

JOINT
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Joint Programme Document:

Advancing Decent Work and Just Transitions in
Pakistan Through Health Sector Skills
Development and Social Protection



COVER PAGE

MPTFO Project Reference Number	<i>(Leave blank, for automatic population in Quantum)</i>
Country	Pakistan
Territorial/Geographic Focus	<i>Islamabad Capital Territory , Punjab and Sindh</i>
Joint programme title:	Advancing Decent Work and Just Transitions in Pakistan Through Health Sector Skills Development and Social Protection
Phase I Duration:	<i>18 months</i>
Phase I Start and end dates:	<i>02/2026 to 07/2027</i>
Short description:	The structural limitations of Pakistan's health and care economy prevent inclusive growth and the resilience of the health system. Women, community-based health workers, and people with disabilities are further disadvantaged by weak employability pathways, fragmented skill recognition and accreditation, unfavourable working conditions, and ongoing underinvestment in health workforce development. Inadequate coordination between health, education, and employment policies as well as financial limitations contribute to informality compromising the quality of the workforce and health service delivery. The initiative will aim to create safer and more supportive working environments for health workers. It will strengthen policies, institutions, and governance capacity across the health sector. It will also invest in building practical skills, recognised qualifications, and resilience to technological change and climate impacts. Formal employment will be promoted, alongside better coordination between health and employment reforms. Through policy engagement and capacity building, the initiative will leverage financing for long term investment in the sector. As a result, Pakistan will move towards a more sustainable and inclusive health and care economy. The sector will generate more skilled workforce and decent jobs. Health workforce governance capacity will be enhanced. Health workers will be more skilled, resilient, and better prepared to meet the country's evolving health needs. Phase I offers high-impact, short-term reforms that produce early results and open the door to larger-scale funding. Increased formalisation and decent job creation through engagement with public and private sector; enhanced workforce mobility through national qualification frameworks and digital credentials; improved skills development, recognition of prior learning, and digital learning pathways for nursing and allied health professionals; strengthened professional standards and accreditation building on USD 2 million in curriculum reform, digitalisation, assessment, and certification and complementing ADB's TA. Cross-cutting priorities support gender-responsive governance, female leadership, and increased social protection and recognition for marginalised cadres like Lady Health Workers. By adopting a National Employment Policy, Provincial Employment Action Plans, and a gender-responsive National Roadmap for the Global Accelerator, Phase I improves policy coherence. In order to scale reforms nationally and produce multiplier effects in employment, productivity, service delivery, and fiscal returns, these enablers mobilise Phase II financing, creating fiscal space, utilising blended finance and PPPs, and aligning with IFI pipelines.



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Joint Programme team:

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Joint Program RCO focal point	Afke Bootsman, afke.bootsman@un.org
Lead PUNO JP Focal point	ILO, Rabia Razzaque, Senior Programme Officer, razzaque@ilo.org
PUNO 2 JP Focal point	WHO, Dr Naveed Asghar, Team Lead - Health System Development, nasghar@who.int

Anticipated Total Budget:	USD 913,000
Phase I Budget (for approval):	\$ 850,000
Source of funds:	Joint SDG Fund
UN Joint SDG Fund (Phase I)	\$ 850,000 (maximum of US\$ 1,800,000)
PUNO 1 co-funding	\$ 65,000
PUNO 2 co-funding	\$ 63,000
Government co-funding	\$ 0
International donor co-funding	\$ 0
Other sources co-funding	\$ 0

Legal context	The legal basis for the joint programme is the Legal Annex for the signed United Nations Sustainable Development Cooperation Framework (2023-2027) and the Decent Work Country Programme 2023-2027. It refers to the cooperation or assistance agreements or other agreements that are the existing legal basis for the relationship between the Government of Pakistan and each Participating UN Organization.
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DECLARATION OF COMMITMENT AND SIGNATURES

By signing this Joint Programme document, all signatories commit to work together in a spirit of partnership to achieve the results identified in the results framework, work plan and budget. I hereby confirm that the funds requested are in accordance with the approved Work Plan & Joint Programme Document. I also certify that the copy transmitted to the MPTF Office is a true copy of the original which is secured by the RC Office. I have received documentation from Participating Organizations demonstrating committed amounts where applicable. I also confirm that the PUNOs' indirect cost does not exceed 7%.

Co-Chairs of JP Steering Committee

Government representative	UN Resident Coordinator
Ministry of Overseas Pakistanis and HRD Aslam Nadeem Chaudhry Signature [Redacted]	Name [Redacted] Signature [Redacted]
Date [Redacted]	Date [Redacted]
Participating UN Organizations	
Geir T Tonstøl Signature [Redacted]	Dr Luo Dapeng Signature [Redacted]
Name of Organization: ILO Date [Redacted]	Name of Organization: WHO Date [Redacted]

Non-UN Partners (as applicable) (note: JPC members are to be nnominated)	
<i>Name of Representative Signature</i>	<i>Name of Representative Signature</i>
<i>Name of Organization</i>	<i>Name of Organization</i>
<i>Date</i>	<i>Date</i>

JOINT PROGRAMME PROFILE

Contribution to Cooperation Framework Outcome(s) and Output(s)	<i>List relevant outcome(s) and output(s) from the country's Cooperation Framework that the JP will contribute to: <verbatim from CF></i> <i>In countries without a CF: list relevant outcome(s) and output(s) from available UNCT-agreed planning frameworks</i> The proposal aligns with the UN Sustainable Development Cooperation Framework (2023–2027), specifically, it contributes towards Outcome 4 “By 2027, women, girls and transgender persons in Pakistan, especially those at greatest risk of being left behind, benefit from an enabling environment where they are empowered and reach their fullest potential; and their human, social, economic, cultural and political rights are fully protected and upheld.” The proposal contributes particularly to: - Output 4.2: National and provincial stakeholders are supported to adopt employment policies and implement programmes to create adequate decent employment, income generation and empowerment opportunities for youth, women and other vulnerable groups, including food insecure communities, to enhance their resilience and livelihoods, as well as to facilitate effective labour market transitions and to output - Output 4.5: Inequalities and disparities in the world of work are reduced by promoting and facilitating women’s economic empowerment, by strengthening the capacities of national and provincial institutions, employers’ and workers’ organizations, and by preventing violence and harassment at work. In addition, the proposal links with Outcome 1 “By 2027, the people in Pakistan, especially the most vulnerable and deprived, have increased equitable access to and utilization of quality, sustainable basic social services.”
SDG Targets directly addressed by the Joint Programme	<i>List min 2 and max 6 SDG targets that the JP will address</i> <i>The JP will address the following SDG targets:</i> Target 1.3: Implement nationally appropriate social protection systems and measures for all, including floors, and achieve substantial coverage of the poor and vulnerable. Target 3.8: Achieve universal health coverage, including access to quality essential health-care services. Target 3.C: Substantially increase health financing and recruitment, development, training, and retention of the health workforce. Target 5.5: Ensure women’s full and effective participation and equal opportunities in leadership and decision-making. Target 8.5: Achieve full and productive employment and decent work for all women and men, including for young people and persons with disabilities, and equal pay for work of equal value.
Expected key results of the Joint Programme	<i>Include (up to) 3 main expected results</i>

Result 1: Enhanced job quality, employability, and skills of the health workforce

Phase I: At least 20,000 nursing, allied health, and community-based cadres have access to upgraded, high-quality, accredited skills development programs¹

Employability, mobility, and productivity are enhanced by Recognition of Prior Learning (RPL), digital/ blended learning, and updated curricula (integrating OSH and use of technology).

With an emphasis on women and under-represented groups, pilot formalisation pathways in public and private hospitals offer safer working conditions, career advancement, and respectable employment.

Phase II: Adopt nationwide curricula, RPL, digital credentials, and formal employment practices to scale up to 80,000 health workers.

Increased female participation and leadership

Result 2: Strengthened governance, accreditation, and workforce regulation

Phase I: Improved the regulatory capacity, accreditation, certification, and governance of organisations like the Allied Health Professionals Council and Pakistan Nursing and Midwifery Council.

Improved standards, standardised curricula, digital credentials, and gender-responsive leadership frameworks indirectly benefit up to 20,000 health workers.

Phase II: Quality assurance, transparency, workforce planning, and mobility are all improved for health workers through the national harmonisation of standards and regulatory systems.

Result 3: Expanded social protection, policy coherence, and financing readiness

Phase I: Through formalisation pilots, social protection and OSH coverage are expanded to up to cover 5,000 frontline and community health professionals.

The gender-responsive National Roadmap for the Global Accelerator, Provincial Action Plans, and the National Employment Policy contribute to policy convergence.

Phase II: 80,000 health and care workers nationwide, including migrant and community-based workers transitioned to formal employment (with access to social protection and OSH)

Increased investment preparedness and policy coherence mobilise multilateral, and domestic funding for long-term reform and sustainability of decent work

¹ The Nursing degree programme is four years; the degree programme curricula will be updated to include elements of decent work including OSH, climate change, and technology use. The curricula will be amended through PNMC, while certification courses for those in nursing and other health sector workers (including Allied Health workers) will be introduced specifically to upgrade existing competencies in OSH, climate adaptation, and emergency response.

	promotion and workforce development in the health sector (focusing nursing, allied health and community based) including bilateral migration agreements including protections for workers in line with <u>ILO guidelines for bilateral labour migration frameworks</u> .
Anticipated direct beneficiaries	In Phase I (18 months), the programme will directly reach at least 20,000 health and care workers through updated curricula, digital learning, and targeted formalisation and social protection pilots in Islamabad Capital Territory (ICT) and Punjab, with at least 80 per cent women. Within the first nine months, early wins will include: endorsement of the Global Accelerator national roadmap and its financing strategy; completion of capacity and regulatory assessments for PNMC and AHPC; validation of the community/PHC nursing qualification package; launch of a prototype digital training platform and testing of model contracts and enrolment procedures for a first group of community and other informal health workers. Building on these foundational achievements, Phase II will focus on scaling reforms nationwide, with an ambition to reach at least 80,000 health workers through upscaling of upgraded curricula in Nursing and other health teaching institutions, recognition of prior learning, and digital platforms, and to extend formalisation and social protection coverage health workers, subject to policy decisions and fiscal space created during and immediately after Phase I.
Anticipated financial leverage (both phase I and phase II)	<i>The total amount in USD</i> - Co-funding (within the JP budget): US\$ 63,000 (WHO) - Co-financing (parallel to JP budget): US\$ 65,000 (ILO)

The secondary focus on SDG Transitions in the JP <i>Select all that are incorporated into the JP strategy and results, in addition to Social Protection and Jobs transformation as the primary focus.</i>	☒ Digital Transformation ☐ Food Systems Transformation ☐ Energy Access and Affordability ☒ Transforming Education ☒ Climate, Biodiversity, Pollution
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JOINT PROGRAM DESCRIPTION

Respect the max number of pages / words – all other content to be included in additional annexes. Unless explicitly mentioned, refer to the overall JP, including both phase I and phase II.

1. Baseline and Situation Analysis (max 500 words)

PLEASE KEEP THIS SECTION BRIEF. Provide a concise, evidence-based description of the specific challenges affecting social protection and jobs in the context and the barriers hindering progress towards financially sustainable, universal extension of social protection and decent jobs' transformation. Focus only on the precise problems your joint programme will address, highlighting its transformative approach, integration methods, scale potential, and sustainability. Avoid general economic context or generic references to global challenges.

Pakistan's healthcare workforce faces a range of deeply interconnected structural challenges that undermine the delivery of quality care across the country. There is a persistent and severe shortage of essential personnel—particularly nurses, midwives, and Lady Health Workers (LHWs)—coupled with a significant imbalance in their distribution between urban and rural areas. These structural weaknesses are clearly reflected in critical workforce indicators. The nurse-to-doctor ratio remains around 0.5:1. Pakistan is on the WHO Health Workforce Support and Safeguards List, indicating critical health workforce shortages that threaten progress toward Universal Health Coverage.²

A misaligned skills mix, inadequate training for emerging priorities, unsafe workplaces, weak career pathways, and emigration undermine capacity, while widespread informality excludes most workers from benefits; women, specially working in informal settings, face added barriers through pay inequity, limited leadership access, and insufficient protection from workplace violence and harassment.

Fragmented coordination between social protection and employment policies, together with constrained fiscal space, limits the extension of meaningful social protection coverage to health workers. Pakistan's persistently low tax-to-GDP ratio and long-standing underinvestment in human capital further restricts the sector's capacity to adopt digital innovations and to prepare for the growing health impacts of climate change.

In response, the Joint Programme aligned with the integrated policy and financing approach of the Global Accelerator on Jobs and Social Protection for Just Transition adopts a comprehensive, systems-level strategy. It deliberately links skills upgrading, employment formalisation, and the extension of social protection with strengthened institutional capacities, workplace based improvements, regulatory frameworks, and sustainable financing arrangements.

Key elements include modernisation of curricula, professional certification, and the expansion of digital and blended training modalities to enhance employability, facilitate career mobility, and improve workforce productivity while reducing both the time and cost of scaling training. Pilot pathways for formalising employment in public and private health facilities aim to improve working conditions and extend social protection coverage to both formal and informal frontline workers. Concurrently, by leveraging ongoing support of the ADB programmes focusing governance and institutional reforms focus on strengthening accreditation and quality assurance systems, the joint programme will further inclusive, gender-responsive leadership, while facilitating sustainable allocation of resources from public and private sources.

A central output of Phase I is the development of a nationally owned Global Accelerator roadmap for the health and care workforce. This roadmap will be prepared through a broad, participatory process involving federal and provincial governments, workers' organisations, employers, development partners, and civil society. The roadmap will clearly define priorities, outline necessary reforms, and identify financing requirements and sources, thereby creating the conditions for scaling successful Phase I interventions in Phase II.

In Phase I, up to 20,000 health workers are expected to benefit directly from accessing upgraded curricula at nursing and training institutions (short certifications available through health academies, TVET stream, formalisation, and

² WHO health workforce support and safeguards list 2023.

social protection pilots. Phase II will extend these reforms nationwide, reaching hundreds of thousands of workers, particularly women and those in underserved cadres, while strengthening institutional capacity to roll these out at scale.

Promoting decent working conditions and securing protected jobs for health workers, the joint programme aims to achieve reduced illness-related absenteeism and disability, increased productivity, higher household incomes (especially for women), greater labour force participation, decreased pressure on tertiary facilities, and more efficient use of public resources.

2. Programme strategy and Theory of Change

(max five pages or 4000 words in total, excluding graphical representation of the ToC and tables).

Demonstrate the rationale and description of the strategy, anticipated results and the Theory of Change for the joint programme. The section should encompass both phases I and phase II and clearly identify the critical elements necessary to trigger phase II.

The section should be coherent with the integrated results framework, work plan and budget, and other annexes.

Provide a brief one paragraph summary first, all other information should be included under the following headings. Whenever adequate, present the approach in bullet points, graphs and tables, while not exceeding the maximum number of pages/words.

The Joint Programme will deliver meaningful and lasting results for Pakistan's health and care workforce. Through strengthened skills development, many frontline workers including nurses, midwives and other informal cadres will gain formal recognition of their experience, access updated curricula, professional certification, and flexible digital and blended learning opportunities that make career progression faster and more achievable. A significant number will move from informal to formal employment, benefiting from safer working conditions, clearer promotion structures, and comprehensive social protection coverage, including pensions, health insurance, and paid leave. The nationally owned Global Accelerator roadmap will establish a coherent national strategy that unites workforce planning, employment policies, social protection expansion, and sustainable financing across federal and provincial levels, reducing fragmentation and enabling more reliable and equitable resource allocation.

The Joint Programme takes a systematic approach to strengthen employment systems, social protection including health protection, and enhances the skills of health workers, with particular attention to women, youth and vulnerable groups. The programme has two distinct strands;

- I) improving working conditions and environment in the health sector, while improving policy frameworks and institutional capacities, governance and financing;
- ii) improving capacities of health workers for improved service provision, employability and resilience to changing climate and technological advancements;

The programme will concentrate on three strategic areas to deliver on its objectives. It will support policy reforms aligned with global standards, helping health workers meet occupational safety and health requirements and respond to technological and climate challenges. It will also strengthen institutions by improving the recognition of prior learning, aligning certifications with international standards, and ensuring skills recognition are better linked to professional licensing systems. In addition, the programme will encourage targeted investments in the health sector, guided by the Global Accelerator Roadmap developed under the Joint Programme.

Through coordinated policies that promote decent work, improve qualification and licensing systems, extend social protection to underserved health workers, and strengthen healthcare governance and financing, the programme seeks to build a more inclusive and sustainable health system. This approach will help accelerate progress towards SDG 8 and SDG1, by generating decent jobs, enhancing protection and reducing poverty, particularly those that are most

marginalized, finally contributing to inclusive development. The policies will be accompanied by a costed implementation framework identifying domestic financing and others as part of its financial sustainability. The policies however, will be drafted in parallel to the pilots which will be initiated as soon as stakeholders are ready during the initial inception phase, this will also allow for the JP to consider realistic cost estimates for scaling of pilots, and adapt the policy development drawing from the experience on the ground. The integrated employment and OSH policies will also take into account the scaling of pilots including digitalisation of training and parity in access; in addition, these policies shall also include frameworks that will project costs for formalisation in the sector, including labour and social protection coverage, and the potential revenues from the extension of tax and contributory social security bases.

The private sector is a major contributor to the provincial employees' social security institutions. 6% of the wages is contributed to extend a range of benefits to the secured worker. These benefits include health coverage, invalidity, employment injury, maternity protection among others. The Joint Programme will therefore engage provincial ESSIs to leverage health facilities governed under ESSI Act to extend benefits to all workers beyond the nature of contract and employment. The ILO has already signed a MOU with Punjab Employees Social Security Institution, through actuarial studies, the viability of the expansion of benefits will be assessed and this will contribute to the design and upgrade of existing coverage and adequacy of benefits.

2.1. Theory of Change (max 1000 words)

Anchored in the Theory of Change of the Cooperation Framework, develop a model of anticipated transformation of the broader (eco)system. The model relates to impact and/or results at outcome level, beyond the specific interventions of the joint programme through selected entry/leverage points, as such an overall change is the responsibility of a larger group of stakeholders.

- *Within the model, refer to the domain of change (the (sub)system in the focus of the joint programme) and the relationship between the problem space and solutions space, focusing on the selected pathways of systems change and transformative impact through both phase I and phase II.*
- *Integrate the expected joint programme results into the overall model by linking them to the impact/outcomes of the broader group of stakeholders (in particular, the Government).*
- *Identify the most important assumptions that lay at the foundation of the overall anticipated model of transformation. Note that the validity of the model presented in the Theory of Change depends on these assumptions – if they change, the model might need modification, and hence a necessary course correction of the overall joint programme strategy and adaptive implementation. These assumptions should be aligned with the risks from the relevant section “6. Challenges and Risks”.*
- *Identify the critical elements that must be accomplished in phase I to ensure that phase II remains viable and strategically coherent.*

The Joint Programme’s theory of change is that;

If Pakistan strengthens workforce skills and recognition pathways, reinforces regulatory and institutional capacity, and promotes formalisation, social protection, and gender equality in an integrated manner in the health sector, then workforce investments become lower-cost, lower-risk, and fiscally viable. This, in turn, enables provincial and federal governments, as well as international financial institutions, to scale up investments through recurrent budgets, development programmes, and results-based financing mechanisms. As a result, Pakistan’s health system becomes more adaptive, resilient, and responsive to national and global health challenges and decent work and inclusive economic growth is ensured in the health sector.

First, if health sector professionals—particularly those at the primary, community, and informal levels—gain access to up-to-date, competency-based curricula that integrates occupational safety and health, climate adaptation, biohazard management, disaster preparedness, digital health, and gender-responsive practice, and if Recognition of Prior Learning (RPL) is embedded as a formal pathway into certification and licensing, then the workforce becomes more skilled, motivated, and deployment-ready. The introduction of digital and blended learning material and modules reduces costs and expands access to underserved districts, making workforce development more efficient and scalable.

Second, if regulatory and governance institutions, particularly the Pakistan Nursing and Midwifery Council and the Allied Health Professionals Council, are strengthened through institutional capacity building, accreditation, and competency-based licensing systems, then workforce quality, transparency, and accountability improve. As regulatory capacity improves, provinces are better positioned to absorb and manage large-scale financing through Annual Development Plans, recurrent budgets, and IFI-supported operations.

Third, if skills development and certification are linked to formal employment pathways, access to social protection, and gender-responsive labour policies, then informality in Pakistan’s health labour market can be progressively reduced. Improving working conditions and environment will bring meaningful impacts at workplaces improving health coverage and strengthens the economic and social case for increased public financing and IFI co-financing, while aligning with national priorities on women’s employment and care economy expansion.

2.2. Strategic Approach

The JP is focused on the following integrated framework to enable the transformation in the health sector:

Strengthening the regulatory frameworks and Institutions

Phase I will strengthen regulatory and governance systems through social dialogue and inclusive engagement of employers and workers. The policy environment will be reinforced to promote decent working conditions, enable formalisation, and expand labour and social protection for health workers. Institutional capacity building will focus on upgrading curricula for degree and in-service training, modernising certification systems (including recognition of prior learning), and rolling out training-of-trainers to ensure scale and sustainability.

Political commitment and stakeholder wide ownership

Political commitment will be anchored in a national health workforce roadmap that brings together all relevant stakeholders. The roadmap will explicitly address the often-overlooked nexus between jobs, social protection, and cross-cutting priorities linking health, labour, environment, and sustainability, fostering a whole-of-government and whole-of-society approach.

Sustainable Funding

Supporting the investment of adequate and sustainable financial resources for cascading updated curricula through degree programmes, certification and training programs, availability of training modules digitally and leveraging ongoing regulatory reforms will be a key to the programme's strategy. Phase I will focus in setting up financing frameworks with government systems, improving the investment environment to attract private investment, and deepen partnerships and co-creation of operations to invest in the sector with IFIs. Phase II will focus on ensuring the resources needed are indeed being directed to the sector, monitor and evaluation expenditure and investment patterns, and support the further leveraging of financing.

Demonstrating change through pilot interventions

The JP will pilot key interventions in geographic location(s) where impacts can be demonstrated. Pilot programs in Phase I, such as community nursing, digital training platforms or workforce formalization processes and workplace based improvement through HealthWISE, will allow for the testing of new ideas and solutions in a controlled environment before they are rolled out on a larger scale in Phase II.

Awareness and Communication

Finally, a well-thought-out public awareness and communication strategy is essential for fostering public support and understanding of the transformation process. A strong awareness and communication strategy highlighting the critical role of nurses and health workers in protecting populations and their right to secure, protected, and decent employment will be designed.

The focus of the two phases of the JP is presented below.

Phase I: Immediate Interventions and Capacity Building

Phase I is deliberately designed as a system-preparation and de-risking phase. It addresses institutional, regulatory, and capacity constraints that currently prevent large-scale public, private and IFI investments from flowing effectively into Pakistan's health workforce. By establishing credible standards, delivery mechanisms, governance and financing arrangements, Phase I creates the preconditions required for Phase II scaling, institutionalisation, and sustained financing. The three major components of this phase are:

1. Curriculum Reform and Digitalisation

In Phase I, the rapid updating and standardising competency-based curriculum, including primary care, occupational safety and health including violence and harassment, climate adaptation, digital health and gender-responsive practice, serves a dual purpose.

The introduction of digital and blended learning modules establishes a low-cost, high-reach delivery, enabling outcome-based financing models increasingly favoured by institutions such as ADB and the World Bank. In Phase I, this programme is designed as a scalable national model, endorsed by regulators and linked to employment policy.

2. Institutional and Regulatory Strengthening as a Precondition for IFI Engagement

Phase I investments in strengthening regulatory bodies, are essential to unlocking Phase II financing. IFIs require strong counterpart institutions capable of accreditation, certification, data reporting, and fiduciary oversight. By enhancing regulatory capacity, alignment with international standards and leveraging ongoing reforms to assessment and licencing, Phase I reduces implementation risk for large-scale investments, while improving the effectiveness of already allocated resources.

The programme's alignment with ADB technical assistance to provinces, including support for Centres of Excellence, directly positions Phase I outputs within existing and pipeline IFI operations. In addition, strengthening worker representation and advocacy capacity builds the political and institutional demand for sustained public financing, including the possible ratification and implementation of ILO Conventions C149 and C190³.

3. Formalisation, Gender Equality, and Social Protection as Fiscal Anchors

ILO's studies point to systemic gaps in social protection, working conditions, and labour recognition, in the formal and informal streams, further marginalising contract, and women-dominated cadres such as LHWs and CHWs.

Phase I initiatives on formalisation, introducing contracts, social security enrolment, and benefit packages, guided by ILO frameworks linking skills development with social protection, the programme creates a workforce that can be financed through government budgets, private sector investments and IFI-supported reforms.

For IFIs, formal employment relationships and social protection coverage are critical conditions for financing recurrent costs such as salaries, benefits, and workforce expansion. Phase I establishes these foundations, particularly for women-dominated cadres, thereby enabling Phase II investments in decent working conditions.

Phase I to Phase II transition:

GA National roadmap

To ensure the program's success, Phase I must establish a robust and comprehensive foundation. This roadmap will serve as the cornerstone for securing national ownership of the program's activities, as well as the broader priorities needed to support the ecosystem required for achieving the desired outcomes, including resources. The strategic framework will outline the necessary inputs to drive the catalytic changes, ultimately delivering the expected outcomes for the joint program and guiding Phase II. Design and piloting of formalisation pathways and social protection extension packages for community and other informal health workers, including costing and financing options, will provide the basis for government decisions to expand contributory schemes and allocate additional resources in Phase II.

Phase II: Scaling, Institutionalising, and Sustaining Change

Phase II builds on the foundations laid in Phase I and focuses on scaling the reforms and interventions to ensure sustainability and institutionalisation. The goal is to embed the changes into the core health systems to create an adaptive, resilient, and inclusive health workforce.

³ ILO Convention No. 149 (Nursing Personnel Convention, 1977), ILO Convention No. 190 (Violence and Harassment Convention, 2019)

1. Sustainability and expansion:

In the long term, the skills upgrading and recognition of prior learning for health and care workers will be consolidated and supported by sustainable financing solutions for cascading (see ahead). The availability of digitalised certification courses in upgraded skills and competencies will enhance the workforce's access and ability to respond to climate-related health risks, biohazards, and disaster situations, leading to more effective, proactive and quality healthcare delivery.

The scale up of the community nursing program and concurrent work on inclusion of jobs for nurses through employment policy will enhance the employment opportunities for females to enhance social protection.

2. Gender-Sensitive Policies and Leadership:

Building upon an initial assessment of the barriers and enablers of women's leadership in the health sector in Pakistan conducted under the ILO-OECD-WHO Working for Health Programme, this work will ensure that evidence-based strategies inform policy reforms, fostering an inclusive environment where women can fully participate and thrive in leadership roles. The implementation of the HealthWISE toolkit will provide a practical and systematic way of gender mainstreaming.

The HealthWISE ensures integration of gender-sensitive policies (such as those ensuring safety at workplace and discrimination free environment) creating a more equitable environment for women, enabling them to access the same training and career development opportunities as their male counterparts. Promoting sector specific labour standards that promote equal access to training and opportunities, rights to organise and access to social protection, both women and men can thrive equally in the health workforce,

3. Sustainable Financing Mechanisms:

The ADB is funding infrastructure improvements in the nursing sector in the 2 provinces (150 million \$ for Punjab and 100 million \$ for Sindh), through the program, WHO and ILO will assist the Govts/the ADB programme in policy development, capacity-building, introduction of new programs such as community nursing and strengthening regulatory frameworks. ADB is also locking in grant support for the nursing council to strengthen its capacity. By partnering with these organizations, the programme can tap into global funding pools and expertise, ensuring that the reforms are not only implemented but also sustained over the long term. This approach also enhances the credibility and international support for Pakistan's health sector reforms, which can lead to additional financing and collaboration opportunities.

In parallel, developing sustainable financing mechanisms both through channelling domestic financing and unlocking private sector contributions through investment in capacity building, improving working conditions and extending social protection will remain the focus of the JP.

Assumptions:

Assumption	Risks	Practical Mitigating Measures
Health workers will adopt new training models, including digital platforms and updated curricula for emerging health challenges.	Rural workers may lack internet access or digital skills, slowing training uptake.	Combine digital with in-person mentoring, and run short digital literacy workshops using existing community centers.
Regulatory bodies (PNMC, Allied Health Professionals	Weak funding or political interference could limit	strengthen reporting systems, provide targeted training to regulators to maximize impact with

Council) will have resources and political support to enforce standards.	enforcement, creating an underqualified workforce.	minimal budget.
Health workers/employers will participate in the health insurance programmes	governments/employers may resist due to costs or bureaucracy, slowing formalization.	Start with phased enrollment and simple benefit packages, provide incentives such as recognition, certificates, and use mobile or local registration points to reduce administrative burden.
Gender-sensitive employment and OSH policies will be implemented successfully.	Workplace resistance may limit women's access to training, career growth, or leadership.	Promote mentorship programs, flexible scheduling, safe reporting mechanisms, and awareness sessions using local leaders or champions; emphasize policy changes like equal pay policies and anti-harassment guidelines.
Climate change and related health risks will be integrated into health policies and workforce training.	Lack of integration leaves workforce unprepared for disasters or climate-sensitive health issues.	Incorporate short modules on climate and disaster response into existing curricula
Pakistan will secure long-term financing for health workforce reforms.	Economic instability or reduced external funding could threaten sustainability.	Use phased interventions with clear cost-benefit tracking, mobilize existing provincial budgets, encourage modest employer contributions, and leverage partnerships with local NGOs or community organizations to co-fund training and OSH initiatives.

Ensure a coherent and strategic narrative of the Theory of Change and summarize it (max half a page).

Add a graphical representation (eg systems map, synthesis map, influence diagram or related).

Note that the Theory of Change is not limited to the specific results of the joint programme (including both phase I and phase II) – these are included along with the other results (outcome/impact) that are beyond the immediate scope of the joint programme. The results of the joint programme represent particular catalytic interventions into the broader (eco)system.

Ensuring decent employment conditions, fair remuneration, supportive working environments, and effective labour market policies for health workers is fundamental not only for building resilient, equitable health systems capable of delivering universal health coverage, but also for realising broader development objectives such as sustained economic growth, gender equality, and the achievement of the 2030 Sustainable Development Goals

The Joint Programme is designed to strengthen Pakistan's health workforce, making it more capable, resilient, and responsive to current and future health challenges. It targets key gaps through focused, practical interventions that improve the quality and reach of health services across the country.

The programme prioritises upskilling of health workers; nurses, midwives, Lady Health Workers, community health workers, and allied professionals, in essential areas including evidence-based practice, health policy, leadership, research, patient safety, professional development, management of biohazards, disaster response, and climate-related health risks. Particular emphasis is placed on digital and blended learning platforms to extend quality training to rural and underserved districts where access has historically been limited.

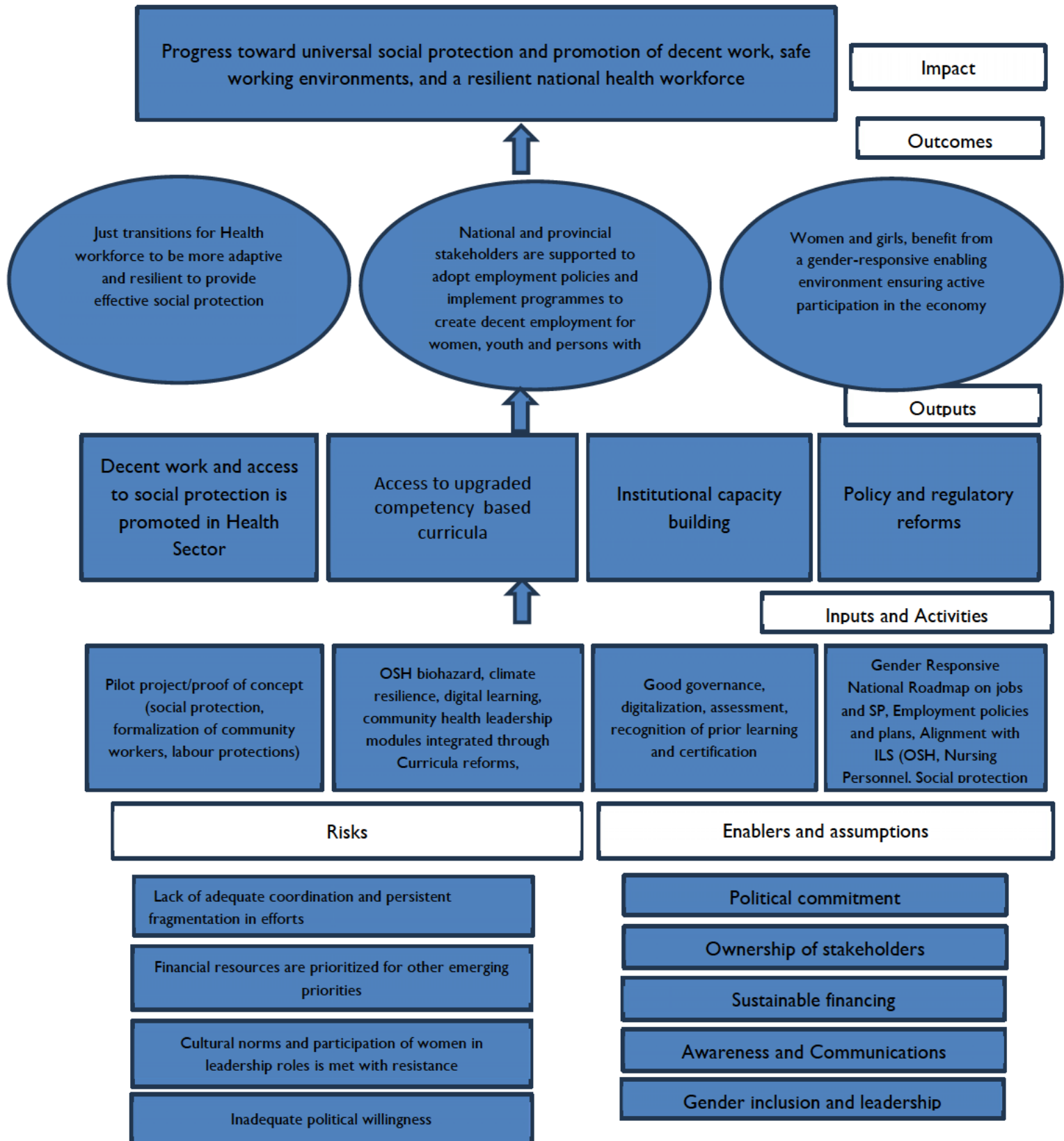
While digital training offers significant advantages in terms of cost and coverage, challenges such as limited digital literacy, unreliable internet connectivity, and inadequate infrastructure in remote areas must be addressed through offline modules, hybrid models, and targeted support.

A core component of the programme is the strengthening of regulatory institutions, particularly the Pakistan Nursing and Midwifery Council (PNMC) and the Allied Health Professionals Council. With adequate resources, updated systems, and consistent political support, these bodies can enforce national standards, improve licensing and accreditation processes, and enhance overall professional credibility. Continued reform efforts, including implementation of the amended PNMC Act and the National Nursing and Midwifery Policy Framework (2023–2035), provide a strong foundation for this work.

The programme also seeks to reduce informality in the health workforce, especially among women in community-based and lower-tier roles. By developing pathways for formal contracts, social health protection, pensions, maternity benefits, sick leave, and improved occupational safety and health measures, it aims to provide greater job security, better working conditions, and long-term workforce stability. While financial constraints and administrative challenges exist, carefully designed pilots and policy advocacy can help make formalisation viable and sustainable.

Gender equity remains a central focus. The programme promotes equal opportunities for women in training, career progression, and leadership positions, alongside measures to address pay gaps, precarious employment, and workplace harassment. Overcoming cultural and societal barriers will require sustained effort, but increased female representation in decision-making roles will contribute to more responsive health policies, particularly in areas such as maternal and child health, family planning, and gender-based violence.

These interventions are not intended to operate in isolation. Rather, they are deliberately catalytic, aimed at triggering broader systemic improvements in workforce governance, lifelong learning, domestic and international investment, and overall health system performance. The ultimate objective is a more inclusive, equitable, and future-ready health workforce that can effectively serve all segments of Pakistan's population.



2.2 Description of the Transformative impact

As an extension of the Theory of Change, describe the “end game” (situation when the intervention ends, with a lasting catalytic impact, after phase II). It should present in a clear and brief manner the anticipated scenario of what will have changed by the end of phase I and phase II, including the following:

- **Alignment:** Explain how the JP aligns with strategic national policy document, including the current Global Accelerator Roadmap on Jobs and Social Protection and other national related policy frameworks. Show how the JP directly supports their implementation and scaling up.
- **Key Results:** Clearly state what specific, measurable, at scale and medium to long-term changes will occur by phase I, phase II, and in its follow-up, in terms of beneficiaries, resource flows, policies, behaviors, and partnerships. Specify the expected impact in terms of 1) long term social protection and poverty reduction outcomes; 2) social protection system finance; 3) increased agency of national actors and institutions; 4) The change in the lives and livelihoods of the relevant LNOB groups. What will be this JP’s lasting legacy in the country?
- **Systemic change** reflected in: 1) new or increased resource flows (including a pipeline of projects ready for financing), 2) norms/purpose/policy/goals, 3) legislative/regulatory and institutional framework unlocking/enabling transformation, 3) behavior (eg new or stronger incentives), 4) KPIs/performance of the system (eg in service delivery), 5) relationships/partnerships (including bringing in new actors), and 6) implementation arrangements (redesign for efficiency, effectiveness, quality and access) and power dynamics, 7) enhancement of capacity and development of partnerships of the key stakeholders to sustain transformation change and further scale the impact.
- **Causal Logic:** Explain how your specific activities and outputs will directly lead to these outcomes.
- **Adaptive implementation:** Focus on a **phased approach** that takes into consideration the assumptions, changing context and the need for course correction. Hence, identify milestones in both phase I and phase II for review of the strategy, depending on possible changes in the context and/or assumptions of the Theory of Change. Identify the “**low-hanging fruits**” that would be produced already within the first 9 months of implementation.

The Joint Programme is fully aligned with Pakistan’s strategic policy landscape and national priorities. It advances the Government of Pakistan’s priorities as outlined in draft national health & population policy, and provincial health sector strategies, National Nursing and Midwifery Framework, the Pakistan Nursing Council and Midwifery Council reform agenda, and climate change and disaster risk reduction policies. In doing so, the programme supports the operationalization of these policies at scale through pilots, institutional reforms, capacity-building initiatives, and the strengthening of regulatory and governance structures. It also aims to develop a national roadmap for the Global Accelerator, expanding social protection coverage for informal health workers, promoting decent and safe workplaces, strengthening workforce skills to enhance resilience to climate change, digital transformation, and future health emergencies, and establishes sustainable financing pathways for integrated social protection and workforce systems.

From the outset, the programme focuses on strengthening the foundations of the health workforce and social protection. Health workers, both formal and informal, receive training in occupational safety and health, climate-resilient practices, digital skills, and decent work standards, with particular attention to enhancing gender equality. Informal and community health workers are linked to social protection schemes and pilot interventions that expand access to income security and essential services. Institutional reforms include the establishment and piloting of a digital learning platform, the adoption of regulatory strengthening frameworks by the Pakistan Nursing and Midwifery Council and partner institutions, and the development of schemes for financing broader social protection coverage of CHWs. Early behavioural changes are evident as health facilities adopt safer practices and workers engage with digital training tools. Multi-sectoral partnerships are fostered across ministries, regulatory bodies, provincial authorities, social protection institutions, and UN agencies to ensure coordinated action.

As the programme matures, its focus shifts to scaling and institutionalizing reforms. Training reaches a broader set of health workers, including women, rural workers, and other groups often left behind, while pathways for formalizing informal health workers are strengthened. Institutional reforms are integrated into provincial health sector plans, labour and occupational safety frameworks, and regulatory systems. Competency-based licensing and continuous professional development systems are implemented, and national strategies for scaling digital training and social protection coverage are advanced. Behavioural shifts are reinforced as digital training becomes embedded in routine professional development and employers adopt safer, more equitable workplace practices. Partnerships expand to

include private sector actors, donors, and training institutions, supporting co-financing and sustainability of interventions.

The programme envisions a resilient, professional, protected, and gender-responsive health workforce embedded in national policy and financing systems. Informal and community health workers enjoy predictable income security and access to essential services, supported by blended financing models and strengthened fiscal space. Regulatory councils, provincial authorities, and training institutions operate enhanced systems autonomously, while groups often left behind experience improved livelihoods, reduced vulnerability, and greater agency. This transformation contributes directly to achieving universal social protection, strengthened health systems, improved workforce conditions, and climate and disaster resilience.

The programme’s approach is guided by a clear causal logic. Training, social protection pilots, digital platform development, curriculum reform, alignment with international labour standards, and regulatory strengthening generate outputs such as a skilled and resilient workforce, enhanced regulatory systems, expanded social protection coverage, improved workplace practices, and gender-responsive systems. These outputs lead to outcomes where the health workforce is effective, resilient, and enjoys access to decent work opportunities, ultimately contributing to long-term impacts including universal social protection, poverty reduction, and stronger, shock-responsive health systems. Adaptive implementation is central to the programme’s strategy. Early milestones focus on establishing digital training platforms, developing occupational safety and climate resilience curricula, assessing regulatory and institutional capacity needs, mapping informal health workers, analysing gender barriers, and setting up multi-stakeholder partnership mechanisms through the roadmap. As evidence emerges, interventions are refined and scaled, ensuring alignment with evolving political and financing contexts, and stakeholder priorities.

Describe the overall impact through the five dimensions of transformative change using the table below (in brief bullet points)

Key pillars of transformative change	Key elements of the joint programme demonstrating transformative change
Integration	The programme brings together multiple sectors; health and labour and social protection policies, gender equality initiatives, training and fiscal reforms, into a unified approach that ensures cross-sectoral coordination. The integration of workforce training, regulatory strengthening, developing employment policies with healthcare reforms will create decent jobs in the health sector, enhance healthcare delivery, and promote transitions from informal to formal employment. By addressing the overlapping challenges of healthcare, employment, social protection and gender equality, the programme will create a holistic response to the interconnected barriers to equitable healthcare access.
Scale	The programme will directly reach up to 20,000 health workers during Phase I, operating at the federal level to establish policy, regulatory, and financing frameworks while informing structured scale-up at provincial level to ensure nationwide impact, including rural and underserved areas. International financial institutions, particularly the Asian Development Bank and the World Bank, play a pivotal role in this pathway. The ADB is already financing USD 150 million in nursing education and infrastructure in Punjab and USD 100 million in Sindh, providing a ready platform for integrating workforce quality, regulatory strengthening, and new cadres such as community nursing. Within this framework, WHO and ILO will provide complementary technical assistance for policy development, institutional capacity building, curriculum reform, introduction of community nursing programmes, and strengthening of regulatory bodies, including support to the Pakistan Nursing and Midwifery Council, for which ADB is also exploring targeted grant support. By anchoring workforce reforms within ongoing and pipeline IFI lending, the programme leverages global financing and expertise while enhancing the credibility and sustainability of Pakistan’s health sector reforms and opening pathways for additional co-financing and collaboration.

	Digitalisation of training enables rapid geographic expansion and cost-efficient reach to underserve populations, while Communities of Practice promote national adoption of best practices and their systematic cascading through health systems. In parallel, the programme advances sustainable financing mechanisms to ensure long-term workforce resilience in the face of demographic pressures, climate risks, and economic volatility. This includes strengthening social protection arrangements (such as health insurance and pensions) sick leave, and occupational safety and health—which are essential for retention, productivity, and workforce stability. Sustainable funding models are progressively embedded within federal and provincial budget frameworks, ensuring that recurrent allocations for training, salaries, safety and health, and social benefits are prioritised and maintained beyond the programme lifecycle. Blended financing approaches, combining domestic budgets with private and IFI resources, support iterative pilots and learning cycles that allow interventions to be tested, refined, and adapted before wider rollout, ensuring that scale-up remains fiscally feasible, institutionally anchored, and contextually relevant across Pakistan’s diverse provincial settings.
Speed	The programme will adopt a phased approach, with the first nine months focused on delivering foundational reforms. During this period, a costed national roadmap for collective action will be developed and endorsed through established federal–provincial coordination mechanisms. This allows financing pathways and priorities to be agreed rapidly and aligned with ongoing and pipeline ADB and World Bank programmes. In parallel, employment and occupational safety and health policy frameworks for the health workforce will be developed or updated by adapting existing drafts, regulatory instruments, and international standards to Pakistan’s context. The emphasis will be on policy frameworks and implementation guidelines that can be adopted administratively, avoiding lengthy legislative processes while still producing concrete policy outputs within nine months. During these first nine months, professional development programmes will be rolled out using modular, competency-based training aligned with international standards and delivered through blended in-person and digital modalities. This approach enables rapid upskilling of health workers without waiting for full curriculum reform. At the same time, digital training and continuing professional development platforms will be expanded by leveraging existing public and partner systems, allowing immediate reach to health workers in both urban and rural areas and reducing unit training costs. In parallel, coordination mechanisms will be operationalised through existing inter-ministerial and federal–provincial forums, supported by light programme management, continuous monitoring, and adaptive learning. This ensures rapid uptake, timely resource mobilisation, and early identification of bottlenecks, allowing the programme to build momentum and lay the institutional and financing foundations for sustained scale-up in subsequent phases.
Sustainability	The programme will focus on creating sustainable, long-term change through domestic resource mobilization pathways. This includes improving budgetary planning, enhancing domestic resource mobilization, and advocating for public-private partnerships to ensure ongoing funding for healthcare reforms. A key strategy will be increasing fiscal space for health investments, leveraging blended financing models, and working with international financial institutions to secure stable, long-term support for the programme’s initiatives. Furthermore, aligning the programme with Pakistan’s broader development priorities (such as

	Vision 2025, the SDGs, new national health and population policy (draft) and other national development frameworks) will ensure that the programme supports Pakistan's long-term goals and receives broad institutional backing for sustainability. The programme's focus on strengthening institutional capacity, especially at the provincial and district levels, will ensure that reforms are embedded within government structures, enabling the government to continue supporting the initiative even after its formal completion. Institutionalising of the interventions within Government policies, strategies, structures and resources and institutional strengthening through capacity building interventions and improved processes.
Local context-specific	The interventions have been aligned to Government policies and strategies, in particular by focusing on the health sector and broader care economy. The existing budgetary allocations in national budget have been assessed with entry points for interventions in the sector. A context-specific roadmap will be tailored to Pakistan's socio-economic realities, with careful adaptation to regional disparities and needs. The roadmap will account for provincial variations in healthcare infrastructure, workforce availability, and social protection coverage, ensuring that each province has a customized plan that fits its unique challenges and opportunities. The programme will also address local barriers to healthcare access and employment, including the need for gender-responsive policies and interventions for marginalized communities. By aligning the programme with Pakistan's local context, it will be more effective and inclusive, ensuring that reforms address the real needs of diverse populations across the country. This local adaptation will be a key driver of the programme's success and transformative impact.

The JP implementation will be organized around a results framework, which results expected are as follows:

Development Objective: To strengthen Pakistan's health workforce by recognising and building on its skills and competencies, while promoting gender equity, so that it can deliver accessible, high-quality, and community-focused health services. The programme aims to ensure decent work, social protection, and meaningful career opportunities—particularly for women in nursing, community outreach, and allied health—through strengthened governance, modernised training systems, and formalised employment structures

Outcome 1: The Joint Programme will create a resilient, skilled, and gender-equitable health workforce in Pakistan that delivers high-quality, accessible care, works in safe and supportive conditions, and drives a sustainable, efficient, and inclusive health system.

Output 1: Strengthened Governance, Regulation, and Institutional Capacity

- Gender-sensitive National Global Accelerator (GA) Roadmap developed, with clear priority given to health and care work.
- Detailed capacity assessments completed and institutional roadmaps prepared for PNMC and AHPC.
- Regulatory strengthening plans finalised (covering licensing, accreditation, RPL, and coordination).
- National Employment Policy and OSH Policy drafted, including health-sector-specific strategies.
- Regulators and health managers trained on inspection, quality assurance, and decent work principles building on the Working for Health Project and achievements in Pakistan.
- Financing and investment framework developed for health workforce development.
- Policy advocacy undertaken for ratification of ILO Conventions C149 and C190.

Output 2: Improved Training, Skills Development, and Digital Learning Systems

- National competency and skills gap assessment conducted (focusing on community nursing, allied health, and disability-inclusive cadres).
- Competency-based curricula updated (covering PHC, digital health, climate resilience, OSH, biohazards, and gender).

- Faculty capacity-building programmes implemented.
- Blended and digital learning platforms piloted, specially targeting rural and underserved areas.
- Standardised national qualification package for community/PHC nursing finalised (including RPL and licensing).
- Master trainers and provincial facilitators trained.
- Feedback, evaluation, and adaptive learning systems established.

- **Output 3: Enhanced Social Protection, Gender Equality, and Formalisation**

- Gendered mapping completed for informal and semi-formal health workforce segments.
- Formalisation packages designed (including contracts, wage grids, and grievance mechanisms).
- Social protection extension for health workers designed and piloted (health insurance, maternity leave, pensions, disability support, sick leave).
- Women's leadership capacity-building initiatives carried out.
- Costing and fiscal analysis completed for formalisation and protection scale-up.
- HealthWISE expanded in hospitals across Punjab.
- Worker organisations engaged for enrolment and awareness-raising.

Phase I outputs collectively create specific enabling conditions that unlock Phase II financing and scale:

Phase I Results and Systemic Transformation

Policy and Regulatory Certainty: Nationally endorsed GA Roadmap, aligned employment and OSH policies, and strengthened regulators significantly reduce political and fiduciary risk for public, private and IFI financing. Ratification-ready frameworks for key international labour standards prepared.

1. **Bankable Workforce Pipelines:** Standardised curricula, qualification packages, and accreditation systems create predictable, scalable supply chains suitable for programme and budget financing. Digital learning platforms reduce marginal training costs and improve cost-effectiveness.
2. **Fiscal Visibility and Costed Reform Options:** Costed formalisation and social protection extension pathways and workforce investment frameworks enable integration into MTBFs, ADPs, and PSDPs. Nursing and workforce information systems support results-based financing and expenditure tracking.
3. **Institutional Absorptive Capacity** PNMC, AHPC, provincial departments, and training institutions demonstrate readiness to absorb and manage large-scale financing and reforms. Centres of Excellence serve as strong implementation anchors.
4. **Social and Political Buy-in** Early engagement with worker organisations, women leaders, and provinces builds trust and reduces resistance. Expanding (HealthWISE, digital learning, social protection) demonstrate tangible benefits.

Phase II Outcomes and Systemic Transformation

- Nationwide scale-up of community nursing and allied health cadres.
- Digital lifelong learning systems institutionalised for community nursing and allied health cadres.
- Formal employment and social protection extended across frontline health workforce tiers.
- Gender-equitable leadership and career progression embedded in institutions.
- Sustained public, private and IFI financing anchored in national systems.
- Resilient, adaptable health workforce established, capable of responding to routine PHC needs, shocks, and climate-related risks.

3. Financing Jobs and Social Protection (max 1000 words)

Financing leverage:

Demonstrate potential funding and financing leverage through comprehensive partnerships (target: minimum leverage ratio of 1:5).

- *Leverage Ratio: Provide a verified leverage number supported by evidence/data with explicit assumptions. Clearly state whether amounts are committed or anticipated.*
- *Funding Sources: Leverage may include resources from public-private partnerships, private investments, UN co-funding, government contributions, DFI/IFI commitments, or other sources, regardless of UN channeling.*
- *Resource Categories: Resources can be categorized as:*
 - Co-funding of joint programmes: Financial resources that flow directly through the Joint Programme structure supported by the Joint SDG Fund (e.g. Matching funds within the JP structure)*
 - Co-financing of financing solutions: Financial resources that are invested or committed to the financial solutions developed or enhanced with support from the Joint SDG Fund (e.g. EBRD co-financing of the renewable energy financing facility in North Macedonia; Proceeds of the SDG bonds launched in Indonesia)*
 - Scale-up of policy services and demonstrative impact: Financial resources that are unlocked based on the integrated policy services or scaled up based on piloting and demonstrations supported by the Joint SDG Fund (e.g. Government budget allocation for cash transfer scheme in Mongolia, Government budget allocation for the chronic malnutrition programme in Guatemala, Bilateral donor scale up of INFF coordination actions in Comoros).*

Developing financing mechanisms:

Describe how your JP plans to develop a financing mechanism with up to 20% of the programme budget. Describe your proposed national financial leverage and/or mechanisms including its nature, modalities, key actors, and instruments to be deployed. Include size, capital structure, and sources of co-funding from private, public, and IFI/DFI partners, how these are contributing to reshaping the national social protection and labour policy architecture, and prospects for scale-up beyond the duration of the JP.

- *Visual Schematic: Include a visual schematic depicting the various actors and components of the financing solution and its territorial and localization focus.*
- *Governance Arrangement: Describe the proposed governance structure for the financing mechanism. This should include the roles and responsibilities of key national actors, particularly in relation to making investment decisions, providing strategic guidance, ensuring that investments and financial flows systematically advance economic, social and environmental sustainability and how the governance will ensure territorial ownership.*
- *If relevant: Business Model - present the specific financial metrics including projected annual cash flow over the project lifecycle and key metrics (e.g. return on investment, payback period, cost per development outcome). Explain the level of concessionality and its justification based on context.*
- *If relevant: Investment Pipeline - Outline the key projects, sectors, or companies targeted by the intervention. Assess the current development stage of the pipeline and the readiness of clients/beneficiaries to receive financing.*

The strategic approach of the Joint Programme includes dedicated actions and development of partnerships to ensure financing is leveraged to implement, sustain and scale the actions of the programme. By triggering additional allocation of government budget, attracting and aligning concessional financing and grants from IFIs and investments from the private sector, extending the coverage of contributory social protection and health insurance, and exploring blended finance models to create sustainable financing mechanisms, the joint programme will develop a robust and diversified resource base to advance the capacity and working conditions of the health workforce in Pakistan, and to develop a financing strategy for the GA national roadmap.

The overall design of the JP is underpinned by interventions that directly support the development of concrete financing pathways. In Phase I, the GA roadmap development and regulatory reforms will be accompanied by the introduction of new or repurposed budget lines in government, the development of IFI investment operations, the attraction of private investors, and the pilot formalization and social protection interventions will generate the evidence, administrative systems and financing architecture required for scaled expansion in Phase II. These pathways are reflected in the results framework through Phase I indicators that track, inter alia, roadmap endorsement, establishment of budget lines, integration of JP products into ADB and other IFI operations, and design and initial enrolment into adapted social protection schemes.

These efforts are expected to lead to a substantial financial leverage at the conclusion of phase II. The expected financial leverage is based on already existing commitments and partnerships, and on opportunities that the joint programme will explore during its implementation.

Regarding public financing, the Ministry of Finance, Government of Pakistan has initiated the assessment of creating a new budget line for the Global Accelerator for the purpose of budget allocations in the upcoming Financial Years and to contribute towards the development and implementation of the National Roadmap. Among existing commitments, the Government of Pakistan has planned the allocation of US\$ 25 million to TVET reform, which will include upgrading of curricula, digitalisation of learning activities, and ensuring better linkages between skills training and labour market needs. From the total investment from Government on TVET reform, it is being explored to channel some funds towards the roll out of the upgraded training curricula for health sector workers, through traditional training institutions, the planned digital training platform, and centres of excellence. This allocation is expected to take place between 2026 and 2027.

While the full US\$ 25 million TVET allocation will not be attributable to the joint programme, the JP is expected to influence and help operationalise the health-sector share of this envelope by acting as a convener for the different ministries and institutions involved, and by providing the technical outputs that facilitate discussions – such as the updated curricula, digital modules and centre of excellence models that can be financed under the reform. This allocation is currently planned by Government and considered a soft commitment, with the precise amount benefiting health workforce development to be determined during Phase I.

The joint programme will also benefit from aligned investments from the Asian Development Bank (ADB). The ADB will support the PNMC with US\$ 2 million grant that will supplement elements of the JP, including with curriculum reform, digitalization, assessment, and certification processes of the professional body. Nurses' curricula can be upgraded by shifting to competency-based, skills-focused training that integrates digital health, climate resilience, disaster preparedness, and occupational safety and health, while using blended learning approaches and recognition of prior experience to reach rural and underserved areas. Standardised curricula and certification will align with national and international nursing standards. ILO's value-add lies in embedding decent work, occupational safety, gender equity, and women's leadership into training, supporting the formalisation of informal nurses, linking skills development to social protection and fair employment. The US\$ 2 million ADB grant to PNMC is a confirmed commitment and constitutes co-financing that will directly contribute to the implementation and scale several JP outputs under Phase I.

This partnership also provides the opportunity to the joint programme to support and influence the design and implementation of ADB's pipeline projects "Sindh Nursing and Health Workforce Strengthening Project" and "Punjab Nursing and Health Workforce Reform Program", which will provide the respective provincial governments with loans of US\$ 100 million and US\$ 150 million, respectively. These loan operations will support the scaling of training of nurses and other health sector professionals, and the operationalization of the centres of excellence that the joint programme will support to develop. These provincial ADB loan operations are currently in the pipeline and the joint programme's Phase I outputs – particularly the design of centres of excellence, competency-based curricula, nursing and allied health qualification packages, and strengthened regulatory and information systems – are expected to support implementation of planned activities under these loans to revamp the nursing sector in Pakistan. Considering that a significant portion of the loans will be targeted at health infrastructure development, it is estimated that between 5 and 10 per cent of the operations (between US\$ 12.5 million and US\$ 25 million) will be destined to health workforce development, where the JP will be instrumental in guiding investments. The joint programme will pursue similar engagements with the World Bank and the Islamic Development Bank, both also investing the health sector of Pakistan.

Considering the magnitude of the supply gap in the number of health professionals in Pakistan, particularly nurses, it is unlikely that public financing alone will be able to overcome the challenge on its own. The JP will also work with private sector and investors to address barriers and bottlenecks to unlock investments in the health sector of Pakistan. Particular efforts will be made to attract investor for the extension of private skill development service providers, supported by a more enabling business environment, and increased demand for training in the sector resulting from

the JP's efforts on awareness raising and increased allocation of public investments. At the moment, the potential leverage for this cannot be established, but will be monitored during the implementation of the JP.

Through the design and extension of adapted social protection instruments to extend coverage to health sector workers, particularly CHWs, the joint programme will further leverage financial resources in the form of contributions from workers and employers. The joint programme estimates that within the first years of extension of coverage, between 20,000 health workers would benefit from social security and health insurance – amounting to an estimated US\$ 500,000 to US\$ 1,000,000 in yearly contributions collected. These contributory flows are expected to materialise primarily in Phase II and early post-programme years and are therefore treated as potential leverage, contingent on successful design, piloting and political adoption of adapted social protection instruments during Phase I. In similar fashion, employer financed skills training for the sector will be explored, anchored in the institutional development interventions with PNMC and AHPC.

In addition to these measures for financial leveraging, the joint programme will develop a financing strategy for the GA Roadmap that sets out practical pathways for implementation of the Global Accelerator beyond the JP. This strategy will outline indicative financing instruments (e.g. targeted budget reallocations and new lines for health workforce and social protection, potential adjustments to existing health insurance and pension schemes, public revenue enhancement, performance-based transfers to provinces, and a possible blended skills fund drawing on private training providers and employers), identify lead institutions such as the Ministry of Finance, Planning Commission, federal and provincial health and labour departments, PNMC, AHPC and social protection institutions, and sequence responsibilities over time. These will be complemented by efforts to mobilize bilateral and multilateral resources to support the implementation of the roadmap, and the technical assistance required. During Phase I, the focus will be on diagnostic work, options appraisal, stakeholder agreement and the design of priority instruments, with Phase II expected to support their embedding in medium-term budget frameworks and sector plans and, where feasible, to pilot selected instruments at provincial level.

Therefore, the JP is expected to leverage between US\$ 15 million and US\$ 28 million by 2028 – without considering larger scale public and private investments that the JP will endeavour to mobilize. This would lead to an estimated financial leveraging of the JP between at least 1:8 and 1:15.

Table 1: Joint Programme Financial Leveraging Potential Phases I + II

<i>PUNO</i>	<i>Description</i>	<i>Amount</i>	<i>Co-funding Co-financing</i>	<i>/ Status</i>
<i>WHO</i>	UHC Partnership Phase V funding 2026-28	US\$ 63,000	Co-funding	Confirmed
<i>ILO</i>	ILO in kind contribution	US \$ 65,000	Co-financing	Confirmed
<i>ILO/WHO</i>	Government budget allocation for years 2026-2027	To be determined	Co-financing	Soft commitment
<i>ILO/WHO</i>	Private sector investments directed to the sector	To be determined	Co-financing	Estimated
<i>ILO/WHO</i>	ADB's grant to NMC for curriculum reform, digitalization, assessment, and certification processes	US\$ 2,000,000	Co-funding	JP will leverage the funds to complement and co-deliver on commitments
<i>ILO/WHO</i>	ADB's pipeline projects "Sindh Nursing and Health Workforce Strengthening Project" and "Punjab Nursing and Health Workforce Reform Program"	US\$ 12,500,000 to US\$ 25,000,000	Co-funding	JP will leverage the funds to complement and co-deliver on commitments
<i>ILO/WHO</i>	Health insurance and social security contributions of health workers/employers supported by the JP (phase II)	US\$ 500,000 to US\$ 1,000,000/ yearly.	Co-financing	Domestic finance mobilised through the project interventions

4. Partnerships and stakeholder engagement (max 500 words)

Present key stakeholders and describe the multi-stakeholder engagement structure for programme implementation and oversight. Focus on:

- *National Government Leadership: Describe specific mechanisms ensuring government (national and or sub-national) ownership and steering as well as their specific roles in terms of guiding the implementation of the joint programme and the financing solution.*
- *Financing partners: Detail specific actions and initiatives engaging financial institutions, government finance decision makers, private investors (domestic and/or external), and IFI/DFIs as well as projected impact (in terms of quantity and quality of food system finance) by the end of the JP and beyond.*
- *Other Strategic Partnerships: Outline specific engagements with major relevant development partners, CSOs, businesses, and other relevant stakeholders at all levels.*
- *Ensure coherence with the detailed table in Annex 1.*

The programme's implementation and oversight are grounded in a robust multi-stakeholder engagement structure that reflects Pakistan's national priorities, devolved governance arrangements, and institutional landscape. Central to this architecture is strong government leadership at both federal and provincial levels. Given Pakistan's devolved system, the programme ensures that responsibilities are appropriately shared: federal ministries provide strategic direction and regulatory alignment, while provincial departments lead on operational planning and delivery.

A National Steering Committee for the Global Accelerator will serve as the apex coordination body, guiding strategic decisions, ensuring coherence across sectors, and facilitating inter-ministerial collaboration. The programme also draws on Pakistan's National Roadmap for strengthening the health workforce and expanding social protection, supported by a detailed stakeholder mapping exercise that clarifies institutional roles, identifies coordination entry points, and establishes accountability mechanisms.

Social partners, including workers' organisations, employers' federations, and professional bodies such as the Pakistan Nursing and Midwifery Council, Pakistan Medical and Dental Council, and associations representing community health workers are central to this structure. They contribute directly to programme design, monitoring, and the alignment of interventions with labour rights, workforce development needs, and service delivery realities. Workers' organisations, in particular, will play a crucial role in mobilising, organising, and supporting community health workers and other frontline cadres. This inclusive governance model strengthens national ownership, enhances sustainability, and ensures strong oversight of both programme implementation and the proposed financing solutions.

Financing partners form a second pillar of the engagement framework. The programme works closely with government finance decision-makers including the Ministry of Finance, the Planning Commission, to mobilise resources, align public budgets, and identify fiscal space for the expansion of social protection schemes, digital training systems, and workforce development initiatives. Engagement with private sector investors, commercial banks, microfinance institutions, and international financial institutions supports the exploration of blended financing models that combine public investment with private capital. Ongoing sectoral programmes such as ADBs supported provincial health reforms, digital health initiatives, and federal workforce training programmes will be leveraged to ensure technical complementarity and avoid duplication. By the end of the programme, these efforts are expected to increase both the volume and quality of financing directed to the health workforce and social protection systems, establishing scalable and sustainable mechanisms for continued investment.

Other strategic partnerships further enhance the programme's reach and impact, such as the ILO-OECD-WHO Working for Health (W4H) Programme. Development partners offer technical guidance, global knowledge, and capacity-building support. A Community of Practice composed of civil society organisations, workers groups representing informal workers and district level governance entities will be engaged at grassroots level, enabling the programme to reach vulnerable and marginalised populations while promoting inclusive participation. The private sector including health service providers, training institutions, digital solution providers, and industry bodies contributes to co-designing interventions, delivering skills development programmes, and scaling digital platforms. Knowledge sharing platform will be established to ensure multi-level coordination joint planning, shared learning, and continuous monitoring of progress.

5. Towards the Right to Decent jobs and Social Protection (max 500 words)

Apply the UNSDG operational guide on leaving no one behind showing how different population groups will directly benefit from the JP, both in terms of achieving their right to adequate food, and by increasing their agency. Explain how the programme will:

- *Target beneficiaries: Demonstrate how the JP will directly benefit marginalized groups (especially rural and urban poor, women and youth, indigenous peoples) using an intersectional lens. Refer to this OHCHR and ILO jointly developed human rights checklist in joint programmes, where relevant, and explain how the JP will achieve a contribution on this domain by listing up to 5 human rights mechanisms that the joint programme will directly contribute to.⁴*
- *Focus on Gender: Show specific contributions to gender equality and women's empowerment, with detailed markers in the annex. Consider referring to the this curated list of resources on gender analysis in social protection and jobs.*
- *Focus on Youth: Show specific contributions to youth empowerment and enhanced inclusion in social protection and decent jobs.*
- *Participation and agency: Briefly explain how the programme will ensure meaningful participation of rightsholders, particularly marginalized groups, throughout implementation, increase their capacity to influence national decision making and advocate for themselves.*

The Joint Programme (JP) is designed to generate direct, meaningful, and lasting benefits for marginalized and vulnerable groups—including women and girls, children, youth, persons with disabilities, older persons, indigenous peoples, refugees and asylum seekers, and internally displaced persons—by addressing the multiple, intersecting inequalities that shape their lives.

Women and girls are among the primary beneficiaries. The programme expands entry points for women into the health sector and the broader care economy through training, certification, improved working conditions, and recognition of community health workers and care roles. It reduces unpaid care burdens by strengthening community-based services, supports women's economic empowerment through targeted skilling and employment pathways, and enhances their access to social insurance. These measures particularly benefit rural women, informal workers, and women from minority and displaced communities, who face mobility restrictions, social norms, and limited formal employment opportunities.

Youth will benefit from expanded opportunities for employability, digital skills, apprenticeships, and career progression in the health sector. The JP promotes youth participation in policy dialogues, enabling young people especially marginalized youth, young women, and youth with disabilities to influence long-term reforms. Through improved access to skills and decent jobs, the programme contributes to reducing youth unemployment and underemployment.

Persons with disabilities gain through disability-inclusive employment initiatives, accessible training platforms, and strengthened social protection schemes that address diverse needs. Improved accessibility in health and social services ensures that people with disabilities receive equitable care and support.

Informal health workers will receive clearer job descriptions, standardized contracts, performance standards, and defined career pathways. By establishing national frameworks for employment terms and job classification, the JP reduces arbitrary contracting, short-term arrangements, and exploitation. Formalisation contributes directly to better wages, job security, and recognition within the health system.

Strengthening health sector enhances social protection across life cycle. Children and older persons are supported by better-resourced health and care systems, community-based services, and expanded social insurance mechanisms that enhance dignity, independence, and income security. Strengthening the health and care workforce directly benefits older persons who rely on long-term care.

⁴ Please consult the full list of human rights mechanisms

here: https://docs.google.com/document/d/1Yu6wJSofqhZV_J5HpC-jlsmUBWtA4Baw/edit?usp=drive_link&oid=102351661986173461034&rtpof=true&sd=true

Capacity-building in leadership, digital literacy, rights awareness, and advocacy equips rightsholders to influence policy processes, hold institutions accountable, and claim their rights.

Through this intersectional approach, the JP ensures that structural inequalities are addressed, rightsholders gain voice and opportunities, and reforms deliver sustained, equitable impacts across Pakistan's most marginalized communities.

<i>List of marginalized and vulnerable groups⁵</i>	<i>Dedicated JP Output</i>
<i>Women and girls</i>	<i>Output 1, 2, 3,4,5</i>
<i>Children</i>	<i>Output 5</i>
<i>Youth</i>	<i>Output 1,2,3,4,5</i>
<i>Persons with disabilities</i>	<i>Output 1,2,3,5</i>
<i>Older persons</i>	<i>Output 5</i>
<i>Indigenous peoples</i>	<i>Output 5</i>
<i>Refugees & asylum seekers</i>	
<i>Internally displaced persons</i>	
<i>Other groups: workers in informal health sector</i>	<i>Output 1, 2, 3,4,5</i>
<i>Other groups: (please specify which)</i>	
<i>Other groups: (please specify which)</i>	

6. Challenges and Risks (max 500 words)

Identify potential roadblocks that may affect successful programme implementation, including:

- *External Factors: Political transitions, natural disasters, economic shifts, or regulatory changes that could impact priorities.*
- *Internal Constraints: Institutional capacity limitations, technical expertise gaps, political will issues, budget constraints, or stakeholder engagement challenges.*

Describe how these may affect timelines, resources, implementation, and collaboration⁶. In particular, highlight the 'deal-breaker' challenges that would require restructuring of the proposal, coherently with those in focus in the Theory of Change sections. Outline specific mitigation measures or contingency plans and risk owners.

1. Lack of Adequate Coordination and Persistent Fragmentation

Misalignment between federal and provincial health authorities, regulatory councils, and training institutions may

⁵ The other marginalized and vulnerable groups include, amongst other, minorities (incl. Ethnic, religious, linguistic...), people of African Descent, persons deprived of their liberty, peasants and rural workers, human rights defenders (incl. NGOs, journalists, union leaders, whistleblowers...), migrants, stateless persons, LGBTIQ+ persons (sexual orientation and gender identity), persons living with (HIV/AIDS, leprosy...), persons with albinism, victims or relatives of victims of enforced disappearances, victims of (slavery, torture, trafficking, sexual exploitation and abuse...). List as per the standard 20 LNOB groups according to the Implementation Guide for the Output Indicator Framework for measuring the United Nations contribution towards the Sustainable Development Goals: https://102656428-files.gitbook.io/~files/v0/b/gitbook-x-prod.appspot.com/o/spaces%2F-MbDdHe_y0zwBb9YT4W%2Fuploads%2F4114YgYQuQo7qKb5ycyL%2FG%20-%2020221031-%20Implementation%20Guide.pdf?alt=media&token=e54c735a-c0a6-4984-8025-2f8b777d1d89.

⁶ For reference, find the Fund's risk categories here: [Joint Programming Risk Categories for reference.pdf](#)

delay key approvals, slow rollout of training programmes, and reduce synergies across interventions. Fragmentation can result in duplicated efforts and inefficient use of resources.

If coordination gaps prevent institutionalizing regulatory reforms or digital training platforms, the programme may fail to achieve systemic change, necessitating a restructuring of governance mechanisms.

Establishing multi-level steering committees and working groups with clear roles and accountability as well as implementing regular progress reviews and inter-agency MOUs.

National and provincial Ministry of Health units, PNMC, AHPC are the risk owners.

2. Financial Resources Prioritized for Other Emerging Priorities

Budget reallocations could delay scaling of digital platforms, social protection coverage, and workforce development. Limited funding may reduce training capacity, formalisation initiatives, and sustainability of reforms. If insufficient funding persists, the programme may not be able to formalize informal workers or expand social protection, undermining critical outcomes linked to the Theory of Change.

Engaging Ministry of Finance and provincial finance departments early to secure multi-year budget allocations. Develop blended financing strategies, leveraging IFIs, DFIs, and private sector contributions. Including contingency budget lines and phased implementation to manage cash flow constraints.

Ministry of Finance, provincial finance departments and private health systems are the risk owners.

3. Cultural Norms and Resistance to Women's Leadership

Slow uptake of gender-sensitive policies and limited women's participation in leadership roles can reduce the programme's impact on gender equality and workforce inclusivity. Training, mentorship, and career development initiatives may be underutilized.

Failure to address entrenched gender norms could prevent institutionalization of C149 and C190-related reforms, reducing systemic impact on equity in health workforce governance.

Conducting gender awareness and sensitization campaigns targeting leadership and staff. Introduce mentorship programmes and policy incentives to increase women's participation.

The PNMC, Ministry of Health, gender focal points, professional councils are the risk owners.

4. Continued Political Support and Ownership

Shifts in government priorities, political transitions, or competing policy agendas could delay approval of curriculum reforms, workforce formalization, and sustainable financing mechanisms. Implementation timelines may be extended, and cross-sectoral collaboration weakened.

Without political support, systemic reforms and financing mechanisms cannot be institutionalized, threatening the core objectives of the Theory of Change.

Establishing formal political engagement strategies, including regular briefings for policymakers and inclusion of reforms in national roadmaps. Building multi-party consensus and embedding programme objectives within broader national development frameworks and the Global Accelerator National Roadmap.

Ministry of Health, national steering committee, UN agencies are the risk owners.

7. Sustainability and exit strategy (max 500 words)

Provide a description of how the expected JP results will be sustained beyond the timeline of the JP and CF with a focus on community, financial, and institutional dimensions. Outline specific responsibilities of each partner (from section 2.6) in ensuring long-term sustainability, for each dimension. Explain the programme's potential for replication/scale-up in other territories or sectors. Describe your exit strategy, mentioning assumptions and preconditions.

- *Financial Mechanism continuity: describe how the financial mechanism(s) or its design process will remain active after programme closure.*

The Joint Programme (JP) is designed to maximize long-term impact and sustainability beyond the current financing period. The sustainability strategy is framed around three dimensions: community, financial, and institutional.

- 1. Sustainability of health givers

To ensure that programme benefits endure at the grassroots level, communities and primary beneficiaries will be actively engaged throughout implementation. This includes informal and community health workers, nurses, midwives, and local leaders in rural and urban areas. Meaningful participation will involve orientation sessions, consultations, and inclusion in planning and monitoring of activities. Community engagement ensures that

training, social protection, and workforce formalization interventions are relevant, contextually appropriate, and widely accepted. Establishing mechanisms for continuous feedback from these groups will enhance ownership and strengthen the likelihood of sustained uptake of reforms and practices, including occupational safety, digital learning, and gender-sensitive workforce development.

- **2. Financial Sustainability**

From the outset, the JP will secure government ownership and leadership to embed financing within existing national and provincial budgets. Key Ministries, Departments, and Agencies including the Ministry of Health, Ministry of Finance, provincial health departments, labour departments, and regulatory councils will be engaged to adopt and fund strategic activities beyond the project's initial funding window. The programme will leverage existing government programmes, policies, and funding streams, such as social protection schemes, health sector reforms, and skills development initiatives, integrating JP interventions into these platforms. Blended financing approaches will also be explored, combining domestic resources, international financial institutions, and private sector contributions to ensure long-term fiscal sustainability.

- **3. Institutional Sustainability**

The JP will operate fully within Pakistan's government and regulatory structures, avoiding parallel systems. Strengthening institutions such as the Pakistan Nursing and Midwifery Council (PNMC), Allied Health Professionals Council (AHPC), and provincial health departments will ensure that workforce development, governance, and social protection reforms are institutionalized. The programme will support the integration of JP interventions into national policies, such as the National Health Vision, Universal Health Coverage plans, National Social Protection Policy, and provincial workforce development strategies. Regulatory and governance improvements including digital monitoring systems, certification frameworks, and competency-based curricula will become standard institutional practice.

- **4. Governance and Oversight**

A multi-level governance structure will reinforce sustainability. At the national level, a Joint Programme Steering Committee, including heads of relevant Ministries, regulatory councils, and development partners, will provide strategic oversight and policy guidance. A Joint Programme Implementing Team will support day-to-day implementation, capacity-building, and coordination. At the provincial and district levels, health department committees will oversee programme activities, while community health committees and professional associations will act as local entry points. These structures, aligned with government-approved frameworks, ensure accountability, long-term institutional memory, and continuity of programme initiatives.

- **5. Integration and Exit Strategy**

The JP's operating and exit strategy is focused on embedding reforms within existing government structures. Activities such as digital training platforms, social protection schemes, and gender-sensitive leadership programmes will be fully integrated into ongoing government initiatives. By the end of the programme, the strengthened regulatory bodies, trained health workforce, and community engagement mechanisms will be fully capable of sustaining and scaling interventions independently, ensuring a lasting impact on Pakistan's health workforce and social protection ecosystem.

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8. Management arrangements (max 500 words)

This section describes how the joint programme will be implemented, including the management arrangements. It does not substitute for organization-specific arrangements required by the respective internal policies of PUNOs. It offers a brief description of key groups, their composition, and major roles and responsibilities.

- *The JP Steering Committee: Refer to ToRs in the UNSDG Guidance Note on Joint Programmes. Specify Co-chairs (one of which has to be the RC), Committee members, frequency of meetings and tasks, only if deviating from ToRs.*

- *The JP Team: Refer to ToRs in the UNSDG Guidance Note on Joint Programmes. Specify members, member roles, frequency of meetings and tasks, only if deviating from ToR.*

As relevant, this section will indicate common business services that will be used to enhance JP implementation.

1. Joint Programme Steering Committee (JPSC)

The JPSC is accountable for the achievement of the Joint Programme's results and provides strategic oversight and guidance to the JP team throughout implementation, including adjustments to the workplan, strategy, and programme priorities. The Steering Committee will review and approve progress and evaluation reports and

provide guidance on financing, policy alignment, and institutionalization of interventions.

The JPSC will be co-chaired by the Ministry of Overseas Pakistanis and HRD, Ministry of National Health Services, Regulations and Coordination (MoNHSR&C), along with the United Nations Resident Coordinator Office in Pakistan. The provincial governments, being the primary entry point for implementation, will play a central role in guiding programme activities and ensuring alignment with provincial health strategies.

Other members will include:

- UN Agencies: ILO (lead PUNO), WHO
- Government ministries: Ministry of Finance, Provincial governments representing labour and health departments, Ministry of Human Rights, National Commission on Status of Women
- Private sector representatives: healthcare providers, training institutions, technology firms
- Representatives from workers' and employers' organisations, professional councils (PNMC, AHPC)

The Steering Committee will meet every six months, with the possibility of ad hoc meetings as needed.

2. Joint Programme Implementing Team (JPIT)

The JPIT is responsible for ensuring the achievement of results in accordance with the results framework, workplan, and budget. The team will comprise personnel from ILO, and WHO, supported by national experts seconded to the programme.

The JPIT has dual reporting lines: to the JPSC for programme-level oversight, and to their respective PUNOs for technical accountability. The JPIT will meet at least once per quarter, with ad hoc meetings possible for urgent matters.

3. Joint Coordination Unit (JCU)

A Joint Coordination Unit or the project secretariat will be established to support day-to-day operational and programmatic coordination. Its key responsibilities include:

- Coordination among all JP partners, including national and provincial government agencies and UN bodies
- Compilation of joint workplans, progress reports, and final narrative reports
- Monitoring and evaluation support to track progress toward annual targets
- Facilitating reporting to the Steering Committee, donors, and government counterparts
- Assisting in data management and analysis related to programme activities
- Providing guidelines for partnerships with NGOs, civil society, and private sector stakeholders

The JCU will be composed of a representative from each participating PUNO, led by a coordinator from the lead UN agency. The Lead Government Focal Point from the Ministry of Overseas Pakistanis and HRD, Ministry of Health will ensure effective government leadership and ownership during implementation, while coordinating with provincial health authorities to embed programme interventions into routine health systems and workforce management structures.

9. Monitoring, accountability, financial management, and public disclosure

Standard text – do not change

Reporting on the Joint SDG Fund will be focused on concrete results and grounded in evidence. The RCO focal point and lead PUNO is responsible for coordinating and drafting a concise annual report (using the Fund Secretariat template/guidance), which is submitted to the Joint SDG Fund Secretariat through the RC by January 31st of the following year. Additionally, a final narrative report must be prepared and submitted to the Joint SDG Fund Secretariat through the RC no later than two (2) months after the operational closure of the Joint Programme activities.

The JP Steering Committee, co-chaired by the RC, is mandated to oversee and monitor the implementation of the joint programme, with the involvement of Joint SDG Fund Secretariat to which it must submit data and information upon requested. Additionally, the Joint SDG Fund Secretariat may request additional insights, such as policy papers, value-for-money analysis, case studies, infographics, or blogs/articles, as needed.

PUNOs will be required to include information on complementary funding received from other sources (both UN cost sharing, and external sources of funding/financing) for the activities supported by the Fund, including in kind contributions and/or South-South Cooperation initiatives, in the report.

PUNOs at Headquarters level shall provide the Administrative Agent with the following statements and reports prepared in accordance with its accounting and reporting procedures, consolidate the financial reports, as follows:

Annual financial reports as of 31st December each year with respect to the funds disbursed to it from the Joint SDG Fund Account, to be provided no later than four months after the end of the applicable reporting period; and
A final financial report, after the completion of the activities financed by the Joint SDG Fund and including the final year of the activities, to be provided no later than 30 April of the year following the operational closing of the project activities.

The JP will be using a pass-through fund management modality where UNDP Multi-Partner Trust Fund Office will act as the Administrative Agent. The programmatic UN entity of the Facility shall assume full programmatic and financial accountability for the funds disbursed to it by the Administrative Agent of the Joint SDG Fund (Multi-Partner Trust Fund Office). Such funds will be administered by each UN Agency, Fund, and Project in accordance with its own regulations, rules, directives and procedures. The entity shall establish a separate ledger account for the receipt and administration of the funds disbursed to it by the Administrative Agent.

A minimum of 5% of the JP budget is allocated for monitoring, reporting, evaluation, audit and communications. Indirect costs of the Participating Organizations recovered through project support costs will be 7%, with exception of WFP and UNHCR which should be 6,5%. All other costs incurred by each PUNO in carrying out the activities for which it is responsible under the Fund will be recovered as direct costs. Procedures on financial transfers, extensions, financial and operational closure, and related administrative issues are stipulated in the Operational Guidance of the Joint SDG Fund. PUNOs and partners must comply with Joint SDG Fund brand guidelines, which includes information on donor visibility requirements.

ANNEX 1: Mapping of related projects, investments and other development initiatives

List relevant initiatives from the UN system, Government, IFIs, bilateral donors , civil society, the private sector, and other partners, as relevant.

Name of project / investment / initiative	Relevance for the JP	Lead actors and partners	Budget and funding source	Timeframe
	<i>In this column, specify how the initiative will have a direct influence on the JP, or how it will be directly influenced by the JP. Explain the connection highlighting substantial elements, beyond mere alignment of objectives.</i>			
Support to Ministry of National Health Services, Regulations and Coordination for restructuring PNMC in line with revised ordinance and global best practices to strengthen its capacity.	JP will be help to implement the findings and recommendations of the assessments of PNMC conducted by WHO on request from MOH and ensure the continuity of support.	WHO, MOH, PNMC	WHO Core funds, UHC Partnership funds	2025-28
Support for strengthening nursing sector in 2 provinces (Punjab and Sindh)	ADB primary focus is on operational level in provinces to provide support for improving infrastructure in nursing schools and capacity building of faculty. Whereas JP will leverage this funding and complement the capacity building and institutional governance for implementation of standards and ensuring quality education.	ADB, Punjab and Sindh governments Joint programme as partners to dovetail.	ADB Loan (250 m \$) \$150 m (Punjab) \$100 m (Sindh)	Confirmed in Dec 2025 Under negotiation
ILO-OECD-WHO Working for Health (W4H) Programme	In Pakistan, W4H f supports improved working conditions in the health sector by strengthening health workforce governance, policies and regulatory frameworks; supporting the development of gender-transformative and non-discriminatory policies and practices; and promoting	ILO, Ministry of Health, Ministry of Overseas Pakistanis and HRD, Health Services Academy, Employees Social Security Institutions	\$100,000 (MPTF)	2025-2026

	safe and healthy working environments for health workers through the implementation of the ILO–WHO HealthWISE approach.			

ANNEX 2: Integrated results framework, work plan and budget

Remarks:

- There should be a minimum of one outcome from the CF.
- All results and related budgets under a joint programme are tagged as 'joint' in UN Info and UNO ERP systems for reporting on the QCPR and Funding Compact.
- A minimum of 5% percent of the JP budget is allocated for monitoring, reporting, evaluation, audit and communications.
- For gender equality, human rights, and peace markers (the latter optional) the coding is done per output. Further annex asks for justification. Please add a column for the Sustaining Peace Marker should it be applicable for the joint programme.
- For the QCPR function, kindly refer to the UN Info guidance [here](#).

Joint Programme Outcomes				
CF Outcome statement 1: National and provincial stakeholders adopt employment policies and implement programmes to create decent employment for women, youth and persons with disabilities ⁷ .				
Outcome indicator 1.1: Number of Gender responsive Employment Policy (ies)/ action plans and national roadmap for promoting decent employment and social protection	Baseline: 0 NEP 0 Provincial employment action plans 0 national roadmap for GA	Target Year 1/Phase I: NEP drafted NEP informs architectural framework of the provincial employment action plan A resourced national roadmap is developed	Target Year 2/ Phase II: At least two larger provinces have employment action plans	Means of verification: Policy approved by Cabinet, action plans notified by provincial governments, national roadmap notified by NSC for GA.
Outcome indicator 1.2: # of initiatives by provincial governments to promote decent working conditions for health workers and vulnerable groups (informal, with disabilities, community health workers, rural women and youth)	Baseline: 0 projects focusing on decent work for health workers	Federal government introduces decent work framework for health sector (formalisation of CHWs, social protection for workers, wage reforms) at Islamabad Capital Territory	At least two larger provinces adapt the DW framework	Means of verification: Notification of CHWs, model for social protection coverage, wage notifications
[JP-specific outcome] 2: Just transitions for Health workforce to be more adaptive and resilient to provide effective social protection				
Outcome indicator 2.1: Number of workers who benefit from	Baseline: information not consolidated (health workers are trained in	Outreach to : up to 20,000 workers reached	At least 80,000 workers reached	Means of verification: Verified training reports by the project

⁷ Outcomes under CF are impacts, Outputs are equivalent to Outcomes. [UNSDCF abridged summary june2023 RLv8 ed.pdf](#)

initiatives on just-transition measures (e.g., retraining, upskilling, recognition of prior learning) in targeted areas (rural through digital learning).	updated primary care competencies, emergency response but inadequately in self care and wellbeing and climate and technological changes)			
Outcome indicator 2.2: Professional councils and regulatory bodies effectively govern and enforce qualification standards aligned with global requirements.	Baseline: PNMC and AHCW have limited capacities	PNMC at ICT has improved capacity to govern and enforce nursing qualifications and standards	AHCW at ICT has improved capacity to govern and enforce qualifications and standards for allied workforce. At least one larger province scales the model	Means of verification: PNMC notifications
[JP-specific outcome]3 : Women and girls, benefit from a gender-responsive enabling environment ensuring active participation in the economy				
Outcome indicator 3.1: Number of workplace policies or programmes implemented that promote gender-responsive economic participation and inclusivity in the health sector (through HealthWISE)	Baseline: workplace policies and programmes are not gender sensitive	At least 5 health facilities implement gender responsive policies (maternity benefits, access to training, grievance mechanisms, women in leadership positions etc)	Scaling of gender responsive policies and workplace practices in 15 large facilities	Notified workplace G.E policies
Outcome indicator 3.2: Government prioritises to ratify ILO Conventions 190 and 149	Baseline: Gaps assessment for C190 and C149 is available	Federal tripartite consultative committee approves the ratification of C190 and action plan developed	Federal tripartite consultative committee approves the ratification of C149 National roadmap developed for implementation of C149	FTCC minutes Notified roadmaps

Joint Programme Outputs				
Outputs and Output Indicators	Baseline:	Target Year 1/Phase I:	Target Year 2/ Phase II:	Means of verification:
OUTPUT 1– Strengthened Governance, Regulation, and Institutional Capacity				

Output indicator 1.1: Number of regulatory bodies receiving technical support for alignment with WHO or global nursing/health standards and International Labour Standards and Decent Work.	Baseline: ADB is supporting integrated health programme in Punjab	The JP supports PNMC, AHC at ICT and Punjab Health department	Support is extended to all provinces	MOU signed
Output indicator 1.2: Number of training sessions delivered for regulators, officials, and health managers on workforce oversight, quality assurance, and decent work practices.	Baseline: Trainings are not focusing on decent work principles	Atleast 10 trainings are organised for officials in ICT and one province	Trainings are extended to all provinces.	Training reports and participants lists
Output indicator 1.3: Integrated policies on jobs creation and social protection	Baseline: policies lack coherence and integration	National roadmap with integrated framework for policy and sectoral interventions	Roadmap is rolled out in select geographic location and incrementally scaled	National roadmap notified
Output 2: Improved Training, Skills Development, and Digital Learning Systems				
Output indicator 2.1: Curricula integrating climate adaptation, OSH, gender sensitivity, and biohazard management finalized.	Curricula for health workers is lacking OSH and emerging risks due to climate and other occupational hazards	Nursing curricula updated	Curricula for Allied Health professionals is updated	Updated curricula notified by PNMC and AHPC
Output indicator 2.2: Number of digital training modules developed and deployed	Digital training modules are not available for nursing and allied health workers	Digital modules are developed and tested at ICT level	standards updated for Allied Health Workers Council and digitalised	Links to digital training modules
Output indicator 2.3: Recognition of prior learning and linkages to licensing	RPL doesn't exist for informal workers	RPL models reviewed and established	RPL linked with licencing through NAVTTC	Govt notifications
Output indicator 2.4: Community nursing curriculum developed and pilot initiated in selected schools	No community nursing curriculum available as of now	Development of community nursing curricula and its piloting in selected schools	Scale of community nursing program to all provinces	Curriculum developed and approved Community nursing program piloted. PNMC notification and student admissions

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OUTPUT 3 – Enhanced Social Protection, Gender Equality and Formalisation of the Health Workforce				
Output indicator 3.1: Number of proposals developed by regulatory bodies and implementers for allocations for long-term formalisation and social protection of frontline health workers.	Baseline: 0	Target: 1 proposal	Budgets mainstream allocations for social protection of informal workers in the health sector, specially CHWs	Proposal Financial year budgets at federal and provincial levels
Output indicator 3.2 : Enhance health workers' occupational health and safety capacity building through the adaptation and application of the ILO-WHO HealthWISE tool	Baseline: 9	Target: 5 hospitals develop action plans to implement decent work principles	15 large hospitals in provinces adapt the HealthWISE approach for improving health workplaces, including through integrating occupational safety and health measures, gender equality, and participatory improvement processes.	Action plans by hospitals
Output indicator 3.3: Advocacy for ratification of Nursing Personnel Convention and Convention on Violence and Harassment at Workplace (C149 and C190)	Base line: gaps assessment report for C149 and C190	Target: action plan for C149 and C190	Ratification of C149 and C190 prioritised	Ratification plan of the government

PHASE I Joint Programme Workplan

Outcome/Output	Geographic focus	Phase I Start	Phase I End	PUNO	SDG Targets	Gender Equality Marker	QCPR function	Phase I Budget (US\$)
Outcome 1: National and provincial stakeholders adopt employment policies and implement programmes to create decent employment for women, youth and persons with disabilities⁸.								
Output 1.1 : Strengthened Governance, Regulation, and Institutional Capacity in promoting decent work and skills standards	ICT for first phase and expanding to provinces	Jan 2026	June 2027	WHO, ILO	8.5,3.C	2	4	300,000
Activities: i. Develop National roadmap defining policy and institutional framework for full and productive employment, including skills development and social protection for priority sectors. ii. Conduct capacity assessments of health workforce regulatory bodies to identify gaps iii. Develop regulatory strengthening plans covering assessment, restructuring plan, educational standards, and accreditation processes. iv. Conduct national and provincial trainings for regulators and health managers on oversight / inspection, quality assurance, and decent work principles. v. Support for establishing modernized information system for nursing (phase 1) capacity building vi. Build capacities of PNMC and AHC's and other government entities responsible for regulation of health and labour, skills standards setting and enforcement.								
Outcome 2: Just transitions for Health workforce to be more adaptive and resilient to provide effective social protection								
Output 2.1: Improved Training, Skills Development, and Digital Learning Systems	ICT in phase I and scaled at the national level	Jan 2026	June 2027	WHO, ILO	1.3, 3.8, 3.C, 5.5	2	4	400,000
Activities: i. Conduct a national competency needs / gap assessment for introducing community nursing program and selected cadres of allied health professionals (PI) ii. Assessment to identify gaps in the competencies of faculty for nursing and selected allied health professions and develop tailored training programs for faculty capacity building in gap areas (PI) iii. Develop a standardized national community / PHC nursing training package, including upskilling pathways in nursing, and emergency response focusing young men and women.(PI) iv. Design and deploy digital training platforms for continuous development and lifelong learning, prioritising rural and underserved areas. (P2)Pilot blended learning programmes (online and in-person) in selected geographic location (s). (P2) v. piloting community nursing programs in selected institutions (PI) vi. Build in recognition of Prior learning for workers in the informal tiers (PI and 2)								

⁸ Outcomes under CF are impacts, Outputs are equivalent to Outcomes. [UNSDCF abridged summary june2023 RLv8 ed.pdf](#)

Outcome 3: Women and girls, benefit from a gender-responsive enabling environment ensuring active participation in the economy								
Output 3.1: OUTPUT 3 – Enhanced Social Protection, Gender Equality and Formalisation of the Health Workforce	ICT in phase I and scaled at the national level	Jan 2026	June 2027	WHO, ILO	5.5,8.5	2	4	150,000
Activities: i. Gendered assessment and Mapping informal and semi-formal workforce segments (LHWs, CHWs, technicians, contract-based staff) focusing young women and men and those with disabilities. (PI) ii. Design formalisation pathways including standard contracts, job descriptions, wage frameworks, and grievance mechanisms. (PI) iii. Advocacy and support the model design and piloting for the extension of social protection packages schemes for health workers excluded by current social protection schemes, CHWs (health insurance, pensions, maternity benefits, disability cover, sick leave) coordinated with the implementation of the qualification package (output1). (PI&2) iv. Build capacities of women in leadership in the sector (PI) v. Design and pilot integration measures linking the skills and training interventions with social protection measures. (P2) vi. Conduct costing and financing analyses for Phase II expansion of social protection. (P2) vii. Engage workers' organisations in mobilisation and awareness campaigns to boost enrolment (PI&2) viii. Advocate for long-term public budget allocations for frontline workforce formalisation and protection. (PI&2) ix. Advocate for ratifications of ILS focusing decent work for nursing personnel and working conditions including C149 and C190 (PI&2) x. Implement HealthWISE in select hospitals and scale and develop public private partnerships to improve workplace practice (PI &2)								

ANNEX 3: PHASE I Budget per UNSDG Categories

UNSDG BUDGET CATEGORIES	ILO		WHO		TOTAL	
	Joint SDG Fund (USD)	PUNO Contribution (USD)	Joint SDG Fund (USD)	PUNO Contribution (USD)	Joint SDG Fund (USD)	PUNO Contribution (USD)
1. Staff and other personnel	200,000	65,000	70,000	63,000	270,000	128,000
2. Supplies, Commodities, Materials	0		95,000		95,000	
3. Equipment, Vehicles, and Furniture (including Depreciation)	3,561		0		3,561	
4. Contractual services	110,000		170,000		280,000	
5. Travel	15,000		0		15,000	
6. Transfers and Grants to Counterparts	0		0		0	
7. General Operating and other Direct Costs	92,000		38,832		94,832	
Total Direct Costs	420,559		373,832		794,393	
8. Indirect Support Costs (7% of total direct costs – except for WFP and UNHCR which should apply 6.5% of total direct costs)	29,439		26,168		55,607.51	
TOTAL Costs	450,000	65,000	400,000	63,000	850,000	128,000

ANNEX 3: Gender Equality, Human Rights, Peace markers

Gender Equality Marker

Please copy the output as per in the workplan and add the Gender Equality marker score and justify the scoring. Please refer to the UNSDG guidance here:

<https://help.uninfo.org/un-info/results-framework/results-framework-structure/suboutput-level/guidance-on-applying-tags-and-markers/guidance-on-applying-the-gender-equality-human-rights-and-sustaining-peace-markers>

Joint Programme Outputs	GEM Score	Justification
OUTPUT 1 – Improved Training, Skills Development, and Digital Learning Systems	2	This output prioritizes women health workers, especially in rural and underserved areas, by integrating gender-sensitive content into curricula that addresses workplace discrimination, harassment, and career progression. Digital and blended learning platforms reduce mobility and geographic barriers, making professional development more accessible to women specially in the lower occupational groups within the health sector.
OUTPUT 2 – Strengthened Governance, Regulation, and Institutional Capacity	2	Regulatory and institutional reforms under this output embed gender-responsive policies in certification and accreditation, and workforce management. Centres of excellence model gender equality in governance, and support for ratifying ILO conventions (C190 and C149) institutionalizes protections for women.
OUTPUT 3 – Enhanced Social Protection, Gender Equality and Formalisation of the Health Workforce	2	Formalizing informal health workers, most of whom are women, links them to social protection schemes such as insurance, pensions, maternity benefits, and grievance mechanisms. This helps empowering women and girls and reduces their vulnerability in low-paid, precarious roles. In addition, by conducting workforce gender analyses, implementing gender-sensitive policies, and establishing mechanisms to prevent workplace harassment and gender-based violence. It advances women's leadership, decision-making, and access to safe, inclusive, and equitable work environments.

Human Rights Marker

Please copy the output as per in the workplan and add the Human Rights marker score and justify the scoring. Please refer to the UNSDG guidance

here: <https://help.uninfo.org/un-info/results-framework/results-framework-structure/suboutput-level/guidance-on-applying-tags-and-markers/guidance-on-applying-the-gender-equality-human-rights-and-sustaining-peace-markers>

Joint Programme Outputs	HRM Score	Justification
OUTPUT 1 – Improved Training, Skills Development, and Digital Learning Systems	2	This output strengthens the capacity of health workers to claim and exercise their economic, social, and cultural rights, including the right to education, the right to safe and decent work, and the right to non-discrimination in employment and professional development
OUTPUT 2 – Strengthened Governance, Regulation, and Institutional Capacity	2	This output aims to build the capacity of regulatory bodies to protect health workers' rights, ensure fair treatment, and uphold safe working conditions. Additionally, it focuses on strengthening institutions, aligning standards with international benchmarks, and advocating for ratification of ILO Conventions institutionalizes accountability, transparency, and protections against discrimination and harassment.
OUTPUT 3 – Enhanced Social Protection, Gender Equality and Formalisation of the Health Workforce	2	This output focuses on formalizing employment and linking workers to national social protection schemes, it will further strengthen legal protections, reduces vulnerability, and promotes equitable treatment. Engagement with workers' organizations and establishment of grievance mechanisms further safeguard their labor and economic rights, embedding human rights principles into workforce policies and practices. This output also addresses discrimination, ensures equal access

		to training and career advancement, supports leadership opportunities for women, and establishes mechanisms to prevent and respond to workplace harassment and violence. By integrating gender-sensitive policies, leadership development, and protections aligned with ILO conventions, the programme strengthens women's rights to fair and safe working conditions, equal treatment, and meaningful participation in decision-making.
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Sustaining Peace Marker

(optional- please only fill out if relevant, and add the marker to the workplan above)

Please copy the output/outcomes as per in the workplan and add the Sustaining Peace marker score justify the scoring. Please refer to the UNSDG guidance here: Please refer to the UNSDG guidance here: <https://help.uninfo.org/un-info/results-framework/results-framework-structure/suboutput-level/guidance-on-applying-tags-and-markers/guidance-on-applying-the-gender-equality-human-rights-and-sustaining-peace-markers>

Joint Programme Outputs	SPM Score	Justification

ANNEX 4: Overview of the Communications and visibility plan

Present the strategy and activities for strategic communications for the joint programme. It should be integrated into the work plan of the joint programme and costed. Communication results and approach should reflect country and programme context. Relate this plan with the objectives to the overall SDG communication approach (plan/strategy) of the UNCT, and relevant government communication strategy/ies.

- *Note that the joint programme must respect Joint SDG Fund brand guidelines, including information on donor visibility requirements*
- *Use the format provided below and do not exceed 2-3 pages, not counting eventual graphs.*

Overall narrative

- *Briefly formulate the main narrative for the joint programme that will be communicated about the joint programme – max one paragraph*

The communication strategy for the Joint Programme is designed to raise awareness, promote behaviour change, and foster partnerships to strengthen Pakistan's health workforce and social protection systems, while remaining closely aligned with national priorities, including provincial health sector strategies, the draft National Social Protection Policy Framework, the Pakistan Nursing and Midwifery Council reform agenda, and the Global Accelerator Roadmap on Jobs and Social Protection for Just Transitions. It focuses on three complementary priorities: (i) ensuring that government ministries, regulatory bodies, development partners, provincial authorities, and the social partners understand the programme's purpose and collectively contribute to the national roadmap in alignment with national policies; (ii) supporting health workers, training institutions, facility managers, and informal workers in adopting safer workplace practices, digital tools, and social protection schemes; (3) strengthening multi-sectoral partnerships and advocating for the scaling and institutionalization of interventions that demonstrate pathways for sustainable financing. Progress across these priorities will be monitored through dissemination and engagement metrics, uptake of training and social protection pilots, behavioural change evidence, policy adoption, partner commitments, and annual reporting.

The JP will be presented to the UNSDCF steering committee at the national level as part of the UNCT existing communications protocols.

Objectives and main activities

- *Include max 3 objectives, referring to the main audiences, and list maximum 5 activities under each. Indicate who will be responsible and how the progress will be monitored*

Objective	Key Audiences	Activities	KPIs
1. Ensuring that government ministries, regulatory bodies, development partners, provincial authorities understand the programme's purpose and align under the national roadmap	Federal ministries (Health, Finance, Labour, Climate, Social Protection), Provincial health departments, care commissions & social protection bodies- Regulatory councils (Pakistan Nursing & Midwifery Council), Parliamentarians & donors	1. Targeted policy briefs linking programme outputs to national priorities 2. High-level advocacy meetings & briefings (DGs, steering committees, bilateral meetings) 3. Policy roundtables and technical working groups for regulatory & digital governance 4. Documenting and dissemination of best practices from the pilots 5. Joint UN/Donor events to signal coordination and co-financing opportunities	● # ministries/provinces endorsing recommendations ● # policies/plans adopting programme inputs ● # joint collaborations and projects emanating with the project support
2. Supporting health workers, managers and employers, and informal workers in adopting safer workplace practices, digital tools, and social protection schemes	Formal health workers (nurses, midwives, allied health), Informal/community health workers & associations, Training institutions & educators, Employers (public, private, NGO facilities)	1. Digital learning platform rollout (occupational safety, climate resilience, digital skills) 2. Targeted outreach campaigns (radio, WhatsApp, SMS, community meetings, social media pages) 3. Peer champions & mentorship; employer engagement toolkit; community of practice	● # health workers enrolled/completed courses ● % female & rural participants ● # informal/community workers linked to social protection
3. Strengthening multi-sectoral partnerships and advocating for the scaling and institutionalization of interventions that demonstrate pathways for sustainable financing	General public & communities Private sector (hospitals, training providers, CSR)- Donors, IFIs, development partners, media, civil society, universities and research inst	1. Public communications campaign (human-interest stories, social media, radio) 2. Partnership outreach pack & donor engagement 3. Media briefings, knowledge products, webinars & annual roundtable	● Media mentions & reach ● Social media engagement & video views ● # New programmes, initiatives and technical assistance packages negotiated include support to GA ● Joint briefings and proposals with IFIs and Banks