countries and four ECOWAS countries (Ghana, Guinea, Liberia and Nigeria). Country case studies have been completed highlighting the diverse situation across the region and the fact that policy responses vary significantly from country to country. The results and lessons learned will be presented and discussed at a subregional workshop. These studies are well aligned with the recommendation 6 of the W4H action plan "Ensure investment in the International Health Regulations (2005) core capacities and ensure the protection and security of all health workers and health facilities in all settings", as this is one area of investments of the UEMOA and countries health workforce investment plans. In addition, for a selection of countries, a broader review of the subregional WAEMU and country health workforce investments plans will still be undertaken.

Global level

International Platform on Health Workforce Mobility

2020 has been an incredibly challenging year 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. The work carried out as part of the "mobility platform" has been geared towards improving the evidence base to inform 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 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 national policy dialogue and development 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. In the meantime, background work has been ongoing to ensure the timely delivery of other milestone outputs in 2021.

Inter-Agency Data Exchange (IADEx)

The IADEx mechanism aims at consolidating and maximizing the value of existing HWF data and information, ensuring greater consistency and synergies as well as reducing the data collection burden on countries. In early 2020, a meeting was hosted by OECD and attended by WHO, Eurostat and ILO to review the availability and comparability of data on graduates from health education programmes as a key variable to address workforce shortages. The main purpose of the meeting was to compare the aim, scope, methodology and results from the following international data collections on graduates from health education programmes, with a view to improve the availability and comparability of data across countries:

- OECD/Eurostat/WHO Europe joint questionnaire on non-monetary health care statistics (covering 62 OECD and European countries);
- United Nations Educational, Scientific and Cultural Organization (UNESCO)/OECD/Eurostat (UOE) joint collection of education statistics, and;
- NHWA graduates data reported by focal points in selected countries.

Another important joint activity is the second round of the joint analysis of Labour Force Surveys (LFS) using microdata available from ILO to assess the availability and comparability of data on health workers in general and some specific occupational groups (e.g. physicians, nurses and midwives, and personal care workers) across 60 countries worldwide. The key findings were summarized in a descriptive statistical report. A set of country profile sheets complements the report to provide more context-specific detailed data for all countries. Such country profiles will be available for more than 50 countries.

Results

This second annual report presents the activities undertaken in the 12 months spanning from January to December 2020.

In December 2020, the W4H Secretariat finalized further inputs to the results matrix to enhance the results-orientated reporting to the MPTF. The Secretariat will continue to report against the results matrix in the next reporting period. The full results can be found in the results matrix (Annex 1).

Health workforce strategies improved at country and area level through a multisectoral approach

South Africa

1. Provided technical and catalytic funding support to develop and finalize the endorsed 2030 National Human Resources for Health Strategy and its 5-year HRH Strategic Plan (2020/21–2024/25)

2. Provided technical and catalytic funding support to develop and finalize the endorsed National Strategic Direction for Nursing and Midwifery Education and Practice: Roadmap for Strengthening Nursing and Midwifery in South Africa (2020/21–2024/25).

3. Reprogrammed technical and 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.

4. Supported the establishment of the tripartite technical working group comprised of Eastern Cape Department of Health, Department of Employment and Labour, and Organized Labour (unions organizing in the health sector), which coordinates all work related to COVID-19, OHS and human immunodeficiency virus/tuberculosis in the workplace.

5. Provided technical guidance and support to the Eastern Cape Department of Health on OSH and COVID-19.

6. Developed a tool to conduct assessments and situation analysis with support and guidance from the ILO, building on existing tools (COVID-19 and health facilities – checklist of measures to be taken in health facilities; WHO-ILO interim guidance on COVID-19: occupational health and safety for health workers; HealthWISE action and learning package). The tool was used to conduct the assessments at three selected health facilities in the Eastern Cape. The results were used to advise the province to develop a work plan for improving health worker protection.

Guinea

1. Trained 66 staff from health facilities with the HealthWISE approach.

2. Organized a capacity-building training for 250 district executives and health workers to improve the quality of services and the working environment using the HealthWISE approach in the health services of five communes in the Labé region.

3. Validated the HRH development policy with the participation of the HWF stakeholders.

Rwanda

1. Reprogrammed COVID-19 response catalytic funding towards the Ministry of Health-led development of the 10-Year Government Programme: National Strategy for Health Professions Development 2020-2030.

2. Established a multisectoral technical HRH secretariat within the Ministry of Health to coordinate, guide and support implementation of the national strategy.

3. Supported priority basic and emergency training for medical officers as part of national COVID-19 response efforts and in line with the revised HRH roadmap.

Niger

1. Supported the employment capacity baseline study in three provinces to implement the Rural Pipeline Programme. The study protocol, tools and plan have been developed (data collection and analysis to be resumed in the second quarter of 2021).

2. Supported the organization of and resource mobilization for a roundtable meeting to implement the National Action Plan and Rural Pipeline Programme. Background concept notes, situation analysis and evaluation were developed and translated. The event has been rescheduled due to the pandemic and national presidential elections to the second quarter of 2021.

Benin

1. Supported the development of the 2019 Annual Health Statistical Report.

2. Supported the upgrade of the nursing and midwifery training curricula.

3. Supported the development of the NHWA.

4. Supported the development of the HWF investment plan – a preliminary investment allocated to fund three HWF projects. The investment plan aims to increase production capacity in Benin, through systematic recruitment of new graduates for 2 years and retention schemes for health workers already recruited.

5. Organized initial consultations with stakeholders to identify the priorities of the HWF investment plan – focusing on rural and underserved areas with a view of creating employment for women and youth.

6. Advocated for the mobilization of the partners in the development and implementation of the HWF investment plan, resulting in a World Bank-funded project to recruit 2384 new graduate doctors, nurses and midwives for a 2-year duration in health facilities.

Chad

1. Provided catalytic and technical support for the development of primary health care models of care to implement the UHC strategy, including national HRH stakeholder and consultation workshops.

2. Supported the development of the HWF competency framework developed for primary health care/UHC.

3. Provided technical support for the HWF projection exercise to estimate the number of health care workers needed per year to achieve UHC goals.

4. Supported the recruitment of 1652 health workers needed to achieve the primary health care/UHC strategy.

5. Supported the development of the NHWA platform.

Mali

1. Supported the Ministry of Health to carry out a situational analysis and stakeholder dialogue on key policy issues and challenges using HLMA.

2. Supported the development of the HWF strategy for the public sector which sets out a minimum quota for staff deployment to priority areas and manages the impact of dual practice on reducing access to and availability of quality care in rural and underserved areas.

3. Supported the development of fast-tracking initiatives to increase and accelerate the production and deployment of quality skilled new health workers to areas where need is greatest.

Mauritania

1. Supported the establishment of a multisectoral platform promoting coordination and collaboration regarding youth and women's employment.

2. Held a tripartite consultative meeting to discuss HWF challenges.

3. Participated in the health labour market workshops.

4. Supported the HLMA and its validation.

Sudan

1. Recruited national consultant to support the development of the National Human Resources for Health Strategic Framework 2030.

2. Established a national taskforce representing all HRH stakeholders to support and oversee the development of the National Human Resources for Health Strategic Framework 2030.

3. Conducted HRH stakeholder mapping and analysis (first draft).

4. Recruited national consultant to support strengthening the Sudan HRH Observatory and to produce the first NHWA (2021).

5. Conducted a comprehensive health information system (HIS) assessment. A national HIS improvement plan was developed to address the identified gaps and challenges. The assessment and improvement plan covered the HRH information system.

6. Established the Nursing and Midwifery Working Group to enhance coordination between different stakeholders.

7. Developed terms of reference (TOR) and agreed on membership of the Nursing and Midwifery Coordination Council. The first meeting of the council is planned for the third quarter 2021.

8. Supported the Curriculum Review and Development Project in collaboration with Sudan Medical Specialization Board. This project aims to improve the content and quality of training programmes to respond to health system needs – focusing on family medicine, nursing, midwifery and paediatric medicine in the first phase.

occupied Palestinan territory

1. Supported the capacity building of health workers in response to the COVID-19 pandemic through conducting trainings in critical care management and basic life support.

2. Supported the drafting of licensing criteria for two new professions of EMTs and paramedics to initiate the process of regulation.

3. Supported the development of a concept proposal for a national emergency training centre to institutionalize capacity-building efforts.

Institutional mechanisms strengthened to develop and implement multisectoral health workforce strategies at regional level

Southern African Development Community

1. Supported the development of a detailed, costed, model implementation plan and monitoring framework, including key milestones and indicators for the SADC Health Workforce Strategic Plan (2020–2030).

2. Supported the consultative engagement, validation process and presentation for endorsement of the strategic plan at the SADC Health Ministers' meeting in November 2020.

3. Supported the development of 12 online courses on OSH and COVID-19 in partnership with OSHAfrica, the East, Central and Southern Africa Health Community, the National Institute of Occupational Health, the South Africa Department of Employment and Labour, and the South Africa Department of Health.

West African Economic and Monetary Union

1. Supported the development of case studies on HWF response and management during the COVID-19 outbreak. The aim was to assess the impact of COVID-19 on the HWF, analyse country responses, and draw key lessons to inform policy-makers.

2. Supported the development of the study protocol, desk review, data collection and analysis.

3. Supported the periodic regional and country consultation meeting process.

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

International Platform on Health Workforce Mobility

1. Supported evidence generation by consolidation of the mapping of bilateral agreements (trade, labour, health, education, migration).

2. Elaborated on 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.

3. Supported development of a bilateral agreement guidebook on international health worker migration and mobility and derivative products.

4. Organized webinars with mobility platform members on the Expert Advisory Group (Health Workers for All Coalition, African Forum for Research and Education in Health, World Trade Organization, International Organization for Migration, African Union, International Council of Nurses, Nursing Now, Commission on Graduates of Foreign Nursing Schools) report in order to advance the principles and articles of the WHO Global Code of Practice, including the approach recommended with respect to the Health Workforce Support and Safeguards List, 2020.

5. Provided support to the United Kingdom to revise its Code of Practice on Ethical International Recruitment, as consistent with the WHO Global Code of Practice.[1]

6. Supported Sudan to operationalize national health worker migration policies, including support to policy dialogue.

[1] https://www.gov.uk/government/publications/code-of-practice-for-the-international-recruitment-of-health-and-social-care-personnel/code-of-practice-for-the-international-recruitment-of-health-and-social-care-personnel-in-england

Inter-Agency Data Exchange (IADEx)

1. Drafted structure and scope of the IADEx, including informal set of operating procedures and agreed roles and responsibilities across and between agencies.

2. Established and implemented informal mechanism to systematically consolidate, exchange and test health and social care workforce data on a defined set of priority indicators. As an example, OECD relevant data are uploaded to the WHO-NHWA data platform. Analytics on LFS conducted jointly by ILO and WHO. WHO agreement with Integrated Public Use Microdata Series (IPUMS) for using population synthesis data to analyse workforce density and distribution.

3. Expanded the partnership and scope of the exchange mechanism to other agencies and institutions collecting and hosting HWF data. In 2020, three other partners approached to join: UNESCO, Eurostat and IPUMS; OECD involved Eurostat in discussions on improving the collection of health education data in the joint questionnaire in follow up to a joint meeting on this topic in January 2021. UNESCO was invited but could not attend. IPUMS confirmed interest in joining.

4. Improved HWF data availability by second round of analysis of the LFS and improvements in data collection specifications in the module of the 2021 OECD/Eurostat/WHO Europe joint questionnaire related to graduates from health education programmes, to improve the guidelines provided to all countries and data comparability (December 2020).

5. Followed-up discussions between December 2020 and April 2021 with national data correspondents for the joint questionnaire to address specific data reliability and comparability issues identified during the IADEx meeting hosted by OECD in January 2020.

6. Conducted global webinars for NHWA focal points.

Achievements, COVID-19 response and lessons learned

In 2020, W4H expanded its operations to 10 countries and areas (Benin, Chad, Guinea, Mali, Mauritania, Niger, Rwanda, South Africa, Sudan, occupied Palestinian territory); continued to support two regional economic areas (SADC and WAEMU); and established two global goods (International Platform on Health Worker Mobility and IADEx).

Providing catalytic support to countries and areas to help unlock and drive investments in education, skills and jobs is a major focus of the programme. Creating jobs and decent work in the health sector is the foundation for achieving SDG 3 and SDG 8 and accelerating UHC. In addition, it is recognized that each new job created in the health sector leads to the indirect creation of additional jobs in non-health occupations – and is an enabler for empowering the economic and labour market participation of women and youth.

The W4H Programme established a technical working group on job creation measurement and is in the process of developing a methodology to track country-led job creation measures, targets and outcomes. The working group developed a guiding framework to assess job creation in the context of W4H projects, including indicators that can be associated with the different typologies of projects, and integrate these measures within the W4H Programme reporting and results frameworks. This work will enable the measurement of nationally determined job creation targets and results in W4H-supported countries and areas, using country-specific indicators, data and means of verification.

W4H has collaborated with partners to mobilize the best global evidence, data, research, guidance, protocols and workforce readiness measures required by countries and areas to prepare and respond to COVID-19. Particular focus was put on countries and areas and regions already benefiting from W4H funding, either for specific local support requests or in the context of subregional activities. W4H reviewed countries and areas progress, highlighting the need to further strengthen and support the HWF within the immediate COVID-19 crisis and post-pandemic response.

The COVID-19 pandemic impacted on the implementation of W4H-supported activities and the programme has responded accordingly. Many of the W4H-supported countries and areas applied lockdown measures for several months, resulting in several key planned activities being cancelled or delayed, due mainly to the repurposing of key counterpart staff and prioritization of the COVID-19 response and preparedness efforts. Many health systems were confronted by greater workload demand generated by the COVID-19 outbreak, with significant increases in both direct mortality from the outbreak and indirect mortality from other diseases such as vaccine-preventable and treatable conditions. Health systems were severely compromised due to excess demand, resource diversion and closure of health facilities.

In March 2020, W4H engaged with supported countries and areas, which enabled programme resources to be reprogrammed towards supporting the implementation of priority emergency response efforts through the initiation of a three-step reprogramming process:

- **Step 1:** Assess the COVID-19 context, continuity of planned W4H activities, and identify the emerging priorities to reprioritize accordingly.

- **Step 2:** Initiate a context-specific response based on bottom-up planning in alignment with other ongoing country preparedness and planning processes.

- **Step 3:** Allow flexible implementation of COVID-related priorities through reprogramming activities, and request a no-cost extension.

The three implementing agencies supported countries and areas to identify, respond to and address their priority needs in this new situation. During the reporting period, several countries and areas supported by the W4H Programme requested either a reprogramming of their W4H-approved activities, additional funds to assist in the COVID-19 response, or a no-cost extension period for implementation. These requests are mainly due to the local countries and areas' reprioritization of resources, local counterparts and staff, and capacity at local level, resulting from the shifting of priorities to fight the COVID-19 pandemic, which has disrupted the implementation of other project activities. Among the proposed solutions in many countries and areas was the need for HWF capacity building on the protection and OSH of the workforce as first-line responders. To address the urgent need for capacity building on OSH for health workers, a practical tool (COVID-19 and health facilities – checklist of measures to be taken in health facilities) to protect health workers in the fight against COVID-19 was developed. The COVID-19 checklist was piloted in web-based training in Senegal, a country supported by W4H, through work in the WAEMU region.

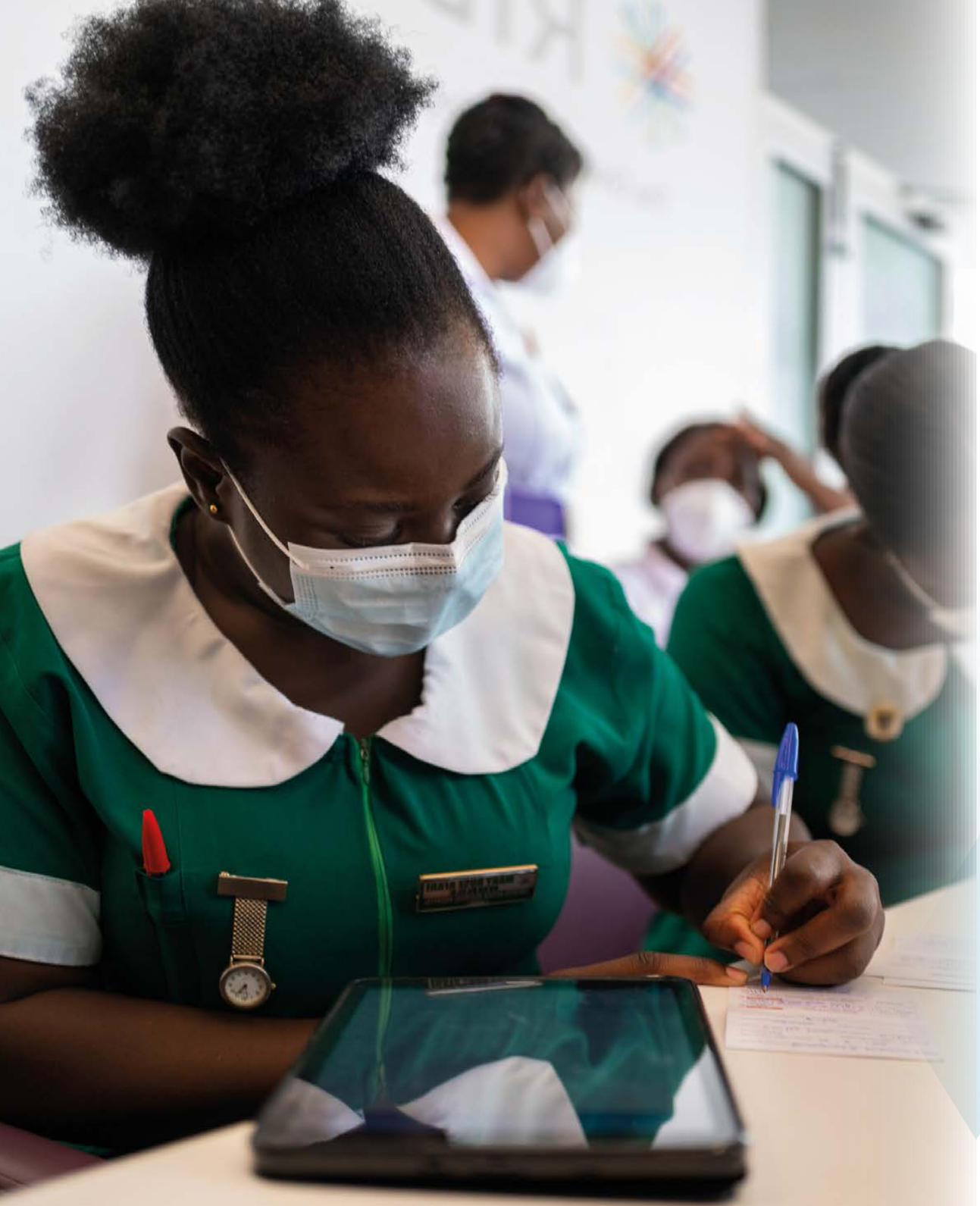
Figure 2 – COVID-19 reprogramming steps

Experience over the pandemic implementation period has yielded the following lessons:

- **Partnership:** The pandemic challenged health systems at large and tested the strength of the W4H partnership within global, regional and country systems. This test revealed the complete commitment and trust in which the W4H is held by its partners.

- **Virtual and catalytic support:** The W4H implementing organizations, in collaboration with constituents and HWF stakeholders, were asked to review and provide virtual technical guidance and support while missions were suspended. This ability to adapt reflected the global mindset shift, national buy-in and sense of co-ownership. This shift, aligned with the strategic alignment and contribution of catalytic support towards country-led priorities, demonstrates a viable and sustainable operating model for W4H.

- **Strengthened national capacity:** Understanding the context, bottom-up planning, adapting and adopting tailored implementation approaches based on local priorities is better leveraged, institutionalized and sustained by enabling and supporting local counterparts, partners and consultants with context-specific tools, guidance and facilitation.



Way forward

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.[1] The review's findings validated and reinforced the continued high relevance of the W4H Programme and its MPTF despite the lower than anticipated funding levels, which has limited its visibility, uptake and impact.

2021 will be an important year for the W4H Programme. It marks the launch of WHO's International Year of the Health and Care Worker campaign,[2] – following the themes of Protect, Invest and Together. The W4H Programme will also initiate support for two additional countries: Pakistan and Somalia. In Pakistan, the W4H Programme will support the implementation of its UHC benefit packages through health workforce strengthening initiatives. In Somalia, the request is to conduct a rapid health workforce assessment and scale-up of the community midwifery and female health workforce programme, among other vital activities.

In line with the 73rd World Health Assembly decision (WHA73.15), and noting the necessity for all WHO Member States to protect and invest in the health and care workforce, a WHO Director-General report was submitted to the 74th World Health Assembly on the W4H's 5-year action plan.[3] This report outlines a pathway for the continuity of the W4H Programme, including the renewal of the W4H action plan and agenda and a scalable level of investment and funding for 2022–2030. Furthermore, at the 74th World Health Assembly in May 2021, resolution 74.14 on "protecting, safeguarding and investing in the health and care workforce" was adopted by the Member States.[4] Accordingly, the anticipated next step is executing a Member State-led process to develop a renewed mandate and action plan throughout 2021.

1 https://www.who.int/publications/i/item/9789240023703
2 https://www.who.int/campaigns/annual-theme/year-of-health-and-care-workers-2021
3 https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74_12-en.pdf
4 https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74_ACONF6-en.pdf

Annex 1 - Working for Health results matrix 2020

Table 1 – W4H results matrix, 2020

	Achieved indicator targets (at country and areas level)	Achieved indicator targets (across countries)	Reasons for variance with planned targets (if any)	Source of verification
Outcome 1: The supply of appropriately skilled health workers meets assessed country needs				
Indicator 1: Total public sector expenditure on health workforce preservice education **Baseline:** Based on country level assessments **Planned target:** % increase to be determined based on country level assessment	N/A	N/A	No data for Guinea and Niger on NHWA portal	Data from annual reports NHA, WHO NHWA portal
Indicator 2: Ratio of newly active domestic trained health workers to total stock of active health workers **Baseline:** Based on country level assessments **Planned target:** Extent of change to be determined based on country level assessment – threshold to be defined at national level	**South Africa:** 4000+ new health care workers have been employed to support the COVID-19 response effort (including: 2367 medical interns, 1693 medical community service practitioners who will form part of a 7895 community service workforce) **occupied Palestinian territory:** Trained 100 nurses and doctors in an internationally recognized course in ICU practices, focusing on several topics; reached over 800 EMTs, nurses and doctors working in emergency rooms of government and private institutions			Data from annual reports, WHO NHWA portal and online article: ***More Health Workers Employed To Fight Against COVID-19***[1]

[1] https://www.careersportal.co.za/news/more-health-workers-employed-to-fight-against-covid-19

Output 1.1: Strengthened country and area accreditation mechanisms to align types of education and training with health labour market demand and population needs

Indicator 1.1.1: Existence of national and/or subnational mechanisms for accreditation of health workforce education and training institutions and their programmes (Yes/ No/Partly) **Baseline:** 0 **Planned target:** 20 countries supported	**occupied Palestinian territory:** Led by the Ministry of Health, 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	N/A	N/A	Data from annual reports

Output 1.2: Models developed for assessing staffing needs for health services delivery

Indicator 1.2.1: Existence of institutional models for assessing and monitoring staffing needs for health service delivery (Yes/No/Partly) **Baseline:** 0 **Planned target:** 20 countries supported	**Guinea:** 70% **Niger:** 70% **Benin:** 100% All three countries have implemented the workload indicators staffing needs (WISN) methodology	Three countries (**Guinea** and **Niger** partially, and **Benin**)	Currently, there is only funding to support 12 countries not 20 Targets should be revised to 12	Data from annual reports

Output 1.3: Strengthened institutional capacity to align skills and competencies with health labour market and population needs

Indicator 1.3.1: Existence of national education plans for the HWF, aligned with the national health plan and the national health workforce strategy/ plan (Yes/ No/Partly) **Baseline:** 0 **Planned target:** 20 countries	**Benin:** Establishment of a programme aimed at increasing training of health workers in rural areas; revision of the programme curricula for the training of nurses and midwives **Guinea:** Primary health workforce training **Niger:** Train young people and women for decent jobs in health to provide them with permanent employ ment opportunities and to improve their skills **Sudan:** Nursing and midwifery education and training is being strengthened in part nership with faculties of nursing and Sudan Medical Specialization Board; improving the content and quality of training programmes to respond to health system needs **occupied Palestinian territory:** Proposed establishment of a local emergency training centre; basic life support course; review of international standards for licensing requirements for EMTs; training on COVID-19 emergency response	Five countries and areas (partially **Benin, Guinea, Niger, Sudan, occupied Palestinian territory**)	Currently, there is only funding to support 12 countries not 20 Targets should be revised to 12 Achieved targets should be then 42%	Data from annual reports

Outcome 2: Health sector jobs created to match labour market and public health needs				
Indicator 1: Percentage of active health workers employed by type of facility ownership **Baseline:** Based on country assessment **Planned target:** Extent of change based on country assessment	**Baseline data for the WAEMU countries:** **Benin in 2018:** Medical doctors: 71.5% in public, 18.5% in private for profit (P4P), 10.7% in private not for profi (PN4P); nurses: 94.1% in public, 1.5% in P4P, 4.2% in PN4P **Burkina Faso in 2017:** Medical doctors: 100% in public; nurses: 100% in public **Côte d'Ivoire in 2018:** Nurses: 100% in public **Guinea-Bissau in 2018:** Nurses: 100% in public **Mali in 2018:** N/A **Niger in 2016:** 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 **Senegal:** No data **Togo in 2018:** 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	87.5% (seven WAEMU countries)	N/A	Data from the WHO NHWA portal
Indicator 2: Density of health workers per 10 000 population **Baseline:** Based on country assessment **Planned target:** % change based on country assessment	**Change in comparison to the baseline:** **Benin 2018–2019:** -0.14 for medical doctors; -0.71 for nurses; -0.15 for midwives; no change for pharmacists **Burkina Faso 2017–2019:** +0.09 for medical doctors; +0.18 for nurses; +0.26 for midwifery; -0.01 for dentists; no change for pharmacists **Côte d'Ivoire 2018–2019:** +0.01 for medical doctors; -1.67 for nurses; +2.18 for midwifery; +0.01 for dentists; no change for pharmacists **Guinea-Bissau 2016–2018:** No change in medical doctors; +1.7 nurses; no change for midwifery; no change for dentists; no change for pharmacists (2016) **Mali in 2018:** 1.29 for medical doctors; 2.71 for nurses; 1.70 for midwifery; 0.01 for dentists; 0.1 for pharmacists **Niger 2016–2018:** No change for medical doctors; -0.45 for nurses; +0.01 for midwifery; no change for dentists; no change for pharmacists **Senegal 2017–2019:** +0.19 for medical doctors; +1.94 for nurses; +0.33 for midwifery; +0.05 for dentists; and +0.01 for pharmacists **Togo in 2018–2019:** +0.01 for medical doctors; +0.17 for nurses; +0.37 for midwifery; +0.02 for dentists; no change for pharmacists	N/A	Densities in the eight WAEMU countries	WHO NHWA portal

Output 2.1: Strengthened country capacity on gender-responsive health labour market analysis, to inform and feed into the development of workforce policies, strategies and reforms				
Indicator 2.1.1: Number of W4H supported countries where health labour market analysis has been applied to inform health workforce planning **Baseline:** 0 **Planned target:** 20 countries	**South Africa:** 100% HLMA **Rwanda:** 100% HLMA completed in 2019	10% (two countries) **South Africa:** 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; **Rwanda:** Comprehensive HRH situation analysis; initiated the development and costing of the new HRH roadmap and 2-year implementation plan)	Currently, there is only funding to support 12 countries not 20 Targets should be revised to 12 Achieved targets should be then 16.67%	Data from annual reports

Output 2.2: Improved capacity to develop enhanced multisectoral national health workforce strategies and plans				
Indicator 2.2.1: Existence of mechanisms and models for health workforce planning (yes/no/partly) **Baseline:** Eight WAEMU countries **Planned target:** 20 countries	**South Africa:** 100% National Health Workforce Strategic Framework: 2019–2030 and HRH Strategic Plan Sector: 2019/20-2024/25 published **Rwanda:** 10-Year Government Programme: National Strategy for Health Professions Development 2020–2030	50% (10 countries): eight **WAEMU countries** of have elaborated investment plans with situation analysis, HRH projections and scenarios with estimated costing and health service coverage, plus **South Africa and Rwanda**)	N/A	Data from annual reports

Output 2.3: Strengthened countries' capacity to secure sustainable funding for health workforce strategies and plans				
Indicator 2.3.1: Number of W4H supported countries with investment case for job creation in the health sector (public and private) **Baseline:** 0 **Planned target:** 20 countries	**South Africa:** 100% National Health Workforce Strategic Framework: 2019–2030 and HRH Strategic Plan Sector: 2019/20-2024/25	All eight **WAEMU countries** did return on investment studies – 100% case studies on job creation potential of health sector planned in three countries **SADC:** 100% – SADC Health Workforce Strategic Plan: (2020–2030): Investing in Skills and Job Creation for Health	Currently, there is only funding to support 12 countries not 20 Targets should be revised to 12 Achieved targets should be then 100%	Data from annual reports

Output 2.4: Strengthened tripartite intersectoral mechanisms to coordinate the development and implementation of health workforce policies and strategies				
Indicator 2.4.1: Existence of institutional mechanisms or bodies to coordinate an intersectoral health workforce agenda (Yes/No/Partly) **Baseline:** 0 **Planned target:** 20 countries	**Chad:** Establishing OSH committees in selected hospitals **Sudan:** Nursing and Midwifery Working Group established to enhance coordination with different stakeholders	All eight **WAEMU countries** have either a national committee on HRH or a HRH Observatory or a HRH working group ILO provided support for multisectoral tripartite dialogue to (**Chad, Mauritania, South Africa)** plus SADC region	N/A	Data from annual reports

Output 2.5: Improved systems and processes for monitoring of and accountability for health workforce strategies at country level				
Indicator 2.5.1: Number of W4H supported countries producing annual monitoring and accountability reports for health workforce strategies **Baseline:** 0 **Planned target:** 20 countries	All W4H countries	**SADC countries:** Updated and revised data and baseline; implementation plan, costing model and M&E framework initiated **WAEMU countries:** Monitoring framework developed and pilot is ongoing in two countries		Data from annual reports

Outcome 3: Health workers are recruited and retained according to country needs				
Indicator 3.1: Density and distribution of active health workers, by occupation and subnational level **Baseline:** SDG – based on country assessment **Planned target:** 15% increase	All W4H countries	**SADC:** 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 ***(country specific data is in Table 5 of the strategy document)*** **WAEMU countries:** planned but due to COVID-19 not executed	N/A	SADC Health Workforce Strategic Plan (2020–2030): Investing in Skills and Job Creation for Health

Output 3.1: Health workforce deployment and distribution mechanisms strengthened for primary health care in rural and underserved areas				
Indicator 3.1.1: Density of active health workers per 10 000 population by occupation at subnational level **Baseline:** Based on in country assessment **Planned target:** Density change to be determined based on country level assessment	**Change in comparison to the baseline:** **Benin 2018–2019:** –0.14 for medical doctors; –0.71 for nurses; –0.15 for midwives; no change for pharmacists **Burkina Faso 2017–2019:** +0.09 for medical doctors; +0.18 for nurses; +0.26 for midwifery; –0.01 for dentists; no change for pharmacists **Côte d'Ivoire 2018–2019:** +0.01 for medical doctors; –1.67 for nurses; +2.18 for midwifery; +0.01 for dentists; no change for pharmacists **Guinea-Bissau 2016–2018:** No change in medical doctors; +1.7 nurses; no change for midwifery; no change for dentists; no change for pharmacists (2016) **Mali in 2018:** 1.29 for medical doctors; 2.71 for nurses; 1.70 for midwifery; 0.01 for dentists; 0.1 for pharmacists **Niger 2016–2018:** No change for medical doctors; -0.45 for nurses; +0.01 for midwifery; no change for dentists; no change for pharmacists **Senegal 2017–2019:** +0.19 for medical doctors; +1.94 for nurses; +0.33 for midwifery; +0.05 for dentists; +0.01 for pharmacists. **Togo in 2018-2019:** +0.01 for medical doctors; +0.17 for nurses; +0.37 for midwifery; +0.02 for dentists; no change for pharmacists	**SADC:** 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 ***(country specific data is in Table 5 of the strategy document)*** **WAEMU:** planned but due to COVID-19 not executed	N/A	SADC Health Workforce Strategic Plan (2020–2030): Investing in Skills and Job Creation for Health; WHO NHWA portal

Output 3.2: Strengthened capacity to address gender bias and inequalities in health workforce policy and practice

Indicator 3.2.1: Gender wage gap **Baseline:** Based on in country assessment **Planned target:** % change to be determined based on country level assessment	W4H advocates gender equality in all the countriess	**SADC:** Set an objective of developing and implementing strategies to mainstream gender equality in the health 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	N/A	SADC Health Workforce Strategic Plan (2020–2030): Investing in Skills and Job Creation for Health

Output 3.3: Improved occupational health and safety of health workers in all settings at local level

Indicator 3.3.1: Existence of local occupational health and safety plans or programmes integrated in health workforce strategies **Baseline:** Based on in country and area assessment **Planned target:** 10 countries	Four countries and areas **(Guinea, Senegal, South Africa, occupied Palestinian territory):** Implemented the HealthWISE approach	**SADC:** The African Union Development Agency and ILO conducted a series of webinars focusing on OSH and COVID-19, including HealthWISE and COVID-19 checklist-related content	N/A	Data from annual reports

Output 3.4: Strengthened health workforce social protection coverage

Indicator 3.4.1: Existence of national/ subnational policies/ laws regulating social protection (Yes/No/Partly) **Baseline:** based on in country assessment **Planned target:** 10 countries	One country **(Chad):** Increased capacity building of stakeholders engaged in the development of a social health protection strategy for UHC **SADC:** Developing strategies on OSH measures to protect health and care workers at the frontline; enhanced working conditions and equal remuneration	N/A	N/A	Data from annual reports

Outcome 4: Health workforce data inform effective policy, planning, monitoring and international mobility

Output 4.1: An international health labour mobility platform established to advance knowledge and internationa cooperation

Indicator 4.1.1: Number of countries participating in the platform **Baseline:** 0 **Planned target:** 50	Seven W4H countries **(Benin, Chad, Rwanda, Pakistan, Sudan, South Africa, Somalia):** have a designated national authority, and/or submitted a national report	**SADC:** 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)

Output 4.2: Strengthened country capacity to understand and manage health worker flows, in order to inform the development of national policies and bilateral agreements

Indicator 4.1.2: Platform established to maximize benefit from international health worker mobility **Indicator 4.2.1:** Number of national policies and bilateral agreements supported **Baseline:** 0 **Planned target:** 10 countries	N/A	Platform established; one bilateral agreement signed	The OECD is starting a consultation process with its Member States on the bilateral agreements (planned for fourth quarter 2021)	Germany-Salvador agreement and meeting notes

Output 4.3: Increased monitoring of health worker mobility through the WHO Global Code of Practice reporting system				
Indicator 4.3.1: Number of countries supported by W4H which report on the WHO Global Code **Baseline:** 0 **Planned target:** 20 countries	N/A	**United Kingdom:** Revising its code of practice for its approach to international recruitment; explicitly aligning with WHO Global Code of Practice	Fourth round of code reporting to take place in 2021	Secretariat report to the World Health Assembly; meeting notes
Output 4.4: New harmonized metrics and definitions established through an interagency global data exchange on the health labour markets				
Indicator 4.4.1: Number of countries using the data exchange platform **Baseline:** 0 **Planned target:** 50 countries	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	N/A	Currently, there is only funding to support 12 countries, not 50	WHO NHWA portal; Global Health Observatory data repository
Output 4.5: Improved quality and reporting of health workforce data through national health workforce accounts				
Indicator 4.5.1: Number of W4H supported countries that report NHWA core indicators to WHO annually **Baseline:** 0 countries **Planned target:** 20 countries	Eight countries **(Benin, Chad, Guinea, Niger, Mali, Mauritania, Rwanda, South Africa):** 2016–2019	N/A	Currently, there is only funding to support 12 countries, not 20 Targets should be revised to 12 Achieved targets should be then 66.7%	WHO NHWA portal

Annex 2 - Fund financial performance 2020

Introduction

This consolidated annual financial report of the W4H MPTF is prepared by the United Nations Development Programme (UNDP) MPTF Office in fulfilment of its obligations as administrative agent, as per the TOR, the memorandum of understanding (MOU) signed between the UNDP MPTF Office and the participating organizations, and the standard administrative arrangement (SAA) signed with contributors.

The MPTF Office, as administrative agent, is responsible for concluding an MOU with participating organizations and SAAs with contributors. It receives, administers and manages contributions, and disburses these funds to the participating organizations. The administrative agent prepares and submits annual consolidated financial reports, as well as regular financial statements, for transmission to contributors.

This consolidated financial report covers the period 1 January to 31 December 2020 and provides financial data on progress made in the implementation of projects of the W4H MPTF. It is posted on the MPTF Office Gateway.[1]

The financial data in the report are recorded in US dollars and due to rounding of numbers, totals may not add up exactly.

Sources and uses of funds

As of 31 December 2020, two contributors deposited US$ 4 813 814 in contributions and US$ 38 328 was earned in interest.

The cumulative source of funds was US$ 4 852 142.

Of this amount, US$ 4 185 921 has been net funded to three participating organizations, of which US$ 1 312 253 has been reported as expenditure. The administrative agent fee has been charged at the approved rate of 1% on deposits and amounts to US$ 48 138. Table 1 provides an overview of the overall sources, uses and balance of the W4H MPTF as of 31 December 2020.

Table 1 – Financial overview, as of 31 December 2020 (in US$)

	Annual 2019	Annual 2020	Cumulative
Sources of funds	-	-	-
Contributions from donors	2 177 856	1 477 880	4 813 814
Fund earned interest and investment income	27 755	9015	38 328
Interest income received from participating organizations	-	-	-
Refunds by administrative agent to contributors	-	-	-
Fund balance transferred to another multi-donor trust fund	-	-	-
Other income	-	-	-
Total: sources of funds	**2 205 612**	**1 486 895**	**4 852 142**
Use of funds	**-**	**-**	**-**
Transfers to participating organizations	2 943 651	893 450	3 837 101
Refunds received from participating organizations	-	-	-
Net funded amount	**2 943 651**	**893 450**	**3 837 101**
Administrative agent fees	21 779	14 779	48 138
Direct costs (Steering Committee, Secretariat, etc.)	268 570	80 250	348 820
Bank charges	62	41	143
Other expenditures	-	-	-
Total: uses of funds	**3 234 061**	**988 520**	**4 234 202**
Change in fund cash balance with administrative agent	**(1 028 450)**	**498 375**	**617 940**
Opening fund balance (1 January)	1 148 015	119 565	-
Closing fund balance (31 December)	**119 565**	**617 940**	**617 940**
Net funded amount (includes direct costs)	3 212 221	973 700	4 185 921
Participating organizations' expenditure (includes direct costs)	329 963	982 290	1 312 253
Balance of funds with participating organizations	-	-	**2 873 668**

Partner contributions

Table 2 provides information on cumulative contributions received from all contributors to this fund as of 31 December **2020**.

The W4H MPTF is currently being financed by two contributors, as listed in Table 2, which includes commitments made up to 31 December 2020 through signed SAAs, and deposits made through 2020. It does not include commitments that were made to the fund beyond **2020**.

Table 2 – Contributors' commitments and deposits, as of 31 December 2020 (in US$)

Contributors	Total commitments	Prior years as of 31 Dec 2019 deposits	Current year Jan–Dec 2020 deposits	Total deposits
Government of Norway	3 313 814	2 335 934	977 880	3 313 814
Silatech	2 000 000	1 000 000	500 000	1 500 000
Grand total	**5 313 814**	**3 335 934**	**1 477 880**	**4 813 814**

Interest earned

Interest income is earned in two ways: on the balance of funds held by the administrative agent (fund earned interest); and on the balance of funds held by the participating organizations (agency earned interest) where their financial regulations and rules allow return of interest to the administrative agency.

As of 31 December 2020, fund earned interest amounts to US$ **38 328**. Details are provided in Table 3.

Table 3 – Sources of interest and investment income, as of 31 December 2020 (in US$)

Interest earned	Prior years as of 31 Dec 2019	Current year Jan–Dec 2020	Total
Administrative agent	**-**	**-**	**-**
Fund earned interest and investment income	29 313	9 015	38 328
Total: fund earned interest	**29 313**	**9 015**	**38 328**
Participating organization	**-**	**-**	**-**
Total: agency earned interest	**-**	**-**	**-**
Grand total	**29 313**	**9 015**	**38 328**

Transfer of funds

Allocations to participating organizations are approved by the Steering Committee and disbursed by the administrative agent. As of 31 December **2020**, the administrative agent has transferred US$ **3 837 101** to three participating organizations (see Table 4).

Transfer by participating organization: Table 4 provides additional information on the refunds received by the MPTF Office, and the net funded amount for each of the participating organizations.

Table 4 – Transfer, refund and net funded amount by participating organization, as of 31 December 2020 (in US$)

	Prior years as of 31 Dec 2019			Current year Jan–Dec 2020			Total		
Participating organization	**Transfers**	**Refunds**	**Net funded**	**Transfers**	**Refunds**	**Net funded**	**Transfers**	**Refunds**	**Net funded**
ILO	681 345		681 345	124 120		124 120	805 465		805 465
OECD	328 897		328 897				328 897		328 897
WHO	1 933 409		1 933 409	769 330		769 330	2 702 739		2 702 739
Grand total	**2 943 651**		**2 943 651**	**893 450**		**893 450**	**3 837 101**		**3 837 101**

Expenditure and financial delivery rates

All final expenditures reported for the year **2020** were submitted by the headquarters of the participating organizations. These were consolidated by the MPTF Office.

Project expenditures are incurred and monitored by each participating organization, and are reported as per the agreed categories for interagency harmonized reporting. The reported expenditures were submitted via the MPTF Office online expenditure reporting tool. The **2020** expenditure data has been posted on the MPTF Office Gateway[1].

Expenditure reported by participating organizations: in **2020**, US$ **893 450** was net funded to participating organizations, and US$ **713 795** was reported in expenditure. As shown Table 5.1, the cumulative net funded amount is US$ **3 837 101** and cumulative expenditures reported by the participating organizations amount to US$ **1 043 758**. This equates to an overall fund expenditure delivery rate of **27%**

Table 5.1 – Net funded amount, reported expenditure and financial delivery by participating organization, as of 31 December 2020 (in US$)

Participating organization	Approved amount	Net funded amount	Expenditure			Delivery rate %
			Prior years as of 31 Dec 2019	Current year Jan–Dec 2020	Cumulative	
ILO	805 465	805 465	38 898	83 318	122 216	15.17
OECD	328 897	328 897	99 136	159 022	258 158	78.49
WHO	2 702 739	2 702 739	191 929	471 455	663 384	24.54
Grand total	**3 837 101**	**3 837 101**	**329 963**	**713 795**	**1 043 758**	**27.20**

[1] http://mptf.undp.org/factsheet/fund/WHL00.

Expenditure by project: Table 5.2 displays the net funded amounts, expenditures reported and the financial delivery rates by participating organization.

Table 5.2 – Expenditure by project within sector, as of 31 December 2020 (in US$)

Sector/project no. and project title		Participating organization	Project status	Total approved amount	Net funded amount	Total expenditure	Delivery rate %
Global							
00116408	W4H initial implementation	ILO	Ongoing	353 390	353 390	112 459	31.82
00116408	W4H initial implementation	OECD	Ongoing	328 897	328 897	258 158	78.49
00116408	W4H initial implementation	WHO	Ongoing	1 121 279	1 121 279	593 493	52.93
00118644	W4H country support Jan–Dec 20	ILO	Ongoing	381 455	381 455	9757	2.56
00118644	W4H country support Jan–Dec 20	WHO	Ongoing	1 158 810	1 158 810	69 892	6.03
00125249	W4H country support 2020–2021	ILO	Ongoing	70 620	70 620	-	0
00125249	W4H country support 2020–2021	WHO	Ongoing	422 650	422 650	-	0
Global total				**3 837 101**	**3 837 101**	**1 043 758**	**27.20**
Grand total				**3 837 101**	**3 837 101**	**1 043 758**	**27.20**

Expenditure reported by category: Project expenditures are incurred and monitored by each participating organization and are reported as per the agreed categories for interagency harmonized reporting. In 2006 the UNDG established six categories against which UN entities must report interagency project expenditures. Effective 1 January 2012, the UN Chief Executive Board modified these categories as a result of IPSAS adoption to comprise eight categories. All expenditure incurred prior to 1 January 2012 have been reported in the old categories; post 1 January 2012 all expenditure are reported in the new eight categories:

1. Staff and personnel costs
2. Supplies, commodities and materials
3. Equipment, vehicles, furniture and depreciation
4. Contractual services
5. Travel
6. Transfers and grants
7. General operating expenses
8. Indirect costs

Table 5.3 – Expenditure by UNDG budget category, as of 31 December 2020 (in US$)

Category	Expenditure			Delivery rate %
	Prior years as of 31 Dec 2019	Current year Jan–Dec 2020	Total	
Staff and personnel costs (new)	69 613	192 978	262 591	27.03
Supplies, commodities and materials (new)	-	1 734	1 734	0.18
Equipment, vehicles, furniture and depreciation (new)	-	-	-	-
Contractual services (new)	70 225	342 694	412 919	42.50
Travel (new)	41 108	73 503	114 611	11.80
Transfers and grants (new)	91 967	44 738	136 705	14.07
General operating expenses (new)	21 228	21 855	43 083	4.43
Programme costs total	**294 141**	**677 501**	**971 642**	**100.00**
Indirect support costs total[a]	35 822	36 294	72 116	7.42
Total	**329 963**	**713 795**	**1 043 758**	

[a] **Indirect support costs** charged by participating organization, based on their financial regulations, can be deducted upfront or at a later stage during implementation. The percentage may therefore appear to exceed the 7% agreed upon for ongoing projects. Once projects are financially closed, this number is not to exceed 7%.

Cost recovery

Policies for the fund are guided by the applicable provisions of the TOR, the MOU concluded between the administrative agent and participating organizations, and the SAAs concluded between the administrative agent and contributors, based on rates approved by UNDG. The policies in place, as of 31 December **2020**, were as follows:

The administrative agent fee: 1% is charged at the time of contributor deposit and covers services provided on that contribution for the entire duration of the fund. In the reporting period US$ **14 779** was deducted in administrative agent fees. Cumulatively, as of 31 December **2020**, US$ **48 138** has been charged in administrative agent fees.

Indirect costs of participating organizations: Participating organizations may charge 7% indirect costs. In the current reporting period US$ **36 294** was deducted in indirect costs by participating organizations. Cumulatively, indirect costs amount to US$ **72 116** as of 31 December **2020**.

Accountability and transparency

In order to effectively provide fund administration services and facilitate monitoring and reporting to the UN system and its partners, the MPTF Office has developed a public website, the MPTF Office Gateway[1]. Refreshed in real time every 2 hours from an internal enterprise resource planning system, the MPTF Office Gateway has become a standard setter for providing transparent and accountable trust fund administration services.

[1] http://mptf.undp.org

The Gateway provides financial information including: contributor commitments and deposits, approved programme budgets, transfers to and expenditures reported by participating organizations, interest income and other expenses. In addition, the Gateway provides an overview of the MPTF Office portfolio and extensive information on individual funds, including their purpose, governance structure and key documents. By providing easy access to the growing number of narrative and financial reports, as well as related project documents, the Gateway collects and preserves important institutional knowledge and facilitates knowledge sharing and management among UN organizations and their development partners, thereby contributing to UN coherence and development effectiveness.

Direct costs

The fund governance mechanism may approve an allocation to a participating organization to cover costs associated with secretariat services and overall coordination, as well as fund level reviews and evaluations. These allocations are referred to as "direct costs". In the reporting period, direct costs charged to the fund amounted to US$ 80 250. Cumulatively, as of 31 December 2020, US$ 348 820 has been charged as direct costs.

Table 6 – Direct costs

Participating organization	Net funded amount	Expenditure	Delivery rate
WHO	348 820	268 495	77%
Total	**348 820**	**268 495**	**77%**

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