Positive Practice Environment Campaigns

Evaluation Report

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August 2012
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## Glossary

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<th>Definition</th>
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<tr>
<td>AMSITS</td>
<td>Association Marocaine des Science Infirmières et Techniques Sanitaires</td>
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<tr>
<td>FDI</td>
<td>World Dental Federation (Fédération Dentaire Internationale)</td>
</tr>
<tr>
<td>FIP</td>
<td>International Pharmaceutical Federation (Fédération Internationale Pharmaceutique)</td>
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<tr>
<td>ICM</td>
<td>International Confederation of Midwives</td>
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<td>ICN</td>
<td>International Council of Nurses</td>
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<td>IFPMA</td>
<td>International Federation of Pharmaceutical Manufacturers and Associations</td>
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<td>IHF</td>
<td>International Hospital Federation</td>
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<tr>
<td>ILO</td>
<td>International Labour Organization</td>
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<td>GHWA</td>
<td>Global Health Workforce Alliance</td>
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<td>HRH</td>
<td>Human Resources for Health</td>
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<tr>
<td>M &amp; E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<td>NCD</td>
<td>Non-Communicable Disease</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<td>PPE</td>
<td>Positive Practice Environment</td>
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<td>Q &amp; A</td>
<td>Question and Answer</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>WCPT</td>
<td>World Confederation for Physical Therapy</td>
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<td>WHPA</td>
<td>World Health Professionals Alliance</td>
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<td>WMA</td>
<td>World Medical Association</td>
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Executive Summary

Analytical Framework

The Positive Practice Environments (PPE) Campaign is a global campaign aiming to improve work environments for health professionals and thereby strengthening staff retention and recruitment as well as quality of care. Positive practice environments are defined as settings that support the provision of quality patient care by ensuring health, safety and personal wellbeing of staff. While the Campaign has a global outlook it has focused on supporting activities in three pilot countries: Morocco, Uganda and Zambia.

The Global Health Workforce Alliance (GHWA) has provided 643,146 CHF to the Campaign since 2007. That funding was discontinued at the end of 2010 but there was a small carry-over of funds with the permission of GHWA to wrap up the work. At that point in in early 2011, the funder, together with core partners, decided to assess strengths and weaknesses of the Campaign both at the global and the country levels, analyse achievements and derive lessons learned. The present evaluation report was produced in January 2012 to assist GHWA and other potential funders in making decisions about supporting the Campaign and to help partner organisations take stock and develop a way forward.

Besides a review of background materials and tools and an analysis of web statistics, the methodology applied includes an online survey as well as individual and group interviews. Close to 40 key stakeholders, approximately half of whom work on global level and half in-country, were consulted as key informants. 33 of those completed an online survey and 21 were interviewed individually or in focus group discussions.

The evaluation report presents an overview of the Campaign’s activities and assesses key strengths, weaknesses, opportunities and threats as well as achievements and issues related to resource mobilisation on a context-by-context basis. It also discusses key stakeholders and value for money before presenting conclusions and recommendations.

Strengths of the PPE Campaign include its multidisciplinary nature, high levels of commitment by Campaign partners and the relevance of the topic. Weaknesses relate to the sustainability and predictability of funding, the absence of a framework for monitoring and evaluation of the overall campaign and time constraints by key partners, particularly on country level. The global focus on health systems strengthening and human resources for health (HRH) as well as potential alignment with other, related campaigns are seen as opportunities. The global financial crisis is identified as a major threat, in addition to lost momentum for HRH.

Key achievements identified include awareness in all contexts (global, Morocco, Uganda and Zambia) as well as successful collaboration by different categories of health workers towards the achievement of one common goal, particularly in Uganda and Zambia. In these two countries, the Campaign has also led to encouraging changes in policy and practice.

Besides these outcomes, a number of outputs were created, such as Campaign tools and materials, including a website. The tools and materials generated appear widely used and appreciated. Nevertheless, a number of improvements are suggested, particularly in regard to making better use of the website as a cost-effective core tool for campaigning.
Overall key recommendations include the following:

- **Alignment.** Take stock of other, potentially similarly focused campaigns and initiatives, both on global level and in-country, and seek partnership or alignment to the extent possible and necessary.
- **Campaign design.** Keep the overall structure of the Campaign and work towards more systematic sharing of best practice between countries as well as between countries and the global level.
- **Project management and reporting.** Provide adequate staff support to ensure thorough project and financial management to facilitate focusing on results and sharing of information. Ensure reporting requirements are clear.
- **Stakeholders.** Engage additional stakeholders both as partners and as supporters of the Campaign.
- **Human resources.** Select and adequately remunerate key individuals who are able to drive the Campaign forward on global and country level.
- **Website and other tools.** Harness the actual and potential impact of the website by investing in it more to improve user-friendliness and ensure it becomes a campaign tool rather than staying a vehicle for information sharing only. Ensure all tools and materials are succinct and visually appealing.
- **Funding.** Continue to fund the Campaign from central level while maximising opportunities for additional resource mobilisation for an expanded scope, including on country level. Ensure funding is sustainable and predictable with clear reporting requirements.
- **Monitoring and evaluation.** Develop an M&E framework, including goals, outputs and outcomes of the Campaign as well as indicators for measuring their achievement.
- **Communication and information sharing.** Prioritise regular communication and information sharing, not least through making the evaluation report widely available.
Introduction

Background and Purpose

In November 2011, the Global Health Workforce Alliance (GHWA – the Alliance) commissioned an evaluation of the Positive Practice Environments (PPE) Campaign with particular focus on activities and achievements in 2010 and 2011. The terms of reference for the evaluation are in the Annex 4. GWHA had financially supported the Campaign since 2007 but had to discontinue funding in 2010 with a small carry-over of funds to finalize the committed work.

Despite an evaluation not originally foreseen for this point of time, the core partners of the campaign agreed with the Alliance to review the campaign’s progress to date and thus inform the planning of new and continuation of existing campaigns, such as the PPE Campaign. Therefore, the aim of this analysis is to assist GWHA and other partners in:

- Reviewing the progress made to date
- Assessing strengths, weaknesses, opportunities and threats
- Documenting lessons learnt
- Deciding on a way forward, particularly in light of current resource constraints

It should be noted that a comprehensive internal progress report was published in late 2010, i.e. only a year prior to this evaluation. This report aims to offer complementarity and additional analysis and avoid duplication. Besides presenting an external view, this report provides insights and a synthesis of views shared by about 40 key stakeholders.

Structure of the Report

After providing a short introduction and outlining the methodology used in this evaluation, the findings are presented. These focus on the following elements:

- Activities and Status Quo
- Achievements
- Strengths, Weaknesses, Opportunities and Threats
- Campaign Tools and Materials
- Funding and Value for Money
- Stakeholders
- Lessons learned

After the presentation of findings, the Consultant’s conclusions and recommendations are presented. An Annex provides tools used in the evaluation and a list of key informants.
Methodology

Analytical Framework

No monitoring and evaluation (M&E) framework is available to guide implementation of the PPE Campaign. Comprehensive project planning templates were provided for the three country workshops in December 2010 and project proposals were developed during the workshops using a participatory process. However, these were to provide framework for the country based proposals but funding to support the work going forward was discontinued at that stage. In other words, there is no logical framework or similar project document that provides objectives, indicators or expected outputs for the whole campaign and may thus guide the evaluation. Therefore an analytical framework was designed from scratch for the purposes of this evaluation. It can be summarised as follows:

- Assessment of the campaign’s status quo, both globally and at country level, at the end of 2011
- Overview of key stakeholders driving the campaign forward as well as their potential concerns and strategic interests
- Assessment of campaign tools and materials
- Analysis of campaign activities on global level
- Analysis of campaign activities on country level
- Overview of resources used and potentially available
- Other enabling and disenabling factors affecting the campaign

This framework was revised slightly over the course of the evaluation to reflect emerging insights and necessary areas of focus.

Desk Research

A review of key background materials was conducted to inform the design of the analytical framework and the development of questionnaires, to assist the interpretation of empirical data gathered and to form the consultant’s opinion on quality and usability of campaign tools and materials. The documents and materials reviewed include the following:

- PPE Campaign Internal Progress Report 2010
- PPE Campaign website
- PPE Campaign tools (Fact sheets, Advocacy guide, Guidelines on incentive systems, Call to Action, Campaign overview, poster, sample press release, etc.)
- Country case studies
- PPE Campaign newsletters
- Letters and other evidence of communication related to the PPE Campaign
- Several project funding proposals developed by Campaign partners on global and country level
- National-level workshop documents
- National-level action plans

1 The Fact Sheet on Positive Practice Environments, one of the tools presented in the Findings section, does in fact contain a short paragraph stating results and outcomes the Campaign aims to achieve. However, it is not sufficiently specific or linked to the overall objectives of the campaign as outlined in the Annex.
The consultant also collected and analysed data regarding access and use of the PPE Campaign website (http://www.ppecampaign.org). This exercise was conducted using Google Analytics, a password-secured web-based programme to monitor, analyse and evaluate use of websites.

Empirical Research

Based on the analytical framework, several evaluation tools and procedures were designed. They include an online survey as well as topic guides for telephone and face-to-face interviews and focus group discussions with key stakeholders.

Online survey

As the main tool for evaluation, an online survey was conducted using the web tool SurveyMonkey. The online questionnaire was sent to 71 individuals identified as key stakeholders by the International Council of Nurses (ICN). In addition, the English version of the online questionnaire was translated to French and sent to five members of the campaign’s national steering committee in Morocco. Therefore, a total of 76 individuals received the online questionnaire. Of these, 41 responded, indicating a response rate of 54 percent.

A two-week deadline was set for response to the online survey. A reminder was sent just before this period had passed with an additional week granted for completion of the survey. It should be noted that some of those who did not respond indicated that another representative of their organisation would be better suited for responding to the survey or that they felt one response per organisation was sufficient. In other words, the response rate can be considered high.

76 percent of respondents completed the survey, i.e. they accessed every page of the questionnaire. Of those that did not, some are based in locations with unreliable internet connection, which may have prevented them from completing the entire survey. Except for eight responses which only contained information about the respondent but no answers to the actual survey questions, these were therefore factored into the analysis nevertheless. In sum, 33 questionnaires were used as basis for quantitative and qualitative analysis. A list of respondents, also called key informants in this report, is provided in the Annex.

As for the professional background of those 33 individuals, almost a third are nurses, about a quarter are doctors and 12 percent are health or hospital managers. About six percent are pharmacists, physiotherapists and advocates respectively and a few are dentists, biochemists, public health programme managers or other health professionals. They represent a variety of professional associations at global and national level as well as universities, research institutes, WHO, NGOs and ministries of health.

As can be seen in the chart below, the majority of respondents to the online survey (42 percent) are based in Europe, followed by Uganda (27 percent) and Zambia (15 percent). One respondent (three percent) is located in each Morocco, Mauritius, Taiwan, Thailand and the United States.

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3 http://www.surveymonkey.net
4 All messages were accompanied by an explanatory text about the evaluation and provided an option for feedback and discussion of potential concerns as well as a link for opting out of the survey.
5 The ICN, who has housed the campaign’s secretariat, has maintained contact details of key stakeholders.
6 For Morocco, only five key stakeholder email addresses were available.
7 An additional five individuals were contacted by email but the message bounced back, indicating that the account was no longer functional. In some cases more than one email address was used to contact one individual.
8 It should be noted that to facilitate readability and understanding, in the text all percentages are rounded to whole numbers. In the charts one decimal place is provided.
respectively. In other words, overall approximately half of respondents to the online survey are based in developed countries and half in developing countries.

In terms of gender, respondents are fairly equally distributed, with 55 percent of respondents being female and 45 percent being male. This is depicted in the chart below.

Questions were designed to fit with the respective theme and ranged from open to closed questions, rankings, ratings and multiple-choice questions. Only selected questions were mandatory and thus required an answer before the respondent was able to move to the next survey page. Each closed question provided an "I cannot say" option in order not to force respondents to provide an answer where they could or did not want to. Before being sent out, the

Positive Practice Environments Campaign
online survey was tested by two key stakeholders and adapted in accordance with their suggestions. The English and French versions of the questionnaire are provided in the Annex.

Key stakeholder interviews

In total 19 individual interviews were held with key stakeholders. Of these, six were held face-to-face and one over the phone with individuals in Uganda, eleven on the phone or over skype with individuals on global level and two on the phone with individuals in Zambia\(^9\). In addition, a face-to-face focus group discussion was held in Uganda, involving four participants two of whom had also been interviewed individually\(^10\).

Interviews took between 20 minutes and one hour. They were semi-structured with a topic guide being used. In cases where the interviewee had responded to the online survey prior to the interview, which was the majority, their answers were analysed beforehand to facilitate in-depth questioning, obtain clarification where necessary and maximise discussion outcomes. In the smaller number of cases where the interviewee had not responded to the survey beforehand, they were encouraged to do so following the conversation.

Constraints and Delimitations

In order to be able to focus on the Campaign in question, this evaluation has largely left out more far-reaching structural issues that affect effective, efficient and equitable provision of quality healthcare, including accountability. Furthermore, other global or national campaigns that may have similar goals and structures as PPE were not assessed as part of this evaluation.

The main constraint relates to the unavailability of an M&E framework which may have guided the evaluation. Even though the annual contract with GHWA succeeded in fulfilling its obligations for the annual workplan, it did not include a full monitoring and evaluation framework for the full campaign, though provided some strategic guidance. Moreover, stakeholders in Morocco were very difficult to reach. A French version of the questionnaire was designed and submitted and a reminder was sent. In addition, several emails were sent requesting phone interviews and additional feedback. However, only one comprehensive response could be gathered to the online survey from stakeholders in Morocco\(^11\).

No visits were made to Zambia and Morocco. In the case of Zambia this was decided following the insight that comprehensive data was successfully collected electronically and telephonically. In the case of Morocco, an insufficient number of stakeholders could be reached to set up a visit and it was thus decided that a visit could not be justified from a value for money point of view. Some pre-agreed interviews had to be cancelled due to non-availability of the interviewee.

While being managed by GHWA, the consultant had to partly rely on support and guidance provided by ICN, who hosted the Secretariat for and thus has been one of the key stakeholders of the campaign. The consultant made every effort to separate more ‘technical’ aspects of the campaign under evaluation from questions relating to funding of the campaign but in some instances had to link them regardless.

\(^{9}\) Despite substantial efforts to contact stakeholders in Morocco no interview could be arranged.

\(^{10}\) In addition, a number of other individuals working in the health sector in Uganda were also interviewed for a separate assignment (development of the advocacy component of a health programme funded by the UK Department for International Development). Most of them were asked whether they knew of the PPE Campaign but none of them indicated that they did. Some expressed an interest in learning more.

\(^{11}\) Two additional stakeholders accessed the online survey but only completed the first few questions relating to their background and did not answer any questions regarding the Campaign itself.
Activities and Status Quo

Status Quo

The Positive Practice Environments (PPE) Campaign aims to improve work environments for health personnel and thereby strengthen staff retention and recruitment as well as quality of care. Positive practice environments are defined as “settings that support the provision of quality patient care by ensuring health, safety and personal well being of staff”.

By promoting safe and cost-effective work environments worldwide, the campaign also aims to strengthen health systems and improve patient safety. At the same time, the Campaign addresses related factors, such as the shortage of health professionals and underinvestment in the health sector.

On the global level, the Campaign is led by six core partner organisations which are represented in the Global Steering Committee:

- International Council of Nurses (ICN)
- International Hospital Federation (IHF)
- International Pharmaceutical Federation (FIP)
- World Confederation for Physical Therapy (WCPT)
- World Dental Federation (FDI)
- World Medical Association (WMA)

Five of these partners (all except IHF) are also members of the World Health Professions Alliance (WHPA). Therefore, the PPE Campaign “may be seen as a WHPA+ campaign”.

The Campaign goes back to a campaign originally conceived by ICN and taken on board by the other core partners in 2007 as well as discussions at the First Global Forum on Human Resources for Health held in Uganda in 2008. The Campaign’s Secretariat was housed by ICN. Besides core partners, there is a group of international collaborating partners consisting of international governmental and non-governmental organisations such as CapacityPlus, Cordaid, Global Healthcare Information Network, Health Care Without Harm, International Commission on Occupational Health, Public Services International, World Federation of Occupational Therapists and World Health Organization.

Three countries were selected as first-round target countries, based on considerations regarding the shortage of health personnel and the presence of professional associations affiliated with the core partners. These countries are:

- Morocco
- Uganda
- Zambia

Findings

In this section of the report (Findings), quotes are provided to give a voice to key informants themselves. Direct quotes are marked in grey, bold italics.


Ibid.
The global management structure is also reflected on country level, where a National Steering Committee was led by a National Resource Person and supported by a group of collaborating partners.

Between 2007 and early 2011, the PPE Campaign was financially supported by the Global Health Workforce Alliance, which was launched in 2006 with the objective of serving as a common platform and a catalyst for an effective response to the health workforce crisis at global, regional and country level. Its mission is to "advocate and catalyse global and country actions to resolve the human resources for health crisis, to support the achievement of the health-related millennium development goals and health for all." Campaign partners have made significant contributions in terms of human as well as other resources (e.g. office space) and many continue to do so when conducting advocacy on PPE, presenting PPE to their constituencies or indeed while participating in this evaluation as key informants.

Activities in 2009 and 2010

The bulk of PPE Campaign activities took place in 2009 and 2010 when the Campaign was designed, planned and groundwork done to facilitate campaigning on country level. In-country activities took place in 2010 after which the funding was discontinued. The Campaign’s main thrust in all three countries has been the combination of a baseline assessment resulting in a ‘case study’ report, with national-level workshops to discuss HRH (Human Resources for Health) issues and devise strategies on improving work environments for health workers, thus defining the national PPE campaign.

Key activities in 2009 and 2010 included:

- Selection and recruitment of staff
- Establishment and appointment of global and national steering committees
- Development and dissemination of a variety of tools, including a website
- Selection and appointment of national resource persons in Morocco, Uganda and Zambia
- Development of case study reports in the three campaign countries
- Organisation of two sets workshops in each of Morocco, Uganda and Zambia and development of workshop tools during 2010

In Zambia, the following activities were conducted in 2010 meetings of the national steering committee; awareness raising at University Teaching Hospital and at the annual physiotherapy congress; proposal writing; sensitisation workshops at Kitwe Central Hospital; and advocacy with the Ministry of Health to introduce PPE in the national MNCH policy. Moreover, key Campaign partners “continue to speak about PPE” when holding meetings with the Ministry of Health and others.

In Uganda, members of the Campaign team continued to share information about the Campaign; advocated with the Government and negotiated with the Social Services Committee of Parliament regarding pay levels; they also prepared funding proposals; visited pilot facilities; and participated in one meeting of the steering committee. In addition, an award ceremony was held for the best PPE performer at one campaign facility.

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15 See GHWA website http://www.who.int/workforcealliance/en/
16 More information on continuing activities is below.
17 See section on tools for a complete list.
18 Note that the activities listed for Zambia and Uganda were mentioned by informants as having taken place in 2011. However, it has been confirmed by ICN that most of these activities in fact took place in 2010, the ‘peak’ year of the Campaign, and that respondents were unable to remember exactly when a certain activity had taken place, particularly since some activities would have been ongoing for some time.
In Morocco, the PPE case study was finalised in 2010 and PPE action plans for four regions elaborated. Moreover, sensitisation activities continued.

Details on activities up to end 2010 can be found in the PPE Campaign Internal Progress Report 2010.

Activities in 2011

In 2011, the available level of funding decreased substantially to around 50,000 USD. Core partners felt that this amount was insufficient to continue the Campaign and, as a result the Campaign was officially suspended around mid-year. This also coincided with the depletion of funds carried over from the previous year to support the Campaign coordinator housed by ICN. A number of activities nevertheless continued. One event mentioned by several respondents as a key PPE Campaign activity conducted in 2011 is the Second Global Forum on Human Resources for Health\textsuperscript{19}, which also included a session on PPE. This was an all day workshop with 11 international speakers, including country campaign national resource persons, WHO (HRH and occupational health and safety), CGFNS (The Commission on Graduates of Foreign Nursing Schools), Health Information For All 2015, IntraHealth, etc. It was attended by representatives from various Ministries of Health and many other key stakeholders.

Some global level core partners also participated in meetings of the Steering Committee, which focused on defining political priorities for the Campaign and on “planning for PPE after GHWA”. While a number of global stakeholders did not engage in any activities relating to the Campaign in 2011, a few mentioned that activities related to PPE were ongoing within their respective associations and across wider audiences.

For example, high-level representatives of ICN chaired sessions, gave keynote speeches and presented on PPE in a number of national and international meetings and fora. These include the Asia Workforce Forum; Latin America Workforce Forum; Pan-Pacific Nursing Conference; European Association of Senior Hospital Physicians meeting on Skill Mix in Hospitals; ICN’s International Congress; and others. On all of these occasions, PPE tools and materials were distributed. Future engagements, including the ICN’s next Quadrennial Congress to be held in 2013, will also feature elements of PPE.

The same is true for other partner organisations who “talk about PPE whenever they go to conferences” and other relevant meetings and continue to disseminate tools and materials. It is in fact “difficult to isolate the Campaign” from the organisations’ other work as HRH issues, which include positive practice environments, are their main focus.

In addition, campaign partners developed a number of publications featuring elements of PPE. For example, recent ICN publications include a French journal, Elsevier Masson SAS article titled Positive Practice Environments: supporting Quality Workplaces for Quality Care and a report commissioned by the ICN International Centre for Human Resources in Nursing entitled Reforming Primary Health Care: A Nursing Perspective and a report commissioned the International Centre for Nurse Migration entitled Positive Practice Environments: Key Considerations for the Development of a Framework to Support the Integration of International Nurses.

Originally, there were plans for other countries besides Zambia, Uganda and Uganda to join the Campaign in 2011. However, due to the discontinuation of funding this plan for expansion could not be realised. The discontinuation of funding also affected global partners as well as the existing in-country campaigns which, as a result, were largely unable to implement their anticipated activities as planned. At the time of this evaluation (November 2011 – January 2012) it appears

\textsuperscript{19} Held in January in Bangkok

Positive Practice Environments Campaign
that while some activities are ongoing, the bulk of activity has stalled or at least slowed significantly, mostly due to uncertainty about the continuation of GHWA funding as well as the current unavailability of other funding.

**Achievements**

The Campaign has not had much time to demonstrate results, particularly at country level due to the short duration the campaign, namely 8-10 months with the funding, in participating countries, though they were able to continue some level of activities in some settings. Nevertheless, there have been a number of achievements, both in terms of outputs as well as outcomes. It is noteworthy that country-level stakeholders, in particular, are able to cite positive changes in policy and practice. In contrast, only few key informants on global level were able to name any concrete outcomes of the Campaign. Whether this is due to the Campaign’s focus on country-level, a potential lack of focus or results on global level or simply a failure to communicate concrete global-level achievements is uncertain. An overview of achievements mentioned by key informants and synthesised and structured by the consultant is presented in the table below.

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<th>Stakeholders</th>
<th>Outputs</th>
<th>Outcomes(^{20})</th>
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| **Global level**  | • **Website**. Creation and maintenance of a functional website that provided updates, tools and other materials on PPE\(^{21}\) | • **Awareness**. Creation of awareness about PPE at local, national and international level and putting positive practice environments on the international agenda.  
• **Collaboration**. Collaboration between different categories of health professionals in contexts where this had been unheard of or difficult in the past  
• **Definition**. The Campaign has led to definition of PPE principles as well as tangible activities that can be considered retention strategies. The Campaign has “put the needs of health workers at the centre of all our efforts”  
• **Mainstreaming**. The Campaign and thus advocacy around PPE “having become regular part of some of the core partners' activities” can be considered a key achievement. |
| **Zambia\(^{22}\)** | • **Proposals**. Funding proposals developed as part of a workshop.  
• **Research**. Documentation of PPE issues in the Zambia case study report  
• **Steering Committee**. Formation of the National Steering Committee | • **Advocacy skills**. Development of advocacy skills in a workshop  
• **Awareness**. Creation of awareness among key stakeholders, particularly the Ministry of Health, about the Campaign and its goals  
• **Engagement**. Inclusion of PPE in the advocacy agenda of the Churches Health Association of Zambia, an organisation highly influential in health advocacy  
• **Policy change**. Introduction of PPE issues in the National Policy on Maternal, Newborn and |

\(^{20}\) With the data available it is not possible to further quantify outcomes of the Campaign.  
\(^{21}\) More specific data on website use is provided below.  
\(^{22}\) Core partners in Zambia had planned to conduct an evaluation of the Campaign in Zambia. With stalled funding, this has now been put on hold.
<table>
<thead>
<tr>
<th>Positive Practice Environments Campaign</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child Health</strong></td>
</tr>
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</table>

**Uganda**

- **Action plans.** Action plans were developed.
- **Research.** Generation and documentation of research findings on PPE in the case study report.
- **Awareness.** Increased awareness among key stakeholders, for example through presentations on PPE in various fora.
- **Collaboration and communication.** The Campaign has resulted in collaboration of different groups of health professionals and improved communication between them.
- **Commitment.** Creation of hospital award to encourage additional units and individuals within Mulago hospital to participate in the Campaign. This award was well received by its recipients.
- **Dissemination.** Dissemination of materials, including to president Museveni and his wife.
- **Media.** Media coverage, particularly at the time the first workshop was launched. Articles on PPE were also included in the UNMU (Uganda Nurses and Midwives Union) newsletter.
- **Relationships.** Improved relationship between supervisors and supervisees in health facilities, with a positive impact on the delivery of care and thus better relations between health workers and their clients.
- **Sensitisation.** Sensitisation of health managers and staff through sustained implementation of activities in the pilot health facilities. For example, in one of facility, 20 midwives were deployed following sensitisation of top management and awareness was created among staff.

**Morocco**

- **Awareness and sensitisation.** Awareness was created about PPE being a priority for health professionals and key stakeholders were sensitised in this regard.

Key informants were also asked to rate the Campaign’s success in a number of areas that typically represent campaign goals. As can be seen in the chart below, the PPE Campaign is rated fairly highly in terms of creating awareness about issues relating to PPE (close to 80 percent rate the Campaign as ‘excellent’ or ‘good’ in this regard), thus corroborating the evidence presented above. It is also rated highly in terms of developing high-quality advocacy materials and in regard to information sharing and dissemination of materials (over 60 percent give an ‘excellent’ or ‘good’ rating). In terms of influencing policy, creating pressure on governments and increasing financial resources for PPE, on the other hand, the Campaign is rated fairly poorly which may have been due to the short duration of the campaign at country level (with only ten to 25 percent of ‘excellent’ or ‘good’ ratings in total).
The chart above shows overall ratings for the PPE Campaign by all participants combined. The chart below disaggregates ratings by where respondents are located, i.e. on global or country (Morocco, Uganda and Zambia) level. It can be seen that global level stakeholders (depicted in the chart below on the left) rate the Campaign’s success somewhat more highly than informants on country level (depicted in the right chart). Moreover, global-level respondents are less likely to provide a specific rating than their country-level counterparts. Therefore, the green bars (representing the ‘I cannot say’ option) are more pronounced in the left chart than in the right. This may indicate that country-level respondents are in a better place to judge campaign outcomes than global-level stakeholders. Country-level stakeholders are also more likely than global-level respondents to rate success in a certain area as fair or poor rather than good or excellent, which is why the violet and bright red bars are more pronounced in the chart on the right. Whether this is because achievements on country level were actually poorer than those on global level or whether country-level respondents simply have a clearer view than global-level stakeholders of Campaign successes overall cannot be said with certainty.23

23 It is important to note that this analysis does not distinguish between successes at global vis-à-vis country level. Instead, it shows how different stakeholder groups (global and country-level) evaluate the success of the Campaign.
The fact that attribution is difficult when it comes to advocacy and policy change in particular does not lessen the positive impact the PPE Campaign has made in some areas, such as raising awareness.

**Strengths, Weaknesses, Opportunities and Threats**

**Key Strengths**

Strengths are positive characteristics of the Campaign. Feedback from key informants clearly demonstrates the necessity and value of the PPE Campaign.

Global-level respondents point to the following strengths:

- **Collaboration.** The Campaign brings together different categories of health professionals and encourages them to focus and collaborate on a common goal. Such collaboration can be seen as a means to an end as well as an end in itself. Importantly, while in some contexts different categories of health professionals are already used to jointly addressing common issues, in other contexts they are not, thus reinforcing the significance of the Campaign.
- **Commitment.** Most member organisations on global and country level, as well as the individuals working for these organisations, have been very committed to the Campaign.
- **Design.** The Campaign is innovative and has a solid design, complementing advocacy on global level with campaigning on country level. Links with and support by the global level increase motivation on country level. The national campaigns are country-led rather than defined and imposed by actors on the global level. In addition, the model is easy to replicate and can yield high gains at a relatively low cost.
- **Funding.** The fact that some key positions (National Resource Persons, Project Officer, Project Coordinator) in the campaign were funded is considered a key strength, thus allowing for coordination, focus and leadership.
- **Languages.** The website and most tools are available in three languages (English, French and Spanish)
- **Relevance.** The subject matter is relevant and one that needs to be addressed with urgency, particularly since “everybody else tends to focus on numbers of health workers” rather than focusing on working conditions. The combination of addressing working conditions and occupational health at the same time is also appreciated. Moreover, the Campaign is seen as being applicable from both the employers’ as well as the employees’ perspectives.

In addition, Zambian respondents stress the following:

- **Communication.** The Campaign facilitates communication between managers and staff at health facilities.
- **Health workers.** The Campaign reminds health workers that they are part of the solution and that some solutions do not necessarily require funds “but change of attitude among health care providers”.
- **Media.** The Campaign also worked with media.
- **Messages.** Campaign messages are seen as “correct and well focused to target groups in terms of advocacy”.
- **Public-private mix.** Plans included working in both public and private health facilities and comparing outcomes. “The message would have been there is no need to have two different standards.”

Key stakeholders in Uganda mentioned the following strengths:

- **Global collaboration.** Collaboration between local, national and global level
- **Materials.** Availability of tools and other materials
• **Replication.** The Campaign offers simple interventions that can easily be adapted to fit local contexts.

• **Stakeholders.** Involvement of all key stakeholders, such as the Ministry of Health

Strengths mentioned in Morocco are as follows:

• **Multidisciplinarity.** Positive practice environments affect all health workers.

• **Relevance.** The topic is relevant, particularly today.

### Key Weaknesses

Weaknesses are limitations inherent in the Campaign. The majority of respondents point to the current lack of funding as a key weakness. Several other weaknesses mentioned by respondents also relate to funding:

• **Focus.** “Mission creep”, leading to focus on “understanding and addressing the basic needs of healthcare providers” being lost and increasing overlap with other campaigns.

• **Funding: Discontinuation.** The discontinuation of funding led to plans and investments already made having to be abandoned due to unavailability of alternative funding. It also caused a significant level of de-motivation from what used to be a high level of momentum and commitment when the Campaign first started.

• **Funding: Insecurity.** A prolonged period of insecurity about funding in 2010 and 2011 caused confusion and decreases in motivation of key stakeholders.

• **Funding: Sustainability.** The unavailability of sustainable funding despite initial funding commitments for five years24 is seen as a key weakness. The funding discontinued at a time when the campaign was not yet self-sustainable, particularly in Morocco, Uganda and Zambia, where the Campaign had only started in 2010. Reliance on one funding organisation is also mentioned as a weakness. Some stakeholders feel that this exclusivity of funding was originally mandated by GHWA.

• **M&E.** The Campaign lacks an M&E framework specifying inputs, outputs and outcomes as well as indicators for measuring these.

• **Reporting.** Procedural and communication issues between GHWA and core partners, such as delays in release of funds, frequent changes in reporting requirements and policies, high staff turnover at GHWA, etc. are mentioned as a weakness causing inefficiencies. As one respondent puts it: “there was so much time spent on GHWA, for example for reporting, rather than on the Campaign itself.”

• **Scope.** Inability of the funds provided to match the Campaign’s vision and ambitions in terms of scope, visibility and coverage.

• **Stakeholders.** Not all campaign partners demonstrated the same level of interest and engagement. At the same time, additional stakeholders were “invited to join and accepted participation on global advisory group” but with the end of funding those stakeholders were informed that this group would not be developed.

In addition, Zambian stakeholders mention the following weaknesses:

• **Political sensitivity.** A low profile needed to be kept in 2011 as elections were being held that year and the team wanted to avoid being “suspected of being political”.

• **Perceived antagonism.** Health managers initially felt threatened as they thought the Campaign “was another union which would fight the management”. This meant that a considerable amount of preparatory communication and explanation was necessary before activities could be implemented in pilot sites.

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24 Budgets and written communication shared by GHWA indicate that in 2008, the Alliance had intentions to fund the campaign for five years with up to around one million CHF/USD per annum.
• **Stakeholders.** Lack of participation by Zambia’s medical association.
• **Time constraints.** The Zambian Secretariat (National Resource Person) was only able to work part-time on the Campaign.

Respondents in Uganda stress the following weaknesses:

• **Funding.** Inadequacy of resources provided for the Campaign, for example to organise meetings. This also limited the scope of the Campaign.
• **Meetings.** Steering Committee meetings took place at irregular intervals.
• **Time constraints.** Competing priorities draw on team members’ time and availability, thus limiting the time they can spend on the PPE Campaign.

In Morocco, the following weaknesses are mentioned:

• **Funding.** Funding is seen as having been insufficient.
• **Stakeholders.** Certain cadres of health workers do not see their interests reflected in the Campaign and, as a result, are not involved. Moreover, there is a lack of involvement by political decision makers.

Key Opportunities

In contrast with strengths, which are inherent, opportunities are external factors that may positively influence the Campaign. A number of opportunities for the PPE Campaign lie in the current policy climate which pays significant attention to health systems strengthening, and human resources in particular. Opportunities identified by key informants are as follows:

• **Alignment.** PPE could link with other campaigns focusing on health workforce issues, such as HIFA2015, the initiative to ensure Healthcare Information For All by 2015. The PPE Campaign had close collaboration with HIFA 2015, from which the experiences were positive and this collaboration should be continued.
• **Awareness.** Awareness about the importance of PPE has been created. This can be seen as fertile ground for continuing the campaign and building on early achievements.
• **Focus on health systems.** Recruiting, retaining and motivating health workers through the facilitation of positive practice environments can be seen as an important aspect of health systems strengthening, a topic that has enjoyed significant political interest, funding and commitment for a number of years.
• **Focus on NCDs.** “Increased attention to priority health conditions such as NCDs” (non-communicable diseases) can also be seen as “an opportunity to flag PPE issues” as NCDs and other conditions are diagnosed and treated within the same practice environments.
• **Funding.** Resource mobilisation for the Campaign may be facilitated if PPE was presented “more as a development issue”.
• **Global policy agenda.** The global policy agenda includes human resources for health as a key priority and focuses on several aspects pertinent to PPE, such as quality of care and productivity of health workers, for example.
• **Human resource shortage.** Some see the fact that there is a shortage of human resources for health as an opportunity in itself as it forces policy makers to think outside the box. It is argued that “there is no other retention strategy” and that “the WHO strategy in urban settings is based on PPE”.
• **Participation.** There is a growing recognition of the value of engaging health professionals in discussions relating to human resource issues.
Opportunities mentioned by respondents in Zambia are as follows:

- **Awareness.** Awareness of health managers about the campaign and recognition that PPE may improve the quality of clinical practice. Health facility managers are cooperative and willing to implement the strategies proposed.
- **Mainstreaming.** PPE has potential for being mainstreamed into programmes of the MOH and individual health institutions.
- **Networks.** The network of different categories of health professionals that was created can now be used.
- **Political commitment.** Growing realisation (and commitments, for example in the Abuja Declaration\(^{25}\)) by the government that allocations to health must increase.
- **Solutions.** Realisation by the government that retention issues are not exclusively due to financial compensation of health workers and that working conditions are the “missing factor”\(^{26}\)
- **Stakeholders.** While the national medical association has been absent from discussions on national level, on facility level doctors did participate in the Campaign. They may be able to influence the association towards participation.

Opportunities mentioned by respondents in Uganda are as follows:

- **Collaboration.** Willingness of health workers from different professions to collaborate leading to “acceptance of the campaign in the government and pilot health facilities”.
- **Free airtime.** The Uganda Medical Association has access to free airtime on TV and radio which it has used for medical Q&A sessions with the public, for example. Such airtime may be harnessed for PPE.
- **Leadership.** The new ministry of health leadership has a keen interest in addressing human resources for health issues. The new minister is a former hospital director and thus understands PPE issues well. The ministry has developed a framework for bringing together initiatives that address quality of health service provision.

Key opportunity mentioned in Morocco:

- **Link with ILO.** Inclusion of PPE issues in ILO (International Labor Organization) policies and strategies

Key Threats

In contrast to weaknesses, which are internal, threats are external factors that may cause challenges for the Campaign. Threats mentioned by key stakeholders largely relate to the lack of funding and competition for resources:

- **Collaboration.** In some contexts, collaboration of different categories of health workers has traditionally been difficult. As one respondent describes an experience when asking medical doctors to cooperate with nurses: “It was as if I asked them to travel to the moon”.
- **Credibility.** The lack of continuity in funding and related uncertainty “has frustrated people on global and country level”. It may even have “damaged the reputation of individuals in country who have built relationships with key actors”.
- **Financial crisis.** The global financial crisis means that resources are even more scarce than they used to be. As a result, competition for resources has become high. There are “\(^{26}\)better

\(^{25}\)In The Abuja Declaration, African governments committed to spending 15 percent of national budgets on health. Nevertheless, only few countries have so far managed to realise this goal.

\(^{26}\)The respondent argues that brain drain from Zambia to other African countries is high and cannot be explained by financial motives alone as health worker salaries in Zambia are comparatively high.
focused” projects than the PPE Campaign that may have clearer objectives, more continuity and therefore potentially higher returns on investment. Given current financial restrictions, “resources will have to be allocated to activities with a proven and effective return on investment”.

- **Lost momentum.** The focus and momentum created in 2008 around human resources for health, including issues like task shifting and health regulations for health personnel, has decreased, partly as a result of the financial crisis. This has also meant that focus has moved from working conditions back to “minimum stuff, like job losses or pay cuts”.
- **Underlying constraints.** Structural changes in the way the health systems are organised or financed represent crucial underlying constraints in implementing positive practice environments and cannot be addressed by the Campaign itself.

Key threats mentioned by respondents in Zambia are as follows:

- **Financial crisis.** The “continuous economic depression for many countries is a serious threat”.
- **Focus on infrastructure.** The Ministry of Health currently focuses on infrastructure development rather than HRH, for example.
- **Funding.** The absence of a “local budget to continue the activities” is seen as a threat.
- **Political instability.** Advocacy and campaigning activities may be seen as “partisan”, particularly around elections. Therefore, caution is necessary and may affect smooth running of the Campaign. Political instability and related sensitivity of health issues may “hamper progress” in some countries.

Potential threats mentioned by respondents in Uganda:

- **Accountability.** Lack of accountability and adequate financial management. For example, while there may be a large number of ‘missing’ health workers there are also significant numbers of ‘ghost’ health workers on payrolls.
- **Attention.** Campaign partners and their advocacy targets may be losing interest as the campaign “is not taking shape” due to financial restrictions.
- **Financial crisis.** The global financial crisis negatively affects opportunities for resource mobilisation.
- **Funding.** Lack of financial support for the Campaign and potential donor dependence in view of ‘self-funding’ not being an option.
- **Health budget.** Implementing some of the Campaign’s recommendations also requires funding. This is typically scarce, particularly in government health facilities. The “health sector has not demonstrated improvements in efficient use of existing resources” and thus is seen as unlikely to receive increased resource allocations from the ministry of finance.
- **Proliferation of campaigns.** Presence of similar strategies and initiatives may cause scattering, duplication or overlap.

Potential threat mentioned in Morocco:

- **Collaboration.** Lack of willingness among health professionals from different categories to collaborate
- **Health budget.** The health sector budget is limited, thus affecting health facilities’ ability to implement recommendations.

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27 Advocacy targets can be defined as individuals or organisations who the PPE Campaign aims to influence as they have the power to make decisions and thus create change in policy and practice.
Tools and Materials developed by the Campaign

Overview of tools

A number of tools have been developed to support the campaign on global, national and local level and facilitate learning, information sharing as well as evidence-based advocacy. These tools are key outputs produced by the Campaign.

Background documents

- **Campaign Overview**
  2-page document providing a brief summary of the Campaign and its goals
- **Key Characteristics of Positive Practice Environments for Health Care Professionals**
  2-page (plus one page references) document (checklist) describing the elements of a positive practice environment

Factsheets

- **Fact Sheet: Incentive Systems for Health Professionals**
  3.5-page (plus one page references) document defining incentives and describing effective incentive systems
- **Fact Sheet: Positive Practice Environments for Healthcare Professionals**
  4-page (plus one page references) document defining positive practice environments and explaining benefits as well as steps for implementation
- **Fact Sheet: Meeting the Information Needs of Health Professionals**
  3-page (plus one page references) document explaining the importance of information for safe quality healthcare

Guidelines

- **Guidelines: Incentives for Health Professionals**
  44-page document outlining various types of financial and non-financial incentives and making recommendations for an effective incentive scheme and providing an example approach (checklist) to developing an incentive package
- **Advocacy Guide for Health Professionals**
  60-page step-by-step guide for health advocacy, including a glossary and references

Tools for engagement

- **Call to Action: Quality Workplaces for Quality Care**
  2-page advocacy document including a PPE checklist
- **PPE Campaign Poster**
  Poster outlining key elements of a positive practice environment
- **Sample Press Release**
  1-page template for a press release on the benefits of positive practice environments

Tools for information sharing

- **Newsletter Winter 2009**
  4-page document
- **Newsletter Summer 2010**
  6-page document
Use of tools

All tools mentioned above are available on the PPE Campaign website for download. Except for the newsletter, which is only available in English and French, the website and all other tools exist in both English, French and Spanish. They are presented as a ‘Campaign Toolkit’. The Newsletter was decided in agreement with GHWA to be produced firstly in English and French as the country work was to take place at first in 2 English and 1 French speaking countries.

Access and download statistics of the website are one indicator for use of materials. In 2011 the website had close to 5,000 visits from just over 4,000 individual visitors located in close to 140 countries. On an annualised rate this is slightly less than in 2010 but still considerable with 14 daily visits. It is noticeable that the average time spent on the PPE Campaign website decreased from 4.5 to 2.5 minutes, the number of pages viewed per visit decreased from 3.26 to 2.17 and average daily downloads decreased from 6 to 4. At the same time, the bounce rate, i.e. the percentage of single-page visits, or visits in which the visitor left the website straight from the entrance (landing) page, has increased from 52 to 64 percent. Key statistics for 2010 and 2011 are summarised in the table below.

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total visits</td>
<td>3,963</td>
<td>4,911</td>
</tr>
<tr>
<td>Average number of visits/day</td>
<td>15</td>
<td>14</td>
</tr>
<tr>
<td>Total unique visits</td>
<td>2,807</td>
<td>4,103</td>
</tr>
<tr>
<td>Unique visitors</td>
<td>70.38%</td>
<td>82.02%</td>
</tr>
<tr>
<td>Returning visitors</td>
<td>29.62%</td>
<td>17.98%</td>
</tr>
<tr>
<td>Average time spent on site/visit</td>
<td>4.5 minutes</td>
<td>2.5 minutes</td>
</tr>
<tr>
<td>Page views per visit</td>
<td>3.26</td>
<td>2.17</td>
</tr>
<tr>
<td>Total downloads</td>
<td>1,483</td>
<td>1,554</td>
</tr>
<tr>
<td>Average downloads/day</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Peak visit dates</td>
<td>8 April (54 visits), 31 August (126 visits), 22 September (77 visits)</td>
<td>23 February (61 visits), 7 September (40 visits), 22 September (50 visits)</td>
</tr>
<tr>
<td>Bounce rate</td>
<td>52.21%</td>
<td>63.98%</td>
</tr>
<tr>
<td>Top visitors location (in descending order)</td>
<td>US, UK, Switzerland, Mexico, Canada, Taiwan</td>
<td>US, Mexico, Columbia, Switzerland, Canada, UK</td>
</tr>
<tr>
<td>Top documents downloaded</td>
<td>Newsletter Summer 2010 (English), PPE checklist, PPE fact sheet</td>
<td>Newsletter Summer 2010 (English), PPE checklist, PPE fact sheet</td>
</tr>
</tbody>
</table>

The most frequently downloaded documents in both years were the Summer 2010 newsletter, the PPE checklist as well as the fact sheet on positive practice environments. In both years, US, UK, Switzerland, Canada and Mexico featured under the top six countries in regard to accessing the PPE website. The table also indicates peak visit dates on which the number of visits was several times higher than on an average day. These may indicate the follow-up to conferences, workshops and other meetings where PPE was discussed.

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28 All data were derived from Google Analytics. It should be noted that the website only went online in April 2010, with the programme starting data generation on 7 April. In order to compare 2010 and 2011 figures, therefore, daily averages or annualised rates must be used.
Close to 90 percent of key stakeholders who provided feedback to the online survey have accessed the website at least once, with more than half of all key stakeholders having accessed the site four times or more. This indicates that the target group actually accesses the site and is depicted in the chart below.

![Website Visits Chart]

About 75 percent of key stakeholders who provided feedback to the online survey have downloaded documents from the website at least once and close to 30 percent have done so four times or more. This is depicted in the graph below.

![Website Downloads Chart]
The quality of tools is at least as important as their availability and use. PPE campaign tools and materials receive fairly good ratings with ‘excellent’ and ‘good’ ratings dominating and no respondent to the online survey giving them a ‘poor’ rating. Three tools were rated specifically, these are the PPE Campaign Advocacy guide, the fact sheets (rated as a group rather than individually) and the website. Of these, the fact sheets received the best rating with 45 percent rating them excellent and close to 40 percent as good, resulting in a combined ‘excellent’ or ‘good’ rating of over 80 percent. 61 percent of respondents rate the website as ‘good’ and close to 20 percent as ‘excellent’. The advocacy guide is rated as excellent by 32 percent and as good by close to 40 percent of respondents. This is shown in the chart below.

![PPE Campaign Tools Rating Chart](chart.png)

Improving the Set of Materials

Some respondents in country feel that the majority of the tools are fairly complex and “more for executives” than tailored to health workers. As actual tools for campaigning among health workers (as opposed to political advocacy with policy makers) they recommend a stronger focus on posters as well as badges. In addition, a number of stakeholders stress that more practical tools, such as checklists, would be in order. Improvements for website and materials were considered but the cost for redesign was significant and the non-availability of resources did not allow the planned work.

As one respondent puts it: “If you have a complicated topic to explain, the design and materials are crucial.” Suggestions made by key informants for improvement of PPE Campaign tools include the following:

- **Design.** Review the design for improved readability and a fresher look. Add pictures, case studies, graphs, charts to the text of various tools to improve readability and user-friendliness. Consider a redesign of the logo, which currently “is a mix of everything”.
- **Share.** Promote the tools beyond the Campaign as they may be useful also for other stakeholders in similar settings or who are working on similar initiatives.
- **Update.** Continue to update tools and materials on a regular basis to take account of political developments and new evidence generated.
Regarding the website specifically, the following suggestions are made:

- **Accessibility.** Many partners in country normally access the internet from handheld devices, such as mobile phones. Consider creating a version of the website that takes less time to load for settings with unreliable internet connection.

- **Language.** Ensure that the French and Spanish versions of the website are updated as much as the English version. Include links to other language tools directly on the tools page in order to ensure users know the toolkit is available in more than one language. Translate into additional languages as necessary.

- **Link.** Provide a link to the PPE Campaign on the World Health Professionals Alliance (WHPA) and individual member websites

Respondents also suggest the following additional tools and materials that may be useful in driving the Campaign forward:

| Internet tools | • Global email and/or online discussion forum  
|               | • PPE Campaign Facebook page  
|               | • PPE Campaign banner to be added to member organisations' websites at global and national level |

| Tools for engagement in campaigning and political advocacy | • Brochures, pins, badges, etc.  
|                                                           | • Briefing on PPE that includes arguments to address potential objections by the advocacy target  
|                                                           | • Fact sheet on the relevance of PPE in the current economic situation  
|                                                           | • Sample advocacy letters to government |

| Technical tools and materials | • Practical guidelines (checklist) for employers to help them “evaluate whether they are good PPE employers”  
|                               | • Practical guidelines (checklist) for health workers on how to deal with patients  
|                               | • Overview of best practice to monitor and share across countries  
|                               | • Summary of case studies, potentially even as short as half a page to put on website and include in newsletters  
|                               | • Cost-benefit overview of recommended actions to demonstrate possible savings when implementing PPE  
|                               | • Tool for funding applications |

It should be noted that the quality, dissemination and use of tools are potentially more important than the quantity of available materials. One respondent argues: “Please no more tools... there are too many at the moment.” and suggests that is better “to have only a few and simple tools” while ensuring that they are disseminated and used.

**Stakeholders**

**Actual Stakeholders**

On the global level, the funding partner GHWA as well as the six member organisations of the global steering committee can be considered key stakeholders. Among these, the International Council of Nurses (ICN), who originally conceived of the PPE Campaign and had hosted the Secretariat, has been the key driver of the Campaign. According to stakeholders, the World Medical Association (WMA), who chairs the World Health Professionals Alliance (WHPA), has also been particularly active in driving the Campaign forward. Other core partners, for a number of
reasons, including the fact that their constituencies are smaller in number, have taken on more the role of “followers” albeit with active participation in meetings and decision-making.

In Zambia, the Pharmaceutical Society, Physiotherapy Society, Union of Nurses and General Nursing Council are mentioned as the most active member organisations. The National Resource Person is a senior research fellow at the Centre for Health, Science & Social Research. The lack of involvement by the Medical Association is noticeable. It may be explained by large workloads or indeed by the fact that many doctors “are immigrants from neighbouring countries and perhaps do not want to get in trouble” as well as a weak representative body.

In Uganda, the Nurses and Midwives Union, Medical Association, Dental Association and Pharmaceutical Society as well as the Ministry of Health and IntraHealth have been mentioned as most active in driving the Campaign forward. The National Resource Person is the principal nursing officers at Uganda Heart Institute based at a large government hospital (Mulago) in the capital Kampala.

In Morocco, the National Resource Person is the executive director of AMSITS (Association Marocaine des Science Infirmières et Techniques Sanitaires), the Moroccan Association of Nursing and Health Technology.

It should be noted that most of these stakeholders have invested considerable amounts of (human) resources in the PPE Campaign and many are prepared to continue doing so in the future. Nevertheless, while some stakeholders on global level pledge continued support in terms of human resources and technical advice, and in some cases office space, some mention that they “can only act if [the organisation] receives funds covering its costs” or that they are “at the limit” and have to reduce spending due to the impact of the financial crisis. Some say that they cannot make any commitments before the Campaign’s needs and plans for the future have been established and that potential support will depend on the nature of their involvement in the Campaign, which is yet to be decided.

In Uganda and Zambia, almost all stakeholders offer continued support in terms of human resources, particularly for technical advice, sensitisation, advocacy, dissemination of tools and information sharing; some are also able to provide office space. Morocco appears to be unable to contribute any further resources.

Potential Stakeholders

Suggestions have been made as to which additional stakeholders not currently engaged should be involved in the Campaign. These include ILO, educators in training institutions and, in Zambia, medical doctors. Moreover, there is a feeling in Morocco, Uganda and Zambia that ministries of health need to be more strongly involved.

No respondent mentioned the International Confederation of Midwives (ICM), the global representative body of midwives, as being absent from the Campaign. This is noteworthy as the Confederation was part of the group of global representative organisations that submitted the original proposal for the Campaign in 2007. While the absence of ICM may be partly explained by the fact that ICN also represents nurse-midwives, it is unclear what caused the Confederation to drop out of the group or prevented it from joining again later.

Global stakeholders concede that potential partners may be discouraged from participation in the Campaign by a lack of funding; competing obligations coupled with time constraints; lack of visibility; language barriers; lack of focus and clear objectives of the Campaign; and lack of knowledge about the Campaign. It should also be noted that among global stakeholders “there was a lot of excitement about the Campaign and very active participation” when the Campaign started but as the questions around funding and other complexities arose “some
people got tired of it”. They started feeling that, given the situation of uncertainty, their limited time and energy may better be invested elsewhere.

Key stakeholders in Morocco, Uganda and Zambia, on the other hand, mention the following reasons that may keep individuals from becoming involved: limited information and knowledge about PPE and the Campaign; lack of clarity of Campaign goals; lack of visible results; “fear of the unknown” and the fact that many health workers are not used to collaborating with other categories of health professionals, may be worried about losing their professional identity or may “feel they have more power to push things more personally rewarding, immediate and dear to them than PPE”.

In order to encourage stakeholders to get involved, global stakeholders recommend financial support; technical advice; visibility of achievements and results, including from other countries and contexts; availability of ready-to-use tools; “a series of dynamic email forums for engagement, each one looking at different aspects of PPE”; and continued open dialogue. It is also recommended that Campaign partners “be engaged actively and continuously” and even “pushed consistently” in order to be able to continue prioritising the PPE Campaign.

The following proposals are made by respondents in Morocco, Uganda and Zambia: continuous dissemination of appropriate information; regular invitation to meetings and inclusion in decision making; setting and communication of clear and achievable goals; demonstration that PPE provides an opportunity to raise the image of health professionals and thus encourage young people to consider a career in health; better harmonisation and alignment with other initiatives.

### Related Campaigns
Several stakeholders are also involved in a number of other, related campaigns. These include the Collaborative Practice Campaign and the Campaign on Non Communicable Diseases. The Collaborative Practice Campaign aims to identify best practice models of technical collaboration between different categories of health workers. A literature review is currently being conducted of best practice models that lead to decreased cost, increased motivation of health professionals and improved patient satisfaction. The Campaign is currently self-funded and led by the WHPA. The Campaign on Non-Communicable Disease is funded mainly by IFPMA (International Federation of Pharmaceutical Manufacturers and Associations) and aims to promote tools to ensure appropriate and cost-effective ways of assessing risk and influencing policy.

### Funding and Value for Money

#### Past Funding

The Campaign has received 643,146CHF from the Global Health Workforce Alliance. In addition, its members and partners have invested a great deal of human and other resources. GHWA has been the only funder so far. This, as some stakeholders understand, has been a requirement by GHWA. However, there appears to have been some miscommunication as GHWA maintains such a restriction was not communicated in the more recent past and that, on the contrary, partners were encouraged early on to seek alternative and additional funding.

#### ‘Self-funded’ countries

Campaigns and other initiatives relating to positive practice environments also run in a number of countries other than Morocco, Uganda and Zambia. For example, a Taiwanese initiative has recently conducted research into attitudes and workplace issues focusing on nurses and drawing

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29 See summary note provided by GHWA in November 2011.

30 A restriction communicated early on may have been in regard to working with corporate funders, such as pharmaceutical companies, which at one point had expressed strong interest in funding the Campaign according to one informant.
comparisons between Taiwan and global indicators. However, there are currently no resources to fully align such campaigns with the PPE Campaign.

Following the discontinuation of funding, the Campaign “had to manage its way out of the project in country to minimise potential damage”. Therefore, the second set of in-country workshops were re-designed to help partners develop funding proposals which they could use to generate funding from other sources than GHWA. However, no additional resources were identified so far.

Value for Money

Assessing value for money of a campaign that was discontinued when it had just taken off, as is the case in Morocco, Uganda and Zambia, is difficult. This is because investments are typically high at the beginning when initial consultations and workshops are held, tools developed and materials disseminated. Once a campaign is established, the level of necessary investment typically decreases. Moreover, budget data available for the Campaign are not entirely conclusive and disaggregated to an extent that would allow detailed analysis. Nevertheless, the following observations are possible:

- Dissemination of materials has been one of the highest non-wage cost factors. A more specific and detailed analysis of the cost effectiveness of disseminating hardcopies vis-à-vis electronic materials might be warranted, as would be a closer analysis of whether and how hardcopies are used, and whether and how money could be saved in the dissemination process.
- Compared to other cost factors in the budget, actual ‘seed money’ allocated to local initiatives and campaigns for improving practice environments has been low. For example, in the revised 2010 budget a total of just over 30,000 CHF was allocated in seed funding for local projects in Morocco, Uganda and Zambia while funding allocated to workshops in the same three countries totalled almost 120,000 CHF. Budgets allocated to editing, translation, printing and dissemination of the total of three country case studies was also significantly higher at 46,000 CHF.
- Generally speaking, documents, such as case studies aimed for publication and distribution, should be as succinct as possible. This would also help to reduce costs for editing, translation and dissemination.
- Workshops could be shortened from three days to two days. Experience shows that (health) professionals are rarely able to commit more than one or two full days to an activity which is not fully part of their regular occupation, thus sometimes leading to incomplete attention and lower returns on investment.
- Financial compensation for participants attending meetings and workshops has been subject to debate, for example in Uganda where a ‘workshop culture’ means that some individuals expect payment in return for participating in a workshop. If at all possible, such payments should be avoided, not least because they may cause stakeholders to participate for the wrong reasons and therefore potentially attract the wrong stakeholders to the Campaign.
- Given the relatively high ‘frontloading’ of campaigns, it is likely that returns on investment would increase significantly as activities continue and the generation of results accelerates.

It should be noted that the investments made in the Campaign to date can be considered ‘sunk costs’, i.e. costs that have already been incurred and cannot be recovered. While in reality most actors tend to be loss-averse and thus factor past costs into decision-making, economic theory recommends avoiding this and only taking prospective costs into account. In other words, decisions on whether and how to continue (funding) the Campaign should not be based on the amount of funds that have already been spent.

31 For example, two different currencies are used in one budget without explanation.
At the same time, it is important to realise that investments so far have enabled the provision of a fertile ground on which campaign activities may easily bear fruit. This indicates that the faster resources can be mobilised the more likely past activities and achievements can be effectively and efficiently built on. Evidence shows that the PPE Campaign cannot run without sustained and predictable funding.

Potential funders

It is noticeable that none of the key stakeholders indicated that their organisations would be able to make financial contributions to the Campaign. Key informants on global level recommended a number of potential sources of funding for the PPE Campaign. Besides WHO and GHWA, these are: donor governments, particularly “those interested in patient safety, such as Japan, Norway and UK”; the Bill and Melinda Gates and Rockefeller Foundations; private sector actors such as insurance companies and hospital chains; the Global Fund for Aids, TB and malaria; core partners of the campaign on global or national level (for example, ICN chapters in a developed countries may link with ‘sister’ chapters in a developing country).

Stakeholders on country level suggest the following potential funders: Fondation Mohamed VI, Initiative Nationale pour le Développement Humain, Association Lalla Salma (Morocco); Ministry of Health, WHO, USAID, Global Fund, Churches Health Association of Zambia and other NGOs (Zambia); and Rotary clubs, the Ministry of Health, UNFPA and USAID (Uganda).

The survey did not explore which of these potential funders have been approached and how in any level of detail. Nevertheless, it may be said that some funders were approached both by global as well as by country-level stakeholders, albeit with no success so far.

One country-level respondent argues: “The principle is the more money is available, the more activities can be undertaken. More money also means more respect. Nevertheless, time and money are never enough. This is about prioritising therefore.” And another one sums up their optimism as follows: “It is a good initiative so should not be too difficult to fund”.

Lessons Learned and Ways Forward

Global level stakeholders identified the following key lessons learned:

- **Collaboration.** Dialogue between different categories of health professionals associations is key and collaboration is indeed possible. Nevertheless, in some countries such collaboration is less common and therefore more sensitive than in others, for example in Asia. “Giving health workers a focus to work together for mutual benefit is really important, particularly at a time that task shifting is promoted and perceived to be taking work away from some groups”
- **Ownership.** Ownership by key partners is crucial for the Campaign to move forward
- **Project management.** Clear focus and a strong management approach with well-defined roles and responsibilities as well as an M&E framework must be established early on. Individuals with dedicated time for driving the Campaign forward are key
- **Rights.** Many health professionals understand only their obligations in regard to PPE but not their rights
- **Sustainability.** Long term vision and sustainability are necessary for a successful campaign. Implementing activities in country without sustained funding is difficult.

Country-level stakeholders identified the following key lessons learned:
• **Collaboration.** Synergies can be created when different categories of health workers collaborate. It is crucial to involve all categories of health workers present in a given setting, even those not represented in the global core group, such as lab technicians in hospitals for example. Otherwise they may feel ostracised and are unlikely to feel ownership.

• **Funding.** In order to achieve impact on national scale, considerable resources are necessary. A successful campaign “needs comprehensive planning and financing”.

• **Political advocacy.** Political actors need to be involved for the Campaign to succeed. Influencing the government is indeed possible: “Sustained advocacy breaks the chains of resistance”

• **Relevance.** Positive practice environments are instrumental in improving health care delivery. A number of “HRH issues can be addressed through innovations in resource limited settings”.

• **Rights.** Health workers have a right to be compensated in case of hazards/damage.

Key informants also made the following recommendations to make the Campaign more successful:

• **Alignment.** Harmonisation and alignment with other, related initiatives, particularly several WHO campaigns and initiatives. One respondent feels that “all WHO campaigns targeting frontline health workers should come in one package. This would save health worker time.”

• **Communication.** Strengthened communication and information sharing among all Campaign partners.

• **M&E.** Continued monitoring and evaluation and dissemination of lessons learned.

• **Ownership.** Stronger ownership of the Campaign by partners, particularly at the global level.

• **Participation.** Continue to reach out to additional partners, including national governments and GHWA members. Even “loose relationships” where organisations ‘only’ pledge awareness of the importance of PPE and include information on PPE in their dissemination practice are important.

• **Sustainable funding.** Ensure more, and more sustainable, funding. “Sound resource mobilisation” will help to sustain the campaign long-term and allow members to plan ahead for more than one year.

In Zambia, key stakeholders recommend the following:

• **Advocacy.** Include sessions on PPE in Ministry of Health workshops at national and provincial levels.

• **Funding.** Work closely with local funding organisations to scale up activities.

• **Materials.** Continue dissemination of PPE messages and materials through professional associations and also involve undergraduate health workers in dissemination activities.

Key stakeholders in Uganda made the following suggestions:

• **Funding.** Ensuring consistent funding as every step taken as part of the campaign does require some funding.

• **Harmonisation.** Align the Campaign with ongoing activities, such as the Quality Improvement Framework elaborated by the Ministry of Health.

• **Meeting.** Regularly conduct meetings and share written information on HRH across partner networks.

• **Political advocacy.** “Developing PPE campaign pressure groups to lobby government and private partners to increase funding for health care” and address political concerns about HRH more generally.

• **Tools.** Focus more on campaigning through large posters and keep putting them up in health facilities around the country.
For Morocco, the following recommendation was made:

- **Political advocacy.** Involve political actors and decision makers to ensure PPE becomes a priority for the ministry of health and thus gets incorporated into MOH programmes and plans.

In addition, respondents were asked what they would change about the campaign if it was in their power to change one single thing, thus indicating what they consider most important in maximising Campaign outcomes. The recommendations cover a noticeable variety of suggestions and are summarised in the table below.

<table>
<thead>
<tr>
<th>Global level</th>
<th>Country level</th>
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<tbody>
<tr>
<td><strong>Branding:</strong> give the Campaign “a new look which is easy recognisable” and update materials accordingly.</td>
<td><strong>Advocacy.</strong> Increase focus on political advocacy with policy makers.</td>
</tr>
<tr>
<td><strong>Communication.</strong> Establish a global email communication forum for multi-stakeholder engagement in discussions of key HRH and PPE issues.</td>
<td><strong>Alignment.</strong> Align the Campaign with ongoing activities, such as the MOH Quality Improvement Framework in Uganda, and other initiatives.</td>
</tr>
<tr>
<td><strong>Differentiation.</strong> Use different approaches in larger hospitals vis-à-vis smaller health facility settings (community pharmacy, dental practice, etc.).</td>
<td><strong>Funding.</strong> Ensure funding to match planned activities and increase the scope of the campaign by scaling the campaign up to include stakeholders and health facilities across the country.</td>
</tr>
<tr>
<td><strong>Funding.</strong> Ensure sustained funding. Provide resources for expansion to additional countries; increased scope within existing countries; and ensuring all key stakeholders can be involved without having to self-fund. Also build linkages with the informal and private health sector.</td>
<td><strong>Involvement.</strong> More strongly involve government and other key decision makers, particularly the ministry of health, to mainstream PPE issues in its operations. Sensitise governments using international fora, such as the World Health Assembly.</td>
</tr>
<tr>
<td><strong>M&amp;E.</strong> Establish a framework for monitoring and evaluation that contains specific objectives and indicators, thus enabling the Campaign to better understand success.</td>
<td><strong>Momentum.</strong> Rapidly re-invigorate the campaign to avoid losing momentum altogether.</td>
</tr>
<tr>
<td><strong>Ownership.</strong> Aim to ensure that all core partners are equally committed and engaged.</td>
<td><strong>Resource mobilisation.</strong> Ensure that PPE issues identified on the ground inform global level to help leverage funding for country level campaigns.</td>
</tr>
<tr>
<td><strong>Tools.</strong> Render campaign materials more concrete and link them to tangible political action.</td>
<td><strong>Steering Committee.</strong> Consider involving service providers and their employers in Campaign leadership.</td>
</tr>
<tr>
<td><strong>Visibility.</strong> Ensure better visibility of the Campaign, partly by making it “more active”.</td>
<td></td>
</tr>
</tbody>
</table>

32 Asking this question rather than, or in addition to, general recommendations for improving the campaign gets respondents to think outside the box and allows for better understanding of their key priorities.
Conclusions

Relevance
Human resources for health (HRH) are still in crisis, and some argue that the human resource crisis is worsening, not least due to the global financial crisis. Therefore, the PPE Campaign is crucial in addressing working conditions and demonstrating to policy makers that health worker salaries are not the only important factor explaining recruitment and retention issues in the sector. This is all the more relevant as political momentum for HRH, which was high when the Campaign started, has slowed down.

Actual and potential achievements
The PPE Campaign has considerable potential for improving working conditions of health professionals globally and thereby quality of care as well as patient satisfaction. It has already produced a number of important outputs and outcomes, such as increased awareness. On country level, in particular, it has led to some tangible results in regard to policy and practice. Nevertheless, the relatively short duration of the Campaign on country level, coupled with the fact that change in policy and practice takes time, means that a great deal more could have been achieved had the Campaign continued to receive funding in 2011.

Strengths, weaknesses, opportunities and threats
Key strengths of the PPE Campaign include its multidisciplinary nature, high levels of commitment by Campaign partners and the relevance of the topic. Key weaknesses relate to the sustainability and predictability of funding, the absence of an M&E framework and time constraints by key partners, particularly on country level. The global focus on health systems strengthening as well as alignment with other campaigns are seen as key opportunities. The global financial crisis is identified as a major threat, in addition to lost momentum for HRH in general and the PPE Campaign in particular. Strengths, weaknesses, opportunities and threats identified in the four key contexts (global, Morocco, Uganda, Zambia) are largely congruent and complement each other.

Multidisciplinarity
A key feature of the Campaign, its multidisciplinarity is also one of its key strengths and areas of success as well as an area of weakness and potential threats. While in some contexts collaboration among different categories of health professionals is common, in other contexts it is a key achievement of the Campaign that different cadres of health professionals work together and have a joint focus at all. This indicates that collaboration among different categories of health professionals is very difficult in some contexts. While this is no news to most individuals working in the sector, it is nevertheless something that needs to be taken into account when designing, refining and evaluating PPE Campaigns across different countries and contexts.

Harmonisation and alignment
Generally speaking, successful advocacy and campaigning involves working in partnership. This helps create synergies, increase influence and save resources. At the same time, it avoids advocacy targets receiving potentially conflicting messages, which may render advocacy efforts futile. Decisions on whether the PPE Campaign should be a stand-alone campaign or linked to other HRH initiatives pursuing similar goals must be made on a context-by-context basis. PPE actors must be aware of ‘competing’ campaigns in any given context and make informed decisions on whether and how to engage with them. At the moment, such systematic awareness does not appear to be sufficiently present. The depth of partnership sought with ministries of health and other policy makers should also be strategically assessed. It is not possible to make recommendations as to the ‘ideal’ degree of involvement of the ministry as strong involvement may mean increased ownership and potentially faster change in policy and practice while action may be slowed down when perceived as being political.
Website and other tools
Currently, the PPE Campaign website is a tool for information sharing rather than campaigning. For example, it does not provide a forum for engagement and exchange or even an option to ‘subscribe’ or sign-up for a newsletter. An improved and updated website will also facilitate the generation of additional campaign resources. The Campaign has made a number of quality tools available, including an excellent guide for health advocacy as well as fact sheets and technical guidelines. By budgeting and planning accordingly it has been effective in ensuring that tools produced also get disseminated. Moreover, there is evidence that these tools are being used. Producing and disseminating materials electronically is typically more cost-effective than producing and disseminating printed materials. At the same time, accessing materials electronically on a consistent basis is not possible in some contexts. Therefore, a more in-depth assessment of the use of electronic vis-à-vis printed materials would be in order.

Human resources
Selection of the right individuals to lead and drive the Campaign forward is crucial. Such individuals must be committed, knowledgeable and well connected. At the same time they must possess leadership skills and understand advocacy and policy-making as much as the practicalities of working in a healthcare setting. Importantly, they must have sufficient time to devote to the Campaign. While it is often enough challenging to identify health workers who are attune to strategic and political advocacy, particularly in developing countries, such individuals are commonly very busy and, even if committed to a given cause, often not in the position to spend considerable amounts of time on it. Therefore, decisions on potentially necessary compromises must be made carefully. Partners on global level are similarly constrained in regard to time. Therefore, and given their competing interests and commitments, it is necessary for the Campaign leadership to engage them actively and continuously and to ensure clarity of perspective.

Past funding
A number of key informants see the lack of sustained funding as a key weakness of the Campaign itself. Questions of funding have apparently caused a few misunderstandings. For example, while GHWA argues that core partners were encouraged to seek alternative and additional funding early on, some stakeholders feel that restrictions had been imposed in approaching other funders, at least when the Campaign was initiated. Moreover, while core partners maintain that GHWA had indicated that it would provide significant levels of funding for at least five consecutive years, the funder argues that its commitment to catalytic funding only has always been made clear. This is evidence that communication and engagement between GHWA and core partners may have been insufficient, insufficiently documented or indeed volatile, potentially due to staff turnover, thus contributing to the misunderstandings mentioned.

Future funding
There is room for maximising value for money by continuing the campaign and re-considering relative budget allocations. It is noticeable that not a single representative of professional associations indicated that their organisation would be able to contribute financial resources to the Campaign. At the same time, it has become evident that sustained and predictable funding from a central level source is necessary to continue a global Campaign. This leaves GHWA in a key position. Nevertheless, funding from other globally placed organisations, including multi- and bilateral donors, should also be considered. Such funding may be complemented on country level, for example to expand scope and replicate campaign activities in additional geographic areas or types of facilities; or indeed by financial supporters of individual associations on global level. Nevertheless, it is arguable that in order to maximise synergy and alignment while continuing to promote a country-led approach, the bulk of funding should come from a central source with a global focus.

Monitoring and evaluation
The absence of a comprehensive budget as well as a clear framework for M&E specifying expected outputs and outcomes as well as indicators can be considered an important limitation of the Campaign. Clear, commonly agreed goals, inputs and objectives developed at the onset of the
campaign are necessary to ensure focus, avoid misunderstandings and allow for effective monitoring of progress and measuring of results.
Recommendations

The Positive Practice Environments Campaign is a necessary campaign with a solid design, thus enabling it to achieve the intended results. It is recommended that the Campaign is continued without delay to capitalise on past achievements and opportunities created. A continuation at any substantial scale requires sustainable and predictable funding, particularly if the important global nature of the Campaign is to be maintained. In order to apply lessons learned and render the Campaign more effective and efficient, thereby further increasing value for money, the following specific recommendations can be made, synthesising, complementing and building on recommendations offered by key informants.

Harmonisation and alignment

- The PPE Campaign must avoid duplication of efforts and seek synergies by linking up with other initiatives, such as the Collaborative Practice and NCD Campaigns, and continue collaboration with HIFA2015, to the extent considered necessary and useful. Therefore, rapid assessments on a context by-context basis are necessary.
- A brief stock-taking exercise of other ongoing advocacy initiatives and fora focusing on human resources for health is also recommended. These include HRH Technical Working Groups which exist in many countries and tend to be important contributors to government policy making, thus providing key entry points for PPE advocacy.

Stakeholders

- Concerted action, including joint workplanning, on global level is key to ensure ownership and participation as well as transparency.
- Moreover, it is recommended that the Campaign continues to seek more partners and supporters. These may range from professional organisations on global and country level to the general public which also has a stake in improving working conditions and thereby the quality of care.
- Campaign partners may continue to work through the World Health Assembly and a variety of other fora to mobilise additional countries for participation in the Campaign.
- Importantly, individual GHWA members may be mobilised to support the Campaign, particularly on country level.

Human resources

- PPE partners must seek to appoint and adequately remunerate individuals with the right mix of credibility, connections, commitment and understanding of national policy making as well as ways of working at facility level. This will be a key factor in driving the Campaign forward and ensuring achievement, documentation and evaluation of results as well as value for money.

Scope

- When expanding its scope, the Campaign must seek to engage not only tertiary-level hospitals but also lower level health facilities in rural areas, thus beginning to address equity issues.
- Similarly, both not-for-profit and for-profit facilities may be engaged.

Project management and reporting

- Sufficient human resource funding must be available for project management to be adequately staffed to ensure sound financial management and reporting of the Campaign.
- Reporting requirements by the funder must be clear, as tight as possible and as detailed as useful for both parties to facilitate financial, project and knowledge management.
- Knowledge created by the Campaign within both implementing and funding organisations must be managed in a way that allows for continuity and consistency in management even in the face of staff turnover.
Website
- The website is a key cornerstone of the Campaign and access statistics confirm that it is visited regularly by actual and potential partners around the world. Precisely because of its importance and frequent use, investments in improving the website are warranted.
- Besides improving its visual design to give it a fresher look, its menu structure may be modified and streamlined to allow for easier navigation.
- The list of tools would benefit from a clearer structure as well as brief descriptions of each tool to guide users.
- Importantly, the website should be used as a tool for campaigning with options for audience engagement such as discussion fora, subscription to mailing lists, expression of support, etc. rather than for information sharing only.
- It goes without saying that the website will need to be regularly updated in all languages.

Other tools and materials
- The website, along with the other tools must continue to be updated, promoted, disseminated and used for expanding the pool of supporters, providing technical support for the improvement of practice environments and conducting evidence-based advocacy.
- Summary versions of the evidence presented in the country case studies are necessary to facilitate advocacy and information sharing.
- More research on whether and how printed vis-à-vis electronic tools and materials are used is also recommended. Based on the outcomes of such an assessment, judgements can be made about relative budget allocations to electronic vis-à-vis other tools.

Funding
- Financial support to the Campaign must be predictable, sustainable and clearly communicated.
- As the PPE Campaign’s goals are very tightly related to the core goals of GHWA, the Alliance appears to be an ideally suited funder. It is therefore recommended that GHWA continues to support the PPE Campaign to the extent possible within the framework of its catalytic role.
- It is also recommended that GHWA continues joint fundraising for the Campaign on global level, particularly to cover costs relating to key human resources and other core elements of the Campaign.
- Nevertheless, it is also recommended that Campaign partners on country level seek additional funding to support an increasing scope of activities and wider geographic coverage.
- Resource mobilisation may target ‘development donors’ since HRH issues affect developing countries in particular.
- Leaving in-country campaigns exclusively to ‘self-fund’ is not recommended as this may cause not only sustainability issues but may also make country campaigns vulnerable to losing focus.

Monitoring and evaluation
- Solid monitoring and evaluation of progress is key. Therefore, an appropriately structured M&E framework must be developed. Such a framework should include goals as well as expected outputs and outcomes of the PPE Campaign. Indicators for monitoring and evaluating these must also be specified and commonly agreed.
- Importantly, the M&E framework must be linked to an agreed budget, which in turn will facilitate the definition of goals.

Communication and information sharing
- In order to maximise capitalisation on the global nature of the Campaign, sharing of information and best practice across countries and organisations, for example through a bi-weekly email newsletter, must be prioritised.
- For instance, country campaigns may use the Ugandan example and set up an award or even accreditation system as an incentive for creating positive practice environments.
- Last but not least, this evaluation report should be shared widely with all core and collaborating partners on both global and country level as well as anyone else who has been involved in the Campaign or may be interested in findings of this evaluation.
## Annex 1

### Key informants

Participants in the online survey

<table>
<thead>
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<th>Europe</th>
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<tbody>
<tr>
<td>Brenda Meyers, WCPT</td>
<td>Clarisse Delorme, WMA</td>
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<td>Elizabeth Adams, ICN</td>
<td>Eric Roodenbeke, IHF</td>
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<tr>
<td>George Pariyo, WHO/GWHA</td>
<td>Jean-Luc Eisele, WDF/FDI</td>
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<tr>
<td>Johan van Rixtel, Cordaid</td>
<td>Julia Seyer, WMA</td>
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<tr>
<td>Luc Besancon, IPF/FIP</td>
<td>Neil Pakenham-Walsh, Global Healthcare Information Network / HIFA2015</td>
</tr>
<tr>
<td>Otmar Kloiber, WMA</td>
<td>Sonia Diaz-Monsalve, n.a.</td>
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<tr>
<td>Susan Wilburn, WHO</td>
<td>Taina Nakari, WHO/GHWA</td>
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<tr>
<td>Uganda</td>
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<tr>
<td>Charles Masitko, IntraHealth</td>
<td>Charles Rwenyonyi, Uganda Dental Association</td>
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<tr>
<td>Ida Mpaata, Baylor College of Medicine</td>
<td>Jacinto Amandua, Ministry of Health</td>
</tr>
<tr>
<td>Janet Obuni, Uganda Nurses and Midwives Union</td>
<td>Juliet Bataringaya, WHO</td>
</tr>
<tr>
<td>Lorna Muhirwe, Uganda Protestant Medical Bureau</td>
<td>Margaret Byabakama, Uganda Heart Institute</td>
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<tr>
<td>Margaret Maimbolwa, University of Zambia</td>
<td>Sumayya Kayitamuu, Islamic University of Uganda</td>
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<td>Zambia</td>
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<tr>
<td>Bonaventure Kasama, Pharmaceutical Society of Zambia</td>
<td>Cleto Mweemba, Zambia Society of Physiotherapy</td>
</tr>
<tr>
<td>Elizabeth Kalunga, Ministry of Health</td>
<td>Margaret Maimbolwa, University of Zambia</td>
</tr>
<tr>
<td>Thabale Ngulube, Centre for Health, Science and Social Research</td>
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<tr>
<td>Morocco</td>
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<tr>
<td>Dris Chennaq, Association Marocaine des Sciences Infirmières et Techniques Sanitaires</td>
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<tr>
<td>Other</td>
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<tr>
<td>Francis Supparayen, n.a.</td>
<td>Jintana Yunibhand, Nurses Association of Thailand</td>
</tr>
<tr>
<td>Lian-Hua Huang, Taiwan Nurses Association</td>
<td>Wanda Jaskiewicz, IntraHealth</td>
</tr>
</tbody>
</table>
Stakeholders interviewed individually

**Europe**
- Brenda Meyers, WCPT
- Clarisse Delorme, WMA
- David Benton, ICN
- Elizabeth Adams, ICN
- Eric Roodenbeke, IHF
- Jean-Luc Eisele, WDF/FDI
- Julia Seyer, WMA
- Luc Besancon, IPF/FIP
- Mubashar Sheikh, GHWA
- Taina Nakari, WHO/GHWA

**Uganda**
- Amande Simon Ongoa, Uganda Nurses and Midwives Union
- Charles Rwenyonyi, Uganda Dental Association
- Jacinto Amandua, Ministry of Health
- Janet Obuni, Uganda Nurses and Midwives Union
- Juliet Bataringaya, WHO
- Margaret Byabakama, Uganda Heart Institute

**Zambia**
- Cleto Mweemba, Zambia Society of Physiotherapy
- Thabale Ngulube, Centre for Health, Science and Social Research

**Other**
- Francis Supparayen, n.a.

Participants in the focus group discussion (Uganda)
- Alison Kantarama, Uganda National Association of Hospital Administrators
- Ida Mpaata, Baylor College of Medicine
- Janet Obuni, Uganda Nurses and Midwives Union
- Margaret Byabakama, Uganda Heart Institute
# Annex 2

## Online Survey Questionnaire (English)

**PPE Campaign Evaluation**

### About You

Thank you for participating in this survey to evaluate the Positive Practice Environments (PPE) Campaign. Please be assured that your responses will be treated confidentially and your input will be released only in summaries with no identification of individuals or organisations. When replying to open-ended questions please feel free to take as much space as necessary. Please note that questions with an asterisk (*) are mandatory.

Your time and input are highly appreciated!

**1. What is your professional background? (please check all that apply)**

- [ ] Doctor
- [ ] Nurse
- [ ] Dentist
- [ ] Pharmacist
- [ ] Physiotherapist
- [ ] Health manager
- [ ] Other health professional
- [ ] Academic
- [ ] Advocate
- [ ] Government representative
- [ ] Other

Please specify

---

**2. Which organisation are you mainly affiliated with?**

---

**3. Where are you mainly based?**

- [ ] Europe
- [ ] Morocco
- [ ] Uganda
- [ ] Zambia
- [ ] Other

Please specify
### PPE Campaign Evaluation

<table>
<thead>
<tr>
<th>4. Are you male or female?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Male</td>
</tr>
<tr>
<td>☐ Female</td>
</tr>
</tbody>
</table>

### PPE Campaign Summary

<table>
<thead>
<tr>
<th>5. How have you been involved with the PPE campaign so far? (please check all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Global steering committee</td>
</tr>
<tr>
<td>☐ National steering committee</td>
</tr>
<tr>
<td>☐ Partner organisation at global level</td>
</tr>
<tr>
<td>☐ Partner organisation at regional level</td>
</tr>
<tr>
<td>☐ Partner organisation at national level</td>
</tr>
<tr>
<td>☐ Partner organisation at local level</td>
</tr>
<tr>
<td>☐ I have not yet been involved with the campaign</td>
</tr>
<tr>
<td>☐ Other</td>
</tr>
<tr>
<td>Please specify</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Please list other campaigns that you may (have been) involved in that relate to health workforce issues.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. What are/were the PPE campaign’s key STRENGTHS (i.e. positive characteristics of the campaign)?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8. What are/were the campaign’s key WEAKNESSES (i.e. limitations of the campaign)?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9. What may be key upcoming OPPORTUNITIES for the campaign (i.e. external factors that may positively influence the campaign)?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>
**PPE Campaign Evaluation**

10. What, in your view, are potential upcoming THREATS to the campaign (i.e. external factors that may cause challenges for the campaign)?

---

**PPE Campaign Activities and Outcomes**

11. Please mention three key PPE campaign activities conducted since the start of the campaign.

---

*12. How do you rate the success of the PPE campaign in the following domains?*

<table>
<thead>
<tr>
<th></th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>I cannot say</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raising awareness of issues relating to PPE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developing high-quality advocacy materials on PPE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disseminating materials and sharing information on PPE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Building alliances among key stakeholders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mobilising communities and the wider public</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creating pressure on government</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influencing policy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influencing practice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increasing financial resources for improving practice environments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please specify

---

13. What is the PPE campaign's most important achievement so far?

---

14. How could the PPE campaign be made more successful?
# PPE Campaign Evaluation

15. In 2011, which PPE campaign-related activities have you been involved in?

[ ]

---

## PPE Campaign Tools and Materials

16. Which PPE campaign tools and materials have you used, and how?

[ ]

17. Have you ever been to the PPE campaign website (http://www.ppecampaign.org/) before participating in this survey?

- [ ] No
- [ ] Yes, once
- [ ] Yes, up to three times
- [ ] Yes, four to ten times
- [ ] Yes, more than ten times

18. Have you ever downloaded documents from the PPE campaign website prior to participating in this survey?

- [ ] No
- [ ] Yes, once
- [ ] Yes, up to three times
- [ ] Yes, four to ten times
- [ ] Yes, more than ten times

Please comment: 

[ ]

---

**19. How do you rate the following tools?**

<table>
<thead>
<tr>
<th>Tool</th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>I cannot say</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocacy guide for health professionals</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>PPE campaign fact sheets</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>PPE campaign website</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Other</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

Please specify: 

[ ]
### PPE Campaign Evaluation

20. Please comment on how these tools may be improved.

[Blank space for comments]

21. What additional tools should be created to help drive forward the PPE campaign?

[Blank space for comments]

### PPE Campaign Stakeholders

**22.** Which stakeholders in your country/region have been most active in driving the campaign forward?

[Blank space for comments]

23. Which stakeholders are not currently engaged but should be engaged?

[Blank space for comments]

24. What may prevent key stakeholders from actively participating in the campaign?

[Blank space for comments]

25. What may encourage key stakeholders to actively participate in the campaign?

[Blank space for comments]

### Conclusion and Outlook

**26.** If there was one thing you could change about the PPE campaign, what would it be?

[Blank space for comments]

27. What are the key lessons learned from the campaign so far?

[Blank space for comments]
<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>28. What FINANCIAL, HUMAN or OTHER (e.g. office space, tools, etc.) resources could your organisation make available (per year) to support the campaign?</td>
<td></td>
</tr>
<tr>
<td>29. Which organisation(s) may be approached for funding, and how?</td>
<td></td>
</tr>
<tr>
<td>30. Do you have any other comments, questions or suggestions?</td>
<td></td>
</tr>
</tbody>
</table>
Evaluation de la campagne EFP

Informations personnelles

Merci de participer à cette enquête en vue de l’évaluation de la campagne Environnements favorables à la pratique des professionnels de la santé (EFP). Vos réponses seront traitées de façon confidentielle et vos contributions n’apparaîtront que dans des résumés sans aucune identification possible des individus ou organisations sources. N’hésitez pas à utiliser tout l’espace nécessaire lorsque vous répondez à des questions ouvertes. Veuillez noter que les questions marquées d’un astérisque (*) sont obligatoires.

Votre disponibilité et votre contribution sont grandement appréciées !

*1. Quel est votre profil professionnel ? (Veuillez cacher toutes les réponses qui conviennent)

- Docteur
- Infirmière
- Dentiste
- Pharmacien
- Kinésithérapeute
- Chef de service
- Autre professionnel de la santé
- Universitaire
- Militant
- Représentant du gouvernement
- Autre

Veuillez préciser

2. A quelle organisation êtes-vous affilié ?

3. Où êtes-vous basé ?

- Europe
- Maroc
- Ouganda
- Zambie
- Autre

Veuillez préciser
* 5. Dans quelle capacité avez-vous été impliqué dans la campagne EFP à ce jour ?

(Veuillez cocher toutes les réponses qui conviennent)

☐ Comité de suivi mondial
☐ Comité de suivi national
☐ Organisation partenaire au niveau international
☐ Organisation partenaire au niveau régional
☐ Organisation partenaire au niveau national
☐ Organisation partenaire au niveau local
☐ Je n’ai encore pas été impliqué dans la campagne
☐ Autre

Veuillez préciser

6. Veuillez lister les autres campagnes auxquelles vous avez participé se rapportant à la question des personnels de santé.

* 7. Quelles sont/étaient les FORCES principales de la campagne EFP (les caractéristiques positives de la campagne) ?

* 8. Quelles sont/étaient les FAIBLESSES principales de la campagne EFP (les limites de la campagne) ?
Evaluation de la campagne EFP

9. Quelles sont les OPPORTUNITÉS principales à venir pour la campagne EFP (les facteurs d’origine externe positifs pour la campagne) ?

10. Quelles sont, selon vous, les MENACES potentielles à venir pour la campagne EFP (facteurs d’origine externe susceptibles de poser des problèmes à la campagne) ?

Activités et résultats de la campagne EFP

11. Veuillez mentionner trois activités clés organisées depuis le début de la campagne.

*12. Quel est selon vous le degré de succès de la campagne EFP dans les domaines suivants ?

<table>
<thead>
<tr>
<th>Sensibilisation sur les questions relatives aux EFP</th>
<th>Excellente</th>
<th>Bon(ne)</th>
<th>Assez bon(ne)</th>
<th>Limité(e)</th>
<th>Je ne sais pas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Développement d’outils de plaidoyer de haute qualité sur les EFP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diffusion des outils et partage de l’information sur les EFP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Création d’alliances entre les acteurs principaux</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mobilisation des communautés et du public au sens large</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pression sur le gouvernement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influence sur les politiques</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influence sur les pratiques</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Augmentation des ressources financières pour l’amélioration des environnements de soins</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autre</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Veuillez préciser
Evaluation de la campagne EFP

13. Quel est, à ce jour, le résultat le plus important de la campagne EFP ?

14. Comment pourrait-on améliorer le succès de la campagne EFP ?

15. En 2011, dans quelles activités de la campagne EFP avez-vous été impliqué ?

Outils et ressources de la campagne EFP

16. Quels outils et ressources de la campagne EFP avez-vous utilisés, et comment ?

17. Aviez-vous déjà visité le site internet de la campagne EFP (http://www.ppecampaign.org/fr) avant de participer à cette enquête ?
   - Non
   - Oui, une fois
   - Oui, de une à trois fois
   - Oui, de quatre à dix fois
   - Oui, plus de dix fois

18. Aviez-vous déjà téléchargé des documents du site internet de la campagne EFP avant de participer à cette enquête ?
   - Non
   - Oui, une fois
   - Oui, de une à trois fois
   - Oui, de quatre à dix fois
   - Oui, plus de dix fois

Veuillez commenter
Evaluation de la campagne EFP

* 19. Quelle est votre opinion sur les outils suivants ?

<table>
<thead>
<tr>
<th></th>
<th>Excellent(e)</th>
<th>Bon(ne)</th>
<th>Assez bon(ne)</th>
<th>Mauvais(e)</th>
<th>Je ne sais pas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guide de plaidoyer pour les professionnels de la santé</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Fiches d'information de la campagne EFP</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Site internet de la campagne EFP</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Autre</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Veuillez préciser

20. Comment, selon vous, ces outils pourraient être améliorés ?

21. Quels outils supplémentaires pourraient être créés pour faire avancer la campagne EFP ?

Acteurs de la campagne EFP

* 22. Quels ont été les acteurs les plus actifs de la campagne dans votre pays/région ?

23. Quels acteurs non impliqués à ce jour devraient être impliqués ?

24. Qu'est-ce qui empêchent certains acteurs clé de participer activement à la campagne ?

25. Qu'est-ce qui pourrait encourager la participation active d'acteurs clé à la campagne ?

Conclusion et perspectives
<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>*26. Si vous pouviez changer une chose au sujet de la champagne EFP, quelle serait-elle ?</td>
<td></td>
</tr>
<tr>
<td>27. Quelles sont les leçons principales de la campagne à ce jour ?</td>
<td></td>
</tr>
<tr>
<td>28. Quelles ressources FINANCIERES, HUMAINES ou AUTRES (ex: espace de travail, outils, etc.) votre organisation pourrait-elle mettre à disposition (par an) pour appuyer la campagne ?</td>
<td></td>
</tr>
<tr>
<td>29. Quelle(s) organisation(s) pourrait(ait) être approchée(s) pour contribuer au financement de la campagne, et comment ?</td>
<td></td>
</tr>
<tr>
<td>30. Avez-vous d'autres remarques, questions ou suggestions ?</td>
<td></td>
</tr>
</tbody>
</table>
## Annex 3

### PPE Campaign Evaluation Analytical Framework

#### Status quo

What is the campaign status quo, both globally and at country level, at the end of 2011?

<table>
<thead>
<tr>
<th>What is the campaign status quo on global level with an emphasis on activities conducted in 2011</th>
<th>Review of background documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess campaign status quo in Morocco, Uganda and Zambia, particularly in regard to activities conducted in 2011</td>
<td>Online survey</td>
</tr>
<tr>
<td></td>
<td>Key stakeholder interviews on global and country level</td>
</tr>
</tbody>
</table>

#### Leaders and other stakeholders

Who are the key stakeholders driving the campaign forward and what are their concerns?

<table>
<thead>
<tr>
<th>Assess key stakeholders driving forward/who used to drive forward/who may drive forward in the future the campaign on global level</th>
<th>Review of background documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess key stakeholders driving forward/who used to drive forward/who may drive forward in the future the campaign on country level</td>
<td>Online survey</td>
</tr>
<tr>
<td>Conduct rapid analysis of their strategic interests and concerns relevant to the campaign</td>
<td>Key stakeholder interviews on global and country level</td>
</tr>
</tbody>
</table>

#### Campaign tools and materials

What are the tools driving forward the campaign and what is their respective usefulness?

<table>
<thead>
<tr>
<th>Summarise use of website</th>
<th>Analysis and interpretation of access data (if available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summarise type and location of downloads from website</td>
<td>Analysis and interpretation of download data (if available)</td>
</tr>
<tr>
<td></td>
<td>Online survey</td>
</tr>
<tr>
<td>Compile complete list of campaign materials developed</td>
<td>Review of materials</td>
</tr>
<tr>
<td>Conduct rapid analysis of content of materials</td>
<td>Online survey</td>
</tr>
<tr>
<td>Compile data on dissemination (number, type, method, geographic area of dissemination)</td>
<td>Key stakeholder interviews on global and country level</td>
</tr>
<tr>
<td>Conduct rapid investigation on actual use of tools and materials</td>
<td>Analysis based on findings through the above methods</td>
</tr>
<tr>
<td>Develop recommendations for improving use and content of tools and materials</td>
<td></td>
</tr>
</tbody>
</table>
## Positive Practice Environments Campaign

### Global level influencing

**What advocacy successes have been achieved on global level, and how?**

- Assess materials used in advocacy
- Assess advocacy activities and opportunities used for influencing (e.g. meetings where PPE campaign partners made systematic input)
- Assess advocacy successes (e.g. WHA resolutions)
- Conduct rapid assessment of advocacy strategy
- Assess media use and uptake
- Assess popular and community mobilisation

<table>
<thead>
<tr>
<th>Resource Use</th>
<th>Methodologies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of background documents</td>
<td>Online survey</td>
</tr>
<tr>
<td>Key stakeholder interviews on global level</td>
<td>Analysis based on findings gained through the above methods</td>
</tr>
<tr>
<td>Review of media reports (if applicable)</td>
<td></td>
</tr>
</tbody>
</table>

### Country level influencing

**What advocacy successes have been achieved on country level, and how?**

- Assess PPE advocacy activities by country
- Assess opportunities used for influencing
- Assess materials used for advocacy
- Assess PPE advocacy alliances
- Conduction rapid assessment of advocacy strategy
- Assess PPE campaign advocacy successes (i.e. changes in policy and/or practice)
- Assess media use and uptake
- Assess popular and community mobilisation

<table>
<thead>
<tr>
<th>Resource Use</th>
<th>Methodologies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of background documents</td>
<td>Online survey</td>
</tr>
<tr>
<td>Key stakeholder interviews on country and global level</td>
<td>Conclusions based on findings gained through the above methods</td>
</tr>
<tr>
<td>Review of media reports (if applicable)</td>
<td></td>
</tr>
</tbody>
</table>

### Resources

**What are the resources spent on the campaign so far and which ones are available in future?**

- Conduct rapid assessment of financial and human resources invested so far on global level
- Conduct rapid assessment of financial and human resources invested so far on country level
- Identify potential additional resources that may be made available or tapped into on global level
- Identify potential additional resources that may be made available or tapped into on country level

<table>
<thead>
<tr>
<th>Resource Use</th>
<th>Methodologies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of background documents</td>
<td>Online survey</td>
</tr>
<tr>
<td>Key stakeholder interviews on country and global level</td>
<td></td>
</tr>
<tr>
<td>Review of media reports (if applicable)</td>
<td></td>
</tr>
</tbody>
</table>
### Other enabling and disenabling factors

**What are the enabling vs disenabling factors for successful continuation of the campaign?**

- Assess factors that encourage individuals and organisations to continue the campaign on global level
- Assess factors that encourage individuals and organisations to continue the campaign on country level
- Assess factors that constitute challenges for individuals and organisations to continue the campaign on global level
- Assess factors that constitute challenges for individuals and organisations to continue the campaign on country level

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Online survey</td>
<td>• Key stakeholder interviews on country and global level</td>
</tr>
</tbody>
</table>
Annex 4

Terms of Reference for Assessment of the PPE Campaign

Introduction

Health workers are the heart and soul of health systems. And yet, the world is faced with a chronic shortage - an estimated 4.2 million health workers are needed to bridge the gap. This critical shortage is recognized as one of the most fundamental constraints to achieving progress on health and reaching health and development goals.

The Global Health Workforce Alliance (the Alliance) was launched in 2006 with the objective of serving as a common platform and a catalyst for an effective response to the health workforce crisis at global, regional and country level. Its mission is to "advocate and catalyse global and country actions to resolve the human resources for health crisis, to support the achievement of the health-related millennium development goals and health for all."

One of the issues aggravating the shortage of health workforce is migration - either in-country or out-of-the-country migration. Poor working conditions are one of the main push factors for health professionals to migrate or change employment. Therefore, developing positive practice environments is a proactive step to addressing and resolving a broad range of issues within any health care environment.

Positive practice environments are cost-effective health care settings that support excellence and decent work, have the power to attract and retain staff and to improve patient satisfaction, safety and outcomes. Characteristically such settings:

1. Ensure the health and, safety and well-being of staff
2. Support quality of patient care
3. Improve the motivation, productivity and performance of individuals and organisations.

The Positive Practice Environments Campaign (PPE Campaign) is an initiative launched by the International Council of Nurses, International Hospital Federation, International Pharmaceutical Federation, World Confederation for Physical Therapy, FDI World Dental Federation, and the World Medical Association with the financial support of the Alliance. The PPE is a multi-professional country and facility-centred focused initiative to improve work environments and aid in-staff recruitment and retention through the development of positive practice environments in all health care settings.

In 2008 the PPE Campaign toolkit for health professionals and managers was piloted during the First Global Forum on Human Resources for Health held in Kampala, Uganda. Since then the PPE Campaign has forged its management structure at the international and national levels and established solid advocacy tools such as the PPE Campaign website (www.ppecampaign.org), a biannual newsletter, a brochure and press releases. The country based activities for the PPE campaign started during 2010 in 3 countries: Morocco, Uganda and Zambia. Baseline research on health worker situation were conducted in all three countries and campaigns were set up to address the issues identifies in the research.

Rationale for the assessment of the PPE campaign

At the global level the campaign activities have already been going on for over three years, when the country based activities have been running only for less than year. Even though an evaluation was not foreseen originally yet at this time, it was agreed by the core partners of the campaign...
and the Alliance to review the progress to date to inform the decisions on continuing the campaign over the next strategic period of the Alliance.

An analysis of the campaign's first years of existence will allow the partners to review the progress made, document the lessons learnt, and concentrate on and consolidate further the campaign's areas of strength and address its weaknesses. It will also provide guidance and suggestions on the way forward with the campaign, taking into consideration the resource limitations.

**Objectives of the assessment**

It is intended that the objectives of the assessment of the PPE campaign be conducted to:

1. document experiences and lessons learnt
2. assess the results of the campaign to date, and the extent of its contribution to national or trans-national policy dialogue
3. identify successful approaches and methods used
4. inform the partners and stakeholders on the progress made and chart a way forward
5. give recommendations on continuing the campaign in the existing campaign countries and replicating the campaign activities in other settings

The assessment is expected to take place at two levels:

1. Assessment of the global level campaign, including the planning and engagement of the partners for the campaign.
2. Assessment of the country level activities.

**Methods**

The consultant is expected to:

- Conduct the assessment through desk review of documents and through key informant interviews and other appropriate qualitative methods with the participating organizations as well as other relevant stakeholders.
- Conduct a desk review of all the documentation related to the planning, implementation or reporting of the campaign, including the campaign materials.
- Review the process of setting up the global campaign and assess its achievements
- Review the processes used for setting up the country based campaign, assess the feasibility of replicating the process in different setting, in particular in resource constrained situations

The consultant is expected to make a field visit to the programme countries (1-2) and conduct the assessment through review of documents and interviews and other appropriate qualitative methods with key informants as well as visits and interviews at the sites where the campaign was organized or the campaign targeted. The countries will be selected based on the interviews and knowledge on the progress in countries.

**Expected results**

- A report detailing the methodology used in the assessment, findings covering achievements, constraints, value for money, and possible way forward on the issues identified in the above scope of work. The report should also the detail lessons learnt from the campaigns.
- The report, excluding attachments, should not be more than 30 pages long, with sections on, but not limited to:
  - Introduction and methodology
  - Assessment of the campaign at global level
  - Assessment of the campaign at country levels (in 1-2 countries)
  - Lessons learnt and recommendations for the way forward
- Copies of instruments such as questionnaires, key informant guides and observation checklists to be included as separate annexes.
- Policy options and recommendations on the way forward based on the results of the assessment on the way forward, in particular in relation to continuing or setting up and conducting the country based PPE campaigns.

**Approximate Timeframe**

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<tr>
<th>Task</th>
<th>Month 1</th>
<th>Month 2</th>
<th>Month 3</th>
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<tr>
<td>Desk review of documents (one week)</td>
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<tr>
<td>Interviews with key informants at global level (10 days) and writing</td>
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<td>Field visits</td>
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<td>Preliminary findings (by 8 December)</td>
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<td>Drafting of the report (draft ready 4 January)</td>
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<td>Review by participating organizations</td>
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<td>Finalization of the report</td>
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