Stakeholder Conversations on Platform for Global Action on Health Workforce

Input to Inform Global Health Workforce Alliance and Partner Discussions on Needs and Options
Series of Meetings with US and UN Actors

February 2015

"Let there be no misunderstanding. If health workforce deficiencies do not get the high-level political attention the issue sorely needs and it continues to languish as a global health policy afterthought, this Ebola outbreak will continue to threaten both global health security and the tremendous progress the United States has helped to lead in saving women's and children's lives and fighting diseases such as HIV/AIDS and tuberculosis."

Pape Gaye, President and CEO, IntraHealth International
Testimony to the United States Senate Foreign Relations Subcommittee on African Affairs regarding the US and global response to Ebola, December 10, 2014

During the week of February 10-14, 2015, Dr. Sigrun Mogedal led a final exploration activity of a multi-phase global consultation on a post-2015 global action platform for human resources for health (HRH), for presenting options to the Global Health Workforce Alliance (GHWA) Board during its February 2015 meeting. The purpose of the consultations was to contribute to the thinking on the rationale for a global multi-sector and multi-stakeholder HRH platform after the current memorandum of understanding for the GHWA platform, hosted by the World Health Organization (WHO), comes to an end in mid-2016.

IntraHealth International[1], a US-based international nongovernmental organization (INGO) and global leader in human resources for health, supported a series of consultations with Dr. Mogedal, of the Norwegian Knowledge Center for the Health Services (made available to GHWA by Norad to lead the global consultations), to explore some of the key questions related to future options for a global HRH platform. The discussions were informed by consultation notes made available on the GHWA website, and by a preliminary synthesis of findings.

Three questions were posed through the consultation synthesis:

1) To what extent is there a continued need for a global multi-sectoral and multi-stakeholder stewardship and anchoring platform for human resources for health and social care beyond the current mandate? Or are there alternative approaches?
2) What are the characteristics that such a platform should have to make it fit for purpose within the new post-2015 sustainable health and development framework?
3) How can a global platform foster collaboration across different existing and new targeted programs, instruments, agencies and partnerships, in support of sustainable workforce solutions on the ground?

US government donor agencies, private sector partners, INGOs, academic institutions, and international agencies that have headquarters and/or large offices of Americas-based partners[2] engaged in individual meetings and/or participated in roundtable group discussions hosted at IntraHealth International's Washington, DC, office. Group roundtables included meetings with the Health Worker Advocacy Initiative (HWAI) members and Frontline Health Workers Coalition members. Inputs were also solicited from the

[1] www.intrahealth.org
[2] See appendix for list of partners engaged in this week of U.S. based discussions.

New York-based offices of UNICEF, UNDP, UNFPA, UNAIDS, the Executive Office of the Secretary-General, and Every Woman Every Child.

This note covers the key questions explored, with a synthesis of the responses and collective outcomes of those conversations. The responses largely validated the findings of the drafted synthesis report for discussion among the GHWA Board[3], but also served to inspire further thought on what it means for countries to be in the lead, and what global collaboration could contribute.

INPUTS TO THE QUESTIONS RAISED IN THE CONSULTATIONS

Question #1: *To what extent is there a continued need for a global multi-sectoral and multi-stakeholder stewardship and anchoring platform for human resources for health and social care beyond the current mandate?*

Most respondents noted that this is not the time to phase out global action for HRH, but rather strengthen it and capture the new opportunities that are arising from the work on the global HRH strategy and the shaping of the post-2015 global sustainable development agenda. There is a strong need for a collective voice that stands firm on the centrality of HRH for building resilient health systems, for achieving and sustaining women's and children's health, and for advancing toward universal health coverage (UHC).

Health governance, both at the global and the national level, needs to embrace multi-sector and multi-stakeholder action. Health workforce is part of a broader world of work where employment and labor market, public stewardship, and engagement of non-state actors and the private sector cut across sectors and require national policies and institutions that can inform political decision-making.

A national investment and accountability framework for HRH will facilitate democratic accountability of governments to their people and hold partners accountable for alignment and efficiency in their support. The WHO voluntary Global Code of Practice on the International Recruitment of Health Personnel[4] calls on solidarity across borders to make it possible for all countries to build resilient health systems. A global HRH platform should be seen in this perspective.

Discussions put forward the following arguments as to the kind of needs that require global action, including through a global, multi-sector HRH platform:

- ***A Global Voice:*** Even though GHWA today represents the influence and convening power of some 400 members, its voice is not strong enough to leverage concerted action across agencies, health initiatives, and development partners. The long-standing weak and uneven HRH capacity in many of the low- and middle-income countries (LMICs), particularly in fragile states and states in conflict, are not addressed at the level of global policy and decision-making for health. Access gaps put both national and global health security at risk. Despite the workforce's integral position in health development, there is not the equally representative global platform to bear necessary influence on how global partners recognize and act on the workforce aspects and implications of their health programs and health funding, galvanize resources, support program implementation, or drive coordination at country level. Ebola has demonstrated the consequences of weak health systems that have not been able to equip health workers with necessary capacity for carrying out essential public health functions and for delivering

[3] GHWA 18th Board Meeting Agenda 3.2, Future need for a global, multi-sector and multi-stakeholder HRH platform. Synthesis of findings from consultations, with options analysis for Global HRH Governance post 2015
[4] http://www.who.int/hrh/migration/code/WHO_global_code_of_practice_EN.pdf

services that are available and trusted on the ground. There is a need for a voice that can bear influence on governments and partners, moving them to respond to health worker requirements for resilient health systems in new ways. By agreeing to become global champions for HRH in the Sustainable Development Goals process, one or several among the "BRICS" group of countries could make a big difference. To follow GHWA, a new type of mechanism is required, with monitoring and accountability for HRH across the global health landscape as a core function, empowered by its partners and global leaders to establish public accountability for action at country and global levels and to speak to current issues and arising challenges. It could be accompanied by advocacy for fulfillment of global commitments, convening technical exchange and support in the advancement of those commitments.

- ***Protection of the Public Good***: Governments are ultimately responsible to protect the health of their people, and to do that there must be access to trained health workers. Beyond GHWA, there is currently no global mechanism that convenes stakeholders and partners in support of countries, particularly LMIC governments, in their efforts to protect and provide the public good. It is also strongly recognized that access to health workers is a global, interconnected responsibility. All countries need to find solutions for a resilient health and social care system that match their demographic and epidemiological context, avoiding the external and internal drain of health workers that undermines equitable access and progression toward UHC. All countries need to take steps to act and report on how they are accountable to their commitment to the WHO Code of Practice on international recruitment of health personnel. HRH is not just a health sector development issue but a global solidarity, shared responsibility, and mutual accountability issue, at the core of resilient health systems. To this effect, there is a need for global action in order to drive alignment, information exchange, and transparency of actions in support of country efforts to produce, distribute, manage, and retain a health workforce sufficient in numbers and skill set to provide needed health services to populations.

- ***Promoting Justice and Equity—both for the health worker and the population she/he serves***: In Ban Ki Moon's December synthesis report, *The Road to Dignity by 2030: Ending Poverty, Transforming All Lives and Protecting the Planet*[5], the Secretary General captured the aspirations of people around the world through the "World we want" consultations, calling for social justice, equity, inclusion, and rights. The 17 proposed Sustainable Development Goals, negotiated by the Open Working Group, were clustered around six elements, including people, justice, dignity, and partnership. People and human resources are at the center of those aspirations. Health workers serve the needs of their fellow man and their country/community objectives, often putting themselves at physical and psychological risk. Responsible HRH policies are essential to protect and uphold this large part of the national/global workforce, which is even greater if HRH were to include the broader social services workforce, which is so closely related to health; and even to include more widely related workforce groups, such as educational, environmental (pollution/climate), agricultural (food access), and military and police (emergency response and security). Further, it is the health workforce that translates the health system and clinical commodities into a form for human consumption—enabling populations to access their fundamental rights to health care. To ensure this right for populations at the margins is primarily a responsibility of national governments, but also of the global community and requires accountability structures at national and global levels.

- ***Investment and Efficiency in Spending:*** There is a need for a massive increase in domestic and international investment in health workforce, both for policy and stewardship and for delivery

[5] *The Road to Dignity by 2030: Ending Poverty, Transforming All Lives and Protecting the Planet.* Synthesis Report of the Secretary-General on the Post-2015 Agenda. United Nations. New York, December 2014. Available online. http://www.un.org/disabilities/documents/reports/SG_Synthesis_Report_Road_to_Dignity_by_2030.pdf

functions. The health workforce, because its development and management is so complex and addressed by multiple but vertical programs, is an area of health development that is particularly fragmented. Requiring 60% to 80% of the health budget, the health workforce is often the first place to cut costs and the most difficult to autonomously support. There are important job opportunities in the health sector, such as for the youth population, and significant economic benefits from investment in jobs in primary health care. The health field is an employment resource that is significant in most countries. Countries will benefit from making a more consolidated investment case for HRH that matches their policies for ensuring resilient health systems and UHC, identifying capacity gaps and aligning partner contributions and public and private sector opportunities to meet these gaps. No overview is available about the overall partner contributions to health workforce development. Both global and national levels must be engaged in making the investment case, track resource flows, increase efficiency, and drive alignment in investment across partners including the donor agencies, the professional organizations, the academic sector, the NGOs, and the private sector.

- ***Managing National and Global Labor Markets***: The health sector has limited policy space and capacity for managing employment and employment conditions in order to deal with remote and rural access gaps and in the context of broader labor market realities. There is a need for countries to build and promote a labor market that can sustain the necessary health and related workforce. An optimum framework for managing that labor market, with the inclusion of key actors in the "world of work," would catalyze economic drivers of growth, while safeguarding equity of public service access and ensuring health and safety of the health and social service workers. The health and social workforce cannot be handled in isolation from the workforce in other related sectors, such as education and social protection, in that all must be developed within a sustainable model that enables and incentivizes engagement in and commitment to the responsible delivery of quality services. National labor markets are strongly interconnected with global labor markets, which call for alignment in global engagement and accountability to ethical policies.

- ***Leveraging Access and Opportunities for Women and Adolescents:*** Women particularly need access to the labor markets, and a strengthened health workforce not only raises their opportunities to access quality care but opens opportunities for employment. According to WHO 2008 statistics,[6] approximately 42% of the global paid labor force is comprised of women; 75% of the health sector in most countries is made up of salaried women. Further, the health sector, because of its vast shortage of health professionals, offers an entrée toward more equitable vertical labor status of women – where women are needed to fill higher positions rather than only support positions. Finally, to advance women's health, children's and family health, and reproductive rights, the health workforce is the lynchpin. The situation of women will improve at both the national and the global level when countries are held accountable for the employment and treatment of women. A platform that monitors equitable recruitment, training, and employment and salary levels of women in the health workforce at country level will be a critical influencer in advancing the broader global agenda to achieve gender equity and women's rights, and women's reproductive rights. That agenda will also be supported when countries make sure women health workers are promoting and leading reproductive rights and family planning choices in communities. Movements and agencies, such as led by UNFPA on reproductive health and rights for women and adolescents, can benefit from and leverage the role of a global HRH platform in advancing their agenda.

[6] World Health Organization: *Gender and health workforce statistics*. Spotlight on Statistics: A Fact File on Health Workforce Statistics; 2008. Available online. http://www.who.int/hrh/statistics/spotlight_2.pdf

- ***Overcoming Fragmentation:*** Fragmentation and inefficiencies in HRH and HRH-related responses represent a major challenge, both at global and national levels. Bilateral and multilateral agencies provide support through disparate and uncoordinated programs and funding flows, both from within the agencies and between agencies. International financing institutions and UN system agencies will most effectively optimize their contributions by overcoming fragmented and inefficient HRH interventions and harmonizing their support in building national and institutional capacity to provide the necessary workforce that will ensure essential public health and service delivery functions. Governments have needed to partner with bilateral and non-profit implementers to train, distribute, support, and remunerate health workers—particularly those at the sub-national level, working in rural and remote areas. As these partnerships have populated the public health space, their individual agendas and varied resource bases have led to fragmented eco-systems of clustered health workers delivering diverse services at different quality levels. Overcoming fragmentation is urgent so that governments can develop policies and design strategies with the matching resources, and harmonize standards and levels of care across the country. It is necessary for the external actors to engage in this collaboration and harmonization to empower country ownership and enable sustainable stewardship of national health systems. Despite the important on-the-ground role that community systems play, there need to be mechanisms that connect the service delivery (implemented by the providers), the sub-national system management (implemented by health workers that manage regions, provinces, and districts) and the national government. Whether service delivery and systems management is carried out by donors and their partners or by national entities, there needs to be an accountability framework that connects the political decision-making with the technical realities. Overcoming fragmentation requires both national and global action.

- ***Overcoming the Burden of Corruption in the Health Sector:*** There is a need to address vulnerabilities to corruption in the health sector. Some of the common corrupt practices identified by UNDP[7] include absenteeism, theft of medical supplies, informal payments, fraud, weak regulatory procedures, and improperly designed procurement procedures, all of which can be associated with the health workforce and weak national stewardship capacity to diagnose and tackle these vulnerabilities. At the same time, they are not unique to the health sector and can best be addressed working across sectors and through the aligned efforts of national and global partners. Health worker monitoring helps to significantly reduce the opportunity to "hide" money or mis-distribute funding allocations. If hospitals register the number of health workers on full-time employment with FOE salary, and differentiate from those on contract or with temporary status, then salary and benefit payments can better align with actual health worker labor rather than with assessed health-worker-per-bed allotment. Further, accurate accounting of existing health workforce, including where they actually work will reduce, if not eliminate, the common practice of remitting payments to 'ghost workers'[8] (workers who have left or moved posts but are still on the payroll). Monitoring health workers, as well as holding accountable the implementing agencies that work with them, can help limit corruption. IntraHealth International, by helping countries track and manage health workforce through its open-source iHRIS software, has helped governments to save over $232 million compared to what they would spend on proprietary software and support and by eliminating redundancies and ghost workers.

- ***Unrest and Security Threats:*** In times of financial uncertainty, political unrest, and pandemic threats, access to health workers and protection of the security of health workers is a must, as part of national and global commitment to peace building. Destabilizing factors include targeted attacks on health

[7] United Nations Development Programme: "Fighting Corruption in the Health Sector: Methods, Tools and Good Practices," 2011
[8] "Sierra Leone: Ebola Fund Mismanaged – Auditor General." Arab Bank for Economic Development in Africa. Panapress. February 2015 http://www.panapress.com/Sierra-Leone--Ebola-Fund-mismanaged---Auditor-General---12-630423791-144-lang2-index.html

workers, strikes of health workers due to ineffective incentives, and loss of health workers due to ineffective retention strategies and civil unrest that responds to unmet needs and demands. The Hyogo Framework for Action (2000-2015),[9] or HFA, will be re-evaluated and reshaped for the future, with its multi-sector body that supports the HFA, called Global Platform for Disaster Risk Reduction.[10] HRH could be more readily integrated into the new framework, and thus be linked to the UNISDR (UN Office for Disaster Risk Reduction) stakeholder platform. Currently, in action priorities 3 and 4 of the Hyogo Framework, there is clear opportunity to mention the fortification and readiness of the health workforce specifically, rather than merely the "health sector and facilities."

Question #2 *What are the characteristics that such a platform should have to make it fit for purpose within the new post-2015 sustainable health and development framework?*

This question was most directly addressed during the roundtable conversations held in Washington, DC, and is reported here as a result of the group work and brainstorm discussions. Characteristics were discussed in three realms. The first was the function, the second was the membership, and the third was the structure and leadership.

It was noted that the response could be a multi-centric approach where functions are taken on by different groups of actors, with a coordinating hub. It was emphasized that whatever the structure, it would need to adapt and fit into the broader health and development architecture as it evolves.

2A FUNCTIONS

- ***Convene***: Using an appreciative inquiry assessment, a key accomplishment of the GHWA that should be an ongoing characteristic of a post-2015 platform is the convening role. That role achieved a global awareness across all sectors around health, and galvanized national and international stakeholders in health to publish, report, debate, and progress in the area of HRH. As Ariel Pablos-Mendez reminded a high-level meeting of stakeholders, in the recent Third Global Forum on HRH in Recife, Brazil, the membership of GHWA advocated strongly for a greater inclusion of a research agenda in the GHWA functions. Moving to this point from the initial Kampala Declaration[11] of 2007, demonstrates the power of what a convening role is able to achieve. One example of a successful convening role that might be emulated and/or leveraged in carrying out this function is the World Medical Association (WMA)[12], which is able to convene and engage 8 million physician members through medical associations from 70 countries and is funded by membership.

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[9] Hyogo Framework for Action 2005-2015: Building the Resilience of Nations and Communities to Disasters. World Conference on Disaster Reduction. United Nations, January 2005. Available online. http://www.unisdr.org/files/1037_hyogoframeworkforactionenglish.pdf

[10] The Global Platform for Disaster Risk Reduction is a biennial forum for information exchange, discussion of latest development and knowledge and partnership building across sectors, with the goal to improve implementation of disaster risk reduction through better communication and coordination amongst stakeholders. It is for government representatives, NGOs, scientists, practitioners, and UN organizations to share experiences and formulate strategic guidance and advice for the implementation of the HFA. Global Platform for Disaster Risk Reduction is a biennial forum for information exchange, discussion of latest development and knowledge and partnership building across sectors, with the goal to improve implementation of disaster risk reduction through better communication and coordination amongst stakeholders. It is for government representatives, NGOs, scientists, practitioners, and UN organizations to share experiences and formulate strategic guidance and advice for the implementation of the HFA.
http://www.unisdr.org/we/coordinate/global-platform

[11] *The Kampala Declaration and Agenda for Global Action*. World Health Organization (acting as the host organization for, and secretariat of, the Global Health Workforce Alliance), 2008. Available online.
http://www.who.int/workforcealliance/Kampala%20Declaration%20and%20Agenda%20web%20file.%20FINAL.pdf

[12] http://www.wma.net/en/10home/index.html

- ***Publish an Annual Report***: An annual report, such as the UNAIDS report[13] or the State of Midwifery report[14] galvanizes the stakeholders around a purpose, and incentivizes participation. Advocacy for global action is articulated and disseminated. Accountability is achieved. The question remains as to what the report will present. The message that continually came through was a value proposition report—where are investments in HRH, both at national and international levels, making an impact. One of the important aspects of the annual report will be linking the report to subsequent action—not unlike the challenge of the HRH Recife commitments.

- ***Advocate***: Advocacy was considered as an outcome of the convening role and the reporting role. There was consensus that advocacy cannot be pursued without technical inputs and data. This expectation means that as part of the structure of the platform, leading members and/or the secretariat must provide functions. One of those functions will be to contribute data for the report.

- ***Provide Accountability***: Data registration on population and the health workforce, inclusive of numerous cadres, in countries and by partners, is uneven and poorly supported, and does not match the need to inform policy and planning, manage access gaps, and measure results. Available HRH-specific data are presented in the WHO annual indicator report as well as in OECD reports. ILO follows coverage gaps due to health professional staff deficit[15]. There are a number of global monitoring and accountability mechanisms that provide information on flows of money (such as the World Bank's National Health Account [NHA] expenditure database[16]), that track donor alignment with national health sector objectives (IHP+)[17], and that track results of targeted health initiatives (such as the UNAIDS reporting and reports of Gavi, the Global Fund, and the Partnership for Maternal, Newborn & Child Health [PMNCH]). The presence of HRH data in these reports is small or non-existent. The planned reporting for GFF will seek to consolidate reporting from countries.[18] To highlight HRH within these various accounting mechanisms and make sure that the HRH agenda is reflected in national and global levels, an investment framework that feeds information on impact/return-on-investment/value of HRH investments for each of these initiatives would present a "value-added" incentive for these individual reports to include HRH. It would also be beneficial for these groups to provide HRH information to a national and global level platform that could synthesize information that would be useful for their own HRH investments to best advance their objectives.

- ***Support an Investment Framework:*** If there is an investment framework, what does that look like? What indicators would measure value? Some of the key value interests that were relayed were:
    - Access: numbers/skill mix; related to UHC; also maybe the package of services that are provided per population (a new and more relevant way to measure access)
    - Quality: could be a number of Institute of Medicine definition-related indicators—also related to UHC
    - Nutrition: increased iron provision at community level (for example) shows performance of community health workers (CHWs)/facilities' workers; relates to the World Bank's International Development Association
    - Workforce Impact Assessment: indicator; leverages existing mechanism
    - Human Rights and Gender Equity: Related to UNFPA, Every Woman Every Child, UNAIDS

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[13] *The Gap Report*. 2014 Annual Report from UNAIDS. http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Gap_report_en.pdf
[14] A Universal Pathway, A Woman's Right to Health. 2014 report on The State of the World's Midwifery. UNFPA 2014. Available online. http://www.unfpa.org/sowmy
[15] International Labor Organization: World Social Protection Report 2014/15 Ch 5: Towards universal coverage in health, ILO 2014
[16] http://apps.who.int/nha/database
[17] http://www.internationalhealthpartnership.net/en/results-evidence/
[18] http://www.worldbank.org/content/dam/Worldbank/document/HDN/Health/GFFExecutiveSummaryFINAL.pdf

- Employment: Related to World Bank, development indicators, SDGs, youth, eradication of poverty
- Employment Conditions: relates to ILO
- Education: relates to SDGs
- Stewardship of public administration: related to SDGs, governance, UNDP
- Resiliency: Related to Ebola, security, health systems, rebuild, governance
- South-to-South cooperation (or cooperation in general): relates to political framework interests of countries and to
- Security: security of health workers (relates to ILO), and relates to global security
- Corruption: elimination of redundancies, mismanagement, false payments
- Private sector contribution: this would just track contributions of global and domestic investment in health worker development—would have to have strict parameters.

Including 10-15 varied indicators would help to bring in partners that have vested interests in these indicators, and demonstrate HRH across the sectors and global bodies.

2B MEMBERSHIP

Currently there are almost 400 members in GHWA. The 2013-2016 strategy calls for an enhanced partnership model, with a progressive shift of responsibility for activities to members and partners, and the facilitating role of the Secretariat. This approach has proven difficult to implement. The challenge therefore is to expand both country and global level collaboration and engagement of the membership in the Alliance.

The model of the Frontline Health Workers Coalition (FHWC)[19] can serve as an example of an active, highly functional alliance of partners. The FHWC is a US-based consortium of state and non-state actors, primarily made up of NGO, civil society, and private sector stakeholders who directly work to develop and support the health and related social services workforce, and/or who work in related sectors that are impacted by the health workforce in some of the dimensions described above. Membership is voluntary and no dues or fees are required. Staff time is donated by the organizations for their staff to participate in meetings and discussions, to contribute to technical reports or research, and to serve in leadership roles within the secretariat. Resources and supplies are furnished through private grants and in-kind contributions from the member organizations.

This coalition (currently with a membership of 40 organizations) was initially formed to advocate for stronger investments of the US government into health and social human resources, and for stronger policies to support and sustain these workers. Given the inter-connectedness and inter-dependence of the national and global health workforce and the inherent development challenges, the FHWC has expanded its advocacy and information/evidence dissemination toward global issues as well as domestic issues. For example, the FHWC was instrumental in convening and advocating the global community in support of the Joint Commitment to Harmonized Partner Action for CHWs and Frontline Health Workers.[20]

Members of this coalition, along with broader stakeholder representation that convened through several different roundtable meetings, agreed that this type of membership coalition at country level might serve a similar function to advocate and convene at national level and to coordinate at global level. It was

[19] http://frontlinehealthworkers.org
[20] http://www.who.int/workforcealliance/knowledge/resources/chw_outcomedocument01052014.pdf

discussed that the members are often varied, representing broad interests that share workforce needs, so that these coalitions might provide support to different or targeted issues, while at the same time being effective in connecting related issues.

The GHWA members will need to provide guidance and support through the transition of the current platform to a different structure and membership mechanism. The FHWC example of a national level construct that links to regional and global representation may present a viable option for this transition. Most certainly a national level membership mechanism will be important to engage broader stakeholder representation, to respond to national needs and translate those needs effectively to the global dialogue, and to establish more direct accountability that the membership is not only nominal but is driven by the need for action.

Membership without responsibility compromises the sustainability and effectiveness of the platform. In an assessment of characteristics of successful coalitions, Jared Raynor of the TCC group lists the "seven deadly sins of coalitions;"[21] one of those sins is "no ongoing role for members." It will be important for the membership to define their roles, and to establish a process for measuring and accounting for contribution and impact. As one interlocutor quite colorfully explained, "you have to have skin in the game if you are going to take action and make a difference." Whatever the membership construct, it should be designed within a framework of accountability. Membership that comes with a pre-requisite for some "skin" might include contribution of direct or indirect resources, technical expertise, or influence. These requisites at global and national level will need to be clearly articulated. Public reporting of members and their contributions to the platform will maintain both external and internal accountability.

2C STRUCTURE AND LEADERSHIP

Widely shared was the opinion that a global secretariat is needed to guide the agenda, give stature to the significance and relevance of the health and wider workforce, and to facilitate the synthesis and exchange of information, promote the coordination of various initiatives and programs integrating HRH into their work streams, and lead global advocacy to keep HRH development and support within the priority objectives of the global programs.

Several individuals suggested that WHO was the obvious body where the platform should be held. However, the majority of actors and discussants expressed that the HRH action needed to go beyond the health sector and that WHO therefore may have limitations in hosting a multi-sector platform. There is a need to position HRH politically at a high level and across sectors in order to drive the needed alignment and support and to affect impact. If WHO is not the body to take "ownership" and political leadership of such a platform, suggestions were consistent that it should be supported by another UN agency or group of agencies that deal with health and other development related workforces.

One of the weaknesses of the current GHWA that was consistently noted was the "top down" disconnect. There seemed to be a lack of effective linking between the Board of GHWA, where decisions are made, and the membership; the structure and communication mechanisms established should represent a bottom up configuration to ensure stronger engagement of country actors and country voices in decisions.

- **Country level bodies,** including existing cross-sector bodies formed to support HRH (under various names—HRH Observatories, HRH Technical Working Groups, CFF) can be strengthened by broader

[21] Jared Raynor; What Makes an Effective Coalition: Evidence-Based Indicators of Success. TCC Group. The California Endowment, March 2011. Available online. http://www.mcf.org/system/article_resources/0000/1297/What_Makes_an_Effective_Coalition.pdf

engagement of country civil society, faith-based organizations, and public service sectors, including education, security, and social services. Country offices of global secretariat member organizations would take greater responsibility for partnering with these country groups supporting their activities.

As described above (2B), the Frontline Health Workers Coalition of the US advocates at national level for domestic action to support HRH as well as for domestic investment and participation in global HRH issues. It also links to global advocacy bodies, such as the HWAI, WHO, and the GHWA secretariat, and contributes to global information dissemination and the global level convening responsibilities.

It provides "value-added" to the country-level organizations because it disseminates information on key national and global workforce issues that inform country-level organization decisions. It also provides a vehicle through which country-level organizations may influence the national or global agenda, and feed important information for advocacy. This two-way information stream creates value for this organization. That information stream can only happen through dedicated staff time. It will be important that the country level organism have sustainable funding, which might be achieved through contribution of membership organizations or country offices of the global secretariat. Or it may be achieved through seconded staff.

- **Regional bodies** need to be better utilized; already the Asia-Pacific Action Alliance on Human Resources for Health and PAHO play significant roles, and so do bodies in Africa, including the Economic Community of West African States (ECOWAS); West African Health Organization (WAHO); Common Market for Eastern and Southern Africa (COMESA); and the East, Central, and Southern African (ECSA) Health Community. The bodies could be linked to representation from the country level cross-sector groups. There were several suggestions that at regional and country levels there might be important engagement from the International Council of Nurses, World Medical Association, and university/college associations.

- **Committees at the global level** were also recommended that might address particular issues or interests that link to country activities and that can be created to mobilize and respond to emergencies or key topics, but this was not explored in depth. These committees might be formed through cross-regional collaboration with the global level.

- **Board/Secretariat:** There was broad consensus, with few exceptions, that a board or secretariat should have permanent members from key organizations across the UN or related bodies that can be most effective and most interested in driving workforce action.

  Key countries that significantly contribute to HRH may rotate their membership and represent regions more broadly than the current GHWA. Finally, it was widely considered that a private sector corporate partner might be represented as part of this leadership body.

- **Volunteer steering group**: The staff needed to drive the global agenda and implementation of its convening and information dissemination functions requires significant funding support and can unlikely be sustained over time. Rather than a staff, the recommendation for a steering group was widely supported, which would include representation from the Board/Secretariat and its rotating membership organizations and representation from some of the regional and country bodies. This steering group was seen as the vehicle to sustain the administration, implementation, and technical support needed at the global level.

- Representatives from the Secretariat or Board, along with other organizations that rotate onto the Board, and platform member organizations at country level, could contribute a percentage of staff time to carry out the global responsibilities of the platform.
- Technical Leadership (annual report, convening meetings with country and regional bodies, etc.). For those agencies and organizations with keen interest in HRH, more senior staff could contribute technical and leadership responsibilities.
- Coordination of global meetings and management of website: One working group recommended that consultants be engaged to manage the website and organize global meetings. Another recommendation was that Board/Secretariat member organizations might contribute junior staff time to manage the website, convene meetings, coordinate webinars, etc. It was suggested that staff time might be donated as part of the platform membership agreement. One model recommended was the current HWAI. The HWAI could be strengthened with broader membership beyond the health workforce and with staff time dedicated by organizations.

FUNDING

Lack of predictable funding was an impediment at the heart of the current global construct of the GHWA, and was seen as key to the success of any future mechanism. Recommendations were not thoroughly defined, but were presented as concepts. They included:

- Membership at Board/Secretariat level might include a commitment to budget line a percentage of grant funds toward organizational participation in an HRH/workforce body
- Participation at global steering group level may be directly linked to M&A responsibilities, and linked to each organization's own value proposition; thus staff and resources dedicated to participation and contribution would benefit represented organizations. It was agreed that staffing the steering group was too expensive; seconding time and administrative resources would allow staff to remain in their own organizations but contribute dedicated time that is coordinated with other steering group members outside of a global office.
- General membership at country level would need to be seen as value added, as noted in the FHWC model.
- Also noted in the FHWC model is the need for a small seconded or funded staff at national level. A WHO country office or other secretariat member country office might host that staff and provide administrative resources. Salary might be supported by membership contribution or by secondment mechanism from several organizations.

Question #3: *How can a global platform foster collaboration across different existing and new, targeted programs, instruments, agencies and partnership, in support of sustainable workforce solutions on the ground?*

Engaging participation across sectors and agencies at global and national levels is the first step in fostering that collaboration. In order to achieve such engagement, the platform must meet concrete needs and add real value, with authority and legitimacy for its functions given by its partners, members, and collaborating institutions.

This is the basis for the focus on a core mandate that will serve independent monitoring and accountability, based on an accountability framework agreed by all stakeholders, and informed by national investment frameworks for HRH and HRH Workforce Accounts.

The cost of inefficiencies and fragmentation in domestic investment and global support will continue to thwart countries' ability to build and strengthen resilient public systems that can support a thriving

workforce, enable citizens to access health and other public goods, and uphold and protect equity and social justice. Demonstrating the value of overcoming these inefficiencies will benefit all stakeholders, individually and collectively.

Global partners that advise countries on and fund elements of HRH action, such as norms and standards, education, pay for performance, various "short cut" solutions and salary "top ups" for priority programs, need to be transparent and buy into an accountability framework that contributes to sustainable HRH solutions and country plans for UHC. By soliciting the thinking and including the interests of key actors who are shaping national and international strategy for the coming decades, this process will make the case for the significance of the health and related workforce in the broader framework and plans.

Collaboration will be fostered by adding the strength of monitoring and accountability to the momentum that has been gained over the last decade—a momentum that began with the JLI report[22], continued with the 2006 WHO annual report[23], advanced through the Kampala Declaration[24], and was reinforced with the resounding statement from the 2013 Global Forum on HRH in Recife, Brazil: "There is no health without a health workforce."[25]

[22] Joint Learning Initiative, Human Resources for Health: Overcoming the Crisis. The President and Fellows of Harvard College, 2004. Available online. http://www.who.int/hrh/documents/JLi_hrh_report.pdf
[23] *Working Together for Health*. World Health Report 2006. WHO. Available online. http://www.who.int/whr/2006/en/
[24] *The Kampala Declaration and Agenda for Global Action*. WHO and GHWA. 2008. Available online. http://www.who.int/workforcealliance/Kampala%20Declaration%20and%20Agenda%20web%20file.%20FINAL.pdf?ua=1
[25] *A Universal Truth: No Health without a Health Workforce*. WHO and GHWA. Third Global Forum on Human Resources for Health Report. 2013. Recife, Brazil.

END NOTE

Global stakeholders from Geneva to Delhi and from Sao Paolo to New York recognize the critical role of the health worker in achieving development goals, achieving equitable access to health, and improving the health and well-being of all populations. According to the International Labor Organization Social Protection Report 2014/2015, more than 80 percent of the population across low-income countries lacks access to health care due to the absence of health workers needed to provide such services.

Widening access to trained community and frontline health workers in rural and remote areas has enabled immediate gains in achieving MDGs 4, 5, and 6, as well as other health indicators. Institutional collaboration, South-to-South collaboration, and investment in transformative education have demonstrated the value of investing in the health workforce.

Even with this understanding, the collection of data that maps the production, distribution, management, and migration of health workers is still inconsistent and insufficient. In addition, evaluating and reporting on the impact of HRH development investments remains elusive. The consequences of weak public health institutions, major HRH capacity gaps in providing access to services, fragmented support, and inefficiencies was painted devastatingly clear most recently in Guinea, Liberia, and Sierra Leone and have underlined how health workers are essential for resilient health systems. The response needs to be built from country-level up; there are multiple partners and organizations that are engaged and it is possible to do a lot better by overcoming fragmentation and inefficiencies.

Despite the broad consensus of HRH importance, and the gains that have been made through the advocacy and convening role of the GHWA, the articulation of HRH strategies with the complimentary allocation of funding still struggles to find its appropriate representation in health and related development programs and strategies. There is a need for more rather than less focus on HRH; this is not the time to phase out, even if there is a need to find a better fit for purpose global mechanism to drive alignment and collaboration.

Advocacy and strategic engagement at national, regional, and global levels is now needed from global health leaders, civil society partners, and all stakeholders to maintain the achievements and increase the momentum in workforce strengthening so that actions on health and social service workforce will be adequately integrated into women, children and adolescent health, universal health coverage, and resilient health systems, as the global sustainable development agenda is being taken forward in 2015.

As the GHWA hosting agreement comes to an end and the work of the Alliance moves into a phase of transition, stakeholders need to define and establish an adapted mechanism that is both articulated at country and global levels and that drives alignment, investment, collaboration, and accountability on actions around workforce development and support. Ensuring a trained, distributed, and supported health workforce at the core of UHC and resilient health systems is a responsibility that must be assumed and shared by all actors that are committed to equitable access to quality health care and social services across all countries.

"One of the challenges for achieving universal health coverage is ensuring that everyone—especially people in vulnerable communities and remote areas—has access to well-trained, culturally-sensitive and competent health staff."

Dr. Carissa Etienne
Executive Director, PAHO/WHO
Recife, Brazil, November 11, 2013

Appendix: Meetings with Stakeholders in New York and Washington DC

Group / Organization	Representation
Frontline Health Workers Coalition	US based organizations advocating for greater and more strategic investment in frontline health workers; 40 member organizations Meeting with full membership
Health Workforce Advocacy Initiative	Global Civil Society network advocating for health workers and health workforce development; 30+ member organizations Meeting with full membership
PAHO / WHO	Americas Regional Branch of WHO • Director, Carissa Etienne • Out-going Director of External Affairs, Partnerships, Resource Mobilization, Ok Pannenborg • In-coming Director of External Affairs, Partnerships, Resource Mobilization, Alberto Kleinman
World Bank	• Lead Health Specialist, Health, Nutrition and Population Network, Akiko Maeda,
Global Social Service Workforce Alliance	Alliance of workers – paid & unpaid workers of the social service system; (member organizations not listed) • Coordinator, Amy Bess • Communications Director, Nicole Brown
Multi-Stakeholder Leadership	Full-day meeting with high level meeting with policy makers, researchers, educators, and technical experts *(Representatives from academia, NGO, INGO, international development agencies, World Bank, Implementing Agencies, US Government)*
UNICEF	• Director, Public Partnerships Division, Olav Kjorven • M&E Lead, (Representing Mickey Chopra), Teresa Diaz
UNAIDS	• Director, New York Liaison Office, Simon Bland
UNFPA	• Chief, Sexual and Reproductive Health, Laura Laski • Chief, Gender, Human Rights and Culture, Luis Mora • Advisor, Gender Equality, Rights, and Sustainable Development, Eva Johansson
Council for Foreign Relations	• Senior Fellow for Global Health, Laurie Garrett
Every Woman Every Child UN Initiative	• Senior Manager, Every Women Every Child Health Team, Taona (Nana) Kuo
UNDP	• Programme Manager, UNDP's Global Anti-corruption Initiative (GAIN), Anga R Timilsina

Case Study

The Pan American Health Organization (PAHO), the Americas branch of the WHO, offers an example of a successful effort to galvanize support at state, sub-region, and regional levels for the development and monitoring of human resources for health. Framing HRH development around five key dimensions, PAHO provided leadership and technical guidance to country governments and stakeholders in tracking 20 goals to demonstrate progress toward improved HRH policies and strategic planning, alignment of education with health sector objectives, equitable distribution of providers, improved labor relations, management of migration, and supportive working conditions for the health workforce. PAHO successfully engaged member states to contribute political will, financial and technical resources, and action toward monitoring 20 goals over a decade of human resources for health. [26] [27]

Countries such as Canada and Brazil contributed resources to advance the monitoring of the goals across all countries of the region, and with leadership and technical support from PAHO and partners, data were collected, evaluated, and reported from the countries, aggregated into sub-regional reports (Caribbean, Andean, Central American, and South American sub-regions), and then disseminated as an accountability mechanism at the regional level.[28]

This effort, which began as a Call to Action at a 2005 meeting of state members, progressed to a Regional Resolution in 2007, and has continued to track and report countries' commitment to and investment in health, represents a successful platform for monitoring and accountability for countries of the Americas. The lessons learned and best practices developed through the guidance of Dr. Charles Godue, then Regional Coordinator, and the country teams of the Human Resources Development Unit of PAHO/WHO may inform a roadmap to achieving similar success at the global level.

[26] Regional Goals For Human Resources for Health 2007-2015. Resolution CSP27.R7. PAHO, October 5, 2007. Available online. http://iris.paho.org/xmlui/bitstream/handle/123456789/3733/csp27.r7-e.pdf?sequence=1

[27] Handbook for Measurement and Monitoring Indicators of the Regional Goals for Human Resources for Health. A Shared Commitment. Pan American Health Organization, Pan American Sanitary Bureau, Regional Office of the World Health Organization. May 2011

[28] http://www.observatoriorh.org/?q=node/368