Options for a Global Multi-sector Response to HRH
(For phase 2 GHWA consultations, Nov 2014)

1. Introduction

There are strong examples of successful national and regional approaches to build effective health workforce solutions. Even so, the analysis of the status and trends of the HRH situation, (the recognized fragmentation in the response and the many missed opportunities to deal with systemic barriers (phase 1 consultations)), make it clear that there is a pressing need for more concerted efforts.

It is equally clear that **countries hold the key**: capacity in national institutions is essential for a transformational HRH response - to make the necessary political choices, establish policy with a regulatory framework, ensure basic funding and set up a national collaborative platform for action. The academic community, professional associations, private sector and civil society must be key partners with governments to make it work.

**Very few of the countries with the most urgent challenges have the institutions they need** to take the response forward. They are offered multiple initiatives and tools, yet HRH plans are often left unused, poorly funded and hardly implemented.

At the same time, no country can establish sustainable, national and cross-border health workforce solutions in isolation. Even so, current approaches to global action for HRH (all stakeholders, including GHWA, WHO, WB and other multilateral and bilateral agencies, INGOs, associations and networks) have not been suitable for offering the necessary enabling link between national and global action.

The preliminary conclusion from the phase 1 consultations is that **this is not the time to phase out global action for HRH**. Rather, the challenge is to **renew and adapt global approaches** to make our efforts more responsive to country needs, more effective and more innovative in meeting new trends and opportunities. The WHO/GHWA work on the new global HRH strategy will make these challenges and opportunities more concrete.

2. Priority needs for continued global HRH efforts

The summary from the phase 1 consultations show the complexity of the health workforce challenges we face. The complexity makes it necessary to identify where and how global action can make the most difference.

Priority needs for global HRH efforts going forward, as expressed in the phase 1 consultations, can be summarized as three basic "clues" and three "crosscutting" challenges.

*The basic clues indicate that unless these are in place in the global HRH response, we will continue to miss sustainable solutions.*
The cross-cutting challenges point to priority HRH actions that are best addressed together with broader HSS and UHC action, but with a specific HRH focus. It is unacceptable to leave these challenges as unresolved gaps in the response.

Three basic "clues"

1. **INSTITUTIONS**
   - Critical national institutional capacity for leadership and stewardship of the health workforce is essential for global support to be effective in enabling sustainable HRH solutions

2. **INTEGRATION**
   - Fragmentation, gaps and inefficiencies hinder country solutions. Often driven by global partners. Necessary actions require further concerted efforts, both within and beyond the health sector, by state and non-state actors. Must be addressed by global partners. The type and skill-mix of the health workers must be fit for purpose in each local context.

3. **INVESTMENT**
   - More, better aligned, more predictable and higher quality investment for HRH to achieve UHC and to harvest the economic benefit - must be responsive to country context and needs, including optimize the domestic investment opportunities

Three crosscutting challenges

a) **SOLIDARITY**
   - It is unacceptable that there are countries with highly inequitable distribution of skilled health workers that leave large communities, regions and groups with major access gaps. Each country has the responsibility for safeguarding health for its own population and for fulfilling its obligations to the International Health Regulations. But it is also in the interest of the global community that countries are able to undertake these tasks. Skilled health workers move across borders in the international labor market. National and global health security is only as strong as its weakest link. Even so, international solidarity in response to the inequitable distribution of the health workforce has largely been activated as a response to crisis and not for investment in preparedness and long-term solutions.
   - The application and follow up of the Global Code of Practice on the International Recruitment of Health Personnel needs to be stimulated and applied more consistently and transparently by all partners engaged in health services and health systems development
   - Stronger attention must be given to ensure local, national, regional and global health workforce capacity for preparedness and health security, including with appropriate linkages to the capacities of the humanitarian system, both at global, national and local levels

b) **DATA**
   - It is unacceptable that the database for HRH at national and global level continues to be weak and fragmented. The need has been established since the early days of the response, but has not been adequately addressed. Better data is essential as a basis for planning, stewardship, management, accountability and monitoring of health workforce - such as in terms of accessibility/coverage, appropriateness and quality.
   - Calls for pressing work at both global and national levels, with collaboration between HMIS stakeholders and across agencies within and outside the health sector (WHO, ILO, WB, UNDP etc)
   - Need for integrated solutions with health systems and universal health coverage data, but with distinct HRH indicators.
ACCOUNTABILITY

It is unacceptable that there has been no agreed accountability framework for HRH - neither for national HRH public and partner investments, nor for international contributions to HRH. Monitoring and accountability has been the weakest part of the follow up to the Kampala Declaration and Agenda for Global Action, which made collaborative monitoring and mutual accountability at the country level the basic building block. Without a shared action agenda and a national platform to receive reports and hold all accountable, collaborative monitoring and accountability will not work.

- **Access to health workers means access to skilled, motivated, equipped and supported health workers. Accountability for HRH must be linked to accountability for progress in UHC.**
- **There are now HRH commitments from countries and international partners made public at the Third Global Forum on HRH (Recife). It is therefore vital to capture this momentum for collaborative monitoring at national level; feeding up to the global. Incentives to participate will be stronger if mutual accountability for HRH action, among partners is made part of a broader national accountability framework for UHC.**
- **Global partners that advise countries on and fund elements of HRH action, such as - norms and standards, education, pay for performance, various "short cut" solutions and salary "top up"s for priority programs, need to be transparent and buy into an accountability framework that contributes to sustainable HRH solutions and country plans for UHC.**

As the work on the Global Strategy for HRH progresses, it is expected that it will highlight new opportunities and challenges and will call for innovation and collaboration that add concrete recommendations to the agenda going forward. It is, however, expected that the priority needs identified here will remain at the foundation of the new and accelerated response.

3. **The Partner Landscape - different actors with different contributions**

3.1 Multilateral institutions and agencies with HRH as part of their core mandate

WHO, ILO, UNESCO, the World Bank and the UNDP are examples of multilateral agencies with mandates and responsibilities that in different ways include health workforce, but which are not fully activated, not well linked across agencies and not focused on capacity.

Also other UN agencies have engagement in health workforce issues for target programs such as UNICEF and UNFPA, as has the UNAIDS joint program. WHO and ILO have a global mandate, whereas the World Bank and the UN funds and programs are largely tools for development assistance.

The World Bank has the strength of dealing with both health and education sectors (including higher education) as well as ministries of finance. UNDP in its focus on public sector and local governance, rights and integrated development has also a multi-sector mandate highly relevant for dealing with the health workforce.

WHO has the strength of its Collaborating Centers and its Health Observatories across the world that could do more on health workforce issues. It is worth noting that WHO and each of the health related UN partners, have multiple streams of activity with a health workforce component, without having brought these components together in a consolidated agency approach.

The UN agencies are primarily inter-governmental instruments, with limited space for inclusion of non-state actors. ILO has a special tripartite construction with governments and non-state actors in the world of work, which offer additional possibilities in convening multiple partners.
These core partners must better compliment each other by collaborative action making explicit and predictable commitments and contributions to the essentials of the health workforce agenda that apply to their mandate. Capacity in national institutions for an effective multi-sector response is essential for ensuring a functioning national platform that can provide the necessary leadership and stewardship for building the health workforce.

3.2 Global initiatives and governmental donor partners

GAVI and the Global Fund are at the forefront of the global health partnerships that bring multiple stakeholders together for achieving results in immunization, AIDS, TB and malaria, but belong to a broader family of private-public partnerships in the health architecture. In contrast to the other private-public partnerships, GAVI and the Global Fund are primarily funding instruments, based on applications submitted to the global decision making body.

Health workforce investment is not a main priority for these initiatives and partnerships. Rather, they are forced to engage because their results depend on delivery, including with health workers. There is an critical need for agreement on how these inputs can contribute better to context specific, coherent and aligned health workforce action at country level.

Funding from governmental donors to country health programs in general show a shift away from bilateral country programs to multilateral/global initiatives. There is a continued challenge to establish coherence at country level between the country-based donor collaboration in support of health sector programs, the programs funded by the global initiatives and the programs supported by the UN. The health workforce issues - raising challenges beyond what the health sector can control - are seen as a domestic recurrent expenditure, and costed HRH plans fail to get priority attention.

IHP+ is an initiative that has its focus on development assistance for health systems development, following the OECD principles of aid effectiveness and facilitating consolidated system investment in selected countries, based on mutual commitments between the country and its partners. Health workforce has so far not been a focus in IHP+. The World Bank and WHO are partners in IHP+, and could use this platform more actively to facilitate a stronger focus on health workforce development among partners at country level.

Governmental donor partners that have had an explicit engagement in health workforce issues over the last decade include Japan, EU, France, UK, Ireland, Norway and the US, most with a combination of multilateral funding (UN agencies and Global health initiatives) and bilateral funding of country programs. These donors support a range of different programs, including community based and facility based front line health workers (often via NGOs), institutional collaboration for capacity development at different levels and policy/systems research. The US has developed specific programs for medical education under both PEPFAR and USAID, (nurses and MDs, - NEPI and MEPI). Countries need to have the capacity to align, optimize and manage these multiple and diverse inputs so they match the national HRH policies, plans and implementation strategies.

South-south collaboration has a particular strength in capacity development, where knowledge and experience in building and managing institutions and sharing skilled people represents a major resource. The potential of these contributions and how they can be further optimized in the overall country level collaboration on health system and health workforce development has not been fully recognized or explored by partners.
3.3 Academic institutions and research networks

Academic institutions across the world have multiple ways for networking and collaboration, in developing the knowledge base, exchange of students and faculty, in undertaking research, developing methodology and publishing results. More than the other actors, the academic sector has self-interest in fostering collaboration. At large, they have the independence to be critical correctives and to push new frontiers.

The potential of academic institutions as key actors in health workforce development was recognized in the early efforts to build GHWA. The presence and contributions of the academic sector has been strong in the three global forums convened by GHWA. Yet in making the response, the focus has been more on public sector and has provided limited space and demand for contributions from the in-country academic community. This needs to be changed.

National academic institutions need to be at the core of the transformative education and HRH policy agenda that is now needed, and must be the point of orientation when the academic sector in countries with high capacity engage in academic and research collaboration.

The national academic institutions are critical for building a broad based national capacity to respond to health workforce challenges, support innovation and provide back-up knowledge and information for the policy choice of the public sector. There is a need to expand the circle of dialogue and debate at country level and to build the basis for more independent monitoring and evaluation.

3.4 Professional Associations

Health professions have organized their interests and mutual support in professional membership associations with both a national base and strong global expressions. They act by maintaining and enforcing standards of education, practice, ethics and sometimes licensing practitioners within their profession, to build the profession and ultimately with the aim to ensure quality in serving the public.

While the strength and the mix of professions in national structures, including trade unions, are different from country to country, the voice and engagement of the health professions in matters relating to health workforce must be included at all levels of policy development, planning and decision-making. Professional associations have a key role in capacity building in country, driving up standards and collaboration with fellow professional associations and other bodies – governmental and non-governmental.

It is legitimate for professional associations to seek influence for the good of their professions; the interests of individual professionals, and that of the public. The ways national and international professional bodies engage in maintaining professional standards (norms), regulation and education standards, career structures, working and employment conditions, represent interests that are essential drivers for finding health workforce solutions.

Multi sector and multi stakeholder platforms at national and global levels need the dynamic in the meeting points between professional interests and other interests and considerations, within a shared commitment to universal health coverage and equity in access.
3.5 Non-governmental organizations and networks

The non-governmental organizations and networks ideally represent voices from the ground up in advocacy and watch functions. At the same time they represent important instruments for donors in in-service delivery, training and capacity development, and thereby both employers and key implementers. This creates a mixed role in health workforce development. The role as advocates may be challenged by the role as implementers, dependent on funding contracts and appeals and the need to show results for the particular programs they implement.

NGOs in the role of advocates for social justice is critical for the right to health and achieving UHC. "Equity watch" on behalf of the un-served and demand on governments and their partners for accountability is critical for health workforce development. A special focus for watch is the monitoring of access to skilled and supported health workers on the ground. Member based NGOs with volunteers and members living in communities have very unique contributions that often are not fully recognized.

NGOs in the role as implementers operate a large part of the health programs in some countries, and have responsibilities for training, employment and working conditions for a large part of the workforce. They are often not brought into the policy and planning arena at country level and the public sector do not take the responsibility for the necessary regulatory framework and alignment, in order to optimize their contribution. Their accountability can therefore be limited to the donor/funding partner and not to the national system.

The role and expectations of NGOs and local civil society organizations will grow, as community systems are increasingly being challenged to cope an aging population; chronic diseases; infectious diseases.

In addition, international, national and regional NGOs are established as independent entities to offer consultancy service and technical support for national governments, for government donors, for private sector and for other NGOs. The potential of these NGOs in support of health workforce solutions can also be enhanced by more dialogue and consultations across partners. Shared commitment and vision among these NGOs for health workforce development as part of UHC can help to bridge the current fragmentation across the various partner funded programs that they engage with as consultants.

The different roles and contributions of NGOs must be recognized. It is critically necessary to ensure multi-sector and multi-stakeholder platforms at country level that are more inclusive of NGO actors, and to facilitate mutual accountability within a UHC framework.

3.6 Private sector actors

The private sector is increasingly engaged in developing new models for health care delivery, finding alternative ways to supply and optimize the health workforce, financing care and boosting performance. Engagement ranges from health care for workers, health care as corporate social responsibility to health and social care as competitive business nationally and internationally.

Technological innovations in education of health workers, management of the health workforce, information systems delivery of care represent important opportunities for UHC. But workforce innovators depend on an “enabling environment” of health and business institutions, capabilities, capital and labor markets, and legal systems that allow health-related businesses and organizations to form and grow.
In order to harness the contribution of the private sector, there is a need for a broader and more inclusive strategic dialogue that identify opportunities for innovation and collaboration, with a shared commitment to UHC, to the CODE and to quality health and social care models that are appropriate, affordable, acceptable and accessible.

3.7 Regional bodies and platforms relevant to HRH collaboration

The growing role of south-south collaboration and the increasing interest in regional and sub-regional structures have a strong potential to foster closer collaboration between countries and groups of countries in the region.

The Asian based A-A-A-H platform has demonstrated approaches that have added major value to health workforce development in the region, and where there have been strong enough shared interest to sustain and further adapt and develop the collaboration to shifting needs.

Africa has a number of regional and sub-regional and inter-governmental collaborative mechanisms that take an interest in the health workforce as part of a broader agenda for health and development. The ECSA collaboration has a primary focus on the health workforce, and so has the AU collaboration among Ministers of health on HRH issues.

The African Platform on HRH aim to serve as a multi-stakeholder mechanisms like the A-A-A-H in Asia. While it has been hard to find a dynamic and participatory approach that overcomes the barriers of fragmentation across the continent, including the necessary funding commitments and contributions (technical, knowledge development and other engagement) from the different African stakeholders, the Platform does provide a multi stakeholder mechanism available for the regional and sub-regional public and private sector actors.

In Latin America PAHO has over many years contributed as a lead convener of high significance for health workforce development in member countries. Important inter-ministerial initiatives were taken from the seventies onwards, and observatories launched in the mid nineties. The South American Institute of Government in Health (ISAGS) is a public intergovernmental institution of UNASUR whose main goal is to promote exchange, critical thinking, knowledge management and generate innovation in policy and governance for health. Together with National Health Institutes and Schools of Health, these are key institutions for collaboration on the health workforce in the region.

A renewed effort to build a stronger global response to health workforce development will require further attention to the potential of the regional platforms and networks, including in relation to the political and policy processes in the regions conducted by the regional and sub-regional institutions for economic and social development.

4. The Current GHWA Model

The MoU between GHWA and WHO as a host for the platform, states in its preamble:

"In the same way that human resources represent the muscle of the health system, essential for holding the various components together, coordinated action addressing the HRH crisis can effectively link and strengthen joint work between existing global initiatives. HRH provides a common unifying theme. Addressing the crisis in HRH requires a modality to accelerate and sustain more effective, more comprehensive action. In addition, without greater cohesion there are real risks of fragmentation, competition and duplication".
With this vision of HRH as a common, unifying theme, the Alliance was created as an "agile, responsive and non-bureaucratic movement, mission driven and time limited", to "promote country-initiated and country-led actions, work with and offer support to country leaders in addressing key gaps while at the same time promoting country leadership, ownership and capacity development."

The main approach was to "catalyze and facilitate the activities of its members through networking, working groups and task forces, to promote participation and enhance efficiency."

*It is worth noting that there is a strong match between the priority needs identified for continued global HRH effort today and the basis for the creation of GHWA in 2006.*

The life-course of GHWA demonstrates the difficulty in putting the intended approach into operation. The focus on country initiated and country led actions, promoting country leadership, ownership and capacity development shifted - to match the constraints of a largely Geneva based operation without a country presence and with members engaging in HRH issues doing so without looking to GHWA for holding the various components together in coordinated action.

While significant progress was achieved through the initial work of the task forces, the convening of global forums and the HRH advocacy in global and regional intergovernmental processes, the intended priority of enabling more effective action at country level proved difficult to achieve. A promising effort to facilitate country platforms for coordinated, multi-sectoral and multi stakeholder action through on the “Country Collaboration Frameworks” (CCFs) could not be followed up, and it proved complicated to come to agreement with WHO and other partners about roles and responsibilities for country level action.

In spite of a broad membership of the alliance, funding of the GHWA secretariat has depended on a few donor governments. With limited opportunities to show direct result of the alliance work in countries, continued funding of secretariat functions and process work related to advocacy, knowledge sharing and convening has been difficult to secure.

The hosting arrangement with WHO has met with similar challenges as for other WHO hosted private-public partnerships, including the dual governance problem and the limitations inherent in a large bureaucracy. On the other side, the benefit of the global reach and the WHO legitimacy for its work has been a definite strength. The experience with joint leadership for GHWA and the WHO HWF department will add more insights as to what kind of arrangement for hosting a multisector and multistakeholder platform could be made for the future.

A key feature of GHWA is the way it was constructed as an "all inclusive" partnership, created as a common platform for national governments, civil society, international agencies, finance institutions, researchers, educators and professional associations. As discussed in the section on the "partner landscape", this is a very diverse group of stakeholders with roles and interests that need quite a bit of "brokering" in order to achieve alignment for a shared purpose.

It is the experience in health partnerships that a common pot of funding can be the "glue" to have diverse actors and interests collaborate and align actions. For GHWA it was expected that a shared interests in overcoming the health workforce crisis would be sufficient to bring diverse actors around the table. Sharing and building knowledge together, the strength of joint advocacy and convening and the opportunity to make actions more effective by working together was perceived to be enough to sustain the alliance function. This perception has not proven true.

Apart from the convening and participating in global forums together, there have been little to demonstrate shared interest across the GHWA membership in joint activity. Global stakeholders have
their own workplans, fund raising and funding streams, their own contact with multilateral and bilateral partners and their own approaches to results and accountability. The Board members make decisions on what is expected from GHWA, but do not discuss what their own institutions contribute to the cause and how better coherence and alignment can be achieved.

GHWA was established with a time-limited mandate. This provides the opportunity to review the strength and the limitations of the current model and make choices that can better address the limitations while at the same time building on the strength.

The GHWA strategy for its two last years of operation seeks to address this by asking for clearer roles of members 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.

This offers important strategic guidance from the GHWA Board itself to the kind of alliance they want to see carry the GHWA legacy and serve to mobilize a coherent HRH response with a renewed commitment as enablers of country solutions; addressing persistent and new challenges and capturing the opportunities of the new global strategy, negotiated by WHO member states as a base for shared action.
5. **Approaches to Global Multi-sectoral Collaboration, Health Workforce**

5.1 Continued need beyond the current GHWA mandate

The early vision that led to the creation of GHWA is still relevant; the need for an "agile, responsive and non-bureaucratic movement to "promote country-initiated and country-led actions", work with and offer support to country leaders in addressing key gaps while at the same time promoting country leadership, ownership and capacity development." With the vision of HRH as a common, unifying theme, the Alliance was to "catalyze and facilitate the activities of its members through networking, working groups and task forces, to promote participation and enhance efficiency."

The identified priority needs (section 2) brings us back to the same key elements required for acting on the current health workforce challenges and responding to new opportunities. Much has changed in the way countries and regions now take the shared health workforce agenda forward. Even so, the summary of phase 1 consultations on status and missed opportunities highlight how global partners must be part of the solutions. Also new opportunities for action will likely require collaboration across sectors and between multiple stakeholders.

The GHWA Board decided in 2014 on an enhanced partnership model with clearer roles of members and partners, regional and global networks, with a progressive shift to member and partner-based activities in support of countries. Even if this shift in approach will be successful, it is expected that a global facilitating role, inclusive of all, will continue to be required.

*Just closing GHWA after the end of its agreed mandate is therefore not a desirable option. A phase out of GHWA as it operates today will require an analysis of mission critical tasks to take forward. The possible new HRH Stewardship and Anchoring Platform should be designed to take take these critical tasks into consideration and at the same time reflect agreed priority needs and new opportunities. The discussion should not be limited to a possible extension or adaptation of the current model.*

5.2 The Health workforce seen in the broader context of UHC and SDG

This discussion of approaches to multi-sectoral HRH collaboration and stewardship beyond the current GHWA mandate, takes as the starting point that there is a continued need for global collaborative and concerted action to enable all countries to meet their health workforce needs.

At the same time HRH action needs to be seen in the broader context with the growing momentum for achieving universal health coverage (UHC) and the ongoing global discussions of social justice and equity as a basis for sustainable development, and calling for more interconnected and more inclusive strategies across the various sustainable development goals being formulated.

It is not just in response to the health workforce that we see fragmented action. There are clearly expressed needs for developing more interconnected action between the education and the health sector, between health protection and social protection and between health and the world of work, gender and rights. All these "bridging challenges" require a multi-sector and multi-stakeholder response. An early pathfinder was the response to AIDS which already before the turn of the millennium was given an interconnected multi-sector mandate, including non state actors and communities affected in policy and planning as well as implementation. The question is therefore how does HRH depend on work across sectors and with multiple stakeholders, find approaches that benefit from this momentum, and seek collaboration with key actors that have similar challenges and have an interest in finding health workforce solutions.
While it is too early to spot where the potential for broader collaboration and alignment would be the highest, there are some obvious possibilities for seeking convergence of interest. Universal Health Coverage represent an umbrella for health systems development that require the health workforce component as much as the work on HRH need UHC as a unifying principle across sectors and actors.

Other health systems dependent alliances that seeks to overcome fragmentation and consolidate their partnership in support of equitable access in countries are PMNCH, the Alliance for Health Policy and Systems Research, the UN joint program on AIDS and IHP+. They represent a mixed bag of priorities, approaches and interests, but have many of the stakeholders in common and can contribute through their specific mission to a unifying UHC umbrella.

The global alliances and partnerships have to a large extent been perceived as "donor dominated" and "donor dependent". In the context of the new realities of transition from development assistance for health to a growing proportion of domestic funding supplemented with a mix of resources, there is a need to rapidly change the dynamics in the global partnerships to a country responsive mode of operation. This is also a trend for Global initiatives such as GAVI and the Global Fund.

Options for a Global multi-sector HRH partner platform should be discussed with this broader context and with these opportunities in mind.

5.3 Moving forward

For the purpose of developing options, this section starts with matching priority needs and stakeholder groups, to show that the expectations to these groups may be different in terms of where they take major responsibility (M) and where they have supportive (S), problem solving (X) and pathfinding (P) functions. Accountability mechanisms must be clearly defined.

In addition, there is a need for a construction that will be able to generate innovation, capture new opportunities and optimize linkages with the emerging new architecture for health and sustainable development post 2015.

The primary focus is to be responsive to countries with a clear commitment to support their capacity development in national institutions, in order to take the lead in finding solutions to their health force challenges, in terms of access, availability, appropriateness and quality. In principle countries carry the prime responsibility for setting up the structures and policies required to respond to the priority needs, the need for linkages and innovation. Global partners cannot take this responsibility away, but must be responsible for actions that are conducive to what countries intend to do and what countries can best do together. Building a community of sharing and learning is everybody's business.

It is all the stakeholders - countries, regional and global partners - that must be at the core of constructing the new alliance. The partners must have sufficient interest and stake in the work that they are called to do together, be ready to contribute in shared action to make collaboration work and be mutually accountable.
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<td>Core partners with HRH mandate and country engagement</td>
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<td>Partners that depend on HRH to achieve results</td>
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Major responsibility (M) supportive (S), problem solving (X) pathfinding (P) advocacy (A)

This preliminary effort to demonstrate that stakeholders have different strengths and opportunities is neither scientific not comprehensive. Within each of the stakeholder groups there are great variations. It also does not show the shift from a development perspective to a global sustainable perspective, where the role of each country around the world need to share responsibilities in new ways and in solidarity, given that health security for all depends on health security for the weakest part.

The table does, however, serve to highlight that an all inclusive platform for acting on these priority needs may not be the most appropriate to ensure that different stakeholder groups have enough of a shared interest to work together. An example is how key multilateral agencies representing different sectors and with engagement in response to HRH priority needs in countries can act better if they align their actions, make clear what they are ready to contribute and stand accountable for it to each other as well as to the broader community.

In the same way groups of HRH policy-practitioner-research-advocacy-implementing partners may find ways to act together around specific issues and themes where they can be pathfinders, innovators, problem solvers etc. The private sector is included but not made explicit as a part of this group but the way to explore interest and opportunities need to guide how to optimize their contribution.
5.4 Putting the pieces together - exploring options

Option I

GHWA negotiated extension - following the 2013-2016 model

The benefit is that we know the challenges, based on experience. In order to make an extension a viable option, these challenges need to be addressed: This model has not been "fundable", it has not been fit for harnessing country support, there has been slow pick up of the intended transition from the secretariat to members as the main implementers, and there is a need of further clarification of a conducive relationship to WHO

Option II

GHWA new version 2.0

a) GHWA as a cross-sectoral platform for health workforce that cuts across health and social care, employment, financing and education. As such, it could be structured as an "all inclusive partnership" where members take the responsibility for implementation ("PMNCH model"). In order to work it would need to establish strong linkages to implementation platforms for health workforce and health systems support to countries, such as IHP+.

b) GHWA as convener of a polycentric action alliance, bringing together different distinct stakeholder groups that collaborate on specific action agendas, such as i) international agencies with a core mandate on health and social care workforce - acting together in support of national institutions essential for stewardship of the HR response, ii) donors and global funds and initiatives acting together to overcome fragmentation in HRH action iii) Policy - practice - research - implementer networks that develop and share knowledge, ideas and solutions iv) stakeholders that focus on monitoring and accountability ...

c) GHWA as a platform for monitoring and accountability, tracking, monitoring and evaluating multiple contributions to health and social care workforce development, possibly linked to other independent accountability platforms, such as for EWEC

Option III

UHC as the umbrella for several partnerships

GHWA represented as a HRH partnership under the umbrella of a broader UHC partnership that bring together different partnerships and alliances aiming to contribute to UHC and benefiting from broader linkages

For all the options, there is a need to explore how the focus on the health workforce should be expanded to the health and social care workforce, with particular reference to the epidemiological and demographic shift, chronic care and integrated delivery.