WORKING FOR HEALTH MPTF

ANNUAL REPORT 2020

Stimulating Investments in the Health and Social Workforce for the SDGs

International Labour Organization

OECD
BETTER POLICIES FOR BETTER LIVES

World Health Organization

WORKING FOR HEALTH MPTF
ANNUAL REPORT 2020

Stimulating Investments in the Health and Social Workforce for the SDGs

Administered by the MPTF Office

International Labour Organization

OECD
BETTER POLICIES FOR BETTER LIVES

World Health Organization

Contents

Definitions

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

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

Contributor Commitment: Amount(s) committed by a donor to a Fund in a signed Standard Administrative Arrangement with the UNDP Multi-Partner Trust Fund Office (MPTF Office), in its capacity as the Administrative Agent. A commitment may be paid or pending payment.

Contributor Deposit: Cash deposit received by the MPTF Office for the Fund from a contributor in accordance with a signed Standard Administrative Arrangement.

Delivery Rate: The percentage of funds that have been utilized, calculated by comparing expenditures reported by a Participating Organization against the 'net funded amount'.

Indirect Support Costs: A general cost that cannot be directly related to any particular programme or activity of the Participating Organizations. UNDG policy establishes a fixed indirect cost rate of 7% of programmable costs.

Net Funded Amount: Amount transferred to a Participating Organization less any refunds transferred back to the MPTF Office by a Participating Organization.

Participating Organization: A UN Organization or other inter-governmental Organization that is an implementing partner in a Fund, as represented by signing a Memorandum of Understanding (MOU) with the MPTF Office for a particular Fund.

Project Expenditure: The sum of expenses and/or expenditure reported by all Participating Organizations for a Fund irrespective of which basis of accounting each Participating Organization follows for donor reporting.

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

Project Operational Closure: A project or programme is considered operationally closed when all programmatic activities for which Participating Organization(s) received funding have been completed.

Project Start Date: Date of transfer of first instalment from the MPTF Office to the Participating Organization.

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

US Dollar Amount: The financial data in the report is recorded in US Dollars and due to rounding off of numbers, the totals may not add up.

Acronyms

HWF	Health Workforce
ILO	International Labor Organisation
IADEx	Interagency Data Exchange
LFS	Labour Force Survey
MPTF	Multiple Partner Trust Fund
OECD	Organisation for Economic Co-operation and Development
PHC	Primary Health Care
SDG	Sustainable Development Goal
SADC	Southern African Development Community
UNDP	United Nations Development Programme
UHC	Universal Health Coverage
WAEMU	West African Economic and Monetary Union
W4H	Working for Health Programme
WHO	World Health Organization

Executive summary

The joint Working for Health (W4H) programme was adopted by the World Health Assembly in 2017, and welcomed by the OECD Health Committee and the ILO Governing Body, to support countries to invest in the expansion and transformation of the health and social workforce for SDG 3 (health), SDG 4 (education), SDG 5 (gender) and SDG 8 (decent work). The programme provides catalytic support to governments, social partners and key stakeholders to develop, finance and implement multi-sectoral national health workforce strategies and investment plans to improve the supply and employment of trained health workers, create decent jobs, maximise the performance of health workers, and accelerate progress towards Universal Health Coverage (UHC).

A first phase of 'initial implementation projects: 2019-2021' was approved by the steering committee in April 2019, with MPTF funding of USD 3.3 Million immediately disbursed by June 2019. This report reviews progress of the MPTF for this initial implementation phase. It summarises achievements, challenges and lessons learned through its interventions, technical assistance and policy advice at country, regional and global levels.

Over the reporting period the W4H programme supported four (4) countries on initiating and implementing health workforce strategies and investment plans to achieve UHC. It enabled two (2) regional economic communities to develop and implement harmonised health workforce strategies to expand education, skills and jobs; and it developed and established the Interagency Data Exchange and the International Platform on Health Worker Mobility as major global initiatives for driving evidence-based health workforce policy, reform and investments.

The anticipated financial needs for the programme and its 5-year Action Plan are USD 70 million. This MPTF is managed by the UNDP Multi-Partner Trust Fund Office, which serves as the management and administrative interface between the donors and the participating UN Organizations. The MPTF has mobilized USD 7 million since its creation with contributions from NORAD and Silatech.

SDG achievements

1 One vision	Accelerate progress towards universal health coverage and the SDGs by ensuring equitable access to health workers within strengthened health systems
2 Two goals	Expansion and transformation of the health and social workforce
3 Three Organisations	International Labour Organisation, Organisation for Economic Co-operation and Development and World Health Organisation
4 Four SDGs	An expanded, trained and supported health workforce is critical to achieving the health SDG 3 targets – almost fifty percent of resources needed to achieve SDG 3 involve workforce education and employment and training requirements. Working for Health will increase numbers and education and training catalyse investments and action needed to make the health workforce fit for purpose. Other SDGs-education (SDG 4), gender equality (SDG 5), decent work and economic growth (SDG 8) will also be advanced. 
5 Five streams of work	Facilitate country-driven intersectoral action: 1. Advocacy, social dialogue and policy dialogue 3. Data, evidence and accountability 3. Education, skills and jobs 4. Financing and investments 5. International labour mobility

Key highlights

At country, regional and global level the W4H programme supported intersectoral collaboration, action and capacity building efforts to develop, finance and implement multi-sectoral workforce policies, strategies and plans, and to enhance institutional capacity and analytics to achieve the following expected outcomes:

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

Country level

Republic of South Africa

The W4H programme supports the creation of jobs in the health sector through the development of a National 2030 HRH Strategy Framework and 5-year HRH Strategic Plan. The project supported the National Department of Health-led (NDOH) multistakeholder process for developing the HRH strategy, including direct technical assistance to an assigned Ministerial Task Team (MTT) and a rapid health labour market and political economy analysis to inform the process. The strategy also supports the role of National Health Insurance, in which South Africa aims to create 97 000 additional jobs in the health sector by 2025, the majority of which are for primary health care expansion. These new jobs will contribute to improved access and coverage of health services.

Towards meeting these needs, in 2019 the government of South Africa has recruited and deployed additional 5,000 newly trained health workers, including 2,329 medical interns, 1,723 community service medics (medical doctors) and 650 medical officers, as well as an additional number of nurses and community health workers. The strategy is near complete and the next phase of project supports the costing and the development of an investment case to be initiated in 2020.

Guinea

As part of the rural pipeline approach, Guinea anticipates creating 16,000 community-based health care jobs in rural areas by 2025, which represents a national increase of 47%. Currently, 10,000 community-based health care providers have been recruited, expanding health coverage for 50% of Guinea's rural population. Half (5,000) of these new providers are estimated to be young women. Improved access to health care is anticipated for 2,952,266 population in four catchment areas through this rural pipeline programme.

The W4H programme created a space where different stakeholders work jointly on health workforce investment. It has helped influence a strategic shift in mindset, visibly demonstrated through increased political commitment and participation on the development of a new National Community Health Policy, which ensures community ownership of health issues.

Niger

The W4H programme supported the implementation of Niger's Rural Pipeline programme aimed at accelerating rural development through the creation of jobs for rural women and youth. The National Health Workforce investment plan and the subsequent National Strategic Plan for Community Health are driving the creation of approximately 40,00 additional health sector jobs by 2021 in underserved areas. Furthermore, contributing to an increase of 10% rural health coverage to reach a total of 58% by 2021. In 2019, the programme created 2,500 community-based health worker jobs and 5,000 indirect jobs in 2019 in three regions (Diffa, Tillabéri and Tahoua).

The rural pipeline approach aims at translating the demographic dividend into social and economic development by improving labour force participation for women and youth in rural and remote areas to reduce health inequities in access to care. As a result, this contributes toward limiting migration to cities or abroad, generates local economic developmentand reinforces social cohesion.

Rwanda

Under the guidance of a MOH-led HRH technical working group, a Health Labour Market Analysis (HLMA) survey was conducted, to be followed by a comprehensive HRH situation analysis and to intitiate the development and costing of the new HRH Strategic Plan,

W4H is helping to further strengthen collaboration across sectors, government agencies and partners to address the health workforce shortfall through a roadmap to improve workforce planning capacity, capability and increase investment and resource mobilisation for skills development, job creation and employment opportunities for women.

Regional Level

Southern African Development Community (SADC)

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

West African Economic and Monetary Union (WAEMU/UEMOA)

The W4H programme enabled coordination across the eight UEMOA countries to implement the sub-regional health workforce-related investment plan. The WAEMU strategy and investment plan aims to harmonise health system regulation and governance mechanisms, with a shared investment plan across all eight countries. WAEMU countries have jointly agreed to support sustainable economic growth through the creation of decent jobs in the health and social sectors, while also targeting other key areas such as the scale up of training of community-based health and social care workers, improvements in the work environment and the use of digital and new technologies. Countries have committed to create a minimum of 40,000 decent health work jobs by 2022. The W4H Programme is in the process of extending the approach to the broader ECOWAS region (eight additional countries).

Global Level

Health Workforce Mobility

Support from the W4H Programme to the ILO, OECD and WHO International Platform on Health Worker Mobility, has resulted in the development of new knowledge products that provide a significantly more comprehensive understanding of international health worker mobility than previously available. The updated information and evidence, including perspectives from members of the International Platform on Health Worker Mobility (representing national governments, international organisations, national professional regulatory bodies, employers organisations, trade unions, international credential verification organisations, academia and civil society), informed the 2nd Member State-led relevance and effectiveness review of the WHO Global Code of Practice on the International Recruitment of Health Personnel. The knowledge products developed have informed deliberations among Member State governments. As part of planned year 1 activities, work is currently underway to utilise the strengthened knowledge and evidence to provide targeted support at country and regional levels.

Inter-Agency Data Exchange

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

Achievements

The anticipated outcomes of the programme are outlined in the Working for Health Result Matrix, including detailed indicators and targets, further described in the assessment table.

Health Workforce Strategies improved at national level through a multisectoral approach

Republic of South Africa

1. Supported the NDOH-assigned Ministerial Task Team to develop a draft HRH Strategy Framework: 2030.

2. Supported the preparation of a draft 5-year HRH Strategic Plan 2020/21 to 2024/5, based on the revised government template, to include a preliminary list of projected outcomes, objectives and five-year targets.

Rwanda

1. Rwanda W4H 2-year operational plan developed with a first phase (2 years) of options that identifies and targets the development of HRH skills and the creation of employment/job opportunities and supports tripartite/multisectoral engagement.

Guinea Rural Pipeline

1. Supported the quality component of health services with the improvement of working environment for health workers through training 92 health workers on the ILO-WHO HealthWISE approach in health centers in the 5 rural pipeline convergence communes of the Labé region under the leadership of department heads of care units and in collaboration with health workers.

2. Supported the development and adoption of the Rural Pipeline program by local government and communities, through the integration of Operational Action Plans of the twenty (20) Municipalities of Convergence of the Rural Pipeline approach into the local development plans.

3. Supported the assessment of competencies and training requirements of health workers and community health workers through the development of the plan for the employment and integration of young people into the labour market in the 20 convergence municipalities where the Rural Pipeline Approach is implemented, to give visibility to the employment needs in the targeted communities.

Niger Rural Health Worker Pipeline project in Diffa region

1. Supported the rural HW pipeline project to improve access, use of health care and services for rural populations and underserved areas, health coverage to increase to 60% in 2021, of the peripheral level of the health service delivery system, composed of health posts, IHCs and District Hospitals (DH).

2. Supported initial evaluations and studies on job creation and youth employment to guide catalytic fund investment and the preparation of a Donor roundtable to mobilise resources for the implementation of the HRH Investment Plan and the Rural Pipeline Program.

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

Southern African Development Community (SADC)

1. Supported the development of a SADC regional Human Resources for Health Strategy and a 5-year Action Plan, through technical consultation, mapping and identification of strategic themes.

2. Conducted a 3-day HRH consultative session to set the foundation and evidence base for the strategy.

3. Conducted a 3-day tripartite technical meeting with representatives from 12 SADC member States, including Ministries of Health, Ministries of Employment and Labour, employers' and workers' organisations. Participants jointly identified and adopted recommendations for the SADC HRH strategy.

4. A draft framework was submitted to the SADC secretariat, and presented to the SADC meeting of ministers in November 2019.

West African Economic and Monetary Union (WAEMU/UEMOA)

1. Assessment of the health workforce investment plans of all WAEMU countries is being planned and consultant recruitment in process.

2. Discussions are ongoing with WAHO to take the lead of the monitoring process.

3. Inception meetings in 5 ECOWAS countries to extend the WAEMU investment plan to the ECOWAS countries is planned.

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

Inter-Agency Data Exchange established

1. Conducted a scoping analysis of new labour force surveys with health occupations at the 3 and 4-digit levels of ISCO-08 and ISCO-88 (and ISIC 2 digits). This formed a first basis of work with the aim to complement and update the data generated during the 2018 pilot, notably adding new data on countries and new variables, while using and adjusting existing data calculation programmes.

2. In total, data for 13 new countries was added to the database. New (and sometimes re-run) country-periods were added to the new and existing countries. In total 288 country-periods were added to the previous 100 country-periods data points that had been created during the pilot. Two new variables are also now available, Citizenship and Place of Birth that may contribute to exploring questions around migration and mobility of health workers.

3. Data was produced for 59 individual countries, with approximately 280 country-period pairings, during this first phase of the IADEx project. This included some re-runs from last time with more up to date data. There is now a total of 65 countries with 300 country-period data points available.

Health Workforce Mobility

1. Support from the Working for Health Programme has resulted in the establishment of the ILO, OECD, WHO International Platform on Health Worker Mobility.

2. Key knowledge products are in the process of development and will be published prior to the end of the first year. These include:
   - Quantification of international migration and mobility of doctors and nurses to and within OECD countries for the period 2000 to 2017/2018.
   - A report consolidating the mapping of bilateral agreement notified to WHO and WTO is also in the process of development.

3. Support from the Working for Health programme also enabled organisation of a public hearing through which members of the International Platform on Health Worker Mobility presented evidence and perspectives from across sectors and stakeholders to the 2nd Member State led-review of the WHO Global Code of Practice. A workshop to share positive practices with respect to the regional harmonisation of health professional regulation is planned for June 2020.

1 Outcome 1

The supply of appropriately skilled health workers meets assessed country needs

Indicators and outputs	Achieved indicator targets (at country level)	Achieved indicator targets (overall)	Reasons for variance with planned targets (if any)	Source of verification
Indicator 1: Total public-sector expenditure on health workforce pre-service education **Baseline: Based on country level assessments** **Planned target: % increase to be determined based on country level assessment**	Planned for next phase	N/A	A mid-term evaluation of countries' investments plans will be carried out mid-March 2020 and will include these indicators	Data from Annual Reports NHA, NHWA and GHED
Ratio of newly active domestic trained health workers to total stock of active health workers **Baseline: Based on country level assessments** **Planned target: Extent of change to be determined based on country level assessment – threshold to be defined at national level**	Planned for next phase	N/A	A mid-term evaluation of countries' investments plans will be carried out and will include these indicators	Data from Annual Reports, NHWA and labour force surveys
Strengthened country accreditation mechanisms to align types of education and training with health labour market demand and population needs **Indicator 1.1.1:** Existence of national and/or subnational mechanisms for accreditation of health workforce education and training institutions and their programmes (Yes/No/Partly) **Baseline:** 0 **Planned target:** 20 countries supported	Planned for next phase			
Output 1.2: Models developed for assessing staffing needs for health services delivery **Indicator 1.2.1:** Existence of institutional models for assessing and monitoring staffing needs for health service delivery (Yes/No/Partly) **Baseline:** 0 **Planned target:** 20 countries supported	**Guinea:** 70% **Niger:** 70% Both countries have implemented the Workload Indicators Staffing Needs (WISN) methodology	10%: 2 countries (**Guinea and Niger:** Partly)	Currently, there is only funding to support 10 countries not 20. Targets should be revised to 10. Achieved targets should be then 20%.	Data from Annual Reports and NHWA

Indicators and outputs	Achieved indicator targets (at country level)	Achieved indicator targets (overall)	Reasons for variance with planned targets (if any)	Source of verification
Output 1.3: Strengthened institutional capacity to align skills and competencies with health labour market and population needs **Indicator 1.3.1:** Existence of national education plans for the health workforce, aligned with the national health plan and the national health workforce strategy/plan (Yes/No/Partly) **Baseline:** 0 **Planned target:** 20 countries	**Guinea:** 50% A teachers' training assessment is underway to substantiate the Community Health providers' education plan.	5%: 1 countries (**Guinea:** Partly)	Currently, there is only funding to support 10 countries not 20. Targets should be revised to 10. Achieved targets should be then 10%.	Data from Annual Reports / NHWA

2 Outcome 2

Health sector jobs created to match public and labour market needs

Indicators and outputs	Achieved indicator targets (at country level)	Achieved indicator targets (across countries)	Reasons for variance with planned targets (if any)	Source of verification
Indicator: 1. Percentage of active health workers employed by type of facility ownership **Baseline:** Based on country assessment **Planned target:** Extent of change based on country assessment	In progress	Baseline data for the WAEMU countries: **Benin** in 2018: medical doctors: 71.5 in Public, 18.5 in Private for Profit (P4P), 10.7 in Private non-for Profit (PN4P); nurses: 94.1 in Public, 1.5 in P4P, 4.2 in PN4P. **Bissau** in 2018: nurses: 100 in Public. **Burkina Faso** in 2017: medical doctors: 100 in Public; nurses: 100 in Public. **Cote d'Ivoire** in 2018: nurses: 100 in Public. **Mali:** N/A **Niger** in 2016: medical doctors: 84.1 in Public, 15.9 in P4P, 0 in PN4P; nurses: 86.8 in Public, 13.2 in P4P, 0 in PN4P. **Senegal:** N/A **Togo** in 2018: medical doctors: 75.5 in Public, 24.5 in P4P, 0 in PN4P; nurses: 78.5 in Public, 21.6 in P4P, 0 in PN4P		Data from end of project assessments, NHWA and/or workforce registry
Indicator: 2. Density of health workers per 10,000 population **Baseline:** Based on country assessment **Planned target:** % change based on country assessment	In progress	**Benin** in 2018: 0.79 for medical doctors; 2.97 for nurses; 0.92 for midwifery; 0.01 for dentists; 0.27 for pharmacists; **Bissau** in 2016: 1.27 for medical doctors; 5.15 for nurses; 0.79 for midwifery; 0.04 for dentists (2017); 0.03 for pharmacists; **Burkina Faso** in 2017: 0.85 for medical doctors; 5.41 for nurses; 3.42 for midwifery; 0.04 for dentists; 0.15 for pharmacists; **Cote d'Ivoire** in 2018: 1.61 for medical doctors; 6.05 for nurses; N/A for midwifery; 0.14 for dentists; 0.37 for pharmacists; **Mali** in 2018: 1.29 for medical doctors; 2.71 for nurses; 1.70 for midwifery; 0.01 for dentists; 0.1 for pharmacists; **Niger** in 2016: 0.43 for medical doctors; 2.28 for nurses; 0.41 for midwifery; 0.01 for dentists; 0.01 for pharmacists. **Senegal** in 2017: 0.69 for medical doctors; 1.83 for nurses; 1.30 for midwifery; 0.08 for dentists; 0.11 for pharmacists; **Togo** in 2018: 0.77 for medical doctors; 2.47 for nurses; 1.63 for midwifery; 0.01 for dentists; 0.27 for pharmacists;	Baseline densities in the 8 WAEMU countries	NHWA

Indicators and outputs	Achieved indicator targets (at country level)	Achieved indicator targets (across countries)	Reasons for variance with planned targets (if any)	Source of verification
Ratio of previous year graduates who started practice to total number of previous year graduates **Baseline:** Based on country assessment **Planned target:** % change based on country assessment		N/A		Data from Annual report for SC, NHWA
Output 2.1: Strengthened country capacity on gender-responsive health labour market analysis, to inform and feed into the development of workforce policies, strategies, and reforms **Indicator 2.1.1:** Number of W4H-supported countries where health labour market analysis has been applied to inform health workforce planning **Baseline:** 0 **Planned target:** 20 countries	RSA 100% HLMA	5% (1 country: **South-Africa**: A National Health Workforce Strategic Framework: 2019-2030 and HRH Strategic Plan Sector: 2019/20-2024/25 based on inter-sectoral and tri-partite dialogue and health labour market analysis)	Currently, there is only funding to support 10 countries not 20. Targets should be revised to 10. Achieved targets should be then 10%.	Data from Annual Reports RSA HLMA Study Report
Output 2.2: Improved capacity to develop enhanced multi-sectoral national health workforce strategies and plans **Indicator 2.2.1:** Existence of mechanisms and models for health workforce planning (Yes/No/Partly) **Baseline:** 8 WAEMU countries **Planned target:** 20 countries	RSA 70% HLMA Study Report Rwanda 20% Acceleration plan developed	RSA Finalisation of strategic plan (5%) Costing and investing/implementation plan (25%) Rwanda 45% (9 countries: 8 countries of **WAEMU** have elaborated investments plans with situation analysis, HRH projections and scenarios with estimated costing and health service coverage, plus **South-Africa**)		Data from Annual Reports RSA: 2030 HRH Strategy Document/Report
Output 2.3: Strengthened countries' capacity to secure sustainable funding for health workforce strategies and plans **Indicator 2.3.1:** Number of W4H-supported countries with investment case for job creation in the health sector (public and private) **Baseline:** 0 **Planned target:** 20 countries	WAEMU 20% SADC 90% A SADC regional Human Resources for Health Strategy and a 5-year Action Plan that meets goals and targets for employment	10% (2 **WAEMU** countries: did return on investment studies; **Cote d'Ivoire** in 2017; **Benin** in 2018)	Currently, there is only funding to support 10 countries not 20. Targets should be revised to 10. Achieved targets should be then 20%.	Data from Annual Reports SADC: Regional Health Workforce Strategic Framework, 2020 – 2030 Document/Report
Output 2.4: Strengthened tripartite intersectoral mechanisms to coordinate the development and implementation of health workforce policies and strategies **Indicator 2.4.1:** Existence of institutional mechanisms or bodies to coordinate an intersectoral health workforce agenda (Yes/No/Partly) **Baseline:** **Planned target:** 20 countries		40% (all 8 WAEMU countries have either a National Committee on HRH or a HRH Observatory or a HRH working group)		Data from Annual Reports

Indicators and outputs	Achieved indicator targets (at country level)	Achieved indicator targets (across countries)	Reasons for variance with planned targets (if any)	Source of verification
Output 2.5: Improved systems and processes for monitoring of and accountability for health workforce strategies at country level **Indicator 2.5.1:** Number of W4H-supported countries producing annual monitoring, and accountability reports for health workforce strategies **Baseline:** 0 **Planned target:** 20 countries		0%	Recruitment of consultants is underway to support the elaboration of a roadmap to implement this activity in the WAEMU countries	

3 Outcome 3

Health workers are recruited and retained according to country needs

Indicators and outputs	Achieved indicator targets (at country level)	Achieved indicator targets (across countries)	Reasons for variance with planned targets (if any)	Source of verification
Indicator 3.1: Density and distribution of active health workers, by occupation and subnational level **Baseline:** SDG - based on country assessment **Planned target:** 15% increase	**2016 Baseline** in **Niger** at national level: 3.15 (total 3c); 0.43 for medical doctors; 2.28 for nurses; 0.41 for midwifery; 0.01 for dentists; 0.01 for pharmacists; in **Diffa** region: density of doctors, nurses and midwifes was 2.5 p.10.000 in 2017; in **Guinea** at national level: 2.2 (total 3c); 0.83 for medical doctors; 0.86 for nurses; 0.38 for midwifery; 0.04 for dentists; 0.09 for pharmacists			NHWA 1-01; 1-02
Indicator 3.2: Ratio of unfilled posts to total number of posts **Baseline:** Based on country assessment **Planned target:** 10% increase	no data for Guinea and Niger on NHWA platform			Data from Annual Reports, Labour and NHWA
Indicator 3.3: Ratio of active health workers voluntarily leaving the health sector labour market to total stock of active health workers **Baseline:** Based on country assessment **Planned target:** % change based on country assessment	no data for Guinea and Niger on NHWA platform			Data from Annual Reports, and NHWA
Output 3.1: Health workforce deployment and distribution mechanisms strengthened for primary health care in rural and underserved areas **Indicator 3.1.1:** Density of active health workers per 10,000 population by occupation at subnational level **Baseline:** Based on in country assessment **Planned target:** density change to be determined based on country level assessment	in **Guinea 2016 baseline**: 2.2 (total 3c); 0.83 for medical doctors; 0.86 for nurses; 0.38 for midwifery; 0.04 for dentists; 0.09 for pharmacists; 5.7 for CHW; 0.01 for medical imaging equipment technicians; 0.18 for medical laboratory technicians			Data from Annual Reports
Indicator 3.2.1: Gender wage gap **Baseline:** Based on in country assessment **Planned target:** % change to be determined based on country level assessment				Data from Annual Reports and NHWA

Indicators and outputs	Achieved indicator targets (at country level)	Achieved indicator targets (across countries)	Reasons for variance with planned targets (if any)	Source of verification
Output 3.3: Improved occupational health and safety of health workers in all settings at national level **Indicator 3.3.1:** Existence of national occupational health and safety plans or programmes integrated in health workforce strategies **Baseline:** Based on in country assessment **Planned target:** 10 countries	**Guinea:** Yes, The HealthWise approach is being implemented **Niger:** Yes; Both with the support of ILO	20% (2 countries: **Guinea** and **Niger**)		Data from Annual Reports
Indicator 3.4.1: Existence of national / subnational policies/ laws regulating social protection (yes/no/ partly) **Baseline:** Based on in country assessment **Planned target:** 10 countries	Planned for next phase			Data from Annual Reports and NHWA
Indicator 3.5.1: Existence of national / subnational policies/ laws regulating working hours and conditions (yes/no/partly) **Baseline:** Based on in country assessment **Planned target:** 10 countries	Planned for next phase			Data from Annual Reports and NHWA

4 Outcome 4

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

Indicators and outputs	Achieved indicator targets (at country level)	Achieved indicator targets (across countries)	Reasons for variance with planned targets (if any)	Source of verification
Indicator: Number of countries that have developed health workforce policy, planning and monitoring, including on mobility, based on harmonized metrics and definitions **Baseline:** 0 **Planned target:** 20 countries				Data from end of project assessments; NHWA
Output 4.1: An international health labour mobility platform established to advance knowledge and international cooperation **Indicator 4.1.1:** Number of countries participating in the platform **Baseline:** 0 **Planned target:** 50		30 countries excluding non-state actors Over 50 including non-state actors		Meeting notes
Output 4.2: Strengthened country capacity to understand and manage health worker flows, in order to inform the development of national policies and bilateral agreements **Indicator 4.1.2 Platform established to maximize benefits from international health worker mobility** **Indicator 4.2.1:** Number of national policies and bilateral agreements supported **Baseline:** 0 **Planned target:** 10 countries		Platform established 1 bilateral agreements		Germany-Salvador agreement and meeting note
Output 4.3: Increased monitoring of health worker mobility through the WHO Global Code of Practice reporting system **Indicator 4.3.1:** Number of countries supported by W4H which report on the WHO Global Code **Baseline:** 0 **Planned target:** 20 countries		-	4th Round of Code reporting to take place in 2021	Secretariat Report to the WHA
Output 4.4: New harmonized metrics and definitions established through an inter-agency global data exchange on the health labour markets **Indicator 4.4.1:** Number of countries using the data exchange platform **Baseline:** 0 **Planned target:** 50 countries		79 countries have reported nursing workforce data for the years 2016, 2017 and 2018 in the NHWA platform		NHWA

Indicators and outputs	Achieved indicator targets (at country level)	Achieved indicator targets (across countries)	Reasons for variance with planned targets (if any)	Source of verification
Output 4.5: Improved quality and reporting of health workforce data through National Health Workforce Accounts **Indicator 4.4.1:** Number of W4H-supported countries that report NHWA core indicators to WHO annually **Baseline:** **Planned target:** 20 countries		5% (1 country: **Rwanda** has reported data on the main 5 health workers categories until 2018)	Currently, there is only funding to support 10 countries not 20. Targets should be revised to 10. Achieved targets should be then 10%.	NHWA

Fund financial performance

This Consolidated Annual Financial Report of the Working for Health MPTF Fund is prepared by the United Nations Development Programme (UNDP) Multi-Partner Trust Fund Office (MPTF Office) in fulfillment of its obligations as Administrative Agent, as per the terms of Reference (TOR), the Memorandum of Understanding (MOU) signed between the UNDP MPTF Office and the Participating Organizations, and the Standard Administrative Arrangement (SAA) signed with contributors.

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

This consolidated financial report covers the period 1 January to 31 December 2019 and provides financial data on progress made in the implementation of projects of the Working for Health MPTF Fund. It is posted on the MPTF Office GATEWAY (http://mptf.undp.org/factsheet/fund/WHL00).

The financial data in the report is recorded in US Dollars and due to rounding off of numbers, the totals may not add up.

2019 Financial performance

This chapter presents financial data and analysis of the Working for Health MPTF Fund using the pass-through funding modality as of 31 December 2019. Financial information for this Fund is also available on the MPTF Office GATEWAY, at the following address: http://mptf.undp.org/factsheet/fund/WHL00.

1. Sources and uses of funds

As of 31 December 2019, 2 contributors deposited US$ 3,335,934 in contributions and US$ 29,313 was earned in interest. The cumulative source of funds was US$ 3,365,247 Of this amount, US$ 3,212,221 has been net funded to 3 Participating Organizations, of which US$ 329,963 has been reported as expenditure. The Administrative Agent fee has been charged at the approved rate of 1% on deposits and amounts to US$ 33,359. Table 1 provides an overview of the overall sources, uses, and balance of the Working for Health MPTF Fund as of 31 December 2019.

Table 1. Financial Overview, as of 31 December 2019 (in US Dollars)

	Annual 2018	Annual 2019	Cumulative
Sources of Funds			
Contributions from donors	1,158,078	2,177,856	3,335,934
Fund Earned Interest and Investment Income	1,558	27,755	29,313
Interest Income received from Participating Organizations	-	-	-
Refunds by Administrative Agent to Contributors	-	-	-
Fund balance transferred to another MDTF	-	-	-
Other Income	-	-	-
Total: Sources of Funds	**1,159,636**	**2,205,612**	**3,365,247**
Use of Funds			
Transfers to Participating Organizations	-	2,943,651	2,943,651
Refunds received from Participating Organizations	-	-	-
Net Funded Amount	**-**	**2,943,651**	**2,943,651**
Administrative Agent Fees	11,581	21,779	33,359
Direct Costs: (Steering Committee, Secretariat...etc.)	-	268,570	268,570
Bank Charges	40	62	102
Other Expenditures	-	-	-
Total: Uses of Funds	**11,621**	**3,234,061**	**3,245,682**
Change in Fund cash balance with Administrative Agent	**1,148,015**	**(1,028,450)**	**119,565**
Opening Fund balance (1 January)	0	1,148,015	-
Closing Fund balance (31 December)	**1,148,015**	**119,565**	**119,565**
Net Funded Amount (Includes Direct Cost)	-	3,212,221	3,212,221
Participating Organizations' Expenditure (Includes Direct Cost)	-	329,963	329,963
Balance of Funds with Participating Organizations			**2,882,258**

2. Partner contributions

Table 2 provides information on cumulative contributions received from all contributors to this Fund as of 31 December 2019.

The Working for Health MPTF Fund is currently being financed by 2 contributors, as listed in the table below. The table below includes commitments made up to 31 December 2019 through signed Standard Administrative Agreements, and deposits made through 2019. It does not include commitments that were made to the fund beyond 2019.

Table 2. Contributors' Commitments and Deposits, as of 31 December 2019 (in US Dollars)

Contributors	Total Commitments	Prior Years as of 31-Dec-2018 Deposits	Current Year Jan-Dec-2019 Deposits	Total Deposits
NORWAY, Government of	2,335,934	1,158,078	1,177,856	2,335,934
SILATECH	1,000,000	-	1,000,000	1,000,000
Grand Total	**3,335,934**	**1,158,078**	**2,177,856**	**3,335,934**

3. Interest earned

Interest income is earned in two ways: 1) on the balance of funds held by the Administrative Agent (Fund earned interest), and 2) on the balance of funds held by the Participating Organizations (Agency earned interest) where their Financial Regulations and Rules allow return of interest to the AA. As of 31 December 2019, Fund earned interest amounts to US$ 29,313. Details are provided in the table below.

Table 3. Sources of Interest and Investment Income, as of 31 December 2019 (in US Dollars)

Interest Earned	Prior Years as of 31-Dec-2018	Current Year Jan-Dec-2019	Total
Administrative Agent			
Fund Earned Interest and Investment Income	1,558	27,755	29,313
Total: Fund Earned Interest	**1,558**	**27,755**	**29,313**
Participating Organization			
Total: Agency earned interest			
Grand Total	**1,558**	**27,755**	**29,313**

4. Transfer of funds

Allocations to Participating Organizations are approved by the Steering Committee and disbursed by the Administrative Agent. As of 31 December 2019, the AA has transferred US$ 2,943,651 to 3 Participating Organizations (see list below).

4.1 Transfer by participating organization

Table 4 provides additional information on the refunds received by the MPTF Office, and the net funded amount for each of the Participating Organizations.

Table 4. Transfer, Refund, and Net Funded Amount by Participating Organization, as of 31 December 2019 (in US Dollars)

Participating Organization	Prior Years as of 31-Dec-2018			Current Year Jan-Dec-2019			Total		
	Transfers	Refunds	Net Funded	Transfers	Refunds	Net Funded	Transfers	Refunds	Net Funded
ILO				681,345		681,345	681,345		681,345
OECD				328,897		328,897	328,897		328,897
WHO				1,933,409		1,933,409	1,933,409		1,933,409
Grand Total				**2,943,651**		**2,943,651**	**2,943,651**		**2,943,651**

5. Expenditure and financial delivery rates

All final expenditures reported for the year 2019 were submitted by the Headquarters of the Participating Organizations. These were consolidated by the MPTF Office.

Project expenditures are incurred and monitored by each Participating Organization, and are reported as per the agreed upon categories for inter-agency harmonized reporting. The reported expenditures were submitted via the MPTF Office's online expenditure reporting tool. The 2019 expenditure data has been posted on the MPTF Office GATEWAY at http://mptf.undp.org/factsheet/fund/WHL00.

5.1 Expenditure reported by Participating Organization

In June 2019, US$ 2,943,651 was net funded to Participating Organizations, and US$ 329,963 was reported in expenditure.

As shown in table below, the cumulative net funded amount is US$ 2,943,651 and cumulative expenditures reported by the Participating Organizations amount to US$ 329,963. This equates to an overall Fund expenditure delivery rate of 11 percent.

Table 5.1. Net Funded Amount, Reported Expenditure, and Financial Delivery by Participating Organization, as of 31 December 2019 (in US Dollars)

Participating Organization	Approved Amount	Net Funded Amount	Expenditure			Delivery Rate %
			Prior Years as of 31-Dec-2018	Current Year Jan-Dec-2019	Cumulative	
ILO	681,345	681,345		38,898	38,898	5.71
OECD	328,897	328,897		99,136	99,136	30.14
WHO	1,933,409	1,933,409		191,929	191,929	9.93
Grand Total	**2,943,651**	**2,943,651**		**329,963**	**329,963**	**11.21**

5.2 Expenditure by project

Table 5.2 displays the net funded amounts, expenditures reported and the financial delivery rates by Participating Organization.

Table 5.2 Expenditure by Project within Sector, as of 31 December 2019 (in US Dollars)

Sector / Project No.and Project Title		Participating Organization	Project Status	Total Approved Amount	Net Funded Amount	Total Expenditure	Delivery Rate %
Global							
00116408	W4H Initial implementation	ILO	On Going	353,390	353,390	38,898	11.01
00116408	W4H Initial implementation	OECD	On Going	328,897	328,897	99,136	30.14
00116408	W4H Initial implementation	WHO	On Going	1,121,279	1,121,279	191,929	17.12
00118644	W4H Country Support Jan-Dec 20	ILO	On Going	327,955	327,955		0
00118644	W4H Country Support Jan-Dec 20	WHO	On Going	812,130	812,130		0
Global: Total				**2,943,651**	**2,943,651**	**329,963**	**11.21**
Grand Total				**2,943,651**	**2,943,651**	**329,963**	**11.21**

5.3 Expenditure reported by category

Project expenditures are incurred and monitored by each Participating Organization and are reported as per the agreed categories for inter-agency harmonized reporting. See table below.

Expense Categories

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

Table 6. Expenditure by UNDG Budget Category, as of 31 December 2019 (in US Dollars)

Category	Expenditure			Percentage of Total Programme Cost
	Prior Years as of 31-Dec-2018	Current Year Jan-Dec-2019	Total	
Staff & Personnel Cost	-	69,613	69,613	23.67
Supplies, Commodities, Materials	-	-	-	
Equipment, Vehicles, Furniture, Depreciation	-	-	-	
Contractual Services	-	70,225	70,225	23.87
Travel	-	41,108	41,108	13.98
Transfers and Grants	-	91,967	91,967	31.27
General Operating	-	21,228	21,228	7.22
Programme Costs Total	**-**	**294,141**	**294,141**	**100.00**
[1] Indirect Support Costs Total	-	35,822	35,822	12.18
Total	**-**	**329,963**	**329,963**	

6. Cost recovery

Cost recovery policies for the Fund are guided by the applicable provisions of the Terms of Reference, the MOU concluded between the Administrative Agent and Participating Organizations, and the SAAs concluded between the Administrative Agent and Contributors, based on rates approved by UNDG.

The policies in place, as of 31 December 2019, were as follows:

- The Administrative Agent (AA) fee: 1% is charged at the time of contributor deposit and covers services provided on that contribution for the entire duration of the Fund. In the reporting period US$ 21,779 was deducted in AA-fees. Cumulatively, as of 31 December 2019, US$ 33,359 has been charged in AA-fees.

- Indirect Costs of Participating Organizations: Participating Organizations may charge up to 7% indirect costs. In the current reporting period US$ 35,822 was deducted in indirect costs by Participating Organizations. Cumulatively, indirect costs amount to US$ 35,822 as of 31 December 2019.

7. Accountability and transparency

In order to effectively provide fund administration services and facilitate monitoring and reporting to the UN system and its partners, the MPTF Office has developed a public website, the MPTF Office Gateway (http://mptf.undp.org). Refreshed in real time every two hours from an internal enterprise resource planning system, the MPTF Office Gateway has become a standard setter for providing transparent and accountable trust fund administration services.

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

8. Direct costs

The Fund governance mechanism may approve an allocation to a Participating Organization to cover costs associated with Secretariat services and overall coordination, as well as Fund level reviews and evaluations. These allocations are referred to as 'direct costs'. In the reporting period, direct costs charged to the fund amounted to US$ 268,570. Cumulatively, as of 31 December 2019, US$ 268,570 has been charged as Direct Costs.

Table 7. Direct costs

Participating Organization	Net Funded Amount	Expenditure	Delivery Rate
WHO	268,570		
Total:	**268,570**		

Way forward

The strength of partnerships across health, employment and financing stakeholders, has been welcomed at country, regional and global levels, with increasing recognition amongst stakeholders of the investment value of the health sector as a vehicle to deliver multiple development goals: health, employment, gender equality, inclusive economic growth, social cohesion, and promoting peace and security.

Joint efforts by the three agencies over this initial implementation period is strengthening health workforce policy and governance; both globally and across supported countries and regions, by providing a multisectoral and multi-stakeholder perspective and approach for building the evidence base, engagement and investment choices to deliver UHC and the SDGs.

For 2020, projects in an additional six countries have been approved. At country level, communication, preliminary planning, baseline mapping and related start-up activities were conducted in the approved new countries, namely: Benin, Chad, Mali, Mauritania, the Palestine Authority and Sudan. Furthermore, joint WHO-ILO inception missions were conducted in Chad and Mauritania, where Tripartite policy dialogue and health labour market analysis work was initiated. Work is also ongoing on identifying and developing the next phase of health workforce interventions for supported countries, as well as respond to MPTF support requests from other countries to strengthen their primary health care workforce to deliver UHC, including potential new requests for MPTF support from Pakistan and Somalia. Due to the COVID-19 pandemic, some of the immediate and near-term joint missions are on hold until further notice. The W4H technical secretariat are working directly with country and regional counterparts to adapt and modify context-specific approaches to respond to the evolving situation and to help ensure continuity.

Moving forward with the Interagency Data Exchange, the second phase of project activity (2020) will be devoted to analytical work along an agreed analysis plan that aims to produce different sets of knowledge products – including sets of country profile documents and specific data profiles of W4H supported countries. A generic program has been created to produce a model with data from one country, and this will be applied for other countries where solid data are available. Further, a report on the health workforce will be produced based on the analysis of this new data.
Regarding health workforce mobility, Sudan has been identified as a country where operationalisation of its Health Worker Migration Management Policy can benefit from support of the International Platform on Health Worker Mobility. Work is underway to support the development of bilateral agreements, retention policy and engagement with diaspora.

The recent COVID-19 pandemic reaffirms key lessons from the previous Ebola crises in Africa, notably the need for investments in the preparedness, mobilisation, protection and safety of the health workforce in line with global protocols, standards and guidelines to ensure global health security. It is necessary to invest in strengthened public health and primary health care systems and capability, whilst simultaneously maintaining continuing core service capability. The disproportionate burden of care on the predominantly female health workforce because of pandemics and other health shocks is significant and therefore must be adequately recognised, balanced and addressed as a key priority.

Annex 1.

Health workforce: Investing for health — The case of Niger

Niger is the first country in the West African Region to take up the recommendations of the United Nations High-level Commission on Health Employment and Economic Growth. Following the adoption of the Commission's report by the World Health Assembly in 2017, Niger engaged with a range of sectors and ministries to translate the Commission's recommendations to the national context. This resulted in the *National action plan for investment in health and social sector employment and growth in economic health 2018-2021*, endorsed by the Government and adopted through a Presidential decree. In addition, based on an analysis of the community health situation and the analytical framework of policies and strategies for reproductive, maternal, new-born, child, adolescent health and nutrition, Niger also developed the *National strategic plan for community health 2019-2023*.

The National Action Plan was informed by WHO's technical assistance on a health labour market analysis (HLMA). The analysis provided an evidence-based assessment to inform multi-sectorial policy dialogue. The evidence confirmed employment in the health sector represents less than 4% of the active labour force, compared to an average of 1.6%[1] in sub-Saharan Africa. Of those employed, there is an inequitable distribution within the country undermining access to health care: only 35% of health workers are practising in the rural areas that serve 60% of the population. Further there is evidence of inefficiency in the health labour market: less than half (45%) of health graduates in the period 2010-2014 found jobs in the health sector, and approximately 15,000 health graduates (including physicians) were unemployed or occupied precarious jobs.

The National Action Plan called for the creation of an additional 11,500 health professionals and other socio-economic sector jobs nationwide and the establishment of 147 new health facilities by 2021, prioritising expanded coverage of health services to underserved areas and reaching 1.8 million additional people. The Strategic Plan for Community Health called for the creation of an additional 28,500 community health workers jobs by 2021. Jointly, both plans target a total of approximately 40,000 new jobs over a period of 5 years.

In this context, the Government launched the implementation of the 'Rural Pipeline Programme' (RPP) in 3 rural regions: Diffa, Tahoua and Tillabéri. The RPP is based on a community development approach covering health, education and economic activities with the aim of accelerating rural development through the creation of jobs for women and youth. It further aims to identify and educate students from rural areas to practice in rural areas. A national assessment of the quality of nursing and midwifery education and training institutions was undertaken by WHO to provide recommendations on improving quality standards of education and training institutions and to support developing accreditation mechanisms. Niger has subsequently established an agency for the accreditation of nursing and midwifery education and training schools and opened a new midwifery and nursing school in the Diffa Region: the school itself creating economic development and jobs in the region.

The programme has already led to the creation of an estimated 2,500 community-based health worker jobs in the three Regions. Approximately 1,400 (58%) of the newly recruited health personnel are young women. The density of health personnel per 10,000 population has subsequently doubled in Diffa Region, from 2.5 to 5, tripled in Tahoua Region, from 1 to 3, and witnessed a 333% increase in Tillabéri Region from 1.2 to 4. Data is validated through the implementation of National Health Workforce Accounts to strengthen the availability, comprehensiveness and quality of health workforce data

Additional mobilization of investment is required to expand the implementation of the National Action Plan. With WHO support, the government has developed a human resources for health investment plan, detailing the return on investment to leverage multi-year funding from human capital resources.

---

[1] Improving Employment and Working Conditions in Health Services: Report for discussion at the Tripartite Meeting on Improving Employment and Working Conditions in Health Services, Geneva, 24–28 April 2017, International Labour Office, Sectoral Policies Department, Geneva, ILO, 2017. P13.

Annex 2. Programme mandate

In September 2016, the United Nations Secretary General's High-Level Commission on Health Employment and Economic Growth proposed 10 recommendations and five immediate actions to stimulate the creation of health and social sector jobs to support universal health coverage and advance inclusive economic growth. Following extensive consultations with Member States and other key stakeholders, the 70th World Health Assembly, OECD Health Committee and the 331st ILO Governing Body adopted the Five-Year ILO-OECD-WHO Action Plan on Health Employment and Inclusive Economic Growth in 2017. The Working for Health programme was established by the three agencies to assist countries in carrying out the plan, in response to the UNGA Resolution A/RES/70/183 on 'Global Health and Foreign Policy'.

Working for Health was created in 2017 by the World Health Organization, the International Labour Organization, and the Organisation for Economic Co-operation and Development to support countries to expand and transform the health and social workforce for the SDGs. The three organizations together view investments in skilled, trained and empowered health and social care workers as an opportunity to help countries meet not only the SDG on health and well-being, but also on employment and decent work, education and gender equality. Linking improved health care access with job creation and economic development, the programme provides direct assistance to governments, social partners and key stakeholders to develop, finance and implement multi-sectoral national health workforce strategies that improve the supply of trained health workers, create decent jobs, optimize recruitment and performance of health workers, and assure mutual benefits from the migration of health workers from lower-income to high-income countries.

The programme partners with countries to address shortfalls through the creation of decent jobs in health and social care, particularly by applying various tools, approaches and policy options to help them take action to tackle underinvestment and gaps in their health and social care workforce. In some cases, we work directly with countries. For example, in Guinea, where a global Ebola outbreak originated in 2014 and which has only a sixth of the health workers it needs to meet the SDGs, Working for Health is supporting a technical training and rural job creation programme that will produce and employ 10,000 community-based health workers. We also work with national governments and regional alliances to help them advance multi-sectoral workforce development plans aimed at the health and social sectors. More broadly, Working for Health is collaborating with partner agencies and national governments in developing data, data, tools, social dialogue and evidence-based national health workforce strategies and action plans. We have also established an International Platform on Health Worker Mobility, through which we will convene stakeholders in policy dialogue that will result in systematic, evidence-based and ethical responses to health worker mobility and migration, as well as improve global data and information and assist source and destination countries to establish bilateral agreements.

Annex 3. Governance structure

The ILO, OECD and WHO are the participating organisations of the Working for Health programme and MPTF. They oversee and coordinate the implementation of the Working for Health programme and MPTF (Figure 1) through regular decision-making meetings at the senior management level; a senior-level Steering Committee of the three organisations has been established for that purpose. Working under the direction of the Steering Committee, a joint technical secretariat is responsible for developing annual operational plans and ensuring effective implementation, communications and knowledge management, stakeholder engagement, consultative processes, and monitoring and reporting. A high-level Strategic Advisory Board is established to provide strategic input and political support once the programme reaches a significant operational scale[1].

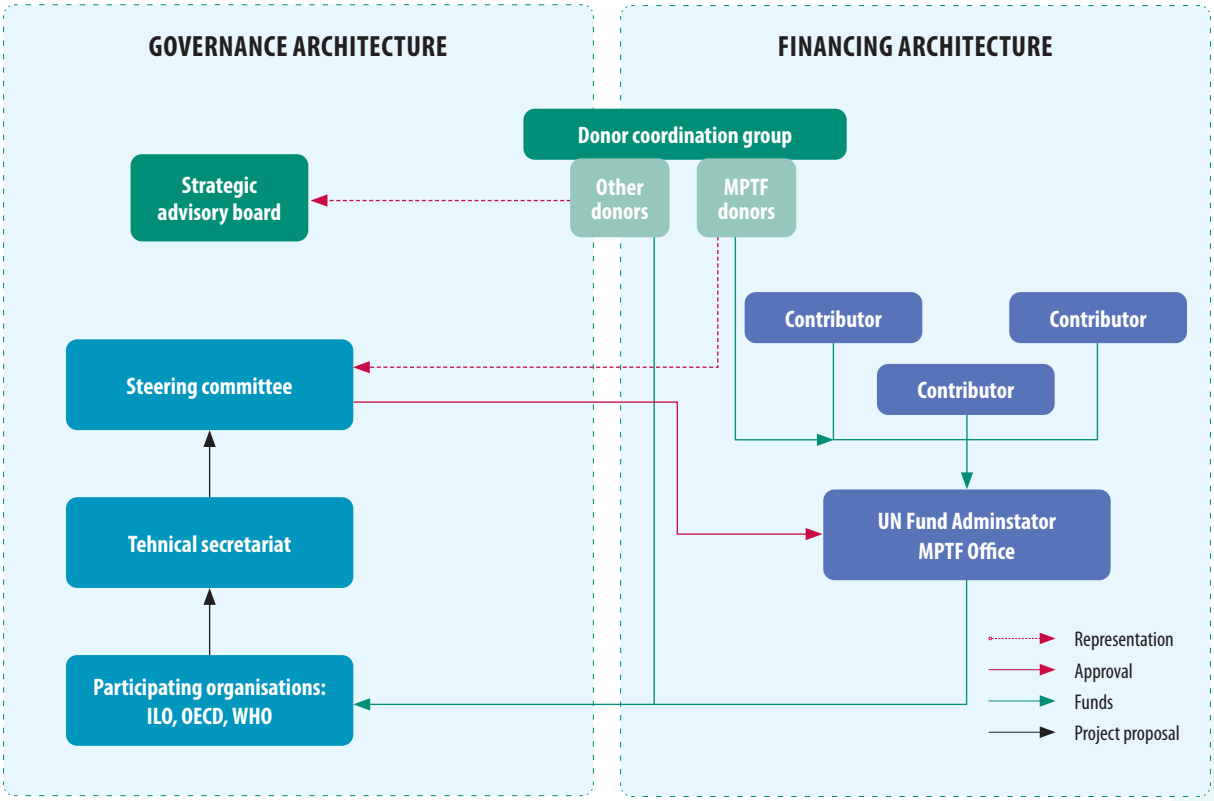

Figure 1. Overview of governance structure

www.working4health.org
working4health@who.int
#working4health