

Achieving the MDGs by Investing in Human Resources for Health

The following is a shortened version of a paper that presents evidence that the health-related MDGs can only be achieved by focusing more on health workers, and offers extensive recommendations for the MDG action agenda on the health workforce and developing equitable and accountable health systems.

Full paper available at:

<http://physiciansforhumanrights.org/library/report-2010-5-20.html>

Introduction: The UN Secretary-General report on progress towards the MDGs, *Keeping the Promise*, recognizes that health workers are of “paramount importance to speed up progress where current trends make achievement of the [MDGs] unlikely.”¹ The Secretary-General affirmed what leading health authorities such as the WHO, national health authorities, and health program implementers themselves have recognized: one of the greatest obstacles to achieving the health MDGs – in particular MDGs 4 (child survival), 5 (maternal health), and 6 (combat major diseases), as well as 1c (reduce hunger) – is the deep and persistent shortage of health workers.

Without more – and smarter – investments in the health workforce, the health MDGs will remain out of reach for many countries, and many people’s lives will needlessly, tragically, be lost.

Progress in some countries demonstrates rapid scale-up of the health workforce is possible,² and that investments in improving how health workers are managed and how they are distributed within countries enhance the performance and reach of the existing workforce.³ If the final five years of the MDGs include a greater commitment to and investment in strengthening the health workforce, these successes can be replicated and built upon.

Global Health Worker Estimates: In its *World Health Report 2006*, WHO determined that countries below a threshold of 2.3 doctors, nurses, and midwives for every 1,000 people were “very unlikely” to achieve the MDGs.⁴ Fifty-seven countries fell below this threshold. This amounted to a critical global shortage of nearly 2.4 million nurses, doctors, and midwives, and nearly 4.3 million health workers overall.⁵

In 2009, the High Level Taskforce on Innovative International Financing for Health Systems offered two estimates on health worker needs to achieve the MDGs. One, developed by WHO, found that 3.5 million more health workers (plus additional managers and administrators) across 49 low-income countries were required to accelerate MDG progress while also expanding coverage for other diseases and contributing to the hunger target in MDG 1.⁶ The second set of calculations, by the World Bank and other institutions, found that these same countries required 2.6-2.9 million additional health workers, including managers.⁷

Only with a significant scale-up in the health workforce, including through investments in pre-service training capacity and health worker retention, can a significant number of countries meet the health MDGs. Other health workforce dimensions also must be addressed, such as equitable distribution, skills mix, motivation, management, productivity, and migration).

MDG 1 – Reducing hunger: Community health workers (CHWs) have an important role in addressing malnutrition, including educating community members on proper nutrition, identifying cases of pediatric malnutrition, treating and monitoring child malnutrition, providing micronutrient and other nutritional supplementation, and where health facility-based treatment is required, monitoring the condition of the child once discharged from the hospital. Other health workers have important roles as well.

MDG 4 – Child survival: Health workers are the bridge between children and the well-known, often simple interventions – such as immunizations and oral rehydration therapy for diarrhea – that will save their lives. WHO’s *World Health Report 2005* (WHR 2005) emphasizes the need for more health workers, estimating that 4.6 million community health workers and the equivalent of 100,000 – and possibly many more – additional health professionals are required to scale up child health activities. Other calculations have found that most countries that do not have at least 150 qualified health workers per 100,000 population fail to achieve 80% coverage for measles immunizations.⁸

MDG 5 – Maternal health: The WHR 2005 stated that “[p]utting in place the health workforce needed for scaling up maternal, newborn and child health services towards universal access is the first and most pressing task.”⁹ To reduce maternal mortality, properly trained nurse-midwives and other skilled personnel who can assist with childbirth are needed. So too are doctors, non-physician clinicians, specially trained nurses, and health workers able to provide anesthesia to provide back-up emergency obstetric care. Non-physician clinicians (e.g., clinical officers) have a particularly important role in extending emergency obstetric care into rural areas.

CHWs have important roles as well, including to sensitize community members to the importance of pre- and post-natal care and of having a skilled health worker attend births and to reduce women’s risk of maternal death in other ways, such as by improving access to family planning information and commodities, providing insecticide-treated bed nets, and recognizing and managing anemia.^{10 11}

WHO has estimated that achieving 95% coverage for maternal and newborn health interventions in 51 high-burden countries requires more than 2 million additional health workers.¹²

MDG 6 – Major diseases: Few issues placed the health workforce more squarely on the

international map than the efforts to rapidly scale up AIDS treatment in the face of significant health worker shortages. A full range of health workers, including doctors, nurses, non-physician clinicians, laboratory and pharmacy staff, community health workers including people living with HIV/AIDS, and managers, all have vital roles in the AIDS response. Health workers must be legally empowered, and properly trained and supported, to provide services under a task-shifting approach, such as enabling nurses to initiate anti-retroviral therapy.

Tuberculosis program managers and others involved in the TB response have recognized that health worker shortages are among the top constraints to meeting TB program targets,¹³ including to expand programs to address drug-resistant tuberculosis.

An enhanced malaria response will also require addressing health workforce needs, including expanding the community health workforce to educate communities on malaria, distribute insecticide-treated bed nets, diagnose malaria, and treat uncomplicated cases of malaria.

Abbreviated Recommendations for the Action Agenda for Achieving the MDGs

We urge the following commitments and steps to be included in the action agenda for achieving the MDGs that will be agreed to at the UN MDG Summit in September 2010. **The unabridged list recommendations can be found in the full paper.**

Recommendation #1: Commit to health workforce targets required to achieve the MDGs

Overall HRH targets: Commit to an ambitious target to increase the number of health workers. This target should be feasible and drawn from the best available estimates of global health worker needs to achieve the MDGs. The target for 2015 and possibly beyond should be incorporated into the action agenda for achieving the MDGs. The action agenda should include health worker benchmarks to be achieved before 2015.¹⁴

Increase coverage of skilled health workers at and immediately after birth: Commit to a significant increase in the coverage and number of properly trained skilled health workers at birth and of health workers with the skills needed to provide back-up emergency care, including non-physicians clinicians.

Community and mid-level health workers: Commit to developing the community-level health workforce, including by rapidly scaling up community health workers and mid-level health workers in conjunction with scaling up more highly skilled health workers.

Reduce inequalities in health worker distribution: Commit to an ambitious target to reduce internal inequities in health worker distribution, in particular between urban and rural areas (and other nationally defined hard-to-reach or particularly underserved areas), to move rapidly towards an equitably distributed health workforce.

Recommendation #2: Significantly increase health workforce and health system investments

Health workforce investments: Develop benchmarked commitments on the health workforce investments required to achieve health workforce targets and to fully fund national health workforce strategies, and a process to develop a common method to measure and track these investments to ensure accountability.

Increased domestic health spending and development assistance: Developed nations should rapidly increase official development assistance to at least 0.7% GNP, and create very near-term timelines for reaching this target. Developing countries should significantly increase health spending. African countries should develop timelines to rapidly scale up health spending to at least 15% of the government's budget, per the 2001 Abuja Declaration commitment.

Introduce financial transaction taxes: Implement a currency transaction levy (particularly on major currencies) and other financial transaction taxes for

improving global health, fighting poverty, and addressing climate change.

More flexible macroeconomic policies: Commit to develop more flexible, expansionary fiscal and monetary policies (including as they relate to fiscal deficit, currency reserve, and inflation targets), developed through inclusive and participatory processes, that enable greater health and other social expenditure by the government. These policies will help enable countries to use international funding to add to rather than replace domestic funding for health and its determinants.

Recommendation #3: Develop and implement robust and comprehensive HRH strategies

Comprehensive approach: Commit to implementing the comprehensive approach to health workforce strengthening as laid out in the Kampala Declaration and Agenda for Global Action.¹⁵

Robust and rights-based health workforce plans: Commit to have in place by 2012, developed through an inclusive multi-stakeholder, multi-sector process, comprehensive national health workforce plans that are "costed and evidence-informed, consistent with human rights principles, including gender sensitivity, and based on projected needs,"¹⁶ and include robust, participatory, monitoring and evaluation processes to ensure progress and to rectify any shortcomings in the plans or their implementation.

Human resource management: Commit to strengthening human resource management to ensure health workers feel appreciated and understand their responsibilities, better match health workforce demands to health worker distribution, broaden the scope of health worker roles and redistribute tasks as appropriate (task-shifting), improve productivity, ensure supportive supervision, strengthen the links between the clinic and community as well as between different departments (including health, finance, education, civil service, labor, and gender), and implement performance-based management systems.

Health leadership and management: By 2012, develop and begin to implement a comprehensive strategy to strengthen leadership and management at all levels and in all aspects of the health system.

Code of Practice: Commit to fully implementing the WHO code of practice on the international recruitment of health personnel.

Recommendation #4: Develop participatory, inclusive, and effective accountability mechanisms for health services

Community-level accountability mechanisms: Commit to, by 2012, map in communities the existence and functionality of community-level health service accountability mechanisms, such as village health committees, health facility management boards, and formal arrangements for community monitoring and feedback. Commit to, by 2014, having developed and begun to implement plans to strengthen these mechanisms and establish at least one form of health accountability mechanisms in all communities.

Civil society organization capacity building: Affirm the important role of civil society organizations and communities in holding governments to their commitments, including to achieve the MDGs and to meet human rights obligations (including securing the rights of marginalized populations). Commit to greatly increased capacity building of and funding to support civil society and community initiatives that seek to build accountability from the ground up, and to effectively engage governmental planning, budgeting, and monitoring and evaluation processes. Remove any laws restricting civil society organizations' ability to hold governments accountable.

Human rights education: Commit to, by 2012, develop and begin to implement strategies to increase people's knowledge of their human rights, including the right to health and other health-related rights. Government and civil society education efforts should ensure that people understand their government's right to health obligations, such as to include them in health-related decision-making, to develop equitable and

non-discriminatory health systems, and to spend the maximum of available resources towards progressively achieving this and other rights, as well as people's right to non-discriminatory, respectful, confidential care. Also train health workers on human rights.

Audit program for MNCH: Commit for all countries to develop national strategies to audit maternal, newborn, and child deaths, emphasizing their fact-finding rather than fault-finding primary purpose, as mechanisms to capture the structural and systematic factors that must be addressed to reduce maternal, newborn, and child deaths. Engage communities and health workers in the auditing process.

Recommendation #5: Enable poor, marginalized, and remote populations to access health services

Marginalized population MDG sub-targets: Adopt, wherever possible, specific sub-targets for achieving the MDGs not only at the aggregate country level, but also specifically among the poorest members of the population and other excluded or marginalized groups (for example, reducing maternal mortality by $\frac{3}{4}$ for the lowest income quintile).

Remove financial and other barriers to access: Commit to removing user fees on health services in developing countries on an accelerated basis. They should be replaced by equitable health financing schemes that raise necessary health funding (through increased domestic health spending, complemented as needed by long-term, predictable development partner support), including for health facilities that may have partially depended on user fees. Prioritize removing other barriers to health services.

Address discriminatory laws and practices: Commit to an accelerated timeline to identify and change laws and policies that discriminate against or fail to adequately protect the rights of marginalized populations. Replace these with and robustly enforce rights-protective laws and policies. Develop or adapt multilateral mechanisms to promote and monitor these changes and support their implementation.

¹ UN Doc. A/64/665, *Keeping the promise: A forward-looking review to promote an agreed action agenda to achieve the Millennium Development Goals by 2015: Report of the Secretary General* (Feb. 12, 2010), at para. 64. Available at:

http://www.un.org/ga/search/view_doc.asp?symbol=A/64/665

² In Malawi, an Emergency Human Resource Programme led to rapid increases in the number of health workers in post, and an overall increase in physicians by 137% from 2004 to 2009, following 30%, 40%, and 50% increases of, respectively, nurses, doctors, and clinical officers in post from 2003 to 2007. Combined with other health system investments, access to the Essential Health Package expanded from 9% to 74% of facilities, and access to basic emergency obstetric services increased from 2% to 56%, from 2004 to 2009, while AIDS treatment expanded exponentially as well. Powerpoint presentation by Hilario R. Chimota, Controller of Human Resources Management and Development, Ministry of Health, Malawi, *Country Co-ordination Mechanisms for addressing the Human Resources for Health (HRH) Situation in Malawi*, presented Oct. 26, 2009, Accra, Ghana, at slide 10; Global Health Workforce Alliance Task Force on Scaling up Education and Training of Health Workers, *Country Case Study: Malawi's Emergency Human Resources Programme* (2008), at 2. Available at:

http://www.who.int/workforcealliance/knowledge/case_studies/Malawi.pdf. Ethiopia began to implement a plan to train Health Extension Workers – female community health workers who are salaried and receive one year of training – in 2004, and by 2009, had trained more than 30,000 Health Extension Workers. Global Health Workforce Alliance, *Country Case Study: Ethiopia's Human Resources for Health Programme* (2008). Available at: http://www.who.int/workforcealliance/knowledge/case_studies/Ethiopia.pdf; UNICEF, *Malaria testing and treatment for Ethiopians in remote regions* (Nov. 25, 2009). Available at: http://www.unicef.org/infobycountry/ethiopia_51921.html.

³ For example, in Ghana, a Community-Based Health Services and Planning initiative has brought health workers into underserved communities, including by deploying nurses (community health officers) to community health compounds. In one district, for example (Birim North), child immunization coverage tripled, the TB treatment defaulter rate decreased from 73% in 2001 to 0% at the end of 2004, and maternal and child mortality rates decreased significantly. Capacity Project, *Providing Doorstep Services to Underserved Rural Populations: Community Health Officers in Ghana* (Oct. 2006), at 8. Available at: http://www.capacityproject.org/images/stories/files/community_health_workers_ghana.pdf. A mix of allowances and other incentives has helped attract health professionals to and retain them in rural areas in Zambia. The U.S. global AIDS program reported that some of its initial support for this program, which enabled 30-35 additional physicians to serve in rural areas, brought AIDS treatment to 5,000 people who would otherwise have had no treatment. Office of the Global AIDS Coordinator, *The President's Emergency Plan for AIDS Relief Report on Work Force Capacity and HIV/AIDS* (July 2006), at 12. Available at:

<http://www.state.gov/documents/organization/69651.pdf>

⁴ World Health Organization (WHO), *World Health Report 2006* (2006), at xviii. See also Joint Learning Initiative, *Human Resources for Health: Overcoming the Crisis* (2004), at 23. ("Overcoming the constraint of human resources is necessary but alone insufficient for accelerating progress toward the MDGs"). Available at: http://www.who.int/hrh/documents/JLI_hrh_report.pdf

⁵ *Id.* at 11-13.

⁶ Under the WHO funding scenario, MDG targets on child health and maternal mortality would be achieved by 39 and 22 countries, respectively, coverage of services for HIV/AIDS, tuberculosis, and chronic diseases would expand, and global malaria targets would be achieved. WHO, *WHO Report submitted to Working Group I of the High Level Taskforce on Innovative International Financing for Health Systems* (2009), at 2-3. Available at: http://www.who.int/choice/publications/d_ScalingUp_MDGs_WHO_report.pdf. This scenario would also include investments in nutrition that would contribute to achieving the hunger target in MDG 1. *Id.* at 35, 37, 50.

⁷ World Bank, UNICEF, UNFPA & PMNCH, *Health Systems for the Millennium Development Goals: Country Needs and Financing Gaps: Background document for the Taskforce on Innovative International Financing for Health Systems Working Group 1: Constraints to Scaling Up and Costs, Final Draft* (Oct. 2009), at 70-71. Available at:

http://www.internationalhealthpartnership.net/CMS_files/documents/wb_unicef_unfpa_pmnch_background_to_constraints_to_scaling_up_and_costs_EN.pdf

⁸ Phyllida Brown, "The health service brain drain – what are the options for change?" *Immunization Focus* (Oct. 2003).

⁹ WHO, *World Health Report 2005* (2005), at 7. Available at: <http://www.who.int/whr/2005/en/index.html>

¹⁰ In the Uganda village of Ruhira, a Millennium Village, community health workers sensitized community members on the importance of skilled care at birth and delivering in health units. A health facilitator with the Millennium Village Project in Uganda reports that this increased the number of women giving birth in health units, with skilled care available, from five to fifty (per year). Email communication from Muhereza Christostome, Health facilitator, UNDP/MVP-Ruhira, Uganda. April 20, 2010. Posted to Health Information for All by 2015 listserv. Available at:

<http://dgroups.org/ViewDiscussion.aspx?c=e95b885f-14b0-4452-a819-06cf188ee6b0&i=d9cb65ef-2dfa-417e-811c-5d8a6366ae45>

¹¹ Zulfiqar A. Bhutta, Zohra S. Lassi, George Pariyo & Luis Huicho, *Global Experience of Community Health Workers for Delivery of Health Related Millennium Development Goals: A Systematic Review, Country Case Studies, and Recommendations for Scaling Up* (2010), at 62-63.

¹² MDG 4&5 Costing and Impact Estimate Group (UNFPA, UNAIDS, Aberdeen University, Southampton University, Johns Hopkins University & NORAD), *Approach taken to update WHR 2005/MNCH+FP costs for the first year report of The Global Campaign For The Health MDGs* (2008).

¹³ José Figueroa-Munoz, Karen Palmer, Mario R Dal Poz, et al. "The health workforce crisis in TB control: a report from high-burden countries." *Human Resources for Health* (Feb. 24, 2005) 3:2. Available at: <http://www.human-resources-health.com/content/3/1/2>

¹⁴ Work is currently underway to develop the appropriate target based on the identified need, as well as benchmarks and sub-targets.

¹⁵ Global Health Workforce Alliance, *Kampala Declaration and Agenda for Global Action* (March 2008). Available at:

<http://www.who.int/entity/workforcealliance/Kampala%20Declaration%20and%20Agenda%20web%20file.%20FINAL.pdf>.

¹⁶ Global Health Workforce Alliance, *Moving Forward from Kampala: Strategies, Priorities, and Directions of the Global Health Workforce Alliance: 2009 to 2011* (2009), at 9. Available at: http://whqlibdoc.who.int/publications/2009/9789241598033_eng.pdf.