

## **Achieving the MDGs by Investing in Human Resources for Health**

*The Health Workforce Advocacy Initiative is an international civil society-led coalition supported by the Global Health Workforce Alliance.*

### **Executive Summary**

The February 2010 report from the UN Secretary-General on progress towards the Millennium Development Goals (MDGs), *Keeping the Promise*, recognizes that health workers are of “paramount importance to speed up progress where current trends make achievement of the Millennium Development Goals unlikely.”<sup>1</sup> The Secretary-General was acknowledging what leading health authorities such as the World Health Organization (WHO), national health authorities, and health program implementers themselves have also recognized: in many countries, 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.

Despite this common recognition, in many countries progress in meeting health workforce needs has been slow, and at the global level, the level of investments in the health workforce remains severely inadequate compared to the need. Simply put, 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.

Yet genuine progress in some countries demonstrates that rapid scale-up of the health workforce is possible,<sup>2</sup> and investments in improving how health workers are managed and how they are distributed within countries enhance the performance and reach of the existing workforce.<sup>3</sup> 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, and many more countries will have a real chance to achieve the health MDGs.

### Global health workforce need and connections to the MDGs

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.<sup>4</sup> WHO identified 57 countries that 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, including laboratory and pharmacy staff, and managers and administrators.<sup>5</sup> More recently, in 2009, the High Level Taskforce on Innovative International Financing for Health

Systems (HLTF) offered two estimates of the number of health workers required to achieve the health-related 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 progress towards and in many cases to achieve the health-related MDGs, particularly MDGs 4, 5, and 6, while also expanding coverage for other diseases and contributing to the hunger target in MDG 1.<sup>6</sup> The other set of calculations, by the World Bank and other institutions, found that these 49 countries required 2.6-2.9 million additional health workers – including managers, whose critical role is too often overlooked.<sup>7</sup>

The message from these estimates is clear: 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. At the same time, greater numbers alone are not enough. Other dimensions must be addressed as well, such as the equitable distribution of health workers – so that their distribution reflects that of the population – their skills and motivation, their supervision and other support, their productivity and management, and the strength of the health systems in which they work.

#### MDG 1: Reducing hunger

Community health workers 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. As hospital-based treatment of malnutrition may be needed, other health staff have important roles in reducing nutrition, including physicians, nurses, pharmacists, and nutritionists.

#### 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. The more than 10,000 paid community health workers in Malawi have been called the country’s “most powerful weapon” in improving child health. With “medical checklists to aid them in diagnosing childhood killers and hardy bicycles to get around, they dispense medicines and give injections,” diagnosing and treating many childhood killers.<sup>8</sup> WHO’s *World Health Report 2005* similarly emphasizes the need for more health workers, estimating that 4.6 million community health workers and the equivalent of 100,000 additional health professionals are required to scale up child health care activities – and far more health professionals under health service delivery models that use fewer community health workers.<sup>9</sup> 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, whereas the vast majority of countries with at least 200 qualified health workers per 100,000 population do achieve this coverage.<sup>10</sup>

#### MDG 5: Maternal health

WHO's *World Health Report 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.”<sup>11</sup> To reduce maternal mortality, a professional health workforce is required. Many more 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, all of whom have a role in providing back-up emergency obstetric care. Non-physician clinicians such as clinical officers and assistant medical officers have a particularly important role in extending emergency obstetric care into rural areas where physicians are less likely to serve.

Community health workers 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.<sup>12</sup> Community health workers and community mobilization can also 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.<sup>13</sup>

In 2008, WHO estimated how many additional health workers would be required to provide universal access – defined as 95% coverage – to reproductive, maternal, and newborn health services in the 51 countries with low incomes and the highest burden of disease in these areas. Their calculations found the need for 1.3 million additional health professionals (including 850,000 midwives, 220,000 doctors, and 230,000 specialists), 700,000 non-professionals including community health workers, and 130,000 managers. That is, more than 2 million additional health workers are required to achieve MDG 5, which includes the target of universal access to reproductive health services, while contributing to MDG 4 by reducing newborn mortality.<sup>14</sup>

#### 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. As WHO's then-Acting Director-General Dr. Anders Nordstrom said in 2006, “Perhaps the most important area to ensure success in achieving universal access [to HIV services] is a skilled and motivated workforce...the situation calls for drastic measures.”<sup>15</sup> In 2009, UNAIDS estimated that achieving universal access using a comprehensive task-shifting approach will require, by 2015, the full-time

equivalent of an additional 133,200 health workers.<sup>16</sup> 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,<sup>17</sup> including to expand programs to address drug-resistant tuberculosis. An expanded malaria response will also require addressing health workforce needs, including expanding the community health workforce to educate community members on malaria, distribute insecticide-treated bed nets, diagnose malaria, and treat uncomplicated cases of malaria. It will also require improving staffing levels at primary care facilities and, as in all health areas, ensuring that health workers are properly trained.

## Health Workforce and Rights Recommendations for the Action Agenda for Achieving the MDGs

Based on the priority that must be given to health workforce strengthening to achieve the health MDGs, as outlined with evidence above, we urge the following commitments and steps to be included in the action agenda for achieving the Millennium Development Goals that will be agreed to at the UN MDG Summit in September 2010.

### 1. Commit to health workforce targets required to achieve the MDGs

*A. 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. These include the WHO's 2006 estimate of a critical shortage of 4.3 million health workers globally<sup>18</sup> and estimates of 2.6-3.5 million additional health workers needed in 49 low-income countries according to calculations developed for the High Level Taskforce on Innovative International Financing for Health Systems (HLTF).<sup>19</sup> The target should be incorporated into the action agenda for achieving the MDGs, and include a target for 2015 and possibly beyond. The action agenda should also include health worker benchmarks to be achieved before 2015.<sup>20</sup>

The exact targets and benchmarks that should be adopted are currently being developed.<sup>21</sup> Drawing on needs identified by the HLTF, an appropriate target may be increasing the health workforce in low-income and other countries suffering critical shortages by more than 2.5 million health workers by 2015, and more than 5 million by 2020. This is based on two calculations developed for the HLTF of the additional health workers required to achieve the MDGs in low-income countries that were part of work for the HLTF. This target also incorporates preliminary work to expand the HLTF figures to also cover 15 countries that WHO identified in its *World Health Report 2006* as having critical health worker shortages but were not included in the HLTF calculations. An appropriate target, which may differ from the preliminary targets and methodology presented here, should be developed before the MDG Summit in September, and incorporated into the action agenda.

*B. Increase in 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 to a significant increase in the coverage and number of health workers with the skills needed to provide back-up emergency care, including non-physicians clinicians (e.g., clinical officers), specially trained nurses, and health workers trained to administer anesthesia.

*C. 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. This will help expand health service into even remote areas, enable relatively rapid expansion of the health workforce, and better match the responsibilities of more highly skilled health workers to their level of training. This expansion should occur in conjunction with strategies to ensure proper training, regular and supportive supervision, fair compensation, and an effective referral system – as needed for these and all health workers. It will often be appropriate and desirable to broaden the scope of practice of nurses and other health workers who serve at the community level (task-shifting), including empowering community health workers to assume increased roles, and to ensure compensation is appropriate to these expanded responsibilities.

Countries should simultaneously significantly expand pre-service training capacity and invest in retention strategies for health professionals, as skilled health workers at all levels are required to provide a continuum of care that comprehensively addresses people’s health needs. A rapid expansion of the community-level health workforce (which may include both non-professional health workers and professionals, such as community nurses) should not detract from the importance of scaling up the professional workforce.

*D. 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, which may also include urban slums), to move rapidly towards an equitably distributed health workforce. This target may be, for example, at least a 50% reduction in disparities of health worker to population ratios by 2015 compared to 2010, and at least doubling the health workforce density in rural and other hard-to-reach areas by 2015 compared to 2010.<sup>22</sup> In addition, commit to developing and implementing the strategies – such as incentives, investments in rural infrastructure, expanded use of community and mid-level health workers, and recruiting health professional students from rural areas and other education-based strategies – required to achieve this target.

## 2. Significantly increase health workforce and health system investments

*A. 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.

The WHO costing for the HLTF estimated that 25% of the additional health funding required in the 49 low-income countries it analyzed was for training new health workers, paying them,

and providing incentives to new and existing health workers (a total of 74% of the additional funding was for health systems strengthening). This amounted to an additional \$62 billion from 2009 through 2015 for clinical personnel, and \$76 billion including health managers and administrators, with funding requirements reaching more than \$16 billion in 2015.<sup>23</sup> The World Bank and others, using a different methodology, also developed an estimate for the HLTF, which would require an additional \$24-31 billion to be invested in the health workforce from 2009 through 2015 to achieve similar results.<sup>24</sup> Actual funding needs would likely be higher, especially as the HLTF costing does not cover 15 countries that WHO identified as having critical health worker shortages.<sup>25</sup>

*B. Increase 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. This should including provide at least \$20 billion to the Global Fund to Fight AIDS, Tuberculosis and Malaria – an increasingly important source of health workforce funding – during the period covered by its October 2010 replenishment conference, 2011-2013. This is the minimum required to support program scale-up in line with what is needed to reach the MDGs.

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. In order to significantly increase per capita health expenditure, along with increase the share of the budget devoted to health, developing countries should also assess and undertake equitable measures to increase total revenue, and hence funds available for public social expenditures. Measures may include addressing capital flight and other forms of tax evasion, enacting dedicated taxes for health (or a broader set of public social expenditures), taxing extractive industries, and increasing trade-related tariffs. Countries should introduce and strengthen transparency and accountability measures to ensure the effective use of health spending. Increases in other social expenditures, besides health, are also required to meet the health-related MDGs which, along with direct health expenditures, require addressing social determinants of health (e.g., clean water, adequate sanitation, nutrition, education) and other multi-sectoral issues. For example, health worker training is often paid for through education budgets.

*C. 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.

*D. 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. The action agenda should commit international financial institutions to promoting such policies. These policies will help enable countries to use international funding to add to rather than replace domestic funding for health and its determinants.

### 3. Develop and implement robust and comprehensive HRH strategies

*A. Comprehensive approach:* Commit to implementing the comprehensive approach to health workforce strengthening as laid out in the Kampala Declaration and Agenda for Global Action.<sup>26</sup> Achieving the health MDGs will require not only more health workers, but also ensuring that they are in the right places, motivated and supported, have the needed knowledge, skills, medicines, and equipment, and are part of a well-managed, well-functioning health system.

*B. 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,”<sup>27</sup> and include robust, participatory, monitoring and evaluation processes to ensure progress and to rectify any shortcomings in the plans or their implementation. All countries (developing and developed) should have such costed plans with actionable implementation strategies. Plans consistent with human rights principles will, among other features:

- Prioritize equity
- Train health workers on the right to health, including women’s rights
- Incorporate comprehensive strategies on reducing stigma and discrimination, and increasing respect for patients’ rights
- Ensure that marginalized populations, including poor populations, linguistic minorities, people with disabilities, and indigenous populations, are involved in health workforce planning and monitoring and evaluation
- Integrate gender concerns, including supporting women in health leadership positions, ensuring health worker safety, and addressing workplace violence and sexual harassment
- Include health workers, civil society organizations, and marginalized populations in health workforce planning and monitoring and evaluation.

It is important to place weight on both developing these plans and implementing them, including their full funding. There is an increasing and important global focus on developing quality plans, for the health workforce and health sector generally, but too often, even when quality plans are developed, they are either not implemented or inadequately implemented. These plans should have actionable implementation strategies, and strong and participatory

monitoring and evaluation processes. These processes should identify bottlenecks and ensure steps to rapidly overcome them.

*C. 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.

*D. 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. Health workers in leadership and management positions require skills such as budgeting, human resource management, motivating staff, program management, priority setting, strategic planning, team building, resource allocation, and developing sustained partnerships with the community, civil society, private sector, and other government ministries. Countries should undertake a comprehensive review of the health system, including the government (across ministries and national and sub-national levels, and including the health ministry and its human resources department), health workers, facilities, and training institutions, and civil society, community members, the private sector, and the informal health sector. A strategy should define leadership and management needs and objectives in each area, and identify the policies, skills, tools, systems, and other approaches required to meet these needs. Special priority may be given to planning, management, and leadership skills among district health management teams, and to building the capacity of the health ministry's human resource department.

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

#### 4. **Develop participatory, inclusive, and effective accountability mechanisms for health services**

*A. Community-level accountability mechanisms:* Commit to, by 2012, map in all communities the existence and functionality of community-level health service accountability mechanisms, such as village health committees, health facility management boards that include community members and health workers, and formal arrangements for community monitoring and feedback into health service operations and government processes. Further, 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. Through these mechanisms, community members can:

- monitor and evaluate their health services;
- identify gaps and weaknesses, and identify and advocate for possible solutions;
- promote and ensure the effective presence of health workers posted to health facilities (e.g., are health workers who are supposed to be at health facilities in fact present? during the hours the health facility is supposed to be open? do they respect patients' rights, and women's rights overall?);
- identify and help redress barriers to community use of health services, and;
- strengthen the relationship between health workers and the communities they serve, including to build trust, address stigma, and contribute to a continuity of care addressing comprehensive services (including those addressing determinants of health outside of the health sector) that extends into the community.

These mechanisms must include participation of women and cover all socioeconomic groups, including poorer members of the community and members of marginalized populations.

*B. Civil society organization capacity building:* Affirm the important role of civil society organizations and communities in holding governments to their responsibilities and obligations, including to achieve the MDGs and to meet human rights obligations (including securing the rights of marginalized and vulnerable 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. Every development partner should commit to develop, through a highly inclusive process, strategies (including targets and greatly increased funding) for providing significant support for strengthening the organizational capacity and programmatic reach of national and community-based civil society organizations promoting human rights, women's empowerment, health, education, the environment, poverty reduction, democracy, and government accountability.

Developing countries should commit to increase support for such organizations as well, including through funding, greater inclusion in decision-making, and stronger partnerships. All countries should commit to providing civil society full space to operate, including by 2013 removing any laws and policies that restrict civil society's ability to operate independently and engage on and hold governments accountable, including to their human rights obligations.

*C. 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. The education should also address specific health-related commitments and obligations (e.g., what health workers are supposed to be available in local health facilities and at what times, any fees that may be required for health services). People should also be informed of processes (including judicial and non-judicial) by which they can hold their governments accountable to these rights.

Countries should commit to, by 2013, educate health workers on the right to health through incorporation of human rights education into pre-service and in-service training curricula.

*D. 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. Such audits should identify medical as well as social, economic, and cultural factors that contribute to each such death, involve the community to help ensure their accuracy and comprehensiveness, and provide recommendations on how to avoid such deaths in the future. Health workers and community members should be sensitized to and engaged in the auditing process. These audits should include processes for determining whether their recommendations have been undertaken, and propose specific measures that could increase political will, improve monitoring, or otherwise enhance the uptake of its recommendations. The audits themselves should be carefully assessed to ensure that they are being properly conducted.<sup>28</sup>

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

*A. 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 (e.g., the lowest income quintile) and other excluded or marginalized groups (for example, reducing maternal mortality by  $\frac{3}{4}$  for the lowest income quintile). The action agenda may specify groups that are marginalized virtually everywhere (e.g., people with disabilities, poorest segments of the population), and supplemented with sub-targets for additional marginalized populations, based on country context.

*B. 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. The process of removing user fees should be carefully managed, including clearly communicating the decision and its implications to the public and to health workers, addressing any concerns that may arise, planning for increased health service utilization, and carefully monitoring implementation of the new policy, including to prevent the emergence of informal fees. In addition, prioritize removing other barriers to accessing health care (including language barriers, stigma, discrimination, informal fees, distance from health facilities, inadequate transportation and communication possibilities) and promoting health seeking behaviors.

*C. Address discriminatory laws and practices:* Recognize that laws and policies that discriminate against people based on gender, sexual orientation, and other characteristics<sup>29</sup> are impediments to achieving the MDGs. Countries should affirm the need to develop protective legal and policy frameworks for marginalized populations, including sexual minorities, people with disabilities, injecting drug users, and sex workers. All countries should commit to specific, accelerated timelines to undertake a participatory review (involving civil society) of laws and policies to identify those that discriminate against or fail to adequately protect the rights of marginalized populations. All countries should further commit to removing discriminatory laws and policies, to replacing them with and implementing rights-protective laws and policies, and to robustly enforcing these laws and policies. This should be accomplished before 2015. The action agenda should develop mechanisms to promote and monitor these changes (which should be harmonized with existing mechanisms, including through the UN treaty bodies), and support their implementation, through relevant law enforcement and judicial training, capacity building, community education, civil society support, and other activities.

<sup>1</sup> 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](http://www.un.org/ga/search/view_doc.asp?symbol=A/64/665)

<sup>2</sup> 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](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](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](http://www.unicef.org/infobycountry/ethiopia_51921.html).

<sup>3</sup> 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](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>

<sup>4</sup> 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](http://www.who.int/hrh/documents/JLI_hrh_report.pdf)

<sup>5</sup> *Id.* at 11-13.

<sup>6</sup> 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](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.

<sup>7</sup> 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](http://www.internationalhealthpartnership.net/CMS_files/documents/wb_unicef_unfpa_pmnch_background_to_constraints_to_scaling_up_and_costs_EN.pdf)

<sup>8</sup> Celia W. Dugger, “Child Mortality Rate Declines Globally.” *New York Times*, Sept. 9, 2009, at A6.

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

<sup>10</sup> Phyllida Brown, “The health service brain drain — what are the options for change?” *Immunization Focus* (Oct. 2003).

<sup>11</sup> WHO, *World Health Report 2005* (2005), at 7. Available at: <http://www.who.int/whr/2005/en/index.html>

<sup>12</sup> 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-Ruhiira, 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>

<sup>13</sup> 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.

<sup>14</sup> 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).

<sup>15</sup> WHO, Address by Anders Nordström, Acting-Director-General, XVI International AIDS Conference, Toronto, Aug. 18, 2006. Available at: <http://www.who.int/dg/nordstrom/speeches/2006/toronto2006/en/index.html>

<sup>16</sup> UNAIDS, *What Countries Need: Investments needed for 2010 targets* (2009), at 15. Available at: [http://data.unaids.org/pub/Report/2009/JC1681\\_what\\_countries\\_need\\_en.pdf](http://data.unaids.org/pub/Report/2009/JC1681_what_countries_need_en.pdf)

<sup>17</sup> 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>

<sup>18</sup> WHO, *World Health Report 2006* (2006), at 11-13. Available at: <http://www.who.int/whr/2006/chapter1/en/index.html>.

<sup>19</sup> Working Group 1, Taskforce on Innovative International Financing for Health Systems, *Constraints to Scaling Up and Costs: Working Group 1 Report* (2009). Available at:

[http://www.internationalhealthpartnership.net//CMS\\_files/documents/working\\_group\\_1\\_report\\_EN.pdf](http://www.internationalhealthpartnership.net//CMS_files/documents/working_group_1_report_EN.pdf); World Health Organization, *WHO Report submitted to Working Group I of the High Level Taskforce on Innovative International Financing for Health Systems* (2009), at 22, 32. Available at: [http://www.who.int/choice/publications/d\\_ScalingUp\\_MDGs\\_WHO\\_report.pdf](http://www.who.int/choice/publications/d_ScalingUp_MDGs_WHO_report.pdf); 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). Available at: [http://www.internationalhealthpartnership.net//CMS\\_files/documents/wb\\_unicef\\_unfpa\\_pmnch\\_background\\_to\\_constraints\\_to\\_scaling\\_up\\_and\\_costs\\_EN.pdf](http://www.internationalhealthpartnership.net//CMS_files/documents/wb_unicef_unfpa_pmnch_background_to_constraints_to_scaling_up_and_costs_EN.pdf)

<sup>20</sup> Work is currently underway to develop the appropriate target based on the identified need, as well as benchmarks and sub-targets.

<sup>21</sup> The Health Workforce Advocacy Initiative, an international coalition, is discussing health workforce targets and associated costing with health workforce experts, including at WHO and the Global Health Workforce Alliance, and expects to have agreed upon health workforce targets and associated targets in advance of the September 2010 UN MDG Summit. For more information, please contact Eric Williams ([ewilliams@phrusa.org](mailto:ewilliams@phrusa.org)) and Eric Friedman ([efriedman@phrusa.org](mailto:efriedman@phrusa.org)) at the Health Workforce Advocacy Initiative and Physicians for Human Rights.

<sup>22</sup> As part of the Health Workforce Advocacy's work on health workforce targets, in collaboration with WHO and the Global Health Workforce Alliance, appropriate targets for reductions in the unequal distribution of health workers are also being developed.

<sup>23</sup> WHO, *WHO Report submitted to Working Group I of the High Level Taskforce on Innovative International Financing for Health Systems* (2009), at 2, 19. Available at: [http://www.who.int/choice/publications/d\\_ScalingUp\\_MDGs\\_WHO\\_report.pdf](http://www.who.int/choice/publications/d_ScalingUp_MDGs_WHO_report.pdf)

<sup>24</sup> 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 15, 69, 149. Available at: [http://www.internationalhealthpartnership.net//CMS\\_files/documents/wb\\_unicef\\_unfpa\\_pmnch\\_background\\_to\\_constraints\\_to\\_scaling\\_up\\_and\\_costs\\_EN.pdf](http://www.internationalhealthpartnership.net//CMS_files/documents/wb_unicef_unfpa_pmnch_background_to_constraints_to_scaling_up_and_costs_EN.pdf)

<sup>25</sup> The Health Workforce Advocacy Initiative, an international coalition, is discussing health workforce targets and associated costing with health workforce experts, including at WHO and the Global Health Workforce Alliance, and expects to have agreed upon health workforce targets and associated targets in advance of the September 2010 UN MDG Summit. For more information, please contact Eric Williams ([ewilliams@phrusa.org](mailto:ewilliams@phrusa.org)) and Eric Friedman ([efriedman@phrusa.org](mailto:efriedman@phrusa.org)) at the Health Workforce Advocacy Initiative and Physicians for Human Rights.

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<sup>26</sup> 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>.

<sup>27</sup> 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](http://whqlibdoc.who.int/publications/2009/9789241598033_eng.pdf).

<sup>28</sup> UN Special Rapporteur on health, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Preliminary note on the mission to India*, Addendum, A/HRC/7/11/Add.4 (February 29, 2008). Available at: [http://www.essex.ac.uk/human\\_rights\\_centre/research/rth/docs/preliminary\\_note\\_india.doc](http://www.essex.ac.uk/human_rights_centre/research/rth/docs/preliminary_note_india.doc); Human Rights Watch, *No Tally of the Anguish: Accountability in Maternal Health Care in India* (Oct. 2009). Available at: <http://www.hrw.org/en/reports/2009/10/08/no-tally-anguish-0>; South Africa Every Death Counts Writing Group, "Every death counts: use of mortality audit data for decision making to save the lives of mothers, babies, and children in South Africa." *Lancet* (April 12, 2008) 371: 1293-1304.

<sup>29</sup> Committee on Economic, Social and Cultural Rights, *General Comment 14, The right to the highest attainable standard of health*, U.N. Doc. E/C.12/2000/4 (2000), at para 18. Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>