



The ILO component of the ILO-OECD-WHO Working for Health (W4H) programme at country level

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Type of Evaluation: Project

Evaluation timing: Mid-term

Evaluation nature: Internal

Project countries: Cameroon, Chad, Kenya, Malawi, Pakistan, & South Africa

P&B Outcome(s): Output 1.5. Increased capacity of constituents, partners and stakeholders to implement sectoral international labour standards, codes of practice, guidelines and tools

SDG(s): 3, Good Health and Well-being, 5, Gender Equality, & 8, Decent Work and Economic Growth

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This evaluation has been conducted according to ILO's evaluation policies and procedures. It has not been professionally edited, but has undergone quality control by the ILO Evaluation Office.

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List of Acronyms

CBA	Collective Bargaining Agreement
ComHEEG	High-Level Commission on Health Employment and Economic Growth
DWCP	Decent Work Country Programme
FPRW	Fundamental Principles and Rights at Work
HRH	Human Resources for Health
HSA	Health Services Academy
ILO	International Labour Organization
IHRA	Islamabad Healthcare Regulatory Authority
KII	Key Informant Interview
M&E	Monitoring and Evaluation
MPTF	Multi-Partner Trust Fund
OECD	Organisation for Economic Co-operation and Development
OSH	Occupational Safety and Health
PESSI	Punjab Employees Social Security Institution
P&B	Programme and Budget
SDG	Sustainable Development Goals
TOR	Terms of Reference
UHC	Universal Health Care
WHO	World Health Organization

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Executive Summary

Project Background

The W4H programme is a joint initiative between ILO, the Organisation for Economic Co-operation and Development (OECD) and the World Health Organization (WHO). It is designed to respond to the recommendations of the United Nations Secretary-General's High-Level Commission on Health Employment and Economic Growth (ComHEEG) report (2016), which identified a projected shortfall in the supply of health and care workers to meet demands by 2030, and analysed a series of challenges contributing to this challenge.

The ComHEEG report led to the development of a five-year action plan for interventions by the ILO, WHO, and OECD between 2018 and 2022, funded by a multi-partner trust fund (MPTF). The programme was extended for a second phase between 2023 to 2030. As part of the extension, the ILO is, among others, implementing a series of three-year country level initiatives. These are undertaken in Chad, Cameroon, Malawi, Kenya, Pakistan, and South Africa. The ILO is also implementing regional and global components of the programme but these are outside the scope of this evaluation.

The overall objectives for the programme are:

- 1) The existing health and care workforce is optimized through data-driven policy, planning and investment in education, jobs and skills.
- (2) The diversity, availability and capacity of the health and care workforce is built, to address critical shortages and meet country needs.
- (3) Health systems resilience and performance are strengthened to deliver UHC and respond to public health preparedness through equitable, protected and efficient workforce.

Current Status of the Programme

The ILO has completed two years of the three-year programme. Concept notes developed for each country detailed the activities to be undertaken for the first two years. The programme has experienced a shortfall in funding and as such most actions have focused on completing activities detailed in the first round of concept notes, with more limited activities added for the second year. The programme is currently assessing what can be achieved with the current funding in 2026.

Purpose, scope and clients of the evaluation

The purpose of the evaluation was to provide an independent assessment of the progress of the country level projects within the overall programme towards their intended objectives. It focused on both assessment of the achievements to date and lesson learning for future projects. The results will contribute to the mid-term evaluation of the entire W4H programme that is being led by WHO.

The evaluation covered the implementation of ILO's activities at the country level. While it included all six countries, specific attention was paid to Malawi and Pakistan. Malawi and Pakistan were chosen for more in-depth analysis because they are countries where a significant amount of activities has taken place and because the working language of the programme in these countries is English. The evaluation covered the programme's activities from December 2023 to November 2025.

The main users of the evaluation will be the team leading the ILO component of the Working for Health programme in SECTOR, the ILO field offices in the six target countries, tripartite constituents

in the target countries, and programme partners who support the implementation. Secondary users will include other departments with an interest in the programme including SKILLS, OSHE and GEDI, as well as the OECD, the WHO, and the donors of the MPTF.

Methodology

The evaluation primarily relied on qualitative methods, with the inclusion of quantitative data that had been collected by the programme's monitoring processes. The evaluation was conducted entirely remotely. The main methods included a desk review of key programme documents, briefing sessions with programme staff from the ILO (headquarters and field offices), online key informant interviews with external stakeholders from Malawi and Pakistan, and online focus group discussions with HealthWISE trainers from Malawi and Pakistan (and one staff member from a health institution in Malawi who was not a Master Trainer).

Sampling was purposive based on suggestions by the ILO programme staff and the desk review. The evaluator spoke to 27 participants (12 women and 15 men), including 9 ILO officials (5 women and 4 men), 1 WHO official (1 man), 7 officers from partner institutions (3 women and 4 men), and 10 HealthWISE trainers and staff of the health institutions who were not trainers (4 women and 6 men).

Findings

Relevance and Coherence

Key Finding 1: The participatory approach to identifying challenges and designing country level interventions was critical for ensuring ownership of activities by national stakeholders and addressing key needs.

The country level projects took an inclusive approach to designing the interventions involving the tripartite constituents and other key stakeholders, forming steering committees to monitor progress, and in some cases tasking the constituents to implement activities themselves. Programme stakeholders reported the programme was relevant to key needs in the country, including raising awareness about health and safety for health and care workers and addressing key OSH deficits in the sector.

Key Finding 2: The limited funding and length of the country level interventions reduces to an extent the relevance of the programme to key stakeholders.

The programme has struggled to secure necessary funding. This has limited the scope of activities and made it difficult to offer certainly about long-term technical support and follow up activities. This has reduced the relevance of the programme. While there is interest in the topic and a belief that the ILO has a considerable comparative advantage in this area, only being able to respond in a limited manner means stakeholders are drawn to other initiatives and priorities.

Key Finding 3: The programme has managed to integrate ILO's cross-cutting issues into the country level interventions. The HealthWISE approach includes a focus on gender equality and inclusion of persons with disabilities, as well as issues related to environmental sustainability. The actions have also included a focus on aligning national approaches with ILO's normative framework and social dialogue.

There is a strong gender focus in the programme, which is working with a sector where the workforce is prominently female but senior management and government positions are often occupied by men. HealthWISE has a focus on gender equality that has raised awareness of this in the pilot institutions. Policy reform has also included aligning provincial and national policies with ILO

conventions, including those focused on gender equality. Although not included in the programme document, institutions that have implemented HealthWISE did report the methodology had encouraged the inclusion of staff with disabilities in assessments and an increased attention to accessibility. Environmental sustainability is also part of the HealthWISE approach. Attention to international labour standards has been achieved through policy reforms that align policies and guidelines with ILO conventions, particularly those focused on OSH and the health sector. Social dialogue improvements can be identified both at the national level, through the involvement of different constituents and other stakeholders in policy design and programme implementation, and at the institutional level in hospitals, where management and workers have interacted more effectively on OSH and the working environment following the implementation of HealthWISE.

Key Findings- Effectiveness and Efficiency

Key Finding 4: The programme has achieved most of its expected outputs and outcomes. However, there are gaps in the design of the results framework, including a lack of outcome indicators and the means to measure change, and this limits assessment of achievement.

There have been important achievements in each of the countries that have contributed to different outcomes of the overall Working For Health results framework. These include implementing HealthWISE in Malawi and Pakistan, supporting the drafting of the National Occupational Health and Safety Strategy 2024-2030 for the health sector in Chad, developing the Handbook on Social Dialogue and Labour Relations in the Health Sector in Kenya, updating the Minimum Service Delivery Standards to align with ILO Standards in particular C190, C100, C111, C149 among others, for the Islamabad Health Regulatory Healthcare Regularity Authority in Pakistan, improving the capacities of the labour inspectorate in Chad, supporting the implementation of the HealthWISE methodology and Human Resources for Health Strategy in East Cape Province in South Africa and supporting the revision of the MoH Care of Carers Policy to include explicit provisions on violence and harassment aligned with ILO Convention No. 190.

However, gaps in the results framework make it challenging to measure progress, particularly at an outcome level. Many indicators do not include targets, and most indicators are output level rather than outcome. The results framework does include some results that if measured would provide a useful indication of the impact of the programme, but the framework does include targets, baselines, or the means of verification.

Key Finding 5: The programme has utilised limited resources effectively, maximising potential from limited funding. This has been supported by strong involvement from ILO field offices and the effective use of existing tools and methodologies such as HealthWISE.

The programme has been implemented efficiently on a very tight budget. Each country had a budget of under \$100,000, and some considerably less than that. To try to bridge the resource gap, the ILO has effectively leveraged existing resources and used the skills and capacities of the country offices to maximise its reach.

Key Finding 6: The short timeframe for country level interventions and limited financial resources reduces the overall efficiency of the programme as it prevents longer term planning and does not allow for stronger economies of scale in implementation. It also reduces opportunities for monitoring of the programme's outcomes.

The efficiency of the programme is affected by the limited finance available that had reduced the timeframe for country level activities. The programme has been unable to plan for the full three-

year cycle and cannot provide longer term guarantees to partners on programming and the availability of funds. This impacts the sustainability of the activities, and should momentum from programme successes be lost, the value for money of the intervention will reduce. The limited resources have also reduced the resources available for monitoring.

Key Findings- Sustainability and Likelihood of Impact

Key Finding 7: The programme has supported several policy changes. If fully implemented, these have the long-term potential to provide important impacts for health and care workers in the target countries by strengthening the regulatory framework, guidelines, and the labour inspectorates' attention to health and safety deficits and the working environment in healthcare settings.

The policy changes the programme has influenced have the most potential for broad impact and long-term sustainability. Changes include the revision of the Minimum Service Delivery Standards for the Islamabad Healthcare Regulatory Authority and the drafting of an OSH strategy for the health sector in Cameroon. The programme has also supported the revision of guidelines, toolkits, and training curricula, such as the Handbook on Social Dialogue and Labour Relations in the Health Sector in Kenya and revision of the Health Services Academy's public health curriculum in Pakistan. The short-term nature of the programme means that most of these changes have yet to be implemented. Support in implementing and disseminating the policy changes and guidelines will be important to ensure the long-term impact of this work.

Key Finding 8: Behavioural changes in pilot institutions demonstrate the success of HealthWISE in achieving quick results.

There is strong evidence of changes in behaviours, practices, and policies in the HealthWISE pilot institutions. Evaluation participants shared several examples of changes including improved awareness and attitudes of management and workers towards worker safety, greater attention to harassment and violence against health and care workers, and increased usage of existing resources to tackle identified problems.

Key Finding 9: Ownership of the programme activities is strong, improving the potential for long-term sustainability, with the development of policies and guidelines providing good examples of sustainability.

There was effective involvement from tripartite constituents and other stakeholders in programme activities, including the delivery of activities in some of the countries. The effort to ensure a participatory approach to designing activities has contributed to this. This provides a good basis for sustainability if the momentum of the programme can be maintained.

Key Finding 10: The unavailability of long-term funding harms sustainability by reducing opportunities for planning lengthier interventions or providing follow-up support after programme activities.

Although the ownership of the programme was adjudged to be positive, the achievements are threatened by the limited resources and thus the ability of the ILO to provide technical support in the future. Many of the target countries have extremely limited resources for the health sectors and expanding programme activities to additional institutions and regions and rolling out policies will be challenging without additional support.

Key Findings- Interagency Collaboration

Key Finding 11: Collaboration with the WHO has been good in some countries, but this is often dependent on the individual interests within country offices. A systematic approach to joint interventions has not been pursued.

The coordination between the ILO and the WHO varies between countries. There were examples of very strong collaboration, particularly in Chad, Malawi, and at the national level in South Africa. In other countries, such as Kenya and Pakistan, the coordination was much more limited. It appears that coordination is very much depending on the individual interests of the organisations within the country offices and a fully integrated and collaborative joint implementation approach, as originally envisaged under the Working for Health Programme has not been consistently realised in practice. This is partly due to the very decentralised nature of management in the WHO and the level of funding available for both organisations in each country.

There was good evidence of coordination of different stakeholders within the country projects, with key stakeholders being involved. The ILO country projects have also collaborated well within the country offices and with Geneva, but lesson learning could be strengthened if a system for sharing experiences between the country offices is developed.

Recommendations, Lessons Learned, and Emerging Good Practices

Recommendations

1. Review whether the current funding modality is feasible for continued work.
2. Focus on completing the outstanding activities.
3. Develop outcome indicators that can be used to measure progress in the programme.
4. Ensure longer term follow-up mechanism for support and monitoring of HealthWISE.
5. Strengthen coordination and knowledge sharing between ILO staff in different countries.
6. Develop and / or disseminate materials that demonstrate the successes of HealthWISE to other institutions
7. Focus on country level cooperation with the WHO to leverage funds for further programming.
8. Include disability inclusion in the results framework and PRODOC.
9. If funds allow, translate HealthWISE training materials in the local language and ensure interpreters are available for workshops.

Lessons Learned

1. Not securing complete funding for a 3 year programme limits opportunities for long-term planning and can reduce interest from stakeholders to participate.

Emerging Good Practices

1. Ensuring external collaborators contracted to implement programme activities are tasked with monitoring progress and measuring change helps address gaps in monitoring processes.
2. Involving senior management in the hospitals right from the start of HealthWISE ensures acceptance of the approach in targeted institutions.
3. The participatory approach to developing the programme, including ensuring line ministries beyond the ILO's traditional partner of the Ministry of Labour was involved in design.

1. Background and Project Description

1.1 Background

Spending on health was approximately 10% of global GDP in 2022¹ reflecting the sector's scale and its role as a major source of employment worldwide.² Investment in healthcare provides good economic returns for a country's economy. Improvements in health have estimated to contribute to around a quarter of economic growth in low and middle income³⁴.

The Sustainable Development Goals (SDGs) have set ambitious targets for global health by 2030 which will only be achievable through adequate investments in the health and care profession. Target 3.c directly addresses the healthcare workforce, aiming to 'Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States'. Other SDGs are also relevant to the healthcare sector, including indicators within SDG 4, ensure inclusive and equitable quality education and promote lifelong learning opportunities for all, SDG 5, achieve gender equality and empower all women and girls, and SDG 8, promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all.

Currently though, there are significant challenges in ensuring decent work conditions in the health sector, which in turn contribute to high staff turnover rates, substantial retention obstacles, and critical workforce shortages across many settings. Low pay and benefits, considerable risks to working conditions and health and safety, limited access to social protection schemes, and violence and harassment, particularly for women, all need to be addressed to ensure decent work is available for all in the health services sector and to promote equal access to high-quality, resilient health services.

Healthcare also relies considerably on informal and unpaid work. Unpaid care is often provided by family members or within the community. The burden of care falls disproportionately on women and girls. The unpaid nature of the work means, in addition to the lack of financial compensation, it does not support access to social security systems, leads to either missed economic opportunities through foregoing other work or a lack of free time and social activities, and can lead to considerable mental and physical health problems for the carer themselves⁵. The work done by unpaid carers is also predominantly unrecognised, with skills developed during the care being uncertified and the months and years spent doing it, not seen as work experience by employers or governments.

Without stronger investment in the health and wellbeing of health and care workers, the shortage of workers will be exacerbated. Burnout and mental fatigue, injury and illness, and better opportunities in other professions will lead to qualified and experienced professionals leaving the sector. The ultimate impact of death of health and care workers remains a threat, and was highlighted by the estimated deaths of at least 115,000 healthcare workers during the COVID-19 pandemic⁶.

¹ World Bank data. <https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS>

² WHO, (2024). Health and care workforce Global strategy on human resources for health: workforce 2030 https://apps.who.int/gb/ebwha/pdf_files/EB156/B156_15-en.pdf

³ WHO, (2016). Working for Health and Growth. Investing in the health workforce.

⁴ Ibid.

⁵ PAHO, (2020). Unpaid healthcare work. A gender equality perspective. https://iris.paho.org/bitstream/handle/10665.2/54847/9789275122310_eng.pdf

⁶ Working for Health informational brochure.

To address these challenges the United Nations Secretary General established the United Nations Secretary-General's High-Level Commission on Health Employment and Economic Growth (ComHEEG) in 2016, co-chaired by France and South Africa. ComHEEG published a final report in September 2016 which calls for greater investment in the health workforce through job creation, education and training, technological innovation, decent work and gender equality, optimized skills and productivity, better governance and financing, responsible management of health worker migration, stronger multisectoral partnerships, and improved data and accountability to maximize health, social, and economic gains.

1.2 Programme Description

The W4H programme is a joint initiative between the ILO, the Organisation for Economic Co-operation and Development (OECD) and the World Health Organization (WHO). The ComHEEG report and its recommendations led to the development of a five-year action plan for interventions by the ILO, the OECD, and the WHO to be supported through the Working for Health initiative. Activities to implement the action plan were funded under a multi-partner trust fund (MPTF) between 2018 and 2022. The programme was extended for a second phase from 2023 to 2030. The programme is implemented at the global, regional, and country levels. As part of the extension, the ILO is, among others, implementing a series of three-year country level initiatives. These are undertaken in Chad, Cameroon, Malawi, Kenya, Pakistan, and South Africa. The ILO is also implementing regional and global components of the programme but these are outside the scope of this evaluation.

The overall objectives for the programme are:

- 1) The existing health and care workforce is **optimized** through data-driven policy, planning and investment in education, jobs and skills.
- (2) The diversity, availability and capacity of the health and care workforce is **built**, to address critical shortages and meet country needs.
- (3) Health systems resilience and performance are **strengthened** to deliver universal health care and respond to public health preparedness through equitable, protected and efficient workforce. (emphasis included in the PRODOC)

This evaluation will focus on the country-level activities of the ILO, with an in-depth look at the work in Malawi and Pakistan. Concept notes were developed for each country for the first year (2024) and these were reviewed and revised to update progress and match available funding for the second year (2025). They include seven country level outputs and one regional output for ILO's part of the programme:

Output 1: Social dialogue mechanisms to support stable labour relations in the health sector strengthened

Output 2: A safe and healthy working environment for health workers promoted through the implementation of the HealthWISE approach

Output 3: Uptake of social protection for health and care workers enhanced

Output 4: Implementation of the HRH Strategy supported through social partner involvement and multisectoral engagement

Output 5: Development of gender transformative policy, practices and non-discriminatory working conditions in the health sector supported

Output 6: Skills and lifelong learning system development needs and opportunities to ensure national capacity to identify skills needs and mismatches assessed

Output 7: Health workforce governance, policies and regulation systems strengthened

Output 8: Adoption of the Africa Health Workforce Investment Charter and the Regional Health Workforce Investment Forum supported

Each country has a concept note with specific objectives.

For Malawi these are:

Objective 1. Assess the skills and lifelong learning system development needs and opportunities to ensure national capacity to identify skills needs and mismatches, develop and award credentials for care workers, establish flexible learning pathways for health and care occupations and provide an assessment of potential gains in key system development measures.

Objective 2. Enhance health workers' occupational health and safety capacity building through the adaptation and application of the ILO-WHO HealthWISE tool

For Pakistan these are:

Objective 1. Strengthen occupational safety and health for health workers in Pakistan

Objective 2. Provide guidance on the implementation of international labour standards

Objective 3. Support the development of gender transformative policy, practices and non-discriminatory working conditions in the health sector

The ILO also included work on global public goods, which was mainly conducted under the Skills component and the Mobility Platform work.

The programme is designed to run for three years. However, full funding was only secured for the first year of implementation (2024). It has proved challenging to obtain funding for the remainder of the project. The ILO obtained some funding for 2025 and a small amount for 2026, but the overall funding is below what was initially identified as needed. The shortfall in funding has led to the revision of programme's activities in years 2 and 3.

2. Evaluation Background

2.1 Purpose, Scope, and Clients of the Evaluation

Purpose

This was a mid-term evaluation of the ILO component of the W4H programme, and thus had significant formative learning elements. It assessed progress to date in the current phase of the project from December 2023 to November 2025 and identified lessons learned and recommendations that can be used for future implementation. The evaluation used the criteria of relevance and coherence, effectiveness and efficiency, orientation toward impact and sustainability, and inter-agency collaboration. The results will contribute to the mid-term evaluation of the entire W4H programme that is being led by WHO.

Scope

The evaluation covered the implementation of ILO's activities at the country level. While it included all six countries, specific attention was paid to Malawi and Pakistan. In depth reviews of implementation in Malawi and Pakistan were conducted through engagement of key stakeholders that have supported the implementation of the programme. The evaluation included assessing the extent to which the programme contributed to ILO's Outcomes 1 - more specifically to Outputs 1.5 Increased capacity of constituents, partners and stakeholders to implement sectoral international labour standards codes of practices, guidelines and tools as well as relevant Sustainability Development Goals (SDGs).

Evaluation Clients/Users

The main users of the evaluation will be the team leading the ILO component of the Working for Health programme in SECTOR, the ILO field offices in the six target countries and regions, tripartite constituents in the target countries, and project partners who support the implementation. Secondary users will include other departments with an interest in the programme including SKILLS, OSHE and GEDI, as well as OECD, the WHO, and the donors of the MPTF. The findings will be used for the mid-term evaluation of the whole project being led by WHO.

2.2 Evaluation Criteria and Questions

The evaluation criteria for the evaluation were relevance and coherence, effectiveness and efficiency, orientation toward impact and sustainability, and inter-agency collaboration. A series of questions were identified in the terms of reference (TOR). These were reviewed by the evaluator and a small number of changes proposed. The following questions were utilised during the evaluation:

1. Relevance and Coherence

- To what extent were the project's design and activities appropriate and responsive to national priorities, stakeholder needs, and the decent work challenges identified in each country?
- How well did the project's focus and approach align with the ILO's P&B outputs 1.5, DWCPs in selected countries, and the SDGs?
- How effectively did the project design and implementation integrate cross-cutting issues, including gender equality and non-discrimination, climate change, and the ILO's normative mandate?

2. Effectiveness and Efficiency

- To what extent have the expected outputs and outcomes been achieved and what factors have contributed to or hindered their achievement?
- To what extent were project's financial and human resources utilized efficiently to achieve project outputs and outcomes?

3. Sustainability and Likelihood of Impact

- What are the emerging impacts of the project?
- What extent are these outcomes and benefits likely to be sustained beyond the project's completion?

4. Interagency Collaboration

- How effective has the collaboration between ILO and WHO been in supporting the project objectives at country level?
- To what extent do the project activities complement related efforts by ILO, national actors, and partners like WHO?
- What gaps or challenges have been identified in the interagency collaboration?
- What opportunities exist to strengthen joint delivery toward the Working for Health goals?

2.3 Methodology

To achieve the purpose of the evaluation described above, the evaluation used a mixed methods approach. This primarily relied on qualitative methods, with the inclusion of quantitative data that had been collected by the project's monitoring processes. The primary methods used were a document review and key informant individual and group interviews. The evaluation ensured participation from a broad range of stakeholders, including representatives of key partners and tripartite constituents, ILO staff, and WHO staff.

The evaluation considers implementation in all countries, but focused specifically on actions in Malawi and Pakistan. The assessment for Cameroon, Chad, Kenya, and South Africa relied on programme documents and discussions with the Technical Specialist, Health Services Sector and ILO country staff.

Online interviews were conducted with stakeholders in Malawi and Pakistan for a more in-depth understanding of the intervention in these countries. The selection of the countries was made by ILO during the development of the evaluation TOR. Selection criteria included a focus on the countries where the most has been achieved. For example, in Kenya and South Africa, the country level projects have faced various delays due to political tensions in the country and the roll out of health reforms from October 2023, and thus there would be only limited activities to evaluate. There has been much more implementation of activities in Malawi and Pakistan. Additionally, given the limited resources of the evaluation budget, language was part of the selection criteria, and as such a decision was made to not focus on the francophone countries.

The evaluation was conducted in line with ILO's Policy Guidelines for Results-Based Evaluation: Principles, Rationale, Planning, and Managing for Evaluations (2020). The evaluation covered the cross-cutting themes required for evaluations which are set out in the ILO's guidelines. These are gender equality and non-discrimination, social dialogue, international labour standards, and the just transition to environmental sustainability. A specific question on the cross-cutting issues was included in the relevance section, but the issues will also be considered throughout the other criteria appropriate.

Evaluation Methods:

1. Evaluation design and inception phase
 - Secondary document and data review

During the inception period programme documentation such as the PRODOC, progress reports, presentations, project output documents, and videos were reviewed. The documents review served both as a basis to introduce the evaluator to the projects and help the design of the evaluation, but also as a data source which can be triangulated against findings from evaluation data collection. As such the documents were revisited regularly during the data collection and report writing periods.

- Inception period briefings with key ILO staff

During the inception phase the evaluator had an initial briefing with the Technical Specialist, Health Services Sector, who has overall responsibility for the the ILO component of the W4H programme at country, regional and global level., who is responsible for the day-to-day operations of the projects, and the Technical Officer, Project Management & Resource Mobilization for SECTOR, who is responsible for M&E within the department. Country level briefings were held with the Senior Programme Officer and the National Project Officer for the Pakistan Country Office, the National Project Officer, who is the focal point for HealthWISE and National Programme Officer, who is the focal point for the Skills Study in the Malawi Country Office, and the Regional HIV & AIDS Technical Specialist, based in Pretoria who has provided backstopping to the programme for Malawi, Kenya and South Africa. These discussions allowed an opportunity for the evaluator to understand the progress to date in the programme and the context around the design and implementation at the country level.

- Development of Inception Report

An inception report was developed during this phase of the evaluation to form a basis of understanding between the evaluator and ILO on the scope, purpose, and approach of the evaluation. Evaluation questions proposed in the TOR were reviewed and refined where necessary and an evaluation matrix developed which details lines of enquiry and indicators, sources of data, and approaches for each question.

2. Data collection period

Data collection was conducted remotely using Teams. During the data collection period, the following data collection techniques were used:

- Key Informant Interviews (individual and group)

A series of semi-structured interviews were conducted with key stakeholders from Malawi and Pakistan. The stakeholders included ILO county office and regional office staff who have supported the project, representatives of Ministries of Labour⁷, officials from other relevant ministries and departments, workers' representatives, hospital management, HealthWISE Master Trainers and participants, and officials from WHO. A list of all interviews can be found at annex 3.

Two forms of interviews were used during the evaluation, individual and group interviews. Group interviews were used with groups of participants who had similar roles or engagement in the programme, and were similar to focus group discussions. The group interviews allowed more participants to be involved in the evaluation than would have been possible if just using individual KIIs. Additional time for the group interviews was allocated to ensure all participants had a chance to contribute fully to them.

The interviews were semi-structured, using open ended questions that allowed for follow-up of emerging points of interest during the conversation.

⁷ The name of the Ministry of Labour can vary in different countries, such as Pakistan, but the general term is used to refer to the government constituent of the ILO.

Sampling

Sampling was purposive based on suggestions from the W4H team.

Category	Women	Men	Total
ILO Officials	5	4	9
WHO Officials	0	1	1
Partners (Government, Trade Unions, and Hospital Management)	3	4	7
HealthWISE Trainers and Staff of Hospitals who were not trainers	4	6	10
Grand Total	12	15	27

Table 1: Interview Sample per category

Category	Women	Men	Total
Global	1	1	2
Chad and Cameroon	0	1	1
Kenya	1	0	1
South Africa	0	1	1
Malawi	5	7	16
Pakistan	5	5	10
Grand Total	12	15	27

Table 2: Interview Sample by location

- Preliminary Findings/Evaluation Debriefing Workshop

A debriefing workshop was held in December 2025 with key programme staff, officials from other ILO departments, and WHO officials to present the findings of the evaluation. The workshop was designed to allow for questions and discussions concerning the emerging findings, including reflection on next steps. Feedback from the workshop was incorporated into the report.

2.4 Norms, standards and ethical safeguards

The evaluation was conducted in line with ILO's Policy Guidelines for Results-Based Evaluation: Principles, Rationale, Planning, and Managing for Evaluations (2020). The evaluation also adhered to the UN Norms and Standards (2016), paying attention to the 10 norms laid out in the guidance. The evaluation was conducted independently with impartiality ensured by recruiting an evaluator not previously involved with implementing the project.

All KIIs and group interviews began with an explanation of the evaluation and informed verbal consent, including explaining the confidentiality of responses, was asked from participants. Data in the report has been anonymized to ensure confidentiality.

2.5 Limitations and Potential Sources of Bias

Remote data collection: All data collection was conducted remotely using Teams. Given the size of the programme budget and the fact the programme involves work in six countries, as well as global stakeholders, this was necessary to ensure the budget for the evaluation was reasonable and stakeholders in the deep dive countries could participate. Remote data collection provides challenges, including potential loss of nuance and a lack of understanding over specific questions and responses. However, the evaluator is experienced in conducting remote interviews and thus was able to mitigate this concern during interviews.

Limited number of days to conduct data collection: The evaluation budget needs to balance attempts to ensure as much data as possible is collected with what is feasible considering the programme's size and budget. As such the evaluation focused on Malawi and Pakistan, which were selected because of their more advanced implementation and availability of results. This selection had the potential to introduce a positive bias, as countries where implementation faced greater challenges (e.g., Kenya, or South Africa) are less represented. However, this was mitigated by reviewing documentation from the other countries and incorporating this data to balance the analysis. The deeper focus on Malawi and Pakistan allowed for an assessment of performance and lessons learned in these countries, which is more detailed than would be possible if trying to include every of the countries of implementation. As such, this decision is justified by the final product of the evaluation.

3. Findings

3.1 Relevance and Coherence

Key Findings- Relevance and Coherence

Key Finding 1: The participatory approach to identifying challenges and designing country level interventions was critical for ensuring ownership of activities by national stakeholders and addressing key needs.

Key Finding 2: The limited funding and length of the country level interventions reduces to an extent the relevance of the programme to key stakeholders.

Key Finding 3: The programme has managed to integrate ILO's cross-cutting issues into the country level interventions. The HealthWISE approach includes a focus on gender equality and inclusion of persons with disabilities, as well as certain issues related to environmental sustainability. The actions have also included a focus on aligning national approaches with ILO's normative framework.

Evaluation Questions

- To what extent were the project's design and activities appropriate and responsive to national priorities, stakeholder needs, and the decent work challenges identified in each country?
- How well did the project's focus and approach align with the ILO's P&B outputs 1.5, DWCPs in selected countries, and the SDGs?
- How effectively did the project design and implementation integrate cross-cutting issues, including gender equality and non-discrimination, climate change, and the ILO's normative mandate?

Aligning with Stakeholder Needs

The evaluation found that the programme aligns with key needs in the target countries. This was driven by the approach to designing the programme. The participatory design process of national level activities has helped the programme be successful in aligning with stakeholder needs and national priorities.

The programme is implemented in contexts where responsibilities for working conditions in the health sector often lie with multiple ministries, and not just the Ministry of Labour. The Ministry of

Health has a critical responsibility in most contexts but also the Ministry of Education is also often involved with learning and skills development. The roles of workers' and employers' organisations also vary. There are often many workers organisations representing different cadres of health workers. Workers' organisations include those representing doctors, nurses, general government workers, and sanitary workers, and the employers are a mixture of private healthcare providers and the government, who thus plays a dual role in a tripartite structure. This can be further complicated by federal or devolved systems, as in Pakistan, where the employer is the federal or provincial government depending on the jurisdiction, in Kenya where the employer is the county governments, or South Africa where the employer is the central government, but health care administration lies with the provincial governments. As such, the programme has operated in an environment where the involvement of stakeholders beyond the traditional tripartite constituents is crucially important. The approach to designing interventions through multi-stakeholder consultations has been critical for ensuring relevance and ownership of the country-level projects. The evaluation found evidence that country level interventions had been designed either through a participatory stakeholder workshop, such as in Malawi, or as a direct response to a request for technical assistance from the government constituent, such as in Cameroon.

The flexibility of design supported this finding. Although the activities in the countries do need to fit within the overall structure of the Working for Health programme, there has not been a one-size fits all approach. The outcomes vary quite considerably from country to country. For example, Malawi focuses mainly on improvements in knowledge of health and safety in hospitals, with an additional focus on improving learning on skills gaps, whereas Kenya has focused on improving collective bargaining, with the goal of reducing workplace disputes and increasing collaborative negotiation between workers, employers and government. This flexibility, combined with the aforementioned participatory approach, has ensured strong relevance of the programme to country level stakeholders.

The flexibility also aligns with the goals and mandate of the Working for Health programme in supporting countries to implement the ComHEEG Commission's recommendations, in this case, in areas that align with the comparative advantages of the ILO and key areas of its work in the health sector including but not limited to job creation, particularly for women and youth, gender equality and women's economic empowerment, workers' rights; decent working conditions, including occupational safety and health, education, training and skills, social protection, social dialogue; and labour migration.

Stakeholders were keen to stress to the evaluator that the country-level projects responded to serious challenges within the health sector, often addressing topics that had not been effectively addressed or recognised in the past. Stakeholders in both Pakistan and Malawi regularly repeated a similar theme of not previously recognising the importance of focusing on the wellbeing of the workers.

"One of the key achievements of HealthWISE was highlighting the issues and thinking about the safety of the workers. The patients had been the priority before." (External Stakeholder Pakistan)

"When the ILO came and people trained us on HealthWISE, it was an eye opener. Usually, we just look for the patients' wellbeing. HealthWISE taught us that their (worker) safety was important and we needed to look after each other ourselves." (External Stakeholder, Malawi)

The programme was credited with helping management, administrators, and workers all recognise that improved worker safety in healthcare settings can also contribute to improved safety for patients as well.

The main challenge to relevance comes from the time and scope of the project. While the activities are needed and respond to need, it was noted by stakeholders that they often only address a very limited part of a much larger problem. The approach of piloting activities in a small number of hospitals, such as Malawi, or working with particular provincial health authorities in federalised systems such as Pakistan and South Africa, have been useful approaches to initial engagements in the countries, but to make a long-lasting and deeper impact, this work would need to be expanded beyond these initial facilities and provinces. ILO is currently unable to offer funding that would expand the programme, as such, this does limit interest in the activities from different stakeholders. The programme has also been successful in supporting policy in certain areas, but again lacks the resources or time to address all the gaps that exist.

Alignment with P&B, DWCPs and SDGs

The programme is designed to align with output 1.5 of the 2024/25 Programme and Budget (P&B), 'Increased capacity of constituents, partners and stakeholders to implement sectoral international labour standards, codes of practice, guidelines and tools'. The key indicator for this output is 1.5.1. 'Number of Member States with new or improved initiatives to apply ILO sectoral standards and sectoral codes of practice and guidelines endorsed by the Governing Body.' The programme has supported sectoral standards in Cameroon and Pakistan, through technical advice for the drafting of the National Occupational Health and Safety Strategy 2024-2030 for the health sector in Cameroon and the alignment of the Minimum Delivery Service Standards of the Islamabad Regional Health Authority with the ILO's normative framework. The programme also aligns with other areas of the P&B, most notably Output 5.2. 'Increased capacity of constituents to promote investments and decent work in the care economy' and Output 6.1. 'Increased capacity of Member States for the realization of a safe and healthy working environment'.

The individual country projects also align with their Decent Work Country Programmes (DWCPs). The focus countries of Malawi and Pakistan both demonstrate this. In Pakistan, priority 4 of the DWCP is 'Promoting a world of work which is safe, healthy, gender and disability-responsive, and free of violence and harassment'. HealthWISE is referenced in the indicators for outcome 4.1. 'By 2027, the Government of Pakistan and social partners have adopted and implemented new or strengthened gender and disability-responsive policies, laws and measures to improve occupational safety and health (OSH), and promote a violence and harassment-free world of work.' Priority 3 of the Pakistan DWCP focuses on strengthening the application of international law standards and FPRW. While Pakistan has not ratified the two fundamental OSH conventions, work within the programme has supported the alignment of policies with the conventions, particularly the support given to amending the Minimum Service Delivery Standards. The Malawi DWCP's priority 2 is 'Priority 2: Ratification and application of International Labour Standards and Fundamental Principles and Rights at Work'. Malawi ratified C155 and C187 in 2019, and addressing OSH deficits is a key area of priority 2.

In the other countries of implementation, there is also alignment with the DWCP. In Kenya, the programme aligns with DWCP Priority 3 on Social Dialogue and Tripartism Output 3.1.1.1: Policy, legal and institutional frameworks strengthened to promote social dialogue bipartism and tripartism for enhanced industrial harmony, organizational productivity and creation of decent jobs competitiveness. In South Africa, DWCP outcome 3.2 is Outcome 3.2: Enhanced capacity of employers and workers organizations to participate in collective bargaining and social dialogue. The Working for Health's focus on supporting collective bargaining in the East Cape Province helps support this objective. In Cameroon, the programme supports DWCP Outcome 2.3, By 2026 Workers, including those in the informal sector and in vulnerable areas, benefit from healthier and safer workplaces, free from violence and harassment and Outcome 3.2 : By 2026, the social climate is improved through a more effective and efficient participation of the tripartite constituents in the implementation of the ILS. In Chad, the work has aligned with country programme outcome TCD 102.

The programme also helps the ILO respond to the conclusions of the tripartite working group on improving employment and working conditions in health services⁸. The conclusions tasked the ILO with actively contributing to the implementation of the ComHEEG Commission's recommendations with a particular focus on 'the promotion of decent health sector job creation, maximizing women's economic participation and empowerment, and strengthening fair and rights-based health worker migration governance'. The tripartite working group also encouraged tripartite constituents to 'actively engage in effective social dialogue in its various forms in order to advance areas of common interest and to promote decent work and productive employment as well as continued professional development and lifelong learning for all health workers'. This report identified the contributions the programme has made to supporting social dialogue as being an important achievement in many of the target countries.

As described above in the introduction of the background of the programme, the SDGs have set ambitious targets for global health by 2030 that will only be achievable through adequate investments in the healthcare profession. The programme contributes to these, particularly target 3, 'Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States'. There are other SDGs that are also relevant to the health sector, including indicator 5.2, 'Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation' and indicator 8.8, 'Protect labour rights and promote safe and secure working environments for all workers, including migrant workers, in particular women migrants, and those in precarious employment'.

The programme does also highlight the difficulties in achieving the SDGs. Even though the achievement of the SDG goals related to health will only be achieved if all parties work towards indicator 3.C and adequately invest in the health workforce, the programme has struggled to identify funding to support its goals. At the same time, while the interventions have been welcomed by key stakeholders in the country, the government funding to expand the initiatives beyond the pilot stages is very limited.

Cross Cutting Issues

- Gender and Non-Discrimination

The evaluation found that the programme has addressed gender equality, and in certain activities, considered disability inclusion. Outcome 3 of the overall programme includes the output, 'Gender bias and inequalities in health workforce policy and practice are reduced'. The ILO has included a focus on gender equality in various programme initiatives. HealthWISE includes a module on violence and harassment, and this has been a vehicle to address issues related to gender equality. This has supported improved awareness of harassment within the pilot institutions. Gender equality and violence and harassment have also been included as modules in the revised curriculum of the Health Services Authority (HSA) and the update of the Minimum Services Delivery Standards in Islamabad, aligns them with ILO Standards on gender equality and violence and harassment.

The sector itself is highly feminised as women make up around 70% of the workforce. However, policy and senior management roles are still dominated by men, and women are often in lower status and lower paid jobs in the health sector. As such, improvements in working conditions and the empowerment of workers that the programme supports, will contribute to a more gender responsive sector.

⁸ Tripartite Meeting on Improving Employment and Working Conditions in Health Services, TMIEWHS/2017/9, (2017), https://www.ilo.org/sites/default/files/wcmsp5/groups/public/%40ed_dialogue/%40sector/documents/meetingdocument/wcms_553109.pdf

The actions of the programme would probably be rated as gender sensitive or gender specific / responsive on the WHO's 5-Level Gender Responsive Assessment Scale⁹. It considers different gender norms, roles, and relations and in certain cases it includes policies that specifically target men and women based on their needs and gendered norms. The programme mainly focuses on trying to integrate an understanding of gendered dynamics in its programming and the outcomes are mainly anecdotal based on behavioural change rather than focused on specific policies. For example, participants in Malawi suggested there had been a focus on trying to ensure staff were aware of gender equality policy rather than the development of new gender responsive guidelines and policies. There were mixed views as to how much change this had created. As such, these activities would be considered more gender sensitive rather than gender specific / responsive or gender transformative. Some of the work on policy change, such as the Minimum Services Delivery Standards may be elevated to gender specific / responsive, as they offer concrete policies that reduce gender inequalities within the workforce. This has included ensuring that harassment has been incorporated into the Standards for the first time.

The project document does not address disability inclusion. However, evaluation participants detailed several activities that had focused on the needs of persons with disabilities. In both Malawi and Pakistan, examples were given of HealthWISE supporting the inclusion of staff with disabilities in workplace improvements. In Malawi, staff with disabilities were included in the working groups that analysed gaps in health and safety in the hospitals and their views included in the action plans to address the identified gaps. HealthWISE trainers reported that the initiative had ensured management were more aware of the needs of staff with disabilities and staff identified discrimination against persons with disabilities as being a concern that needed addressing. Similar findings were reported in Pakistan. The HealthWISE approach requires acknowledging challenges and utilising existing resources to address them. This aligns with the concept of accommodation for staff with disabilities. Brainstorming about how to resolve challenges becomes part of the approach and helps with an understanding of challenges related to disability and combined efforts to address them. The programme has been implemented in countries where persons with disabilities face considerable barriers to employment, and HealthWISE can contribute to any government initiatives to address this.

“HealthWISE is very good that it is encouraging to work on the disabilities, to accommodate, and not discriminate. We have a background (in Malawi) where people were not employed due to disabilities, now the government is trying to amend this issue and HealthWISE supports this approach.” (External Stakeholder, Malawi)

However, the lack of disability inclusion in the project document, means the approach described above is not mainstreamed throughout the programme's activities. The examples shared with the evaluator have not been reported on by the ILO and the annual progress report does not mention disability at all.

- Just transition to environmental sustainability

The programme's main contribution to the just transition is the focus on waste and chemical management within HealthWISE. There are modules that focus on the safe disposal of medical waste and safe use of chemicals. The approach of HealthWISE supports environmental sustainability through its message of the utilisation and recycling of existing resources, thus reducing waste further.

- Social Dialogue

Social dialogue is embedded into many aspects of the programme. Social dialogue is included in the first output of the project document, 'effective workforce governance and collaboration at all levels',

⁹ <https://genderhealthdata.org/resource/introduction-to-gender-responsive-assessment-and-gender-levels/>

with an indicator of strengthening social and policy dialogue mechanisms. The issue is most clearly addressed in Kenya, where the focus of the project has been developing a guideline on social dialogue that can be used by all parties involved in healthcare. Healthcare governance is quite fragmented in Kenya, with government, workers, and employers involved at both the national and county levels and also due to presence of individual unions from different cadres of the health workforce. A lack of mechanisms for dialogue has led to several strikes. The development of the manual is an attempt to contribute to resolving this problem. Delays to the programme for various external reasons mean that the manual has not yet been validated.

The programme has also addressed social dialogue in other locations as well. In South Africa, the ILO has supported the negotiation of a collective bargaining agreement (CBA) at the provincial level. This has included establishing a bipartite working group of government and workers' organisations. In Cameroon, the government and the social partners were all involved in developing the OSH strategy, thus strengthening dialogue among the tripartite constituents.

Improvements in employer / worker relations were identified by HealthWISE participants. In both Malawi and Pakistan there have been improvements in relationships between management and workers, including the development of OSH committees to address health and safety deficits that are identified.

“Social dialogue started at national level through the road map. This cascaded into the health centres. There was discussion between employers and workers (or managers and workers). There was a lot of engagement between employees and senior managers. This was very helpful for the senior management. There are joint activities happening in a workplace and if they are working jointly to do this, then this is critical for the social dialogue work.” (External Stakeholder, Malawi)

- International Labour Standards

Several key ILO conventions have provided the framework for programme interventions. There is a focus on the Fundamental Principles and Rights at Work (FPRW) through attention to improving awareness and aligning policies with the OSH fundamental conventions and to a certain extent the conventions on gender equality and non-discrimination. The programme has responded to requests for technical assistance from constituents related to FPRW, most notably the work to develop the National Occupational Health and Safety Strategy 2024-2030 for the health sector for Cameroon and the alignment of the Minimum Services Delivery Standards of the Islamabad Healthcare Regulatory Authority with the ILO's conventions on OSH, gender equality, and violence and harassment.

The work is underpinned by several international labour standards, including the fundamental Occupational Safety and Health Convention, 1981 (No. 155) and the Promotional Framework for Occupational Safety and Health Convention, 2006 (No. 187), which are central to HealthWISE and require ILO Member States to respect, promote and realize principles of safe and healthy work environments. Attention to gender equality and non-discrimination is grounded in the Equal Remuneration Convention, 1951 (No. 100) and the Discrimination (Employment and Occupation) Convention, 1958 (No. 111), and measures to prevent violence and harassment in the workplace support implementation of the Violence and Harassment Convention, 2019 (No. 190). In addition, the Nursing Personnel Convention, 1977 (No. 149) provides specific guidance relevant to employment and conditions of work for nursing personnel, further anchoring the programme's normative framework.

Key Findings- Effectiveness and Efficiency

Key Finding 4: The programme has achieved most of its expected outputs and outcomes. However, there are gaps in the design of the results framework, including a lack of outcome indicators and the means to measure change, and this limits assessment of achievement.

Key Finding 5: The programme has utilised limited resources effectively, maximising potential from limited funding. This has been supported by strong involvement from ILO country offices and the effective use of existing tools and methodologies such as HealthWISE.

Key Finding 6: The short timeframe for country level interventions and limited financial resources reduces the overall efficiency of the programme as it prevents longer term planning and does not allow for stronger economies of scale in implementation. It also reduces opportunities for monitoring of the programme's outcomes.

Evaluation Questions

- To what extent have the expected outputs and outcomes been achieved and what factors have contributed to or hindered their achievement?
- To what extent were project's financial and human resources utilized efficiently to achieve project outputs and outcomes?

Achievement of results

The Working for Health programme has an overall results framework that details various outputs within three outcomes. These are:

- Outcome 1: The Existing Health & Care Workforce is OPTIMIZED Through Data Driven Policy, Planning & Investment in Education, Jobs & Skills
- Outcome 2: The diversity, availability and capacity of the health and care workforce is BUILT, to address critical shortages and meet country needs
- Outcome 3: Health systems resilience & performance are STRENGTHENED to deliver UHC and respond to public health preparedness through an equitable, protected & efficient workforce

There are some challenges in using the results framework to identify programme progress. The results framework does not detail which agency will deliver on the individual outputs. The ILO did develop a results framework during the appraisal process for this phase of the programme. The ILO also reports on its inputs into the Working for Health results framework and has developed concept notes for each of the six countries in which it is implementing activities. These include objectives for the programme in that country, outputs, and expected deliverables. While the expected deliverables do include some descriptions that can be translated to indicators, for example the production of a diagnostic study, the concept notes do not provide comprehensive targets for the indicators in the results framework. For example, the concept notes in Malawi and Pakistan include the delivery of HealthWISE training to selected institutions, but do not specify the number of institutions or people to be trained. Similarly, the concept notes and results framework do not include indicators that would allow for the measurement of change such as specifying the number of institutions that improve their health and safety practices following participation in HealthWISE. The indicators are output indicators rather than outcome indicators, although some of the output indicators would

actually be more relevant for outcomes (discussed more in the monitoring section below)¹⁰. The progress report for the overall programme reports on the output indicators in the results.

The ILO contributes annually to the Working for Health Secretariat's report to the Working for Health Steering Committee and the MPTF on the achievements of the programme. This report does provide quantitative data on the activities of the project and identify which outcome and output of the overall programme, the ILO's activities have contributed to. The report also provides a narrative description of the key achievements per country, but this is generally focused on the outputs of the activities and not the outcomes or change they have contributed to. The report is a progress report rather than a final report, and more analysis could be provided at the end of the programme.

It is therefore possible to assess if the broad suggested outputs of the programme have been achieved, but harder to assess whether targets have been met as these were not set in the programme's design documents.

However, key achievements can be identified:

Country	Key Achievements	Initial Outcomes
Malawi	Diagnostic study on skills and lifelong learning system development Training of 40 Master Trainers in 4 health facilities and the roll out of HealthWISE in these facilities	Yet to be fully launched and utilised Improvements in health and safety practices, teamwork, and management/worker relations
Pakistan	Updating Minimum Service Delivery Standards Training of Master Trainers and hospital staff in HealthWISE in Islamabad hospitals Expansion of HealthWISE to Punjab Employees Social Security Institution (PESSI) hospitals Revision of Health Services Academy (HSA) curriculum Delivery of Nursing Boot Camp	More strongly aligned with ILO conventions Community of practice introduced through established government institution responsible for workers education; Directorate of Workers Education Improvements in health and safety practices, teamwork, and management/worker relations The curriculum will be taught to public health students. Longer term outcomes not yet measured 45 Nurses attended. The outcomes this has led to is not yet measured as it is an initial pilot that is intended to become a regular part of the curriculum.
Chad	Set up of tripartite working group to implement the activities Training on social dialogue	Strong ownership of the project by key government agencies and other stakeholders

¹⁰ Outputs are what the project has produced. Outcomes show the change or effect of the outputs.

	Improving capacities in the labour inspectorate on occupational risk assessment, training engineering, and strategic compliance planning.	
Cameroon	Draft of National Occupational Health and Safety Strategy 2024-2030 for the health sector	Yet to be finally approved. Should contribute to improved OSH outcomes for workers.
Kenya	Development of social dialogue handbook	Yet to be approved and launched but should contribute to improvements in understanding of social dialogue within a fragmented healthcare system that involves many national and county actors.
South Africa	Supported the implementation of the Human Resources for Health (HRH) Strategy supported through developing a Department of Health Management Commitment Charter for the Eastern Cape Province and facilitating tripartite involvement in implementing the strategy.	The development of the Eastern Cape Province charter Collective Bargaining Agreement at the provincial level.

Table 3: Key achievements and initial outcomes

Reviewing the concept notes developed for each country suggests there has been relatively positive progress towards meeting the planned targets but there have been delays in certain locations. The limited budget, and uncertainty of funding, has also meant that the countries have not been able to suggest extensive activities for the second and third year of the project, and instead, most of the focus has been on ensuring the activities identified in the year 1 concept notes were achieved. As such, the ambition of the programme has been constrained.

The programme supported the strengthening of policies and the regulatory framework, most notably by supporting the updating of the minimum service delivery standards in the Islamabad Health Regional Authority. This has contributed to Outcome 1, 'The Existing Health & Care Workforce is OPTIMIZED Through Data-Driven Policy, Planning & Investment in Education, Jobs & Skills'. The ILO has achieved policy results in Cameroon, through the support given for updating the National Occupational Health and Safety Strategy 2024-2030 for the health sector.

The ILO has also contributed to outcome 1 through addressing social dialogue in several countries. This has included the development of a handbook that can be used by different actors at the national and county level in Kenya, as well as the multi-stakeholder working groups that have been formed to help select and oversee activities and which encourage dialogue between different tripartite constituents and other stakeholders. The programme has helped ensure the involvement of the social partners in the implementation of the HRH strategy in South Africa.

The programme's main contribution to outcome 2 is in Malawi. The programme has undertaken a diagnostic study on skills and lifelong learning system development that can support the strengthening of national capacities and skills to align with Malawi's needs if the recommendations of the report are implemented. Support is needed to launch and operationalise the findings of the study.

The implementation of HealthWISE has supported achievements in outcome 3 of the overall programme proposal through supporting the strengthening of the resilience and performance of healthcare systems. In Pakistan, the project has supported the implementation of HealthWISE in both Islamabad and Punjab facilities and gains in the health and safety for workers and an increased attention to gender biases have been reported. Amendments to the HSA curriculum and delivery of the nurses' bootcamp have also contributed to this result. Changes in the operating environment of the pilot hospitals in Malawi from implementing HealthWISE were also reported to the evaluation.

Key Strengths

- Utilising the ILO's comparative advantages

The ILO plays a comparatively small role in the global healthcare system. Various other entities, including WHO, other UN agencies, development partners, and global foundations have much larger healthcare portfolios and are more centrally embedded in the system. However, the ILO does bring an added value in a particular niche that gives it a competitive advantage. As the UN agency responsible for international labour standards, backed by its normative framework, the ILO has the reputation and expertise to provide technical advice on decent work and OSH. It was acknowledged by stakeholders that this issue for health and care workers has received less attention than healthcare delivery and the proficiency of the ILO in this field was appreciated by evaluation participants.

- HealthWISE

The HealthWISE tool was suitable for the environments the programme is implemented in and importantly relevant for the budget size of the programme. The tool has various features that supported the implementation of the programme.

Broad inclusion is a key aspect of HealthWISE. Facilities are encouraged to ensure staff from all departments and positions are involved in the planning and implementation of HealthWISE. This not only includes doctors and nurses, but also janitorial staff, security guards, administrative staff, and sanitation workers. Stakeholders reported that this approach had encouraged broad ownership throughout the pilot institutions and supported the creation of team-like atmosphere towards identifying and addressing health and safety deficits.

The on-the-job and practical nature of the approach also supported acceptance of HealthWISE within the pilot institutions. Although the Master Trainers were trained in a workshop, many of the hospital staff receive practical knowledge of the tool through participating in training in the hospital, the identification of health and safety deficits, and the implementation of the action plan to address these deficits. Being able to implement this in the workplace helps strengthen the connection between the modules and their practical application.

"One example (of success) was a hospital where they trained 10 people. They were able to take in an additional 10 people that they trained on the job. The people who were trained on the job were actually more enthusiastic about it because they could connect it to their job more closely. They were able to show us the risks and the improvements they have done, and demonstrate how they had used a low-cost approach that didn't cost much money." (External Stakeholder, Malawi)

HealthWISE is designed to encourage facilities to implement low-cost solutions to improving the working environment., utilising existing materials and resources. The delivery of HealthWISE requires relatively little funding. Master Trainers are selected to deliver training to hospital staff and focal points within different departments participate in disseminating the use of the tool. In Malawi,

the Master Trainers are staff from the hospital, which reduces costs further. In Pakistan, the programme recruited external trainers, who are affiliated with the Directorate of Workers Education, which is an attached department under the Ministry of Overseas Pakistanis and Human Resource Development, which does increase cost but also provides a trained group of professionals who can disseminate the training to other institutions.

- Involvement of senior personnel

The involvement of senior personnel in different settings has been important to the programme. At the national level, the project has been able to engage senior officials from key government ministries to participate in the planning and oversight activities. For example, in Malawi, the consultation meeting to decide the interventions that would be conducted in the programme was attended by the Chief Medical Officer and Director of Human Resources of the Ministry of Health. In Chad, the activities have been implemented by the Ministry of Labour through an implementation agreement agreed with senior leadership.

A similar dynamic was identified at the institution level. HealthWISE participants noted that the involvement of senior management of the hospitals had helped to ensure use of the tool throughout the hospital.

“The management was involved right from the beginning. This was an advantage that HealthWISE had over initiatives from just the quality department. The top management were involved and so it was easy to get people on board. Coming to the top management first is important. It helps to embrace it. If it goes the other way, then the management don’t tend to get involved. But when they are involved from the word go, then you will see them being enthusiastic and participate yourself.” (External Stakeholder, Malawi)

In Pakistan, similar examples were presented. This included the involvement of senior management of PESSI such as the Commissioner and hospital Medical Superintendents, which has led to greater impact in terms of results and compliance.

- Different approaches per country

The country level component of the programme is a series of different projects where the focus varies from country to country. While the country level activities are designed to contribute to the overall Working for Health programme, the individual approaches have been agreed by national level stakeholders and vary between the countries. The programme has not imposed a one size fits all approach on every country. This helped to ensure the relevance of the actions to the situation in each country, as well as the ownership of the programme, because national level stakeholders were involved in decision making about the programme’s direction.

Stakeholders also noted that tools, such as HealthWISE, were adapted to respond to the local context. For example, stakeholders in Malawi suggested the modules were relevant to the health sector there, and that the training focused on ensuring there was alignment with the local context. This supported the practical implementation of the approach in the pilot hospitals.

- Support provided by ILO staff

There was universal satisfaction among external stakeholders with the level of support provided by ILO staff involved in the programme in the focus countries of Malawi and Pakistan. It was recognised that there were limited resources for the country projects, but all stakeholders reported that ILO staff were readily accessible, provided prompt replies to questions, and that the level of technical support was of a high quality.

Challenges

Most of the challenges of the programme were linked to the limited resources as a result the scope of the programme and the time allowed for activities.

- Resources

WHO, OECD, and the ILO have fallen considerably short of the target budget they developed to be able to implement the programme in full. When initially established in 2016, the ambition was to mobilise \$70 million through the multi-partner trust fund. To date, around \$7 million has been obtained. Within this phase of the programme there have also been challenges in obtaining the necessary funding. As a result, funds were available for planned activities for the first year, but only limited funding was obtained for 2025 and even less for 2026. As such, most of the activities planned for the remainder of the programme are to finalise ongoing activities rather than implement any more.

The limited funding reduces opportunities to capitalise on programme gains and limits the ability of the ILO to expand the action to other provinces or institutions. For example, most HealthWISE participants suggested the tool should be rolled out to more institutions. However, without funds, it becomes difficult for the ILO to support this, and any expansion would rely on either government funding or another organisation, such as an international NGO, providing support for the expansion. In the places the programme has been implemented, government budgets are very tight and there may not yet be enough momentum to take the initiative further without the ILO, and funding for NGOs is also considerably limited in the current funding climate.

- Time

Closely linked to the challenge of resources, many stakeholders identified that the time available to implement the activities was too short.

“Squeezing the project into a short period has been a challenge. People have busy schedules so getting the sufficient time from them in the short period has been a challenge.” (External Stakeholder, Pakistan)

Stakeholders in both Pakistan and Malawi identified that the limited time available to deliver the HealthWISE approach made it harder to ensure ownership of the activities by the hospital management and staff.

“The other challenge is the limited time to teach. People are not thinking they way they should. They only have 2 days to train and so people did not grasp the concept completely. They are able to have an idea but they are not necessarily fully aware of not to do. The lack of resources to teach other can affect the rest of the implementation.” (External Stakeholder, Malawi)

- Resources of partners

A common concern raised by evaluation participants was that the limited resources of the partners reduced opportunities to fully leverage the gains they made through the project. Although HealthWISE is designed to encourage the use of existing resources to address health and safety deficits, there were still examples of where the very limited resources of the facilities did impact the implementation of the tool. For example, staff in one facility wanted to repair and repurpose chairs in the hospital but required funds from the district to provide a welder to assist this, and have not yet been able to obtain the funds.

“HealthWISE gives you an eye opener to your situation and hazards and the steps you can take to improve, but it doesn’t go further to helping you improve your situation if you need funding. We sometimes know about problems and can see it everyday because of HealthWISE but we are unable to get support to do anything about it. We have spoken to the district authorities asking for help but they make excuses.” (External Stakeholder, Malawi)

The limited resources also impact sustainability, particularly in the lower income target countries such as Chad and Malawi. Without the support of the ILO, the possibility of the approaches used in the project being rolled out to other locations remains slim.

- Language

The tools ILO has developed are in English and French and the programme lacked the budget to translate these into local languages. While many of the staff in the hospitals spoke English, the participatory nature of the tool means that departments staffed by personnel with lower education levels are involved in the approach, and in many cases, they did not speak English. This was particularly reported as a concern in Malawi. Stakeholders shared that this challenge had been mitigated by some of trainees acting as interpreters, a solution that fits within the spirit of HealthWISE’s focus on using existing resources. However, it was suggested that written material in the local language would be helpful, particular in supporting the delivery of training in the facilities from the Master Trainers.

- Monitoring of results

Neither the design of the programme nor its resources are particularly conducive to establishing a robust monitoring system, and as such, identifying and attributing the change the programme has contributed to is challenging. The results framework in the project document does not contain targets for the outputs, beyond listing which countries work will take place in. The progress report does contain a results framework with more detail, but does not include numeric targets.

This is also the case in the country concept notes. For example, the concept note for Malawi details the diagnostic study on skills and the HealthWISE training as the key activities. These are linked to outputs, which actually read more like outcomes, as they describe the expected change. However, the concept note does not include targets for the outputs and there is not a system to measure the change. The outputs for the HealthWISE work are a reduction in gender bias and inequalities in health workplace policy and improved protection, well-being and OSH of health workers. These are outcomes, which if measured, would demonstrate important change. However, without indicators and a more robust monitoring system, it is difficult to confirm these.

Nevertheless, the programme has been able to utilise some resources for monitoring and evaluation. Budget was assigned for this evaluation, which has been able to identify some examples of change, although these are more anecdotal than systematic, and the scope of the evaluation is limited due to resources. In Pakistan, the Master Trainers were contracted to deliver training, as opposed to Malawi, where staff from the specific facility were selected as Master Trainers. This allowed the Pakistan team to build monitoring into the contract as a requirement for Master Trainers. The reports produced by the Master Trainers are quite detailed and include examples of initial change, lessons learned, and the challenges faced in implementation. Ideally if resources had allowed, the contract would have included a follow up report by the Master Trainers after 6-12 months to allow for understanding of how the hospitals have used the modules in the long-run and what changes it has contributed to. The project has though maintained contact with the hospitals and collected details of the changes made to allow for the development of case studies, as well as

facilitating a community of practice that brings together Master Trainers and hospital management to exchange practices and learn from each other.

Aside from these examples, the programme relies on the country offices to conduct monitoring and reporting. Time for this is limited, with the staff often being only part-time devoted to the programme and responsible for implementation as well as monitoring. ILO staff have managed to conduct informal monitoring through the relationships they have developed with key government officials and other partners. For example, in South Africa, HealthWISE was delivered in the previous phase of the programme, but recently the Health Inspector shared with ILO colleagues the improvements he had seen in the facilities. The challenge though is to systematically document these changes.

It is not surprising that the monitoring system is limited given the resources of the programme. Each country had under \$100,000 for implementation and as such it would not be justified to spend a significant portion of this on monitoring. The contribution of the ILO Officials to collecting information has helped reduce the information gap and probably with the funds available, it would be difficult to achieve much more. However, the programme should consider both the good examples identified and the need for more robust indicators when designing future interventions, particularly if more funds are available, which would then require a stronger monitoring and evaluation system.

Utilisation of Resources

The evaluation found that the programme has been able to utilise resources efficiently to produce considerable benefit from a limited budget. As previously noted, the budget available for each country's activities is under \$100,000 per country (and in most cases considerably less). Given this, the amount of results the programme has achieved is notable. The programme has achieved this by leveraging complementary resources from the country offices, securing strong participation from tripartite and other constituents, and utilising existing resources such as HealthWISE and Caring for Carers. In countries that implemented Working for Health in previous phases, such as Pakistan and South Africa, the programme has been able to build on past work and developed relationships.

The contribution of the ILO country offices has been important in implementing the programme. In most countries, the ILO has not had staff solely dedicated to the programme, but individuals have contributed alongside of other responsibilities. This has allowed the ILO to have technical staff contributing to the programme that could not be funded solely from the Working for Health programme. The ILO does not have a country office in Chad, and the support of national staff from the WHO's country office has been critical in helping support the ILO's remote management of the programme.

The efficiency of the programme is affected though by the resource capacities. The programme has been unable to plan for the full three-year cycle and cannot provide longer term guarantees to partners on programming and the availability of funds. This impacts the sustainability of the activities, and should momentum from programme successes be lost, the value for money of the intervention will reduce.

"It is important to develop at least 3-4 year programmes. We need to support technically the countries for many years, we can't just do it over 1-2 years and make it sustainable." (ILO Staff)

The limited resources do though support some efficiencies. As noted, the programme has had to leverage support from country offices and use existing resources effectively, which may not have

been the case had more funding been available. Additionally, because the funding is limited, there is less competition for the resources between the different implementing agencies. This has probably contributed to less overlap and duplication as a result, thus increasing efficiency.

3.3 Sustainability and Likelihood of Impact

Key Findings- Sustainability and Likelihood of Impact

Key Finding 7: The programme has supported several policy changes. If fully implemented, these have the long-term potential to provide important impacts for health and care workers in the target countries by strengthening the regulatory framework, guidelines, and the labour inspectorates' attention to health and safety deficits and the working environment in healthcare settings.

Key Finding 8: Behavioural changes in pilot institutions demonstrate the success of HealthWISE in achieving quick results.

Key Finding 9: Ownership of the programme activities is strong, improving the potential for long-term sustainability, with the development of policies and guidelines providing good examples of sustainability.

Key Finding 10: The unavailability of long-term funding harms sustainability by reducing opportunities for planning lengthier interventions or providing follow-up support after programme activities.

Evaluation Questions

- What are the emerging impacts of the project?
- What extent are these outcomes and benefits likely to be sustained beyond the project's completion?

With a limited timeframe and budget, identifying impacts at this stage of the programme is challenging. The tight resources also impact opportunities to conduct ongoing monitoring that could identify impacts. However, the approach of focusing on a small number of interventions per country, and where HealthWISE was being implemented, piloting in a limited number of hospitals, does mean ILO teams have been able to follow up to identify changes that have occurred.

Policy Changes

The programme has had some success in supporting the development or amendment of policies and production of guidelines. In Cameroon, the programme has provided technical assistance to the development of an OSH strategy. The actual impact of the strategy cannot yet be assessed as it is still pending final completion, but the strategy is owned by the Government, which will support implementation, and in the long run, improvements in OSH outcomes for health and care workers should be observed.

In Pakistan, the programme has been successful in supporting the Islamabad Healthcare Regulatory Authority (IHRA) to update the Minimum Service Delivery Standards to align with the ILO's standards on OSH, violence and harassment, and gender equality. The programme also helped the HSA to

revise its curriculum for public health students to ensure it aligns with the ILO's standards on OSH, Nursing Personnel, Violence and Harassment, and Gender Equality.

The programme was also reported to have made an important contribution to the development of a new office in Malawi that is focused on OSH within the Ministry of Health. As such, the ILO has supported the institutionalisation of an office that should contribute to enhanced attention, and ultimately policy, concerning OSH within the healthcare sector in Malawi.

"The biggest change in my opinion is the support to the new office. The institutionalisation of the office and having it grow important. The project cannot take full credit as many people contributed but I think the ILO's support has helped a lot." (External Stakeholder, Malawi)

There are some initiatives that are yet to be finalised and as such impact cannot yet be identified. However, it is possible to assess the potential for change these interventions will contribute to. In Kenya, the programme has supported the development of the manual to improve industrial relations in the healthcare sector. While this had not yet been launched, it has been accepted by key stakeholders in Kenya, and once launched next year, it has the potential to improve social dialogue in the sector.

HealthWISE Changes

Various examples of behavioural change including improved teamwork, greater care and attention to safety and hazards, and greater willingness to raise concerns were identified as key changes linked to HealthWISE, as well as improvements in social dialogue and worker-management relations. These had contributed to overall improvements in health worker safety and well-being in the piloted institutions.

Evaluation participants reported that staff in the pilot facilities feel more comfortable about raising concerns about safety deficits, discrimination, and other issues. It was reported that prior to the roll out of HealthWISE, that even when aware of concerns, staff would not report them for fear of being blamed for the problem. Since the training, staff have recognised the importance of a collaborative effort in identifying and reporting concerns. The fact that the management of the pilot hospitals have embraced the programme has helped contribute to this change. An anecdotal example of this was that it was reported that in one hospital in Malawi, staff will shout out "HealthWISE" when they see a safety concern, which helps spur action to correct the deficit.

Evaluation participants shared several examples of improvements in their institutions. One example was of adjustments and replacements being made to the beds in labour wards so the staff could move and attend to patients with less risk to their physical health. This included ensuring the height of beds could be adjusted. Another example had been changing of the chemical used for washing the floors from a harsh chlorine type cleaner to a mixture that created less reactions from health workers and patients.

The training had also promoted cost saving in hospitals through increased attention to water and electricity wastage. Simple solutions such as turning off lights and rigging up a water harvesting system to use rainwater collected from roof drains for gardening, were highlighted as examples. These helped increase the support of HealthWISE from the hospital management, who were pleased with the cost savings.

It was also noted that HealthWISE helped hospitals consider whole areas of risks they had not considered before. Ergonomic risks that staff faced, including those whose job required sitting for

long periods and those required to lift patients, had not been previously addressed by the hospitals. These examples were noted by several evaluation participants. Considering these risks for staff had also led to a recognition that some of these risks also existed for patients. For example, patients who had to wait long periods in waiting rooms, also faced risks related to sitting.

“The most interesting change was they realised they were missing ergonomic hazards and solutions. It wasn’t seen as a vital part of our different criteria before the training. For example, in the reception, staff sitting in the reception were given ordinary chairs. After the assessment we changed the chairs according to their needs. We also put anti-slip tape on the stairs.” (External Stakeholder, Pakistan)

These examples demonstrate the many small incremental changes that HealthWISE can contribute to through the participatory nature of its approach. Taken alone, each improvement is positive but is limited in itself, however the cumulative effect of all the small changes contributes to more significant change. Evaluation participants believed that the approach of HealthWISE of engaging the different cadres of the hospital, including nurses, doctors, janitorial staff, sanitation teams, security guards, and the administration, strongly contributed to its success. The participatory assessment conducted to identify health and safety deficits, followed by the different teams all contributing where they could, has built a momentum in the hospitals for change and supported significant improvements in worker safety.

Sustainability

There were mixed findings on sustainability. On the one hand the project has supported policy change and guideline development that should outlast the programme, and there was evidence of improvements and ownership of the HealthWISE approach in the pilot hospitals that will be taken forward. However, the limited scope of the programme means considerably more work is needed to ensure changes are institutionalised beyond the pilot locations, and the short timeframe has impacted the ability to provide follow-up support and monitoring.

Given the limited resources, the programme’s approach to interventions has probably ensured the actions have maximised the potential sustainability that could be achieved. The engagement of tripartite constituents and other stakeholders in planning the process supported this. For example, in Malawi, the initial planning meeting suggested including twelve hospitals in the pilot scheme, but following confirmation of the budget, the Health for Work Taskforce recommended focusing on only four, to ensure sufficient attention could be given to them.

Similar examples can be seen in Pakistan. Pakistan’s federal system means that each province has a separate healthcare authority, with ownership over that province’s healthcare system. As such, focusing on piloting within one province is a sensible approach. The programme focused initially on the IHRA, building on work done with IHRA in the first phase of the programme. This is both relatively small and also located where the ILO’s country office is based. The programme has since followed this up by working with Punjab Employees Social Security Institution (PESSI), which gives a footprint in a larger province and creates the potential to showcase the successes of the programme to provinces throughout the country.

It was noted that stakeholders though, that this approach means that the ILO may be disconnected from the mainstream health service, although this was a minority viewpoint among stakeholders. It was suggested that the IHRA is small and PESSI is a contained system for specific workers within Punjab, and as such, the ILO has yet to contribute significantly to the mainstream health system. With limited funding, it is difficult to attract the attention of key stakeholders when competing

against much larger implementing agencies. However, stakeholders believe that the ILO has a significant added value and needs to raise its voice more in the sector:

“ILO is a little disconnected from the health system. They aren’t coordinating or integrating with the mainstream health system. They were focusing on PESSI which is few and limited and not in the mainstream health system. The main stakeholder is the government and private sector, and ILO is not there. If you work for labour benefit, they need to be more open than they are. This is probably because of the fear of being small contributors when working in the health sector, but they could be a very good addition, because the skill and knowledge they can provide, no other agency that can provide this.” (External stakeholder, Pakistan)

Other stakeholders believed that the ILO was applying the correct approach to expansion, and that through piloting in ICT and then working with PESSI, who serve millions of workers in the formal sector. This has allowed it to showcase the potential of HealthWISE and the ILO’s programming to potential stakeholders. The differences of opinion could mainly be linked to a need to communicate the ILO’s approach more clearly, or simply reflect that, in a large system, differing approaches are likely to be advocated. It is important for the ILO to continue to showcase the successes of the programme to bigger provinces in order to the dissemination of good practices and operating procedures developed in this programme. This strategy has been applied through engaging stakeholders in Punjab and can be taken to other provinces in the future.

The turnover of personnel in the pilot institutions is also a challenge, but the HealthWISE approach and other training approaches have helped mitigate this to an extent. Stakeholder reported that there can be significant turnover of staff in many of the institutions, and this often means that when an individual who has been trained on a particular subject moves to a different department or institution, the knowledge they have is lost. While this was reported as a challenge to a certain extent in this programme, the approach of cascading training through Master Trainers who then train hospital staff to pass on the training themselves, helps reduce the problem. The participatory nature of HealthWISE means that a lot of staff are involved in the process and can take action to continue it even when some staff leave the institution. Similarly, in Pakistan, the programme worked to revise the curriculum taught to public health students and deliver a bootcamp for nurses, both of which were well received by the trainees. This should help ensure a significant number of health professionals are training on OSH, thus reducing the risk of the knowledge being lost.

3.4 Interagency Collaboration

Key Findings- Interagency Collaboration

Key Finding 11: Collaboration with the WHO has been good in some countries, but this is often dependent on the individual interests within country offices. A systematic approach to joint interventions has not been pursued.

Evaluation Questions

- How effective has the collaboration between ILO and WHO been in supporting the project objectives at country level?
- To what extent do the project activities complement related efforts by ILO, national actors, and partners like WHO?

- What gaps or challenges have been identified in the interagency collaboration?
- What opportunities exist to strengthen joint delivery toward the Working for Health goals?

The Working for Health programme is a collaboration between the ILO, WHO, and OECD. The terms of reference of the Working for Health programme (updated in 2023) provides detail on the expected functions of the Working for Health MPTF. It was expected that the partnership would foster coordinated policy advice and assistance, harmonise and align support of donors and development partners, help meet demand from countries for scale up, maximise United Nations and international organisation expertise, promote policy coherence, facilitate innovation and experimentation, deepen normative policy operational links, and help manage risks. At country level, it was expected that existing country coordination mechanisms would be strengthened or where such mechanisms didn't exist, established. These would engage different ministries, including health, labour, and education, along with employers and workers' organisations, academic, civil society organisations, and think tanks.

The evaluation only assessed the ILO's activities at the country level and does not look at the regional and global activities. At the country level, the ILO and WHO are the two significant agencies, as the OECD has limited presence here.

Overall, there have been positive examples of cooperation between ILO and WHO, but these seem to be reliant on the interest of individual officers in the programme, rather than through a systematic approach of joint implementation between the two agencies as originally envisaged in the Working for Health programme. As a result, there has been a quite active involvement of the WHO in Malawi, Chad, and South Africa, but less interaction with WHO in Pakistan and Kenya. WHO regional and country offices are quite autonomous from the headquarters in Geneva, and ILO staff did indicate that they often had to introduce the programme to their colleagues in the country office, rather than them already being aware of the programme. This may have had an impact in the variation in involvement from different countries. A particularly positive example of cooperation comes from Chad. The ILO does not have a physical presence in the country and manages the activities from Cameroon. The WHO has been heavily involved in the programme in Chad and helped address gaps that occur because of the ILO's limited presence.

The coordination between the WHO and the ILO has contributed to the involvement of more stakeholders. The two agencies have developed strong relationships with different line ministries. The ILO's traditional partner is the Ministry of Labour, who are usually responsible for working conditions and labour inspection. The WHO's traditional partner is the Ministry of Health, who are often the employer of the healthcare workers. The presence of both agencies in the programme has helped reduce the time that would normally be needed for relationship building and this has helped to strengthen ownership of the programme.

The limited resources for each country project have also probably affected the level of coordination between the agencies. The budget does not really allow for significant involvement of more than one agency in activities. As such, interaction consists more of coordination and oversight through the country steering committees, than combined activities. The WHO has participated in supporting certain modules in HealthWISE, including the module on HIV and TB infection prevention but significant joint implementation of activities has not taken place, as the funds for this have not been available.

This is partly a result of the agencies defining their scope and added value and working on areas relevant to them, which can be considered a strength of the programme. The WHO does not focus

specifically on workers' rights and thus in countries where there has been a significant focus on collective bargaining and employer/workers such as in Kenya and in the provincial work in South Africa, it is not surprising that WHO has had limited involvement. South Africa provides an example of coordination that allows collaboration at certain levels where there is joint interest, but also the agencies implementing independently where it is deemed relevant. The Ministry of Health in South Africa was keen for collaboration between the ILO and WHO in the work on the caring of carers manual. This apparently was driven by an individual in the Ministry who has championed OSH in the health care sector and pushed for collaboration between the agencies. The WHO though has limited reach in the provinces and so ILO took the lead on this work. As with other countries, it does appear that this approach was based on relationship building and individuals rather than being a systematic approach to coordination.

There does appear to have been strong coordination among key stakeholders in the target countries. The use of steering committees / taskforces and the participatory approach to identifying key needs and planning responses has contributed to this. Key ministries, employers and workers have been involved in various countries (with the caveat that the government is often the employer in the healthcare sector). The ILO has extended this coordination beyond just the traditional tripartite constituents to involve other key ministries in particular. There is though limited evidence that other international organisations have been involved in the planning process. Other UN agencies beyond the ILO and WHO have had limited involvement, although UNFPA did contribute to the nurses' bootcamp with the HSA in Pakistan. Similarly, none of the large international NGOs that work on healthcare in these countries have been involved in the programme. This may have reduced opportunities to have the approaches of the programme duplicated further through the support of projects of other international organisations.

To strengthen joint delivery of Working for Health, it is likely that more resources would be needed. Given the limited budget, it is difficult to envisage how both the ILO and WHO could be more significantly involved in each other's activities. That said, a more systematic approach to coordination would be advisable to ensure coordination is not just reliant on individual initiatives. Additionally, greater involvement of other agencies in programme events could create opportunities for the successes of the programme to be expanded, if these agencies are interested in including elements of Working for Health in any of their programming. Working at a country level to leverage more financial resources may provide a more productive pathway for expanding activities.

An area where knowledge sharing could be improved is through developing a mechanism for coordination among the ILO staff working on the programme in the different target countries. Although the coordination between HQ offices in Geneva and the individual countries is very good, there is not a mechanism for sharing best practices and lessons learned and discussing joint challenges. As many of the countries are implementing similar activities, such a mechanism could provide a support structure for staff and help address common challenges as they arise.

4. Conclusions, Recommendations, Lessons Learned and Emergent Good Practices

4.1 Conclusions

Overall, the ILO's component of the Working for Health programme at the country level has produced some useful results on a limited budget. The programme has been able to ensure progress has been made in all six countries of implementation and helped to advance the concept of worker health and safety in the health sector. The programme has though had challenges in

implementation, that are mainly related to the availability of sufficient funding to achieve its goals. This has severely constrained the ambition of the programme. Moving forward, the programme should seek to consolidate the achievements to date and identify if there are ways to extend the initiatives it has introduced in the target countries.

The relevance of the programme to the needs of the target countries and the participatory nature of the design of country projects has been critical in ensuring ownership of the results. Both the involvement of the key national actors in the original planning, and also including the management of institutions in the roll out of individual activities has been a key strength. This has allowed the ILO to present individualised activities that address the significant challenges faced in each country. Without this approach, it is unlikely the ownership of the programme by different stakeholders would have been as strong, which would have had a knock-on effect on the achievement of targets and sustainability of the programme.

The programme appears to have met most of the targets. However, this judgement is impacted by gaps in the results framework. The programme does not have measurable indicators that would help demonstrate the change the programme is contributing to. Based on the information the programme has gathered, and the data collected in the evaluation, it is though possible to identify key achievements some areas of emerging impact, including the development of policies that align with the ILO's normative framework and behavioural changes in the hospitals the programme has worked in.

In addition to the collaborative approach to the programme, these results have been achieved because of certain key strengths of the programme. The flexibility to implement different solutions in different countries has ensured the programmes is responsive to individual needs. The ILO has also used its comparative advantages effectively and supported work in an area that is often overlooked in the health sector but dovetails with the ILO's expertise.

The limited availability of funding means there are concerns over sustainability. The country projects have effectively targeted institutions and policies where changes can be operationalised but rolling out both programmes such as HealthWISE and new national policies on a broader scale will need continued attention. It will be important for both the ILO and national constituents to identify ways in which they can continue to work on these issues.

4.2 Recommendations

Recommendations	Addressed To	Priority and Timeframe	Resource Implications
1. Review whether the current funding modality is feasible for continued work. The programme has been unable to obtain long-term funding. This has impacted planning and the ability to provide guarantees of long-term support. The ILO and WHO should consider whether the approach of launching a programme without securing funding to implement it for at least three years is feasible in future and conducive to long-term sustainability.	ILO and WHO	High Ongoing	Impacts whether a programme is given the go-ahead.
2. Focus on completing the outstanding activities.	ILO programme	High Ongoing	None

As funding constraints remain challenging for the programme, the initial focus should be to ensure the outstanding activities are completed and any remaining funds used to support the implementation and follow up of work done to date rather than starting new initiatives.	team		
3. Develop outcome indicators that can be used to measure progress in the programme. The results framework does contain outcomes that if measured would be effective in demonstrating the change the programme is hopefully contributing to. However, the framework does not have corresponding indicators or means of verification. The limited resources of the programme impacts how much monitoring can be done. However, developing a more robust results framework could contribute to highlighting the programme successes more.	ILO programme team	Medium During the design of future phases / projects	More resources, if available, may be needed for M&E
4. Ensure longer term follow-up mechanism for support and monitoring of HealthWISE. Many evaluation participants reported that a system for ensuring support is provided for the hospitals involved in HealthWISE over several months or even years would be helpful, including refresher training and monitoring visits to help identify challenges and provide suggestions for addressing them.	ILO country teams implementing HealthWISE	Medium Ongoing, where resources allow	Would require addition staff time or funds for external contractors.
5. Strengthen coordination and knowledge sharing between ILO staff in different countries. As the countries implementing the activities can face similar challenges, developing a coordination network to share experiences between the country offices may help address concerns as they arise.	ILO programme and country teams	Medium Could be implemented straight away	None beyond staff availability
6. Develop and / or disseminate materials that demonstrate the successes of HealthWISE to other institutions Many HealthWISE participants reported that they would like to be able to introduce the tool more broadly. This applied both in the provincial system of Pakistan, where expanding HealthWISE to other provinces was recommended, and in the centralised system in Malawi, where it was suggested HealthWISE should be expanded to more hospitals, particularly in rural areas. To support this, it is recommended to develop and / or disseminate materials that highlight the successes of	ILO country teams	Medium When funds allow	Would require an EXCOLL to produce the video.

HealthWISE, and that could either be used by the ILO or by healthcare workers. Videos have been produced in Chad, Malawi, and Pakistan and ensuring broad dissemination at the country level to support take up of HealthWISE and at the global level to attract more donors is recommended.			
7. Focus on country level cooperation with the WHO to leverage funds for further programming. Identifying funding at the global level for the programme has been difficult for ILO, WHO, and OECD. However, in many countries, there were indications of positive cooperation between the ILO and the WHO. Focusing on leveraging requests for technical assistance from Ministries of Health and Labour may make identifying funding for specific country activities more successful than for a multi-regional programme.	ILO and WHO country offices	Medium Ongoing	Could potentially unlock funds
8. Include disability inclusion in the results framework and PRODOC. The HealthWISE activities were reported to have addressed disability inclusion, with positive indicators of the participation of persons with disabilities and solutions to increase accessibility being shared. However, disability is not in the PRODOC, results framework, or the progress reports. Reporting on the achievements would be a first step and future interventions should ensure the results frameworks are disability inclusive. This would help build on the currently unreported achievements and ensure greater institutionalising of the topic within programmes.	ILO programme and country offices	Medium	Some resources, leveraging support from ILO's disability experts might be needed.
9. If funds allow, translate HealthWISE training materials in the local language and ensure interpreters are available for workshops. HealthWISE participants in Malawi reported that there had been some challenges related to the HealthWISE workshops and training materials being in English. As the modality involves including staff from different departments with different levels of education, this had created a few challenges for those who did not speak English. The participants had mitigated this by asking one of the trainers to provide interpretation. However, if funds allow, translating the training materials and providing interpretation in future would be beneficial.	ILO country offices	Medium Ongoing	Translation and interpretation costs would be incurred.

4.3 Lessons Learned

More detailed descriptions of the lessons learned are contained in annex 4.

1. Not securing complete funding for a 3 year programme limits opportunities for long-term planning and can reduce interest from stakeholders to participate.

4.4 Emerging Good Practices

More detailed descriptions of the emerging good practices are contained in annex 4.

1. Ensuring external collaborators contracted to implement programme activities are tasked with monitoring progress and measuring change helps address gaps in monitoring processes.
2. Involving senior management in the hospitals right from the start of HealthWISE ensures acceptance of the approach in targeted institutions.
3. The participatory approach to developing the programme, including ensuring line ministries beyond the ILO's traditional partner of the Ministry of Labour were involved in design.

External Collaboration Contract - Terms of Reference

Evaluating the relevance, effectiveness, efficiency and impact of the ILO component of the ILO-OECD-WHO Working for Health (W4H) programme at country level

I. Background and purpose

The Working for Health programme W4H is a joint initiative between the International Labour Organization (ILO), the Organisation for Economic Co-operation and Development (OECD) and the World Health Organization (WHO) through which the three agencies collaborate on and support the implementation of the recommendations of the 2016 United Nation Secretary-General's High-level Commission on Health Employment and Economic Growth to stimulate investment in the health and care workforce. The recommendations cover key ILO focus areas in the health sector, including job creation (especially for women and youth), gender equality, workers' rights, education and skills, social protection, social dialogue, and labour migration.

W4H provides technical support at country, regional and global level to governments, social partners and key stakeholders to expand and transform the global health and social workforce for achieving universal health coverage. This expansion and transformation of the health and social workforce contributes to advance progress on SDG 3 (health), SDG 4 (education), SDG 5 (gender) and SDG 8 (decent work).

Building on the experience and prior achievements from the first phase of the W4H programme (2018-2022), the ILO-OECD-WHO Working for Health MPTF was extended in 2023 until 2030 allowing ILO, OECD and WHO to continue its inter-agency collaboration. In the second phase of the programme (2022-2030), a series of three-year country projects (2024-2026) were developed. These projects aim to strengthen health and care workforce planning, policy, and coordination through multi-sectoral action, with a strong emphasis on addressing decent work deficits and broader employment challenges in the sector.

The internal evaluation led by the ILO focuses on the support provided by the ILO from January 2024 to the present for the following six (6) countries: Chad, Cameroon, Malawi, Kenya, Pakistan, and South Africa. The evaluation aims to assess the relevance, effectiveness, efficiency, sustainability, coordination, and management of ILO's support, along with lessons learned and emerging impact. It will also provide actionable recommendations for improving implementation and outcomes during the remainder of the 2024-2026 cycle and potential follow up projects.

II. Purpose, objectives & scope of the evaluation

Purpose

According to the ILO, evaluation is an essential component in the implementation of development cooperation projects. In the ILO, evaluations are primarily used as a management and organizational learning tool to help constituents and staff members support decent work

and social justice. As such, evaluation is a critical means to improve decision-making, generate knowledge in the organization and provide verifiable evidence of relevance, effectiveness, efficiency, orientation towards impact and sustainability.

Provisions for evaluation are made in all projects according to the ILO evaluation policy, as per the nature of the project and project specific conditions agreed upon during the design phase or as activities are being carried out. The results of this internal evaluation will also be taken into account for the internal mid-term evaluation of the entire W4H programme, which will be led by the WHO in collaboration with ILO and OECD.

Objectives

The internal evaluation of the ILO component will be used to:

- assess the achievement of project outcomes and outputs,
- assess key areas of success and lessons learned, as well as strengths and weaknesses in project design, strategy and implementation, and will generate recommendations for improvement. In doing so, the evaluation will consider project duration and financial resources allocation and sustainability.

More precisely the evaluation aims to:

1. **Relevance and Coherence:** Assess how well project activities align with national priorities, stakeholder needs, and related efforts by ILO, national actors, and partners like WHO.
2. **Effectiveness and Efficiency:** Evaluate the effectiveness in delivering expected outputs and outcomes, and review the efficiency of implementation, including resource use and coordination mechanisms.
3. **Orientation towards impact and Sustainability:** Assess the emerging impact on addressing health and care workforce challenges at the country level and evaluate the sustainability of project results and the likelihood of continued benefits post-completion.
4. **Interagency Collaboration:** Assess the collaboration between ILO and WHO, identifying gaps and opportunities to strengthen joint delivery toward the Working for Health goals.
5. **Lessons Learned and Good Practices:** Identify lessons learned, including challenges encountered and how they were addressed, and document good practices to inform other countries or future initiatives.
6. **Recommendations:** Provide clear, actionable recommendations to improve delivery for the remainder of the 2024–2026 cycle and guide potential follow-up projects.

Scope

In terms of the scope of the evaluation, the assessment will consider the extent to which the project contributed to ILO's Outcomes 1 - more specifically to **Outputs 1.5 Increased capacity of constituents, partners and stakeholders to implement sectoral international labour standards codes of practices, guidelines and tools** as well as relevant SGDs.

The evaluation will cover the implementation period from December 2023 to July 2025.

Geographically speaking, the internal evaluation will cover all six countries through desk review and synthesis of evidence, as well as through remote consultation, providing an overall assessment of ILO's support. It is expected that a more detailed, in-depth analysis for *two* selected countries, namely Malawi and Pakistan, be conducted to better understand context-specific

dynamics, results, and opportunities for learning and improvements. The assessment focus will be discussed with the evaluation manager at the evaluation inception phase.

III. Evaluation criteria and questions

The evaluation will apply the OECD-DAC criteria. A tentative list of questions is outlined below that will be refined and finalized at the inception phase by the evaluator:

► **Relevance and Coherence:**

- To what extent were the project's design and activities appropriate and responsive to national priorities, stakeholder needs, and the decent work challenges identified in each country?
- How well did the project's focus and approach align with the ILO's P&B outputs 1.5, DWCPs in selected countries?
- How effectively did the project design integrate cross-cutting issues, including gender equality, climate change, and the ILO's normative mandate?
- To what extent do the project activities complement related efforts by ILO, national actors, and partners like WHO?

► **Effectiveness and Efficiency:**

- To what extent have the expected outputs and outcomes been achieved and what factors have contributed to or hindered their achievement? How well were cross-cutting issues such as gender equality, climate change, and the ILO's normative mandate addressed throughout implementation?
- To what extent were project's financial and human resources utilized efficiently to achieve project outputs and outcomes?

► **Orientation towards Impact and Sustainability:**

- What are the emerging impacts of the project, and to what extent are these outcomes and benefits likely to be sustained beyond the project's completion?

► **Interagency Collaboration:**

- How effective has the collaboration between ILO and WHO been in supporting the project objectives at country level?
- What gaps or challenges have been identified in the interagency collaboration?
- What opportunities exist to strengthen joint delivery toward the Working for Health goals?

► **Lessons Learned and Good Practices:**

- What key lessons and good practices have been learned from the implementation of the project at country level and overall? How have considerations related to

gender equality, climate change, and the ILO's normative mandate informed or shaped good practices?

The evaluation process will address its relevance to the **ILO's cross-cutting issues**, including the promotion of International Labour Standards (ILS), the enhancement of social dialogue, the advancement of gender equality and non-discrimination, and just transition. Where possible, the methodology will ensure equal representation of women and men in the data collection phase. The evaluation will follow the ILO EVAL Guidelines on integrating gender equality and disability. It is expected that the selected evaluation consultant will operationalize the evaluation questions by taking these issues into consideration.

IV. Detailed tasks

The evaluator(s) will undertake the following key tasks:

- ▶ Conduct an inception phase, including review of project documents and consultations with ILO HQ and country colleagues to finalize the evaluation approach and questions.
- ▶ Develop an evaluation matrix, methodology, and data collection tools tailored to the project scope and objectives.
- ▶ Carry out a desk review of relevant project reports and background materials.
- ▶ Conduct remote interviews with key stakeholders, including ILO and WHO staff, ILO constituents, national partners, and beneficiaries.
- ▶ Analyze collected data, applying a mixed-methods approach to assess the evaluation criteria.
- ▶ Synthesize findings into a draft report, organized around the agreed evaluation questions.

The report will be developed according to the following ILO template:

- i. Title page
 - ii. Table of contents
 - iii. Abbreviations
 - iv. Executive summary
 - v. Background/project description
 - vi. Summary of project results/outcomes
 - vii. Purpose of evaluation
 - viii. Evaluation methodology
 - ix. Evaluation findings
 - x. Evaluation conclusions and recommendations
 - xi. Annexes
- ▶ Present preliminary findings to ILO HQ and country colleagues in an online validation meeting.

- Revise and finalize the report, integrating feedback and ensuring clarity and usability of recommendations.

The evaluation does not foresee any travel. However, as specified in the detailed tasks, the evaluator is expected to collect primary data through remote interviews and focus group discussions. It is foreseen that the evaluation will conduct 25-30 interviews for this assignment. The final number of interviews will be agreed upon during the inception phase.

V. Expected deliverables & timeline

The overall implementation timeframe will be 1 September 2025 – 15 November 2025. The specific timeline for the internal evaluation and respective deliverables will be as follows:

Deliverables	Date of Completion
<u>Deliverable 1: Inception report</u> (including refined evaluation questions, methodology, evaluation matrix, data collection tools, stakeholder list, and detailed work plan)	3 September 2025
<u>Deliverable 2: Draft evaluation report</u> (as a result of data gathering and full analysis structured around evaluation questions. The evaluation report is to include findings, conclusions, lessons learned, good practices, and draft recommendations)	15 October 2025
<u>Deliverable 3: Slide deck</u> summarizing key findings for meeting with ILO HQ and country office colleagues	30 October 2025
<u>Deliverable 4: Final Evaluation Report</u> (revised report incorporating stakeholder feedback, with actionable recommendations and an executive summary)	10 November 2025
Contract end-date	15 November 2025

The deliverables should be written in English and submitted as a Microsoft Word document. The finale evaluation report should have a volume of 10,000 – 15,000 words and should be formatted according to the latest edition of the ILO’s House Style Manual.

VI. Reporting arrangements

The consultant will work under the overall supervision of ILO SECTOR/SERVICES, Maren Hopfe, and Alessandra Scmazzon, SECTOR Evaluation Focal person, in collaboration with the respective ILO offices in Dar-es-Salaam, Lusaka, Islamabad, Yaoundé, and Pretoria.

The Consultant will be required to report to ILO. All materials produced by the Consultant will be reviewed by ILO for technical quality assurance and might be shared with Governments and constituents as ILO product supported by ILO-OECD-WHO Working for Health Programme.

VII. Detailed qualifications, experience and skills required

- Advanced degree in social sciences, health and/or labour policy, or a related field.

- ▶ At least 7 years of experience in evaluating development projects, preferably in OSH, labour rights, governance or health.
- ▶ Knowledge of ILO Conventions, labour policies and preferably health and care worker challenges.
- ▶ Proven experience in using mixed-method evaluations.
- ▶ Excellent analytical and report-writing skills.
- ▶ Fluency in English.

VIII. Indicators for evaluation of outputs

1. Timeliness

All deliverables (inception report, draft report, slide deck, final report) are submitted within the deadlines agreed in the work plan, with no more than one justified delay.

2. Achievement of deliverables

100% of contractual deliverables are completed and accepted by the ILO, including the in-depth analysis for Malawi and Pakistan.

3. Quality of deliverables

The final evaluation report meets the ILO quality standards on final report submission, requiring no more than one round of revisions.

IX. Payment terms

The contract will be issued in USD and payments will be made upon satisfactory delivery and acceptance of the agreed outputs, in line with the deliverables and timeline outlined in the ToR.

The consultant's daily fee will be determined based on the ILO fee structure, which takes into account the consultant's duty station/location, the complexity of the assignment, and the level of education and professional experience.

Payments will be made in accordance with the ILO's external collaboration contract regulations and upon submission of valid invoices.

The payment schedule is as follows:

- ▶ 20% upon submission and approval of the inception report, including the detailed work plan, methodology, and evaluation matrix.
- ▶ 80% upon submission and acceptance of the final evaluation report, incorporating feedback from ILO and stakeholders, and meeting quality requirements.

The final payment is conditional upon acceptance of the final report, confirmation that all deliverables have been met, and satisfactory performance based on the evaluation criteria.

X. Legal and ethical matters

The internal evaluation will comply with UN Norms and Standards. The evaluator will abide by the EVAL's Code of Conduct for carrying out evaluations. UNEG ethical guidelines will be

followed. The evaluator should not have any links to project management, or any other conflict of interest that would interfere with the independence of the evaluation.

Annex 2: Evaluation Matrix

Relevance and Coherence			
Question	Indicators/Lines of Enquiry	Data Sources	Method
To what extent were the project's design and activities appropriate and responsive to national priorities, stakeholder needs, and the decent work challenges identified in each country?	Evidence of needs assessments in the design of the projects. Examples of consultation with tripartite constituents and other key stakeholders. Were stakeholders satisfied the key needs were addressed? Alignment with national policies / action plans	Project documents Relevant national/sectoral policies Representatives of tripartite constituents and other stakeholders ILO staff	Document review (all countries) KIIs (Malawi and Pakistan)
How well did the project's focus and approach align with the ILO's P&B outputs 1.5, DWCPs in selected countries, and the SDGs?	Alignment with key points in paragraph 80 of the 2024-25 P&B. Which areas of the DWCPs do the projects align with? How effectively do the projects align with SDG targets 3.c, 5.1, 5.2, 5.4, 5.c., 8.5, and 8.8?	Project documents ILO documents	Document review
How effectively did the project design and implementation integrate cross-cutting issues, including gender equality and non-discrimination, climate change, and the ILO's normative mandate?	Evidence of gender equality being mainstreamed into policies. Inclusion of gender disaggregated monitoring Have issues of non-discrimination, such as the inclusion of persons with disabilities been considered in the project?	Project documents ILO documents Tripartite constituents and other key stakeholders ILO staff	Document review (all countries) KIIs (Malawi and Pakistan)

	Has the project considered climate change and environmental sustainability in its activities? How does the project align with the ILO's normative framework, including with the Declaration on FPRW and key ILO conventions such as C149, C190, C.100, C.111, C155, and C187. Has the project supported moves to ratify any conventions?		
Effectiveness and Efficiency			
To what extent have the expected outputs and outcomes been achieved and what factors have contributed to or hindered their achievement?	Planned activities vs actual results Has the project achieved outcomes as well as outputs? Is there an M&E framework and / or theory of change that enables the ILO to monitor progress and change from the project? What are the key strengths and weaknesses of the project?	Project documents Tripartite constituents and other key stakeholders ILO staff	Document review (all countries) KIIs (Malawi and Pakistan)
To what extent were project's financial and human resources utilized efficiently to achieve project outputs and outcomes?	Have the projects leveraged non-financial resources? Examples of utilisation of previously developed resources? Has SECTOR coordinated effectively with other branches of the ILO? How has the project addressed limitations on funding in 2025 & 26?	Project documents ILO staff	Document review (all countries) KIIs with ILO staff
Sustainability and Likelihood of Impact			
What are the emerging impacts of the project?	What changes can project participants identify? Have there been policy and guideline changes?	Project documents Tripartite constituents and other key stakeholders	Document review (all countries) KIIs (Malawi and Pakistan)

	Is there a system for identifying the changes?	ILO staff	
What extent are these outcomes and benefits likely to be sustained beyond the project's completion?	Have project partners adapted working plans, guidelines, and policies that will ensure attention to the project's goals continue after the project? Have partners identified the necessary funding to continue to implement these?	Tripartite constituents and other key stakeholders ILO staff External documents/websites	Document review (all countries) KIIs (Malawi and Pakistan)
Interagency Collaboration			
How effective has the collaboration between ILO and WHO been in supporting the project objectives at country level?	To what extent do the project activities complement related efforts by ILO, national actors, and partners like WHO?	ILO staff WHO staff Key partners External stakeholders	Document review (all countries) KIIs (Malawi and Pakistan)
What gaps or challenges have been identified in the interagency collaboration?	How has the ILO attempted to address these?	ILO staff WHO staff External stakeholders	Document review (all countries) KIIs (Malawi and Pakistan)
What opportunities exist to strengthen joint delivery toward the Working for Health goals?	Based on data from the previous questions.		

Annex 3: List of Interviews Conducted

Name	Position	Role in the Project	Organisation	Gender (M/W)	Interview Type	Location
ILO						
Oliver Liang	Head of Unit; Senior specialist: Education, media, culture, sports	W4H secretariat	SECTOR, ILO	M	Individual	Geneva
Maren Hopfe	Technical Officer: Health services	W4H secretariat	SECTOR, ILO	W	Individual	Geneva
Sibia Tracy Mjumira	National Project Officer	Focal point W4H HealthWISE	ILO	W	Group	Malawi
Patrick Makondesa	National Project Coordinator	Focal point W4H Skills study	ILO	M		Malawi
Simphiwe Mabhele	HIV & AIDS Technical Specialist	Backstopping from Pretoria for Malawi and South Africa focal point	ILO	M		South Africa
Rabia Razzaque	Senior Programming Officer	Focal point W4H	ILO	W	Individual	Pakistan
Roohiya Qazi	National Project Officer	W4H NOA	ILO	W	Individual	Pakistan
Mady Diagne	Labour Administration and Social Dialogue Technical Specialist	Focal point for Chad and Cameroon	ILO	M	Individual	Cameroon
Hellen Magutu	National Programme Coordinator	Focal point for Kenya	ILO	W	Group	Kenya
Malawi						
Peter Chalusa	Health Systems Technical Officer	Representative from WHO in the W4H programme	WHO	M	Individual	Malawi
Blessings Chigowo	Human Resources and Development Officer	W4H Task Team	Ministry of Education	M	Individual	Malawi
Jessy Ching'oma	Deputy Director for Organising, Gender and Education	W4H Task Team	Malawi Congress of Trade Union	F	Individual	Malawi
Veronica Ngoma	OSH Directorate Officer- MoH	W4H Task Team	Ministry of Health	F	Individual	Malawi
Liness Chinyamunyanu-	Nurse	HealthWISE beneficiary	Mponela Rural Hospital	F	Group	Malawi

Charity Nkhukuzalira	Nurse	HealthWISE Trainer	Salima District Hospital	F		
Verydear Chilapondwa	Nurse / Matron	HealthWISE Trainer / Interpreter	Mponela Rural Hospital	F	Group	Malawi
Mavuto Nyambi	Senior Medical Officer	HealthWISE Trainer	Ntchisi District Hospital	M		
Patrick Kumwenda	Nurse	HealthWISE Trainer	Chezi Health Center	M		
Maurice Benard	Security Guard	HealthWISE Trainer	Chezi Health Center	N		
Pakistan						
Dr Fatima Asim Shah	Director (Reforms)	Focal point for ILO	Punjab Employees Social Security Institution (PESSI)	F	Individual	Pakistan
Prof Dr Shahzad Ali Khan	Vice Chancellor	Focal point for ILO	Health Services Academy (HSA)	M	Group	Pakistan
Prof Dr Mati ur Rehman	Member, Board of Authority, IHRA	Focal point for ILO	Islamabad Healthcare Regulatory Authority (IHRA)	M		
Dr Saira Saggu Qudus	Healthcare Quality and Patient Safety Lead	Master Trainer, HealthWISE	Capital Hospital (CDA) Islamabad and PESSI	F	Group	Pakistan
Saeed Pasha	Training Consultant		Federal General Hospital Islamabad and MSDS revision	M		
Ch. Anwar	Quality, Health, Safety & Environment expert		Rawal Family Health Hospital Islamabad	M		

Zafar Akhtar	Public Sector Manager		Rawal General & Dental Hospital Islamabad	M		
Dr Sumbul Fouz	Medical Superintendent	Focal point for HealthWISE	Family Health Hospital Islamabad	F	Individual	Pakistan

The ILO component of the ILO-OECD-WHO Working for Health (W4H) programme at country level

Internal evaluation

Project DC/SYMBOL: GLO/23/32/UND

Name of Evaluator: Chris Morris

Date: 09 December 2025

The following lesson learned has been identified during the course of the evaluation. Further text explaining the lesson may be included in the full evaluation report.

LESSON LEARNED ELEMENT	TEXT
Brief description of lessons learned	Not securing complete funding for a 3 year programme limits opportunities for long-term planning and can reduce interest from stakeholders to participate.
Context and any related preconditions	Obtaining funding for the Working for Health programme has proved challenging and funds identified are much less than what was hoped for.
Targeted users / Beneficiaries	ILO and WHO programme designers
Challenges /negative lessons - Causal factors	The programme has been unable to plan for a full three year implementation period. This particularly hampers work on policy changes and prevents the ILO being able to guarantee longer term technical support to constituents and other stakeholders.
Success / Positive Issues - Causal factors	The programme has still managed to utilise resources effectively and build on the relationships developed by the country offices in other projects and previous phases of this programme
ILO Administrative Issues (staff, resources, design, implementation)	

The ILO component of the ILO-OECD-WHO Working for Health (W4H) programme at country level

Internal evaluation

Project DC/SYMBOL: GLO/23/32/UND

Name of Evaluator: Chris Morris

Date: 09 December 2025

The following emerging good practice has been identified during the course of the evaluation. Further text can be found in the full evaluation report.

GOOD PRACTICE ELEMENT	TEXT
Brief summary of the good practice (link to project goal or specific deliverable, background, purpose, etc.)	Ensuring external collaborators contracted to implement programme activities are tasked with monitoring progress and measuring change helps address gaps in monitoring processes.
Relevant conditions and Context: limitations or advice in terms of applicability and replicability	HealthWISE trainers in Pakistan were tasked with producing reports of the HealthWISE process as part of their external collaboration contracts. These included initial reflections on the changes the hospitals had made as a result of the assessments and action plans. The monitoring is limited to the contract period. This was often fairly short, meaning the longer term changes, successes and challenges are not captured in the reports.
Establish a clear cause-effect relationship	The reports include information on changes.
Indicate measurable impact and targeted beneficiaries	Impact can be measured by before and after photos and qualitative interviews.
Potential for replication and by whom	Directly, it can be replicated by other programmes implementing HealthWISE, but the practice could be applied to many external collaboration contracts.
Upward links to higher ILO Goals (DWCPs, Country Programme Outcomes or ILO's Strategic Programme Framework)	The practice would help support the evaluability of programmes
Other documents or relevant comments	

The ILO component of the ILO-OECD-WHO Working for Health (W4H) programme at country level

Internal evaluation

Project DC/SYMBOL: GLO/23/32/UND

Name of Evaluator: Chris Morris

Date: [Click here to enter a date.](#)

The following emerging good practice has been identified during the course of the evaluation. Further text can be found in the full evaluation report.

GOOD PRACTICE ELEMENT	TEXT
Brief summary of the good practice (link to project goal or specific deliverable, background, purpose, etc.)	Involving senior management in the hospitals right from the start of HealthWISE ensures acceptance of the approach in targeted institutions.
Relevant conditions and Context: limitations or advice in terms of applicability and replicability	Several Master Trainers reported that the senior management of the hospitals were involved in the initial planning for HealthWISE and as a result were supportive of the initiative. This helped encourage other staff to actively participate in the activities.
Establish a clear cause-effect relationship	Staff were given time to participate in the training and implement the action plan.
Indicate measurable impact and targeted beneficiaries	Behaviour change was identified in the pilot institutions that had contributed to improvements in the working environment for health and care workers.
Potential for replication and by whom	Programmes implementing HealthWISE.
Upward links to higher ILO Goals (DWCPs, Country Programme Outcomes or ILO's Strategic Programme Framework)	P&B 2024-25, output 1.5
Other documents or relevant comments	

The ILO component of the ILO-OECD-WHO Working for Health (W4H) programme at country level

Internal evaluation

Project DC/SYMBOL: GLO/23/32/UND

Name of Evaluator: Chris Morris

Date: [Click here to enter a date.](#)

The following emerging good practice has been identified during the course of the evaluation. Further text can be found in the full evaluation report.

GOOD PRACTICE ELEMENT	TEXT
Brief summary of the good practice (link to project goal or specific deliverable, background, purpose, etc.)	The participatory approach to developing the programme, including ensuring line ministries beyond the ILO's traditional partner of the Ministry of Labour were involved in design.
Relevant conditions and Context: limitations or advice in terms of applicability and replicability	The programme works with the healthcare sector which has several line ministries with responsible for different aspects of operations. The Ministries of Health, Labour, and Education in particular are involved. The programme managed to ensure support from the different ministries by actively involving them in planning and monitoring of the programme. Additionally, the social partners and other stakeholders were also involved in the planning process, strengthening their ownership of the programme as well.
Establish a clear cause-effect relationship	Different stakeholders have remained engaged with the programme.
Indicate measurable impact and targeted beneficiaries	The programme as a whole has benefitted from this approach.
Potential for replication and by whom	Programme implementers which require input of stakeholders outside of the traditional tripartite constituents.
Upward links to higher ILO Goals (DWCPs, Country Programme Outcomes or ILO's Strategic Programme Framework)	P&B 2024-25, output 1.5
Other documents or relevant comments	

Annex 5: Interview Guides

Examples of the interview guides are included below. Given the wide range of stakeholders to be interviewed, the questions were adapted depending on the role of the stakeholder.

Government Stakeholders

1. Could you introduce yourself and describe the responsibilities of your ministry/department and your role in it?
2. What involvement have you had in the ILO's W4H project?
3. How does the W4H project align with the priorities of your Ministry/Department?
4. What are the main challenges facing healthcare workers in accessing a decent and safe work environment?
5. How does the project address these?
6. What are the key strengths and weaknesses of the project?
7. How effectively have you seen the ILO been in coordinating with different stakeholders including different ministries, provincial level authorities, workers representatives, hospitals etc?
8. In your opinion, how effective has the ILO been in coordinating with WHO and other UN agencies? Do you think there are any areas where coordination between the UN agencies could be improved?
9. Are there improvements in dialogue between different parties you can identify?
10. What changes do you think the project has contributed to?
11. How can these changes be sustained? Has the department made any steps to include activities in future budgets?
12. What recommendations do you have for ILO for future work in this field?

Hospital Management

1. Could you introduce yourself and describe your role in the hospital?
2. What are the main challenges regarding OSH, working conditions in general, personnel management, and environmental health in your hospital? (probe for crosscutting themes too)
3. How did your institution come to be involved in HealthWISE?
4. How has your institution participated in HealthWISE?
5. Who is responsible within the hospital for implementing HealthWISE? What different roles are involved?
6. How are lessons/practices from the HealthWISE training being applied in your hospital? And in what ways have Master Trainers or other staff been able to share these learnings with colleagues? (probe why or why not they have been able to use HealthWISE)
7. What do you think are the strengths of HealthWISE?
8. What do you think are the challenges of HealthWISE?
9. What changes have occurred in the hospital as a result of the project? (probe for crosscutting themes too)
10. Has the project contributed to any changes in relationships between workers and management?
11. How satisfied have you been with the support of the ILO?
12. What plans do you have for continuing to implement HealthWISE in the future?

13. Do you have any recommendations for the ILO?

HealthWISETrainers (Group Interview)

1. Could you introduce yourself and describe your role in the training/hospital?
2. What do you understand are the main challenges regarding working conditions, OSH, personnel management, and environmental health in the health sector? (probe for crosscutting themes too)
3. How did you come to be involved in HealthWISE?
4. What have you been trained on?
5. What are your responsibilities in terms implementing HealthWISE?
6. In your understanding, how have the hospitals been able to implement HealthWISE since the training? (probe for how they have implemented and concrete examples) Have you been able to train others?
7. In your view, what aspects of HealthWISE have worked particularly well or been most useful? Why? How does HealthWISE promote this? What do you think are the challenges of HealthWISE or things that have not worked well? Why? What are the barriers?
8. What changes do you understand have occurred in the hospitals as a result of the project? (probe for crosscutting themes too)
9. Has the project contributed to any changes in relationships between government, workers and management?
10. Do you think that HealthWISE could be used more broadly in Pakistan/Malawi? What lessons learned do you think there are that would help with increasing the use of HealthWISE?
11. How satisfied have you been with the support of the ILO?
12. What plans do you have for continuing to implement HealthWISE in the future?
13. Do you have any recommendations for the ILO?

HealthWISE Participants (Group Interview)

1. Could you introduce yourself and describe your role in the training/hospital?
2. What are the main challenges regarding working conditions, OSH, personnel management, and environmental health in your hospital? (probe for crosscutting themes too)
3. How did you come to be involved in HealthWISE?
4. What have you been trained on?
5. What are your responsibilities in terms implementing HealthWISE?
6. Have you been able to implement the learning in your hospital? (probe for how they have implemented and concrete examples)
7. In your view, what aspects of HealthWISE have worked particularly well or been most useful? Why? How does HealthWISE promote this? What do you think are the challenges of HealthWISE or things that have not worked well? Why? What are the barriers?
8. What changes have occurred in the hospital as a result of the project? (probe for crosscutting themes too)
9. Has the project contributed to any changes in relationships between workers and management?
10. How satisfied have you been with the support of the ILO?
11. What plans do you have for continuing to implement HealthWISE in the future?
12. Do you have any recommendations for the ILO?