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EXTERNAL EVALUATION OF THE GLOBAL HEALTH WORKFORCE ALLIANCE (GHWA) Final Report

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Executive summary

Global Health Workforce Alliance

In response to the global crisis in Human Resources for Health (HRH), GHWA was officially launched in 2006 to: *'advocate and catalyse global and country actions to resolve the human resources for health crisis, to support the achievement of the health-related millennium development goals and health for all.'*¹

The Alliance's priorities are: Advocacy for HRH in global policy agendas; Brokering knowledge and evidence-based responses; and Convening countries, members, partners and other stakeholders to work together for solutions to health workforce challenges.

The Alliance is hosted by the World Health Organisation (WHO) in Geneva, with a Memorandum of Understanding (MOU) until 2016 for its operations. It has its own Board, with broad international representation, and is supported by a Secretariat that utilises WHO administrative and financial procedures. There is a dual system for accountability, with the Secretariat reporting directly to the Board for programmatic results and to WHO for administration, personnel and financial matters. Although WHO was a founder member, it does not fund or direct the Alliance's operations.

External evaluation

The GHWA 11th Board in January 2011 agreed the terms of reference for an external evaluation (see Annex A), with the aim of analysing the Alliance's contributions and to reflect on its present strengths and weaknesses, as well as the opportunities and threats for 2011-2016. The 12th Board on 30 June 2011 accepted the inception report presented by OPM for the evaluation methodology, deliverables and proposed work schedule.

The evaluation used the framework recommended by WHO, World Bank GAVI and Global Fund²³ for monitoring and evaluation of health systems based on five major domains. Since the Alliance only began in 2006, the present assessment was limited to system inputs, processes and outputs, which reflect the present capacity of the Alliance.

The Alliance Secretariat supplied a comprehensive list of 84 contact names for the GHWA board members, donor agencies, Alliance Secretariat, UN agencies, Country Coordination and Facilitation (CCF) focal points, and partners in advocacy and brokering knowledge. This list was the main source for all contacts for the evaluation.

The team visited the Alliance Secretariat and WHO on 14, 15 and 18 July and 3 and 4 August 2011 and made country case study visits to Cameroon and Zambia between 15-19 August and Indonesia between 21-25 August.

Meetings with informants totalled 97, with 52 people (62% response rate) being global-level respondents and 45 in Cameroon, Indonesia and Zambia. For the 52 interviews, 22 (42%) were

¹ WHO (2006) Working Together for Health. Geneva World Health Organisation.

² Modified from Monitoring and Evaluation of Health Systems Strengthening: An operational framework (2010). Prepared by the WHO, World Bank, GAVI and Global Fund. Geneva: World Health Organisation.

³ Monitoring and Evaluation Toolkit: HIV, Tuberculosis, Malaria and Health Systems Strengthening. Geneva: Global Fund. February 2009.

face-to-face interviews and the rest were by telephone (For the list of informants, see Annex B).

The evaluation team first undertook a review of GHWA documentation (see Annex D) and then conducted the following six thematic studies: 1) Alliance at WHO headquarters in Geneva; 2) Task Forces and Working Groups (TF/WG); 3) Country case studies of GHWA support to Cameroon, Indonesia and Zambia; 4) Views of Board Members; 5) Views of main partners and supporting agencies; and 6) Value for money (VfM), sustainability and donor support. Evaluation guidelines for key informant interviews were developed for each study (see Annex C).

This evaluation identified many contributions made by GHWA. However, because it is mandated to collaborate with many different partners at global, regional and country levels, it is difficult to attribute to the Alliance any given changes or achievements. Indeed, to do this could even be interpreted as inconsistent with its original vision.

Review of GHWA documentation

This included an extensive listing of GHWA's publications, Board and Standing Committee reports, strategic plans, annual reports, press releases, newsletters, articles and its contributions to other publications. This review provided an overview of GHWA's achievements during 2006 to 2011 and its many activities in advocacy, brokering knowledge, and convening, including country actions and the monitoring of HRH interventions.

Thematic Study 1: Institutional analysis of the Alliance headquarters

Governance and the role of the Alliance Board

The Board guides the Alliance's overall vision and strategy, holds the Secretariat accountable for its operational activities, approves annual work plans and budgets, monitors financial resources, and approves financial statements and progress reports. The MOU⁴ with WHO allows for 20 members (See the Alliance's Governance Handbook 2010⁵). The Board on 30 June 2011 agreed to extend membership to include two additional members, as well as donors providing more than US\$ 300,000 per year which will have 'Associate Member' status.

The Board is relatively large and meets twice per year. The Standing Committee is often involved between meetings on both financial and operational matters, although it is unclear how well this works. The two Boards cost GHWA alone about US\$ 100,000/annum.

With regard to the Standing Committee it is worth noting three points: It seems to function as a finance sub-committee and provides some financial oversight; Fundraising is the responsibility of all Board members and Secretariat but no formal fundraising strategy exists; And there is an annual financial audit but only as a part of that for the wider WHO as a whole.

Organisation of the Alliance Secretariat

The Secretariat is at WHO Geneva and in the Health Systems and Services Cluster, which also includes WHO's own Department for Human Resources for Health (WHO HRH). Both report to the same Assistant Director General (ADG). The present Executive Director (EXD) has been at the Alliance since May 2008. GHWA has no focal points nor HRH specialists in the WHO Regional or Country Offices and neither does it maintain a country presence. At present, all CCF and country

⁴ Memorandum of Understanding between the Global Health Workforce Alliance and the World Health Organisation: Concerning Hosting, Secretariat and Administrative Services.

⁵ Global Health Workforce Alliance: Governance Handbook. January 2010.

support is organised from Geneva.

GHWA is required to utilise WHO managerial processes, with many outsourced to Malaysia. The Alliance Secretariat is undergoing a reduction in professional staff and will be implementing a leaner organisational structure in 2012. The Secretariat has been relying on temporary/short-term staff contracts and there has been a high staff turnover during the past two years.

The Board Chair has oversight directly with the EXD and through involvement of the Standing Committee. The evaluation team received comments that the Secretariat management style could be more inclusive and that there could be more clarity with regard to financial transactions.

Role in managing global advocacy and information on HRH

GHWA has been very active in global advocacy for HRH and this is often said to be its most successful activity since 2006. However, advocacy has focused mainly on raising awareness and tackling the global deficit in the numbers of health workers in developing countries, particular in sub-Saharan Africa. Advocacy has also moved to a higher political level involving world leaders. GHWA does not keep national HRH information but does support other organisations to do this.

Planning, training and management of HRH

The Alliance is not directly involved in these three items, although it does undertake advocacy to support them, as well as promote knowledge products at all levels. The Alliance recognises that this technical work is best done by the WHO HRH and other partner organisations.

Alliance relationships with WHO

GHWA has attracted funding, identified critical gaps and brought outside partners to WHO and it has often had a high international profile. However, it is said to have encroached on WHO's technical mandate and has made inadequate use of its normative and technical capacity. Confusion exists over mandates, despite both being in the same WHO Cluster. Previously, GHWA invested in technical task forces and more recently has promoted the CCF process. However, the new WHO Code is a good example of joint working between WHO, World Health Assembly and GHWA.

GHWA benefits from being at WHO, but is also seen as being in competition with the Organisation for donor funds. By clarifying their mandates, both WHO HRH and GHWA could strengthen each other and be more complementary. GHWA is seen as being more successful than WHO HRH in advocacy and communications, while HRH is seen to be stronger in technical matters and strategic planning.

The WHO Director General (DG) is open to renegotiate its existing Memorandum agreements. Following the fall in donor funding, both GHWA and WHO HRH staff will be substantially reduced over the next year or so, which has led to suggestions that both should be working much more closely together and that the two mandates urgently need further clarification.

Thematic Study 2: Analysis of the TF/WG

The TF/WGs were set up to address key global priority areas for HRH and produce specific products aimed at accelerating action to strengthen national health workforces. The evaluation examined those for education and training, tools and guidelines, financing, migration, private sector, and universal access to HIV treatment. Each TF/WG was individually constituted, had its own reference, plans, and budgets, and was time bound. The total cost recorded by GHWA for all TF/WGs since 2006 was nearly US\$ 3.3 million.

The evaluation found that the TF/WGs benefited from having international experts and produced reports of a high technical standard. Although each product was specific, all contained useful and practical guidelines for improving HRH. However, the Secretariat was not actively engaged in the roll out and application of the products and no systematic approach was used for dissemination and follow-up. Products do not appear to be widely used and are little known in crisis countries.

Thematic Study 3: Country studies of GHWA support to Cameroon, Indonesia and Zambia

These were undertaken by the evaluation team and focused on the role of GHWA and its CCF process at country level. The evaluation found that each country showed a high political commitment to HRH and had established a multi-stakeholder coordinating committee that was developing a costed national HRH strategy. Catalytic funding was important in both starting and maintaining the process. In addition, each country had a dedicated and committed national leadership.

While the CCF process appears to be reasonably successful, the evaluation also found that GHWA is not well known and that WHO Country Offices only play a marginal role apart from the routing of funds. The potential role of bilateral donors has yet to be strengthened. The real test of GHWA's country support will come as the coordination committees and the ministries of health in crisis countries attempt to go to scale with implementation of their strategy.

Thematic Study 4: Views of Alliance Board Members

The OPM evaluation team sent e-mail requests to 20 Board members and alternates, and made contact with 13 (62%) members, with six being interviewed in person and seven by telephone.

The evaluation found wide agreement that the Alliance's focus on the three functions of advocacy, brokering knowledge and convening remained highly relevant and provided a focus for GHWA's present activities and future priorities. However, apart from this agreement, there were also considerable differences of opinion between Board members on a number of issues, including on the future of the Alliance. This suggests that the Board should reconsider its strategy for 2012–2016. Most members wanted the Alliance to continue, but many did not see GHWA continuing as it is now.

Board members noted that the HRH 'landscape' had evolved since 2006 and that the Alliance faced a growing number of similar international organisations. Members also felt it is time for the Alliance to rethink the relative importance of all three functions at each of the global, regional and country levels. Some members indicated that GHWA is too oriented to 'processes' and 'outputs', with insufficient attention being given to quantifiable objectives and targeted 'outcomes' at country level. Others felt it should raise its advocacy and focus more on presidents, ministers and permanent secretaries. Members also held diverging views on the importance of implementing the new CCF process.

The diverse views amongst Board members suggests that GHWA needs to undertake a full review of its future strategy, including for fundraising, as well as carrying out an analysis of the Board's organisation and its oversight of the Secretariat.

Thematic Study 5: Views of partners for advocacy and brokering knowledge

The evaluation team sought views on the importance of the Alliance, its present strengths and weaknesses and its future priorities. The evaluation found that the Alliance has worked successfully with various global stakeholders, although it has been less successful as a true alliance of many different partners. GHWA has over 330 Members with interests in HRH but their role is unclear and only a few have been encouraged to become more involved in Alliance

activities. The two Global Forums have been instrumental in bringing together many different global partners and regional members.

The evaluation found that, although GHWA is constituted as a global alliance, it is largely perceived to be a Board and Secretariat located at WHO Geneva. Many partners see this as a missed opportunity to work together in support of crisis countries.

Thematic Study 6: VfM, sustainability and donor support

This evaluation assessed the Alliance at the global and headquarters levels. The annual budgets and expenditures were analysed. In addition, the likelihood of future donor commitments and threats to GHWA's sustainability during 2011–2016 were obtained using key informant interviews.

There is a budget shortfall in 2011 due to a reduction in funding by main backers which has not been adequately offset by funding from new donors. Most prominent has been the Norwegian Ministry of Foreign Affairs, which recently announced it would reduce its 2011 allocation by almost 90% over the previous year (US\$ 3.2 million). This has reduced funds to pay for the Alliance Secretariat.

Donors have variable attitudes towards GHWA's future, with several saying that this would depend on the Alliance improving its strategic planning and achieving a stronger focus on outcome results. Donors would also like to see more transparency in the use of funds.

The 2011 revenue will be substantially below the original target and further shortfalls are anticipated for 2012.

The work plan projections for 2009–2011 have been unrealistic, with total accumulated funds for 2009 falling from US\$ 16,640,436 to US\$ 12,570,549 in 2010. Revenues have fallen further in 2011, with a shift of programme funds to cover Secretariat costs. 2011 expenditures will run at 31% of those envisaged. Secretariat costs, which were expected to be 21% of total expenditure, are now projected to be almost 61%, with staff costs now the largest single expenditure, largely due to Geneva post-supplements rising recently to 115% of salary.

GHWA's financial accounting is based on the WHO biennial system, but GHWA's budgets and expenditures are complicated by the absence of a standard accounting format and the use of different accounting sub-heads in different years. Reconciling financial data has proved difficult. GHWA is facing recharges in relation to two over-spends incurred in the previous biennial, which total some US\$ 786,000 or about 10% of the 2011 budget.

Conclusions on the Alliance's achievements

GHWA's strengths are seen as it being strong on global advocacy and convening, the success of the global forums, and that it benefits from being located at WHO Geneva, having an independent Board and Secretariat, and an ability to work at global, regional and country levels. However, there are also significant future threats, including the number of new global and regional HRH organisations, lack of innovation in renewing strategy, increasing competition for donor funds, limited in-house professional HRH expertise, and a possible fall in credibility affecting its ability to lead the global HRH alliance.

The evaluation has also presented its conclusions on the five areas identified in the terms of reference. The main lesson from this evaluation is that GHWA is recognised as having contributed a great deal to raising interest and concerns to improve HRH. However, it is doubtful that continuing with its present strategy and ways of operating will be an acceptable option. GHWA will

need, therefore, to renew both its strategy and organisation if donors and partners are to continue supporting the Alliance.

In considering its future strategy for 2012–2016, GHWA needs to consider what balance it should give to the three strategic functions of advocacy, brokering knowledge and convening, as well as its ability to promote its activities at the three global, regional and country levels.

Other issues that need consideration are whether to remain located at WHO Geneva or become more integrated with WHO HRH, how partners and members can be more involved in the governance of GHWA, and what should be the balance of GHWA working through partners compared with promoting its own activities, particularly at country level.

Given that GHWA is now entering its second five-year period, recommendations are made to underpin and strengthen the Alliance, including that the Board: 1) undertakes an urgent review to assess its effectiveness; 2) engages in discussions to renew the Alliance's strategy for 2012–2016; 3) convenes a WG to renew the Alliance's fundraising strategy; 4) reviews the Alliance's working relationships with WHO; and 5) establishes a small Finance Sub-Committee to oversee on a regular basis GHWA's income and expenditure accounts.

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Abbreviations

AAAH	Asia Pacific Action Alliance for Human Resources in Health
ADF	French Development Agency
ADG	Assistant Director General
CCF	Country Coordination and Facilitation
CHAI	Clinton Health Access Initiative
CHAZ	Christian Health Association of Zambia
CHW	Community Health Worker
CIDA	Canadian International Development Agency
DFID	Department for International Development
DG	Director General (WHO)
EU	European Union
EXD	Executive Director
GHWA	Global Health Workforce Alliance
GIZ	Gesellschaft für Internationale Zusammenarbeit
GMS	Global Management System
HWAI	Health Worker Advocacy Initiative
HWMI	Health Worker Migration Policy Initiative
HRDP	Health Resources Development Plan
HRH	Human Resources for Health
JLI	Joint Learning Initiative
KD-AGA	Kampala Declaration and Agenda for Global Action
MDGs	Millennium Development Goals
MOU	Memorandum of Understanding
NCD	Non-Communicable Disease
NGO	Non-Governmental Organisation
NORAD	Norwegian Development Agency
OPM	Oxford Policy Management
PPE	Positive Practice Environments
PAHO	Pan-American Health Organisation
RRT	Resource Requirements Tool
SWOT	Strengths, Weaknesses, Opportunities and Threats
TFWG	Task Force and Working Group
USAID	United States Agency for International Development

VfM	Value for Money
WHO	World Health Organisation

1 Background

In response to the global crisis in HRH, the GHWA was officially launched in 2006 to:

*'advocate and catalyse global and country actions to resolve the human resources for health crisis, to support the achievement of the health-related millennium development goals and health for all.'*⁶

The Alliance is hosted by WHO in Geneva, with an MOU that envisages a current time limit of 2016 for its operations. It is overseen by the GHWA Board, with broad international representation, and supported by the Alliance Secretariat that utilises WHO administrative and financial procedures. The Secretariat reports directly to the Board for programmatic results and to WHO for administration of personnel and financial matters. Although WHO was involved as a founder member, it does not fund nor direct the Alliance's operations.

The GHWA operational plan 2006–2007 selected eight Pathfinder Countries⁷ from among the 57 countries identified by the WHO World Health Report (2006)⁸ as facing a serious health workforce crises.⁹ To accelerate their HRH country actions, each one received catalytic financial support¹⁰ and progress was summarised by the Alliance in November 2008.¹¹

Early in its advocacy and brokering knowledge roles for HRH, GHWA established TF/WG to tackle urgent technical and programmatic issues and make recommendations for meeting the HRH crisis at global, regional and national levels. These drew on a wide range of international experts in HRH and were either fully or partially funded by GHWA.

In 2008, GHWA convened the first Global Forum on HRH in Kampala, Uganda, which was supported by a large number of different partners. Following the Forum, the Alliance developed a Strategic Plan – called 'Moving Forward from Kampala' – with its strategic ABC priorities for 2009–2011, summarised as follows¹²:

- **Advocacy** for HRH in global policy agendas, including highlighting the HRH crisis, identifying solutions, and providing international support.
- **Brokering knowledge** and evidence-based responses, including use of best HRH practices and recommended planning methods and guidelines.
- **Convening** countries, members, partners and other stakeholders to work together for solutions to health workforce challenges.

In 2009, GHWA developed its strategy for CCF that aimed at supporting key countries to tackle their HRH crisis. Building on the eight pathfinder countries supported by GHWA between 2006

⁶ WHO (2006) Working Together for Health. Geneva WHO.

⁷ The first countries were: Angola, Benin, Cameroon, Ethiopia and Zambia, with Haiti, Vietnam and Sudan added later.

⁸ Working Together for Health: World Health Report 2006. Geneva: WHO. 209 pages.

⁹ The World Health Report definition is having less than 2.28 doctors, nurses and midwives in order to achieve 80% coverage by skilled birth attendants and for measles immunisation.

¹⁰ GHWA (2011) Support for the Pathfinder Countries. Geneva: GHWA. 2011. 6 pages.

¹¹ GHWA (2008) Collaboration with Eight Pathfinder Countries. Geneva: GHWA. 2008, 17 pages.

¹² GHWA (2009) Moving Forward from Kampala: Strategic Priorities and Directions for the Global Health Workforce Alliance 2009–2011

and 2008, the CCF process began with 16 countries, with a further six added in 2011.¹³

In January 2011 the Second Global Forum was convened in Bangkok, Thailand, to review progress in global HRH since Kampala. In preparation for this event a progress report on the Kampala Declaration and Agenda for Global Action (KD-AGA) was published by GHWA¹⁴.

GHWA's main activities for Advocacy, Brokering Knowledge and Convening at global, regional and country levels since 2006 are summarised in Table 1.1 below.

Table 1.1 Summary assessment of GHWA's main contributions during 2006–2011 to HRH at global, regional and country levels

Alliance ABC strategic priorities	Advocacy for HRH in global policy agendas	Brokering knowledge and evidence-based responses	Convening countries, partners, members and stakeholders
Global actions	High-level international meetings , such as G8, UN, WHO	TF/WG	Global forums , held in Kampala and Bangkok
Regional support	Asia Pacific Action Alliance on HRH African Platform on HRH African Public Health Alliance GHWA CCF regional meetings		
Country support		CCF Process	

At the GHWA Board meeting on 30 June 2011, the Alliance adopted an interim strategic framework for 2012 pending the outcome from this external evaluation.

Background to the evaluation

During the 10th Board meeting in June 2010, the board decided to conduct an external evaluation and the 11th meeting in January 2011 agreed on the terms of reference (see Annex A). The overall objective was to review the first five years of the Alliance and its activities for health workforce development since its launch in 2006 and to identify recommendations for the future work of GHWA.

¹³ Afzal M and Codjia L (2011) Convening for Country Actions. Presentation during GHWA board retreat 29–30 June 2011.

¹⁴ GHWA (2010) Reviewing Progress, Renewing Commitment: Progress report on the Kampala Declaration and Agenda for Global Action. Global Health Workforce Alliance. Geneva: World Health Organisation. 2010, 182 pages.

The terms of reference required the evaluation to explore the following key areas of enquiry:

- Coherence of strategy with mandate, added value and complementarity with and contribution to the work of other key HRH stakeholders;
- Results, capacity and credibility acquired to date as:
 - o global advocate for greater political commitment and increased resource mobilisation for HRH;
 - o broker for knowledge for HRH;
 - o convenor of collaborative events and platforms;
- Results in fostering partnerships and promoting consensus for coordinated and integrated responses to HRH challenges at global, regional and country levels;
- Relevance of the work and strategic functions supported by the Alliance at global, regional and country levels on national HRH policy making and HRH development; and
- Track record and future prospects on mobilising financial resources to sustain the core functions of the Alliance Secretariat.

Following the award of the contract for the external evaluation of GHWA to OPM, an inception report, including the evaluation methodology, deliverables and proposed work schedule, was presented to the GHWA Retreat and Board meeting in Switzerland on 29 and 30 June 2011.

The evaluation approach and activities are outlined next, including an explanation of why we focus on evaluating inputs, processes and outputs rather than health outcomes and impact, recognising that only after a further five years would it be appropriate to focus on the latter. An analysis of the most significant GHWA documents follows next and then the findings from the six in-depth thematic evaluation studies. The assessment of the Alliance's achievements is presented under the headings given in the terms of reference and this is followed by the conclusions from this evaluation. Finally, recommendations are made concerning GHWA's future during 2012–2016 and some questions are presented concerning possible options for GHWA's future role for the period up to 2016.

2 Evaluation framework and methods

This evaluation used the conceptual framework recommended by the World Bank, WHO¹⁵ and the Global Fund¹⁶, although this evaluation was restricted to the first three domains of inputs, processes and outputs. The evaluation focused only on HRH issues and the role of the Alliance in relation to these. It did not include any analysis of health outcomes or health impact that might be attributed to the Alliance as to do so would be premature.

2.1 Review of documentation

With the aim of understanding the evolution of the Alliance, as well as how the Secretariat came to be hosted at WHO Geneva in 2006, the evaluation team undertook an extensive review of GHWA documentation for the period 2006–2011 (for the key documents reviewed, see Annex D).

Besides reviewing the GHWA documentation, the external evaluation relied on quantitative financial data as reported by the Alliance Secretariat based on its own accounts as well as other documents provided or referred to by key informants.

2.2 Thematic evaluation studies

In an effort to assess the various dimensions in which the Alliance operates, the evaluation team undertook six in-depth thematic studies selected to investigate the most important aspects of GHWA's work during the period 2006–2011. These were:

- Alliance Secretariat at WHO headquarters in Geneva
- Task Forces and Working Groups
- Country case studies of GHWA support to Cameroon, Indonesia and Zambia
- Views of Board Members
- Views of main partners for advocacy and brokering knowledge
- VfM, sustainability and donor support.

Guidelines for each of the six thematic studies were developed by the OPM evaluation team and shared with the Secretariat for their comments prior to the relevant study. These guidelines defined the scope of each thematic study and the questions to use as a guide when carrying out the key informant interviews (see Annex C).

2.3 Selection of respondents

The Alliance Secretariat supplied the OPM evaluation team with a comprehensive list of 86 contact names that included GHWA Board members, Alliance Secretariat staff, UN partner agencies, CCF focal points, partners in advocacy, partners for brokering knowledge, and for Donors and development partners that were not included as members of the Board. This list formed the main source of contacts for the evaluation (for details of persons interviewed, see Annex B).

The evaluation methodology relied mainly on contacting key selected informants for interview,

¹⁵ Modified from: Monitoring and Evaluation of Health Systems Strengthening: An operational framework(2010). Prepared by WHO, World Bank, GAVI, and Global Fund. Geneva: World Health Organisation. 26

¹⁶ Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria, and Health Systems Strengthening: Part One – The M&E system and Global Fund requirements. Geneva: The Global Fund. Third edition, February 2009.

based on the above GHWA list of names. Contacts were either approached by appointment with the support of the GHWA Secretariat, which included most of the meetings made with staff working at WHO and for GHWA in Geneva, or via e-mail. The latter were sent an e-mail outlining the purpose and scope of the external evaluation and requesting a date and time for an interview in person or by telephone. The e-mail gave questions that indicated the broad areas of concern for the evaluation, as well as a strong reassurance that all interviews were strictly confidential and that no individuals would be identified. The individual contact was only classified as a non-responder if there was no response following a second follow-up e-mail. Certain individuals were also contacted by telephone following the second e-mail.

2.4 Key informant interviews

The evaluation developed study guidelines for the key informant interviews, so as to have an in-depth exploration of the attitudes, expectations and experiences of the Alliance from the perspective of its global partners, donors and HRH crisis countries themselves. Interview guidelines were only used as a guide for the unstructured interviews and not systematically as questionnaires (for details of thematic study guidelines, see Annex C).

The contacts that responded positively to the request for interview were consulted in person or by telephone in a free flowing and unstructured manner. Respondents were encouraged to start with the topics and concerns that they related most closely to during their collaboration with GHWA and no attempt was made to interrupt the conversational flow. This meant that each interview focused on different areas depending on the respondent's area of expertise and level of interaction and engagement with GHWA.

Efforts were made to maintain complete neutrality in the way questions were posed, although the nature of this work meant that respondents tended to spend more time discussing the potential areas of improvement rather than the achievements, which were often discussed more briefly. As a result, this report devotes more space to these areas, which does not mean that they outweigh the positive findings but rather that respondents had more to say about them.

The main points from each interview were summarised and recorded so that the findings for each thematic evaluation study could be analysed separately. No follow-up interviews and no focus group discussions were undertaken with respondents.

2.5 Interviews, visits and fieldwork

The OPM evaluation team leader attended GHWA's Retreat and Board meeting near Geneva on 29 and 30 June 2011 and presented the OPM inception report, which was later approved by the Board. The team also visited the Alliance Secretariat and WHO in Geneva on 14, 15 and 18 July and 3 and 4 August 2011. Unfortunately, because of the timing of the evaluation, a number of contacts were unavailable for interview as the visits were carried out during August when many people were on leave.

The evaluation team also made country case study visits to Cameroon and Zambia between 15 to 19 August and Indonesia from 21 to 25 August. The Alliance Secretariat suggested these three countries as ones which were supported by GHWA and which appear to have made good progress. Findings from the three country case studies, while not being representative, provided useful insights and explanations for the role of the GHWA at country level.

The financial analysis, which was undertaken using the Alliance's own system for its income and expenditure accounts, examined the Secretariat's core running costs and expenditures on collaborative activities with the Alliance's partners. It also looked at GHWA's prospects for

sustaining its income for work during 2011–2016.

2.6 Response rates

The total number of meetings with informants was 97, of which 52 were with global-level respondents and 45 with those in Cameroon, Indonesia and Zambia. Of the 52 at global level, 22 were face-to-face meetings, one was by completing a structured questionnaire and the remainder were telephone interviews. The response rate after at least two e-mail enquiries to global respondents was 52 from 86 possible contacts (60%). For the full list of informants, see Annex B).

Table 2.1 Response rates from key contact list

Category	Number of contacts provided by GHWA Secretariat	Number of respondents interviewed	Response rate
GHWA board members	21	13	62%
GHWA secretariat staff	11	11	100%
UN agencies as partners	7	2	29%
CCF focal points	11	6	55%
Partners in advocacy	10	5	50%
Partners in brokering knowledge	17	6	35%
Donors (excluding board members)	9	9	100%
TOTAL	86	52	60%

2.7 Analysis of informant interviews

It is important to recognise that respondents had various types of engagements with GHWA and different levels of knowledge of GHWA's activities and achievements. Some collaborated extensively and over long periods of time, while others had only interacted with the Alliance for a short period and for a very specific reason. As a result, it did not make sense to quantify the proportion of respondents that held a particular view and nor would this have been possible due to the need to maintain the confidentiality of respondents. Where possible, however, efforts have been made to indicate broadly in the evaluation the volume of respondents that shared a particular view.

In analysing the feedback from respondents, two groups of findings emerged: those topics and concerns where there was a substantial convergence of views and opinions and those issues for which there was considerable variation in the perspectives held by respondents. In order to clearly illustrate the extent of the convergence and divergence of views within and across categories of respondents, the report is deliberately structured in such a way that the findings of each category of respondent are presented separately, rather than structuring the report around a specific theme which would potentially mask this important information.

2.8 Potential sources of bias

In interpreting the findings, the following methodological issues need to be taken into account:

- The contact list provided by GHWA was the principle source of respondents for the evaluation.
- The response rate among global-level contacts was found to be higher than country-level

contacts.

- Contacts that had a recent or ongoing collaboration with GHWA showed a greater willingness to participate in the evaluation, which in some cases led to a greater focus on how GHWA fares on a particular issue now, rather than how it was in the past.
- There appeared to be a lower response rate from French- rather than English-speaking nationals.
- The total sample size was small and when disaggregated by category of respondents was in some cases less than 10 individuals.
- Countries selected for case studies were perceived by GHWA to be successfully implementing the CCF process.
- The variation in the extent of engagement, duration of interaction and how informed respondents were meant that respondents' views had to be weighted accordingly. The evaluation team had to rely on their judgement to do this.

2.9 Identifying GHWA's contributions and attribution

This evaluation has identified many different contributions made by GHWA to solving the global HRH crisis. However, since the Alliance strategies and activities rely heavily on collaboration with a wide range of different partners and organisations, either directly or indirectly, at the global, regional and national levels, it has proved difficult to attribute any of these achievements directly to GHWA, either partially or completely. For similar reasons, assigning causality to GHWA for any constraints in collaboration or for any lack of progress is also a challenging task.

3 Review of GHWA documentation

The evaluation team conducted a review of documents produced by and relating to the Alliance, including: GHWA publications, standing committee and board reports, press releases, newsletters, and academic articles. It also included other publications and reports to which GHWA has made a significant contribution (see Annex B). While it is not possible to present the findings in detail here, this section provides an overview of the key points of interest to this evaluation.

3.1 Beginning of the GHWA

GHWA was launched by the World Health Assembly on 25 May 2006 as the realisation of a shared desire among the main actors in international cooperation to tackle the crisis facing HRH. The initiative built on work undertaken by the Joint Learning Initiative (JLI),¹⁷ pronouncements made at the Oslo Conference (2004), and on the World Health Report (2006),¹⁸ all of which highlighted the HRH crisis as an impediment to achieving the Millennium Development Goals (MDGs). Prior to the formation of the Alliance, the Brazzaville Consultation (18–20 July 2005) made recommendations for overcoming HRH constraints and the establishment of ‘a common platform to facilitate buy-in from global programmes into national plans’.¹⁹

WHO was instrumental in the establishment of the Alliance, as evidenced by the memo from ADG/EIP²⁰ in December 2005 to the effect that a team had been contracted to develop a Business Plan with specific terms of reference for the Alliance. Consultations began on 5 January 2006, with a target to launch the Alliance with the World Health Report in April 2006.

GHWA was envisaged as a worldwide alliance of partners involved in HRH. The main stakeholders in the field of global health included international organisations, donors, recipient governments, national agencies, health initiatives and non-governmental organisations (NGOs). The aim was to seek improvements in the country education, training and organisation of health workforces.

MOU between WHO and the Alliance²¹

The MOU between WHO and GHWA is the legal instrument for the Alliance’s existence. The MOU sets out the Mission, Strategic Objectives and Plan of Action for the Alliance and clarifies its status. It was not to be a funding agency except for catalytic funds. In addition, the Alliance was not expected to be an implementing agency but rather one for leveraging networks and initiatives on HRH. The MOU also outlines the membership of the Alliance, the structures (Board, Secretariat and Forum) and the TFWG, coordination mechanisms and regional networks. According to the MOU, the Alliance may be dissolved on 30 June 2015.

World Health Report 2006

Building on the work of the JLI and the Oslo Conference in 2004, the World Health Report launched in May 2006 succeeded in raising HRH to a very high profile. Through its key messages

¹⁷ JLI (2004) *Human resources for health. Overcoming the crisis* Global health Initiative/Harvard University Press; 2004.

¹⁸ WHO (2006) World Health Report 2006. Working Together for Health. WHO

¹⁹ WHO, NEPAD ACOSHED (2005) Regional Consultative Meeting: Taking the Human Resource for Health Agenda Forward at the Country Level in Africa. Brazzaville Congo. 18–20 July 2005.

²⁰ Evan T (ADG/EIP). Internal Memorandum: Developing a strategy and business plan for the global alliance on the health workforce. WHO, Geneva; 28 December 2005.

²¹ GHWA and WHO (2006) Memorandum of Understanding between Global Health Workforce Alliance and World Health Organization concerning Hosting, Secretariat and Administrative Services; Geneva, October 2006

it was instrumental in positioning the new Alliance at the centre of a worldwide partnership seeking rapid solutions to the present crisis. The Report also identified the crisis countries and called for concerted global action on the low numbers and mal-distribution of available HRH. Apart from the crisis countries, the Report also brought to the fore significant statistics that continue to drive efforts to reverse the HRH crisis, such as the absolute lack of more than 4 million health care workers and the critical mass of 2.28 nurses/midwives/physicians per 1,000 of the population required for the delivery of essential services in primary health care.

Board decisions: 21 June 2006²²

Soon after the launch of the Alliance, the transitional working group met on 21 June 2006 and took a major decision to transform themselves into an interim Board for a period of one year. The interim Board agreed the terms of reference for the GHWA, confirmed the Board members, and determined their length of service. The Board structure was also approved and the various committee members were appointed. The Board Meeting confirmed that the Board would have an executive committee, a nominating committee, and then programme/policy committees, each with designated roles. On strategic issues, the Board identified the following five priority interventions that continue to guide the work of the Alliance today:

- Accelerating country work;
- Strengthening health workforce partnerships and initiatives;
- Advocating for HRH;
- Building and managing knowledge; and
- Addressing specific challenges, such as migration.

Strategic Plan 2006–2016²³

The Alliance Strategic Plan (2006–2016) identified the following deliverables: increased number of countries with strong HRH strategic plans; ramped-up investments in pre-service education; stronger workforce policies and regulations; expanded body of knowledge; the existence of global focal points for information and communication, knowledge and learning; and the provision of catalytic funding. Country-specific initiatives included medium-term HRH plans/roadmaps to stimulate stronger political ownership, more effective and efficient action, multi-stakeholder inclusiveness and central coordination. The strategy also identified pathfinder countries in which the Alliance would start work to effect changes towards better HRH management.

KD-AGA²⁴

The first Global Forum on HRH was held in Kampala, Uganda, from 2 to 7 March 2008 and over 1,500 participants came together to discuss the way forward in tackling the global health workforce crisis. The ensuing KD-AGA called for:

- Building coherent national and global leadership for health workforce solutions;
- Ensuring capacity for an informed response based on evidence and joint learning;
- Scaling up of health worker education and training;
- Retaining an effective, responsive and equitably distributed health workforce;
- Managing the pressures of the international health workforce market and its impact on migration; and
- Securing additional and more productive investment in the health workforce.

²² GHWA (2006) Interim Board Decisions 2006 (Background to GHWA); Geneva

²³ GHWA and WHO (2006) GHWA Secretariat. Strategic Plan. WHO, Geneva, 2006.

²⁴ GHWA and WHO (2008) The Kampala Declaration and Global Agenda for Action. Geneva, 2008.

The meeting endorsed the KD-AGA, which was built on previous commitments by high-level policy-makers and set out a roadmap to guide work on HRH over the following decade. The KD-AGA synthesised the key messages from the Forum in areas such as migration, education, development, inadequate working environment and finance. It called upon all stakeholders at country, regional and global levels to take collective responsibility for addressing the health workforce crisis.

3.2 Continuing advocacy

This section outlines some of the key contributions of the Alliance through various advocacy tools and activities. According to its Advocacy and Communications Strategy (2009–11), the advocacy goal of the Alliance is to:

‘Mobilize governments, international organizations, civil society, the private sector and other stakeholders to expand and implement national and international political programmes and funding commitments – translating commitments into concrete actions.’²⁵

Recognition of HRH in health and development events

The Alliance has played a key role in ensuring the challenges relating to HRH have been addressed in high-level health and development forums, including the following:

- Having made a commitment to addressing the scarcity of health workers during the G8 summit in 2009, the G8 leaders reaffirmed this commitment at the G8 summit in Italy in July 2010 and again at the G8 summit in France in May 2011, each time taking note of the KD-AGA.
- The Alliance Secretariat participated in the WHO Forum and Ministerial Conference on non-communicable diseases (NCDs) in Moscow in April 2011 by speaking at a side session and co-authoring a paper called: *No Health Workforce: No Health MDGs. Is that acceptable?*²⁶
- At the UN High-Level Meeting on Aids held in New York in June 2011, the Alliance sought to bring the HRH issue to the fore in the HIV/Aids response by organising a side event called *Can we achieve MDG 6 with the health workforce we have?*²⁷

Mainstreaming of HRH in development reports

Through its contribution to the development of a number of strategies and reports, the Alliance has played an important advocacy role in ensuring that HRH were mainstreamed into the final versions of important reports, including the following:

- The UN Secretary General’s Global Strategy on Women’s and Children’s Health, launched in September 2010, recognises the central role of training and recruitment of health workers in the response to women and children’s health.²⁸

²⁵ GHWA (2009) Advocacy and Communications Strategy of the Global Health Workforce Alliance (2009–11)

²⁶ GHWA (2010) No health workforce: No health MDGs. Is that acceptable? Summary of discussions at the Side Event on Human Resources for Health at the UN MDG Summit, September 2010

²⁷ GHWA (2011) Can we achieve MDGs with the health workforce we have? Report of the side event at the UN General Assembly High-Level Meeting on Aids.

²⁸ United Nations Secretary-General (2010) Global Strategy for Women’s and Children’s Health. United Nations Secretary-General Ban Ki-moon. New York. September 2010.

- The Alliance contributed to the first State of the World Midwifery Report – *Midwifery Workforce Management and Innovation* – through the development of a chapter on the management and support of midwives.²⁹

Influencing global health initiatives for increased support for HRH

The Global Fund calls on eligible applicants to make use of the funding window available for Health System Strengthening by responding directly to needs in relation to Malaria, TB and HIV/Aids. The Alliance has been actively encouraging countries to use this opportunity to secure funding for HRH. It also contributed to the Global Fund's information note³⁰ that provides essential and practical information on how to develop or integrate HRH components into proposals for Round 11.

Website and media partnerships

In 2009, the Alliance redesigned its website, making it easier to navigate and offering more informative data and material. The new multi-lingual dimension also made it more widely accessible. For example, in an effort to raise awareness of the global health worker crisis, the Alliance partnered with the Guardian newspaper in launching a special and dedicated health workforce micro-site: <http://www.guardian.co.uk/global-health-workers>

Health Worker Advocacy Initiative (HWAI)

In 2007, the Alliance supported the launch of the HWAI, which aims to support civil society-led advocacy initiatives at the country level. The adoption of the Code of Practice on Health Worker Migration and recognition of the HRH crisis by G8 leaders are two examples where the Alliance has collaborated effectively with HWAI.³¹

WHO Code of Practice on the International Recruitment of Health Personnel³²

The Health Worker Migration Policy Initiative (HWMI) was established by the Alliance, which also funded its activities. The Alliance convened Realizing Rights and a WHO-led team of experts. It was established in 2007 to promote and support the implementation of bilateral, regional and multilateral agreements and other policy innovations on health worker migration. Among its key activities, the initiative supported WHO in the development and finalisation of the Global Code of Practice on the International Recruitment of Health Personnel, which was finally adopted at the World Health Assembly in Geneva in May 2010.

This voluntary code sets out recommendations for member states, including both source and destination countries. It is a key milestone in fulfilling the commitment in the KD-AGA. In order to ensure that the provisions of the Code are put into practice, the Alliance Board has pledged to continue its role of convening stakeholders at both global and national level by using the CCF process as an entry point for country-level engagement.

²⁹ Roskam, E *et al* (2011) State of the world's midwifery. Midwifery workforce, management and innovation. June 2011

³⁰ The Global Fund's Approach to Health System Strengthening. Proposals for Round 11, launched August 2011.

³¹ See www.hwai.org

³² WHO. (2010) WHO Global Code of Practice on the International Recruitment of Health Personnel, 63rd World Health Assembly. Geneva, 2010

3.3 Brokering knowledge

The Alliance defines knowledge brokering as the sharing of good practices, contributing to the development of a skilled, motivated workforce by providing evidence of what works and providing links to information for training and capacity building. Through its network of members and partners, the Alliance is in a unique position to identify, select and disseminate information using a range of formats and channels.

TF/WGs

In keeping with its strategic priorities, the Alliance established a number of mission-orientated, time-bound TF/WGs that brought together international experts to develop evidence-based solutions to the HRH crisis. The six main TF/WGs addressed issues relating to: HRH scaling up education and training, development of tools and guidelines, financing, migration, private sector, and universal access to HIV treatment.

Country case studies on Positive Practice Environments (PPE)

GHWA supported, together with other agencies, a review of PPEs in Uganda³³, Zambia³⁴ and Morocco³⁵. The three reports are comprehensive, including reviews not only on PPE-specific issues, but also on the whole HRH context including under-financing of health systems, unsatisfactory conditions of work, lack of tools to manage HRH, and exodus of health care professionals. For Uganda and Zambia there is also a review on the impact of HIV/Aids on the health workforce. Shortfalls in professional working environments were highlighted and recommendations made on how to enhance health worker performance.

Costed HRH Plans: Resource Requirements Tool (RRT)

Developed by the Alliance's TF on HRH Financing, the RRT is an Excel-based costing tool that helps countries to estimate the financial resources required to implement their HRH plans.³⁶ It is designed to capture all the costs of developing and scaling up the health workforce in both the public and private sectors. A modular format enables estimates to be made of the costs, the affordability of pre-service training plans, and HRH employment. The RRT was launched by the Alliance in July 2009 and has since been piloted in Ethiopia, Liberia, Malawi, Mozambique, Peru, the Philippines, Sierra Leone and Uganda.

HRH country profiles

In 2009, the Alliance, in partnership with WHO, initiated a process of supporting the development of HRH country profiles across a number of crisis countries. These profiles, which were based on country self-reporting, have proved useful in providing general HRH information on numbers of health workers and their production, work environment and governance, as well as identified information gaps in relation to each of the countries.

³³ Matsiko CW. Positive Practice Environments in Uganda: Enhancing health worker and health system performance. GHWA and PPE Campaign Partners, Geneva, 2010.

³⁴ Ngulube TJ. The Zambia Country Case Study on Positive Practice Environments (PPE) Quality Workplaces for Quality Care. GHWA and PPE Campaign Partners, Geneva, 2010.

³⁵ Semlali H. Positive Practice Environments in Morocco. GHWA and PPE Campaign Partners, Geneva, 2010.

³⁶ See <http://www.who.int/workforcealliance/knowledge/publications/taskforces/ftfproducts/en/index.html> accessed on 3 December 2011.

Global systematic review of Community Health Workers (CHWs)

With support from USAID, the Alliance commissioned a global systematic review of CHWs in order to expand the empirical evidence on the role of different types of CHW programmes in improving equitable access to health services. It included eight in-depth country case studies from sub-Saharan Africa, Asia and Latin America. In April 2010, policy makers and other experts came together at a global consultation in Montreux, Switzerland, to discuss the findings and agree on the main messages for policy makers and key stakeholders.³⁷ Some countries, for instance Zambia, have subsequently taken up the recommendations.

Joint statement on CHWs in emergency contexts³⁸

The Alliance, in partnership with WHO, IFRC, UNICEF and UNHCR, issued a joint statement and technical briefing in 2011 called *Joint Statement on Scaling Up the Community-Based Health Workforce for Emergencies*. The consensus among the inter-agency group was that CHWs can play a key role in emergency prevention, preparedness, response and recovery.

3.4 Facilitating country actions

Pathfinder countries³⁹

GHWA provided catalytic funding that was not linked to prior plans, as countries were expected subsequently to develop their own HRH policies and plans for implementation. Seven countries received funding in 2006–2007, for activities mainly intended to enhance national capacities, strengthen related systems, and establish mechanisms to develop HRH plans. This approach was subsequently seen to be inadequate by GHWA, which led to a review of its approach to country support and a revision of its strategy.

CCF⁴⁰

The CCF process was first initiated by the Alliance in late 2009 to promote and support multi-stakeholder engagement in the development and implementation of evidence-based and costed HRH plans. Between October 2009 and May 2010, regional meetings were held in Africa, Asia and Latin America to agree on the CCF approach and to develop country-specific recommendations for its implementation.

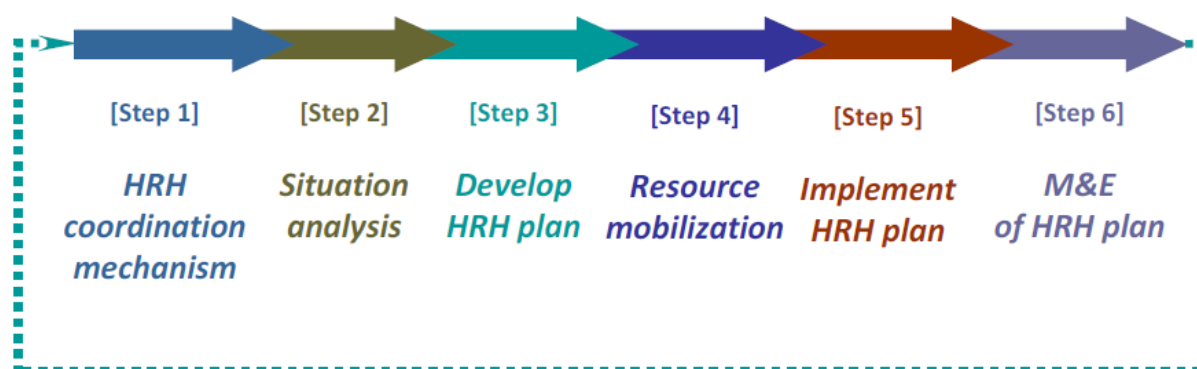
The CCF process outlines six steps, each of which requires the participation and contribution of many key stakeholders (see Figure 3.1). According to GHWA, the process began in 10 countries and by the end of 2010 it was being rolled out in 16 countries selected for priority support by the Alliance. A further six countries were added in 2011. Among the 22 countries that have received CCF support, 13 have completed a situation analysis and eight have completed an HRH plan. In 2011, initially seven countries were provided with catalytic funding to roll out CCF activities and subsequently a further 10 countries have also received this support. Four other countries did not require catalytic funding although they are implementing the CCF process.

³⁷ GHWA (2010) *Global Experience of Community Health Workers for Delivery of Health Related Millennium Development Goals: A systematic review, country case studies and recommendations for integration into national health systems*. Geneva: Global Health Workforce Alliance. 2010.

³⁸ GHWA, WHO, IFRC, UNICEF and UNHCR (2011) *Joint Statement: Scaling up the community-based health workforce for emergencies*. October 2011.

³⁹ GHWA (2008) *GHWA Collaboration with Eight Pathfinder Countries: Status Report*; November 2008.

⁴⁰ GHWA (2011) *Country Coordination and Facilitation: Principles and Process*; Geneva, 2011.

Figure 3.1 CCF process

The CCF process has six programmatic phases and begins by requiring a high level of political commitment to a multi-sectoral coordinating committee that has a wide range of key stakeholders, including representatives of the government ministries of health, education and finance, training institutes, professional organisations and civil society organisations.

3.5 Monitoring of implementation of HRH strategies

First Global Forum on HRH in Kampala, 2008

During the First Global Forum on HRH held in Uganda in 2008, the Alliance was assigned the task of monitoring the implementation of the KD-AGA, which has become a major global reference framework for monitoring progress for HRH.

In *Moving Forward from Kampala*, GHWA outlined the following six priority actions for the Alliance in support of countries: facilitating country actions, continuing advocacy, brokering knowledge, promoting synergy between partners, monitoring the effectiveness of interventions, and programme management and coordination. Each of these was accompanied by indicators against which the Alliance can measure its own progress.

Second Global Forum on HRH and Progress Report in Bangkok, 2011⁴¹

More than 1,000 stakeholders, members and experts attended the second Global Forum on HRH in January 2011 in Bangkok, which was convened by the Alliance, WHO, JICA and Prince Mahidol Award Conference. The Forum included four plenary sessions, 20 parallel sessions and numerous side events, including on the CCF process, Universal Access to HIV/Aids services, HRH partners meeting and the members' forum.

The progress report on the KD-AGA, *Reviewing Progress, Renewing Commitment*, was launched in Bangkok. This was the first attempt to systematically track progress in the health workforce governance and policy environments in HRH crisis countries. It included self-reported survey findings to review progress since the First Forum in 2008, based on selected HRH indicators relating to HRH policy and governance arrangements in the previously identified 57 crisis countries. The indicators were developed by a Monitoring and Evaluation task force and were developed to measure the implementation of the KD-AGA commitments. The report shows that while some progress has been made, considerable work remains to be done in the majority of priority countries to put into practice the commitments made under the KD-AGA.

⁴¹ Prince Mahidol Awards Conference/GHWA/WHO/JICA: Report on the Prince Mahidol Awards Conference 2011 Second Global Forum on Human Resources for Health; Bangkok, Thailand, 25–29 January 2011.

3.6 Summary

The Alliance, having been borne of the need for a global mechanism for catalytic action on the HRH crisis, defined its mandate in terms of advocacy, knowledge brokering and convening. The GHWA Board in June 2006 identified five priority interventions: accelerating country work; strengthening health workforce partnerships and initiatives; advocating for HRH; building and managing knowledge; and addressing specific challenges, such as migration. The evidence reviewed in this section shows that GHWA has had some successes in all those priority areas.

GHWA has contributed to ensuring a greater global political commitment to HRH, as demonstrated by the G8 commitments, and the high profile given to the HRH crisis globally can be at least partially attributed to the concerted efforts of GHWA and its partners. The knowledge-brokering function has resulted in many useful and high-quality products, which are available for use by crisis countries and development partners in response to the HRH challenges. The Alliance has been successful in convening at the global level through the two Global Forums on HRH, and has contributed positively to various regional meetings. Firstly through catalytic funding to pathfinder countries and lately through the CCF initiative, GHWA has sought to strengthen country-level action. A success story and sterling example of effective partnership building is provided by the contribution of the HWMI to the development and ultimate adoption of the Global Code of Practice on International Recruitment of Health Personnel.

The balance of the evidence above supports the view that GHWA has indeed made a positive contribution to tackling the HRH crisis across each of its priority intervention areas. However, in order to investigate whether the best was made of the opportunities available at the time the Alliance was formed, and whether or not more could have been done, we rely on the feedback of our key informants. This is presented in the remaining sections of the report.

4 Findings from the thematic studies

The findings from the six thematic studies are discussed in turn below.

4.1 Thematic Study 1: Institutional analysis of the Alliance Secretariat

The institutional analysis of the Alliance Secretariat included the following five components: Governance and the role of the Alliance Board; Organisation of the Alliance Secretariat; The Alliance's role in global advocacy and information for HRH; Planning, training and management of HRH; and Alliance relationships with WHO.

Evaluation questions (see 0 for evaluation guidelines):

- At the global level since 2006, how effective has the Alliance been in pursuing its mandate as an advocate, knowledge broker and convenor for HRH in crisis countries?
- In support of the Alliance Board and its mandate, how successfully has the Secretariat been managed and organised at the global level?
- What are the advantages and disadvantages for the Alliance in being located at the WHO headquarters in Geneva?

4.1.1 Governance and the role of the Alliance Board

The prime function of the GHWA Board is to guide the overall vision and strategy of the Alliance and hold the GHWA Secretariat accountable for its activities. The Board meets twice per year and attendance is limited to members, or a nominated alternate, as well as some observers. The Board provides oversight by reviewing and approving the operational work plans, annual budgets and work of Board standing committees, and monitors financial resources. In addition, it has to approve GHWA's financial statements and progress reports.

The MOU⁴² with WHO states that the Board consists of not more than 20 members, who should come from key organisations and represent all six WHO regions. The Chairperson is selected from amongst the members, both of whom may serve for three years, renewable for one further period. Membership modalities are specified in more detail in the Alliance Governance Handbook⁴³ as follows: one government national from each of the six WHO Regions; two members from each of the following five organisations – intergovernmental agencies, Global Health Initiative, donors, NGOs, and professional associations. There are also two to represent the private sector and research organisations. As the host agency, WHO headquarters has permanent representation and the Alliance EXD is an ex-officio non-voting member.

The last Board meeting on 30 June 2011 agreed to extend membership to two new categories: health workers and the private sector. In addition, any donor providing more than US\$ 300,000 per year will automatically have 'Associate Member' status and have voting rights for the duration of their funding.

The size of the Board, though in accordance with the MOU with WHO, is large relative to the size

⁴² Memorandum of Understanding between the Global Health Workforce Alliance and the World Health Organisation: Concerning Hosting, Secretariat and Administrative Services.

⁴³ GHWA: Governance Handbook. January 2010.

of the organisation. It meets twice per year and although the governance handbook stipulates that it should generally meet in June and November, in reality the intervals between meetings vary. The Board's Standing Committee is regularly called upon to take interim decisions between meetings on both financial and operational matters. This Committee consists of seven Board members and it meets between each of the full Board meetings. It is not clear how well this works in practice, since several other Board members reported that the work of the Standing Committee could be made more transparent (e.g. by sharing minutes of meetings) and that communications with the other Board members could be strengthened. One board member reported that board members feel remote from GHWA with important decisions being taken by the steering committee.

The cost of Board meetings to GHWA is shown in Table 4.1 below. The average annual cost to GHWA for Board meetings appears to be about US\$ 100,000 per year, though this does not include other expenses incurred by Board members and their organisations. Feedback from Board members revealed that these costs were not deemed to be excessive.

Table 4.1 Expenditure by GHWA for Board meetings, by biennia in US\$
(Information provided by the Secretariat and valid until end July 2011)

Biennium	2006–2007	2008–2009	2010–2011	Total
Cost in US\$	144,204	251,757	220,680	616,641

In terms of financial oversight, the GHWA finances have usually been presented at each Board meeting but the variation in the periods between meetings makes accounting more difficult and forecasts less reliable. It is worth noting three points: the Standing Committee also seems to function as a finance sub-committee and provides some financial oversight; fundraising is seen as the responsibility of all Board members as well as the Secretariat but no formal fundraising strategy appears to exist; and, as stated in the MOU, the financial audit is carried out annually but only as a part of that for the wider WHO as a whole.

4.1.2 Organisation of the Alliance Secretariat

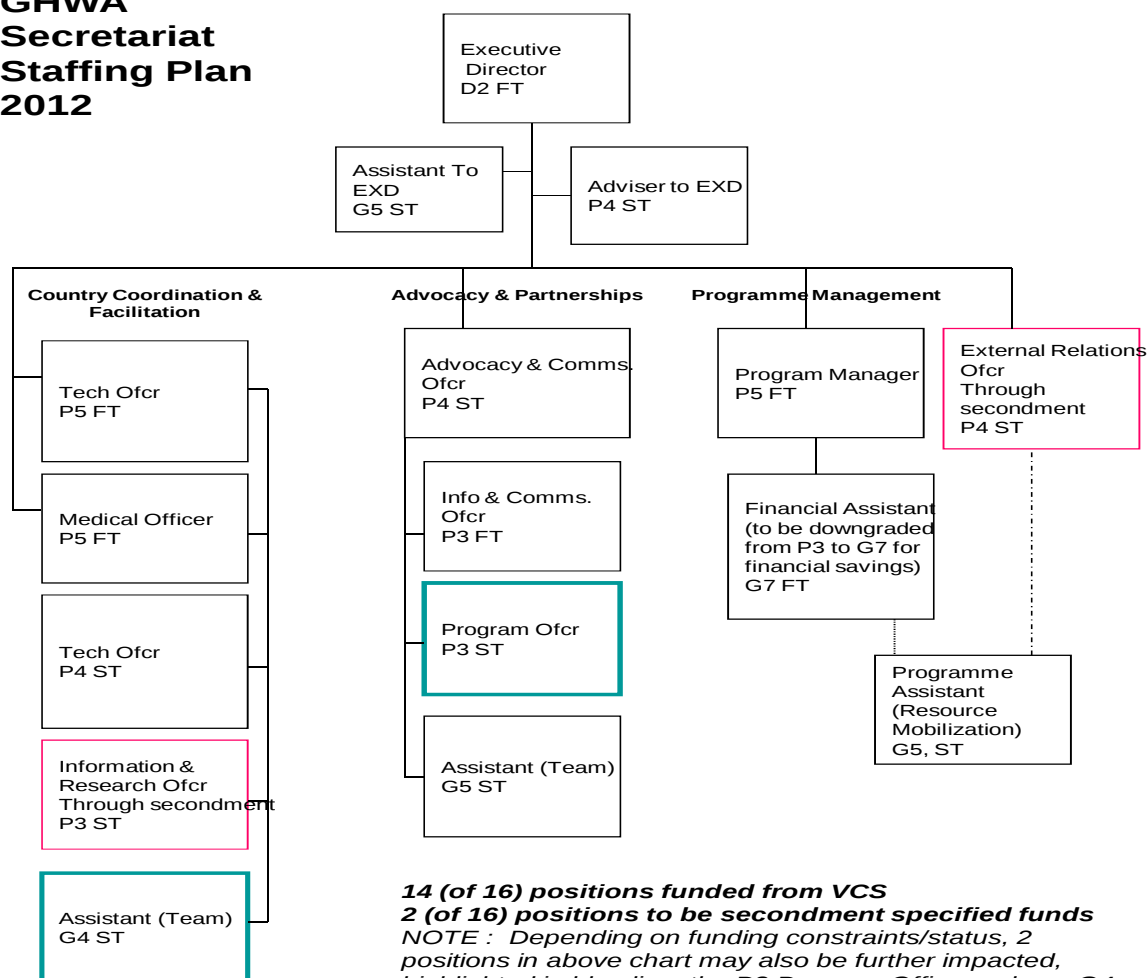
The Secretariat is located in the main WHO headquarters building in Geneva and placed in the Health Systems Cluster, which also includes the WHO HRH. Both WHO HRH and GHWA report to the same ADG. The present EXD has been working in the Alliance since May 2008 and is directly supported by a full-time Adviser, as well as professional and administrative staff. GHWA does not have, and is not expected to have, focal points nor HRH specialists in either the WHO Regional or Country Offices and nor does it maintain a country presence.

The GHWA Secretariat is required to follow and utilise all WHO managerial processes, including for the appointment and dismissal of staff, financial accounting and awarding of contracts. Many of these administrative procedures are decentralised by WHO management to Malaysia, which can lead to delays in finalising appointments and contracts. Although the GHWA Board retains its independence for all strategic and programmatic decision-making, all Alliance management activities still need to be closely aligned with those of WHO. At present, all CCF activities and country support is organised from Geneva.

The Secretariat is undergoing a reduction in professional staff and the approved reorganisation for 2012 is shown in Figure 4.1 below. This reorganisation of the Secretariat will bring together the Brokering knowledge and CCF functions as one Country Facilitation unit, and Advocacy and Partners, including communications, as another unit.

Figure 4.1 GHWA Secretariat staffing plan for 2012

GHWA Secretariat Staffing Plan 2012



To cope with GHWA's recent shortfall in funding (see Thematic Study 6), the Secretariat has undergone a reduction in professional staff and in addition there has also been a turnover amongst all staff categories. This is partly due to the greater use of temporary and short-term contracts so that the Alliance can retain financial flexibility while funding remains uncertain. Unfortunately, the downside of this staffing policy can lead to a lack of professional continuity for GHWA activities, a critical loss of institutional memory, and a reported drop in staff morale. One of GHWA's key partners also commented on the difficulty she faced in having to establish contact with a new person for the same issue every few months without any notification from GHWA that the previous person had left. The fully approved original complement of 22 staff was never achieved.

The present governance arrangements are clearly stated in the MOU between WHO and GHWA, in which the executive director retains considerable responsibilities for independent management. However, there is a dual system of accountability for the Alliance Secretariat, which is to the Board for policies, strategy and funding, and to WHO for all financial and administrative matters. At

present, immediate oversight seems to rest, firstly, by liaison with and involvement of the Board Chair and, secondly, through the Standing Committee and the Board.

The work of the Standing Committee of the Board is laid out in the GHWA Governance Handbook. The EXD explained that when a consultation is needed for an early decision, he requests the Standing Committee to be involved. However, requests from the Committee to the EXD appear to be infrequent, which could mean a rather passive approach to accountability and strategic oversight.

The evaluation team received comments from both Board members and Secretariat staff that the management style within the Secretariat could be more inclusive and that the reasons for some financial transactions could also be more transparent.

4.1.3 Role in managing global advocacy and information on HRH

GHWA has been very active in global advocacy for HRH and in many ways this is widely seen as its most successful activity since 2006, as shown by the number of high-profile advocacy and brokering knowledge products listed in the previous review of documentation. The most widely known activities have been the two Global Forums in Kampala in 2008 and Bangkok in early 2011.

Advocacy has focused mainly on the urgent need to tackle the global deficit in the numbers of health workers in developing countries and in particular in sub-Saharan Africa. In this respect, the Alliance's advocacy has been largely about raising global awareness on the more technical aspects of HRH. In 2008 and 2009, the advocacy efforts began to move to higher political levels by involving world leaders and seeking stronger commitment from global institutions, including mainstreaming its message through the G8 Meetings.

GHWA itself does not keep databases for national HRH information but it does put the national HRH plans it receives from countries on its website, as well as information and data from the monitoring of the implementation of the KD-AGA (data for 2010 placed on the web in 2011). GHWA also collaborates with organisations such as the Avicenna directories, which are jointly managed by WHO HRH and the University of Copenhagen (<http://avicenna.ku.dk/>) and the HRH Resource Centre (http://hrhresourcecenter.org/latest_resources) maintained by Capacity Plus in Washington, USA. Although not taking an active role, the Alliance has been collaborating on the development of national Observatories for countries to monitor their own HRH information.

4.1.3 Planning, training and management of HRH

While HRH planning, training and management are essential within national strategic plans, the Alliance is not directly involved in these three items. GHWA does, however, undertake advocacy in support of these components, as well as promote knowledge products at global, regional and national levels. The Alliance recognises that this technical work is best undertaken by the WHO HRH and other partner organisations, which is a good example of the division of responsibilities for HRH that GHWA can achieve with its partners.

4.1.5 The Alliance's relationship with WHO

Given the importance of the relationship between WHO and GHWA, the evaluation also examined how the Alliance and its staff are embedded within the Organisation, together with the advantages and disadvantages involved in this relationship.

While GHWA has definitely attracted funding, identified critical gaps and brought outside partners to WHO, the evaluation team also received comments that GHWA had encroached on WHO's technical mandate. In addition, the evaluation also received comments that GHWA has sometimes, through its high profile and visibility, drawn attention away from WHO itself, which might have partially contributed to insufficient use being made of WHO's normative and technical capacity. There seems to be, therefore, some confusion over mandates between GHWA and the WHO HRH, despite both being situated in the same WHO Cluster for Health Systems and Services and coming under the same WHO ADG.

As mentioned in Section 3, a good example of successful joint working between GHWA and WHO is the World Health Assembly's approval of the new WHO Code, which benefitted from GHWA's initial support. The Alliance is also promoting other WHO HRH-related tools, such as its retention guidelines and HRH observatories. Previously GHWA invested in technical TFWGs and more recently has promoted the CCF process. Although GHWA claims that these initiatives were coordinated with WHO HRH, both would seem to fall within WHO's own remit for 'norms and standards' and its role in supporting countries in their HRH planning and implementation.

GHWA certainly benefits in terms of status and recognition from being situated within WHO. It is also widely seen, however, as being in competition with the Organisation for donor funds. By clarifying their mandates, both WHO HRH and GHWA could be far more complementary as well as strengthen each other. For instance, GHWA is seen as more successful than WHO HRH in advocacy and communications, while the WHO HRH is stronger in technical matters and for promoting strategic planning.

The DG has decided not to allow any new alliances and the Organisation says it may possibly renegotiate some existing agreements. Alliances, including GHWA, are seen as a cost to WHO and as a competitor for external funds. In addition, the alliances are now being expected to contribute more clearly to WHO-wide results. In addition, such alliances commonly have a dual system of accountability – strategically to their Boards and for management and finances to WHO processes. In 2012, GHWA is expected to leave the WHO programme budget framework, which means that from then onwards there may be less emphasis on the Alliance contributing to WHO-wide results.

Alliance partnerships at WHO seem to experience tension between WHO and themselves and many were established about 10 years ago, when the effectiveness of WHO was being widely questioned. This tension is often difficult to resolve, although some alliance partnerships at WHO are believed to have done better than others. A common opinion is that this often relates to the role and management style of the executive directors.

As WHO undergoes its present reforms, largely driven by the present squeeze on donor funds, both GHWA and WHO HRH will be substantially reduced over the next year or so, in both staffing and capacity. WHO HRH will be downsized from 28 to about 14 staff and GHWA from the original 20 to about 12 or so staff. Such reductions raise substantial concerns about the need for them to work more closely together and less independently of each other.

For many outside observers, GHWA is perceived to be situated 'under' WHO, which leads some funders not to be donors to both HRH and GHWA as they go through an uncertain period of restructuring. In addition, WHO managerial processes are often seen as cumbersome, slow and difficult for alliances such as GHWA, which may need to be more pro-active and respond quickly. Such concerns have led a few Board members to suggest that GHWA might be better situated outside of WHO and thus be more independent.

Although the MOU between WHO and GHWA gives the Organisation one Board member amongst 20, WHO has expressed concern that it is under-represented and that it is often unable to make its concerns properly understood.

As WHO undergoes its new reforms, the above analysis has led to suggestions that both WHO HRH and GHWA should be working more closely together and that the two mandates do require further clarification. At a minimum they could be coordinating and cooperating more closely by systematically sharing information and engaging in some form of joint planning. Once the roles and relationships have been defined and agreed upon, there is a need to clearly communicate these both internally and externally in order to iron out any actual or perceived ambiguities. The value statement approved at the 10th Board meeting is not detailed enough to provide this clarity.

4.2 Thematic Study 2: Analysis of the Task Forces and Working Groups

Evaluation questions (see 0 for evaluation guidelines):

- How significant have the GHWA TF/WGs been in supporting improvements for HRH?
- Which TF/WGs have successfully produced guidelines and tools and other knowledge products for use in addressing HRH challenges?
- Have the TF/WGs been VfM?

The TF/WGs were set up in 2006 by the Alliance to address key global priority areas for HRH. They were required to produce specific products that aimed to improve strategy and accelerate action to strengthen national health workforces. The evaluation examined the six that have been completed – education and training, tools and guidelines, financing, migration, private sector, and universal access to HIV treatment.

Each TF/WG was individually constituted, had its own terms of reference, budgeted work plans and was time bound. Funding for each TF/WG was secured and was often provided by donors. At the same time, the Alliance also supported other partners in civil society that worked on other specific HRH-related initiatives. The WHO HRH was involved as a partner by the Alliance in all TF/WGs.

4.2.1 The taskforces and working groups

Scaling Up and Saving Lives – Task Force for Scaling Up Education and Training for Health Workers

This TF was set up in 2006 and required to develop practical proposals for action to massively increase the production of health workers, particularly for countries in Africa, and help to secure new and significant investment from governments and donors. This included designing a roadmap to assist countries as part of wider health sector plans and labour market strategies.

Supported by GHWA and under the joint chair of Lord Crisp and the African Union, the TF had national and international representatives, with collaborating teams in Canada, the UK and at WHO Geneva. The report, which was launched in 2008, made 10 recommendations for global action and includes a useful summary of potential indicators for assessing country-level progress. The conclusions from this TF have been a useful input into further work being carried out by WHO HRH. The total cost for the TF and Technical Working Group over the three biennia was US\$ 906,944, with 52% being spent during 2006–2007.

Human Resources for Health Action Framework – Working Group on Tools and Guidelines

This WG was set up in 2007 with Manuel Dayrit, WHO Director for HRH, as chair, and seen as complementary to the TF on Scaling Up. It produced the Human Resources for Health Action Framework (HAF) for HRH planning, production and management, together with indicators and guidelines, to assist policy makers and health managers in planning, producing, managing and monitoring national health workforces. The WG was also required to disseminate the framework and show how it could be applied to activities to develop national health workforces. This framework has been taken up by WHO and USAID Capacity Project – now Capacity Plus.

The Framework aimed to suggest ways to solve such issues as shortages and mal-distribution of staff, gaps in skills and competencies, and poor staff retention and motivation. It is presented as a user-friendly and interactive internet-based tool, with country examples and an analysis of critical factors. The WG was led by the head of the WHO HRH in Geneva and included a range of international experts. The total cost of the WG during 2006–2009 was US\$ 233,115, with 95% being spent during 2006–2007.

Financing Framework and RRT – Task Force on Financing

Launched in January 2008, this TF focused on: 1) elaborating a Framework Paper on the financing and economic aspects of health workforce scale-up and; 2) developing and testing the RRT to be used by governments to estimate the cost of implementing their HRH plans, including health worker employment and professional training. It also developed an Action Paper with 29 items for countries to consider for scaling up and improving their health workforce.

The RRT is Excel-based and has worksheets for data entry, scenarios and outputs. Using the requirements in the Human Resource Development Plans (HRDPs), the RRT can be used to estimate the costs of different recruitment and training options, as well as for salaries and incentives (including non-financial incentives), pre-service and in-service training, and capital and equipment needed. These predicted costs can then be compared with projections of available funding, based on the macro-economic and other indicators entered into the tool.

The experience of costing the HRDP in Mozambique and Guinea suggested that the RRT standardised costing approach lacked sufficient flexibility for local situations.⁴⁴ Recognising that a more adaptable and country-specific tool is likely to require resources, the study identifies the need for more research on how best to strike a balance between simplicity and relevance on the one hand and a standardised software approach to be used by country teams. The RRT has been used to support the development of the HRH module in the UN One Health initiative.

Health Worker Migration Policy Initiative (HWMI – Task Force on Migration)

The Alliance's Task Force on Migration, commonly referred to as the HWMI, was formally established in May 2007 to address the critical global challenge in health worker migration by promoting and supporting multilateral, bilateral and regional agreements and other policies on international migration of HRH. HWMI is a partnership of the Alliance, WHO and Realizing Rights, and was co-chaired by Mary Robinson, President of Realizing Rights, and Dr Francis Omaswa, former Executive Director of the Alliance.

A key activity of HWMI has been to support WHO in developing a Code of Practice on health worker migration.⁴⁵ HWMI has been credited with playing a key role in the development of the draft

⁴⁴ Tyrrell *et al.*, Costing the scaling-up of human resources for health: lessons from Mozambique and Guinea Bissau *Human Resources for Health* 2010, 8:14

⁴⁵ The WHO Global Code of Practice on the International Recruitment of Health Personnel. 63rd World Health Assembly, WHO, Geneva. May 2010.

Code of Practice on the International Recruitment of Health Personnel and for supporting accelerated action by WHO in finalising the Code. The adoption of the Code by the 63rd World Health Assembly in May 2010 is seen to be a major achievement.

In order for the Code to take effect, the next stage requires similar efforts to promote and monitor its implementation. It is not yet clear what role the HWMI will play in this.

Private Health Sector – Task Force

The Private Sector Task Force has been active since 2007, with the first meeting held at Duke University, USA, in November 2007⁴⁶. TF members later participated in the First Global Forum on HRH at Kampala at which plans were made for further activities. However, the formal agreement was only signed between WHO (on behalf of GHWA) and Duke University in 2009.

Duke University hosts the TF secretariat and co-chairs were from the Duke Global Health Institute and Anglo American Plc. Membership included a broad representation of stakeholders, including NGOs, private sector, academia, international agencies, and national governments.

At the time of the external evaluation the work of the Private Sector Task Force was not yet complete, due to delays in field studies. A draft report is available but has not yet been finalised. It would appear that the Private Sector Task Force has lost momentum and is not as active as when it was first conceived.

HRH Implications of Universal Access to HIV Prevention, Treatment, Care and Support – Task Force

This TF was established at the First Global Forum in Kampala in 2008 to document practices and identify the strategies needed for country HRH requirements for scaling up HIV/Aids services. The TF sought to take advantage of country-level complementarities between HIV/Aids programmes and health services, rather than focusing on universal access. A Technical Working Group was co-chaired by UNAIDS and the Center for Diseases Control, USA to explore the HRH implications for universal access to HIV prevention, treatment, care and support. The TFWG secretariat is at IntraHealth International, USA.

The TF examined how HIV/Aids and investments had an impact on the health workforce and identified some innovative HRH strategies being applied in a number of countries. This led to policy guidance for scaling up responses to HIV/Aids through sustainable HRH. The work involved an extensive literature review covering 2000–2010 and a multi-country study conducted in Côte d'Ivoire, Ethiopia, Mozambique, Thailand, and Zambia. This collaborative effort involved GHWA, ministries, international HRH specialists, and WHO country offices.

The TF published its report in early 2011 called *Will We Achieve Universal Access to HIV/Aids Services with the Health Workforce We Have? A Snapshot from Five Countries*. This highlighted that the target of universal access was yet to be achieved, due partly to lack of health workers and investment in HIV/Aids services. This was the most expensive of all the TFs, at a cost of over US\$ 701,000, though it is less than the combined cost of the Scaling Up TF and TWG.

⁴⁶ GHWA/Duke Global Health Institute/Duke Health Sector Management/Duke Fuqua School of Business. African Health Care Shortage: Forum on Private Sector Responses. Meeting Summary; 29 November –1 December 2007, Duke University

4.2.2 Lessons from the Task Forces and Working Groups.

Each TFWG benefited from inputs from international experts and those that have delivered their outputs have produced reports of a high technical standard. Each one of the products produced contains useful and practical guidelines for improving HRH both globally and in crisis countries.

The original vision for the TFs was believed to be that they were independent of the Secretariat, with GHWA being a partner but not the sole partner. However, the evaluation team received a few comments that the clarity around what it meant to be a GHWA taskforce was lacking, including who owned the efforts and what were the governance arrangements.

The TFWGs were funded by different donors and the Alliance expenditures by biennia for each one are given in Table 4.2 below. It should be noted that this table only includes those funds that passed through the Alliance, meaning funds coming directly to the TFWGs are not recorded here. A Reference Group for TF/WGs was set up in late 2009 to synthesise the work of the TF/WGs and to recommend ways of carrying forward their work. However, it only met once and had an overall cost of US\$ 48,688.

Table 4.2 Expenditures on TF/WGs (US \$) by GHWA for Biennia 2006–2007, 2008–2009, 2010–2011 (as at July 2011)

TF/WG	2006-2007	2008-2009	2010-2011	Total
TF Scaling Up	370,687	244,778	133,504	615,465
TWG Scaling Up	103,787	54,188		291,479
WG Tools and Guidelines	222,123	10,992		233,115
WG Financing	145,657	429,167		574,824
WG Migration	67,171	434,000		501,171
TF Universal Access		701,431		701,431
TF Private Sector		100,000		100,000
WG Advocacy	56,808	265,262		322,070
Reference Group		34,405	14,283	48,688
Biennial Total	966,233	2,174,223	147,787	3,288,243

TF = task Force WG = Working Group TWG = Technical Working Group

* Provided by Alliance Secretariat

All TF/WG products have been made available in the public domain and posted on the Alliance website. Several TF/WG leaders and members have commented, however, that a major opportunity has been missed by the Alliance Secretariat, which could have been more actively engaged in the roll out and application of the products and tools produced. Following the completion of the TF/WG, responsibility for rolling out the products appears to have shifted between the Secretariat staff and no systematic approach was pursued for dissemination and follow-up training.

The evaluation found that:

- Some of the TF/WG products are more widely used than others.

- While those people or organisations that have come into direct contact with GHWA, for example by participating in a global or regional event organised by GHWA, are likely to know about or have used some of these products, beyond this the products have little visibility.
- The country case studies showed that, in crisis countries, these products do not generally appear to have been used and the GHWA website is not accessed.
- The VfM of the TF/WGs is questionable given the lack of application of their outputs and the total cost of nearly US\$ 3.3 million over 2006–2011.

Following the (near) completion of the above six technical TF/WGs, GHWA has decided it will not invest in similar products in future as there seems to be limited demand at the country level and the costs were considerable. However, this kind of normative and technical work does fall within the remit of the WHO HRH and other global partners. It is likely that in future the Alliance will focus more clearly on work that is primarily within its own expertise.

4.3 Thematic Study 3: Country case studies of GHWA support to Cameroon, Indonesia and Zambia

Evaluation questions (see 0 for evaluation guidelines):

- How significant has GHWA been in supporting developments to improve HRH at country level?
- Which specific initiatives promoted by GHWA since 2006 were seen as being most helpful and which least helpful at country level?
- What future initiatives by GHWA for HRH did national governments, national institutions and donor agencies see as being most helpful?

Country case studies were undertaken to assess how well the Alliance had managed to reach and support countries in tackling their HRH problems. The Secretariat suggested three countries where the Alliance had been actively involved – Cameroon, Indonesia and Zambia. These country case studies focused on analysing the role of GHWA and its CCF process at country level. Each country visit was carried out by a member of the core evaluation team and supported by a local consultant with national health sector experience. The team made country case study visits to Cameroon and Zambia between 15 and 19 August and Indonesia between 21 and 25 August.

4.3.1 Alliance support to Cameroon

In 2009, Cameroon was among the first countries selected by the Alliance to support the national HRDP. Catalytic funding of US\$ 120,000 was made by the Alliance for the CCF process, as well as technical support on the HRDP development, and for regional and global meetings.

Financial support for the HRDP was also provided by the French Development Agency (ADF) as part of the C3D Santé programme to facilitate the contracting of consultants. FCFA 190 million (about US\$ 420,200) was transferred to the WHO country office to be managed by GHWA, following a MOU between the Ministry of Health and WHO in December 2010.

Alliance support to the CCF in Cameroon started following an Alliance regional meeting in Ouagadougou, Burkina Faso, in November 2009. The meeting was designed to develop a consensus on the CCF process and decide on next steps in each country. This helped to initiate the development of the HRDP in Cameroon. Some of the activities the Alliance supported as part of the CCF process include a workshop to identify key stakeholders in December 2009, the

establishment of a technical working group to lead on the HRH policy and strategic plan in early 2010, finalisation of a situation analysis in March 2010, and consultative workshops to identify strategic and specific needs for the HRDP in March and April 2011.

Based on the interviews it was widely agreed that there had been a marked improvement in the involvement of stakeholders in addressing HRH issues and that the process was seen as an extremely important step forward. Many respondents also praised the leadership of the Director for HRH in the Ministry of Public Health in bringing partners together and steering the process. The Director and WHO Country Office both underlined the quality of the technical support provided by the Alliance and stated that, despite being only one of many countries, they found the Alliance to be responsive, supportive and technically sound.

Delegates from Cameroon have been to several international meetings and workshops organised by the Alliance, including a CCF consensus-building workshop in Ouagadougou (2009), a CCF capacity-building workshop in Cairo (2010), the UN MDG Summit in New York (2010), and the 2nd Global Forum on HRH in Bangkok (2011). Feedback from two delegates suggested that while the Ouagadougou meeting was both relevant and useful for participants, the Bangkok Forum was hectic and difficult to follow.

It was found that apart from those in direct contact with the Alliance, which is mainly those in the Ministry and WHO Country Office, together with those participating in meetings, few people had an understanding of GHWA or what kind of support it provided.

4.3.2 Alliance support to Indonesia⁴⁷

Although Indonesia has many of the features of a country with an HRH crisis, it has a midway position amongst other Asian Pacific countries.⁴⁸ The Alliance only became known in Indonesia following attendance in 2008 by senior Ministry of Health officials at the First Global Forum in Kampala, Uganda. The Indonesian Ministry of Health HRH subsequently reviewed the KD-AGA and was stimulated to strengthen its own HRH strategy.

International attention for the need to improve the HRH situation in crisis countries enabled the Ministry of Health to obtain additional funds from the Ministry of Education together with a higher level of support for HRH from the Ministry of Finance. The Indonesian Health Council for Doctors and Dentists and the Indonesian Health Workforce Assembly for nurses, midwives and other professional health workers were also established at this time.

The Indonesian CCF process began in 2009 following support from GHWA of US\$ 15,000, which later led to additional funds becoming available from the Ministry of Education and the GHWA then becoming more widely known. An indication of the high level of political will is that a Presidential Decree was issued that established the Indonesian CCF Committee for HRH Development in September 2010. The Committee has a very wide range of stakeholders and the Chair is from the Ministry of Welfare, a national coordinating ministry. In addition, the President's Office regularly requests updates on the CCF Committee's progress with Indonesia's new HRH strategy.

National funds have been made available by the ministries of Finance, Education and Health for the CCF committee and three working groups which are responsible for HRH planning and

⁴⁷ PowerPoint presentation to 5th Asian Pacific Action Alliance for Human resources for Health, Bali, by Dr Akib Kemas on behalf of the Board for Development and Empowerment of HRH, Ministry of Health, Jakarta, Indonesia. www.aahrh.org.

⁴⁸ Lancet article: Health in Southeast Asia 5: Human resources for health in southeast Asia: shortages, distributional challenges, and international trade in health services. Lancet Online, 25 January 2011.

management, training and production, and supervision and monitoring. The committee participants do not receive any additional salary or an honorarium.

WHO headquarters and regional and country offices have had only a small role in this process. The Asian Pacific Action Alliance for Development in HRH, a regional platform, has well-attended annual meetings and helps with the exchange of information and country experiences.

The GHWA Global Forums have been well attended by senior Indonesian health professionals and the CCF guidelines have been very useful. However, the work of the GHWA TF/WGs remains largely unknown. For instance, the RRT was not known, let alone been used in strategic planning, and the new International Code still remains to be discussed within the Ministry of Health.

At the Second Global Forum in Bangkok in January 2011, GHWA awarded certificates to Indonesia in recognition of its outstanding contribution to teamwork and its achievements in tackling its HRH problems.

4.3.3 Alliance support to Zambia

Zambia is a HRH crisis country, with low numbers of trained professionals, a mal-distribution of the existing workforce, low training capacity, high attrition rates and outward migration. The national response began with a directive from Zambia's President for a coordinated strategic approach, which led to the first HRH Strategic Plan (SP 2006–2010). The Alliance has influenced Zambia's response to the crisis and the new national HRH Strategic Plan (2011–2016) is grounded in the ethos of the Kampala Declaration.

The EU supported the development of the new strategic HRH plan (2011–2016), with its activities now included in the Ministry of Health annual action plans and budgets. There has been a steady increase in all cadres of clinical staff from 12,173 in 2005 to 16,256 at the end of 2010 and 17,682 by the end of May 2011. However, there remains a shortfall of 23,104 clinical health workers according to the establishment. The 2005–2010 figures do not include CHWs, who are largely informal and voluntary.

Funding for the Strategic Plan is from pooled sectoral funds contributed by the government and collaborating donor partners, with the Ministry of Finance distributing the funds. This is seen as a more sustainable way of funding HRH, with all HRH efforts being coordinated within the Strategic Plan framework. Basket funding has made it easier to centrally coordinate all the stakeholders.

Zambia has a new CHW programme for which GHWA provided US\$ 300,000 for the development of the strategy, which is now being implemented with technical support from the Clinton Health Access Initiative (CHAI) and additional funding from the EU.

The Ministry of Health HRH Directorate is aware of the GHWA CCF process and is implementing a similar one using its own HRH Technical Working Group, with multiple stakeholders and representatives from the Ministry of Health and the ministries of Finance and Public Service Management, together with collaborating and implementing partners (e.g. EU, WHO, DFID, CHAI, UNICEF). The group meets bi-monthly to review progress. Group members have been in Zambian delegations to the First and Second Global Forums and to CCF consultations in Accra (2010), Cairo (2010) and Lusaka (2009). Non-governmental participants have also come from the Christian Health Association of Zambia (CHAZ) and CHAI.

Although GHWA is not widely known in Zambia, its role is appreciated in the Ministry of Health, especially for keeping HRH issues high on the international agenda. Ministry of Health officials said that the present high level of global attention for HRH has led to greater engagement by partners in

supporting HRH and health systems strengthening. Previously these were a non-issue.

Ministry of Health officials mentioned that GHWA's financial support and technical assistance had been crucial, particularly for the development of the new CHW Strategy, which is now operational with the first intake of trainees in June 2011 and support from CHAI and GHWA.

However, many other people involved in HRH in Zambia were unaware of GHWA, apart from the Global Forums held in Kampala and Bangkok. For instance, although the EU representative knew about GHWA, it was suggested that the Alliance needed to be present at the multi-stakeholder forum when HRH priorities were being identified if it was to have influence. The general recommendation was that the Alliance should get more engaged at country level, with some suggesting the need for a country office or representative. Without this, the Alliance support may well not get its due credit. While GHWA has had some impact, its visibility was deemed to be too low and most informants wanted the Alliance to be seen to be doing more.

4.3.4 Lessons from the three country case studies

There appears to be a successful implementation of the CCF process in all three countries and each one is involved in their own HRH strategic plans and strategies. However, each one is in the early stages of the CCF process, which then has to be followed by HRH implementation in terms of production, management and monitoring. The real test of GHWA's CCF strategy will come as the coordination committees and the ministries of health in crisis countries attempt to go to scale with implementation.

The three countries were selected by the Alliance Secretariat as positive examples of the CCF process for strengthening of HRH within countries and each one showed the following:

- High levels of political will and commitment to tackle their HRH crisis;
- Importance of establishing a multi-stakeholder coordinating committee;
- Essential need to focus first on developing a costed national HRH strategy and plan in a consultative manner;
- Critical influence of catalytic funding to both starting and maintaining the process; and
- Importance of a dedicated and committed national leadership.

Despite an apparently low level of awareness of GHWA within these three countries, the Alliance is being credited with:

- Enabling the HRH crisis to become better understood through attendance at the Global Forums and regional HRH meetings;
- Using global advocacy to raise HRH issues higher on the agendas of international agencies and bilateral donors;
- Engaging national ministries of Education, Labour and Finance in the strategic importance of investing in HRH and health systems strengthening;
- Providing countries with professional, technical and timely support; and
- Making available high-quality technical HRH publications and tools.

The CCF process is designed to have a catalytic effect and currently it appears to be reasonably successful. However, it is also important to note that GHWA is still not well known in countries; that WHO Country Offices seemed to have only a marginal role apart from the routing of funds; and the involvement of bilateral donors has yet to be strengthened.

4.4 Thematic Study 4: Views of Alliance Board members

Evaluation questions (see 0 for evaluation guidelines):

- How effective has the Board been in its role of determining the strategic directions for the Alliance and in providing the required stewardship to pursue its mandate as an advocate, knowledge broker and convenor for HRH in crisis countries?
- How well has the Board held the Secretariat to account and guided its work at the global level?
- What changes, if any, are required to make the Board better able to perform its role during 2011 to 2016?

Alliance Board members were contacted and, if possible, interviewed directly or by telephone for their understanding and views on the role of the Alliance Board and priorities for its evolution over the period 2011–2016. Some Board members also represent donor agencies that support GHWA. However, the views of present donors that are not currently members of the Board are presented later in relation to the future sustainability of GHWA in Thematic Study 6.

The OPM evaluation team sent e-mail requests to 21 Board members, and their alternate, and established contact with 13 members (62%), of whom six were subsequently interviewed in person, six by telephone and one by written questionnaire. In addition, the previous Chair of the Board and former Executive Director were also interviewed (see Annex D for the full list of people interviewed).

4.4.1 Alliance's achievements and contributions

Most Board members agreed that GHWA had been successful in promoting a coherent strategy for the Alliance since 2006 and also held substantially similar views on GHWA's contributions and achievements during 2006–2011. However, about half of the Board members did express differences of opinion when asked about the future strategy for the Alliance. This suggests that it is time for the GHWA Board to reconsider and probably reformulate its strategy for 2011–2016.

There was a wide convergence of views and agreement that the Alliance's focus on the three ABC functions of Advocacy, Brokering knowledge and Convening remained highly relevant and provide a good focus for GHWA's present activities and future priorities. However, apart from this agreement, there were also considerable differences of opinion in relation to a number of issues and it is difficult to summarise the divergent views, including on what should be GHWA's new priorities.

In general, Board members fully recognised the scale of GHWA's achievements and remained supportive of its present activities and wanted to see the Alliance continue, although not necessarily with its present strategy. Several members also commented that GHWA was established at an opportune time in 2006 when it benefitted from high international expectations, substantial political support and from the availability of new sources of funds for HRH. In addition, at that time there were few similar global or regional alliances. There were high expectations that GHWA would be a focal point for galvanising international support for HRH, particularly in crisis countries.

4.4.2 Alliance's future priorities and strategy

About a third of Board members interviewed remarked that the HRH 'landscape' had evolved since 2006 and that now there were a growing number of new international and regional organisations with a similar role to the Alliance. Thus, while GHWA is recognised as an important global alliance,

it is now only one of the players amongst the different HRH partnerships and interest groups responsible for stimulating international action for HRH. Examples of others include Merlin's Hands up for Health Workers campaign⁴⁹; USAID's Capacity Plus⁵⁰; IntraHealth International⁵¹, the Health Workers Count campaign⁵² and the Community Health Worker programme supported by UNICEF and UNFPA.

Within this increasingly crowded environment, GHWA's role as the main international alliance is less clear. Board members expressed different opinions on what emphasis the Alliance should give in future to the three functions of Advocacy, Brokering knowledge and Convening. Several Board members also felt it is time for the Alliance to rethink its long-term strategy and the relative importance that GHWA should give to these three functions at global, regional and country levels.

Most Board members gave the opinion that GHWA is going in the right direction for advocacy with its reliance on collaboration with partners, but a few also suggested that the Alliance should do more through its partners or members. It was pointed out that as an Alliance the Secretariat should be enabling others to do this work rather than doing so much of the advocacy itself. In addition, a few Board members also felt that GHWA's advocacy, which has focused on mainstreaming HRH into the wider health policy debates, now needs to put less emphasis on the technical aspects of HRH. For instance, less focus is needed on the numbers of health workers required and rather more on placing HRH in context as one of the six WHO health system 'building blocks' necessary for stronger health systems.

Some Board members felt that the Alliance should raise its advocacy to higher levels by giving attention to gaining more political support, particularly from the governments themselves in crisis countries. It could also focus on convening more policy discussions at the highest level amongst presidents, prime ministers, ministers and permanent secretaries.

4.4.3 Country Coordination and Facilitation (CCF)

Board members held divergent views on the importance of implementing the CCF process. A few Board members remarked that the Alliance should strengthen and reinforce its capacity to support implementation of country HRH, whilst others said that the Alliance should focus almost entirely on global advocacy and leave all country-level activities to WHO, other partners and other regional and country-based organisations.

In addition, other Board members suggested that the Alliance now needs to put less emphasis on 'processes' and 'outputs' and place more focus on achieving 'results' in terms of health outcomes. At present, GHWA does seem to give sufficient emphasis to agreeing and issuing high-level policy statements, but comments were also received that more emphasis could now be given to the importance of quantifiable objectives and targeted outcomes at country level.

4.4.4 Donor support and fundraising

Most Board members were aware that there is an acute fall in donor funding and remarked that there was too much reliance placed on the EXD and Secretariat to raise funds for the Alliance. Although Board members do see fundraising as part of their role, they suggested that they could

⁴⁹ <http://www.handsupforhealthworkers.org/>

⁵⁰ <http://www.capacityplus.org/>

⁵¹ <http://www.intrahealth.org/>

⁵² <http://www.healthworkerscount.org/>

engage more if it was clearer what is expected of them. They believe their fundraising role needs clarification and there is a need for better guidance and materials on this. They also remarked on the need for more high-level and internationally recognised champions to engage in fundraising.

In looking forward, Board members commented on the challenge of developing a renewed strategy for acquiring resources, both for HRH at country level and for the Alliance itself, and how to keep these funding issues high on the international agenda. The Alliance's June 2011 Board meeting considered this issue and the Board is developing a new initiative. In order to engage more effectively with potential donors, some members stressed the importance of a better 'packaging' of GHWA's strategies and work plans by the Secretariat.

4.4.5 Effectiveness of Board meetings

A few members commented that there appeared to be some lack of engagement by board members, with some suggesting that they were not clear what was expected of them, particularly between meetings, and one member felt that partners who are being represented on the board are not pushing their representative to actively engage. One board member expressed the view that, while there is good interaction between members which enables them to think creatively, there is not enough focus on taking issues from discussion into action. Several members noted that the original board members were among the global leaders and thinkers on HRH issues, which created an inspirational force. There may be a need therefore to revive that culture of participation within members through strong leadership.

Issues concerning the role of the Standing Committee in decision-making were also raised, with a few stating that the committee processes needed to be more transparent. In some ways, comments suggested that the present Board may be acting as an advisory board rather than being actively involved in strategy development and oversight of the Secretariat.

Other suggestions concerned the effectiveness of the format for Board meetings, which relied on one-day meetings that did not allow sufficient time for in-depth discussions on strategic issues. In order to ensure stronger accountability, some members felt that a longer Board meeting could lead to stronger oversight of the Secretariat activities, which in turn could strengthen trust in GHWA.

In conclusion, the evaluation found that Board members supported GHWA's strategy and achievements for 2006–2011. However, there was less agreement about the Alliance's future priorities for 2011–2016. This suggests that it is time that GHWA undertakes a full review of its future strategy, including for fundraising, as well as carrying out an analysis of the Board's organisation and its oversight of the Secretariat.

Three other future challenges for GHWA were mentioned by Board members: to engage more effectively with partners and members in all aspects of the Alliance's work; to develop a stronger and more convincing fundraising strategy; and to strengthen the monitoring of HRH progress in crisis countries.

4.5 Thematic Study 5: Views of partners for advocacy and brokering knowledge

Evaluation questions (see 0 for evaluation guidelines):

- What are the views of GHWA partners on their contribution to helping solve the global human resources for health crisis?
- How well has GHWA worked together with its partners?
- What changes, if any, would partners like to see for GHWA during 2011–2016?

The evaluation team attempted to contact a selection of GHWA's main partners active during 2006–2011 and to seek their views on the importance of the Alliance, its present strengths and weaknesses and its future priorities. This was done using an e-mail enquiry to establish contact and an e-mail list of questions, followed by direct meetings and/or telephone interviews and follow-up e-mails. A total of seven interviews were carried out with GHWA partners.

There is a wide range of organisations that are partners with GHWA. They are seen as organisations engaged with GHWA at global, regional and country-level efforts to strengthen HRH. For instance, it appears to include both current and potential donors, together with a wide range of organisations that the Alliance collaborates with or has links with. In addition, partners may also be other UN agencies, academic and research institutes, civil society organisations and NGOs.

Each of the partners interviewed are (or have been in the past) actively engaged with the Alliance. These partners credit the Alliance with a number of achievements, notably the quality of their technical outputs and their success in convening stakeholders on the issue of HRH. However, most of the partners interviewed expressed the concern that GHWA has not done enough to actively engage their partners. There is a feeling among the respondents that by showing more leadership, being more participatory in its approach and articulating more clearly what is expected from partners, a lot more could be achieved.

GHWA also has over 330 members, all with an interest in HRH issues and with the intention of supporting the Alliance. New members are organisations that apply to GHWA to become members, although discussions with relevant staff in the GHWA secretariat indicated that virtually no applications are declined. The GHWA Governance Handbook outlines the responsibilities of members, which can be summarised as follows: actively initiate and participate in collaborative activities to achieve MDGs and Health for All; contribute to Alliance activities through funding, technical matters, and media and networking; promote the Alliance principles; and share knowledge and information. The evaluation team understand that, despite efforts made by GHWA such as the members' session convened at the 2nd Global Forum which provided an opportunity to comment on the present situation and to provide feedback to Alliance policies, many members remain unclear on their role and many are not actually encouraged to become more involved in Alliance activities.

The two Global Forums have been instrumental in bringing together many different kinds of global Partners and Members. GHWA has also supported regional platforms, such as the Asia Pacific Action Alliance on HRH (AAAH) in Asia and the African Platform on HRH. It has also encouraged partners to collaborate at both global and regional levels. One respondent expressed the view, however, that the 2nd Global Forum in Bangkok was less participatory than the Kampala forum and that it was more difficult for members and partners to be invited.

Views were also expressed on the need to 'create an outer circle of partners' in order to build up a stronger movement of external partners. Other views include the need to focus more on health workers and their professional agencies as partners and for the Alliance Secretariat to engage more closely with country-level stakeholders and civil society organisations. One of GHWA's Global Champions – another form of partner – reported they have not been included sufficiently to perform any tasks that promote the Alliance

GHWA clearly has some links with a wide range of partners and members and engages with a large number of initiatives and activities. However, several partners expressed the view that the GHWA Secretariat has not done enough to galvanise its members in order to have more of a voice. Many see this as a missed opportunity. It appears, therefore, that the Alliance needs to continue to engage more strongly with partners and members if they are to have a more substantial role in strengthening HRH. In doing this, GHWA could look to other member-based organisations that have succeeded in promoting a more active engagement with members and partners to develop their own model.

4.6 Thematic Study 6: Value-for-money, sustainability and donor support

Evaluation questions (see C.6 for evaluation guidelines):

- Did the GHWA provide VfM at the global and headquarters levels during its first five years, 2006 to 2011?
- How sustainable is the GHWA at the global and headquarters levels for the next five years 2011 to 2016?

Thematic Study 6 was limited to assessing the Alliance's own reported financial data. The team examined the Alliance's fundraising activities, budget allocations, and procurement and financial management systems (as provided by WHO). It then assessed whether the results produced were commensurate with the level of financial inputs and summarised the views of donors and other funders.

The Alliance's financial sustainability was assessed using the following questions:

- How much funding is committed and for how long?
- To what extent have current donors and funders met their commitments?
- What determines whether donors decide to continue funding?
- Does the Alliance have reliable revenue and expenditure forecasting and sound cash management?
- Has the Alliance achieved VfM and effective fiduciary risk management?

The annual budgets and expenditures, together with likely future donor commitments, were analysed and considered through a series of semi-structured questions and key informant interviews at HQ level. The analysis was designed to ensure that the systems used by the Alliance were appropriate and adequate. Where possible, the evidence gained was benchmarked against best practice and areas for improvement were identified. The analysis also estimated likely future financial contributions to the Alliance and identified potential financial threats to its sustainability during 2011–2016.

4.6.1 Fundraising activities

Within the context of the recent international financial downturn, Alliance fundraising has been prioritised by both the Board and Secretariat and the urgency has increased due to budget shortfalls which have become particularly prominent in 2011. The main sources of funding to date have been traditional multilateral and bilateral donors, most of which have been supporting the

Alliance from its conception in 2006, together with the Bill and Melinda Gates Foundation. The recent deterioration in GHWA's finances stems from a reduction in funding from its main backers, which has not been adequately offset by funding flows from new donor sources.

The most prominent cutback in funding has been by Norway, which announced that it would reduce its 2011 contribution to GHWA to NOK 2.1 million. (US\$ 350,000) – almost a 90% decline from the level of funding provided in 2009 of US\$ 3.2 million.⁵³ Norwegian funding has been un-earmarked and, as noted in the Secretariat Report to the 12th Board meeting in June 2011, this reduction in funding diminishes the availability of flexible funding required to pay for the Alliance Secretariat in Geneva.

The Secretariat has sought to develop new funding streams. Japan has increased its funding and, with the appointment of the new Japanese Chair, the Alliance may increase its prominence with Japanese funding sources. The Secretariat has developed project proposals for Irish Aid and ADF for multi-year support to the Alliance Secretariat. The proposal for Irish Aid is for the overall support of the Alliance Secretariat Work Plan, whereas the ADF contribution is part of France's commitment to the Muskoka initiative and earmarked to maternal, newborn and child health, in the context of a larger multi-agency programme.

Other initiatives have yet to bear fruit. For example, GHWA recently applied to USAID for project-specified funding towards selected brokering knowledge activities but this did not materialise. A project proposal has also been developed for possible support by Kuwait, focusing on promoting HRH policy dialogue in the Middle East region, as well as catalytic support for a national HRH response to selected countries in the region. A new coordinated fundraising strategy has been agreed between the Board and the Secretariat.

4.6.2 Donor views and perspectives on funding

As part of the evaluation, telephone interviews were held with representatives of the Bill and Melinda Gates Foundation, DFID, the EC, GIZ, Irish Aid, JICA and NORAD, which accounted for over three-quarters of total funding.⁵⁴ This revealed that attitudes varied towards future funding of GHWA by existing donors. Several respondents highlighted that future funding would depend on improvements to the strategic plans and the introduction of a results focus for GHWA.

In the case of the EC, funding would partly depend on the outcome of another evaluation covering its overall support to WHO, of which GHWA represented only a part. Respondents for GIZ, Irish Aid and NORAD highlighted that funding decisions ultimately rested with oversight ministries, typically their national Ministry of Foreign Affairs.

In terms of their strategy, several donors indicated that GHWA needs to present a more coherent story and, given GHWA's vulnerable financial position, there is an urgent need to show its comparative advantage over other organisations. It is also important that it makes clear its prioritisation given the limited resources available. GHWA's strategy also needs to reflect what it can realistically achieve.

On reporting of results, three donors raised the issue that GHWA is too process-orientated and has not been able to demonstrate clearly what it has done in terms of tangible results. Donors need

⁵³ and 2010 contribution of NOK 4.5 m (US\$ 767,787 equivalent).

⁵⁴ It was not possible to arrange telephone interviews with CIDA or the Government of Japan.

evidence of results and it is not enough to provide a list of activities. It was recognised, however, that as GHWA is a global alliance and acts as a catalytic organisation rather than an implementer, its achievements may be hard to measure – this may mean that it needs to give more attention to benchmarks that are acceptable to donors.

Some donors commented that they would also like to see more clarity in reporting on how funds are used. For example, one donor funded a staff member who ended up doing something entirely different to what was agreed and this has undermined its confidence in GHWA.

Whilst donors remain open to funding GHWA in the future, their decision to do so will require more evidence of results. GHWA needs to put itself in the shoes of donors who face extremely difficult funding decisions. At the end of the day, donors will decide to channel their resources to the organisation that they are convinced will have the most impact. GHWA, like any other organisation currently facing funding constraints, needs to come up with ways of communicating clearly its added value and demonstrating through its strategy that it will deliver results.

4.6.3 Budget allocations and expenditures

GHWA prepared a three-year strategic framework, *Moving Forward from Kampala, Strategic Priorities and Directions of GHWA, 2009–2011*, which contained the budget figures shown in Table 4.3 below.

The resource projections have proved to be unrealistically optimistic. GHWA financial statements indicate that total funds available at the start of the first two years of the three-year plan were US\$ 16,640,436 for 2009 and US\$ 12,570,549 for 2010.

Table 4.3 Work Plan of the Alliance 2009–2011 (US\$ '000)

Area	Activity	2009		2010		2011	
1	Facilitating Country Actions	10,500	47%	8,700	43%	8,700	43%
2	Continuing Advocacy	1,516	7%	1,753	9%	1,773	9%
3	Brokering Knowledge	3,530	16%	3,255	16%	2,055	10%
4	Promoting synergy among partners	905	4%	810	4%	2,470	12%
5	Monitoring the effectiveness of interventions	1,350	6%	1,380	7%	1,080	5%
6	Programme management and coordination	4,371	20%	4,221	21%	4,221	21%
Total		22,174	100%	20,011	100%	20,299	100%
Contingency				2011		2,029	
Grand Total		24,392		22,131		22,323	

* Provided by Alliance Secretariat

Revenues have fallen even further in 2011. GHWA prepared its budget on the basis of three scenarios (A, B and C) and these were presented at the Board meeting in January 2011. The Board selected Scenario A, the most cautious one, as the basis for operations in 2011. However,

even that has proved to be over-optimistic and the main adjustments, as presented in Table 4.4 below, are from programmatic costs to cover Secretariat costs. Since Secretariat staffing numbers in 2011 have remained steady, this change largely reflects the rapid rise in staff costs due to a rise in the value of the Geneva post-adjustment allowance (itself mainly due to the rapid rise in the value of the Swiss franc against the US dollar).

Table 4.4 GHWA financial scenarios for 2011

	Jan 2011	June 2011
1 Mobilise political leadership and key HRH stakeholders for integrated and multi-sectoral response to HRH challenges at country level	150,000	75,000
2 Ensure an evidence- and needs-based response to HRH challenges at country level	380,000	120,205
3 Support selected priority countries to address HRH crisis by establishing or strengthening their HRH coordination process (CCF) for the development and implementation of HRH plans, including provisions of the Code of practice for international recruitment	1,610,000	1,358,213
4 Strengthen partnerships of entities involved in HRH and coordinate their action for more effective responses at national, regional and global level	215,000	219,970
5 Mobilise political leadership in governments, civil society, media, HRH and other global stakeholders for a results-based response to HRH issues	215,000	204,548
6. Address HRH challenges through generation, gathering and dissemination of knowledge to a wide variety of constituencies for use in strengthening and improving HRH, including country-level CCF processes and the Code implementation	440,000	351,734
7. Ensure good governance and management of the Alliance Structures in accordance with (i) board decisions and (ii) the Governance Handbook	3,200,000	3,854,458
8. Evaluate GHWA operations and reflect on lessons learnt and implications in future strategic directions and resource mobilisation	190,000	140,000
Total	6,400,000	6,324,128

* Provided by Alliance Secretariat

On this basis, expenditures for 2011 will run at only 31% of that envisaged for the third year of the strategic plan. This was a matter of considerable concern to a number of donors when interviewed. GHWA has not clearly articulated a more targeted focus in response to these funding shortfalls. It has been observed that the apparent lack of prioritisation and adjustment to the strategic priorities identified in the 2009–2012 plan means that the plan is now unrealistic.

A second concern is that Item 7, which includes Secretariat costs, which were expected to be 21% of total expenditure (excluding contingencies), became 46% in January 2011 and have more recently been projected to be almost 61% of total expenditures. In addition, some staff recruited on short-term consultancy contracts are in effect supporting the Secretariat function.

Overall Secretariat staff costs represent the largest single item of GHWA expenditure. The rapid appreciation of the Swiss franc against the US dollar, in which staff contracts are based, has meant

that cost-of-living increases have been paid by UN bodies, including WHO, and GHWA. Post-supplements for Geneva have risen from an already high (by international standards) 78% of base salary in 2009 to 90% in 2010 and recently to 115%. GHWA has responded by cutting the number of core posts.

The Alliance organogram dated March 2011 showed 22 positions, of which three were vacant. However, at the Board meeting in June 2011 there was a further cut of one position from 17 staff to 16, excluding seconded staff and including three team leaders and the Executive Director. More recently, the number of Secretariat posts has shrunk further to 14, with all of them contributing to GHWA activities – 10 on specific work and four supporting management functions.

Headquarters staff do not simply represent an administrative overhead – the plan for next year is that 10 of the 14 staff will work on and contribute to GHWA activities. However, the Secretariat has observed that the current staffing levels will also be adequate to support scaling up of activities if additional funding becomes available. Just as dis-economies have occurred as revenue has contracted, so economies of scale should be possible if there is a rebound in income.

There has been some reduction in programmatic expenditure, necessitated by the reduction in total income to GHWA, which has meant that some planned activities at country level have not proceeded as planned. This has caused some frustration amongst national stakeholders who had prepared detailed funding proposals only to find that they have been deferred or scaled back. Whilst the Alliance has maintained reserves, there was also a reduction in closing balances from US\$ 7,527,760 on 31 December 2009 to US\$ 4,393,302 on 31 December 2010, based on data presented to the GHWA Board in June 2011. However, this does not reflect the consequences of the unforeseen adverse financial variances identified in the course of 2011 and described below.

It is important to note that severe cost cutting is also ongoing in all departments in WHO headquarters, including WHO HRH, and there will be a considerable fall in the HQ staff of both WHO HRH and GHWA. In addition, the Director of HRH is due to retire next year.

4.6.4 Sources of funds

Table 4.5 summarises the funds received since GHWA's start up. This is presented in gross and net form, taking account of WHO's hosting charges and is also presented showing the net contribution of each funding partner.

Table 4.5 Summary of funds received by GHWA since start up (US\$)

Country/Donor	Gross	Net	Net Contribution as % of Total Funds Received
Canada CIDA	3,436,911	3,042,331	10.4%
Intrahealth	95,000	84,071	0.3%
Norway NORAD	7,903,248	7,021,402	24.1%
Gates Foundation	5,000,000	4,424,779	15.2%
EU	1,771,121	1,653,316	5.7%%
France	2,876,098	2,695,679	9.3%
Germany GIZ	1,983,417	1,755,235	6.0%
Ireland Irish Aid	3,886,003	3,437,165	11.8%%
UK DFID	4,307,865	3,812,661	13.1%%
USAID	1,350,000	1,192,478	4.1%
Total US\$:	32,609,663	29,119,117	100%

* Provided by Alliance Secretariat

It is evident that the cutbacks made by NORAD will have a particularly significant effect as Norway provided almost a quarter of GHWA's total revenues. The Gates Foundation provided a further 15% in the form of a large start-up grant and it is known that this will not be repeated. In addition, Canadian CIDA provided 10.4% overall and its funding is now completed.

4.6.5 Overview of financial management systems

GHWA's budgets and expenditures accounts have to rely on the WHO Global Management System (GMS). Analysis of the Alliance accounts has been complicated by the absence of a standard accounting format, which makes accurate time-series analysis more difficult. GHWA has used different accounting sub-heads (equivalent to a public sector 'chart of accounts') in different years, which remain unstable, with differences between 2010 and 2011, just as there were between 2009 and 2010. In addition, GHWA reports have typically been prepared for individual Board meetings, which have been held at irregular intervals, so comparisons over time are not easy to undertake. This leads to a loss of transparency in financial reporting which should be rectified as a top priority.

GHWA's financial systems are largely, but not totally, based on those operated by WHO systems, which work to a biennial (two-year) cycle. This kind of budget cycle has become much less common in recent years although some US states have retained it. In the WHO context it has several disadvantages, exacerbated by accounting systems that have not provided reliable intra-budget cycle balances.

WHO is in process of modernising its GMS systems with the rolling out of a new accounting system in a phased manner to the WHO regions. However, the extended process of migrating to the new system has constrained the availability of comparable time-series data. A particular weakness is that the WHO system does not provide timely and accurate financial reports to GHWA of funds distributed to countries and regions.

Whereas GHWA headquarters expenditure is identifiable in the WHO system, this does not apply to the regions and effective 'tagging' of GHWA programme expenditure is not possible. This is of great concern as it reduces management oversight by the GHWA Secretariat. Furthermore, it means that funders to GHWA cannot at present be confident that funds released to the Alliance have been utilised as intended. There appears to be a significant time lag between when the Secretariat distributes funds and when regions and countries record their expenditures, which can lead to donor reporting delays and inaccuracies in annual expenditures. A key constraint of the current biennium was the modification of the Alliance's work plan in 2011 as compared to 2010, which required extensive manual adjustments.

Difficulties in reconciling financial data are one consequence of the combination of inadequate accounting systems by WHO and the lack of standardisation of GHWA's internal accounting formats. Input of financial data and subsequent financial analysis requires significant manual reassignment by GHWA accounting staff. This is both time-consuming and creates scope for errors and, as currently functioning, lacks adequate checks and balances. In addition, if accounting staff change there is a risk of loss of institutional memory for previous changes in the financial data, which can increase fiduciary risks.

The consequences of the shortcomings of WHO's financial system may be illustrated by the following two unforeseen and unbudgeted financial shortfalls, which are:

- Losses totalling US\$ 444,520 by GHWA in 2011 in relation to un-hedged fund management. This arose from the belated adoption of a currency hedging strategy by WHO

and slow reconciliation of expenditures incurred.

- Over-expenditure by GHWA of US\$ 342,000 in relation to assumed savings from a secondee from a donor country who cut short their time at GHWA. It had been assumed that this secondee was funded as a Non-Direct Pay Secondment (where the funder makes a subvention to WHO, which takes on responsibility for staff costs) with the donor country continuing to remunerate the individual. The transfer of funds by the donor government did not actually take place so no savings were accrued. This will have an impact on any budget carry-over from 2011 to 2012.

The combined total of US\$ 786,000 represents some 10% of the 2011 budget and has contributed to the situation where the Work Plan agreed with the Board in January 2011 is no longer affordable. Other contributory factors include unforeseen funding cutbacks from donors and cost escalation from employing Secretariat staff in Geneva.

Although direct attribution is not possible, perceived weak financial management by WHO is reported to be a contributory factor in WHO's difficulties in attracting donor funds. GHWA will need to standardise and finalise codes and cost categories to improve comparisons over time, whilst basing information on calendar years rather than the period between Board meetings. GHWA does publish its annual accounts that follow its Work Plan in its own annual reports.

WHO is already developing new standard terms for hosting all partnerships, including GHWA. Consideration should be given to renegotiating the MOU with WHO, so that in cases where adverse financial costs are incurred due to factors that may be attributed to weak WHO financial systems, the costs should be borne by WHO as the host organisation and not by GHWA as the hosted entity.

4.6.6 GHWA governance structures and staffing

The GHWA Biennial reports indicate that the Board consisted of 18 members in 2006–2007 and 20 in 2008–2009. Currently, the Board membership may be increased to 22 or more. Whilst Board members may be in a position to increase fundraising activities, there is a risk that the size and cost of governance arrangements may be disproportionate with the turnover and activities of GHWA. This raises both governance and VfM issues, including the following:

- From a governance perspective, it is not self-evident that a large board improves accountability or fundraising. There is evidence from the private and from the not-for-profit sectors that large boards reduce the degree of responsibility taken by individual board members, as well as undermine effective decision taking and oversight. The overall trend is towards smaller boards.
- The cost of board meetings will tend to increase and become disproportionate to the role and functions fulfilled by the board. This has VfM implications and suggests that greater clarity should be sought between the fundraising and management oversight functions of the board.

Given the prominence of VfM and accountability issues in the current aid climate, it is appropriate to consider the benefits of establishing a small Finance Committee to take responsibility for improving oversight of GHWA's financial management.

4.6.7 Tendering and contracting

WHO has a small procurement department based in its Kuala Lumpur office. Although the WHO procurement process is theoretically centralised, it lacks the resources to undertake many procurement activities. In reality, a high proportion of procurement is undertaken by the different operating departments, which includes hosted organisations such as GHWA. It is understood that WHO maintains tables of typical consultancy fee bands, which may be useful for benchmarking purposes. However, there appears to be considerable discretion regarding the extent of sole-sourcing.

A significant proportion of GHWA contracting involves short-term consultancy contracts which require specific terms of reference that need to be developed by GHWA. This has implications for the necessary management resources. The Agreement for Performance of Work structure is widely applied to consultancy contracts and, where appropriate, the Secretariat will request and include reporting amendments before their final approval. The certifying officer is in Malaysia and WHO lacks resources and technical capacity in Geneva to oversee the contract's details. These contractual arrangements are an area that GHWA needs to address.

4.6.8 Arrangements for air travel

Hosted organisations are required to use WHO's core services, which includes American Express (AMEX) as the contracted travel provider. Air travel, which is a significant cost item to GHWA, is undertaken at the class of travel stipulated by WHO. It is understood that in order to travel business class, the trips need to be at least nine hours, which excludes expensive transatlantic air travel. This tightening up comes against a backdrop where donors, including GHWA's funders, are severely limiting the use of business class travel. UN bodies, including GHWA, have benefitted from more generous travel arrangements, including per diems, than are typical of the donor organisations that are funding them.

4.6.9 WHO–GHWA MOU and hosting charges

Negotiations between GHWA and WHO regarding hosting arrangements took place during May to October 2006 and resulted in a MOU. However, despite the fact that WHO was already hosting various alliances, there was no standard template available. Delays in reaching an agreement for the MOU resulted in delayed staff recruitment which contributed to the situation in which GHWA's total expenditure was US\$ 4.4 million to the end of December 2007, compared to a revised budget for July 2006–December 2007 of US\$ 9.5 million, about 46% of budget.

The Organisation has recently changed its approach to hosting and has decided to stop accepting new hosting arrangements. WHO has been charging a standard rate of 13% of income for hosting GHWA and the current agreement runs through to 2016, in common with GHWA's current mandate. This overhead cost is understood to have been queried by a number of donors. GHWA's hosting arrangements meant that its budget was incorporated within WHO's Programme Budget but as of January 2012 it will be outside of this budget. Although the implications are not clear to the evaluation team, there may be a rise in charges from 13% to an indicative 20%. This is not included in the original MOU.

In addition, a liability fund for WHO partnerships may be set up and GHWA, as a partnership with WHO, is also supposed to pay legal fees associated with staff complaints against management that go to the appeals board.

4.6.10 Sustainability – to what degree will funders maintain their financial support?

Funding to the Alliance varies by donor, with some (e.g. DFID) making multi-year pledges whilst others make single year allocations. Once an MOU has been signed, WHO regulations permit drawdown of funds ahead of their actual receipt, although funding releases have not always equated to pledges. For example, NORAD has been a core funder but has recently cut back on its funding and in 2011 it is understood that releases will be less than the (already scaled back) pledged sum. The reasons for this are not fully clear to GHWA management.

Some funding is pledged to GHWA direct whilst, for other donors such as the EU, funding is pledged to WHO in the form of an *umbrella* award that includes several departments. GHWA's relationship with WHO HRH is, therefore, crucial in this regard. Relations between the WHO HRH and GHWA are reported to have been variable, but as both come under pressure from falling revenues such umbrella rewards will become more important. It should be noted that partners and donors do ask questions about the relative responsibilities. Table 4.6 shows the firm donor pledges for the remainder of 2011, as reported by GHWA.

Table 4.6 Firm donor pledges for the remainder of 2011, reported by GHWA

Donor	Sum Pledged (US\$ Equivalent)
Norway	304,500
Ireland	385,400
Japan	435,000
France (total)	740,000
Total:	1,844,900⁵⁵

* Provided by Alliance Secretariat

For 2012, GHWA's work plan is projecting an expenditure of just over US\$ 7.2 million, with a similar funding stream projected for 2013. Possible projected funding includes:

- Funding from France, which is principally for maternal health-related programmatic activities and is therefore not fungible;
- US\$ 1.7 million from Japan, which has not funded in past years, although the new Chair is from Japan;
- Both DFID and GIZ have stated that future funding is 'open' and decisions have yet to be made. DFID and GIZ representatives who were interviewed expressed concern about the current effectiveness of GHWA, and that it cannot be a foregone conclusion that funding to GHWA will be received from them;
- Ireland reported that it was fully committed to funding GHWA with untargeted funds (which may be used to pay for Secretariat costs) and an early decision on this should be forthcoming.

Overall, it is clear that GHWA still has a financing shortfall for 2012 which means it cannot move forward on its current and projected funding base. The large reduction in funding from Norway makes GHWA extremely short of funding for Secretariat costs, although the employment of staff on time-bound and temporary contracts only provides a small degree of flexibility.

⁵⁵ Reported by GHWA to have increased to US\$ 2,196,000 (mid-November 2011).

Based on initial findings, the 2011 revenue will be substantially under original expectations, although discussions are continuing with potential donors. In essence, funding from new sources (e.g. Japan) may be insufficient to make up for the scaling back of existing sources (e.g. Norway). Previous donors, such as the Bill and Melinda Gates Foundation and Canadian CIDA, have decided to focus their resources elsewhere.

On the future financial sustainability of GHWA, there is still some uncertainty, with the result that it is forced to restructure its budgets on a continuing basis. This situation is further complicated by the fact that previously untargeted funds (e.g. Norwegian funds) could be used for core Secretariat office costs but increasingly donors are providing earmarked funds for specific countries and/or programmes. In addition, many donors are committing funds for shorter time periods.⁵⁶ These changes in donor practice mean a substantial loss of flexibility for GHWA and will make managing its Secretariat and Alliance programmes both challenging and time-consuming as budgets and work plans are restructured.

4.6.11 Conclusions on VfM

Due to the nature of GHWA's work, which makes it difficult to attribute outcomes and impact directly to the Alliance, measuring VfM is not a straightforward task. Furthermore, when asked about whether they considered GHWA to represent good VfM, almost all donors struggled to answer – we did not see this as an indication that it was not, but more that they had not seen the evidence that it was.

On balance, however, the evaluation team would consider that GHWA has represented reasonably good VfM during its first five years of operation. It has succeeded in gaining visibility and credibility across each of its three core functions (advocacy, brokering knowledge and convening) and has done this with a budget that is not excessive. However, as has already been emphasised in this section, in the context of increasing competition for limited resources GHWA needs to do more to provide evidence of VfM by clearly demonstrating results.

⁵⁶ That said, recently GHWA has received pledges with a five-year (ADF) or three-year (Irish Aid) time horizon.

5 Conclusions

The terms of reference included a review of the Alliance's progress since 2006 and a requirement to identify recommendations for its future up to October 2016.

As requested, this evaluation report assesses the Alliance's progress and achievements by analysing both qualitative and quantitative data, mainly from the following three sources:

- Review of the Alliance's main documentation;
- Qualitative information from key informant interviews; and
- Financial data from the Alliance's accounts.

As with all evaluations, in arriving at conclusions this one has had to rely on the available data and information, together with its analysis and interpretation. While attempting to be as objective as possible, the team also needed to rely on making its own judgements. In addition, the team needed to ask the counterfactual question: What might have happened if GHWA had not been started in 2006? These considerations are part of this evaluation process and are reflected in arriving at the following conclusions.

5.1 Strengths, Weaknesses, Opportunities and Threats (SWOT)

In Table 5.1 the evaluation team identifies some of GHWA's most important Strengths, Weaknesses, Opportunities and Threats. It is not meant to be exhaustive but includes some of the key issues that came up across each category of respondents.

Table 5.1 SWOT Assessment of GHWA

Strengths	Weaknesses
• Strong in global advocacy and convening • Credibility in relation to HRH issues • Global Forums on HRH helped to create a movement on the importance of HRH • High quality of technical outputs produced • Increased visibility by being located at WHO Geneva • Evidence of successful implementation of CCF • Independence of Board and Secretariat • Works at global, regional and country levels	• More oversight needed by the Board over the Secretariat and more transparency in relation to decisions made by the steering committee • WHO administrative and financial procedures are cumbersome • Perceived lack of full financial transparency • Lack of resource mobilisation strategy, including how to take advantage of new funding opportunities • Limited resource capacity (HR and financial) to support CCF countries • High turnover of Secretariat staff and reliance on short-term contracts • Failure to galvanise members and partners • Current identity of GHWA needs to be defined as well as comparative advantage
Opportunities	Threats

-
- Widely felt need to continue global advocacy
 - HRH increasingly recognised by donors as crucial to improving health outcomes
 - New funding opportunities
 - With 330+ partners and members, could make a movement and have a voice
 - With downsizing of HRH function in WHO, the complementarities of GHWA are even more important
 - Possible links to other HRH organisations
 - Build on links with WHO and UN agencies
 - Support HRH in group of 'flagship' countries
 - Engage more with regional HRH platforms
 - The global financial crisis
 - More competition for funding on HRH
 - Strategies and approaches need to change in line with an evolving environment
 - Lack of shared vision over future strategy
 - Increasing competition for donor HRH funds
 - Availability of HRH support for CCF countries
-

5.2 Achievements by area of enquiry in the Terms of Reference

The terms of reference specifically requested the evaluation explore the following aspects and the evaluation's conclusions are as follows:

1. Coherence of strategy with mandate, added value and complementarity with and contribution to the work of other key HRH stakeholders

Following the establishment of GHWA, the Alliance's strategy during 2006–2011 has been closely allied to its mandate for all three main groups of activities in Advocacy, Brokering knowledge and Convening, particularly at global and regional levels. In addition, despite the challenges it faced, it has strived to be an Alliance of like-minded HRH stakeholders.

When GHWA was first established, there was a perceived need for a lead organisation that could encourage greater synergy across organisations in order to maximise the overall contribution of all the individual agencies. Rather than being a leader of an alliance, there is a perception, particularly by global partners, that GHWA has become another player in the field of HRH and that, while it has a large number of partners and members, it could be more actively engaged with these organisations.

The Alliance is seen as performing well at the beginning, but many of the stakeholders gave the opinion that the Alliance today is not doing as well as it could. There was mention of the need for GHWA to redefine its 'space' within the HRH landscape and that it needs to become more influential and visible with key HRH stakeholders at country level.

Over time, the Alliance appears to have been undergoing two changes. Firstly, it seemed to want to become a 'brand' and leader in its own right and, secondly, it is perceived as becoming an implementer of its own activities, such as the CCF process, at country level. In addition, the message from some donors is that GHWA has struggled to redefine its strategy and some decisions appear to be opportunistic rather than driven by a clear vision for the future.

2. Results, capacity and credibility acquired to date as (1) global advocate for greater political commitment and increased resource mobilisation for HRH, (2) brokering knowledge in HRH, and (3) convenor of collaborative events and platforms

It is widely acknowledged that the Alliance has been successful in these three sets of activities, particularly at the global level, and there is recognition that both political commitment and resource mobilisation for HRH have increased over the past five years. It remains unclear whether these achievements can be attributed directly to GHWA as an Alliance, but the evidence is also strong for the Alliance's role in brokering knowledge and convening collaborative events.

Overall, GHWA is widely recognised to have performed its convening function well, although criticisms include that more civil society organisations might have been involved and that the Bangkok Forum was less inclusive and participatory than Kampala.

GHWA has contributed to ensuring greater global political commitment, as demonstrated by the G8 commitments, although it is perceived to have been less successful in resource mobilisation for HRH. Suggested missed opportunities include not exploiting new funding streams, too little effort in convincing donors that their resources will have an impact, focusing too much on funding its own activities rather than Alliance partners, and not doing enough to secure funding at the country level.

GHWA has been widely praised for the quality of its knowledge products, produced mainly by the TFWGs, although efforts to ensure access to and awareness of these products might have been stronger and this has undermined the country-level usage of these products.

3. Results in terms of fostering partnerships and promoting consensus for coordinated and integrated responses to HRH challenges at global, regional and country levels

GHWA is probably best known as a global player, although it is also visible at the regional level. GHWA has played a role in fostering partnerships and has supported the emergence of other similar global and regional groupings. There does seem to be a perception, however, that GHWA could have been more successful in its ability to mobilise and coordinate partner responses to HRH challenges at the global level.

At the present time, GHWA is not seen as having a coherent strategy on partnerships and it is unclear what organisations can hope to gain or indeed what they are expected to contribute by becoming a partner or member. As the focal point for the global Alliance, GHWA does need to develop a stronger strategy for partners and to engage more closely with members.

GHWA's global-level strategic functions in advocacy, brokering knowledge and convening have enabled some developing countries to strengthen and renew their own HRH strategies through the CCF process. However, this process is at an early phase and it is too soon to expect measurable changes for HRH outcomes, let alone health impact, in these countries.

The GHWA CCF process does appear to be effective in helping promote nationally coordinated and integrated responses for HRH, at least in the better-performing countries. The Alliance does not appear to be well known in crisis countries and there have been suggestions that if it wants to foster country-level partnerships it will need to establish some presence within countries. An option for the Alliance is to support an HRH specialist within WHO regional and/or country offices to advise crisis countries, though in light of GHWA's funding constraints this is unlikely to be a feasible option in the near future.

4. Relevance of the work and strategic functions supported by the Alliance at global, regional and country levels on national HRH policy making and HRH development

The evidence gathered through this review supports the view that the Alliance has undertaken work that has been highly relevant to the HRH agenda at all levels, including influencing national HRH policy and development. It is widely agreed that there remains a need for a global leader on this issue in order to ensure that the HRH crisis continues to occupy a key position in the global health agenda. The Alliance is in a good position to play this role.

While it is difficult to link work done at the global and regional levels to national HRH policy making and development, the three country studies all provided anecdotal evidence for this connection. The Alliance is now in a position to promote the lessons and successes from these countries to other crisis countries, perhaps by supporting some 'flagship' examples.

Alliance support to countries is very relevant, although its effectiveness appears to depend heavily on a number of factors including, but not limited to, strong national-level leadership on HRH and the availability of catalytic funding to initiate the early stages of the CCF process.

5. Track and record future prospects in mobilising financial resources to sustain the core functions of the Alliance secretariat.

It is clear that GHWA will have difficulties in moving forward in 2011 based on its current and projected funding base. The recent reduction in donor funding leaves GHWA short of finances to cover the costs of the Secretariat, as well as for financial support to Alliance partners and country-level activities. The current mode of operation, with staff on short time-bound and temporary contracts, can only provide some degree of flexibility but this will be insufficient to cover the longer-term financing gap.

On the future sustainability of GHWA, there is still some considerable uncertainty. The result is that GHWA has to restructure its budgets on a continuing basis. Its situation is further complicated by the fact that previously untargeted funds that could be used for core Secretariat costs are being curtailed, with more donors only providing earmarked funds for specific countries and/or programmes. In addition, many donors are now committing funds for shorter time periods. These changes in donor practices mean a substantial loss of financial flexibility for GHWA, which will make managing its Secretariat and programmes both challenging and time-consuming from 2012 until 2016.

6 Recommendations

As GHWA enters the second half of its planned existence, there are a number of important issues that it needs to carefully address in order to ensure its approach reflects the current environment and that it makes the most of current opportunities.

1. Governance and the role of the Alliance Board

The prime function of the GHWA Board is to guide the overall vision and strategy of the Alliance and hold the GHWA Secretariat accountable for its activities. It provides oversight by reviewing and approving the operational work plans, annual budgets and work of Board standing committees, and monitors financial resources. It also approves GHWA's financial statements and progress reports. However, at present there is a dual system for GHWA's accountability, to the Board for all strategic and programmatic activities and to WHO for financial management and administration.

Recommendation: The Board undertakes an urgent review to assess the effectiveness and working of the GHWA Board, with the aim of strengthening the Board's oversight functions for renewing strategy, monitoring programme activities and financial accountability. It should assess the shortcomings of the Governance Handbook both in terms of its stipulations and in the way it has been implemented. The review should also include:

- The format of the biannual Board meetings;
- Working relationship between the Board and the Standing Committee;
- The system of dual accountability between the Board and WHO;
- Representation of WHO on the Board;
- Ways to ensure active engagement of Board members between meetings; and
- Ways to strengthen the oversight function of the Secretariat activities.

2. Alliance's future strategy for 2012–2016

Although both Board members and GHWA partners agreed that the Alliance has been successful in promoting a coherent strategy for the Alliance since 2006, many expressed concerns when asked about the future strategy for the Alliance. This suggests it is time for the GHWA Board to reconsider and reformulate its strategy and priorities for 2012–2016. GHWA's strategy also needs to reflect what can realistically be achieved within this period, particularly given the funding shortfalls.

Recommendation: The Board engages in a detailed discussion on the Alliance's present interim strategy for 2011 prior to renewing its future strategy for 2012–2016. This should aim to enable both WHO and GHWA to fully support the strengthening of HRH progress in crisis countries. Alliance global partners and members should also be fully involved in this process of strategy renewal.

3. Resource mobilisation activities for 2012–2016

Given the limited international resources now available from donors, GHWA needs to present a more coherent fundraising strategy for 2012–2016 that demonstrates its comparative advantages over other organisations and that makes clear its main priorities. Donors need evidence of results, which may not be in the form of outcomes as this may not be possible for GHWA, but a list of activities is not enough to convince donors to invest. GHWA needs to recognise the competition it faces and carefully consider how to meet the needs of donors.

Recommendation: As a priority, a Resource Mobilisation Committee of the Board should be convened to renew the Alliance's fundraising strategy and to put in place stronger efforts to maintain its momentum. This should be given the highest priority by both the Board and Secretariat.

4. Alliance's relationship with WHO

As WHO undergoes its present reforms, GHWA and WHO HRH will both be substantially reduced in staff and capacity. However, there exists considerable potential for WHO and GHWA to support HRH developments in crisis countries, including through WHO country offices and through GHWA's CCF process. This will require, however, improved clarity of their mandates and enhanced working relationships.

Recommendation: WHO and GHWA set up a small joint internal working group to review this relationship and to make recommendations for securing a strong and productive working partnership for 2011–2016. The working group should consider:

- Clarifying the mandates and areas of responsibility;
- How best to communicate the respective roles and responsibilities both internally and externally to donors and partners;
- How to systematically share information amongst the two and plan in a coordinated way;
- Closer joint working in support of crisis countries; and
- Improving coordination for combining their global advocacy and technical support functions.

5. Overview of financial management

GHWA's financial systems are largely, but not exclusively, based on those operated by the WHO GMS, which works to a biennial (two-year) cycle. However, the GMS does not necessarily provide timely and accurate financial reports to GHWA, particularly with regard to funds distributed to countries, regions, and partners. There is a perceived need for greater transparency in the use and distribution of donor funds.

Recommendation: The Board establishes a small Finance Committee to oversee on a regular basis GHWA's income and expenditure accounts, including the costs of the Secretariat and its disbursements to WHO regions and country offices, to partners and to CCF committees in crisis countries.

7 Options for GHWA's future strategy

This section is designed to promote discussion, particularly amongst the GHWA's Board members, partners and members, on the choices facing the Alliance as it develops its new strategy for 2012–2016. Due to the considerable divergence of views expressed by informants and the need for consensus building among stakeholders, the evaluation team are not in a position to identify specific ways forward, but based on our findings, we have suggested some possible options to support the discussion.

7.1 Renewing the Alliance's strategy

While this evaluation found a consensus that GHWA's strategy for 2006–2011 had worked well, there were clearly divergent views about future priorities and the strategy for 2012–2016. It is important, therefore, that GHWA's Board, partners and members debate the options and come to a clear consensus on the strategy for 2012–2016.

The evaluation team doubt whether the Alliance has an effective and sustainable future if it continues with its present strategy and ways of operating. That said, planning to downsize and exit its present role in the short term would also appear to be unacceptable, as the Alliance still has many concerns to address in order to achieve further improvements in HRH. It would appear, therefore, that a renewal of its future strategy for 2012–2016 is the only viable way forward.

To support the debate on what should be prioritised in the revised strategy, this section looks at achieving answers to the following urgent questions:

What relative priority and balance should the Alliance give to:

- GHWA's three strategic functions of **advocacy**, **brokering knowledge** and **convening**?
- Promoting the Alliance activities at **global**, **regional** and **country** levels?

It is doubtful whether GHWA will be able to successfully act for all three functions and at all three levels. Making choices and defining priorities will be necessary. The choices can be illustrated as a 2-by-2 matrix as follows:

Level	Function	Advocacy	Brokering knowledge	Convening
Global				
Regional				
Country				

Two examples of directions mooted by respondents include:

-
- Building on its previous successes, GHWA should focus mainly on **global advocacy** and enable WHO HRH to give technical support to crisis countries; or

- Engagement at the country level is the only way to make a difference. GHWA should therefore focus mainly on strengthening **advocacy and convening at country level** and leave global-level activities to other organisations.

Both of these very contrasting suggestions were stated by a large number of respondents and neither emerged as the favoured option overall. Both need to be weighed up to see which, or a modification thereof, would be more appropriate. This decision must take into account other players at global, regional and country level, the financial and HR capacity constraints, and the perceived comparative advantage of GHWA.

7.2 Strengthening partnerships

During this external evaluation, it emerged that more needed to be done to actively engage partners in GHWA's work. At present, partners are not clear of what is expected of them and only the very active ones have maintained a meaningful interaction with GHWA.

In order to take advantage of the large number of members and partners that have expressed a shared commitment to reducing the global health worker crisis, the role of partners and members must be more clearly defined and communicated. Some areas to be considered include:

- Investigating ways in which other member-based organisations have succeeded in creating a culture of engagement and interaction among partners and members, and based on these findings, develop a set of approaches for GHWA to take forward.
- Organising an annual event for members and partners to engage in discussions. The first event could be used to come up with a clear vision for partners and members, including the procedures that will be used to actively engage. It would be very important to ensure that these events are inclusive and not only for selected partners and members.

7.3 Supporting crisis countries

GHWA's more recent strategy for CCF does have strengths, although it is in the early stages of being implemented in crisis countries. The following are some of the options that have been discussed in a number of interviews and particularly during the country visits.

In terms of the geographic focus of the CCF support, two possible options are :

- Focus efforts on a few 'flagship' countries in order to be able to maintain sufficient engagement and technical support. Their success can then be later disseminated to other countries and donors; or
- Roll out CCF support to a large number of countries. This would require increased staffing capacity and additional financial resources if catalytic funding is to be provided.

Currently, support is centralised at the global level. The options in relation to this would be to:

- Maintain the position of small number of technical staff at global level; or
- Deploy staff at a regional level to support the CCF process at country level. Some advantages of this would include:
 - o Lower staff costs;

- o More scope for interaction with crisis countries because of geographic proximity and staff being able to be assigned a smaller number of countries to support; and
- o Limited technical staff are not taken from their region to live in Geneva from where they may be reluctant to return.

In order to increase visibility at the country level, some of the options available would be to:

- Maintain a full-time presence in each of the crisis countries being supported. The costs associated with this option are likely to be prohibitively high.
- Come up with ways to better utilise the existing CCF process to create awareness about GHWA's knowledge products and website and anything else that could be used as a resource for countries.
- Engage more actively with the WHO country office so that they are effectively seen as the face of GHWA in country.

7.4 Location of the Alliance and the relationship with WHO

While the evaluation team did not seek to focus on the issue of the relationship with WHO HRH or the Secretariat's location in WHO Geneva, it became apparent that there was significant concern among respondents in relation to this.

Should GHWA wish to address these concerns, the following are some options for discussion:

- Review and/or renegotiate the MOU with WHO.
- Become more or less integrated with WHO HRH.
- Change the location of the Alliance in order to save on the high costs mainly relating to staff living in Geneva. There could be a risk of losing legitimacy but the cost saving may be viewed positively by donors and ties could be maintained with WHO. Given the virtual nature of a lot of GHWA's work, the physical location may not be important.
- Consider merging with another international organisation or alliance.

In the late 1990s, WHO Geneva supported the establishment of alliance organisations in the headquarters largely as a means of diversifying mechanisms for funding activities related to but not directly controlled by the Organisation. For example, Roll Back Malaria and Stop TB alliances began about a decade ago and today there are now about 10 alliances at WHO, which vary considerably in their objectives, governance and organisation. Surprisingly, there was never a common format for these new alliances and new MOUs were negotiated each time.

The WHO DG has recently undertaken a review of these alliances and decided that no more will be started and that the current MOU governing existing alliances may need to be renegotiated. This may be an important opportunity for GHWA to renegotiate its existing MOU with a view to tackling the difficult issues around GHWA's dual accountability to both its Board and to WHO.

During this evaluation, a number of external and internal interviewees to WHO and GHWA suggested that the Stop TB Partnership was a respected and good working model for an alliance. An option worth considering is bringing GHWA into a closer working relationship with WHO HRH, in a model similar to that used by Stop TB and the WHO Department for TB. The first focuses primarily on promoting advocacy, communications and fundraising, whilst the latter focuses on the needs of the TB technical programmes and support to countries. Both retain their independence but have a close working liaison through the governance of Stop TB.

This model has the potential to clarify the mandates and relationships between GHWA and WHO

HRH, remove competition for funds and encourage the building of greater confidence amongst donors. GHWA would still retain its independence and would be a central focus for all Alliance activities.

Annex A Terms of reference

Introduction

Health workers are the heart and soul of health systems. And yet, the world is faced with a chronic shortage - an estimated 4.2 million health workers are needed to bridge the gap, with 1.5 million needed in Africa alone. The critical shortage is recognized as one of the most fundamental constraints to achieving progress on health and reaching health and development goals.

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

The Alliance is hosted by the World Health Organization (WHO); the hosting arrangements are governed by a Memorandum of Understanding between the Alliance and WHO, which envisages a time limit of 2015 for the operations of the Alliance.

Governance of the Alliance is overseen by a Board with a broad representation of stakeholders. The Secretariat, administered by WHO as hosting partner, has a small core group of professionals driving and coordinating the implementation of The Alliance Strategic Plan and the Kampala Declaration and Agenda of Action. The Secretariat reports directly to the Board for programmatic results and to WHO for administration of personnel and financial matters. WHO does not fund nor control The Alliance' operations, but is a founding member and partner of The Alliance with a permanent seat on the Board of The Alliance, as are professional associations, NGOs and other constituencies, including donor governments.

Two years after its establishment, the Alliance convened the First Global Forum on Human Resources for Health in March 2008, attended by more than 1500 participants. At the Forum examples of good practice in addressing the HRH crisis were shared and barriers to remedy the situation were identified. The Forum generated further commitment to the work of the Alliance, developing networks and building consensus.

The main outcome of the Forum was the adoption of the Kampala Declaration and the Agenda for Global Action (KD-AGA). This identifies urgent actions to be undertaken by governments, global leaders, multilateral and bilateral development partners, civil society, the private sector, health professional associations and unions. The six interconnected strategies of the KD-AGA are:

- Building coherent national and global leadership for health workforce solutions.
- Ensuring capacity for an informed response based on evidence and joint learning.
- Scaling up health worker education and training.
- Retaining an effective, responsive and equitably distributed health workforce.
- Managing the pressures of the international health workforce market and its impact on migration.
- Securing additional and more productive investment in the health workforce.

The achievement of the KD-AGA requires concerted, coordinated and sustained actions from the multiple players within and across sectors, disciplines and countries, and globally.

The KD-AGA specifically calls on the Alliance to monitor its implementation and to reconvene the Forum in two years' time to review and report on progress. In early 2011 the Alliance and other co-hosts convened the Second Global Forum to review progress, and renew commitments to health workforce development.

Since the Kampala Global Forum, the global community has seen a rapid increase in political commitments to resolving the health workforce crisis. In addition, it was agreed to revisit the initial Strategic Plan of the Alliance to ensure that its strategies were appropriately aligned with the actions outlined in the KD-AGA.

The KD-AGA was translated into a more operational strategy for the Alliance, called "Moving Forward from Kampala", which outlines the strategic priorities for the Alliance in the period 2009-2011.

In the implementation of the "Moving forward from Kampala" strategy, three functional areas have been identified:

1. Highlighting the crisis of human resources for health and keep it on the global agenda through a range of advocacy initiatives and engagements
2. Brokering knowledge and facilitate the sharing of best practices on health workforce issues for more evidence-based responses
3. Convening countries, members, partners, and other relevant stakeholders to work together to find solutions to health workforce challenges, and facilitate their effective implementation.

In the course of 2011 the Alliance will have to develop a new strategic framework to guide its work for its remaining time span.

Rationale for external evaluation

The Alliance will soon complete its first five years of existence. This intermediate and presumed mid-term milestone warrants an analysis of its achievements to date, and a reflection on its strengths, weaknesses, and opportunities and threats for the years to come. An analysis of its first years of existence will allow the Alliance to concentrate on and consolidate further its areas of strength, address its weaknesses, and provide a high value-added contribution in the context of a crowded global health landscape, including its complementarity and synergy with WHO and other health system related partnerships.

Furthermore, the findings of the evaluation will feed into the decision on whether the Alliance operations will be sustained beyond its intended initial ten year life span through to 2016, and, if not, provide input into an exit strategy.

Accordingly the Alliance Board in its 10th meeting in June 2010 took the decision to conduct an external evaluation, and in its 11th meeting in January 2011 agreed to the terms of reference of this evaluation.

It is recognized by the Board and other stakeholder (through the self-assessment conducted in 2010) that the Alliance mandate and its focus on the functions of advocacy, knowledge brokering and convening are valid for the originally envisaged life span of ten years. The findings of the external evaluation will therefore feed into the process for revising the existing and, if needed, identifying new strategic directions of the Alliance.

Once the required decisions are taken by the Board on the future considering the findings and recommendations of the evaluation, necessary adjustments may be introduced the current governance and hosting arrangement with WHO.

Objective.

The independent evaluation will review the first five years of the Alliance activity on health workforce development from its launch in 2006 to identify recommendations for the future work of the Alliance. The evaluation should:

- analyse the Alliance's contribution to date,
- reflect on its strengths and weaknesses,
- explore opportunities, identify ways of mitigating threats, and
- make recommendations for its future strategy for the remaining period mentioned in the MoU with WHO (October 2016).

Areas of enquiry.

More specifically the evaluation will explore the following aspects:

1. Coherence of strategy with mandate, contributions and added value, complementarity with and contribution to the work of other key HRH stakeholders;
2. Results¹, capacity and credibility acquired to date as: (i) global advocate for greater political commitment and increased resource mobilization for HRH; (ii) knowledge broker in HRH; and (iii) convener of collaborative events and platforms,
(In the context of this evaluation the term "results" refers to progress in achievement of the objectives and the deliverables set out in the Alliance foundation documents, its strategies and planning documents, and not to results in a public health or epidemiologic terms, such as health outcomes).
3. Results in fostering partnerships and promoting consensus for coordinated and integrated responses to HRH challenges at global, regional and country levels;
4. Relevance of the work and the strategic functions supported by the Alliance at global, regional and country levels on national HRH policy making and HRH development;
5. Track record and future prospects in mobilizing financial resources to sustain the core functions of the Alliance secretariat.

The above given aspects can be enquired through the use of the following probing questions:

- Has the Alliance strategic and planning approach been aligned with its institutional mandate?
- Have the Alliance contributions as advocate, knowledge broker and convener, and facilitator of partnership and consensus been complementary to and synergistic with the work of other key HRH stakeholders?
- Has the Alliance worked with the necessary credibility to effectively perform its functions?
- Are the work and the strategic functions of the Alliance relevant to address key HRH challenges at all levels?
- Has the Alliance been able to mobilize sufficient resources to sustain its operations?
- What are the prospects for the Alliance to mobilize sufficient resources in the future to operationalize its mandate?
- What adjustments, if any, should be made to future strategies and resource mobilization efforts of the Alliance?
- Should the Alliance operations be sustained beyond 2016?

Approach to the evaluation.

A credible and independent contractor will be selected through a competitive tendering process. The contractor will work in collaboration with an evaluation task team, that will include selected Board members and whose role will be to:

- Provide guidance and advice as appropriate on the conduct of the external evaluation.
- Oversee the contractor selection process, reviewing proposals and selecting the most suitable contractor
- Provide timely feed-back on the proposed detailed evaluation methodology and
- Provide timely feed-back on successive drafts of the external evaluation.

The evaluation task team will be supported by the Secretariat in performing its assigned role.

The contractor will:

- Finalize the development of a detailed evaluation methodology, to be agreed with the task team; and
- Conduct an independent evaluation on the basis of the agreed methodology.

While the identification of a detailed methodology of work will represent the preliminary step to the conduction of the evaluation, it is envisaged that this will include at a minimum:

- Review of selected literature, documents, and publications on relevant health workforce topics;
- Analysis of relevant internal documents of the Alliance, such as strategic documents, work plans, general and project-specific reports, publications, meeting reports, etc (these will be provided to the contractor upon signature of an agreement).
- Key informant interviews with selected HRH stakeholders, and members and partners of the Alliance at global, regional and country levels, selected current and former Alliance Board members, Alliance Secretariat staff.

It is expected that the bidders include in the planning and budget two visits for no more than 2 of its representatives to physically meet with the Board and/ or the Secretariat in Geneva.

With regard to data collection and interview efforts, bidders are encouraged to gather information, to the largest extent possible, by making use of relevant information and communication technology.

The stages will include: Selection of a contractor, Finalization of evaluation methodology, Presentation of methodology to Alliance Board, Literature and documents review, Data gathering, preparation of draft report, Incorporation of feed-back received, development of final technical contents of final report, Professional design and lay-out of the report.

Deliverables

The external evaluation will proceed in stages, with the sequential delivery of intermediate products, which will need to be submitted to the task team.

The contractor is expected to adhere to the timelines provided, incorporate any feed-back or recommendations received with regards to the finalization of the methodology, and consider feed-back and recommendations received on the draft report.

A draft of the evaluation report will be discussed with concerned parties by the task team, and feed-back sought. The evaluation team leader bears responsibility for finalization of the report, incorporating as relevant and appropriate feed-back and suggestions received.

The deliverables and their respective timeframes are:

Deliverable 1: evaluation methodology finalized (by June 15th 2011). An inception report describing how the team intends to organize the work, methodological approach and criteria for the evaluation approach.

Deliverable 2: draft external evaluation report of the Alliance (by August 31st 2011; later modified).

Deliverable 3: final technical contents of the external evaluation report (by October 31st 2011). A final report of no more than 50-60 pages plus annexes, with an executive summary that does not exceed 5 pages.

Deliverable 4: final external evaluation report, inclusive of professional editing, design and lay-out (by December 15th 2011).

Annex B List of key informants interviewed

GHWA, WHO Geneva

1. GHWA Board Members

Board members	Affiliation and position
Dr Masato Mugitani	Chair GHWA Board, Assistant Minister, Ministry of Health, Labour and Welfare, Japan
Prof Eric Buch	Dean, Faculty of Health Sciences, University of Pretoria, South Africa
Prof Francisco Campos	Universidade Federal Minas Gerais, Brazil
Carolyn Miller	Chief Executive Officer, Merlin, UK
Mary Ann Lansang	Director, Knowledge Management, Global Fund, Geneva
Akiko Maeda	Health Adviser, World Bank, Washington, USA
Carissa Etienne	WHO ADG Health Systems and Services Cluster
John Palen	Senior Technical Adviser, US Office of the Global Aids Coordinator, Washington, USA
Bjarne Garden	Acting Director, Department for Global Health and Aids, NORAD, Norway
Prof Miriam Were	Chairperson, AMREF, Kenya
Manuel Dayrit	WHO Alternate, Director Department for Human Resources for Health, Geneva (NB: Also Head of WHO HRH)
Samuel Kingue	Director, Department for Human Resources, Ministry of Health, Cameroon
Otmar Kloiber	Secretary General, World Medical Association, Ferney, France, replaced by Julia Seyer, Medical Adviser, WMA
Sigrun Mogedal	Previous Chair of the Board for GHWA

GHWA, WHO Geneva

2. Donors and funders of the Alliance

Name	Affiliation and position
Alison Beattie	Team Leader, Health Services Team, DFID
Sue Chandler	Health Services Team, DFID
Neil Squires	Head of Profession, Health, DFID
Rozenn Le Mentec	GIZ, Germany
Jason Lane,	Senior Health Policy Adviser, EU
Diarmuid McClean	Irish Aid
Kathy Cahill	Previously worked at the Bill and Melinda Gates Foundation
Ine Måreng	Ministry of Foreign Affairs, Norway

WHO, Geneva

3. WHO staff

Name	Affiliation and position
Manuel Dayrit	Director, Department for Human Resources for Health
Mario Dal Poz	Programme Coordinator for HRH
Carmen Dolea	Technical officer for HRH
Ian Smith	Adviser to the DG WHO Geneva
Ashley Bloomfield	Partnerships Adviser to ADG NCDs and Mental Health
Tessa Edejer (Tan Torres)	Health economist, Health Systems Strengthening
Annemiek von Bolhuis	Special Adviser to ADG NCDs and Mental Health

GHWA, WHO Geneva

4. Partners for advocacy and brokering knowledge

Name	Affiliation and position
Lord Nigel Crisp	Former Chair of Task Force for Scaling Up of Education and Training for health Workers, GHWA
Maurice Middleberg	Vice President for Global health, Capacity Plus, Washington, USA
Neil Pakenham-Walsh	Coordinator, Global Healthcare Information Network, Oxford, UK
Frances Omaswa	Previous Executive Director, GHWA Executive Director African Centre for Global Health and Social Transformation ACHEST, Uganda
Fiona Campbell	Head of Policy, Merlin, UK
Dr Marty Makinen	Managing Director, Results for Development, USA
Julian Schweitzer	Principle, Results for Development, USA
Peggy Clarke	Director, Migration Task Force, Realizing Rights

GHWA, WHO Geneva

5. GHWA Secretariat staff

Name	Affiliation and position
Dr Mumbashar Sheikh	Executive Director, GHWA Secretariat
Alison Osborne	Secretariat Facilitator for Evaluation
Dr Hirotsugu Aiga	Programme Coordinator
Giorgio Cometto	Strategy Adviser to the Executive Director
Lawrence Codjia	Technical Officer for CCF
Sonali Reddy	Technical Officer for Communications
Romana Rauf	Programme manager
Petros Gikonyo	Programme and Administrative Officer
George Pariyo	Medical Officer for Brokering Knowledge
Muhamad Afzal	Technical officer for CCF
Erica Wheeler	HRH Specialist, on secondment to Department for HRH, working as Technical Officer, Health Workforce Education and Production

Taina Nakari	Programme Officer for Partnerships and Memberships
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GHWA, WHO Geneva

6. Cameroon country case study: List of key informants

Name	Affiliation and position
Achille Christian Bela	Technical Assistant, Directorate of Human Resources, Ministry of Public Health
Prof Samuel Kingue	Director of Human Resources, Ministry of Public Health
Dr Francoise Nissak	WHO country office, National Health Systems Advisor
Simon Nyansi	Director of Public Nursing School
Prof Samuel Nko'o Aneveme	Vice Dean, Faculty of Medicine, University of Yaoundé II
Mr Feugang	Secretary General, Board of Nurses
John Essobe	Coordinator of Office of Research for Development, Commission of Protestant Churches of Cameroon
Balla Balla	President of Trade Union for Health Worker Personnel
Dr Joseph Enyegue	Country Director, Sight Savers International
Sylvain Mebara	Head of Division of Forecasting and Strategic Planning, Ministry of Planning and the Economy
Dr René Owona Essomba	Head of Technical Secretariat of the Steering Committee for the Health Sector Strategy, Ministry of Public Health
Pierre Tchamande	Head of Forecasting in the Human Resource Department, Ministry of Finance
Ms Atchoumi	President of the Cameroonian Association of Midwives
Regime Messy	Director of the Catholic School of Nurse Sciences
Germaine Kookily	Technical Advisor No. 2 of the Ministry of Civil Service and Administrative Reform

GHWA, WHO Geneva

7. Indonesia country case study: List of key informants

Name	Affiliation and position
Dr Bam Bang Giant	Director for National Board for the Development and Empowerment of Human Resources for Health, Ministry of Health
Dr Oscar Premade	Centre for Standardisation, Certification and Sustainable Teaching, Ministry of Health
Sri Henna Satiawati	Coordinator, CCF Committee
Anna Kurniati	Head, Sub-division for Migrant Health Workers, Ministry of Health
Dr Abdurrahman	Consultant to Board for Development and Empowerment of Human Resources for Health, Ministry of Health
Dr Adang Bachtiar	Head, Secretariat for CCF for HRH, and President Indonesian Public Health Association
Professor Ghufon Mukti	Dean, Faculty of Medical Sciences, Gadjara Mada University, Yogyakarta, Indonesia

GHWA, WHO Geneva

8. Zambia country case study: List of key informants

Name	Affiliation and position
Dr Peter Mwaba	Permanent Secretary, Ministry of Health
Dr David Lusale	Registrar, Chainama College of Health Sciences
Brown Ngenda	Head, Environmental Sciences, Chainama College of Health Sciences
Dr John Mudenda	Director of Medical Education, Lusaka Apex Medical University
Dr Miriam Libetwa	Deputy Director, Clinical Services (Nursing), Ministry of Health
Ndubu Milapo	Chief Nursing Education Officer, Ministry of Health
Dr Christopher Simoonga	Director, Policy and Planning, Ministry of Health
Dr Prudencia Mwemba	Head, Department of Nursing Sciences, University of Zambia
Dr Fastone Goma	Dean, School of Medicine, University of Zambia
Jere Mwila	Director, Human Resources, Ministry of Health
Bertha Chipepo	Registrar, General Nursing Council of Zambia
Stanford Zulu	Director, HR, CHAZ
Bwembya B Bwalya	Ag Registrar, Health Professions Council of Zambia
Anthony Okoth	Country Director, CHAI
Elizabeth Mwemba	Head of Global AAT, Ag Deputy Country Director, CHAI
Katy Bradford	Programme Manager, HRH, CHAI
Chikusela Sikazwe	Senior HRH Programme Officer in charge of Male Circumcision, CHAI
Nakululombe Kwendeni	HRH Programme Officer (Proposed Bonding Scheme), CHAI
Kris McKee	Senior HRH Programme Officer (CHAs Programme), CHAI
Thom Yungana	President, Zambia Union of Nurses Organisation (ZUNO)
Jennifer Munsaka	Director, Programmes, ZUNO
Liseli Sitati	General Secretary, ZUNO
Dr Paul Kalinda	HRH Focal Person, EU Delegation to Zambia

Annex C Guidelines for thematic evaluation studies

C.1 Institutional analysis of Alliance Headquarters at WHO Geneva

Final Version Date 18 July 2011 Oxford Policy Management

Study 4.1: Global Health Workforce Alliance Evaluation: Institutional Analysis of Alliance Headquarters at WHO Geneva

Objectives: To answer the following questions –

- 6.1 At the global level since 2006, how effective has the Alliance been in pursuing its mandate as an advocate, knowledge broker and convenor for human resources for health in crisis countries?
- 6.2 In support of the Alliance Board and its mandate, how successfully has the Secretariat been managed and organised at the global level?
- 6.3 What are the advantages and disadvantages for the Alliance in being located at the World Health Organisation headquarters in Geneva?

Study Scope:

Since the GHWA was established in 2006, it has been mainly active at the global level and based in its headquarters at the WHO Geneva, but over the next period of 2011–2016 the Alliance's emphasis will be moving towards becoming more active at the regional and national levels.

In terms of inputs into the Alliance, important topics for evaluation include governance, financing, professional resources, administrative procedures, and use of evidence in developing HRH policies and strategies. For an assessment of: (1) processes, including international experience and guidelines which feed into guidance for national HRH planning, training and management, and (2) outputs that focus on HRH regulation and plans, training programmes and institutes, and the management of the health workforce. In addition to the above, the Alliance at the global level has been active in organising other outputs, including two Global Forums, numerous opportunities to promote policy dialogues, task forces and working groups, partnerships with other HRH initiatives, and including the Members and Partners. Since for this evaluation resources and time are both limited, it will not be possible to examine all these facets in real depth.

Study Methods and Analysis:

The evaluation will start by examining the GHWA as it is located and embedded within the WHO headquarters. In addition to using the general evaluation framework, the assessment of the Alliance as an individual organisation will use an adapted ROACH (Results Oriented Approach to Capacity Change) model in order to identify verifiable inputs, processes and outputs and attempt to say which inputs appeared to have been most important in producing the identified outputs.

The analysis will focus on the GHWA as an individual organisation and then examine its related organisations and partners and the linkages between them. The stages used in this ROACH approach can be summarised as follows, starting by identifying organisational inputs, processes and outputs.

This will involve the following five main steps:

1. Identification of changes in inputs, processes and outputs

The evaluation will attempt to identify trends for changes in inputs, processes and outputs and the nature of associated changes in HRH policies and strategies and, if possible, in terms of their effect on the quantity, quality and coverage of national health workforce programmes.

2. Explaining the observed changes

The evaluation will attempt to uncover the factors and linkages between the Alliance and other institutions which might explain the observed changes. For instance, what apparent contribution has the Alliance made to these changes? Could any changes in global policies for HRH have also been due to greater funding, more coherent policies, improved management processes, changes in programme design, or even changes in global priorities?

3. Assessment of selected HRH providers

The evaluation will attempt to identify and assess the contribution of the Alliance at global level in promoting the actual strengthening of human resources, particularly with regard to crisis countries. The selected country case studies will also explore the GHWA's overall influence and support to HRH in national health systems.

4. Assessment of Alliance support

Based on possible changes in global and national HRH policies, the Alliance's contribution to any achievements will be assessed, although it is unlikely that changes can be attributed exclusively to the Alliance. The evaluation will also focus, therefore, on how the Alliance relates to and supports other HRH organisations. The OPM team will attempt to map these relations and the nature of the interactions.

5. Assessment of value-for-money and prospects for sustainability

The sustainability of the Alliance and its achievements for HRH will be examined at the global level. This will also examine the financial implications for the Alliance at global and regional levels. In terms of the Alliance's future the evaluation will analyse the evidence for its probable future requirements for the sustainability of its activities at global and regional levels. This will be undertaken through Thematic Study Number 6 on value-for-money and sustainability.

Identification of the causal chain for improvements from inputs through processes to outputs, as well as any constraints to change, will be difficult and complicated, particularly since Alliance policies, strategies and programmes also rely on partners and require variable amounts of time for implementation before they can lead to the desired HRH output changes within countries. While this evaluation will identify contributions made by the Alliance, it is less likely that it will be able to attribute specific achievements and/or changes to the work of the Alliance with any degree of certainty.

Using the Guidelines:

The following guidelines are used to complete the findings and will contain the evidence gathered for this thematic study. It will also be useful for the written report and the final summarised evidence included in the main body of the final report. Each component identifies an important area for study and each one includes about five or more questions that need some answers. These components and questions are not mandatory and should be seen only as a guide for the study investigator to use.

For each question there are spaces to include any information on indicators, sources of information, names and titles of informants, and comments.

The Five Components Are:

1) Governance and the Role of the Alliance Board; 2) Organisation of the Alliance Secretariat; 3) Secretariat's Role in Managing Global Advocacy and Information on HRH; 4) Planning, Training and Management of Human Resources for Health; And 5) Alliance Relationships with the World Health Organisation.

Component 1: Governance and the Role of the Alliance Board

Evaluation questions	Sources of data and information	Informants	Comments
How effective is the Board since it meets only twice per year, although the Standing Committee meets as well?			
What is the composition of the Board members and how are they renewed?			
Is there equal influence exerted by all the different Board members?			
Which constituencies or interest groups are under-represented on the Board as presently constituted?			
How well is the Board supported by the Alliance's own Secretariat?			
Should Board membership be expanded or reduced, and why?			
What are the costs associated with running the Board?			

Are the costs of running the board justified by its influence and inputs on the effectiveness of the Alliance?

Component 2: Organisation of the Alliance Secretariat

Evaluation questions	Sources of data and information	Informants	Comments
How is the work of the GHWA Secretariat structured and organised?			
What professional and administrative staff work in the GHWA Secretariat?			
What means does the Secretariat use to coordinate its different activities?			
Who is responsible for presenting and allocating the Board's work priorities?			
What are the costs of having the Secretariat at WHO HQ?			

Component 3: Secretariat's Role in Managing Global Advocacy and Information on HRH

Evaluation questions	Sources of data and information	Informants	Comments
What information is held by GHWA on HRH in Member States?			
What HRH evidence-based Alliance guidelines are promoted for use in countries?			
Does the GHWA have a database on numbers of training schools by type or promote the uses of other global databases, such as the Avicenna directories jointly managed			

by WHO and University of Copenhagen (<http://avicenna.ku.dk/>) or the comprehensive and general one managed by Capacity Plus (http://hrhresourcecenter.org/latest_resources)?

What kinds of research into HRH does the Alliance sponsor and/or support?

Has the Alliance been involved in developing and promoting the setting up of national Observatories and information systems for HRH?

What role did the Alliance play in developing the International Code on Migration of Health Personnel adopted at the WHA in 2010?

What role has the Alliance played in bringing HRH to the fore in global health and development policy debates and processes?

What contribution has the Alliance made in mainstreaming HRH in the policy discourse relevant to other health development priorities?

Have the two global forums been useful in catalysing attention and action on HRH?

Component 4: Planning, Training and Management of Human Resources for Health

Evaluation questions	Sources of data and information	Informants	Comments
What methods are promoted by the GHWA Secretariat for national HRH planning?			
What Alliance training materials are available for use in			

countries?

What global policies/strategies are suggested by the Alliance for use by the private sector?

What is the Alliance position on incentives for staff located in remote areas?

What is the Alliance position on countries retaining staff and on international migration?

Component 5: Alliance Relationships with the World Health Organisation

Evaluation questions	Sources of data and information	Informants	Comments
What are the main advantages in the Alliance being based at WHO HQ?			
What are the main disadvantages in the Alliance being based at WHO?			
How well do the WHO management procedures work for the Alliance?			
Which WHO HQ global programmes does GHWA work closely with on HRH?			
What are the donors' views on GHWA being located at WHO HQ?			
What support does the Alliance have from WHO regional and country offices?			
What advantages would be gained by moving the Alliance away from WHO HQ in Geneva?			

Are there Alliance partners and benefactors that are constrained by GHWA being located at WHO?

C.2 Analysis of the TF/WGs' work

Final Version Date 25 August 2011 Oxford Policy Management

Thematic Study 4.2: Global Health Workforce Alliance: Analysis of the Work of the Task Forces and Working Groups

Objective: To answer the following questions –

- 6.1 How significant have the GHWA task forces and working groups been in supporting improvements for human resources for health (HRH)?
- 6.2 Which task forces and working groups have successfully produced guidelines and tools and other knowledge products for use in addressing HRH challenges?
- 6.3 Have the task forces and working groups been value-for-money?

Study Scope:

The GHWA was established in 2006 and has been mainly active at the global and headquarters levels. Early on, the Alliance convened task forces and working groups to tackle important and specific issues that were perceived to be both global and country-level priorities. Their purpose was to produce evidence that would impact on and accelerate action to address health workforce challenges. The outputs/products were expected to support the development of both global and country strategies for improving national HRH plans and actions, as well as address other challenges.

The task forces and working groups had specific terms of reference and time-limited and budgeted work plans approved by the GHWA Board. The task forces and working groups include experts in the issues being tackled. In addition, the Alliance also supported and worked in partnership with civil society groups on specific initiatives. The GHWA also supported the formation of the Health Workforce Advocacy Initiative (HWAI) in a five-year campaign to positively improve practice environments together with six health professional associations.

The Alliance commissioned the following six task forces: Scaling up Education and Training, Tools and Guidelines, Financing, Migration, Private Sector, and Universal Access to HIV treatment. Although an HRH information reference group was also initiated by the Alliance, the assessment will only be concerned with these six groups. However, the OPM evaluation team understands that GHWA has decided not to commission any further task forces or working groups.

The external evaluation will limit its assessment to reviewing the work, products and costs of each of the six task forces. While the products are relevant at the global and multi-country level, the team will also attempt to assess their appropriateness while undertaking the three country case studies in Cameroon, Indonesia and Zambia.

Study Methods:

The OPM evaluation team will summarise and assess the work and output of each task force and working group, as well as its outputs/products to date. Apart from the global value of these products, while undertaking the three country case studies in Cameroon, Indonesia and Zambia the OPM team will also try to assess the usefulness of the products in supporting improvements in a country's HRH situation. Wherever possible, the Chair and the selected contact person for each task team and working group will be interviewed as key informants for their views on their progress and products. In addition, records of meetings and discussions will be reviewed wherever possible. If the financial records permit, the funds allocated to and expended by each task team will be analysed.

Case Study Analysis:

The analysis will attempt to capture the extent of the role of the Alliance and its task forces and working groups in supporting both global and national HRH policies and programmes, as well as their implementation and limitations. The analysis will also utilise the following questions, based on the six components (and their questions) used in the three country case studies, to help in assessing the value of the GHWA task forces/working groups. For more details, see the guidelines for Thematic Study Number 5. Have the products of the forces/groups:

1. Contributed to building coherent leadership for health workforce solutions?
2. Increased national capacity for an informed response based on evidence and joint learning?
3. Been useful in scaling up health worker education and training?
4. Been helpful in enabling countries to retain an effective, responsive and equitably distributed health workforce?
5. Helped manage the pressures of the international health workforce market and its impact?
6. Helped to secure additional and more productive investments in the health workforce at global and country levels?
7. What funds did GHWA spend on each task force/working groups and was this good value-for-money?

Each taskforce and working group had distinct objectives, with some having tangible products while others contributed to an output that was the main responsibility of another partner (e.g. Code of Practice). Hence the relevance of the evaluation questions will vary between the task forces/working groups. Since the work of the forces/groups was mainly outsourced to external groups, for feedback OPM will establish links to the main contact person for each of the taskforces and working groups as given on the GHWA website. Wherever possible we will review any other assessments that have been made of the products and tools produced by the task forces/working groups. The OPM team members will take responsibility for the following task forces: 1: Financing, and Migration - Sarah Fox; 2: Private Sector and Universal Access to HIV treatment - Yoswa Dambyswa; 3: Scaling up Education and Training, and Tools and Guidelines - Patrick Vaughan.

C.3 Country case study on developments in support of HRH

Final Version Date 18 July 2011 Oxford Policy Management

Thematic Study 4.3: Global Health Workforce Alliance Evaluation: Country Case Study on Developments in Support of Human Resources for Health

Objective: To answer the following questions –

- 6.1 How significant has the GHWA been in supporting developments to improve human resources for health (HRH) at country level?
- 6.2 Which specific initiatives promoted by the GHWA since 2006 are seen as being most helpful and which least helpful at country level?
- 6.3 What future initiatives by the GHWA for HRH would national governments, national institutions and donor agencies see as being most helpful?

Study Scope:

The GHWA was only established in 2006 and has been mainly active at the global and headquarters levels. Given the limited resources and time available for the external evaluation, it is only possible to gain some understanding and more qualitative evidence from a selected sample of three countries: two in Sub-Saharan Africa (Cameroon and Zambia) and one in South East Asia (Indonesia). The country case studies should aim to add to understanding the country responses to the HRH crisis and the role of the Alliance in supporting HRH in countries in crisis. This understanding should help determine the future global and regional priorities for the Alliance in support of crisis countries during 2011–2016 and beyond.

The country case studies will utilise the format of the progress indicators contained in the questionnaire previously drawn up by the Alliance Technical Working Group and used for the Monitoring and Evaluation of the Implementation of the Kampala Declaration and Agenda for Global Action (Global Health Workforce Alliance, 2010). The questions will serve as the background against which to exploration of the contribution of the Alliance in supporting these countries.

The evidence base needs to adequately cover the following three mains domains for HRH: planning and financing; basic and higher level training; and management and deployment of national HRH.

Study Methods:

The focus should primarily be on the Alliance's contribution to improving the national HRH situation, although this will also need to be explored by using available documentation and data, as well as considered through a series of semi-structured questions and key informant interviews, mainly at the national level. Whenever possible, separate information should be collected for physicians, nurses, midwives and other allied health workers, including community health workers.

In order to undertake these country case studies a senior OPM evaluation team member will visit each country and, working together with a national consultant over five days, will meet with the most active officials concerned with HRH, **to triangulate evidence for the main findings on the contribution of the Alliance**, as well as identify useful comments and areas of major disagreement. For those areas where the Alliance is believed to have been involved, this will include:

- 1) Collecting published reports and papers and statistical data on the national HRH situation, including data for the numbers of training centres, trainees graduating per year from both government and non-government training centres, numbers of full-time health workers employed in government posts, number of vacancies and, if available, numbers of health workers migrating out and returning to work in the country.
- 2) Collecting national data on financial resources for HRH, including for budgets of national ministries of Health and Education, availability of scholarships and grants, salary scales for different grades of professionals, and incentives for employment in more remote areas.
- 3) Conducting key informant interviews with senior national informants involved in tackling the country's HRH crisis, such as those working in government ministries (health, education, labour and finance), training centres (government, universities, non-government institutes), national planning agencies, regulatory agencies (e.g. professional regulatory councils), development research centres, professional organisations (e.g. for doctors, nurses, midwives and allied health workers), and private health care organisations.
- 4) Meetings with senior officers in: 1) UN multilateral agencies in health (e.g. WHO, UNICEF, UNFPA, Global Fund), 2) development banks (e.g. World Bank, African Development Bank, Asian Development Bank), 3) bilateral donors supporting national HRH initiatives (e.g. NORAD, DFID, USAID, GIS, JICA), and 4) international development NGOs (e.g. Oxfam, Save the Children, CARE).
- 5) Identifying the role of significant regional organisations, including the WHO Regional Offices and other regional GHWA partner organisations, in supporting countries with their HRH plans and developments in the case study countries.

Case Study Analysis:

The priority for the analysis, which will be undertaken mainly through a process of interviews with key stakeholders at national level and through field visits, will be to capture the extent of the role of the Alliance and its policies in support of national HRH policies and programmes, as well as their implementation and limitations.

Where possible, the evidence gained will be compared with the situation in other similar countries in the region and benchmarked against recommendations for best practice. In addition, major constraints to achieving improvements need to be identified. The analysis will also draw conclusions about whether the national HRH systems and plans are fit for purpose and whether the Alliance has had a positive supporting role. The

analysis should also indicate the likely future directions for HRH in the country during the period 2011–2016. It should also identify any potential threats towards sustaining national HRH implementation.

Once the combined analysis of all three case studies has been undertaken, it may be possible to draw tentative conclusions about whether the Alliance's HRH support systems are indeed fit for purpose and are able to support countries. Where areas for improvement are identified, their importance will be noted and the likely benefits from strengthening implementation, together with any constraints, will be highlighted.

Below is a check list to elicit the Awareness and Use of Alliance Initiatives within the country.

The six components that follow are:

1) Building coherent country leadership for health workforce solutions; 2) Capacity for an informed response based on evidence and joint learning; 3) Scaling up health worker education and training; 4) Retaining an effective, responsive and equitably distributed health workforce; 5) Managing the pressures of the international health workforce market and its impact; and 6) securing additional and more productive investments in the health workforce.

Components 1 to 6 are all relevant questions for the general understanding of the HRH situation in the country. However, it is more important to focus directly on determining the specific inputs made by GHWA and its role in providing country support. The following section sets out some probing questions to understand the value and relevance of GHWA's contribution.

Checklist for Awareness and Use of Alliance Initiatives	Sources of data and information	Informants	Comments
Is the work of the Global Health Workforce Alliance known about in the country?			
Did senior HRH country officials attend the Alliance Global Forums in Kampala and/or Bangkok?			
Have they attended other global, regional or country-level events convened by the Alliance?			
Did they find these events useful or not? And why?			
Do senior HRH country officials know about the new WHO Code of Practice on International Recruitment			

of Health Personnel?

Has the Alliance Resource Requirement Tool been used for HRH budgeting and financing?

Have they heard about other Alliance-supported knowledge products, e.g. reports, briefs, communication materials?

If yes, did they find them useful and how have they been applied to their work?

Has the country established a process for 'Country Coordination and Facilitation for HRH?'

If yes, has it been helpful or not in the following areas?

- Advocacy with leaders in other sectors than health
- Coordination and policy dialogue
- Situational analysis
- Planning and strategy formation
- Resource mobilisation
- Implementation of HRH plans

Explain how the Alliance support has been or not been helpful.

If the country has made good progress on HRH, should Alliance support be phased out?

Is the Alliance support for CCF and other activities relevant to the HRH needs of the country? Why? How can the support be improved?

How do you assess the support by the Alliance in terms of timeliness, professionalism and technical

value.

Have senior country officials used the website of the Alliance for information and/or in seeking help?

How do you judge the overall support provided by the Alliance to the country?

Do you have any suggestions for how this support could be strengthened in the future?

Component 1: Building Coherent Country Leadership for Health Workforce Solutions

Evaluation questions

Is there a national, agreed HRH policy, strategy and/or plan?

Has a HRH situational analysis and/or report been used to develop this?

Has the above been fully costed and are finances allocated in the budgets?

Since when and how well is the policy, strategy and/or plan being implemented?

Is there a national intersectoral coordinating committee for HRH planning and, if so, who is represented on this?

Sources of data and information

Informants

Comments

Component 2: Capacity for an Informed Response Based on Evidence and Joint Learning

Evaluation questions

What mechanisms coordinate different stakeholders for policy dialogue?

What HRH statistics exist on numbers of public and

Sources of data and information

Informants

Comments

private health workers?

Which agency collects and updates this data and how frequently?

Who is responsible for analysing the data and presenting the HRH analysis?

Component 3: Scaling Up Health Worker Education and Training

Evaluation questions	Sources of data and information	Informants	Comments
Is national enrolment for training stable, increasing or decreasing and for which categories?			
What is the situation for scholarships and support for basic, post-basic and further professional training?			
Have new training schools and centres been set up and for which categories of health workers?			
Have standard national curriculums been developed and/or recently modernised?			

Component 4: Retaining an Effective, Responsive and Equitably Distributed Health Workforce

Evaluation questions	Sources of data and information	Informants	Comments
What strategies exist to attract and retain workers in underserved urban and rural areas?			
How many vacancies exist in the public sector, for which staff, and why?			
What is the employment situation in the private			

sector and are there any recent changes happening?

Are the number of public and/or private hospitals and clinics stable, increasing or decreasing?

Component 5: Managing the Pressures of the International Health Workforce Market and its Impact

Evaluation questions	Sources of data and information	Informants	Comments
What is national policy on retaining national health workers in the country?			
What is national policy on incentives to encourage health workers to return to their own country?			
Have there been recent improvements in support for workers in career development?			

Component 6: Securing Additional and More Productive Investments in the Health Workforce

Evaluation questions	Sources of data and information	Informants	Comments
Has there been a recent increase in public sector recruitment?			
Have there been any improvements in workplace environments?			
Which donor agencies and/or development banks are supporting implementation of HRH in country?			

C.4 Analysis of the role and effectiveness of the Alliance Board

Final Version Date 25 August 2011 Oxford Policy Management

Study 4.4: Global Health Workforce Alliance Evaluation: Analysis of the Role and Effectiveness of the Alliance Board

Objectives: To answer the following questions –

- 3.1 How effective has the Board been in its role of determining the strategic directions for the Alliance and in providing the required stewardship to pursue its mandate as an advocate, knowledge broker and convenor for human resources for health in crisis countries?
- 3.2 How well has the Board held the Secretariat to account and guided its work at the global level?
- 3.3 What changes, if any, are required to make the Board better able to perform its role during 2011–2016?

Study Scope:

Since the GHWA was established in 2006, the Alliance Board has been setting the strategic direction and overseeing the work of the Alliance Secretariat based in Geneva.

The Alliance Board derives its mandate from the Memorandum of Understanding (MOU) between the Alliance and the World Health Organisation (See the MOU, Annex A: Structure, Operating Guidelines and Functions of the Board, 2006). The Chair is elected from the Board membership and there have been three different Chairs during the past five years. There was originally provision for three standing Board committees but now there are only two: Standing and Nominating.

The Board is required to meet twice per year and attendance is limited to members or a nominated alternate, as well as observers. The prime function of the Board is to guide the overall strategy and vision of the Alliance. In summary, the Board also provides oversight by reviewing the operational work plans, annual budgets, work of Board standing committees, and monitoring financial resources. In addition, it has to approve financial statements and progress reports.

The MOU states that the Board will consist of not more than 20 members, who should come from key Member organisations and represent all six WHO Regions. Members may serve for three years and be renewed for one further period. WHO Headquarters is permanently represented. The Membership is specified in more detail in the Alliance Governance Handbook (2010) as follows: x1 Government national from each of the six WHO Regions; x2 members from each of the following five organisations – intergovernmental agencies, Global Health Initiative, donors, non-governmental organisations, and professional associations. There are also x2 to represent the private sector and research organisations and, in addition, the WHO has permanent representation as the hosting agency and the Executive Director as an ex-officio non-voting member. However, the last Board meeting on 30 June 2011 agreed to extend membership to two new categories: health workers and private sector. In addition, any donor providing more than US\$ 300,000 per year will automatically have "associate member" status and have voting rights for the duration of their funding.

Study Methods and Analysis:

Thematic Study 4 will examine the views of Alliance Board Members on the role of GHWA and its Secretariat as it is located and embedded within the WHO Headquarters in Geneva. The views of past and present Members will be gathered through direct interviews, or through telephone interviews, which will be based on the following general questions:

- How well do you think the Board's present governance arrangements are working?
- As a Board Member how do you judge the performance of GHWA in comparison to your expectations when you joined the Alliance?
- What are the main reasons for your decision to continue or discontinue supporting GHWA?
- What changes, if any, would you like to see in GHWA's future strategy at the global level?
- How do you view GHWA's shift in strategy to greater country-level engagement using the 'Country Coordination and Facilitation' process?
- How do you see the relationships between GHWA and WHO, and in particular the Human Resources for Health (HRH) department?

The more specific set of governance questions are presented below. These are already included in Thematic Study 1 on GHWA at WHO Headquarters.

Using the Guidelines:

If the following guidelines are used and completed with the findings, the evidence will be gathered for this thematic study. It will also be useful for the written report and the final summarised evidence included in the main body of the final report.

Governance and the Role of the Alliance Board

Evaluation Questions	Sources of data and information	Informants and Comments
How effective is the Board since it meets only twice per year, although the Standing Committee meets as well?		
How active are the two Board standing committees, viz: Standing and Nominating and how is their work monitored?		
Do the present Board members agree on the designated composition stated in the Governance Handbook?		
What is the composition of the Board members and how are the Chair and members renewed?		

Is there equal influence exerted by all the different Board members?

Which constituencies or interest groups are under-represented on the Board as presently constituted?

How well is the Board supported by the Alliance's own Secretariat?

How well is the Board providing support to the Secretariat in terms of guidance, stewardship, resource mobilisation etc?

How does the Board approve any changes to the GHWA work plans that are made between Board meetings?

Should Board membership be expanded or reduced, and why?

What are the costs associated with running the Board?

Are the costs of running the board justified by its influence and inputs on the effectiveness of the Alliance?

As a Board member, are you satisfied with the quality and level of detail in the financial and activity reports produced by the Secretariat?

Is the Board asked to make decisions on appropriate issues?

Should the Board be involved more or less often in operational decisions or is the current balance about right?

Do Board members 'own' the policies and strategies of GHWA ?

Do Board members feel their views are adequately reflected in its decisions and strategies?

C.5 Analysis of the views of partners for advocacy and brokering knowledge

Final Version Date 2 September 2011 Oxford Policy Management

Study 4.5: Global Health Workforce Alliance Evaluation: Analysis of the Views of Partners for Advocacy and Brokering Knowledge

Objectives: To answer the following questions –

- 4.1 What are views of GHWA Partners on its contribution to helping solve the global human resources for health crisis?
- 4.2 How well has GHWA worked together with its partners?
- 4.3 What changes, if any, would Partners like to see for GHWA during 2011 – 2016?

Study Scope:

Since the GHWA was established in 2006, Partners in Advocacy and in Brokering Knowledge have made a significant contribution to the work of the Alliance, particularly at the global level. While the Alliance has over 330 members, the Partners have been jointly involved in many of GHWA's most important international activities. Unfortunately, the Alliance has no standard definition of what a Partner is and donors are also often considered to be Partners.

Study Methods and Analysis:

Thematic Study 4 will examine the views of Alliance Partners and their views on their partnership with GHWA and their joint activities. Through meetings or telephone interviews the Partners identified in the Alliance Contact List will be contacted first by e-mail for a request to meet or be interviewed by telephone. If there is no response, at least one further e-mail will be sent as a follow-up. The e-mail will contain the following set of questions for use in the subsequent conversation or telephone call:

GHWA External Evaluation – Outline of interview questionnaire

Here are our questions and we hope this finds you well. As you may be aware, Oxford Policy Management (OPM) has been contracted to conduct an external evaluation of the Global Health Workforce Alliance (GHWA), which is based at the World Health Organisation in Geneva (WHO). For this assignment, we hope to contact its main Partners to obtain their views on the Alliance during its first five years (2006-2011). We are also seeking views on its future priorities for the next five years (2011-2016). **Through our telephone call we want to discuss with you the following:**

- What were the reasons that led your organisation to become a Partner with GHWA?
- How does your organisation, as an Alliance Partner, view the performance of GHWA in comparison to your original expectations?
- What future priorities would you like to see adopted by GHWA?

In addition, do you have any views regarding the following?

- The GHWA Board and the existing governance arrangements
- Management of the GHWA Secretariat based at the WHO Headquarters Geneva
- Relationships between GHWA and WHO and, in particular, the latter Organisation's Department for HRH
- Quality of GHWA's advocacy, knowledge brokering and convening activities to date
- GHWA's recent shift towards more county-level engagement through its Country Coordination and Facilitation (CCF) process
- Quality of reporting by GHWA to its Partners
- Degree to which GHWA represents value for money

And any other issues you would like to raise in relation to the Alliance.

C.6 Thematic Study on VfM and future sustainability

Final Version Date: 18 July 2001. Oxford Policy Management

Study 4.6: Global Health Workforce Alliance Evaluation: Thematic Study on Value-for-Money and Future Sustainability

Objectives: To answer the following questions –

- 8.1 Did the GHWA provide Value-for-Money (VfM) at the global and headquarters levels during its first five years 2006–2011?
- 8.2 How sustainable is the GHWA at the global and headquarters levels for the next five years 2011–2016?

Study Scope:

Since the GHWA was only established in 2006, this study will be limited to assessing the Alliance only at the global and headquarters levels. Given the limited resources and time available for the external evaluation, it is not possible to gain sufficient evidence from a representative sample of either regions or countries to answer these questions at these levels. The country case studies, however, will include some investigation of these items.

Study Methods:

In order to undertake this assessment we will examine (1) the Alliance's fundraising activities, (2) its budget allocations, (3) the procurement and financial management systems it uses, which are those provided by the World Health Organisation, and (4) whether the results produced are commensurate with the level of financial inputs.

The Alliance annual budgets and expenditures, together with likely future donor commitments, will be analysed. These areas will be explored by using available financial data, as well as considered through a series of semi-structured questions and key informant interviews at HQ level. The analysis will be designed to ensure that the systems used by the Alliance are appropriate and adequate for the tasks. The questions include those shown below.

The analysis will draw conclusions about whether the systems and processes are fit for purpose and whether the Alliance has so far achieved value for money. Where possible, the evidence gained will be benchmarked against best practice and, if areas for improvement are identified, these will be presented, with an indication of their importance and the likely benefits from implementation, together with any constraints that may hinder their adoption.

The analysis will also estimate the likely future financial contributions to the Alliance and any potential financial threats to it remaining sustainable

during the period 2011–2016.

Study Analysis:

The analysis will be undertaken through a process of interviews with key stakeholders at HQ level and also in the field visits as a part of the country case studies. Once this analysis has been undertaken it will be possible to draw conclusions about whether the systems and processes are fit for purpose and likely to achieve value for money. Where possible, the evidence gained will be benchmarked against best practice, and if areas for improvement are identified these will be presented, with an indication of their importance and the likely benefits from implementation together with any constraints that may hinder their adoption.

Main Components are:

- 1) Fundraising Activities, 2) Budget Allocations and Expenditures, 3) Procurement Issues, and 4) Financial Management Issues

Component 1: Fundraising Activities

Evaluation questions	Sources of data and information	Informants	Comments
What have been the sources of revenue to the Alliance to date?			
What revenue has actually been received, and when?			
What commitments has the Alliance been made?			
Have funders 'preferenced' or earmarked their funds for particular activities? Would this be permitted?			
What core funding is available to cover administrative expenditure?			
How is the Alliance targeting additional sources of funds?			

What feedback has been received from potential funders and how is this being recorded?

Does the Alliance envisage innovations to its fundraising efforts?

What does the Alliance see as its main strengths and weaknesses when seeking to attract funds?

Does the Alliance see 'critical mass' as an issue in its fundraising efforts?

Component 2: Budget Allocations and Expenditures

Evaluation questions	Sources of data and information	Informants	Comments
How is the Alliance budget-setting process structured?			
Who is involved in budget-setting?			
How does the programme budget differ from core management costs?			
What is the split for staff costs, non-staff overhead costs and operational costs?			
How is the expenditure management system controlled?			
What happens if commitments do not materialise and the Alliance faces an in-year shortfall?			
Can the Alliance borrow funds and, if so, from whom and how?			
Does the Alliance have a preferred level of reserve funds?			

Are Alliance funds kept in interest-bearing accounts?

How does the Alliance manage risks due to changes in currency exchange rates?

What in-year and in-month accounting information is available to the Alliance?

What has been the trend in out-turns against the Alliance forecast?

Component 3: Procurement Issues

Evaluation questions	Sources of data and information	Informants	Comments
Does the Alliance have dedicated procurement personnel?			
How are main inputs to the Alliance's programmes identified (specified), procured, contract managed and quality assured?			
What thresholds are used to ensure services are provided in a timely and responsive manner, whilst also achieving value-for-money?			
What checks and balances are in place concerning levels of authority and degree of decentralisation?			
How is the tendering process managed and is there a tender committee?			
Does the Alliance use standardised contracts?			
What contract variations have been applied by the Alliance?			

What procedures are used for hiring short-term consultants?
How are contracts and fee rates negotiated?

What financial contribution does the Alliance expect from its partners?

How does the Alliance determine staff salaries, gradings and allowances?

What improvements and/or changes would administrative staff like to see over the coming five years?

Component 4: Financial Management Issues

Evaluation questions	Sources of data and information	Informants	Comments
Are the Alliance accounts up to date, and are they publicly available?			
Are accounts prepared on a cash accounting or commitment basis?			
Are there any contingent or other liabilities that should be identified?			
Does the Alliance have any arrears in payments?			
How are the accounts of the Alliance audited and how frequently?			

Annex D List of key documents

GHWA strategic documents

- GHWA (2006) Strategic Plan 2006. WHO, Geneva, Switzerland
- Kampala Declaration and Agenda for Global Action. Health workers for all and all for health workers. 2008
- Moving Forward from Kampala: Strategic priorities and directions of the Global Health Workforce Alliance: 2009–2011
- Reviewing progress, renewing commitment: Progress report on the Kampala Declaration and Agenda for Global Action
- Global Health Workforce Alliance – Value Statement
- Knowledge strategy of the Global Health Workforce Alliance: 2009–2011
- Advocacy and Communications Strategy of the Global Health Workforce Alliance: 2009–2011
- Global Experience of Community Health Workers for Delivery of Health-Related Millennium Development Goals: A Systematic Review, Country Case Studies, and Recommendations for Integration into National Health Systems

Documents relating to the governance and internal management of GHWA

- Memorandum of Understanding between WHO and GHWA. October 2006
- Governance Handbook. Report of the Alliance Secretariat to the 9th Board Meeting Bangkok, Thailand, 1–2 February 2010 Doc # 11
- Value Statement. Approved by the board at its 10th board meeting in June 2010

Annual reports

- Global Health Workforce Alliance Annual Report 2009: Catalyst for Change
- Global Health Workforce Alliance Annual Report 2010: Adding Value to Health

Products and tools of the Alliance taskforces

Financing Human Resources for Health Task Force

- RRT. Documents include: Description; Frequently asked questions; data collection guide; and user guide.
- Framework Paper: Financing and economic aspects of health workforce scale-up and improvements
- Action Paper: What countries can do now: twenty-nine actions to scale up and improve the health workforce

Taskforce on Tools and Guidelines

- HRH Action framework

Taskforce on Scaling up Education and Training

- Scaling up, Saving Lives – Education and Training. Full report and executive summary

HWMI

- WHO Code of practice on international recruitment of health personnel. WHA63.16 63rd World Health Assembly, 21 May 2010

Taskforce on Human Resources for Universal Access

- Will we achieve universal access to HIV/Aids services with the health workforce we have? A snapshot from five countries

CCF

- CCF – principles and processes
 - CCF – country case studies
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