### Abbreviations and acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>Alliance</td>
<td>Global Health Workforce Alliance</td>
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<tr>
<td>AMREF</td>
<td>African Medical and Research Foundation</td>
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<tr>
<td>CCF</td>
<td>Country Coordination and Facilitation</td>
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<tr>
<td>DFID</td>
<td>United Kingdom Department for International Development</td>
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<tr>
<td>HBCI</td>
<td>High Burden Countries Initiative</td>
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<tr>
<td>HHA</td>
<td>Harmonizing Health in Africa</td>
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<tr>
<td>HRH</td>
<td>human resources for health</td>
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<tr>
<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<td>IHP+</td>
<td>International Health Partnership and related initiatives</td>
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<tr>
<td>KD-AGA</td>
<td>Kampala Declaration and the Agenda for Global Action</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
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<tr>
<td>NCD</td>
<td>noncommunicable disease</td>
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<tr>
<td>PEPFAR</td>
<td>United States President’s Emergency Plan for AIDS Relief</td>
</tr>
<tr>
<td>SWApS</td>
<td>sector-wide approaches</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
</tr>
<tr>
<td>UZIMA</td>
<td>Kiswahili word for the abundant life – is a youth empowerment NGO</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>WHPA</td>
<td>World Health Professions Alliance</td>
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<tr>
<td>WHR</td>
<td>World Health Report</td>
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*acting as the host organization for, and secretariat of, the Global Health Workforce Alliance*, 2012

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The Global Health Workforce Alliance (the ‘Alliance’) was launched in 2006 as a response to the global human resources for health (HRH) crisis. Its added value is its mandate to support, convene and harness the capacities of its global partners and members, working across the multiple dimensions of HRH in the health, education, finance and labour sectors. This has enabled a stronger, multi-sectoral focus on HRH within the global health agenda. At the heart of the Alliance is the vision that “all people everywhere will have access to a skilled, motivated and supported health worker, within a robust health system”.

The Alliance plays a catalytic role, addressing the specific and shared challenges in HRH at national, regional and global levels, including: shortages, inequitable distribution, labour mobility and migration, and the working and living environments of health workers. An independent external evaluation of the Alliance operations in 2006-11 was published in 2012. It documented the collective achievements, highlighted some areas in need of improvement, and found that the results in its first five years represented good value for money. The Alliance Board has attentively examined the independent report, took account of its findings, and noted the progress registered as evidence of the multi-sectoral HRH momentum that now exists.

HRH challenges yet persist. Greater collaboration, outputs and results are required to achieve the vision of the Alliance and in doing so address the most critical bottleneck in the attainment of the health Millennium Development Goals (MDGs) and universal health coverage. Moreover, a rapidly evolving global health and development context demands revitalised attention, strategic intelligence and renewed action on HRH. The challenge is to address the past and present gaps while simultaneously anticipating and delivering the transformative actions required for the future.

The members, partners, Board and Secretariat of the Alliance have taken account of this context in developing its 2013-2016 strategy. This recognises that its implementation will unfold in a period of competing attention for political capital and resources, extraordinary changes in the supply and demand for health care, and an evolving discourse for global health and development in the post-2015 agenda. Key pillars in the new strategy include a focus on accountability for results and an enhanced partnership model that multiplies the capacities of its individual members as a collective enterprise. Both will lend support to countries’ efforts at strengthening their health workforce and achieving improved health outcomes.

The Alliance will consider its strategy for 2013-2016 and its current mandate to 2016 accomplished if the following results are achieved:

1. Commitments to train, deploy and retain at least an additional 2.6 million health workers, in support of the United Nations Secretary-General’s Global Strategy for Women’s and Children’s Health and universal health coverage, are delivered and being implemented;
→ evidence-based quality HRH plans, developed through inclusive mechanisms of coordination among HRH stakeholders, are integrated within national health strategies and implemented in at least 75% of the Alliance’s priority countries;
→ a new, equitable, long-term vision for HRH, that seeks to eliminate avoidable morbidity and mortality and promote well-being, is firmly embedded in the post-2015 development agenda;
→ accountability for HRH results is ensured as an integral part of existing health governance and monitoring platforms; and
→ HRH stakeholders mobilized to take proactive roles in support of national HRH development priorities within a health systems strengthening framework.

The Board invites members, partners and other HRH stakeholders to commit to this vision and support the successful implementation of the Alliance strategy in the next four years. Achieving these results and ensuring that all people have access to a health worker is our collective responsibility.

Dr Masato Mugitani, Chair of the Board

Alliance Board

• Prof Ernest Aryeetey, University of Ghana
• Dr Cristian Baeza World Bank
• Dr Kazem Behbehani, Kuwait
• Ms Catherine Bonnau, France
• Prof Eric Buch, University of Pretoria
• Dr Francisco de Campos, Brazil
• Ms Susan Chandler, DFID
• Ms Frances Day-Stirk, International Confederation of Midwives
• Dr Carissa Etienne, WHO, Geneva
• Dr Bjarne Garden, Norway
• Amb Eric Goosby, PEPFAR
• Prof Samuel Kingue, Cameroon

Dr Mubashar Sheikh, Executive Director

• Dr Otnmar Kloiber, World Health Professions Alliance
• Dr Jinfeng Liu, China
• Dr Carolyn Miller, Merlin, UK
• Dr Srinath Reddy, Public Health Foundation India
• Dr George Shakarishvili, Global Fund to Fight AIDS, Tuberculosis and Malaria
• Dr Agnes Soucat, African Development Bank
• Dr David Weakliam, Irish Aid
• Prof Miriam Were, UZIMA Foundation, Kenya
The Global Health Workforce Alliance (the Alliance) was launched in 2006 to serve as a common platform for human resources for health (HRH) practitioners, stakeholders and advocates to collaborate in addressing the global and multi-faceted HRH crisis (Annex 1).

In its first phase (2006–2012) the Alliance actively contributed to an HRH movement in line with its purpose of spurring a “Decade of Action” in this neglected key component of health systems. During this period, collective activities and inputs resulted in significant progress for health workforce development (Annex 2).

In March 2008 the Alliance Secretariat convened the First Global Forum on Human Resources for Health, which resulted in the adoption of the Kampala Declaration and Agenda for Global Action (KD-AGA); this has become an overarching framework of reference for HRH development at all levels. The Second Global Forum on Human Resources for Health, held in Bangkok, Thailand in January 2011, provided an opportunity to reconvene the global HRH community to review progress since the First Global Forum, and renew the momentum and commitment to health workforce development and the principles and strategies of the KD-AGA.

As a result of these efforts, national, regional and global leadership now recognize the critical importance of investing in and developing a supported health workforce to improve health outcomes. These gains are, however, vulnerable: without sustained effort, the increased recognition of HRH risks being diluted to just another element of the health systems strengthening agenda.

Indeed, the HRH crisis is still an acutely limiting factor in countries’ attempts to reduce maternal and child mortality, to control priority infectious and non-communicable diseases, and to attain the broader target of universal health coverage. This is due to a persisting gaps in financing and support for the training and deployment of health workers. Addressing these challenges and ensuring that the Alliance remains relevant to and influences the evolving global health and development landscape (Annex 3) are priorities of its governing Board, members and partners.

An independent external evaluation found that the Alliance Secretariat’s work in 2006–2011 represented “good value for money”, complementing the findings of earlier assessments and analyses. The evaluation enabled the Alliance Board to review the current situation, assess progress and revise its strategies to overcome the health workforce challenges that lie ahead (Annex 4).

The Alliance is firmly committed to achieving greater results, fulfilling its mandate and strengthening its operations.
The new phase of the alliance (2013-2016)

In the context of the complex and unfinished HRH agenda, an uncertain global development scenario, a crowded health landscape and stagnating resources for health, it is imperative that the Alliance retains its leadership position, remains responsive and concentrates its efforts on the priority health workforce actions where it has a comparative advantage.

The Alliance’s vision remains that “all people everywhere will have access to a skilled, motivated and supported health worker, within a robust health system”. While preserving the original core functions\(^1\), the Alliance has adapted its mission to the new environment in which it operates: “to advocate and catalyse country and global actions to address human resources for health challenges, contributing towards and beyond the health-related Millennium Development Goals and for universal health coverage.”

The Alliance will remain an influential and credible coalition of players, anticipating, responding to and monitoring key developments and challenges in the evolving HRH environment. Recognizing the importance of building on its achievements so far, and realigning its focus to respond to the changing global landscape, the second phase of the Alliance (2013–2016) will be characterized by:

- transformed strategic objectives with prioritization of high value-added areas of work where the Alliance has comparative strength;

- greater emphasis on results, with improved clarity on the specific roles of members, partners, regional and global networks, and countries, along with its own governing structures (Board and Secretariat); and

- an enhanced partnership model, with a progressive shift of responsibility for activities to members and partners, and the facilitating role of the Secretariat.

While many have contributed to addressing the HRH crisis, the extent of progress realized thus far would not have been achieved if the Alliance had not existed. Similarly, achieving the ambitious vision of change in HRH by 2016 (Box 1) will require greater synergy and action by all stakeholders. Indeed, delivering this vision will only be possible through collective efforts in support of country actions to strengthen their health workforce and thereby to enhance integrated health systems development. The role of the Alliance governance structures will be to catalyse and foster an enabling environment for these actions. The Alliance Secretariat will support the achievement of this vision through the functions of advocacy, brokering knowledge, and convening partners to promote synergies.

The Alliance was established with an original 10-year time frame. This Strategy covers activities to achieve its mandate during 2013–2016, and serves as a foundation for an exit strategy, envisaging a progressive transition of functions that should continue beyond this time frame to its members and partners, unless otherwise decided by the Board.

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\(^1\) Advocacy, brokering knowledge, convening.
A vision of success in 2016

In 2016 the Alliance will collectively consider its mission accomplished if the following results are achieved:

- commitments to train, deploy and retain at least an additional 2.6 million health workers, in support of the United Nations Secretary-General's Global Strategy for Women's and Children’s Health and universal health coverage, are delivered and being implemented;
- evidence-based quality HRH plans, developed through inclusive mechanisms of coordination among HRH stakeholders, are integrated within national health strategies and implemented in at least 75% of the Alliance’s priority countries;
- a new, equitable, long-term vision for HRH, that seeks to eliminate avoidable morbidity and mortality and promote well-being, is firmly embedded in the post-2015 development agenda;
- accountability for HRH results is ensured as an integral part of existing health governance and monitoring platforms; and
- HRH stakeholders mobilized to take proactive roles in support of national HRH development priorities within a health systems strengthening framework.
Ultimately, the desired results of the Alliance relate to greater access to, and improved performance of, the health workforce in countries as a critical and integral element of health systems strengthening and universal health coverage goals. The Alliance will achieve this by providing an enabling environment to mobilize global, regional and national leadership to adopt and invest in the most appropriate and effective policy options for health workforce development, in collaboration with relevant domestic stakeholders and the international community, through three core objectives:

1. **Enabling solutions**: Promote the adoption of coherent policies and investment decisions through advocacy to strategic constituencies and by stewarding a global HRH agenda.

2. **Catalysing actions**: Foster interaction for more effective HRH coordination, policy dialogue and actions across different sectors and constituencies in society, including government and private sector, civil society and professional associations.

3. **Ensuring results and accountability**: Monitor and report on HRH developments and commitments through a process of accountability underpinned by cutting-edge intelligence and analysis.

### 3.1 Enabling solutions

Advocacy, communication and sensitization activities will be undertaken to promote the adoption of policies and investment decisions that are coherent with the universal health coverage goal and its HRH needs. These activities will target strategic constituencies, across and within sectors, and increasingly aim at the higher political levels. A key priority in this context will be to broker global consensus on appropriate HRH strategies and priorities in the evolving development discourse and ensure that they are embedded within the universal health coverage and post-MDG agenda.

The Alliance will be an inclusive HRH hub, open to contributions from each of its members and other constituencies, and where policy dialogue and advocacy initiatives of a strategic nature can converge or originate. In addition to the direct involvement of the Board and the Secretariat, the latter will gather and disseminate strategic information on global HRH developments, and flag opportunities for policy dialogue to members and partners, enabling them to be influential advocates.

In order to be effective, the Alliance advocacy will target the right audiences, using appropriate forums and relevant channels and delivery mechanisms (Table 1).

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The Strategy differentiates between Alliance-wide achievements, to which members, partners and countries contribute according to their respective roles and mandates, and the specific results expected from the Secretariat. The Secretariat’s annual workplans will detail its expected results, and its human and financial resource requirements will be determined accordingly.
However, the identification of opportunities for policy dialogue and advocacy does not imply that engagement is limited to these events only; rather it illustrates the type of partners with whom the Alliance needs to engage.

### Table 1

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<tr>
<th>Table 1</th>
<th>High-level advocacy approach for greater investment in HRH</th>
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<tr>
<td><strong>Key partners to engage</strong></td>
<td><strong>National level</strong></td>
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<tr>
<td>Heads of government</td>
<td>African Union</td>
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<tr>
<td>Ministries of health, finance, education, labour</td>
<td>ASEAN</td>
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<tr>
<td>National parliaments</td>
<td>UNASUR</td>
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<tr>
<td>Private sector</td>
<td>European Commission</td>
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<tr>
<td><strong>Forums</strong></td>
<td>Cabinet meetings</td>
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<td></td>
<td>Annual health sector reviews</td>
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<td></td>
<td>HRH coordination committee meetings (CCF approach)</td>
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<td>National HRH conference advocacy events</td>
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<td>National HRH observatories</td>
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<tr>
<td><strong>Actors delivering advocacy messaging</strong></td>
<td>Coalitions of Alliance members</td>
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<tr>
<td></td>
<td>Health Workforce Advocacy Initiative, other civil society and private sector organizations with country presence</td>
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AAAH, Asia-Pacific Action Alliance on Human Resources for Health; ASEAN, Association of Southeast Asian Nations; CCF, Country Coordination and Facilitation; G8, a forum for the governments of eight of the world’s largest economies; G20, Group of Twenty Finance Ministers and Central Bank Governors; Global Fund, Global Fund to Fight AIDS, Tuberculosis and Malaria; HRH, human resources for health; IMF, International Monetary Fund; OECD, Organization for Economic Co-operation and Development; UN, United Nations; UNASUR, Union of South American Nations; WB, World Bank; CHOGM: Commonwealth Heads of Government Meeting.
**Expected results**

**Alliance-wide:**
- Global consensus adopted on appropriate HRH strategies and priorities in the post-MDG agenda and for universal health coverage.
- HRH-specific actions and commitments included in political declarations and investment decisions.
- Increased volumes and improved quality of HRH investments achieved, by both domestic and international sources.
- Regular HRH consultations convened by regional, sub-regional networks and intergovernmental organizations.

**Secretariat-specific:**
- The HRH crisis recognized as a global issue, and not limited to 57 crisis countries.
- HRH mainstreamed in proceedings, political declarations and commitments of key global and regional health and development events.
- Thematic issue papers on key HRH topics published and yearly campaigns undertaken.
- Intelligence and information on HRH policy dialogue opportunities gathered and disseminated.
- Two global forums on HRH successfully organized.
- Advocacy support and materials made available to members and partners.

**3.2 Catalysing actions**

The Alliance Secretariat will foster interaction for more effective HRH coordination, policy dialogue and actions across different sectors, constituencies and stakeholder groups in countries, embedded within an integrated health systems strengthening approach. In the last three years the Secretariat has expanded its focus on countries by developing an approach and a set of principles to provide catalytic support to national health workforce coordination and development processes, called Country Coordination and Facilitation (CCF). This includes advocacy for more inclusive coordination and planning processes, provision of backstopping and facilitation of support by partners with the requisite capacity, and demand-driven seed funding based on country requests. This approach was considered effective by multiple independent evaluations in fostering collaboration, catalysing policy dialogue, and planning and action by national stakeholders.

Moving forward, this experience will be further improved and refined, so that HRH coordination and planning processes become an integral part of the wider national (health) policy dialogue, are embedded in existing mechanisms and are driven through members and partners with a local presence, including WHO country offices.

At the heart of country coordination and facilitation is country ownership of a broad framework of principles and actions to be adapted to country circumstances and national health policies, and not a blueprint of prescribed activities.

In essence, the principle of creating a space for interaction and for more effective HRH coordination and policy dialogue will be retained, but the approach will be streamlined (Annex 5), with Alliance partners providing direct country support wherever possible, and the Secretariat facilitating their work.

Complementarity and strategic alignment with WHO will also be highlighted and more clearly communicated. In particular the facilitation of
Principles underpinning country coordination and facilitation processes for HRH development

- Promote the centrality of an HRH committee to bring together all stakeholders, harness more effectively their contributions, and build coherence, coordination and national relevance of their actions, without duplicating existing structures.

- Identify the comparative advantages of the various HRH stakeholders and facilitate collaboration for health systems strengthening around a single national health plan.

- Facilitate the environment for the engagement and development of linkages among programmes with HRH implications.

- Integrate HRH coordination in health systems strengthening mechanisms, such as sector-wide approaches (SWAps), Harmonizing Health in Africa (HHA) and the agreements established under the International Health Partnership (IHP+) umbrella, implementing the Paris principles on aid effectiveness.

HRH policy dialogue will be pursued as a component of wider health sector strategies, and linked to health coordination processes and mechanisms such as the IHP+ and SWAps, to ensure the complete integration of HRH development within the national health systems strengthening agenda.

The Alliance recognizes the great potential of deeper collaboration with and strengthening of regional networks and platforms such as AAAH and the African Platform on HRH, which will be critical in advancing the HRH agenda and promoting policy dialogue in regions. The Alliance will act as a hub to pair country needs with partner support through, for example, the promotion of high-quality HRH plans. The Secretariat will commission the documentation of best practices of HRH coordination, policy, planning and innovative practice, and facilitate the sharing of experience and learning across countries, in partnership with regional networks and forums.

The first phase of the Alliance focused on the 57 countries deemed to face a critical shortage

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2 The International Health Partnership and Related Initiatives is a collaboration, hosted by WHO and the World Bank, that seeks to achieve better health results by mobilizing donor countries and development partners around a single country-led national health strategy. The Alliance contributes to this framework by working with countries to ensure that the HRH component of national health strategies is developed and implemented according to an inclusive process that harnesses the contribution of all relevant stakeholders. Alliance members adhere to the Paris principles on aid effectiveness that form the basis of IHP+ work.
of HRH as assessed through the 2006 World Health Report. Moving forward, the Alliance will promote HRH action by every country, considering shortfalls in wealthier countries have a profound effect globally. Country coordination and facilitation will therefore be promoted also in high-income countries to contribute to addressing their HRH challenges, including under-investment in training and over-reliance on migrant health workers.

At the same time, specific focus will be given to the 75 countries that together account for 97% of maternal and child deaths globally. Particular emphasis will be placed on countries of the H4+ High Burden Country Initiative. The WHO Global Code of Practice on International Recruitment of Health Personnel (the WHO Code) will be promoted for intersectoral policy dialogue among both high- and low-income countries. The Secretariat will provide the foundation and advocate for members and partners to play a more proactive role according to their mandate and comparative strength in countries, to promote the practice of inclusive and evidence-based HRH planning and development, embedded in national health strategies.

### Table 2

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<thead>
<tr>
<th>Phase 1</th>
<th>Phase 2</th>
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<tr>
<td>Members and partners informed about CCF approach, selective involvement in some countries</td>
<td>Secretariat will encourage members and partners to become responsible for providing assistance, following similar principles and/or model</td>
</tr>
<tr>
<td>Focus on HRH coordination and planning (i.e. inputs and processes in HRH development cycle)</td>
<td>Emphasis on concrete steps leading to quantitative scale-up, more equitable distribution and qualitative improvement of health workforce performance and capacity</td>
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<tr>
<td>Cross-sectoral participation encouraged through involvement in national HRH coordination processes</td>
<td>Analyses and policy dialogues on HRH labour markets will be specifically used as an entry point for cross-sectoral policy dialogue and collaboration</td>
</tr>
<tr>
<td>Good practice models developed and partners and countries sensitized to them</td>
<td>Document best practices in national HRH coordination and planning processes</td>
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3 The “Health 4+” (H4+) agencies (United Nations Population Fund, United Nations Children’s Fund, World Health Organization, World Bank and the Joint United Nations Programme on HIV/AIDS) are working together to support the United Nations Secretary-General’s Every Woman Every Child campaign. This includes the H4+ High Burden Countries Initiative (HBCI) that is supporting in-depth national assessments of midwifery in eight countries (Afghanistan, Bangladesh, Democratic Republic of the Congo, Ethiopia, India, Mozambique, Nigeria and the United Republic of Tanzania).
Expected results

Alliance-wide:

→ Increased uptake and implementation of HRH policy options of proven effectiveness in countries.
→ HRH coordination strengthened, policy dialogue facilitated, costed HRH strategies and plans developed and implemented as an integral component of national health strategies, enabled as appropriate by applying country coordination and facilitation principles.
→ Financial and technical support provided to improve HRH training, deployment, retention, distribution and performance, contributing to saving millions of lives through improved coverage with essential health services.

Secretariat-specific:

→ Catalytic support extended to HRH coordination and facilitation as an integral part of national health policy dialogue and planning processes.
→ HRH coalitions supported in priority countries to strengthen capacity at national level.
→ HRH framed as an intersectoral priority, including through labour market analyses in selected countries.
→ Best practices of HRH coordination, policy, planning and innovative approaches, including on the WHO Code implementation, documented and disseminated.

3.3 Promoting results and accountability

Countries and development partners have made significant commitments and adopted resolutions, political declarations and statements on strengthening HRH. Examples of these relate to national health or HRH strategies, development partner support for global health, including the UN Global Strategy for Women’s and Children’s Health, World Health Assembly and African Union resolutions, commitments made in the G8 and the G20, and multilateral initiatives.

The Alliance, as a platform that works directly with its members, partners and with countries, and governed by an independent Board, is well placed to ensure accountability by monitoring progress against these commitments and implementation of initiatives.

Going forward, therefore, as a part of its core functions, the Secretariat will monitor the actions of countries and Alliance members and partners on HRH development, leading to greater accountability by HRH stakeholders on their commitments. An initial step for evidence-based monitoring of progress will be to adopt targets that reflect the diverse composition of the health workforce, and that represent attainable and realistic objectives, considering the financial constraints faced by many low-income countries.4

To address this need, the Alliance will propose that agencies and partners that have the lead in normative mandates (like WHO and the International Labour Organization) develop and broker consensus on fit-for-purpose HRH benchmarks in collaboration with professional associations and other relevant stakeholders.

At the national level, Alliance members and partners will support countries to ensure that HRH benchmarks in national health strategies are met and linked to relevant accountability processes, such as IHP+ country compacts and annual health sector reviews.

The initial review of progress in implementing the KD-AGA at the Second Global Forum on HRH revealed a demand for improved information and regular accountability and reporting both at country level and on the contributions of leading global agencies and development partners.

For subsequent progress reviews, the Alliance Board proposes to focus on convening and coordinating an overall accountability process and framework (including but not limited to implementation of the KD-AGA, resulting in a “State of the World’s HRH” report every two years). These reports will not entail the collection of new quantitative primary data, but rather support and use existing mechanisms, such as national and regional health workforce observatories and databases managed by WHO, the World Bank and the OECD. This will also minimize transaction costs and reporting requirements for countries. Beyond quantitative data, the reports will also include qualitative assessments of best practices, reasons for success and failure, and policies and practices adopted by development partners and other HRH stakeholders.

The accountability process will establish linkages, as relevant, with other monitoring and accountability frameworks, including those of the UN Global Strategy for Women’s and Children’s Health and the WHO Global Code of Practice on International Recruitment of Health Personnel.

**Expected results**

**Alliance-wide:**

→ Credible evidence and strategic intelligence available on HRH availability, distribution and flow in HRH priority countries.\(^5\)

→ Information available on international HRH investment flows, and results of priority global HRH initiatives and programmes promoted by development partners and agencies.

→ Consensus achieved on a set of benchmarks for HRH development and monitoring.

→ Advocacy successfully conducted based on analyses demonstrating impact of HRH investment on lives saved, improved population health and socioeconomic development.

**Secretariat-specific:**

→ Two “State of the World’s HRH” reports developed and disseminated at the HRH Global Forums.

→ Commitment to results and acceptance of a global process of accountability advocated.

→ Results on HRH actions and ongoing commitments under review to address gaps.

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\(^5\) This will require countries and/or national HRH observatories to submit relevant information to the WHO Global Atlas of the Health Workforce, and require WHO to regularly update this database.
Countries are the primary drivers of HRH action, supported by a variety of stakeholders who have been actively involved in implementing the strategies of the KD-AGA since its adoption in March 2008. In this second phase the Alliance will adopt an enhanced partnership model which, while spurring the important role of civil society, the private sector and other stakeholders, recognizes the centrality of national governments and ministries of health in particular.

The identity and the strength of the Alliance lie in its members and partners: the new Strategy will rely on them to be the key implementers and to commit to undertake and deliver on specific activities to assure the achievement of its mandate.

Examples of successful partnerships between countries and Alliance members and partners since its launch in 2006 are given in Annex 2. These examples only represent a fraction of the numerous HRH initiatives undertaken to strengthen the health workforce; however, they illustrate the extensive range and wealth of contributions that the Alliance can bring.

A comprehensive results-oriented agenda that can transform the HRH landscape at global and country levels cannot rest solely with the Secretariat guided by the Board. Since “business as usual” will not achieve the desired results, Alliance operations will be adjusted to secure broader ownership and engagement.

To begin with, the Strategy fully recognizes that WHO provides the organizational location for the Alliance, that WHO’s functions include supporting ministries of health, and that there is scope for improving the partnership between the Alliance and WHO. Accordingly, collaboration with WHO will continue to be improved, strengthened and consolidated to exploit and promote opportunities for greater synergy in the respective mandates and actions. Intensified dialogue on thematic priorities of joint interest will continue resulting in mutual benefits, including on implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel, HRH training and retention, and HRH aspects of the MDG agenda and the NCD response. It is also envisaged that WHO, as a permanent member of the Alliance Board, will use the opportunity to flag areas that require coordination, through review and endorsement of Alliance strategic documents, reflect suitable role clarity and differentiation.

At the outset the Alliance did not set a target for its membership. The current formal membership (over 400) shows the wide interest in HRH, even though geographic distribution and composition can still be improved. Most importantly, the full potential of such a large membership remains under-exploited, and this is a key focus of the Strategy going forward.

The Alliance's identity and affiliations are, however, multi-faceted and not limited to formal membership, as it needs to interface with critical HRH stakeholders that, although not formal members, are essential, by virtue of their role, in advancing the HRH agenda. These stakeholders include governments and the HRH focal points within national ministries of health.

Moreover, while countries have the primary responsibility for the development and deployment of their health workforce, a variety of other stakeholders have a role to play
in providing technical assistance and financial support, continuous professional development initiatives, training and research, and a number of other enabling and ancillary activities.

In defining its future role and providing leadership for collective actions, the Alliance will be ambitious but realistic in setting priorities and targets and clearly delineate a hierarchy of results that distinguishes between the deliverables expected from the Secretariat and from Alliance-wide actions, working together according to respective roles and mandates (Annex 6).

A key principle of 2013–2016 activities will be to galvanize, harness and enable the potential capacity of Alliance members, partners and other relevant stakeholders. A strategy will be developed under the guidance of the Board and in consultation with members and partners to operationalize this principle, including ways and means of facilitating members’ engagement in and contribution to the three objectives.

There will be different levels of engagement by members and recognition of their unique contributions. This takes into account that some members are primarily motivated by information sharing while others have the capacity and interest to play an active role in the various initiatives of the Alliance, as outlined in this Strategy. Voluntary self-reporting on HRH activities conducted by members will be encouraged, to facilitate information sharing and to acknowledge achievements.

Members will be given greater access to information concerning the governance of the Alliance structures, including reports of Board meetings, annual workplans of the Secretariat and the list of staff members and their functions posted on the web site. To improve communication, the membership platform will be enhanced. Online technologies will be used to enable Alliance members and partners to share information on global and country activities and map who is working where to achieve the agreed results. Awards, as well as official recognition of Alliance “implementers” and “advocates” will be used to encourage, reinforce and acknowledge outstanding success at both the institutional and individual levels.

In particular, the Alliance will increasingly focus on mobilizing members and partners with presence in countries who can serve as advocates for HRH and drive forward the country health workforce development agenda, with the Secretariat providing catalytic support and facilitation. This may take different forms in different countries, but the Secretariat will assist and support current and emerging coalitions of constituencies and groups of actors that can foster HRH dialogue, processes and actions at the national level on specific issues (e.g. on the WHO Code, HRH migration, HRH advocacy, KD-AGA monitoring, role of the private sector and professional associations).

The Alliance plans to continue its biennial HRH global forums, while exploring cost-effective options for additional regular member forums to enable more effective planning, sharing and cohesion. This could take the form of virtual platforms or use existing meetings and/or other processes.

The goal is for this enhanced partnership model to play a pivotal role in moving forward the HRH agenda, as it will progressively empower and shift responsibility for activities.
to members and partners, who are responsible for achieving the higher level results of the Alliance Strategy, allowing the Alliance governance structures to focus on their catalytic and enabling role.

In addition to improved mobilization of member and partner strengths, the Alliance will enhance its operations (Annex 7) by:

→ improving the governance work of its Board and its oversight of the operations conducted by the Secretariat;

→ adapting the Secretariat structure and operations to the new objectives and partnership model; and

→ further strengthening the programmatic partnership and hosting relations with WHO.

### Table 3

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<tr>
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<tbody>
<tr>
<td>Overall framework: KD-AGA as part of MDG agenda</td>
<td>Overall framework: responsive to new challenges, environment and players</td>
</tr>
<tr>
<td></td>
<td>Develop new agenda as part of universal health coverage and post-MDG framework</td>
</tr>
<tr>
<td>Advocacy primarily aimed at health sector audience</td>
<td>Advocacy increasingly focused on intersectoral action and higher political level</td>
</tr>
<tr>
<td>Emphasis on development of new knowledge products through task forces</td>
<td>Greater emphasis on uptake and use of existing and emerging knowledge through advocacy and sharing</td>
</tr>
<tr>
<td>No explicit strategy available to facilitate country actions</td>
<td>CCF principles applied, based on country demand, and adapted for stronger linkages with the health systems strengthening agenda</td>
</tr>
<tr>
<td>Focus on 57 HRH crisis countries</td>
<td>Framing the HRH crisis as a global issue for all countries and focusing on the 75 countries of the UN Global Strategy for Women’s and Children’s Health</td>
</tr>
<tr>
<td>First (basic) attempt to monitor KD-AGA progress in 2011</td>
<td>Evidence-based and results-oriented monitoring of wider HRH development for increased accountability</td>
</tr>
<tr>
<td>Diffuse responsibilities within the Alliance and process-oriented approach</td>
<td>Clarity in roles of Alliance governance structures, members and partners for greater results</td>
</tr>
<tr>
<td>5 objectives, 46 indicators</td>
<td>3 objectives, 24 expected results</td>
</tr>
<tr>
<td>Members and partners involved in some initiatives</td>
<td>Systematic empowerment and engagement of members to drive forward HRH agenda</td>
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</table>
This Strategic Plan presents a renewed value-added proposition for the second phase of the Alliance, characterized by:

- empowering members and partners with increased leadership, responsibility and ownership;
- advancing and refining an HRH agenda in the dynamic health development landscape;
- influencing political and policy choices through sharing and uptake of evidence and best practices on HRH coordination, policy, planning and innovation;
- translating commitments into synergistic inter-sectoral actions in countries through high-level advocacy, and strengthened accountability mechanisms; and
- achieving more through a partnership model that enables greater expression and more effective coordination of effort by members, partners and other stakeholders.

During 2013–2016, the Alliance will make the following important contributions by adapting its modus operandi (Table 3):

- As a multi-constituency and multi-stakeholder partnership, the Alliance will convene and create a space for inclusive policy dialogue, coordination and exchange. This will be instrumental in identifying opportunities for synergy, in preventing duplication and in matching demand for and supply of technical products and financial support.

- As an entity hosted by WHO and with its governing Board, the Alliance will undertake high-level, evidence-based advocacy, using its critical capacity to work with civil society, private sector, professional associations and regional networks.

- As a facilitator in agenda setting and reviewing progress, it will reinforce accountability in the current HRH development challenges, and reflect emerging priorities and areas of focus in the universal health coverage and post-MDG agenda.
ANNEXES
The Joint Learning Initiative report, released in 2004, played a significant role in highlighting the growing HRH crisis. Building on that, in February 2005, a high-level consultation in Oslo brought together key stakeholders, who recommended that a new global partnership for HRH should be created for the many players that were routinely involved, or could be constructively engaged, in health workforce-related processes. Coordination among these players was considered crucial, both within the health sector (e.g., government, private sector, civil society, development partners), and across different sectors (health, education, finance, civil service, etc.). While a single organization could not offer all the required solutions, a common platform for players to collaborate could contribute to addressing the global and multi-faceted HRH crisis.

Specifically, an “alliance” was chosen (as opposed to a formal “partnership” or an “organization”), reflecting the vision of a movement engaging and energizing different organizations, without formal and binding arrangements that would constrain individual members and partners. To develop this new initiative, a technical working group drew up a Strategic Plan of what eventually became the Global Health Workforce Alliance.

The findings of the WHO World Health Report (WHR) 2006 indicated a critical shortage of over 4 million health workers worldwide, compounded by maldistribution, uneven performance and quality, insufficient incentives and remuneration, poor working conditions, and inadequate management practices and support. Launching the WHR 2006 on World Health Day, WHO set out a 10-year plan to address the crisis, calling for the establishment of alliances among partners at global, regional and country levels.

The Global Health Workforce Alliance (the Alliance) was formally launched in May 2006 at the World Health Assembly with a 10-year mandate as part of the “Decade of action on HRH”. It sought to address the lack of attention to HRH on the global health development agenda, and the challenges related to the shortage, maldistribution, retention, migration and the inadequate working and living environment of health workers prevalent in many developing countries. The Alliance vision was that “all people, everywhere, will have access to a skilled, motivated and supported health worker, within a robust health system”.

Since then, a wide-ranging programme of activities unfolded aimed at catalysing action on health workforce development at every level. In March 2008 the Alliance Secretariat convened the First Global Forum on Human Resources for Health, which resulted in the adoption of the Kampala Declaration and Agenda for Global Action (KD-AGA), which became an overarching framework of reference for HRH development. The Alliance developed its 3-year strategy for 2009–2011 (“Moving Forward from Kampala”) to facilitate and accelerate the operationalization of the KD-AGA.

The Second Global Forum on Human Resources for Health, held in Bangkok, Thailand, in January 2011, provided an opportunity for the global HRH community to review progress and renew the momentum and commitment to health workforce development and to the principles and strategies of the KD-AGA.

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http://www.healthgap.org/camp/hcw_docs/JLi_Human_Resources_for_Health.pdf
The Alliance contributes centrally to development of the health workforce through the functions of advocacy, brokering knowledge and convening partners to promote synergy and coordinated action for a wider movement involving many organizations and players. The Secretariat activities have been undertaken in the context of a hosting relationship and Memorandum of Understanding with WHO that has also enabled close programmatic collaboration and mutual reinforcement of actions. Significant achievements of the Alliance, at the level of its members and partners as well as the Secretariat, include global breakthroughs as well as progress in specific countries. Examples of important progress in a number of areas are provided below.

Countries, members and partners driving progress:

- **Malawi**, with the support of the United Kingdom Department for International Development (DFID), the Global Fund, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and others, implemented an emergency human resources programme that used innovative approaches to enhance training, deployment and retention of health workers. This initiative is credited with saving 13,000 lives, largely through increased coverage of reproductive, maternal, newborn and child health interventions.

- **Norway** and Thailand spearheaded efforts to develop and adopt the WHO Global Code of Practice on International Recruitment of Health Personnel in 2010.

- **The United States President’s Emergency Plan for AIDS Relief (PEPFAR)** is working towards training 140,000 additional health workers through medical and nursing education partnership initiatives targeting sub-Saharan Africa.

- The Governments of Japan, Italy and France led the G8 commitments in 2008, 2009 and 2011 respectively to support HRH development based on the KD-AGA; in addition, Japan is working towards the training of an additional 100,000 health workers in developing countries as part of its global health strategy, while France and Canada are providing extensive support to strengthen the health workforce in a number of countries as part of their investments in the Muskoka Initiative.\(^7\)

- According to its estimates for 2008–2009, DFID spends approximately 25% of its health budget on HRH, in line with the recommendations of the High Level Taskforce on International Innovative Financing for Health Systems.

- WHO has contributed global public goods of great value to HRH development, including the Global Code of Practice on the International Recruitment of Health Personnel, guidelines for rural retention of health workers, and a toolkit for monitoring and evaluating HRH.

- Members of the Health Workforce Advocacy Initiative, such as the African Medical and Research Foundation (AMREF), the Africa Public Health Alliance and 15%+...

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campaign, Merlin, and Save the Children, have contributed to an unprecedented level of attention to HRH issues (e.g. through the “Hands up”, “Frontline health workers coalition” and “Public Health 15%” awareness campaigns).

The United States Agency for International Development (USAID) Bureau for Global Health has supported Capacity Project/Capacity Plus and other initiatives implemented by organizations such as IntraHealth International, Management Sciences for Health, Abt Associates, which have provided opportunities for institutional capacity-building for HRH in priority countries.

Members of the World Health Professions Alliance (WHPA), in the context of the Positive Practice Environment campaign, have worked to raise awareness and improve working conditions for health professionals in various countries.

The Secretariat driving progress:

The achievements reported below refer largely to activities directly coordinated by the Secretariat in support of wider actions by members and partners, and recognized by an independent external evaluation conducted in late 2011.

At the global level, HRH has been mainstreamed into the health policy and development discourse. New health workforce targets and commitments have been made in political declarations and outcome documents globally.

HRH-specific language and targets were included in the UN Global Strategy for Women’s and Children’s health, which in turn triggered HRH commitments by specific countries, cascading in many instances down to national health and HRH responses and strategies.

Stakeholders have been brought together to support policy dialogue around the development and implementation of sustainable HRH solutions through two global forums on human resources for health, organized in collaboration with Alliance members and partners. Regional conferences such as the Asia Pacific Action Alliance for Human Resources for Health and the African Platform on Human Resources for Health, held in partnership with the headquarters, regional and country offices of WHO and other networks, have provided a platform for policy dialogue and exchange of best practices among countries.

Thematic task forces, convened by or in partnership with the Alliance, and with technical contributions from Alliance members, have led to ground-breaking knowledge products on health workforce development. These include seminal work on health worker education, HRH financing, migration of health personnel (culminating in the adoption of the WHO Code of Practice on the International Recruitment of Health Personnel), task shifting and the role of community health workers, and universal access to HIV prevention and treatment services.

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10 http://www.who.int/workforcealliance/forum/en/
11 http://www.aaaahrh.org/conference.php
13 http://www.who.int/workforcealliance/about/taskforces/en
Action at the country level was strengthened when the Secretariat refined its support strategy, developing and rolling out the Country Coordination and Facilitation (CCF) approach. This has contributed to stronger collaborative platforms at the national level (see also Annex 5), operating in synergy with health-sector coordination mechanisms and processes such as the IHP+.

Annex
The unfinished HRH agenda in an evolving global health and development landscape

The Alliance helped to create and subsequently spearhead a wide movement which has led to increased recognition of health workforce issues at national, regional and global levels.

Attention at global level has in many cases been followed by significant progress made by countries in addressing their health workforce challenges. The Alliance as a whole has played its part in these successes.

Despite this welcome progress, HRH challenges remain one of the largest bottlenecks to achieve the health MDGs and the universal health coverage goal. Much more is needed to realize the vision of the Alliance and the strategic objectives of the KD-AGA. This is reflected in the Alliance’s 2011 tracking report14 (Box 3).

The on-going challenge is to address the past and present gaps while simultaneously anticipating the transformative actions required in the future. In developing this Strategy, the Alliance Board has taken account of this changed and changing scenario with respect to HRH, to define a clear role and programme of work of the Alliance. It also recognizes that this strategy will unfold in the context of competing attention for political capital and resources, significant changes in health care supply and demand, and an unstable era of global health and development, including:

→ climate change, food prices, global security and sweeping political changes;
→ financial and spending adjustments in the global economy – with reductions in health and official development assistance (ODA) expenditures;
→ population growth, to a world of 9–10 billion by 2050;
→ ageing populations and an emerging crisis in noncommunicable diseases;

new discourses on health and development:
→ broadening of the health MDG framework to a wider paradigm of universal access to health services, and taking more explicitly into account the social determinants of health
→ the 20th anniversary of the International Conference on Population and Development (ICPD+20)
→ post-2015 sustainable development goals and universal health coverage; and

The unfinished HRH agenda
→ there is uneven progress across and within countries in addressing shortage and inequitable distribution of health workers;
→ training capacities for health workers are often inadequate and the potential for innovative skills mix approaches under-exploited;
→ countries have not yet developed or fully implemented their health workforce strategies, often due to insufficient technical and financial resources;
→ incomplete information on health workers’ availability, distribution and performance, as well as limited understanding of HRH labour markets, continues to limit effective planning and policy-making;
→ political attention has only partly been translated into revised policies and additional resources for HRH;
→ the role of the private sector is poorly understood, and its potential positive contribution remains to a large extent untapped;
→ addressing the specific needs of fragile states and vulnerable population groups remains a key challenge.

demand for transparency, accountability and results in aid expenditures.

This evolving context demands renewed attention, and strategic intelligence and action on HRH. The Alliance Board and Secretariat, in collaboration with its members and partners, will accordingly develop activities and interventions and measure results in a way that responds to this new reality, as reflected in the objectives and deliverables of the Strategy (Section 3).
The Alliance is committed to reflection and learning and strives to provide its members, partners and stakeholders with feedback opportunities. Results from a self-assessment in 2010 and a member survey in 2011 identified that members and partners:

- value the Alliance as a collaborative mechanism and see its ability to convene, catalyse action and secure consensus on important policy and technical HRH issues as its key strength;
- expect, at the same time, greater coordination and stewardship of their efforts in terms of joint messaging, communications, tools, advocacy targets and benchmarks;
- would like to have more venues and mechanisms for regular interaction and networking, and encourage the Board and Secretariat to involve more effectively the wider Alliance membership (now 400+ strong) and partners to address the HRH crisis.

Similar findings surfaced through an independent external evaluation commissioned by the Board in 2011, which also identified areas for improvement (Box 4).

The external evaluation did not address specifically the counterfactual question, “What would have happened if the Alliance had never been established?” However, the Board

Key issues emerging from the external evaluation

In reviewing whether the Alliance met initial expectations, the external evaluation:

- concluded that the Alliance work in its first five years represented good value for money;
- recognized the critical contributions made by the Alliance Secretariat in moving forward the health workforce agenda at global and country levels through its advocacy, brokering knowledge and convening functions; and
- noted that the Alliance Secretariat’s work was highly relevant at all levels, and considered its support to countries through the Country Coordination and Facilitation (CCF) approach to be highly effective.

The evaluation identified the following areas that required attention:

- better harnessing Alliance member contributions;
- wider use of knowledge products and improved visibility and brand recognition;
- a review of the Board’s effectiveness;
- streamlined administrative procedures and relationship with WHO; and
- more stable income flows.
believes that the Alliance was indeed fundamental in making HRH a more recognized and better supported element of the health development agenda at global, regional and country levels, and in catalysing and accelerating specific actions and commitments.

The Board held a retreat specifically to reflect on the external evaluation and plan the way forward. Building on the experience of Phase I, and in consultation with countries, members and partners, this resulted in realigned strategic priorities to ensure that the Alliance continues to play a unique catalytic role in the future. The Board will also take action where required to improve the coordination and management of the Alliance structures and governance processes.

Annex
Coordinating and facilitating country HRH policy dialogue

Country coordination and facilitation has to follow a set of principles to ensure inclusive HRH policy dialogue, which have been illustrated in box 2 in the strategy document.

The Board considers that this broad framework of principles and behaviours should be adapted to country circumstances and national health policies, and not be interpreted as a blueprint of prescribed activities. Alliance-related support provided according to these principles since 2010 is yielding results (see Box 5 on Cameroon case study): greater inclusiveness in health workforce coordination and planning processes; greater integration of HRH in national health systems strategies and plans; and improved quality of HRH situation analyses and development plans and strategies. Accelerated implementation of HRH plans and strategies is evident, for example, from scaled-up training and production of health workers, established or revamped training centres, improved health worker capability through revised training curricula and continuous professional development initiatives, and increased levels of resource allocation to HRH from both domestic and international sources (Figure 1).

The Alliance Board and Secretariat, building on the positive experience to date, are also keen to refine the approach, incorporating lessons learnt and recommendations that have emerged during the first years.
Strengthening HRH development in Cameroon

Applying country coordination and facilitation principles in Cameroon has led to:
→ greater political commitment to HRH issues;
→ a clear framework of collaboration between the Ministry of Health, WHO and the Alliance, regulated through a tripartite Memorandum of Understanding;
→ more inclusive HRH coordination processes, involving the private sector and the education sector (previously not involved);
→ an updated HRH situation analysis and HRH tracking system;
→ increased resource allocation from domestic sources (additional US$ 6 million mobilized) and international partners (French Development Agency, US$ 1.4 million mobilized);
→ the scaling-up of training capacity for midwifery personnel.

Source: Global Health Workforce Alliance, CCF case study in Cameroon (2012).

Results to date of CCF support to HRH development in countries

Figure 1

Major steps on HRH in the CCF process

Embedded and integrated in national health policy dialogue and national health strategy.
Annex
Definition of roles

Achieving the 2013–2016 objectives and related results through the enhanced partnership model requires effective collaboration and a more careful understanding of the delineation of roles and responsibilities among countries, the Alliance members and partners, the Secretariat, and the Board. The Alliance envisages that:

Countries are the primary drivers of HRH action, in terms of:

→ ensuring coherent national leadership for health workforce solutions;
→ developing capacity for an evidence-based response;
→ scaling up health worker education and training to meet national needs;
→ retaining an effective, responsive and equitably distributed workforce;
→ managing pressures of the international HRH labour market and its impact on migration; and
→ securing adequate investments and productive use of resources for health workforce development.

The wider membership of the Alliance will take actions to support countries in improving availability, accessibility, quality and performance of the health workforce. Examples of actions expected by members and partners include:

→ advocacy to ensure adequate recognition of HRH development priorities at all levels, according to the respective areas of influence;
→ adoption of new, and honouring existing commitments to support HRH development;
→ adoption of and support for appropriate policies, regulations and procedures of direct relevance to HRH priorities;
→ commitment to inclusive HRH multisectoral dialogue and coordination, as an integral component of national health plans and processes like SWAPs and IHP+;
→ provision of technical support to countries to ensure that evidence- and needs-based health workforce development plans are developed and implemented as an integral part of national health strategies, and that health workforce information and evidence are available, through mechanisms like observatories, and used for planning and monitoring; and
→ provision of financial support to health workforce development (for countries requiring external assistance) aligned to national health priorities, which is predictable, long-term and flexible, allowing for both investment and recurrent costs, including pre-service training, and deployment and retention of health workers.

The role of the Secretariat under the oversight of the Board will be essentially enabling and facilitating processes and inputs to country actions and outputs. Examples of Secretariat functions include:

→ developing and conveying joint messaging and positions on HRH, by convening consultation processes, high-level policy dialogue and forums that broker consensus on priority HRH topics;
→ collating and sharing strategic information to enable members and partners to adopt them in policy and programmatic interventions;
→ providing catalytic support and facilitation to strengthen the HRH coordination, planning and policy management environment, and leveraging the technical and financial contributions of partners and members;
→ documenting, disseminating and celebrating best practices and examples of success;
→ providing catalytic support on priority actions undertaken by networks and platforms driven by members and partners; and
→ collating and sharing information to maximize synergy, avoid duplications and foster accountability.

The Board, in constant consultation with members and partners, takes lead responsibility for:
→ providing strategic guidance of the Alliance and monitoring progress in achieving the Alliance vision and the HRH agenda;
→ capitalizing on the influence of Board members to define, advocate and promote the HRH agenda at high levels;
→ ensuring effective governance of Alliance structures and oversight of the Secretariat; and
→ mobilizing sufficient financial resources for efficient operation of the Secretariat.

Complementarity with WHO

The Alliance is a broad-based partnership created to serve as a collaborative platform for many different organizations representing a variety of constituencies and HRH stakeholders. Accordingly, the Alliance Board is committed to continue adding value to the work of all members and partners. Specifically, it recognizes that among its functions, WHO plays a key role in supporting ministries of health and governments at large on matters pertaining to health systems strengthening, including HRH.

During the first phase the Alliance Secretariat operations were undertaken in the context of the hosting relationship with WHO, regulated by a Memorandum of Understanding. This has provided the basis for close programmatic collaboration and for mutual reinforcement of activities. Examples of the positive collaboration include the leading normative and technical role played by WHO in all the task forces convened by the Alliance Secretariat, the joint work on international migration of health workers culminating in the adoption of the WHO Code of Practice on the International Recruitment of Health Personnel, and the successful organization of the Second Global Forum on Human Resources for Health, jointly convened by the Alliance, WHO, the Japanese International Cooperation Agency and the Prince Mahidol Award Conference of Thailand.

At the same time, the external evaluation highlighted the need to pursue and communicate more clearly the complementarity of the Alliance work and that conducted by WHO in the area of human resources for health. WHO has a permanent seat on the Alliance Board: through this role, WHO has the opportunity to review and endorse all Alliance strategic documents and workplans and, importantly, is well positioned to flag areas that require coordination, better clarity and distinct definition of roles. In addition, regular dialogue will be increasingly sought on common priorities and areas of complementarity, such as the WHO Code, HRH aspects of the MDGs, the NCD response and HRH training and retention. This will result in improved and consolidated collaborative relations, and the ability to exploit opportunities for greater synergy in the respective mandates and actions, particularly in supporting countries to overcome HRH challenges as an integral component of national health system plans and related processes like IHP+. 
Annex
Strengthened governance of Alliance structures

**Board effectiveness**

The Alliance will streamline and strengthen its governance and management mechanisms: in terms of transparent and accountable governance, the Board will undertake reviews of its own effectiveness according to the provisions of its governance handbook. This stipulates that the Board should regularly seek member feedback on the inclusiveness, effectiveness and usefulness of Board decision-making and oversight processes. The Board will undertake a first review of this type in the first half of 2013, and will analyse and discuss in depth varying modifications that may be required to its size, composition, competency mix, governance and by-laws, as well as its relationship with and oversight of the Secretariat. Subsequent reviews of the Board effectiveness and performance will be undertaken according to a schedule based on needs and the modifications required, but in any case at least every two years.

The Board is confident that the documented effectiveness of the Alliance during the first phase and the re-definition of its strategic approach in its second phase will bring the expected results. Focusing on selected areas, together with an enhanced business model, will be the pre-conditions for developing an attractive value proposition.

A resource mobilization strategy will be developed to enable the Alliance to mobilize and sustain sufficient predictable and flexible income to meet its responsibilities. Board members, especially those representing development partners and international agencies, share the responsibility for securing adequate financial support for the core operations of the Alliance Secretariat.

**Secretariat oversight, management and administration**

Support to core functions contributes to the achievement of the Alliance objectives and expected results, and the enhancement of its partnership model, through:

→ the management and administration of the Secretariat, responsible for implementing Alliance activities and thus contributing to the results described in this strategy document;

→ the effective organization of core governance processes, and meetings for members and partners (including, but not limited to, the HRH global forums);

→ resource mobilization, grant management, administration and reporting;

→ the production of corporate publications and other products that demonstrate and provide evidence on the effectiveness of the Secretariat operations.

The Secretariat size and competency mix will be reviewed by the Board in the second part of 2012, following the finalization and approval of the Strategy. Changes will be made as required to adapt to the new Strategy and to ensure adequate capacity to deliver a transformed set of objectives, according to the enhanced partnership model.

It is envisaged that the Secretariat will retain its current size following the reductions agreed by the Board in 2011, but re-adapting the skills mix to the revised functions. In this context, a relative reduction of staff responsible for
management and support functions is foreseen, along with an increase in staff directly responsible for the delivery of Secretariat activities. For this, there will be lower emphasis on developing new knowledge products, higher focus on promoting results and accountability, and profiling at a higher level the agenda-setting and advocacy functions.

**Hosting relation with WHO**

The collaboration with WHO is critical also in relation to the fact that the Alliance Secretariat is hosted at WHO headquarters in Geneva. WHO has recently initiated a process to review the terms and conditions for hosting partnerships; related to that, the external evaluation report has raised the option of considering alternative hosting arrangements. While at this point there are not sufficient elements of specificity to assess the revised terms and conditions that WHO will propose to formal partnerships, the Board believes that there is a value in retaining the hosting arrangement with WHO, and all efforts should be made by the Alliance Board and WHO to ensure mutual satisfaction both in relation to collaboration on specific programmatic areas, and in the context of the emerging corporate approach of WHO on hosting formal partnerships. The Alliance Board will evaluate any actions that need to be taken as and when additional specificity is provided by WHO on any changes to the hosting arrangements.
Launched in 2006, the Global Health Workforce Alliance is a partnership dedicated to identifying and coordinating solutions to the health workforce crisis. It brings together a variety of actors, including national governments, civil society, finance institutions, health workers, international agencies, academic institutions and professional associations. The Alliance is hosted by the World Health Organization.

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