

TOOLKIT FOR USING ROUND 9 OF THE GLOBAL FUND HEALTH SYSTEMS STRENGTHENING



October 2008

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**TOOLKIT FOR USING ROUND 9
OF THE GLOBAL FUND HEALTH
SYSTEMS STRENGTHENING**

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2. *Global Fund to Fight AIDS, TB and Malaria*. November 2007. *Strategic Approach to Health Systems Strengthening: Decision Point GF/B16/DPI0*. Geneva, Switzerland.
3. World Health Organization. *The Global Fund and Health System Strengthening: How to Make the Case, in a Proposal for Round 8?* Working Draft. Geneva, Switzerland.
4. Fund to Fight AIDS, TB and Malaria. October 2008. Excerpts on Health Systems Strengthening from *Guidelines for Proposals - Round 9 and Global Fund, Monitoring and Evaluation Toolkit: HIV/AIDS, Tuberculosis and Malaria (2nd ed.) Addendum March 2008 (March 2008)*. Geneva, Switzerland.
5. Global Fund to Fight AIDS, TB and Malaria. September 2008. *Global Fund Fact Sheet Series, 5 of 6: The Global Fund's approach to health systems strengthening*. Geneva, Switzerland.

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10. Global Fund to fight AIDS, TB and Malaria and International HIV/AIDS Alliance. September 2008. *Civil society success on the ground: community systems strengthening and dual-track financing*. Geneva, Switzerland and Brighton, United Kingdom.

4. Human Resources for Health (HRH)

11. Adano, Ummuro and James McCaffery. October 2008. *Global Fund Round 9 Opportunity to Build Human Resource Management Capacity: the central pillar in health systems strengthening initiatives*. Washington DC: Capacity Project (funded by USAID).
12. Cooper, Maggie and Eric A. Friedman. August 2008. *The Right to Health and Health Workforce Planning: A Guide for Government Officials, NGOs, Health Workers and Development Partners*. Washington, DC: Physicians for Human Rights.
13. Association of Nurses in AIDS Care & Physicians for Human Rights. 2008. *Statement on the rights of nurses to health and safety – a global call to action*. Akron, OH and Washington, DC.
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INTRODUCTION

Health Systems 20/20 and the Health Workforce Advocacy Initiative have teamed up to develop a toolkit of existing materials to assist Global Fund applicants to conceptualize and include cross-cutting health system strengthening components in Round 9 proposals. This toolkit provides an overview of HSS in the context of Global Fund, a background on HSS, a section on community systems strengthening and the Global Fund, articles on HRH, and a specific country example showing integration of HSS into Round 8 proposal.

PURPOSE

To help Global Fund applicants better understand how they can use the Global Fund to strengthen their health systems and what resources are available to support them in doing so. With an enhanced understanding of these possibilities, we hope that applicants will develop proposals for cross-cutting health systems strengthening interventions and meeting community needs to overcome AIDS, TB, and malaria.

TARGET AUDIENCE

Country level managers, technical advisors, country coordinating mechanisms

INTRODUCTORY LETTER

October 1, 2008

Dear Colleagues,

Do weaknesses in your country's health system impede efforts to improve outcomes in your country's efforts to combat AIDS, TB, or malaria? For very many countries, the answer will be yes. **You can do something about it – now – by taking advantage of Round 9 of the Global Fund to Fight AIDS, Tuberculosis and Malaria, which is now underway.**

Perhaps your country or community has too few health workers, health workers operating in unsafe conditions, or clinics with empty shelves. Perhaps the health system suffers from inadequate management and planning capacities, crumbling infrastructure, or poor integration between HIV and other health services and between the formal health sector and community organizations and structures. Where these and other undesirable yet undeniably common features of many health systems exist, countries will need to respond to them to enable everyone to access a comprehensive set of quality preventative and curative services, and additional support, that will dramatically reduce the impact of the scourges of AIDS, TB, and malaria on individuals, families, communities, and countries.

The Global Fund welcomes applications that, in addition to addressing other needs related to the Fund's priority diseases, include health system interventions needed to overcome constraints to improved outcomes for AIDS, TB, or malaria. These interventions can – and indeed, quite often should – be cross-cutting, that is, designed to address not only the needs of a program for a single disease, but rather to simultaneously address several diseases or, quite possibly, strengthen basic health system functions in ways that have a still broader impact. The Fund can be used to help build more equitable, effective, and efficient health systems that will deliver on improved outcomes for the Fund's three target diseases and, through these same actions, develop the same systems needed to help reduce maternal and child mortality and meet other basic health needs.

Applicants have successfully used the Global Fund to support many cross-cutting health system needs, such as increasing the number of nursing tutors, paying for health worker salaries and incentives, creating safer working conditions for health workers, supporting a community-based health insurance scheme, electrifying and rehabilitating health facilities, training district management teams in developing comprehensive district health plans, supporting task-shifting, and more. Countries can use – and have used – the Global Fund to cover funding gaps in existing health workforce plans and other aspects of their national health strategies.

And yet, to a large extent the Fund's potential in this regard is untapped. Even as the health system needs for an effective response to the Fund's priority diseases remain immense, there have been few ambitious, high-quality proposals to the Global Fund. Previous rounds have more often seen proposals for minor interventions rather than proposals for interventions to address fundamental health system constraints.

To contribute to changing this dynamic, and in combination with other efforts by ourselves and other partners, the Health Workforce Advocacy Initiative, an international coalition affiliated with the Global Health Workforce Alliance, in collaboration with Health Systems 20/20, the

flagship health systems project of the US government, have teamed up with various technical support providers to prepare and distribute this packet of information.

The material in this packet, described below in more detail, includes information from the World Health Organization, the Global Fund, and other sources that should be useful in conceptualizing and preparing cross-cutting health system strengthening interventions, including to address such key constraints as inadequate human resource management capacity. It also contains information in a related area, community system strengthening. We hope this material will help applicants better understand how to use the Global Fund to strengthen their health systems and what resources are available to support them in doing so. And we hope an enhanced understanding of these possibilities will motivate applicants to develop ambitious proposals for cross-cutting health systems strengthening interventions and for meeting community needs to overcome AIDS, TB, and malaria.

Round 9, which launched on October 1, with proposals due January 21, 2009, provides an immediate opportunity to seek funds for health system strengthening, whether through an entirely new proposal or by revising – and perhaps expanding – health system strengthening-related proposals from Round 8 that the Technical Review Panel rated as Category 3. We also encourage you to look ahead to Round 10, currently scheduled to launch in April 2009 (please check the Global Fund’s website, www.theglobalfund.org, for confirmation) – not putting off until next Round what might be submitted for this Round, but rather using the lead-time available for Round 10 to engage in the planning and consultation that will lay the groundwork for an ambitious, HSS-related proposal that may supplement or build on that which your country submits in Round 9.

As you develop this and future proposals, and engage now and in the months – and years – ahead in developing and implementing strategies to strengthen your country’s health system, we hope that you will ensure that these strategies are grounded in human rights. Adhering to such principles as equity, participation, and accountability will be required to ensure that the increased investments in the three diseases and in health systems are making continuing, equitable, real, and sustainable progress in improving people’s health. Some relevant material is in the packet.

The material included also contains information on seeking additional technical support to develop the proposal. We encourage you to take advantage of the resources available to create the strongest possible proposal, while simultaneously developing a strategy to effectively implement the proposal.

We would also welcome your feedback on the usefulness of this material, so that we can improve upon this effort in future rounds of the Global Fund. Please email Eric Friedman (efriedman@phrusa.org) and Asia Russell (asia@healthgap.org) with any feedback.

Sincerely,

Eric A. Friedman
Chair, Health Workforce Advocacy Initiative
Senior Global Health Policy Advisor, Physicians for Human Rights

I. OVERVIEW OF HEALTH SYSTEMS STRENGTHENING IN THE CONTEXT OF GLOBAL FUND

Compilation of selected publications to provide an overview of HSS:

1. Friedman, Eric A. October 2008. *Guide to Using Round 9 of the Global Fund to Fight AIDS, Tuberculosis and Malaria to Support Health Systems Strengthening*. Washington, DC: Physicians for Human Rights.
2. *Global Fund to Fight AIDS, TB and Malaria*. November 2007. *Strategic Approach to Health Systems Strengthening: Decision Point GF/B16/DPI0*. Geneva, Switzerland.
3. World Health Organization. *The Global Fund and Health System Strengthening: How to Make the Case, in a Proposal for Round 8?* Working Draft. Geneva, Switzerland.
4. *Fund to Fight AIDS, TB and Malaria*. October 2008. Excerpts on Health Systems Strengthening from *Guidelines for Proposals - Round 9 and Global Fund, Monitoring and Evaluation Toolkit: HIV/AIDS, Tuberculosis and Malaria (2nd ed.) Addendum March 2008 (March 2008)*. Geneva, Switzerland.
5. *Global Fund to Fight AIDS, TB and Malaria*. September 2008. *Global Fund Fact Sheet Series, 5 of 6: The Global Fund's approach to health systems strengthening*. Geneva, Switzerland.

I. FRIEDMAN, ERIC A. OCTOBER 2008. GUIDE TO USING ROUND 9 OF THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA TO SUPPORT HEALTH SYSTEMS STRENGTHENING. WASHINGTON, DC: PHYSICIANS FOR HUMAN RIGHTS.

[<http://physiciansforhumanrights.org/library/documents/reports/round9-gf-hss-guide.pdf>]

The Global Fund to Fight AIDS, Tuberculosis and Malaria holds much potential for advancing health systems strengthening (HSS) efforts in the international community, including supporting cross-cutting HSS interventions that benefit more than one of the Global Fund's three target diseases and increase the likelihood of grant performance. This Guide provides information on how to use the Global Fund to support HSS, key opportunities that the Global Fund presents for HSS, advice on developing a strong HSS-related proposal, and more. It is intended for use by Country Coordinating Mechanisms (CCMs) as well as other who will be involved in proposal development.

Guide to Using Round 9 of the Global Fund to Fight AIDS, Tuberculosis and Malaria to Support Health Systems Strengthening

October 2008

Updated from March 2007 Guide developed for Round 7



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Acknowledgements

Eric A. Friedman, JD, Senior Global Health Policy Advisor for Physicians for Human Rights (PHR), wrote this Guide. He can be reached at efriedman@phrusa.org.

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Feedback on this Guide is appreciated, and should be directed to the author.

I. Introduction

The Global Fund to Fight AIDS, Tuberculosis and Malaria holds much potential for advancing applicants' health systems strengthening (HSS) efforts, including by supporting cross-cutting HSS interventions that benefit more than one of the Global Fund's three target diseases, and quite possibly health system needs more broadly. Compared to the immense health system needs facing many countries eligible for Global Fund grants, and the considerable extent to which these are obstacles to near- and long-term progress in improved outcomes for the Global Fund's priority diseases, ambitious, successful proposals to address have been relatively few. Round 9 is a chance to change that.

This Guide provides information on how to use the Global Fund to support HSS, key opportunities that the Global fund presents for HSS, and more. Several points bear immediate emphasis. Applicants should be aware of several key points about the cross-cutting HSS that the Global Fund will support:

- The Global Fund is flexible in terms of the types of HSS interventions it will support; only very few types of interventions are categorically excluded from funding.
- Cross-cutting HSS interventions are those that will benefit the fight against more than one of the Fund's target diseases. These interventions must have "a clear and demonstrated link to improved HIV, tuberculosis and/or malaria outcomes."¹ That is, while there is much scope for interventions that have a broad, positive impact on the health system, all interventions must also have a link to improving outcomes for the Fund's target diseases. Proposals should clearly explain this connection.
- People with health systems expertise should be involved with Country Coordinating Mechanisms (CCMs) and proposal development, including stakeholders with expertise in planning and budgeting. Close collaboration between experts in health systems and particular health system areas (such as human resources) and disease programs will enhance the likelihood of success.
- HSS interventions should be linked to the applicant's assessment of the health systems gaps and weaknesses that are obstacles to improved outcomes in AIDS, tuberculosis, and/or malaria. Applicants may find existing analyses (e.g., for GAVI) that help with this assessment.

Round 9 presents an important opportunity to invest in highly strategic areas, such as strategic development and improvement human resources management capacity, as well as to secure significant funds to invest in human resources and other health system areas, as long as the interventions are linked to improved HIV, tuberculosis, and/or malaria outcomes.

HSS interventions that are rooted in sound national health strategies are most likely to receive support from the Global Fund. If such strategies do not exist, countries should prioritize their development.² These strategies can be used as the basis for support in future funding rounds.

Whether or not applicants submit a Round 9 proposal, they should plan early for Round 10, before the Global Fund releases its Round 10 Call for Proposals, scheduled for April 2009 (check www.theglobalfund.org for confirmation). Applicants can use the time before Round 10 launches to engage in the planning (including, for example, strategic planning, needs assessments, and costing) and consultation that will lay the groundwork for an ambitious, strategic, HSS-related proposal.

¹ Global Fund Round 9 Guidelines for Proposals (Oct. 2008), at 62.

² One of the core obligations of the right to the highest attainable standard of health is that countries "adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population . . . on the basis of a participatory and transparent process . . . [including] methods, such as right to health indicators and benchmarks, by which progress can be closely monitored . . . [and they] shall give particular attention to all vulnerable or marginalized groups." 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. 43(f). Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

II. Using This Guide

IMPORTANT NOTE: This Round 9 Guide contains modest revisions and updates from PHR's earlier Round 7 Guide; much of the content is unchanged. Most of the examples in this Guide are therefore drawn from earlier Global Fund rounds, especially Rounds 5 and 6. This Guide has been updated to reflect Round 9 Guidelines for Proposals. Nonetheless, we urge applicants to carefully review the Round 9 Guidelines for Proposals. If there is any conflict with information contained in this Guide, the official Round 9 Guidelines for Proposals should be followed.

1. Who should use this Guide?

This Guide is intended to assist members of Country Coordinating Mechanisms (CCMs) and others involved in preparing proposals for Round 9 of the Global Fund to Fight AIDS, Tuberculosis, and Malaria. This Guide provides assistance in thinking about and developing proposals that include health system strengthening activities. It might also help motivate countries to use the Global Fund to support such activities. Physicians for Human Rights (PHR) encourages civil society to engage their countries' CCMs about ways to include HSS in their proposals to the Fund, and hopes that the information provided in this Guide will support civil society in these efforts.

2. How definitive is this Guide?

The advice in this Guide is primarily drawn from analysis of successful Round 5 Health Systems Strengthening (HSS) proposals, and Round 6 proposals with significant HSS elements, along with comments by the Technical Review Panel (TRP), the independent experts who review Global Fund proposals and recommend which ones the Global Fund Board should approve. PHR reviewed TRP comments on unsuccessful Round 5 HSS proposals and Round 6 proposals, though the full proposals were unavailable.

The advice provided in this Guide is meant to cover a variety of country circumstances, yet much will depend on the particular nature and goals of each proposal and the situation of each applicant. Applicants should consider how the advice and analysis in this Guide apply to their particular circumstances. This Guide is intended to supplement, not replace, other forms of support.

The advice and information contained in this guide is formed by careful analysis, but the final decision lies with the TRP. This Guide has not been reviewed or endorsed by the Global Fund.

3. Where can applicants turn for further support in developing Global Fund proposals related to health system strengthening?

PHR urges applicants to contact sources of technical expertise as needed. Applicants can contact their country's WHO Country Office. In addition, PHR, in collaboration with the USAID-supported project Health Systems 20/20, has developed a partial list of entities that are available to offer technical support in developing HSS-related Round 9 proposals. This list of technical support providers is available through: http://physiciansforhumanrights.org/hiv-aids/globalfund_round9.html. Other organizations are very likely also available to provide technical support, and other entities are also available to assist in implementing HSS-related components of successful Global Fund grants.

PHR strongly encourages countries to draw on all available resources, especially local experts, to ensure that proposals are technically sound, and to seek external support where needed.

If applicants have questions related to the Global Fund proposal process, PHR suggests that they contact country Global Fund portfolio managers. Their names and email addresses can be found on the country page on the Global Fund website: <http://www.theglobalfund.org>. PHR encourages civil society organizations to contact their country's CCM to learn about their country's particular Global Fund process and to discuss ways in which health workforce and other HSS interventions can be included in the Round 9 proposal.

III. Benefits of Using the Global Fund to Support Health System Strengthening

This section discusses a number of benefits of incorporated health systems strengthening in Global Fund proposals. It begins with overarching values of using the Fund to support HSS, and then provides a number of benefits of using the Fund to support system-wide approaches to health systems strengthening.

1. Overarching value of using the Global Fund to support health systems

a. Enabling HIV, tuberculosis, and malaria programs to succeed

In many countries, weak health systems are a central obstacle to successfully scaling-up and sustaining HIV, tuberculosis, and malaria programs. The Global Fund represents an opportunity to remove these obstacles and create enormous benefits for those affected by the Fund's three target diseases.

b. Helping fulfill obligations to highest attainable standard of health

Using the Global Fund to strengthen health systems to reduce the spread and impact of HIV, tuberculosis, and malaria will help many countries fulfill their human rights obligations, in particular the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health."³ Under international law, states are obliged to take steps "to the maximum of [their] available resources," including resources available through international assistance, to progressively realize the right to the highest attainable standard of health.⁴ By taking maximum advantage of the Global Fund's financial resources to strengthen the national health system in ways that will improve outcomes for at least one of the Fund's priority diseases and may also improve people's health in other ways, states demonstrate their commitment to a universal right to health.

Well-designed Global Fund proposals also provide an opportunity for states to take an important step towards realizing one of their core obligations under the right to the highest attainable standard of health: meeting the needs of poor, rural, and other marginalized populations.⁵ Health system strengthening activities included in Global Fund proposals should be designed with a particular emphasis on these populations.

2. Further benefits from a system-wide, cross-cutting approach to health system strengthening

Health system strengthening activities may be tied to a particular disease (e.g., developing a supply chain for HIV/AIDS medications or incorporating HIV into existing health information systems) or system-wide, cross-cutting activities (e.g., strengthening the national supply chain or health information system) that benefit not only a particular disease program but also a wide range of health priorities - as long as the proposal clearly demonstrates a link between these interventions and disease specific outcomes for AIDS, tuberculosis, and/or malaria. Activities may also fall in the middle and benefit several health priorities including one of the Fund's target diseases; examples might include integrating reproductive health with HIV services, or maternal and child health care with programs which prevent mother to child HIV transmission. The following paragraphs will briefly examine the numerous benefits of a system-wide approach.

³ International Covenant on Economic, Social and Cultural Rights, G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, entered into force Jan. 3, 1976, at art. 12(1). Available at: <http://www1.umn.edu/humanrts/instreetree/b2esc.htm>.

⁴ *Id.* at art. 2(1).

⁵ 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. 43(f). Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

a. Benefiting other health priorities

In addition to supporting HIV, tuberculosis, and malaria programs, system-wide strengthening can benefit other health priorities. By strengthening health workforces and other basic health system elements, applicants can address an array of health areas and create a workforce able to provide a range of health services, helping countries to reach the Millennium Development Goals and other health targets. For example, greater health worker density has enabled countries to increase coverage of measles vaccinations and skilled health workers attending births,⁶ thereby reducing maternal mortality.

b. Avoiding harm to other health priorities

In nations without an adequate supporting infrastructure, scaling up programs to address individual diseases creates an additional burden on a limited workforce and risks harming efforts to address other health priorities, unless support is provided to the system to enable it to successfully handle these additional programs. Countries with severe health worker shortages may be unable to scale up disease-specific programs without drawing health workers away from other health services. Or new or expanded programs may further stress already overworked health workers, possibly compromising quality of care delivery and rendering them more likely to leave the country's health services.⁷

Even singling out disease-specific programs for special benefits poses risks. If only health workers associated with these programs receive financial incentives to promote their retention, health workers not receiving these incentives may feel that they are being treated unfairly.⁸ This may lower their morale and lead to reduced quality of care and staff attrition. A system-wide approach minimizes such harm to other health services and can benefit them instead.

c. Integration of health services

Pursuing a system-wide approach supports the integration of health services rather than developing a parallel, disease-specific infrastructure that duplicates existing delivery systems and wastes scarce resources. For example, duplicate procurement and distribution systems require staff to manage multiple mechanisms for drug ordering, more complex information systems, and duplicate warehouses and distribution systems.⁹

Integration also has significant benefits with respect to improving health outcomes. For example, integrating HIV services with family planning services, maternal and child health services, and other primary health services, will significantly increase the reach of HIV interventions, expanding uptake of HIV services faster than a non-integrated approach. Integration will also enable programs to more

⁶ World Health Organization, *World Health Report 2006: Working Together for Health* (2006), at 9-11. Available at: <http://www.who.int/whr/2006/en/index.html>.

⁷ Malawi's Round 5 proposal successfully argued this very point: "Staffing levels are clearly inadequate in Malawi to scale up the three disease specific programs as well as meet increasing demand for other health services. ART clinics, and other vertical disease programs, are likely to distract staff from other services already suffering from significant staff shortages. At the same time, integrated programs at primary care and hospital facilities...are placing increasing demand on the health workers that remain. . . . With increasing specialized ART/HIV/AIDS testing and counseling services, considerable extra burdens are placed on hospital staff undermining their ability to cope." Government of Malawi, Round 5 Health System Strengthening proposal (Health Systems Strengthening and Orphan Care and Support) (June 2005), at 52. Available at: http://www.theglobalfund.org/search/docs/5MLWH_1142_0_full.pdf.

⁸ For example, Zambia received Global Fund money in Round 4 to provide financial incentives to health workers providing anti-retroviral therapy. Ideally, such an approach would be complemented by efforts to secure funds to provide comparable incentives to other health staff.

⁹ Kate Stillman & Sara Bennett (Partners for Health Reformplus Project, Abt Associates Inc.), *Systemwide Effects of the Global Fund: Interim Findings from Three Country Studies* (Sept. 2005), at 42. Available at: http://pdf.usaid.gov/pdf_docs/PNADF196.pdf.

comprehensively meet the needs of health service users, and help overcome the risk that stigma will deter some people from seeking services from facilities that are associated solely with HIV/AIDS.

Although developing parallel infrastructure may be faster and possibly less expensive in the short term, over time a unified system will result in greater efficiency and sustainability, while the investments to strengthen this system may also benefit other health services. Ethiopia chose to develop its existing procurement and distribution system to handle anti-retroviral medications and drugs for opportunistic infections rather than construct a parallel system. Initially this led to slow procurement and a period of adjustment, but Ethiopia adapted and began “renting more warehouses, hiring more staff on short-term contracts, and contracting out specific elements of the procurement and distribution chain... [resulting in] very positive effects upon the efficiency of procurement.”¹⁰ This is especially critical for HIV. Securing ARVs for all is both an emergency and a lifelong commitment by governments, and needs to be backed by functioning systems for the long-term, making this type of HSS integration imperative.

When applicants do seek support for disease-focused HSS interventions, they should be sure that these interventions do not come, in the words of the Global Fund’s Technical Review Panel, “at the obvious expense of the broader healthcare system...[such as] by attracting staff away from [other elements of the healthcare system], or by developing an entirely vertical disease program in isolation from the remainder of the healthcare system. The TRP is critical of such approaches, and would not recommend them for funding.” The TRP’s expectation is that proposed HSS activities, whether disease-focused or cross-cutting, and however they are incorporated into the proposal, “strengthen, or at a minimum, not undermine the broader healthcare system.”¹¹ The Round 9 Guidelines for Proposals direct applicants to explain possible unintended consequences of responding to health system weaknesses on a disease-specific program basis and how they intend to mitigate those risks.¹²

At a May 2006 meeting in Cape Town, South Africa, a meeting of AIDS advocates, health systems experts, health officials and workers, and people living with HIV/AIDS agreed that countries should undertake “an explicit assessment and evaluation of which components...can be integrated into general health systems and which require vertical implementation in the short to medium term.”¹³ If a vertical approach is chosen for the short-term (perhaps because of urgency combined with the serious weaknesses of existing systems), specific plans should be made – and the necessary measures taken – “for integrating all vertical components into the general health system in the medium and long term.” Finally, program planners should consider possible unforeseen consequences of their approach and “include contingency strategies to address potential problems.”¹⁴

d. Meeting essential needs

Finally, in some cases, a system-wide approach is the only way to meet needs. Rwanda’s and Malawi’s Round 5 HSS proposals are both good examples. Realizing that its human resource shortage was too

¹⁰ *Id.*

¹¹ *Report of the Technical Review Panel and the Secretariat on Round 6 Proposals.* Presented at the 14th Board Meeting of the Global Fund, Oct. 31-Nov. 3, 2006, at 27. Available at: http://www.theglobalfund.org/en/files/boardmeeting14/GF-BM-14_10_TRPReportRound6.pdf.

¹² Global Fund Round 9 Guidelines for Proposals (Oct. 2008), at 31.

¹³ Communiqué from Moving towards Universal Access: Identifying Public Policies for Scaling Up AIDS Treatment and Strengthening Health Systems in Developing Countries, a workshop sponsored by Gay Men’s Health Crisis with support from The Rockefeller Foundation, May 4-5, 2006, Cape Town, South Africa. Malawi’s Round 5 HSS proposal presents a good example of integrating a parallel system into the overall health system. Malawi outsourced the initial responsibility for recruiting Health Surveillance Assistants to a local agency, which will also quickly build the capacity of its National Health Services Commission. The Health Services Commission was to assume responsibility for recruiting Health Surveillance Assistants by 2008. Government of Malawi, Round 5 Health System Strengthening proposal (Health Systems Strengthening and Orphan Care and Support) (June 2005), at 70. Available at: http://www.theglobalfund.org/search/docs/5MLWH_1142_0_full.pdf.

¹⁴ Communiqué from Moving towards Universal Access: Identifying Public Policies for Scaling Up AIDS Treatment and Strengthening Health Systems in Developing Countries, a workshop sponsored by Gay Men’s Health Crisis with support from The Rockefeller Foundation, May 4-5, 2006, Cape Town, South Africa.

severe to resolve only on a disease-specific basis, Malawi secured a Global Fund grant that included system-wide measures to retain health workers and expand its capacity to train new health workers. Rwanda recognized that overall low utilization of health services was an obstacle to the success of its AIDS, tuberculosis, and malaria programs, so it proposed measures to encourage utilization by improving overall access to health services.

IV. Overview of Global Fund and Health System Strengthening Possibilities

This section of the Guide provides key points about the types of activities and ways in which the Global Fund will support HSS interventions in Round 9. For more details, please review carefully the Round 9 Guidelines for Proposals, especially pages 41-45 and Appendix 3 (pages 61-63).

1. Overall scope and requirements for cross-cutting HSS interventions

- The Global Fund will support HSS activities that are specific to a single disease response or that are cross-cutting, that is, addressing more than one of the Fund's priority diseases, and possibly also addressing health needs more broadly, including but not limited to the Fund's priority diseases.¹⁵
- Cross-cutting HSS interventions should have "a clear and demonstrated link to improved HIV, tuberculosis and/or malaria outcomes."¹⁶
- Global Fund Round 9 provides significant opportunities for ambitious proposals to support cross-cutting HSS interventions that have a clear link to improved AIDS, TB, or malaria outcomes. In its comments on HSS activities including in the Round 7 proposals, the TRP observed that "proposals often identified weaknesses in the national health systems, many did not comment on what could be done to improve the situation and restricted their strategic actions to relatively minor interventions...."¹⁷ Round 9 presents an opportunity to support not simply minor interventions, but rather to address fundamental health systems constraints to scaling up AIDS, TB, and malaria health services and improving outcomes for those diseases.
- HSS interventions should be based on an analysis of how health system weaknesses constrain efforts to improve outcomes for AIDS, tuberculosis, and/or malaria, how they "impede the demand for, access to, and the delivery of services" for these diseases.¹⁸ Section 4.3 of the Guidelines for Proposals contains more information on the information to be included in this analysis. The analysis in s.4.3 should include existing analyses (such as from national health strategies), or existing analyses may be included as an appendix to the proposal.¹⁹
- Applicants have considerable flexibility in their HSS interventions. Major categories of interventions are information, service delivery, medical products and technology, financing, health workforce, and leadership and governance. Pages 62-63 of the Round 9 Guidelines for Proposals provide more details. The only specifically excluded interventions are basic research and certain clinical research, and large scale capital investments such as building new hospitals or clinics.²⁰ While Global Fund grants may not be used to build new health facilities, they may be used to rehabilitate health facilities. Cross-cutting HSS interventions need not be limited to the health sector, and may cover, for example, education, the workplace, and social services.²¹

¹⁵ Cross-cutting HSS interventions are those that "benefit more than one of the three diseases." Global Fund Round 9 Guidelines for Proposals (Oct. 2008), at 2.

¹⁶ *Id.* at 62.

¹⁷ Report of the Technical Review Panel and the Secretariat on Round 7 Proposals, Presented at the 16th Board Meeting of the Global Fund, Nov. 12-13, 2007, at 32. Available at: http://www.theglobalfund.org/en/files/boardmeeting16/GF-BM16-05_TRP_Report_R7_AnnexA.pdf.

¹⁸ Global Fund Round 9 Guidelines for Proposals (Oct. 2008), at 6.

¹⁹ *Id.* at 25-26.

²⁰ *Id.* at 61.

²¹ *Id.* at 63.

- Applicants may include up to five cross-cutting HSS interventions in s.4B. Interventions can be broadly conceived (applicants may allocate up to one page to explain the intervention and how it “is essential to the intended disease-specific performance outcomes”²²) and may include various activities and sub-activities.

2. Structure for including cross-cutting HSS interventions in proposal form

- Cross-cutting HSS activities may be included within a disease-specific component of the proposal or as a separate cross-cutting HSS section to any one of the three target diseases, as represented by s.4B. This is most fully laid out in the Global Fund’s HSS factsheet (http://www.theglobalfund.org/documents/rounds/9/CP_Pol_R9_FactSheet_5_HSS_en.pdf). Countries may 1) include all cross-cutting HSS interventions as part of the description of and along with disease-specific interventions (s.4.5.1) of a single disease component; 2) divide cross-cutting HSS interventions among the disease-specific interventions of several disease components (e.g., AIDS and malaria), or; 3) include all cross-cutting HSS interventions in the separate section on cross-cutting HSS interventions (s.4B). There should be no duplication of HSS interventions included in the diseases-specific component and the separate section s.4B. Applicants may only submit one s.4B form, as part of one of the disease components. An applicant could not, therefore, submit one s.4B form as part of a malaria proposal and another as part of an HIV proposal.
- When an applicant’s proposal includes the s.4B section on cross-cutting HSS interventions, the TRP may recommend for approval: a) both that section and the disease-specific interventions (s.4.5.1) of the disease proposal of which s.4B is a part; b) only the disease-specific interventions (i.e., the disease component excluding the cross-cutting HSS interventions in s.4B), or; c) only the cross-cutting HSS interventions in s.4B, but not the rest of the disease component, subject to technical merit and “if the interventions in that section materially contribute to overcoming health systems constraints to improved HIV, tuberculosis and/or malaria outcomes.”²³

This potential de-linking of the diseases-specific activities and the cross-cutting HSS interventions in the approval process has significant implications. Applicants who might otherwise be reluctant to use the Global Fund for ambitious HSS activities for fear that this could harm the chances of other pieces of the proposal being approved can incorporate those ambitious cross-cutting HSS interventions in s.4B without necessarily putting the disease-specific activities at risk, subject to the technical merit of the remaining activities and criteria of TRP review (included in Annex 2 of the Round 9 Guidelines for Proposals).

When cross-cutting HSS interventions are included in s.4.5.1, along with disease-focused activities, the TRP will assess those interventions “as an integral part of its review of the relevant disease component(s).”²⁴ In this case, the cross-cutting HSS interventions and disease-focused activities will rise or fall together - the TRP will recommend the full component for Global Fund approval, including the cross-cutting HSS interventions, or it will recommend that the Fund does not approve that component.

- Disease-focused HSS interventions should be included in s.4.5.1, not in s.4B.²⁵

²² *Id.* at 44.

²³ Global Fund, *Fact Sheet: The Global Fund's approach to health systems strengthening* (September 2008), at 2. Available at: http://www.theglobalfund.org/documents/rounds/9/CP_Pol_R9_FactSheet_5_HSS_en.pdf.

²⁴ *Id.*

²⁵ “All disease program activities (or pre-dominantly disease-specific) that may also benefit the health system must be included in s.4.5.1. and not s.4B.” Global Fund Round 9 Guidelines for Proposals (Oct. 2008), at 42.

- If applicants include the cross-cutting HSS interventions in s.4B, they must also include disease-program activities in s.4.5.1. A proposal may not consist only of interventions in s.4B.²⁶
- While proposals must include some disease-specific activities in s.4.5.1, the Fund does not require that cross-cutting HSS interventions be linked to the particular disease-specific activities including in s.4.5.1. As stated above, the cross-cutting HSS interventions *do* need to be linked to improving AIDS, TB, and/or malaria outcomes.
- Whether to include cross-cutting HSS interventions in s.4.5.1 along with disease-focused activities, or in the separate s.4B cross-cutting HSS interventions section, can be a difficult decision without a clear right or wrong answer (as long as the activities truly cross-cutting, and will benefit more than one of the Fund’s target diseases; otherwise they must be included in s.4.5.1). The following are several factors applicants may consider in deciding whether to include these cross-cutting HSS interventions in s.4.5.1 or s.4B:
 - Consider how related the planned cross-cutting HSS interventions are to the disease-focused activities in the disease proposal. If they are closely related, and the success of the disease-focused activities is linked to the HSS activities, it may make sense to include the cross-cutting interventions in the disease component.
 - Consider whether the HSS interventions will predominantly benefit one disease or more than one of the Fund’s priority diseases. If an intervention is a response to a health system weakness that only affects one of the diseases, or if it will occur through a disease program, it must be included in the component for that disease. If the intervention will benefit more than one of the Fund’s target diseases, but will address a health system weakness that is primarily a constraint to one of the diseases, it may well make the most sense to incorporate the intervention in section s.4.5.1 for that disease component.
 - If the applicant is unsure whether the HSS interventions will benefit more than one disease, the applicant should include the interventions in the disease-focused part of the proposal in case the interventions are not truly cross-cutting.
 - If the health system weaknesses that the HSS interventions will address present significant obstacles to better outcomes for more than one of the Fund’s target diseases, the applicant may want to address them in the separate section s.4B.
 - If the HSS interventions will help achieve outcomes for more than one of the target diseases, and will help achieve these outcomes even if the TRP does not approve the disease-focused activities of the proposal, the applicant should consider including the HSS interventions in a separate s.4B section. That way, in case the TRP does not approve the disease-focused activities, there is still a chance that it will approve the cross-cutting HSS interventions.
 - If the cross-cutting HSS interventions clearly address health system weaknesses that affect more than one of the Fund’s target diseases, and the applicant is therefore having difficulty logically dividing up the interventions among different disease components, the applicant may want to include these cross-cutting HSS interventions in the separate section s.4B.

3. Process of developing HSS interventions

- The Global Fund expects that key health system stakeholders will be involved in developing proposals that include cross-cutting HSS interventions - which is, in any case, critical to the development of successful HSS-related proposals. In particular, applicants must provide “information on the level of involvement of government and non-government (including the private sector) health system stakeholders, including representatives of key affected populations (including women and men), and sexual minorities, who can help identify where in

²⁶ *Id.*

the health system they can best be served.”²⁷ In its 2007 decision on the Global Fund’s strategic approach to HSS, the Fund’s Board “[r]ecommend[ed] that applications provide evidence of the involvement of relevant HSS stakeholders in the Country Coordinating Mechanism – including at least one nongovernment in-country representative with a focus on HSS and one government representative with responsibility for HSS planning.”²⁸

4. Community systems strengthening

- Community Systems Strengthening (CSS) activities are, as the Global Fund explains, “initiatives that contribute to the development and/or strengthening of community-based organizations in order to improve knowledge of, and access to improved health service delivery,” and, in the case of the Global Fund, should be linked to “improved outcomes for HIV, tuberculosis and malaria prevention, treatment, and care and support programs.”²⁹ CSS activities may focus on building organizational capacity of civil society organizations (including physical capacity and organizational development), building partnerships, and sustainable financing (including to achieve predictable resources over a longer period of time).³⁰ For more information on CSS, please see the Global Fund’s CSS fact sheet (http://www.theglobalfund.org/documents/rounds/9/CP_PoI_R9_FactSheet_2_CommunitySystems_en.pdf) and the Global Fund’s report *Civil Society Success on the Ground: Community Systems Financing and Dual-track Financing: Nine Illustrative Case Studies* (2008) (http://www.theglobalfund.org/documents/publications/progressreports/Dual-Track_Report_en.pdf).

CSS activities are critical to ensuring an effective community-level response to the three diseases and to fully incorporating remote, impoverished, and other marginalized populations into national responses to the three diseases – and to ensuring that their voices and perspectives inform these responses. The Global Fund encourages applicants to include CSS interventions in their proposals.³¹

- Applicants may apply for CSS initiatives as part of a diseases specific approach (s.4.5.1) or, if the CSS initiatives will benefit the response to and achieve improved outcomes for more than one of the Fund’s priority diseases, they may be incorporated “within the framework of the HSS cross-cutting interventions optional additional section (s.4B).”³²

²⁷ *Id.* at 44. When identifying disease program and health system barriers, the Guidelines call upon applicants to “[i]nvolve national, sub-national and community level health systems stakeholders (from government and non-government sectors) in needs identification.” *Id.* at 7.

²⁸ Global Fund Board, 16th Board meeting, decision point 10, *Strategic Approach to Health System Strengthening* (Nov. 2007). Available at: http://www.who.int/healthsystems/gf_board_decision07_hss.pdf.

²⁹ Global Fund, *Fact Sheet: Community Systems Strengthening* (September 2008), at 1. Available at: http://www.theglobalfund.org/documents/rounds/9/CP_PoI_R9_FactSheet_2_CommunitySystems_en.pdf.

³⁰ *Id.*

³¹ Global Fund Round 9 Guidelines for Proposals (Oct. 2008), at 34.

³² *Id.* at 35.

V. Finding Opportunities to Support Health System Strengthening

In considering the use of the Global Fund for health system strengthening, applicants can look at opportunities to apply for health strengthening from at least three perspectives.

- The first is the perspective of constraints: what are health system constraints that they must overcome to reduce the spread and impact of the target disease(s)?
- A second is that of existing health sector strategies: are there funding gaps in an existing health sector strategy that the Global Fund can support?
- A third is the need to develop a health sector strategy: does a national, provincial, or district level strategy not yet exist, even though it is needed as a basis to act?

These all represent excellent opportunities for using the Fund to support health systems strengthening.

1. Overcoming health system constraints to reducing the spread and impact of AIDS, TB, and/or malaria

When developing their proposals, applicants should consider the range of HIV/AIDS, tuberculosis, and malaria services needed and the health system constraints on delivering those services to all people in need of them. Applicants should bear in mind national strategies for achieving these goals, as well as commitments such as universal access to HIV services by 2010. What are the HSS current and anticipated constraints to initiating, scaling up, and sustaining interventions to reduce the spread and impact of the target diseases, and what are constraints to successful grant performance, both of previous Global Fund grants and of other activities included in the Round 9 proposal?

While the HSS activities that may be included in the proposal are not limited to those required for successful implementation of disease-specific interventions in the Round 9 proposal, it is important that applicants analyze Round 9 proposal goals and consider how health systems must be strengthened to achieve those goals. It is critical that such health systems strengthening be included in the proposal to enable it to be successful. The TRP will very likely be skeptical of the feasibility of a proposal that identifies system constraints to disease-specific activities, but then fails to explain how the constraints will be addressed.

What are the health system constraints that must be overcome? What HSS activities will be necessary to initiate new activities in the target disease areas or ensure that current programs can succeed? What will be needed to scale up these programs as rapidly as possible, ensure their quality, and sustain progress? What new barriers might emerge as the programs continue to expand? These and other such questions will help shape the proposal.

a. Avoiding harm to fragile infrastructure

A constraint may exist if AIDS, TB, or malaria activities cannot be successfully scaled up within the limitations of the current health systems. Or a constraint exists if implementing disease-related activities may be possible, but would come at the expense of the broader health system. For example, as a result of a human resource shortage, the only way for a country to achieve ART targets may be to draw health workers away from other health care services, thereby harming these other health services.³³ Applicants may seek support from the Fund to overcome such constraints.

³³ Malawi's Round 5 HSS proposal explains this well: "Staffing levels are clearly inadequate in Malawi to scale up the three disease specific programs as well as meet increasing demand for other health services. ART clinics, and other vertical disease programs, are likely to distract staff from other services already suffering from significant staff shortages. At the same time, integrated programs at primary care and hospital facilities, such as [Essential Health Package] TB and malaria interventions, are placing increasing demand on the health workers that remain." Government of Malawi, Round 5 Health System Strengthening proposal (Health Systems Strengthening and Orphan

A lack of long-term capacity can put the sustainability of HIV, tuberculosis, and malaria programs at grave risk. In addition to activities that meet immediate needs, the Global Fund also allows support for applicants in building capacity for the future, as long as applicants can demonstrate that such actions are required for the longer term success of efforts to reduce the spread and impact of the target diseases. In Round 5, Malawi proposed expansion of health professional pre-service training capacity “to have adequate numbers of qualified staff for the future.”³⁴ The TRP agreed that this was appropriate, noting that one of its strengths was that it “address[ed] both the immediate need to deliver services [and] the longer term need to build capacity to train the next generations of workers.”³⁵ In Round 6, Mozambique received funds to expand its pre-service training for basic and middle level health professionals, including support for training 510 basic level and 11 middle level health professionals.³⁶ In Round 8, the Technical Review Panel has recommended for approval Zambia’s HIV proposal, including its cross-cutting HSS section that contains support for expanding and rehabilitating ten health worker training institutions, recruiting tutors as a short-term strategy as more tutors are being produced, maximizing training capacity through public-private partnerships, reducing student attrition, and improving adherence to training standards.³⁷

While the TRP was quite receptive of Malawi’s request to help meet its longer term health workforce needs, the TRP might be more skeptical of a proposal that seeks to meet a country’s longer term needs if no strategy is in place to address more immediate needs.

2. Supporting an existing strategy

Limited funding may prevent the implementation of existing health sector strategies. The Global Fund can help fill those funding gaps, where such funding is necessary to overcome constraints in advancing efforts to fight AIDS, tuberculosis, and/or malaria. PHR encourages applicants to develop HSS interventions that are based on existing strategies. This will ensure that these actions are harmonized with other health sector activities and part of a coherent and comprehensive approach (assuming existing strategies are of good quality), and thus most likely to be effective and to contribute to broader health system strengthening. Also, this will ensure that they are consistent with the national health sector development plan and its timeframe. The Global Fund itself forcefully suggests that cross-cutting HSS interventions should “not be developed in isolation from existing national strategies.”³⁸

If it is not possible to address constraints through an existing strategy, applicants may develop targeted interventions to address the constraints. They might also scale up programs, or replicate interventions that have been successful in other countries, if circumstances are sufficiently similar and local conditions are considered in tailoring the intervention to fit the country context. If cross-cutting HSS actions are not part of an existing, comprehensive plan, applicants should describe how these actions are part of a functioning system or comprehensive approach.

3. Creating or strengthening national health plans

Care and Support) (June 2005), at 52. Available at:
http://www.theglobalfund.org/search/docs/5MLWH_1142_0_full.pdf.

³⁴ *Id.* at 10.

³⁵ This and ensuing references to the Technical Review Panel’s statements and views on Round 5 proposals and Round 6 are based on the TRP review forms for Round 5 and Round 6.

³⁶ Mozambique, Round 6 HIV/AIDS proposal (Mozambican National Initiative to Expand Coverage for Prevention, Care, Support and Treatment for Persons Affected by HIV/AIDS) (Aug. 2006), at 54. Namibia sought funds to provide scholarships to train 40 new nurses, 10 physicians, and 5 pharmacists out of the country in an unsuccessful Round 6 malaria proposal. The TRP cited as a weakness of the proposal that it was seeking funds for training nurses outside the country even though Namibia has a nursing school. This suggests that the TRP was open to supporting pre-service training for health professionals, but was concerned about the lack of a rationale for external training of nurses.

³⁷ Zambia Country Coordinating Mechanism, Round 8 HIV/AIDS proposal (2008), at 5-6, 67-68. This proposal should be available on the Global Fund’s website after the Fund’s Board meeting Nov. 7-8, 2008.

³⁸ Global Fund Round 9 Guidelines for Proposals (Oct. 2008), at 43.

The Global Fund represents an opportunity to support the development or revision of national health sector plans, comprehensive plans at the district or provincial level, or plans that cover a particular element of the health system, such as human resources for health. Such plans have many benefits. They can:

- serve as the basis for a coordinated response by all international and domestic partners;
- create a comprehensive, coherent approach to developing the health sector, which will translate into improved health outcomes and increased opportunities for partners (such as the Global Fund) to invest in the health sector;
- incorporate values, such as equity and a pro-poor response, throughout the health sector;
- provide an opportunity for broad input and participation in developing the national response to the population's health needs;
- catalyze policy reforms and the development of monitoring and evaluation systems that facilitate sustainable strategies;
- clarify funding needs, which can then be used to advocate within government and with international partners for the necessary funding; and
- define investment needs that can then be incorporated into the national budgeting process, including through Poverty Reduction Strategy papers and Medium Term Expenditure Frameworks. This can serve as a basis to help ensure that macroeconomic policies are designed to adequately fund these needs.

Technical and other financial support may be needed to develop a national plan. The Global Fund, which can support strategic planning and strategy development, can help finance this support,³⁹ as long as applicants can demonstrate the necessary link between developing these plans and improving outcomes for the Fund's target diseases. Applicants might argue that the development of a plan is necessary for ensuring a comprehensive, coherent, and effective response to the health system constraints and weaknesses that limit achieving improved outcomes for the target diseases, and to ensure that the response to the Fund's target diseases will contribute to broader health system strengthening, rather than risking unintended negative consequences.⁴⁰

Applicants can also argue that a comprehensive health sector plan can help ensure that health sector investments promote equity and address needs of marginalized populations - and applicants should ensure that their plans do so. Previous TRP comments have indicated the TRP's support for equity, and Round 9 Guidelines themselves expressed the Fund's support for "equitable, efficient, sustainable, transparent and accountable health systems."⁴¹

When developing health sector plans, countries should involve members of civil society (including representatives of marginalized populations), health workers, and other stakeholders in the planning process. Such participation will help ensure the successful implementation of the plan, can build trust among health system users and health workers, and can help ensure that the plan meets the

³⁹ World Health Organization officials agree: "If human resource development plans are not presently available, the framework of the Global Fund permits support to technical assistance to lay those foundations." Sigrid Dräger, Gulin Gedik & Mario Dal Poz, "Health workforce issues and the Global Fund to fight AIDS, Tuberculosis and Malaria: an analytical review." *Human Resources for Health* (2006) 4:23. Available at: <http://www.human-resources-health.com/content/4/1/23>.

⁴⁰ Kenya explained in its proposal that improved district health planning and management capacity is needed so that plans reflect the disease burden and local solutions. Further, improved understanding of the purpose of collecting data, along with developing a culture of operational research to define best practices, will enable district health teams "to define locally relevant approaches for improving health service delivery." This capacity will also enable planners and managers to address the "complex issues of health prioritization, resource need assessment and allocation based on the availability of . . . robust strategic information." Kenya Country Coordinating Mechanism, Round 6 Tuberculosis proposal (August 2006), at 78, 72, 64. Available at: http://www.theglobalfund.org/search/docs/6KENT_1351_0_full.pdf.

⁴¹ Global Fund Guidelines for Proposals Round 9 (Oct. 2008), at 42.

population's health needs, including the needs of poor and other marginalized populations. Applicants should explain in their proposal mechanisms to provide for genuine participation in the planning process.

The Global Fund has previously supported planning. Cambodia's successful Round 5 HSS proposal focused largely on planning, including better linking Global Fund planning to the Ministry of Health's core strategic planning processes, strengthening linkages between health system planning and financing, and strengthening technical planning capacities for health. In Round 6, Kenya received funds to train "district health management teams in the development of integrated, comprehensive and implementable district health plans with a robust monitoring and evaluation system."⁴² This training is expected to enable all districts in Kenya to have good quality and comprehensive health plans by the end of the five-year grant. To our knowledge, however, no country has yet used Global Fund assistance to develop a costed, operational human resource plan, or such a plan for another health system element, or for the health sector overall, though PHR has not completed an analysis of Round 7 or 8 grants. One sample HSS indicator in the March 2008 Addendum to the Fund's Monitoring & Evaluation Toolkit is on directly on point and does support the potential of using the Global Fund to support this planning process: "Health sector development strategic plan developed, agreed, implemented and reviewed annually."⁴³

a. Developing a comprehensive human resources for health plan

Developing human resources plans, along with specific strategies and budgets to implement the strategy, is an important step in beginning to overcome the health workforce crisis that constrain many countries burdened by AIDS, tuberculosis, and malaria. Indeed, African Union health ministers committed to "[p]repare and implement costed human resources for health development plans" in the October 2005 Gaborone Declaration on a Roadmap Towards Universal Access to Treatment and Care.⁴⁴ And the Africa Health Strategy 2007-2015 calls on governments to "[d]evelop costed national human resources development and deployment plans, including revised packages and incentives, especially for working in disadvantaged areas."⁴⁵ Round 9 could provide the funds to begin to meet this commitment.

Such plans are most likely to be successful if a core leadership team meets regularly to help develop the plan and ensure that it is implemented, if there is a consensus-building process among stakeholders, and if a clear monitoring and evaluation strategy is developed to ensure that adjustments are made as necessary. Enabling a wide range of stakeholders to participate throughout this process is pivotal both to the plan's success and as a matter of human rights, specifically the right of people to participate in decisions related to their health.⁴⁶ In August 2008, Physicians for Human Rights released

⁴² Kenya Country Coordinating Mechanism, Round 6 Tuberculosis proposal (August 2006), at 74. Available at: http://www.theglobalfund.org/search/docs/6KENT_1351_0_full.pdf.

⁴³ Global Fund, Monitoring and Evaluation Toolkit: HIV/AIDS, Tuberculosis and Malaria (2nd ed.) Addendum March 2008 (March 2008), at 22. Available at: http://www.theglobalfund.org/pdf/guidelines/M-E%20Toolkit_Addendum_March%202008_en.pdf.

⁴⁴ Gaborone Declaration on a Roadmap Towards Universal Access to Treatment and Care, 2nd Ordinary Session of the Conference of African Ministers of Health (CAMH2), Gaborone, Botswana, Oct. 10-14, 2005, at 2(v). Available at: <http://physiciansforhumanrights.org/library/documents/reports/gaborone-declaration.pdf>. Earlier, the Fourth Ordinary Session of the Assembly of the African Union, meeting in January 2005, urged Member States to "Prepare inter-ministerial costed development and deployment plans to address the Human Resources for Health Crisis." Assembly of the African Union, Fourth Ordinary Session, Jan. 30-31, Abuja, Nigeria, *Decision on the Interim Report on HIV/AIDS, Tuberculosis, Malaria and Polio*.

⁴⁵ Africa Health Strategy 2007-2015, at para. 56. Adopted at the Third Session of the African Union Conference of Ministers of Health, Johannesburg, South Africa, April 9-13, 2007. Available at: http://www.africa-union.org/root/UA/Conferences/2007/avril/SA/9-13%20avr/doc/en/SA/AFRICA_HEALTH_STRATEGY_FINAL.doc.

⁴⁶ "A further important aspect [of the right to health] is the participation of the population in all health-related decision-making at the community, national and international levels." 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. 11. Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

a guide on using a human rights framework in developing a health workforce plan. It is available at: <http://physiciansforhumanrights.org/library/documents/reports/health-workforce-planning-guide-2.pdf>.⁴⁷

WHO and several partners have also developed an HRH Action Framework to assist with health workforce planning. It is available at: <http://www.capacityproject.org/framework/>.⁴⁸

Applicants may also wish to lay the groundwork for a successful health workforce plan by seeking funds to support activities that can help ensure an evidence-based plan. In Round 6, Kenya did this by planning studies on factors that influence health worker motivation and by carrying out TB/HIV workload assessments. Applicants may consider studies in related areas, such as those influencing health worker migration and rural retention, or they may wish to conduct overall workload assessments, that cover but are not limited to the Fund's target diseases.

4. Building human resource management capacity

Many countries that have health workforces that cannot meet their population's health needs suffer from poor human resource management, including a lack of human resource capacity within health ministries and a lack of human resource professionals working in the health sector. This limits the capacity of health ministries to engage in strategic policy development and to effectively implement human resource strategies and policies at the national, district, and facility levels.

Applicants can seek support in a variety of areas to strengthen human resource management, such as building the capacity of human resource directorates in health ministries, developing or strengthening training and mentoring programs for human resources for health managers, and deploying human resource managers to hospitals and larger clinics.⁴⁹

Applicants can argue that without building human resource management capacity, they will be unable to effectively develop and implement the human resource policies that are needed to overcome the crisis in human resources for health, which in many countries is a major constraint to improved HIV/AIDS, tuberculosis, and malaria outcomes.

For more information on how to include interventions to build health sector human resource management capacity in Global Fund proposals, please contact James McCaffery (jmccaffery@capacityproject.org) and/or Ummuro Adano (uadano@intrahealth.org) of the Capacity Project.

⁴⁷ Physicians for Human Rights, *The Right to Health and Health Workforce Planning: A Guide for Government Officials, NGOs, Health Workers and Development Partners* (2008). Available at: <http://physiciansforhumanrights.org/library/documents/reports/health-workforce-planning-guide-2.pdf>.

⁴⁸ Two tools that human resource planners might find useful, particularly in the context of HIV/AIDS, are the joint Management Sciences for Health/World Health Organization publication *Tools for Planning and Development Human Resources for HIV/AIDS and Other Health Services*, available at http://www.who.int/hrh/tools/tools_planning_hr_hiv-aids.pdf, and Management Sciences for Health, *Human Resource Management Rapid Assessment Tool for HIV/AIDS Environments: A Guide for Strengthening HRM Systems* (2003). Available at: http://erc.msh.org/newpages/english/toolkit/hr_hiv_assessment_tool.pdf.

⁴⁹ James McCaffery & Ummuro Adano, *Global Fund Round 9 Opportunity to Build Human Resource Management Capacity: the central pillar in health systems strengthening initiatives* (Oct. 2008). Available through: http://physiciansforhumanrights.org/hiv-aids/globalfund_round9.html.

VI. Selected Issues in Constructing a Successful Proposal

This section examines several aspects of constructing successful proposals: 1) linking cross-cutting HSS interventions to reducing target diseases; 2) sustainability; 3) several issues related to salary support and incentives; 4) the importance of a comprehensive approach; 5) the value of applying for technical support, and; 6) monitoring and evaluation systems.

1. Linking cross-cutting HSS interventions to the Fund's target diseases

In both Rounds 5 and 6, some applicants found it difficult to demonstrate the required link between health system strengthening activities and reducing the spread and impact of AIDS, tuberculosis, and/or malaria.⁵⁰ Malawi's and Rwanda's successful Round 5 HSS proposals, along with Kenya's Round 6 tuberculosis proposal, which focused on HSS activities, all provide good examples of how to demonstrate this link. Each proposal qualitatively described and presented evidence on the severity of the problem; described the relationship of the problem to the target diseases and use data to demonstrate this relationship, and; included impact indicators for the target diseases.

Strategically linking health system activities to HIV, tuberculosis, or malaria activities can strengthen and help affirm the link between the health system activities and the target diseases. For example, all of the health workers supported through Malawi's proposal are to be trained in HIV interventions, and the overseas training for tutors will provide them qualifications for curricula on HIV, tuberculosis, and malaria. Applicants should be sure that when applying for cross-cutting HSS actions, these interventions are designed to ensure that they will contribute to the fight against at least one of the Fund's target diseases, such as by ensuring that new health workers are trained in these diseases. If needed, applicants should apply for funds to support such activities (such as incorporating HIV competencies into the pre-service curricula).

The following paragraphs examine in depth how Rwanda, Malawi, and Kenya demonstrated the link between their proposals' HSS activities and the target diseases.

a. Rwanda's Round 5 HSS proposal

i. Summary of proposal

Rwanda's Round 5 HSS proposal identifies the lack of interaction between the population and the health services as a central obstacle in its efforts to combat AIDS, tuberculosis, and malaria. The proposal seeks to increase this interaction by improving financial access for the poor and other groups and by improving the performance and quality of the health delivery system.

The proposal achieves the first objective through a community-based health insurance scheme. The Global Fund will support the full cost of membership in the insurance scheme for the very poor, people living with HIV/AIDS, and members of vulnerable groups, and 50% of the membership costs for the entire poor rural populations of the six provinces covered by the proposal. The proposal achieves its second objective primarily in two ways: 1) supporting pre-service and in-service training of health professionals and administrative and supervisory staff in health financing, health insurance, financial management of human resources, quality assurance, and monitoring and evaluation,⁵¹ and; 2) providing

⁵⁰ In Round 5, proposals had to demonstrate that all health system strengthening activities "are necessary prerequisites to improving coverage in the fight against any or all of the three diseases," according to the Round 5 Guidelines for Proposals. In Round 6, Guidelines required that health system strengthening activities be "linked to reducing the impact and spread of any or all of the three diseases" and that they be "necessary." In Round 9, cross-cutting HSS interventions should have "a clear and demonstrated link to improved HIV, tuberculosis and/or malaria outcomes." Global Fund Guidelines for Proposals Round 9 (Oct. 2008), at 62.

⁵¹ Notably, the Rwanda proposal includes training for management and administrative cadres, who often receive less attention than clinical staff but are also very important to the functioning of the health system. By contrast, the TRP stated that one weakness of the Round 5 HSS proposal of the Democratic Republic of Congo was that it did

electricity to 74 health centers for facilitate laboratory services, safekeeping of vaccines, and addressing nighttime emergencies.

Through its proposed aims, the project seeks to improve financial accessibility of health services (leading to 30% growth in service utilization), improve access to quality prevention, care, and treatment in the health system's periphery, improve management of district health services, and increase community involvement in the health care system.

Rwanda's Round 5 HSS proposal is available at:

http://www.theglobalfund.org/search/docs/5RWNH_1199_0_full.pdf.

ii. Linking HSS to the diseases

Severity of problem and data to make the case

Rwanda's proposal emphasizes that a major obstacle in controlling HIV/AIDS, tuberculosis, and malaria is the lack of interaction between the health services and affected populations. The proposal states the urgency of improving health access to the fight against the Global Fund's three priority diseases: "This lack of action between the health services and the diseased population jeopardises seriously any progress in the control of HIV/Aids, TB, malaria, and associated diseases."⁵² And elsewhere: "it seems indispensable to assure the financial access to health services and to gradually improve their quality in order to address the disease burdened caused by the three target epidemics."⁵³

The proposal includes powerful statistics to highlight the severity of the problem of lack of access, such as the fact that in rural areas, people contact the health system in only 60% of disease episodes and that "average treatment costs in the case of a single episode of disease are next to equal to the median monthly income of a rural household."⁵⁴

Relationship of problem to target diseases (including statistic link)

The proposal observes that even if particular health services, including TB, are free due to external funding, "the very entry into the health system remains a persisting and principal obstacle."⁵⁵ It specifically notes that the first consultation for TB is subject to user fees, and that "the availability of prompt and appropriate treatment of malaria remains one of the fundamental challenges within the Rwandan health system, and the need to increase the financial accessibility is of paramount importance in this context."⁵⁶

In many countries (and possibly Rwanda itself), much the same could be said with respect to HIV/AIDS: Even if HIV services are free, user fees that deter initial contact with the health services will prevent opportunities for HIV counseling and testing that such contact would promote. Even if the HIV testing and counseling itself is free, if other essential health services require point-of-service payments, people may not interact with the health system in the first place, and so will not have the opportunity to be tested.

not provide for the training needs of management and administrative cadres, suggesting that countries should pay attention to these cadres.

⁵² Rwanda Country Coordinating Mechanism, Round 5 Health System Strengthening proposal (Assuring Access to Quality Care: The Missing Link to Combat AIDS, Tuberculosis and Malaria in Rwanda) (June 2005), at 39. Available at: http://www.theglobalfund.org/search/docs/5RWNH_1199_0_full.pdf.

⁵³ *Id.* at 43.

⁵⁴ *Id.* at 39.

⁵⁵ *Id.*

⁵⁶ *Id.* at 40.

The proposal provides data to connect health service utilization to the fight against AIDS, tuberculosis, and malaria. These three diseases account for at least half of the country's entire disease burden,⁵⁷ and that of the 3 million annual health consultations in Rwanda, 1 million are related to malaria, 400,000 to cough as the first sign of tuberculosis, and 300-600,000 to HIV-related diseases.⁵⁸ Therefore, a significant portion of the increased health service utilization can be expected to be related to HIV, tuberculosis, and malaria.

Impact indicators linked to target diseases

Rwanda's proposal links its activities to a direct impact on HIV and tuberculosis. Its impact indicators include maintaining a stable HIV prevalence rate in pregnant women (5.1%), increasing tuberculosis detection rates from 45% to 70%, and improving tuberculosis treatment completion rates from 58% to 85%.⁵⁹

b. Malawi's Round 5 HSS proposal

i. Summary of proposal

Malawi's Round 5 HSS proposal is dedicated to human resource strengthening, as Malawi has one of the most significant health worker shortages in the world. The proposal seeks to achieve its goals of reducing HIV transmission and mortality and increasing output of highly skilled health workers through four objectives:

- Increase community-based services by recruiting and training 4,200 health surveillance assistants (HSAs), including 1,000 people living with HIV/AIDS. Compensation levels for these and other HSAs will enable these community-based health workers to benefit from the 52% salary increase already provided to other health cadres.
- Recruit and retain the 54 doctors, 100 nurses, 100 clinical officers, and 100 counselors needed to staff planned ART clinics, support expenses of 25 expatriate pediatricians and 20 internal medicine specialists, and recruit and support the additional 1,028 community nurses needed to provide the Essential Health Package, which includes tuberculosis and malaria services.
- Expand number and skills of nurse and other health professional tutors (teachers) by supporting 100 tutors in overseas training programs and developing advanced degree programs at health professional training institutes.
- Build capacity of training institutions through support for scaling up facilities and supporting curriculum development.

Achieving these objectives will fill substantial gaps in Malawi's Emergency Human Resource Programme and expand the capacity of health facilities to deliver the Essential Health Package and HIV/AIDS services.

Malawi's Round 5 HSS proposal is available at:

http://www.theglobalfund.org/search/docs/5MLWH_1142_0_full.pdf.

ii. Linking HSS to the diseases

Severity of problem and data to make the case

Malawi's proposal states that "[a]nalysis of the previous national AIDS strategy and the phase 1 of the Global Fund Round 1 HIV/AIDS grant showed that human resource capacity is a major constraint to

⁵⁷ *Id.* at 38.

⁵⁸ *Id.* at 43.

⁵⁹ *Id.* at 45.

scaling up.”⁶⁰ The country’s “health system’s civil service suffers from one of the worse staffing shortages in Africa creating a near breakdown in capacity to deliver a basic level of health care, especially in rural areas.”⁶¹ The proposal emphasizes the Malawian government’s desire to scale up HIV, tuberculosis, and malaria services as well as other health services, and to scale up services for the target diseases in a way that did not harm other health services. It states that this is not possible at current staffing levels: “The shortage of health workers in Malawi is the most major constraint to meeting the EHP [Essential Health Package] service requirements for the Millennium Development Goals including scaling up ART and other HIV/AIDS/TB/malaria services.”⁶²

The proposal then provides data to back up these statements. Among other things, it compares detailed information on Malawi’s health worker shortage to shortages in other sub-Saharan African countries, provides vacancy rates of health worker cadres, observes that four districts have no physicians at all, and presents the nurse-to-patient ratios, which are very poor. The proposal includes specific information on human resource needs for ART scale-up, based both on international norms and a workload analysis from Malawi’s own ART clinics.

Like Rwanda’s proposal, Malawi’s proposal highlights the high level of overall health services delivery in the country that is related to the three diseases, including that 60% of hospital occupancy is due to HIV-related diseases, and the fact that more than the majority of work of health surveillance assistants - many of whom are trained through the proposal - is related to the three diseases.⁶³

Relationship of problem to target diseases (including statistic link)

The proposal links the shortage in human resources to the country’s ability to address HIV, tuberculosis, and malaria. “Only a small fraction of PLWHA have access to ART and less than 10 percent of all health centers in Malawi are capable of delivering the” Essential Health Package (EHP), which includes tuberculosis and malaria services. The proposal further explains, “Community based services especially in rural areas are almost devoid of EHP services.”⁶⁴

The proposal also explains that the health workers whose numbers are to be increased through the proposal are critical to ART delivery, counseling, and home-based care, as well as to an improved response to tuberculosis and malaria, and that they will improve the effective utilization of existing HIV/AIDS finances. They will also fill human resource “gaps left by staff moving to ART clinics.”⁶⁵ All health workers supported by the proposal will be trained in HIV interventions and, since the majority of patients in Malawi are HIV-positive, all health workers funded by the proposal will also provide HIV services.

Impact indicators linked to target diseases

Malawi’s proposal directly relates human resource improvements to specific HIV-related improvements that human resource development will result in, including increasing the percent of community members who receive HIV counseling and testing from 3% to 10%, enabling above ART adherence to increase from 95% to 98%, and increasing the percent of home-based care patients who are followed-up and provided treatment from 25% to 75%.⁶⁶

⁶⁰ Government of Malawi, Round 5 Health System Strengthening proposal (Health Systems Strengthening and Orphan Care and Support) (June 2005), at 8. Available at: http://www.theglobalfund.org/search/docs/5MLWH_1142_0_full.pdf.

⁶¹ *Id.* at 50.

⁶² *Id.*

⁶³ *Id.* at 10.

⁶⁴ *Id.* at 49.

⁶⁵ *Id.* at 68.

⁶⁶ *Id.* at 55.

c. Kenya's Round 6 TB proposal

i. Summary of proposal

Kenya recognized that its previous tuberculosis proposals to the Global Fund, which had been approved, would increase demand on the health system, and that health system capacity had to be increased to meet this demand. The proposal addresses three areas to build capacity to scale up the country's integrated TB/HIV program.

- Most of Kenya's dispensaries, primary level health facilities, lack the ability to offer even basic TB/HIV services. The proposal seeks funds to rehabilitate many of these facilities so that in five years, at least 80% would be able to provide basic TB/HIV services, up from 16% at present. Activities included procuring microscopes, other laboratory equipment, furniture, and power supply equipment; renovating examination rooms, and; maintaining equipment and physical infrastructure.
- The proposal seeks build health workforce capacity, including by recruiting 155 additional staff (40 nurses, 15 clinical officers, and 100 laboratory technologists) and improving in-service and pre-service training, primarily for TB/HIV. The proposal will fund studies on health worker motivation, and will support the production and distribution of a variety of job aids. To improve health workforce planning and deployment decisions, the proposal will fund TB/HIV workload assessments. These will be used to develop a human resource development plan for TB, which will be merged with overall human resources for health plan that Kenya will develop.
- The proposal will support health planning and management capacity by training district health management teams in the development of comprehensive, implementable district health plans. These are to include robust monitoring and evaluation systems and built-in operational research to define best practices in the delivery of integrated TB/HIV services.

Kenya's Round 6 TB proposal is available at:

http://www.theglobalfund.org/search/docs/6KENT_1351_0_full.pdf.

ii. Linking HSS to the diseases

Severity of problem and data to make the case

The proposal focuses on how a lack of health facilities, especially at the primary level, that offer integrated TB/HIV services immediate access to these services, and includes several powerful statistics to demonstrate this fact. The proposal explains that these primary level facilities, especially dispensaries, are critically important because "the bulk of the population accesses its health care from them."⁶⁷ Higher level facilities that are more likely to offer TB/HIV services are at large health facilities that may be inaccessible to most communities. Further, the proposal states that user fees are still charged at hospitals, but not primary level facilities.⁶⁸

The proposal states that "Kenya is facing a human resource for health crisis," that due to "an attempt to control the Government wage bill there has been no significant recruitment of health staff in the public sector for over a decade and therefore, large human resource gaps have emerged that threaten the ability of the country to deliver on its health objectives." Further, the proposal explains the need to expand the number of health facilities as the population rises - and that in fact funding is being used to develop new facilities - yet "[w]ithout bringing in more [human resources], this [increase in the

⁶⁷ Kenya Country Coordinating Mechanism, Round 6 Tuberculosis proposal (August 2006), at 71. Available at: http://www.theglobalfund.org/search/docs/6KENT_1351_0_full.pdf.

⁶⁸ *Id.* at 56, 64.

number of health facilities] will worsen the human resource gaps.”⁶⁹ Kenya’s proposal observes that “several health care facilities . . . closed as a result of lack of health care staff.”⁷⁰

In less detail, the proposal also refers to both low productivity - “[t]he human resource for health equation does not end with numbers alone,” the proposal correctly observes - and weak health management capacity.⁷¹ “There has been a lot of effort to “expand the financial envelope available for health,” the proposal asserts, “but there has been no equal zeal to pursue better health planning and health resource management.”⁷² Yet “[i]t is critical that health planners and managers at district level are well versed with the complex issues of health prioritization, resource need assessment and allocation based on the availability of a robust strategic information.”⁷³

The proposal refers to the fact that “only 16% of dispensaries, a small proportion of truly primary level facilities, are able to provide the basic package of TB/HIV services.” Even “of the 1605 health units that offered TB services in 2005 only 700 (43.6%) were offering smear microscopy services.”⁷⁴ With respect to health personnel, the proposal includes the statistic that based on current staff numbers of staffing ratios, the country is experiencing a shortage of 17,041 health personnel,⁷⁵ yet “[i]f the needs are to be based on workload, it is very likely that larger gaps will emerge.”⁷⁶

Relationship of problem to target diseases (including statistic link)

Kenya’s linkage between the problems its Round 6 proposal addresses and tuberculosis is founded on two principles. First, reminiscent of both Malawi’s and Rwanda’s proposals, is to increase access to health services, in this case integrated TB/HIV services. The central goal of the proposal “is to expand the capacity of the health care system to deliver integrated TB/HIV services, especially at primary levels of the health care system, in order to improve access to these services and thus, increase TB case detection and treatment success rates.”⁷⁷

Second, the proposal is premised on an increase of demand for TB services that the full implementation of earlier Global Fund proposals will create without a commensurate increase in the capacity of the health system to deliver these services: “The full implementation of activities in round of 2 and 5 and in particular the Communication and Social Mobilization activities of round 5, may lead, as intended, to a massive increase in the demand for services yet both grants were not designed to strengthen the system to cope with this demand. This proposal is intended to form the bridge between demand for health services that the previous grants may create and the supply of those services.”⁷⁸

That only 16% of primary care facilities dispensaries provide integrated TB/HIV services provides a clear link between the lack of capacity at these facilities and the availability of TB/HIV services. To further bolster this link, the proposal includes a table with “data to suggest that TB case notification is directly related to health facility density in Kenya,” while conceding that “the evidence is imperfect.”⁷⁹

The proposal also presents data on decreasing improvements in TB case notification, which had been increasing “at 12-16% annually, [though] in 2005 there was an increase of only 3% compared with 2004.” Kenya’s proposal offers that “[o]ne hypothesis for the decline in annual case notification between 2003-05 is the possibility that the health care system has reached a ‘saturation’ point and can

⁶⁹ *Id.* at 63.

⁷⁰ *Id.* at 57.

⁷¹ *Id.* at 63.

⁷² *Id.* at 63-64.

⁷³ *Id.* at 64.

⁷⁴ *Id.* at 56.

⁷⁵ *Id.* at 62.

⁷⁶ *Id.* at 63.

⁷⁷ *Id.* at 71.

⁷⁸ *Id.* at 76.

⁷⁹ *Id.* at 55 (the table is on page 56).

no longer cope find additional cases. This would imply that TB case notification will only rise again if the health care system is 'boosted' to increase its capacity to cope with the demand for TB services."⁸⁰

Impact indicators linked to target diseases

The proposal includes indicators both on key TB measures as well as health system capacity to deliver TB services and the population to access them. These include increasing case notification by 50% by year 5, increasing successful outcomes from 82% to at least 85%, increasing the proportion of dispensaries offering the full basic DOTS package and select HIV services from 16% to 40%, and increasing the total number of sputum smear examinations for new patients by 50% by year 5, and maintaining updating of HIV testing for TB patients at over 80%.⁸¹

2. Sustainability⁸²

The Global Fund's Guidelines for Proposals require countries to explain how they will sustain activities included in their proposal, including financial sustainability. As the Round 9 Guidelines for Proposals emphasize, this does **not** mean that applicants need "to demonstrate financial self-sufficiency for the targeted interventions by the end of the proposal term." Rather, "applicants should include how the proposal is addressing issues such as capacity to absorb increased resources and recurrent expenditures, and how national planning frameworks are seeking to increase available financial and non-financial resources to ensure effective prevention and control of the disease(s)."⁸³

Examined below are the ways in which several countries have addressed the sustainability of health systems strengthening costs, especially salaries, in Global Fund proposals. These are not mutually exclusive possibilities; an applicant might demonstrate sustainability through several different approaches, such as through an increasing domestic health budget along with support from international partners. The Global Fund does not have different standards or special requirements for demonstrating sustainability of salaries as compared to other interventions.

a. Absorbing costs into national budgets

Particularly where only a small number of health workers are being hired, countries might simply state that they will be absorbed into the national budget, as Sierra Leone did in a Round 4 proposal. Where more substantial numbers of health workers will be hired, and are expected to be covered by the government after the Global Fund grant ends, applicants should explain, if possible, what will enable the government to absorb these additional expenditures. For example, a country might have a policy to increase its health budget, which could accommodate the additional salaries. Rwanda used a planned national health budget increase to help demonstrate sustainability in a successful Round 3 HIV proposal.⁸⁴

If a country proposes to sustain activities by increases in domestic health spending, if possible the proposal should explain how these increases will be possible. Otherwise, the TRP might be concerned about sustainability, as for example in Round 5, when the TRP expressed concern about the sustainability of Kenya's HSS proposal, in part because "[a]lthough the government has a policy to increase health sector budget it is not linked to any ability to mobilize additional resources."

⁸⁰ *Id.* at 55.

⁸¹ *Id.* at 87.

⁸² Parts of this section not referring to Round 5 are quoted from the *Guidance to the Global Fund to Fight AIDS, Tuberculosis and Malaria and Support for Human Resources for Health* (pages 14-15), which Physicians for Human Rights produced in April 2005 and is available at:

<http://physiciansforhumanrights.org/library/documents/reports/guidance-to-the-global-fund.pdf>.

⁸³ Global Fund Round 9 Guidelines for Proposals (Oct. 2008), at 34

⁸⁴ Rwanda Ministry of Health, Round 3 HIV proposal (Decentralisation of the overall management of people living with HIV/AIDS), (2003), at 48. Available at: http://www.theglobalfund.org/search/docs/3RWNH_711_0_full.pdf.

There are several ways a government might be able to demonstrate that increased domestic resources will be available for health. A government might plan to reallocate its budget priorities towards health, in line, for example, with the commitment of African countries to allocate at least 15% of the government budget to the health sector.⁸⁵ Several countries have discussed in their proposals policy reforms that will increase funding for the health sector. Zambia stated in its Round 4 HIV proposal that it is implementing a public sector reform plan, freeing additional resources “which will be channeled to the social service sectors, especially health.”⁸⁶ Malawi’s Round 5 HSS proposal cited a medium-term pay reform policy that it is implementing, which includes “eliminat[ing] donor dependency and lessen[ing] the threat of employee earning loss should donor funding decrease.”⁸⁷

A government might have a strategy to increase overall revenue, such as through economic policy changes or economic growth. Rwanda’s Round 5 HSS proposal explained several mechanisms through which the economy would grow, making more money available for health. That proposal described how poverty reduction, economic development, and the government’s commitment to health will increase domestic funds available for health. As the country implements its Poverty Reduction Strategy, people’s economic situation will improve so an increasing proportion of people will be able pay towards the health insurance. The proposal noted that improved health – in part due to the impact of the proposal – will lead to “increased population wealth through improved health,” this “[i]n concordance with the insight of the WHO Commission on Macroeconomics and Health.” Furthermore, the Rwanda’s government will be able to contribute more funds to health due to economic growth, funds from debt cancellation, and its commitment to increase the health sector’s share of the government budget.⁸⁸

If countries include support for both salary payments and human resource management in their proposals, the proposal could at least partially pay for itself: the elimination of ghost workers (workers who are on the payrolls but are not actually working, or might not even exist) and unearned allowances that is made possible through improved human resource management can free enough resources to hire significant numbers of health workers.

b. *Progressive involvement*

The TRP has expressed support for approaches that progressively shift salaries from the Fund to the government. The TRP cited as one weakness of Botswana’s unsuccessful Round 6 tuberculosis proposal was that “[I]ab technical and support personnel salaries are to be fully supported via the requested funding from the Global Fund and without the progressive involvement of the” Ministry of Health. By contrast, the TRP praised how Swaziland’s Round 6 malaria proposal addressed sustainability (though the proposal failed), noting the “increasing contribution of the government up to >50% of the overall budget.”

A similar TRP interest in the gradual transfer of responsibility away from the Global Fund and its structures relates to the development of local capacity. The TRP saw as a weakness in the unsuccessful Round 6 Central African Republic malaria proposal that “[n]o description of the local

⁸⁵ *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases*, Organization of African Unity summit, adopted April 27, 2001, Abuja, Nigeria, at para. 26. Available at: http://www.un.org/ga/aids/pdf/abuja_declaration.pdf.

⁸⁶ Zambia Country Coordinating Mechanism, Round 4 HIV proposal (Scaling-Up Antiretroviral Treatment for HIV/AIDS in Zambia) (2004), at 54. Available at: http://www.theglobalfund.org/search/docs/4ZAMH_831_0_full.pdf.

⁸⁷ Government of Malawi, Round 5 Health System Strengthening proposal (Health Systems Strengthening and Orphan Care and Support) (June 2005), at 73. Available at: http://www.theglobalfund.org/search/docs/5MLWH_1142_0_full.pdf.

⁸⁸ Rwanda Country Coordinating Mechanism, Round 5 Health System Strengthening proposal (Assuring Access to Quality Care: The Missing Link to Combat AIDS, Tuberculosis and Malaria in Rwanda) (June 2005), at 54. Available at: http://www.theglobalfund.org/search/docs/5RWNH_1199_0_full.pdf.

capacity to administer malaria grants included how UNDP intends to phase out its role as the recipient of Global Fund grants in [the Central African Republic] (after four previous grants)."

c. Support from development partners

Countries may also be able to maintain support for salaries through donor-supported country plans or other possibilities of receiving additional external resources. For example, Swaziland referenced its Poverty Reduction Strategy in its Round 4 HIV proposal.⁸⁹ Cambodia, in its Round 4 HIV proposal, referred to the support it receives from the United Kingdom's Department for International Development (DFID), the World Bank, and the Asian Development Bank, which provide funding to the country's Health Sector Support Project.⁹⁰ Malawi's Round 5 HSS proposal stated that Malawi had received a commitment from DFID for a minimum of 6-10 years beginning in 2004.⁹¹

Importantly, however, external commitment need not be quite this explicit. Rwanda's Round 5 HSS proposal expressed confidence that "[i]t is extremely probable that eventually additional needed funds for the project's continuation" will be available because the project [community-based health insurance] is within a framework "endorsed by practically all development partners in Rwanda, among them [the] World Bank, UN Agencies, bilateral partners, and the Churches."⁹²

Where external resources will be needed for sustaining salaries or other health systems spending, but have not yet been secured, applicants should provide any evidence that they are likely to secure such funding. Rwanda's description of how the community-based health insurance is within a framework endorsed by development partners is a good example. Countries may want to state (where it is true) and provide any evidence that: (1) health (and sustaining salaries and supporting the health workforce, if that is the issue at hand) is a national priority; (2) the government is committed to aggressively seeking the necessary external resources; and (3) to the extent possible, increased domestic resources will be used to sustain the salaries. It would also be useful to refer to any budgetary and development plans or frameworks (such as Medium Term Expenditure Frameworks) of which the salaries or other health system strengthening activities are a part.

d. Innovative financing sources

Malawi's Round 5 HSS proposal included an innovative financing strategy. Its Medical College has a strategic plan that will enable the College to generate income through "enrolment of students from [Southern African Development Community] countries, income generation from private practice by various departments, and the opening of a medical clinic to the public."⁹³

In determining their strategies, Physicians for Human Rights urges countries to adhere to the right to health, including its requirement to protect marginalized populations, including the poor.⁹⁴ For

⁸⁹ Swaziland's Round 4 HIV/AIDS proposal is available at: http://www.theglobalfund.org/search/docs/4SWZH_820_0_full.pdf, at 69.

⁹⁰ Cambodia's Round 4 HIV/AIDS proposal is available at: http://www.theglobalfund.org/search/docs/4CAMH_775_0_full.pdf, at 73.

⁹¹ Government of Malawi, Round 5 Health System Strengthening proposal (Health Systems Strengthening and Orphan Care and Support) (June 2005), at 73. Available at: http://www.theglobalfund.org/search/docs/5MLWH_1142_0_full.pdf.

⁹² Rwanda Country Coordinating Mechanism, Round 5 Health System Strengthening proposal (Assuring Access to Quality Care: The Missing Link to Combat AIDS, Tuberculosis and Malaria in Rwanda) (June 2005), at 54. Available at: http://www.theglobalfund.org/search/docs/5RWNH_1199_0_full.pdf.

⁹³ *Id.* at 65.

⁹⁴ 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). Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

example, one possible financing strategy, user fees, has been found to significantly reduce access to health services by the poor,⁹⁵ and so recommends against using this mechanism to pay for salaries.

e. *Special circumstances*

Malawi's Round 5 HSS proposal argued that the severity of the country's health worker shortage required sustainability to be viewed differently than might otherwise be the case. The proposal explained that DFID's Permanent Secretary for Health has "indicated that the human resources shortages in Malawi had reached such a critical point that 'measures that might not otherwise be considered as sustainable' needed to be urgently implemented."⁹⁶

3. Salaries and incentives: Several important considerations

Applicants may include support for salaries in their Global Fund applicants. The Fund frequently supports salaries of health workers in its grants. In some cases, such as Malawi's Round 5 HSS proposal and Kenya's Round 6 TB proposal, the Fund supports salaries of significant numbers of health workers. The Malawi proposal has had the most extensive salary support, covering salaries for more than 1,000 community nurses and several hundred of other health professionals, along with the full salaries of more than 4,000 Health Surveillance Assistants and salary increases for several thousand more. As with other HSS activities, if a proposal includes cross-cutting HSS interventions to recruit health workers and pay their salaries, the applicant will have to demonstrate "that there is a clear and demonstrated link" between the HSS interventions and "improved HIV, tuberculosis and/or malaria outcomes."⁹⁷

Several considerations related to using the Global Fund to support salaries and incentives are discussed below.

a. *Salary support*

In its comments to the Global Fund Board on Round 6 proposals, the TRP suggested "that the following points be taken into account in guiding future proposals for the funding of" human resource strategies, which the proposals should locate within the broader national context:

i. *Proposals for salary support and/or premiums within the public sector and/or NGOs and private sector institutions should be located within and justified in terms of:*

- *the overall human resources policy of the relevant institution(s);*
- *the existing salary scales;*
- *the expected specific contribution of such additional resources to the disease specific targets;*
- *the expected impact (positive and negative) of the strategy on other aspects of the healthcare system;*
- *how any negative expected impacts will be mitigated; and*
- *plans to shift the salary costs to the national budget and the timetable for this; and*

ii. *For NGO and/or private sector institutional proposals, particular attention should be given to describing the nature of the relationships and interactions between these institutions and the*

⁹⁵ See discussion and citations in Physicians for Human Rights, *An Action Plan to Prevent Brain Drain: Building Equitable Health Systems in Africa* (June 2004), at 82. Available at: <http://physiciansforhumanrights.org/library/documents/reports/report-2004-july.pdf>.

⁹⁶ Government of Malawi, Round 5 Health System Strengthening proposal (Health Systems Strengthening and Orphan Care and Support) (June 2005), at 73. Available at: http://www.theglobalfund.org/search/docs/5MLWH_1142_0_full.pdf.

⁹⁷ Global Fund Round 9 Guidelines for Proposals (Oct. 2008), 62. Elsewhere, the Guidelines for Proposals strongly recommend that "there must be a clear and logical justification given between the planned *HSS cross-cutting interventions*, the national health development plans or strategies, and improved outcomes for HIV, tuberculosis and/or malaria." *Id.* at 43.

relevant public sector institutions, and how the proposal might improve these for mutual benefit (to the extent that this is feasible);⁹⁸

The TRP would seem most likely to recommend for proposals that include significant salary support if the levels and nature of salary support is based on national health strategies or other planning frameworks.

b. Incentives

If applicants seek funding for retention and incentive schemes, whether to retain health professionals in the country or to induce them to serve in rural and other deprived areas, they should provide the details of these incentives and retention strategies. What is the incentive package? In Round 5, countries frequently failed to include detail on incentives for health workers, a weakness that the TRP cited on several occasions. Proposals should also be clear on who will be eligible for incentives - for example, only health workers at government health facilities, or also those at church-run health facilities - as well as the districts or other areas that such health workers will be located, and why these areas were selected. Applicants should also present any evidence that incentives will work, such as success of a pilot program or health worker input in designing the incentive package.

c. Mitigation or avoiding harm to other health services, and the potential for broad-based incentives or salary support

i. What potential do incentives have for harming non-targeted health services or regions?

One common strategy to help retain health workers is to provide salary top-ups or other incentives and benefits, such as housing allowances, car loans, and special training opportunities. If such incentives are provided to only some health workers, the incentives are likely to attract workers to the opportunities that provide these incentives. For example, if the incentives are provided only to health workers in ART clinics, the incentives could draw health workers away from primary health services to these clinics, or if incentives are only provided to health workers in only certain regions of the country, health workers are likely to migrate to that region.

This migration can be the point of incentives, as when incentives are provided to health workers to serve in rural or other hardship areas. When not part of an intentional strategy to redeploy health workers, the migration can harm regions that lose health workers. The Global Fund's Round 9 Guidelines for Proposals use the movement of health workers from one area or sector to another as an example of a potential unintended consequence of HSS interventions.⁹⁹

As indicated above, the TRP has expressed severe reservations about health systems strengthening activities that harm other parts of the health system. It was this concern that the TRP cited as a weakness in Zimbabwe's unsuccessful Round 6 HIV proposal. That proposal would have provided increased salaries through a Salary Augmentation Program to nurses, pharmacists, and physicians in the 39 districts in Zimbabwe that had ART programs. Health workers in other districts would not receive the augmented salaries. The TRP stated, "It may be difficult to avoid serious inequities/inequalities with the SAP [Salary Augmentation Program] between supported districts and those that are not." The TRP was evidently concerned that these inequities in health worker pay would lead to harmful distortions and internal movement of health workers.

It should be noted that this was not the only concern that the TRP had about Zimbabwe's Salary Augmentation Program. The TRP further explained that no evidence had been "presented that this salary augmentation would lead to significant improvement in health worker retention. Without some

⁹⁸ *Report of the Technical Review Panel and the Secretariat on Round 6 Proposals*. Presented at the 14th Board Meeting of the Global Fund, Oct. 31-Nov. 3, 2006, at 27. Available at: http://www.theglobalfund.org/en/files/boardmeeting14/GF-BM-14_10_TRPReportRound6.pdf.

⁹⁹ Global Fund Round 9 Guidelines for Proposals (Oct. 2008), at 31, 44-45.

evidence that this intervention would have the desired impact this cannot be recommended at this time.” As explained more below, applicants seeking funds to support investments should always provide evidence that the incentives are likely to succeed. Zimbabwe’s hyperinflation may have presented an extra difficulty in providing evidence of a positive impact.

In Round 4, Zambia successfully sought Global Fund support in its HIV proposal for more than 5,000 nurses, doctors, and other health workers who were to be providing ART services (as well as other health services).¹⁰⁰ One factor that may have helped Zambia’s proposal succeed where Zimbabwe’s failed was that Zambia’s ART program was not limited to particular parts of the country. Instead, “ART centres are targeted for both urban and rural populations in all the 72 districts of the Country to ensure the service is as near as possible to the persons in need.”¹⁰¹

ii. How can applicants avoid or mitigate harmful distortion from incentives? Can applicants seek funding for broad-based incentives or salary support?

Applicants can engage in several strategies to help ensure that incentives serve their intended purpose of helping to retain health workers without risking harm to other parts of the health sector or country. Preferably, the incentives for which applicants seek funds from the Global Fund should be part of a comprehensive approach to incentives (and if possible, an overall, comprehensive approach to strengthening the health workforce) that covers all health workers, unless the incentives are aimed at strategically encouraging health workers to serve in rural or other underserved areas. PHR strongly encourages applicants to consider the use of incentives and other strategies to deploy health workers to rural and other underserved areas.

The Global Fund could then be used to fund a piece of that strategy, for example, connected to health workers provided in activities related to the Fund’s target diseases, as Zambia and Zimbabwe did for anti-retroviral therapy. If this is the approach applicants take, they should if possible have a strategy for funding the rest of the incentives strategy, whether from the government or international partners. If funding is not available for the rest of the strategy, applicants should make clear that the incentives for which they seek support are part of a comprehensive plan, and that the applicants are actively seeking sources of funding for the rest of the strategy, as they should be.

In at least several cases, an applicant has successfully used the Global Fund to provide incentives and regular salary increases on a nationwide basis. In its Round 5 HSS proposal, Malawi received funding to increase the compensation of all Health Surveillance Assistants, a community-based cadre of health workers who have an important role in providing Malawi’s Essential Health Package, including HIV/AIDS, tuberculosis, and malaria health services. That is, their retention was clearly linked to providing services in the Fund’s priority areas. If applicants seek funding for salary increases or incentives to help retain all health workers of one or more category, they should if at all possible explain these workers’ involvement in AIDS, tuberculosis, and malaria activities to demonstrate that their retention is necessary to sustaining and scaling up services in these areas.

The nationwide salary enhancements in Malawi that the Fund supported were for a single cadre, extending to Health Surveillance Assistants salary increases that other cadres were receiving through other funding sources. A proposal seeking salary support or incentives for a wider range of health workers, on a national basis, would be more ambitious still. But it should be possible for the Global Fund to support such a proposal – as long as the applicant makes the necessary connection to improving outcomes for at least one of the Fund’s priority diseases.

¹⁰⁰ Zambia Country Coordinating Mechanism, Round 4 HIV/AIDS proposal (Scaling-Up Antiretroviral Treatment for HIV/AIDS in Zambia) (2004), at 54. Available at: http://www.theglobalfund.org/search/docs/4ZAMH_831_0_full.pdf.

¹⁰¹ *Id.* at 29.

Indeed, Lesotho's Round 8 HIV proposal suggests that in the face of serious health workforce challenges, the TRP may well look favorably on proposals that seek salary support or incentives for large numbers of health workers from multiple cadres whose responsibilities contribute to addressing the Fund's priority diseases - and hence to improved outcomes for these diseases - but who also provide a wide range of other health services. Lesotho's Round 8 HIV proposal, which the TRP recommended for approval, includes salary complements for more than 1,200 health workers at all levels (not only a single cadre) - nearly one-third of the entire formal sector health workforce¹⁰² - as well as monthly hardship allowances for 391 health professionals working at rural primary health care clinics. These health workers provide a full range of health services, including HIV and TB services, but also many other health services. The salary complements and hardship allowances are based on Lesotho's national human resource strategy.¹⁰³

PHR has not completed a comprehensive review of Round 7 and 8 proposals to determine whether there are additional cases of applicants using the Global Fund to provide incentives on a nationwide basis in these rounds.

It is not clear how the TRP would react to a proposal that seeks funding for incentives to significant numbers of health workers who are not providing services in the Fund's target disease areas (as well as for a significant number of health workers who are engaged with these diseases), on the grounds that such funding is necessary to ensure that providing incentives to the health workers who *are* providing these services does not harm the broader health system. This would be different from a case like Malawi or Lesotho, where incentives or salary complements are broadly based, but in general the health workers will indeed be providing services that address the Fund's priority diseases, even as they will provide a wide range of other health services as well. On the one hand, the TRP would welcome efforts to mitigate harm to other health services. On the other hand, the TRP might see this as outside the Global Fund's mission, and not sufficiently linked to improved outcomes for at least one of the Fund's target disease. Ethiopia's success Round 4 HIV proposal appears to include some funds for a small number of health professionals not involved in HIV services.¹⁰⁴ And while Zimbabwe's Salary Augmentation Program would have supported health workers in districts where anti-retroviral therapy was being or going to be provided, it is doubtful that all of the health workers would have been involved in providing AIDS treatment. Particularly in light of the high HIV prevalence in Zimbabwe, however, they very well might be involved in other HIV services. This is not one of the issues that appeared to concern the TRP.

Quite a number of countries where the health workforce needs are greatest also have high prevalence of HIV/AIDS, tuberculosis, or malaria, or several of these diseases, as is the case for Malawi and Lesotho. In such countries, most or nearly all health workers will be engaged (among other activities) in activities related to increasing coverage of interventions that will improve the outcomes for these diseases. If this is the case in the applicant's country, and the applicant is seeking support for incentives on a broad (e.g., nationwide) basis, the applicant should make this point, that most or all of the health workers will be engaged in HIV/AIDS, tuberculosis, and/or malaria health services.

¹⁰² Lesotho's 2004 human resource for health strategic plan reports that in Lesotho, "approximately 3,790 [health workers] are employed in the formal health sector operated by the Government of Lesotho (GOL), the Christian Health Association of Lesotho (CHAL), other Non Governmental Organizations (NGOs), and the private for-profit sector." The large major of these health workers are employed by the Government or CHAL. Lesotho Ministry of Health and Social Welfare, Human Resources Development and Strategic Plan 2005-2025 (2004), at 3-1. Available at: http://www.equinet africa.org/bibl/docs/LEShres_200307.pdf.

¹⁰³ Lesotho Country Coordinating Mechanism, Round 8 HIV/AIDS proposal (Stepping up Universal Access: A Multi-Sectoral Partnership Response to HIV at Community Level) (2008), at 73-74. This proposal should be available on the Global Fund's website after the Fund's Board meeting Nov. 7-8, 2008.

¹⁰⁴ Ethiopia's Round 4 HIV proposal stated that "[m]ost of the professionals employed will work on VCT, PMTCT, ARV therapy and clinical care," implying that some might not be involved in HIV services at all. Ethiopia's Round 4 HIV/AIDS proposal is available at: http://www.theglobalfund.org/search/docs/4ETHH_785_0_full.pdf, at 66.

In all cases, applicants must explain the link between the incentives or salary support for which they are seeking Global Fund money and achieving improved outcomes for AIDS, tuberculosis, and/or malaria. Applicants should also explain how the salaries and incentives are linked to national health workforce strategies and other planning frameworks.

Applicants should also consider innovative incentive possibilities, beyond salary support, including various allowances (such as for housing), loans, enhanced professional development possibilities, flexible hours, and more. For more on incentives, see *Guidelines: Incentives for Health Professionals*, available at: http://www.who.int/workforcealliance/documents/Incentives_Guidelines%20EN.pdf.¹⁰⁵

4. Pursuing a comprehensive approach

It may be useful to explain how interventions included in cross-cutting HSS actions are part of a comprehensive approach. For example, if interventions include providing incentives for health workers to serve in rural areas, the applicant might explain how these incentives are part of a comprehensive approach to strengthen the health workforce overall, part of a comprehensive approach to strengthening the health workforce particularly in rural areas, or part of an otherwise well-functioning health system in rural areas.

This discussion might include several aspects. In above example, the incentive structure could itself be comprehensive, such as the package received by physicians serving on contract in rural parts of Zambia, including a hardship allowance, housing allowance, allowance for their children's education, and graduate training opportunities.¹⁰⁶ The Global Fund proposal might add one or several incentives - for example, hardship and housing allowances - to an existing incentive, such as preference in receiving certain training opportunities. The proposal might explain what other actions are being taken to retain health workers and improve their motivation overall, in addition to the incentives to serve in rural areas, such as activities to improve recruitment procedures, improve human resource management, and improving working conditions. Another dimension to comprehensiveness might be explaining other efforts to improve rural health infrastructure so that health workers posted in rural areas can do their jobs, such as electrifying and rehabilitating rural health facilities and improving the drug distribution system. Applicants may also find it appropriate to describe planned but not yet implemented activities that would contribute to a comprehensive approach. If these activities do not yet have a source of funding, applicants should consider whether the Global Fund is an appropriate financing source for these activities.

It may also be that the intervention is filling a gap in an otherwise functioning system. For example, the physical infrastructure might exist in the rural areas, systems might exist to get medicines and other key items to clinics in a timely fashion, but the clinics have too few health workers. Incentives to encourage health workers to serve in rural areas would then help fill this gap and create a functioning system where health services can be delivered.

The Round 9 Guidelines for Proposals recommend that the HSS interventions that applicants include should be related to national health development plans or strategies, rather than being developed in isolation of such plans.¹⁰⁷

¹⁰⁵ International Council of Nurses, International Hospital Federation, International Pharmaceutical Federation, World Confederation for Physical Therapy, World Dental Federation & World Medical Association, *Guidelines: Incentives for Health Professionals* (2008). Available at: http://www.who.int/workforcealliance/documents/Incentives_Guidelines%20EN.pdf.

¹⁰⁶ Jaap Koot et al., *Supplementation Programme Dutch Medical Doctors 1978-2003 Lessons learned; Retention Scheme Zambian Medical Doctors 2003-2006 Suggestions: Final Report* (Dec. 2003), at 27.

¹⁰⁷ Global Fund Round 9 Guidelines for Proposals (Oct. 2008), at 43.

5. Technical support for implementing proposals

One challenge some successful Global Fund applicants face is that they receive short-term technical support to help develop their proposal, but then lack needed support in implementing that proposal once approved. Therefore, applicants should do their best to determine what technical support they will need to implement their proposal, include in the proposal a request for funds for that technical support, and if possible, identify where that technical support will come from.

6. Health systems monitoring and evaluation system

A strong monitoring and evaluation system can also help ensure the success of Global Fund programs. It would enable problems to be quickly identified and understood, and thus help lead to their rapid correction. Developing these systems is particularly important for health systems strengthening activities given the complexities of health systems, their many interacting parts, and the resulting difficulties of quickly identifying and correcting problems absent a systematic approach to health systems monitoring and evaluation. Such a systematic approach will also provide important information about the effectiveness of new strategies that the Global Fund may support, such as those related to health worker retention, and enable those strategies to be adjusted if they are not yielding the expected results.

WHO, with support from the Health Metrics Network, has developed a Service Availability Mapping tool which forms the basis of a health systems monitoring and evaluation system. This tool combines a simple questionnaire on health facility capacity (as it relates to human resources, basic infrastructure, equipment, and supplies) with software and personal digital assistants (PDAs) to create a detailed picture of health system capacity to deliver certain health services. For example, the tool can measure whether the various health system elements required for a facility to deliver comprehensive HIV/AIDS services are in place. Along with measuring health systems, the tool can be adjusted to measure other areas of interest, such as coverage of school-based HIV education programs.

The tool has been employed in about a dozen countries to paint a picture of health systems at the district level. In one case, in the Mwanza Region of Tanzania, the Service Availability Mapping has taken place at the level of the individual health facility. More information is available at <http://www.who.int/healthinfo/systems/serviceavailabilitymapping/en/index.html>. To learn more, applicants should contact the Health Metrics Network at:

Telephone: +41 (0)22 791 5494

Fax: +41 (0)22 791 5855

Web-form: Available through: <http://www.who.int/healthmetrics/contact/en/index.html>

The Global Fund explicitly encourages countries to use Round 9 to strengthen the ability of monitoring and evaluation frameworks to “disaggregate data by age and sex to enable countries to undertake gender sensitive programming” if the frameworks do not currently do so.¹⁰⁸

¹⁰⁸ *Id.* at 36.

VII. Features of Successful Global Fund Proposals on Health System Strengthening

The two largest HSS proposals approved in Round 5, those of Malawi and Rwanda, include a number of common features. Proposals that include health systems strengthening activities may be more likely to be approved for funding if they include many of the following features. This may be particularly important for more ambitious proposals.

1. Strong links to reducing spread and impact of target diseases: As detailed in section VI.1, both proposals included strong links to the Global Fund's target diseases. They both explained the linkages convincingly and provided data to support these linkages.

2. Strong health system analyses: Both proposals had strong and detailed analyses of the current health system situation and relevant national strategies and plans. The proposals had particularly detailed analyses of the health system element that was the focus of each proposal - the major gap in current efforts against the target diseases - human resources in the case of Malawi and health system utilization and financing in the case of Rwanda.

3. National commitment and strategies: Both proposals were based on national strategies to which the countries were clearly committed. Rwanda's community health insurance program was already being funded by multiple development partners in various provinces, and was the subject of a draft national law, which would create a national policy of covering all families with health insurance, with a special emphasis on vulnerable groups. Malawi's proposal sought to fill in funding gaps in that country's Emergency Human Resource Programme. The government of Malawi had shown a clear commitment to addressing its human resource shortage. Five years earlier, in 2000, Malawi had "developed an HR Finance Plan that was submitted and rejected by the GF." Malawi had since designed and begun to implement the emergency program, which was integrated into the country's Sector Wide Approach and included "6-year staffing targets and sets out cost-effective, sustainable strategies for meeting the targets."¹⁰⁹

4. Strong chance of success: Both proposals made a convincing case that they would have an impact. Malawi sought to fill in gaps in their Emergency Human Resource Programme, which addresses both immediate and longer-term needs and focused both on training and retaining health workers, so that new health workers would not simply leave the country. Rwanda's proposal was able to cite country-specific evidence that members of health insurance schemes utilized the health services three to five times more than non-members.¹¹⁰

5. Pro-poor and pro-marginalized populations: Both proposals were pro-poor. Rwanda's proposal was fundamentally about improving access to health services by the poor. The first objective of the proposal was to remove financial barriers to health service utilization. The grant from the Global Fund will enable Rwanda to co-finance health insurance membership fees for the poor and to fully cover the cost of the health insurance membership fees for the very poor, orphans, and people living with HIV/AIDS. An estimated 83% of the people who will benefit from Rwanda's proposal live in rural areas.

Malawi's proposal, too, will have considerable benefits for the poor and rural dwellers, who are hit hardest by the health worker shortage. The country's Essential Health Package, which the increased health staff levels will support, "is based on the premise of reducing inequities in access to service

¹⁰⁹ Government of Malawi, Round 5 Health System Strengthening proposal (Health Systems Strengthening and Orphan Care and Support) (June 2005), at 52. Available at: http://www.theglobalfund.org/search/docs/5MLWH_1142_0_full.pdf.

¹¹⁰ Rwanda Country Coordinating Mechanism, Round 5 Health System Strengthening proposal (Assuring Access to Quality Care: The Missing Link to Combat AIDS, Tuberculosis and Malaria in Rwanda) (June 2005), at 10. Available at: http://www.theglobalfund.org/search/docs/5RWNH_1199_0_full.pdf.

delivery for all Malawians.”¹¹¹ The proposal explains, “Of primary importance is the positive affect additional [human resources] will have on health services at rural community levels that have been critically compromised by staff migration.”¹¹² The proposal includes interventions to recruit, train, retain, and support health surveillance assistants, whose community outreach functions will primarily benefit rural communities. The purpose of including health surveillance assistants in the proposal is to “rapidly scale-up ARV and other HIV/AIDS services in underserved areas, to improve equity in HR supply and compensation, and to build rural community access to the EHP including TB/malaria services.”¹¹³

6. Support from other development partners: Both Rwanda’s community-based health insurance scheme and Malawi’s human resource program are receiving support from other development partners. Rwanda sought Global Fund money to introduce the insurance scheme in six of twelve districts because Rwanda’s government and development partners, including U.S. Agency for International Development (USAID), the World Bank, and the German Agency for Technical Co-operation (GTZ), were already funding similar programs, or would soon be funding programs. Malawi’s Emergency Human Resource Programme was also receiving support from the United Kingdom’s Department for International Development (and from reprogrammed funds from Malawi’s Round 1 Global Fund grant).

7. Discrete focus: Both Malawi’s and Rwanda’s proposals had a relatively narrow focus within the area of health system strengthening. Malawi’s proposal was entirely focused on human resources for health. Rwanda’s proposal addressed two key obstacles to increasing on health service utilization, financial barriers and perceived low quality.

The Global Fund certainly has no rules against proposals that cover multiple areas of health system strengthening (except insofar as the separate cross-cutting HSS section, as represented by form s.4B, is limited to five cross-cutting HSS interventions), and the experiences of Rwanda and Malawi do not mean countries should restrict themselves to a single area of health system strengthening. Cambodia’s successful Round 5 HSS proposal, for example, covered two areas, health system planning and drug forecasting, procurement, and distribution. These experiences do, however, suggest that a proposal that is focused on a limited number of areas within the realm of health system strengthening might have a greater chance of success than a proposal that addresses a very wide range of issues. This might be because the TRP would view more focused proposals as being more realistic and achievable than a proposal that covers many different issues. A proposal that is more ambitious in the scope of activities covered should take extra care to demonstrate its feasibility.

8. Address major obstacles: The proposals both focused on particularly significant obstacles to scaling up HIV, tuberculosis, and malaria interventions. Malawi faces “overwhelming [human resource] obstacles,” and the proposal calls the human resource shortage “the major constraint to delivering effective health care.”¹¹⁴ Rwanda’s proposal states that the lack of the population’s interaction with health services “jeopardises seriously any progress in the control of HIV/Aids, TB, malaria, and associated diseases.” The very name of the proposal indicates the importance of access to quality health services, calling it “the missing link” in Rwanda’s efforts to combat AIDS, tuberculosis, and malaria.¹¹⁵

¹¹¹ Government of Malawi, Round 5 Health System Strengthening proposal (Health Systems Strengthening and Orphan Care and Support) (June 2005), at 76. Available at: http://www.theglobalfund.org/search/docs/5MLWH_1142_0_full.pdf.

¹¹² *Id.* at 52.

¹¹³ *Id.* at 61.

¹¹⁴ *Id.* at 49, 9.

¹¹⁵ Rwanda Country Coordinating Mechanism, Round 5 Health System Strengthening proposal (Assuring Access to Quality Care: The Missing Link to Combat AIDS, Tuberculosis and Malaria in Rwanda) (June 2005), at 39. Available at: http://www.theglobalfund.org/search/docs/5RWNH_1199_0_full.pdf.

VIII. What Applicants Can Learn from the Technical Review Panel's Comments on Earlier Proposals

The TRP's comments previous proposals provide important guidance to countries applicants in developing their Round 9 proposals. Comments in this section are drawn primarily from the 30 Health System Strengthening proposals from Round 5. Several comments are also included from Round 6 proposals. Where not otherwise noted, proposals described are Round 5 HSS proposals.

This section will review some of the weaknesses and strengths that the TRP cited in these proposals. The comments discussed below are divided into two overarching categories, those that relate to the Global Fund proposal writing in general, and those that are specific to the health system strengthening content of the proposals.

This section relies entirely on the TRP comments. Proposals that the TRP did not recommend for approval were not available to Physicians for Human Rights. Characterizations of proposals used below are those used by the TRP, unless otherwise indicated.

Each proposal is unique. Brief TRP observations on particular proposals cannot always serve as an absolute guide to other proposals. Some of the TRP's comments are indeed likely to apply in all or nearly all cases, such as the need to include unit costs in the budget. Other observations, however, particularly those related to the content of proposals, depend more upon the particular proposal and country circumstances. Final judgment rests with the TRP.

A. General Advice Arising from HSS-Related Proposals

In addition to the analysis below, PHR strongly recommends that people involved in preparing proposals review Chapter 4 of *The Aidspan Guide to Round 8 Applications to the Global Fund - Volume 1: Getting a Head Start*, available through <http://www.aidspan.org/guides/>, which provides lessons from Round 3-7.

1. Detailed, realistic budgets: Countries should be very careful in developing budgets. Countries should be sure to:

- Ensure that budget summaries and budget details are consistent with each other.
- Include quantities and unit cost for each budget item.
- Ensure that overall budgets are realistic, neither unreasonably high nor low for the interventions proposed, and that unit costs are realistic.
- Ensure that expenditure projections are not unrealistically front-loaded (such as determining that the work for a 3-year, \$10 million contract to computerize medical records would be completed by the second quarter of year one) and that they are spread over the period of time that the activities are most likely to take.
- Describe funding projections from partners for activities similar to those included in the proposal.
- Include a budget for 5 years if activities proposed will cover 5 years.
- Ensure that budget allocations to various entities (such as a Christian Health Association or Central Board of Health) are consistent with the level of activities those entities will provide, and that the budget is not allocated to entities not described in the work plan.

The TRP comments to the Global Fund Board on Round 6 and HSS also provided advice on budgeting and certain HSS activities:

Several of the proposals also contained budget items for improvement of infrastructure and/or procurement of equipment aimed at HSS. The TRP would like to make the following suggestions in relation to guiding proposals that cover these items:

i. Proposed expenditures should be justified in terms of the national infrastructure development plan;
ii. The contribution of the proposed expenditures towards achievement of the disease specific targets in the proposal should be made explicit;
iii. Unit costs should be justified in terms of unit cost patterns within the national budget; and
iv. Provisions for long term maintenance, as well as provision of necessary supportive environment (power supply, trained technicians etc) should be clearly spelled out to avoid the situation where, as was seen in Round 6 in a number of proposals, applicants are applying for funding for new infrastructure, rather than proposing an effective arrangement to more effectively utilize resources that they already have;¹¹⁶

2. Modest administrative costs: The TRP may question a proposal that devotes a significant portion of its budget to administrative costs. One weakness of Liberia's Round 6 malaria proposal was that it allocated 25% of its budget to cover administrative costs, which the TRP felt "seem[s] excessive." A weakness that the TRP cited of Nigeria's Round 6 malaria proposal was that 21% of its budget was for planning and administrative costs. Excessive administrative costs were also a common weakness in Round 5.

3. Proposal size: feasible and not too small:

Not too small...

Countries must be sure that their proposals are not too small to justify a separate grant. In Round 5, Georgia's proposal was deemed too small to merit a separate Global Fund grant. Georgia's proposal was worth \$436,320 over two years and \$814,320 over five years. Such concerns are less likely to arise in Round 7, where health system strengthening activities will be included in disease components and therefore, will typically (but not necessarily) be supplemented by disease-specific interventions.

...but not beyond applicant's capacity to implement

In several cases, the TRP expressed concern that proposals were too ambitious or broad. This concern appears to be closely linked to doubts about the proposals' feasibility. The TRP indicated that South Sudan's Round 5 HSS proposal was overly ambitious for a country emerging from a 50-year conflict. Similarly, referring to Burkina Faso's proposal as "too unfocused and broad," the TRP stated that "[i]t does not appear to be feasible to implement effectively in the timeframe." The TRP did not approve Eritrea's grant request in part because the TRP viewed it as too ambitious, covering a very wide range of needs. The TRP was concerned about the proposal's feasibility; the TRP observed that "[t]he workplan lacks unit costs and sufficient details to determine that full implementation can feasibly be accomplished." Therefore, all applicants need to demonstrate that they will be able to carry out the proposed activities. Applicants with ambitious proposals should make extra efforts to demonstrate their proposal's feasibility, including through detailed budgets and work plans.

Further, recall the need to link each item to the target disease. An applicant that seeks funding in a wide range of health system areas should include solid analysis explaining why activities in each of these areas are needed to help fill gaps in achieving and sustaining HIV, tuberculosis, or malaria programs, or to initiate new activities in these disease areas.

4. Sufficient details: Applicants should provide sufficient details on their planned activities, including work plans and the timing of their activities. Given that the TRP criticized approximately 13 HSS proposals in Round 5 for lacking details or specificity - nearly half of the HSS proposals - countries are advised to err on the side of including more detail when in doubt of how specific to be. Along with

¹¹⁶ *Report of the Technical Review Panel and the Secretariat on Round 6 Proposals.* Presented at the 14th Board Meeting of the Global Fund, Oct. 31-Nov. 3, 2006, at 27. Available at: http://www.theglobalfund.org/en/files/boardmeeting14/GF-BM-14_10_TRPReportRound6.pdf.

general concerns about lack of details and clarity on timing and work plans, the TRP noted that one country listed multiple implementing entities, but did not explain which entity would do what.

5. Relationship to previous grants and other sources of funding: A number of HSS proposals in Round 5 were either poorly integrated into previous grants that countries had received from the Global Fund or poorly integrated with other sources of funding. For example, the TRP observed that North Sudan's proposal was insufficiently clear and detailed on how the proposed HSS activities would link to, complement, and build on USAID and Secretary of Health funding for similar issues. By contrast, the TRP noted that a strength of Ethiopia's proposal was that it "addresses one of the key weaknesses in the implementation of previous Global Fund grants," procurement and supply management, while a strength of Madagascar's Round 5 HSS proposal was that the geographic regions covered by that proposal matched those covered by HIV/AIDS, malaria, and tuberculosis proposals from Round 1-4.

Countries should also make any appropriate links between HSS activities and related disease-specific interventions for which they are seeking funding in Round 9. In Round 5, for example, the TRP faulted Burundi's HSS proposal for not linking the training included in the HSS component with training included in the HIV and malaria components.

6. Realistic indicators: A number of countries had trouble with their indicators. The problems varied. Some proposals included activities without any indicators for those activities; applicants should be careful to include indicators for all activities. The TRP called several countries' indicators weak or unrealistic. Several specific critiques were that indicators focused too much on committees, that indicators seemed designed to meet the needs of donors rather than of local decision makers, and that the indicators could not be measured.

Chapter IV of the March 2008 addendum to the Monitoring & Evaluation toolkit (January 2006) (http://www.theglobalfund.org/pdf/guidelines/M-E%20Toolkit_Addendum_March%202008_en.pdf) provides suggested indicators on health systems strengthening. Applicants lacking relevant expertise would also be well-advised to work with technical partners with health systems expertise in developing appropriate indicators.¹¹⁷

Countries that are facing difficulties with health system strengthening-related indicators may also consider contacting the Health Metrics Network (<http://www.who.int/healthmetrics/>), which is hosted by the World Health Organization. The Health Metrics Network should be able to help or direct applicants to the relevant individuals or organizations who will be able to assist. The contact information for the Health Metrics Network is:

Telephone: +41 (0)22 791 5494

Fax: +41 (0)22 791 5855

Web-form: Available through: <http://www.who.int/healthmetrics/en/>

7. Realistic pace of activities: The TRP deemed several proposals to have overly ambitious schedules for constructing and rehabilitating facilities. In the first year of its grant, Ethiopia sought to complete work upgrading 100 health facilities, from identifying which facilities needed upgrading through completing the work and commissioning the facilities. Liberia's timeline was even more ambitious, as its proposal called for rehabilitating and reconstructing several hospitals and training institutions, along with 100 primary care clinics, in six months. Countries should therefore ensure that the pace for their activities, including facility construction and rehabilitation, is realistic.

8. Principal recipient capacity: Countries should be sure that the Principal Recipient has the capacity to carry out its responsibilities. One country's Round 5 HSS proposal was rejected in part because the

¹¹⁷ The monitoring and evaluation toolkit is available through: http://www.theglobalfund.org/en/performance/monitoring_evaluation/.

Principal Recipient lacked management and information systems, had not been subject to an external audit, and had extremely limited staff.

9. Proposal coherence: If various entities or regions contribute to the proposal, the CCM should ensure that the pieces come together to form a coherent whole. The TRP reported that South Africa's Round 5 HSS proposal was a collection of proposals from provinces, NGOs, and the private sector, rather than a coherent national proposal.

10. Added value for regional proposals: Regional proposals must demonstrate how they add value to strictly national strategies and approaches. Three of the weaknesses that the TRP listed for the one regional HSS proposal in Round 5, which aimed to create a network of public health training institutions in four African countries, were related to a failure to demonstrate the added value of a regional approach and a failure to adequately integrate the proposal with national plans. In particular, the TRP reported that the proposal did not make the case for a regional network, did not adequately link the proposal to the training needs and demands of each country, and did not make a convincing case for a regional approach as opposed to having each training institution work within its country's national strategy.

11. Capacity to manage significant scale-up: If institutions will receive significantly increased funds and responsibilities, applicants should explain how those organizations will be able to manage the increased funds and responsibility. In the Round 5 regional training institution HSS proposal, the TRP stated, "Other than adding of project staff at [the Makerere University Institute of Public Health], the proposal does not address how these training institutions will be able to manage teaching programs and funds that are much larger than their current operations."

B. Health System-Specific Strengthens and Weaknesses

1. Careful health systems analysis, including gaps: The TRP values careful analysis of the health system, particularly as relevant to the proposal. The TRP noted that a number of Round 5 HSS proposals were weak in this area. Several countries provided inadequate details on their current health staff situation. For example, Liberia's proposal did not include proposed staff levels of rural clinics, health centers, and district hospitals and Mali's proposal did not address the baseline number of staff. Benin's proposal did not include what the TRP called "basic simple information" on public and private sector coverage. Burundi's proposal, according to the TRP, had only a superficial analysis of health system weaknesses, ignoring such underlying problems as governance, while Nigeria failed to explain how its proposal fit into other health system reforms.

Applicants should explain in detail gaps in health system needs, especially those for which funds are sought. For example, a weakness of the Round 5 HSS regional (Ghana, Uganda, Zimbabwe) proposal, which was focused on training, was that it included only a "superficial" analysis of the gaps in training needs. A country that seeks Global Fund support for health workforce strengthening, therefore, should include a careful analysis of the current health workforce and its gaps, including as related to the country's capacity to initiate, implement, and sustain HIV, tuberculosis, and/or malaria activities.

2. Health system element details: Health system strengthening activities should include a certain level of detail. The TRP noted a number of health system strengthening areas in which proposals were inadequately detailed. In Round 5, applicants provided insufficient details on a scheme to reduce financial barriers for the poor; on improving conditions of service for health workers; on rehabilitating training schools and health facilities in poor condition, including detailed unit costs; on what contracting services at the community level would entail; on a doctor retention scheme; on how more than 1,000 health personnel proposed to be recruited would be recruited, selected, and retained, and; on the costs and on the number of health workers in different categories, including community health workers, to be trained.

The TRP noted the following proposed activities as insufficiently detailed in Senegal's Round 5 HSS proposal: "Agree to contracts for people (150 workers), resources and skills available to help fight against the 3 diseases," "Implement incentive measures," "Implement risk-sharing mechanisms," "Implementing case management mechanisms for the indigents," "Promote the practice of self-evaluation in care facilities," "Implement a drug monitoring system," and "Awareness-raising of personnel on ethical matters."

a. Explaining why beneficiary regions are selected

Proposals that will benefit particular regions should state which those regions are and how they are selected. For example, according to the TRP, Zambia's Round 5 HSS should have included information on which districts would benefit from the increased human resources and how those districts would be selected. Thus, if an incentive scheme will increase the number of health workers in rural or deprived areas, the applicant should explain which these regions are and how they have been selected. Senegal's Round 5 HSS proposal was also criticized for not explaining how target districts would be selected.

3. Strategies likely to succeed - demonstrating feasibility: The TRP will not approve a proposal that it believes cannot achieve its goals. Applicants therefore will have to propose strategies that can succeed, and demonstrate to the TRP that these strategies can succeed. This concern about the proposal's chance of success appears to underlie the TRP observations that a weakness of several proposals was that they did not address certain issues. Presumably, the TRP believed that these issues had to be addressed, whether or not through the Global Fund, in order for the proposal to succeed.

For example, Burundi's Round 5 HSS proposal, which addressed human resources largely through incentives, gave "[i]nsufficient attention . . . to understanding motivation, placement, retention, or professional development," according to the TRP. The TRP likely viewed the proposal's response as a simplified or superficial response to a complicated problem, and thus one unlikely to succeed. Incentives will not always be seen as a simplified response. If the goal is overall human capacity development, a strategy that relies only on incentives is indeed overly simplistic. But if the goal is to increase health services in rural areas, incentives - so long as they are detailed and the areas to be served as well as how they are selected are described - may be a perfectly reasonable approach, one that is the focus of an increasing number of country efforts (even as this is not the only strategy to increase access to health providers in rural areas).¹¹⁸

The TRP will have to believe that the incentives can work. Mozambique proposed only staff housing to assist in retention in rural areas, which the TRP believed would be insufficient, as it noted as a weakness of the proposal that no other mechanisms were suggested.

a. Comprehensive response to health workforce crisis

Zambia's Round 5 HSS proposal, which addressed recruitment, pre-service training, and staff retention, had according to the TRP, "little if any discussion of how other HR issues will be addressed; for example, supervision, in-service training, and overall personnel management." This suggests that proposals that address human resources should be as comprehensive as possible in discussing plans and activities to address the human resource situation in its totality. A comprehensive approach to a human resource crisis, one that includes both the elements that Zambia's proposal included and those that the TRP cited that it did not, is indeed important to a successful response.

The proposal itself need not seek funding for activities in all of these areas. For example, Malawi's successful proposal did not include funds for the critical area of human resource management.

¹¹⁸ Several strategies to strengthen the health workforce in rural areas are described in an excerpt from PHR's Round 6 version of this Guide, available at: <http://physiciansforhumanrights.org/hiv-aids/docs/excerpt-guide-globalfund-round6.pdf>.

However, the proposal discussed Malawi's longer term human resource development strategy, which includes multiple strategies on improving human resource management, such as staff development and career management, building Ministry of Health human resource policy and planning capacity, and developing performance-based management approach, as well as such critical issues as staff working and living conditions.¹¹⁹ In other ways, Malawi's proposal was itself comprehensive. For example, Malawi sought funds not only to train and cover the current salaries of Health Surveillance Assistants, but also to increase their salaries in line with other health cadres in order to help retain them, to provide them in-service training, and to supply them with bicycles.

Many countries are not presently implementing a comprehensive response to the health workforce crisis. To the extent that an applicant's response to the health workforce crisis is comprehensive, however, the applicant should clearly make the full breadth of its response to the TRP, as discussed above at section VI.4. And the applicant should strongly consider using the Round 9 application to help fill in gaps, to complement existing measures on human resources so as to implement a more comprehensive approach.

4. Meaningful community participation: Countries should involve communities in health and health system planning. Not only do people have the right to participate in decisions that affect their health, but the TRP may well look more favorably upon proposals that demonstrate meaningful community participation in health systems. The TRP criticized Burundi's Round 5 HSS proposal for taking a superficial approach to community participation in health systems. By contrast, the TRP expressed clear interest in Madagascar's proposed "process of involving community in the administration of equity funds," as the community would "decide who among the poor should be eligible for subsidies and get equity funds."

5. Integrated approach for addressing target diseases: The TRP has explicitly recognized the value of an integrated approach for health information systems, where countries avoid creating separate, parallel structures for different diseases, instead developing structures that integrate the needs of various programs. The TRP cited as a weakness in Burundi's proposal the fact that in the proposal, "Health information systems are organized around needs of programs (HIV, TB, malaria) rather than the decisions that need to be made by different levels of health workers and organizational units." This, the TRP stated, could result in "continually adding data requests without coherent integration and simplification of" health information systems.

6. Integration into health system strengthening strategies: To the extent possible, proposals should explain the national strategy for addressing identified health system needs, especially constraints that a country identifies as interfering with efforts to reduce the spread and impact of the target disease(s). The Global Fund is increasingly concerned with the connection between proposed HSS interventions and national strategies, and as explained elsewhere in this Guide, this is reflected in the Round 9 Guidelines for Proposals.¹²⁰ The TRP observed that in its Round 5 HSS proposal the Democratic Republic of Congo failed to elaborate a strategy for health system strengthening. By contrast, the TRP commended the Round 5 HSS Eritrean proposal for being consistent with the draft National Health Strategic Plan, the Ethiopian proposal for being "well embedded in the national health sector development strategy," Ghana's proposal for being "well integrated in the national health

¹¹⁹ Government of Malawi, Round 5 Health System Strengthening proposal (Health Systems Strengthening and Orphan Care and Support) (June 2005), at 61. Available at: http://www.theglobalfund.org/search/docs/5MLWH_1142_0_full.pdf.

¹²⁰ The Guidelines for Proposals suggest that applicants should not develop responses to health system weaknesses and gaps "should not be developed in isolation from existing national strategies." Global Fund Round 9 Guidelines for Proposals (Oct. 2008), at 43. The March 2008 addendum to the Global Fund's Monitoring and Evaluation Toolkit notes the importance of having HSS being "[c]onsistent with (where they exist) national policy directions, for example, a health sector development plan, a national financing strategy or a health workforce plan." Global Fund, Monitoring and Evaluation Toolkit: HIV/AIDS, Tuberculosis and Malaria (2nd ed.) Addendum March 2008 (March 2008), at 19. Available at: http://www.theglobalfund.org/pdf/guidelines/M-E%20Toolkit_Addendum_March%202008_en.pdf.

sector development strategy and plan,” and Rwanda’s proposal for being “fully integrated in the national health sector development and health care financing strategy.” Zambia’s Round 5 HSS proposal “is consistent with a broad range of national policy instrument.” Rwanda detailed its health financing strategy, and Malawi’s proposal, based on that country’s Emergency Human Resources Programme, provides considerable detail on the country’s strategy for addressing its human resource crisis.

7. Inclusion of non-government sector: Countries should define how the proposal will impact non-governmental sectors and how it will divide activities and responsibilities between the government and non-government sectors. The Round 9 Guidelines for Proposals “recognize that non-government organizations, the private sector and communities affected by the disease(s) are each an integral component of the health system, as is the government sector.” And accordingly, the Guidelines encourage applicants to “consider the broad range of non-government sector needs in any assessment of overall weaknesses and gaps in strategies to ensure increase demand for, and access to required services and/or care.”¹²¹

The TRP cited as a weakness of several Round 5 proposals their failure to address how the Ministry of Health would work with the private sector, how activities would be divided between the public and church-based sectors, and how health facilities not run by the government would be involved in and impacted by the proposal.

While the roles of the governmental and non-governmental health sectors vary by country, in general proposals will benefit by addressing both sectors. Ethiopia’s proposal covered needs of both the public and private sectors, which the TRP cited as a strength of that proposal. Similarly, the TRP commends Ghana’s proposal for “acknowledg[ing] the key role of NGOs, religious organizations, the private sector, and non-health personnel,” and Mali’s “use of civil society [to complement] the public sector program.” Applicants may benefit from including information on the proportion of health services provided by each sector, which is in both Rwanda’s and Malawi’s successful proposals. If a proposal focuses exclusively on the public sector, the proposal can only benefit from explaining this limitation.

8. Evidence of success: Where applicants can provide evidence that the strategies included in their proposals are likely to succeed, they should do so. For example, Ghana’s Round 5 HSS proposal included a focus on community-based health care staff which, the TRP observed, had been tested in Ghana and resulted in “evidence that it can generate major health benefits.”¹²² Rwanda’s successful proposal “is evidence-based on several years of experience and evaluation of the community health insurance system in Rwanda.”

By contrast, although Ethiopia proposed higher training incentives to retain staff in rural areas, the TRP questioned whether these incentives would in fact help retain staff in rural areas. Any evidence that incentives will work - perhaps they are designed based on input from health workers who are the target of the incentives, or a pilot program suggests that such incentives would have an impact - should be presented.

9. Support for rural/deprived areas: The TRP looks favorably on proposals that effectively address health worker and systems needs in rural and other deprived areas. A weakness of Kenya’s Round 5 HSS proposal was that it failed to demonstrate whether its scheme to recruit more than 1,000 health workers would “ensure the availability and retention of qualified personnel at the lower, more remote area where the gaps are the greatest.” This weakness also arose from a failure to link the proposed activities with the proposal’s objectives; a more equitably distributed workforce to promote equal access to essential health services was one of the Kenyan proposal’s objectives.

¹²¹ Global Fund Round 9 Guidelines for Proposals (Oct. 2008), at 42.

¹²² More information on community-based health care in Ghana is available in *Providing Doorstep Services to Underserved Rural Populations: Community Health Workers in Ghana* (Oct. 2006), is available at: http://www.capacityproject.org/images/stories/files/community_health_workers_ghana.pdf.

The TRP observed with dismay that Uganda’s proposal made “no mention of the approach needed to deliver services in the areas of the country suffering from ongoing conflict.” The TRP again demonstrated concern about the ability of poor people to access health services when it included in a comment about weaknesses of Senegal’s Round 5 HSS proposal the observation that the government “maintains user-fees in its health facilities.”

By contrast, the TRP considered on strength of Zambia’s Round 5 HSS proposal that it “focuses on strengthening health services for underserved and poor rural populations.” Another strength of that proposal was that its focus on “human resources capacity is consistent with the plan to roll out ART to rural hospitals and health centers.” The TRP describes Rwanda’s successful proposal as “an innovative and creative effort to address an issue that is largely neglected in current international development programs, i.e. to establish a system of social protection for the very poor, for orphans, and for people living with AIDS.” In addition, the TRP commended Ghana for its focus on community-based primary health care services. Such a community-based approach is particularly important to providing care in rural areas.

10. Limited focus on workshops, meetings, and research: The TRP is skeptical of proposals that focus too heavily on activities that do not directly benefit patients or strengthen the health system, such as workshops, meetings, consultants, and research. These activities are permitted, but a high proportion of the budget generally should not go to these activities. Of South Africa’s proposal, the TRP observed: “A large proportion of the budgets from the provinces is allocated to salaries, workshops, meetings and consultancies with very high fees. There is no evidence of direct benefit to people living with HIV and AIDS strengthening of health infrastructure.” The TRP stated that 20% of Pakistan’s budget going to research amounted to “an overemphasis on research . . . given the Global Fund’s mandate.”

11. Salaries consistent with national standards: The TRP found a number of salary costs in Liberia’s Round 6 TB proposal to be excessive. It considered the proposed annual salaries for medical officers and salaries to be “excessive when compared with [Ministry of Health] salaries.” A salary of \$65,000 for a TB expert seemed excessive to the TRP, as did incentives for the program manager and deputy program manager.¹²³

12. On-site training where possible: Botswana’s Round 6 TB proposal included external venue costs for training that required equipped laboratory benches. The TRP criticized this, stating that the training should take place in a reference laboratory.

13. Length of training should reflect position responsibilities: In Cote d’Ivoire’s Round 6 HIV proposal, the TRP believed that the proposed short training courses would be inadequate to prepare trainees for the responsibilities they would assume.

14. Avoid creation of highly vertical programs: As explained earlier in this guide, the TRP is critical of vertical disease programs that risk harming the overall health system. Swaziland’s Round 6 HIV proposal would have created a “highly vertical HIV treatment system,” with health workers assigned to exclusively HIV programs, and with salaries that appear to be significantly higher than those of other health workers in Swaziland. The TRP expressed its concern that this might “have a potentially serious negative impact on overall health sector performance in Swaziland. This highly vertical approach appears to be the major reason that the TRP did not recommend this proposal for approval.

¹²³ Please see section VI.3 above for more information about including salaries in Round 9 proposals.

IX. Resources

1. Publications related to the Global Fund and technical support

For a broader overview of applying to the Global Fund, PHR recommends applicants review *The Aidspace Guide to Round 8 Applications to the Global Fund*, available through <http://www.aidspace.org/guides/index.htm>. Volume 1 includes an important section on lessons from previous rounds, which will be very useful for people involved in preparing proposals read. *The Aidspace Guide to Developing Global Fund Proposals to Benefit Children Affected by HIV/AIDS* is also available through this website.

For perspective on how global health initiatives such as the Global Fund can be used to support health systems, see the WHO working paper on Opportunities for Global Health Initiatives in the Health System Action Agenda: World Health Organization, Department of Health Policy, Development and Services, Evidence and Information for Policy, *Making Health Systems Work: Working Paper No. 4: Opportunities for Global Health Initiatives in the Health System Action Agenda* (2006). Available at: http://www.gavialliance.org/resources/17brd_5_HealthSystemsGHIs_6Dec2005.pdf

The World Health Organization has various documents that should be useful in supporting inclusion of HSS interventions in Global Fund proposals, including a short paper on making the case for health system strengthening, available at: http://www.who.int/healthsystems/gf_round9/en/index.html

The Health Workforce Advocacy Initiative and Health Systems 20/20 have developed a packet of information on using the Global Fund to support health systems strengthening in Round 9, available at: http://physiciansforhumanrights.org/hiv-aids/globalfund_round9.html

The Global AIDS Alliance is producing *Guidelines for Integrating Sexual and Reproductive Health into the HIV/AIDS Component of Country Coordinated Proposals to be submitted to the Global Fund to Fight AIDS, Tuberculosis and Malaria Round 7 and Beyond*. It is available through: <http://www.globalaidsalliance.org/index.php/355>

A publication on technical support interventions for HIV/AIDS, tuberculosis, malaria, and other major diseases, including health systems strengthening activities, and available technical support related to the Global Fund and other sources of global health financing, is accessible through: <http://www.backup-link.de/>

2. Selected resources on human resources for health

Physicians for Human Rights, *An Action Plan to Prevent Brain Drain: Building Equitable Health Systems in Africa* (2004). Available at: <http://physiciansforhumanrights.org/library/documents/reports/report-2004-july.pdf>

Physicians for Human Rights, *Bold Solutions to Africa's Health Worker Shortage* (August 2006). Available at: <http://physiciansforhumanrights.org/library/documents/reports/report-boldsolutions-2006.pdf>. Several other innovative responses to health worker shortages, excerpted from PHR's Round 6 version of the present Guide, can be found at: <http://physiciansforhumanrights.org/hiv-aids/docs/excerpt-guide-globalfund-round6.pdf>

Physicians for Human Rights, *The Right to Health and Health Workforce Planning: A Guide for Government Officials, NGOs, Health Workers and Development Partners* (2008). Available at: <http://physiciansforhumanrights.org/library/documents/reports/health-workforce-planning-guide-2.pdf>. This guide explains how to ground health workforce plans and the planning process in human rights. For an authoritative explanation of the right to the highest attainable standard of health, please see Committee on Economic, Social and Cultural Rights, *General Comment 14, The right to the*

highest attainable standard of health (2000), available at:
<http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>

The Capacity Project has published a series of case studies as part of their *Health Workforce "Innovative Approaches and Promising Practices" Study*. These cover promising practices in Ghana, Malawi, Namibia, and Uganda, are available through:
http://www.capacityproject.org/index.php?option=com_content&task=view&id=164&Itemid=158

World Health Organization, *World Health Report 2006: Working Together for Health* (2006). Available at: <http://www.who.int/whr/2006/>

The World Health Organization and several partners have developed an HRH Action Framework to assist with health workforce planning, available at: <http://www.capacityproject.org/framework/>. The Framework links to a number of human resources for health tools. Some human resources for health tools can also be accessed at <http://www.who.int/hrh/tools/>. A smaller set of tools that have been reviewed by people with expertise in human resources for health can be found at the HRH Tools Compendium, available at: <http://www.hrhcompendium.com/>.

The HRH Global Resource Center is a "digital library devoted to human resources for health (HRH)," and is available at: <http://www.hrhresourcecenter.org/>

EQUINET has an extensive set of publications on the health workforce and other issues pertaining to health and equity in Africa through their website: <http://www.equinet africa.org/>

An open access (free) journal on Human Resources for Health is available at: <http://www.human-resources-health.com>

The Manager's Electronic Resource Center, which contains a wide range of tools for health managers in such areas as human resources for health, leadership, finances, information, managing drug supplies, community health services, health systems reforms, and organizational management, is available at: <http://erc.msh.org/>

The Eldis Health Systems Resource Guide, which contains an extensive set of resources on human resources for health and other health system issues, is available at: <http://www.eldis.org/healthsystems/index.htm>



Physicians for Human Rights (PHR) mobilizes health professionals to advance health, dignity, and justice and promotes the right to health for all.

Since 1986, PHR members have worked to stop torture, disappearances, and political killings by governments and opposition groups and to investigate and expose violations, including: deaths, injuries, and trauma inflicted on civilians during conflicts; suffering and deprivation, including denial of access to health care, caused by ethnic and racial discrimination; mental and physical anguish inflicted on women by abuse; loss of life or limb from landmines and other indiscriminate weapons; harsh methods of incarceration in prisons and detention centers; and poor health stemming from vast inequalities in societies.

Health Action AIDS, a PHR campaign, mobilizes health professionals to support a comprehensive AIDS strategy and advocates for funds to combat the disease. The Campaign develops ways for US health professionals to support colleagues and activists around the world and researches the connection between human rights and HIV/AIDS.

As one of the original steering committee members of the International Campaign to Ban Landmines, PHR shared the 1997 Nobel Peace Prize.

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**2. GLOBAL FUND TO FIGHT AIDS, TB AND MALARIA. NOVEMBER 2007.
STRATEGIC APPROACH TO HEALTH SYSTEMS STRENGTHENING:
DECISION POINT GF/B16/DPI10. GENEVA, SWITZERLAND.**

[http://www.who.int/healthsystems/round9_11.pdf]

This document, from the Global Fund Sixteenth Board Meeting, outlines the Board's decision to provide funding for health systems strengthening actions within the overall framework of funding technically sound proposals focused on HIV/AIDS, tuberculosis and malaria.



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The Global Fund

To Fight AIDS, Tuberculosis and Malaria

Sixteenth Board Meeting
Kunming, China, 12 - 13 November 2007

Strategic Approach to Health Systems Strengthening

Decision Point GF/B16/DP10:

The Board refers to the principles set forth in its decision GF/B15/DP6 and reaffirms that the Global Fund should continue to support the strengthening of public, private and community health systems by investing in activities that help health systems overcome constraints to the achievement of improved outcomes in reducing the burden of HIV/AIDS, tuberculosis and malaria ("ATM").

The Board decides that the Global Fund shall provide funding for health systems strengthening ("HSS") actions within the overall framework of funding technically sound proposals focused on the three diseases and that such funding shall be based on the following principles:

1. The Global Fund shall allow broad flexibility regarding HSS actions eligible for funding, such that they can contribute to system-wide effects and other programs can benefit. With this principle in mind, the Global Fund shall develop guidance with few prescriptions for applications for HSS funding, which may take the form of the following:
 - a. the specification of categories of HSS actions that the Global Fund recommends applicants consider when developing applications for funding;
 - b. the specification of principles to guide applicants in deciding which categories of HSS actions to apply for; and
 - c. the specification of any category of HSS actions that may not be financed by the Global Fund.
2. The Global Fund shall encourage applicants, wherever possible, to integrate requests for funding for HSS actions within the relevant disease component(s). Such HSS actions will be assessed by the Technical Review Panel ("TRP") as part of its review of that disease component.
3. Recognizing that some HSS actions ("cross-cutting HSS actions") may significantly benefit more than one disease, the Global Fund shall allow applicants to request funding for such HSS actions by completing a distinct but complementary section (a "cross-cutting HSS section") within a disease component, provided that:
 - a. An application shall not contain more than one cross-cutting HSS section.
 - b. Where cross-cutting HSS actions are proposed, the applicant shall articulate how they address identified health systems constraints to the achievement of improved ATM outcomes.
4. In reviewing a disease component which contains a cross-cutting HSS section, the TRP may recommend for funding either:
 - a. The entire disease component, including the cross-cutting HSS section;



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- b. The disease component excluding the cross-cutting HSS section; or
 - c. Only the cross-cutting HSS section if the interventions in that section materially contribute to overcoming health systems constraints to improved ATM outcomes.
5. The Global Fund shall also:
- a. Recommend that proposals containing material HSS actions be based on the results of a recent assessment (the coverage of which need not be limited to ATM) identifying health systems constraints to the achievement of improved outcomes in reducing the burden of HIV/AIDS, tuberculosis and malaria; and
 - b. Recommend that applications provide evidence of the involvement of relevant HSS stakeholders in the Country Coordinating Mechanism – including at least one non-government in-country representative with a focus on HSS and one government representative with responsibility for HSS planning.

The Board requests the Portfolio Committee to modify future application forms and guidelines (including for the Rolling Continuation Channel), effective from 1 March 2008, to incorporate the above principles and propose for approval at the Seventeenth Board Meeting any modifications to the Terms of Reference of the TRP (including with respect to the composition of the TRP) that are required in light of the strategic approach reflected in this decision point

The Board requests the Secretariat to provide to the TRP information on the principles that are set forth in this decision. The Board also requests the Secretariat to communicate clearly, working closely with relevant partners, to country stakeholders the Global Fund's amended strategic approach to HSS – including the flexibilities inherent within it.

The Board requests the Secretariat and the TRP to review the results of the Round 8 proposals with regard to HSS actions, and to report to the Eighteenth Board Meeting on the impact of this decision on the application and review process. The report should discuss the quality of proposals that include HSS actions, the proportion recommended by the TRP for approval, and the extent to which applicants have articulated how cross-cutting HSS actions address identified health systems constraints to the achievement of improved ATM outcomes.

The budgetary implications of this decision point in 2008 amount to US\$ 235,000.

Signed: 12 November 2007

Luis Riera Figueras
Rapporteur

Dianne Stewart
Secretariat

3. WORLD HEALTH ORGANIZATION. THE GLOBAL FUND AND HEALTH SYSTEM STRENGTHENING: HOW TO MAKE THE CASE, IN A PROPOSAL FOR ROUND 8? WORKING DRAFT. GENEVA, SWITZERLAND. [http://www.who.int/healthsystems/gf_hss.pdf]

This brief paper summarizes some critical points that proposals with HSS activities should make to have a strong chance of success. Country examples from Tanzania, Malawi, Kenya, and Rwanda illustrate credible lines of argument.



The Global Fund and Health System Strengthening

How to Make the Case, in a Proposal for Round 8?

Working Draft

This note has been prepared by WHO for its Round 8 workshops. It is based on several sources: proposals; TRP comments from previous rounds; WHO staff experience; the latest Fund guidance.

The Global Fund and Health System Strengthening How to Make the Case, in a Proposal for Round 8?

The challenge

The Global Fund's approach to health system strengthening consists of "investing in activities to help health systems overcome constraints to the achievement of improved outcomes for HIV/AIDS, TB and malaria". The question is therefore not *whether* the Global Fund invests in strengthening health systems but *how*. However, many have found it difficult to 'make the case' for such investments when preparing proposals. This note summarizes some critical points that proposals with HSS activities must make if they are have greater chances of success. Experience suggests the *process* of proposal development is also a critical determinant of a strong proposal.

There are fairly consistent messages on the biggest constraints to improved HIV/AIDS, TB and malaria outputs and outcomes, from different sources. These are summarised in box 1.

Box 1: Summary of the biggest constraints for improved HIV/AIDS, TB, malaria outputs and outcomes

- Availability, skills and motivation of health workers
 - Drug procurement and distribution systems
 - Diagnostic services
 - Access - especially financial access
 - Management and coordination of services
 - Information and monitoring systems
-

Source: The Global Fund Strategic Approach to Health System Strengthening. Report from WHO to the Global Fund Secretariat, September 2007

Within any of the broad areas listed above, some constraints can be resolved by intervention at the service delivery level, while others can only be resolved by actions at higher levels of the system. There is increasing support for moving away from the stale vertical versus horizontal debate. A key message is that programmes are part of any health system, and it is impossible to scale up services to any significant extent without a stronger health system.

The main messages from the Global Fund regards HSS for round 8 are that:

- The **parameters for HSS funding have not changed** from previous rounds. The only explicit exemption is large infrastructure projects. This decision recognizes that countries are diverse and have different priorities. It aims to encourage innovation.
- The **application form has been modified**. As for round 7, there is no separate HSS component. There is however an optional section ('part B') for 'cross-cutting' HSS actions. Global Fund guidance states that HSS activities may be included under either the disease specific part of the form, or part B.
- **Only one part B section can be completed per country**. This section is *only* for 'cross-cutting' activities. i.e. designed to benefit more than one disease. Part B can only be submitted if there is also either an HIV/AIDS, TB or malaria proposal. It cannot be submitted on its own.

The response: points to make when requesting funds for HSS interventions

1. **The proposed activities clearly respond to constraints** to improved HIV/AIDS, TB or malaria prevention and control identified in other parts of the proposal.

Comment: Proposals often do not link their proposed HSS activities to the specific constraints identified in the analysis section of the proposal form. Examples of proposals in which this is well done are in Annex 1.

2. **The proposed activities are required in order to improve HIV/AIDS, TB or malaria service delivery**, but lie beyond the mandate of an individual programme, or could disrupt other priority services if implemented by one programme alone.

Comment: Successful proposals have made a compelling case. However, in many proposals, the case has been superficial and unconvincing. Good examples are given in Annex 1.

3. **The proposed activities fit within overall national health policies**, plans and strategies, and fill a gap in available resources

Comment: Many proposals have contained actions that appear to be planned in isolation of the wider health system. This makes it difficult for the TRP to judge the extent to which the proposed activities are part of a balanced approach that fits with overall national policy and strategy.

4. **The proposed activities have been defined in consultation** with key stakeholders

Comment: in determining any response, it is important to remember that a health system, like any system, is a set of inter-connected parts. Changes in one part will have repercussions elsewhere, which may be positive or negative. The involvement of key HSS stakeholders in the CCM is required by the Global Fund. Moreover, in order to effectively address shared health systems barriers in a proposal, early collaboration between those preparing AIDS, TB and malaria components has also become important in round 8.

5. **Proposed activities are clearly defined; of a realistic scale, and credibly costed**

Comment: The TRP notes that successful HSS proposals share characteristics of other successful Fund proposals: they focus on a manageable set of activities, not major sector reforms; they are judged to be realistic, and have clear objectives and budgets. Unsuccessful HSS proposals conversely contain actions considered too broad, too ambitious or too vague in terms of objectives, work plans and budgets.

6. **Returns from investment are possible within a reasonable timeframe**

Comment: the proposals need to give a sense of when improvements resulting from the proposed interventions might begin to materialise. These may be short of more medium-term changes.

7. **A small set of credible health system indicators have been selected**, for tracking progress

Comment: the WHO Health System Metrics working group has worked with the Fund to suggest a revised set of HSS indicators for the Fund's toolkit, to assist countries for round 8. These are **examples** that need to be adapted to the proposed HSS interventions. The Fund stresses that applicants must show a convincing link between the HSS interventions and outputs, and disease specific outputs.

Annex 1: Linking constraints to proposed actions that are required to improve outcomes: four brief examples

These examples illustrate how credible lines of argument can be developed for HSS actions. The lines of argument used to justify proposed actions are valid irrespective of whether or not the application form had a separate component.

Tanzania, selected HSS strategic action, from round 7 malaria proposal

The problem The proposal argues that malaria remains a major cause of under 5 mortality in Tanzania. Around half of deaths in children under 5 in health facilities are malaria related. It provides relevant information on where people go for care and what it costs them: it notes that 35% of children with fever are treated in private outlets including formal private clinics, pharmacies, drug shops (duka la dawa baridi) and 'Accredited Dispensing Drug Outlets' (ADDO), of which the most important - especially in rural areas - are the duka la daw baridis. The price of ACTs in private outlets is 'prohibitively high', and the proposal reports estimates that 75% of malaria expenditures are borne directly by households, with the greatest burden on the poorest ones. All these factors contribute to constraining access to treatment. The proposal also reports that duka la dawa baridis are not necessarily providing the right drugs, nor the right information on dose and adherence, and their regulation and supervision is poor. An associated problem in both public and private facilities is the considerable over-diagnosis of malaria. The proposal notes the successful role that the public sector - the MOHSW, with partners, the Tanzania Food and Drug Authority, local governments and district health authorities - has played in recent years in initiating upgrading of duka la dawa's to ADDOs, with systems for accreditation (based on existing TFDA standards) and supervision. This model began in one region in Tanzania, and has begun to be extended to others.

The response The proposal emphasizes that its objectives are the same as those in the National Malaria Medium-term Strategic Plan, and that reducing malaria mortality will help halve the under 5 mortality rate, in line with the national Poverty Reduction Strategy and MDG targets. As part of a larger package of HSS Strategic Actions, it aims to improve access and quality of care for uncomplicated malaria by rolling out existing successful accreditation activities: by upgrading 4000 duku la dawa baridi's into ADDOs across 8 more regions over five years. It provides details on how this will be done: involving the identification, mapping, inspection of duku la dawas, then training in stock, dispensing and financial management, and accreditation and subsequent supervision. These grass roots outlets will be licensed to provide ACTs as well as other essential drugs, and knowledgeable enough to initiate early referral of severe malaria and also other severe childhood illnesses. This strategy is combined with subsidised ACTs; a communication campaign for caretakers of children, and actions to enhance the emergency care of severely sick children when they reach hospitals and health centres. The proposal argues these actions will improve more than just malaria services, but are essential for tackling malaria. It shows how it will link with and reinforce other quality of care enhancing activities, such as the Emergency Triage, Assessment and Treatment approach, and supportive supervision, implemented as part of IMCI.

Full proposal: http://www.theglobalfund.org/search/docs/7TNZM_1589_0_full.pdf

Kenya, from the round 6 TB proposal

The problem The proposal outlines how TB has become a leading cause of morbidity and mortality, especially in young adults, but that case detection is low, and that the need for better services, as part of an essential package, has been noted in the National Health Plan. It records multiple constraints to improving TB/HIV services. First, that most dispensaries and other primary level health facilities lack the ability to offer even basic TB/HIV services including diagnostics. Second, management capacity is weak, and health provider knowledge is low. Third, there are staff shortages and low productivity.

"Currently the perception is that the level of productivity is due to low staff morale occasioned by perceived low remuneration; lack of clear career pathways; inadequate training and technical support and sub-optimal working environments"

The proposal provides supporting information on these constraints, including the density and distribution of health facilities, less than half of which offer diagnostic services, and notes that a quarter of TB patients first point of contact is at dispensaries. It also makes the point that that Kenya's previous TB proposals to the Global Fund have addressed the demand side, and this proposal complements those by addressing supply side constraints.

The response The proposal sets out 4 objectives. It aims to improve primary level health care provision, especially integrated TB/HIV services, by a package of measures including 1) improved physical infrastructure, and equipment and training to provide Kenya's essential laboratory package 2) improved human resources capacity through recruitment and training 3) improved productivity through intensified support, regular appraisals, incentives 4) improved district health planning and management capacity, through workshops run by the Department of Planning and Health Sector Reform Secretariat. These are consistent with objectives in the National Health Sector Strategic Plan.

The expected HSS outputs are clearly defined and linked to specific programme results. They include ensuring that in five years, not less than 80% of all public sector dispensaries are able to offer basic TB/HIV service including smear microscopy, HIV testing and counselling. The proposal has been endorsed by a large number of partners specified in the proposal form.

Full proposal: http://www.theglobalfund.org/search/docs/6KENT_1351_0_full.pdf

Malawi

This example comes from a round 5 HSS proposal, but the line of argument used to make the case remains equally valid for a round 8 proposal, despite there no longer being a stand-alone component.

The problem The proposal argues, with supporting data, that health workforce shortages have led to a near breakdown in capacity to deliver basic level health services including ART and other HIV/AIDS, TB and malaria services, especially in rural areas. It also argues that the shortages are too severe to be resolved on a disease specific basis. It mentions that only 56% of nursing posts, and 32% of doctors posts, are filled. The proposal provides other powerful data to illustrate the severity of human resource crisis, including an African regional perspective to demonstrate that the problem is even more severe in Malawi than in other countries. It outlines the key elements of the 6 year Emergency Human Resources Programme which has been designed to implement the Malawi Essential Health Package (EHP) - which includes prevention and treatment of HIV/AIDS, TB and malaria and that has been developed, costed and agreed with partners.

"Malawi's health service system has ceased to function within a pro-poor and MDG target disease frame in terms of access to skilled human resources. Without an additional staffing complement addressing health needs at all service levels, the gap in access to community based HIV/AIDS/TB/Malaria services is likely to suffer further".

The response The proposal asks for funding for a portion of its national Emergency Human Resource Programme. The overall aim is to scale up services for the target diseases in ways that do not harm other health services. It identifies the main gaps in funding of the Plan. The four specific objectives in the proposal are 1) to increase community-based services by recruiting, training and retaining health surveillance assistants for meeting the current shortfall and scaling up EHP and ARV/HIV/AIDS services, 2) increase health sector supply to carry out ART and HIV/AIDS services as well as meet other critical HR gaps needed to provide the Essential Health Package services, 3) upgrade and strengthen training institution tutor capacity, 4) upgrade training institution physical facility capacity and provide support for operation costs resulting from increased capital investment. The accompanying text explains how each objective will be met, and what the targets are.

The proposal include clearly stated expected outcomes e.g. expanded training capacity by over 50% on average, and more in key cadres.

14 funding partners support the health SWAp in Malawi. The consultative process that led to the Fund proposal also involved major stakeholders such as NGOs, the private sector and research and academic institutions.

Full proposal: http://www.theglobalfund.org/search/docs/5MLWH_1142_0_full.pdf.

Rwanda, round 5 HSS

This example comes from a round 5 HSS proposal, but the line of argument used to make the case remains equally valid for a round 8 proposal, despite there no longer being a stand-alone component.

The problem: The proposal described how a lack of financial resources at the peripheral level of the health system meant health centres were charging user fees. It argued that this had contributed to a steady decline in service utilization over the last five years. Low service quality was also thought to contribute to low utilization by people with HIV/AIDS, TB or malaria.

"This lack of action between the health services and the diseased population jeopardizes seriously any progress in control of HIV/AIDS, TB malaria and associated diseases.....the very entry into the health system remains a persisting and principal obstacle."

The proposal provided supporting information and statistics on poor access, especially in rural areas, and gave specific examples for the three diseases.

The response addressed both of the identified constraints to demand for health care by those in need. It built on existing activities for which there were insufficient funds from other sources. First, it aimed to improve financial access by financing membership of a community based insurance scheme in six provinces, complementing activities in other provinces. The expected result was that the whole Rwandan population would then be covered by such schemes. Second, it aimed to improve quality by improving management of district services - by supporting pre-service and in-service training of health professionals and administrative and supervisory staff in health financing, financial management, quality assurance and monitoring and evaluation, and by putting electricity into 74 health centres.

It anticipated four outcomes from implementation of the proposal, including a 30% rise in service utilization, and includes HIV/AIDS, TB and malaria indicators as measures of progress.

It said explicitly that the proposed approach had been "endorsed by all development partners in Rwanda, among them World Bank, UN agencies, bilateral partners and the Churches".

Full proposal is on the Global Fund website: www.theglobalfund.org

**4. FUND TO FIGHT AIDS, TB AND MALARIA. OCTOBER 2008.
EXCERPTS ON HEALTH SYSTEMS STRENGTHENING FROM
GUIDELINES FOR PROPOSALS - ROUND 9 AND GLOBAL FUND,
MONITORING AND EVALUATION TOOLKIT: HIV/AIDS, TUBERCULOSIS
AND MALARIA (2ND ED.) ADDENDUM MARCH 2008 (MARCH 2008).
GENEVA, SWITZERLAND.**

Full guidelines:

[http://www.theglobalfund.org/documents/rounds/9/CP_Pol_R9_Guidelines_Single_en.pdf]

Full M&E Toolkit: [http://www.theglobalfund.org/pdf/guidelines/M-E%20Toolkit_Addendum_March%202008_en.pdf]

This is the official Global Fund document that guides applicants through the proposal development process. This HSS Toolkit includes portions of the Guidelines that are focused on HSS, as well as the HSS section of the Global Fund's Monitoring & Evaluation Toolkit. Applicants should be sure to review the full Guidelines for Proposals, not only those excerpts included here.

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Documents required in support of the proposal strategy in s.4.5.1.

In addition to describing the planned implementation approach in detail, applicants should submit:

- (a) A 'Performance Framework' by disease ([Attachment A](#) to the Proposal Form). This framework identifies the performance measures that will apply to the program over the proposal term, and this document will form an integral part of any grant agreement signed with the Global Fund; and
- (b) **A detailed work plan, quarterly for years 1 and 2.** The work plan should show the anticipated start and end dates for all activities over the initial two years, set out like the description in s.4.5.1. of the Proposal Form (i.e., by objective, SDA, and specific activities). The work plan should also use the same or similar numbering as in the detailed budget (s.5.2.) to enable a review of both documents together.

→ *In the work plan, the TRP is looking to see that applicants have a clear understanding of when work must start to ensure timely service delivery. **This work plan does not replace the need to provide a detailed written narrative of activities in s.4.5.1.***

Performance based funding principles can be found in the Multi-Agency "Monitoring and Evaluation Toolkit", Second Edition, January 2006 (**M&E Toolkit**). Further information on this toolkit is provided under the instructions for s.4.5.1.

How to include health systems strengthening in Round 9 proposals

1. The Global Fund acknowledges that the **responses** to identified health systems weaknesses or gaps that constrain the achievement of outcomes for the three diseases may differ substantially in different settings. The Global Fund intends therefore to allow applicants maximum flexibility in addressing these weaknesses and gaps. Applicants can apply for funding to respond to these issues either through a program (by-disease) approach, or by a cross-disease approach.
2. If the most appropriate **response** to a system weakness can be made through a disease program, applicants are encouraged to include the relevant response (activities/interventions) in the program description of the disease proposal (s.4.5.1) as any other disease program activity.
3. However, part or all of the response to system weaknesses that affect outcomes for the three diseases may be more appropriately undertaken on a cross-cutting basis. If so, applicants may request support for these activities/interventions by either:
 - (a) including the activities/interventions in the various disease proposals (if appropriate), separated between the disease proposals as the applicant believes most appropriate; or
 - (b) including relevant activities/interventions in only one disease proposal as an optional additional "cross-cutting" group of activities. If so, these activities are included in s.4B. (s.4B. is available as a download from the Global Fund website [here](#)). The financial information relating to these interventions should then be included in a corresponding s.5B. of the same disease (s.5B. is available as a download from the Global Fund website [here](#)).
4. *HSS cross-cutting interventions* included in a one disease proposal in s.4B. cannot be the only interventions included in that under a disease proposal. That is, there must also be program activities described in s.4.5.1. This is because there is no separate funding window for HSS.

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4.10.7. Multi-drug resistant tuberculosis *(not malaria proposals)*

→ *This section should be completed for tuberculosis and HIV proposals where HIV/TB collaborative interventions are included.*

Applicants should identify whether the proposal requests funding for multi-drug resistant tuberculosis ('MDR-TB').

To help limit resistance to second-line anti-tuberculosis pharmaceuticals, the Global Fund requires procurement of pharmaceuticals to treat MDR-TB to occur through the Green Light Committee ('GLC') of the StopTB Working Group on drug resistant tuberculosis.

As the GLC provides essential services to Global Fund grants targeting MDR-TB, relevant applicants must budget US\$50,000 for each year of the proposal term. These costs must be clearly visible in the detailed proposal budget (s.5.2.), and the funds must be reserved for payment to the GLC during the proposal term. These funds cannot be used for any other implementation activities.

4B. PROGRAM DESCRIPTION – HSS CROSS-CUTTING INTERVENTIONS

This is an optional additional section for applicants to complete.

SUGGESTED STEPS:

- | | | |
|--------|---|---|
| Step 1 | → | Read s.4B below fully first. It contains important information on the potential inclusion of s.4B in a Round 9 proposal (<i>as first introduced in Part A1 of these Guidelines, regarding any funding request for 'HSS cross-cutting interventions'</i>). |
| Step 2 | → | Undertake a cross-disease joint review (including HIV, tuberculosis, malaria, and health systems experts) of health system strengths, weaknesses and gaps. (<i>Include government and non-government entities involved in planning, budgeting and financing of the broader health system</i>). Ensure that people with health systems and cross-disease knowledge are included throughout the whole process. |
| Step 3 | → | Identify priority health systems weaknesses and gaps that affect the achievement of HIV, tuberculosis and/or malaria outcomes (<i>and which may affect outcomes in respect of other diseases or efficiencies in the broader health system</i>).

Annex 3 to these Guidelines includes information on the types of interventions that may be necessary to remove address weaknesses. These examples could be relevant to the disease program or the health system, and therefore are relevant to steps 4 and 5 below. |
| Step 4 | → | Determine whether, in the planned response to identified health system weakness and gaps:

(a) It is most appropriate to do so on an individual program basis. If so, the interventions are included in s.4.5.1. for the disease(s).

(b) It is more appropriate to include, in one of the diseases only , an additional combined request for <i>HSS cross-cutting interventions</i> . If so, this is made through the inclusion of s.4B. in one disease proposal.

<i>** This election is at the applicant level (and not by disease). That is because s.4B. can only be included in one disease only in the applicant's Round 9 proposal.</i> |
| Step 5 | → | If Step 4(b) above applies go to the Global Fund website here and download one copy of: |

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	<ul style="list-style-type: none">• Sections 4B.1. – 4B.3., and copy all of that material into <u>the selected disease only after</u> s.4.9.7. (for HIV or tuberculosis) <u>or</u> s.4.9.6. (for malaria), as indicated; <p>and</p> <ul style="list-style-type: none">• Sections 5B.1. – 5B.4., and copy all of that material into <u>the same disease proposal after</u> s.5.5. , here <p>Then complete those sections as part of that disease proposal.</p>
Step 6	→ Prepare budget, work plan and 'Performance Framework' (<i>Attachment A</i>) material to support the program description of the <i>HSS cross-cutting interventions</i> as explained further below. This material can be in the same 'file' or work book as the disease program interventions, or separate materials that are clearly labeled.

This section of the Guidelines discusses important topics in the following order:

- A. Objectives of health systems strengthening
- B. Restrictions on including s.4B. in Round 9
- C. Possible indicators and tools available to applicants
- D. What health systems strengthening interventions will the Global Fund support
- E. Community systems strengthening that benefit the three diseases
- F. How to complete s.4B. (*detailed instructions on completing the tables*)
- G. TRP review of funding requests for *HSS cross-cutting interventions* in s.4B

A. Objectives of health systems strengthening

The Global Fund's **major objectives** in providing funding for health systems strengthening are to: (i) improve grant performance, and (ii) increase overall impact of responses to the three diseases. We recognize that supporting the development of equitable, efficient, sustainable, transparent and accountable health systems furthers achievement of these objectives.

We also recognize that **non-government organizations**, the **private sector** and **communities affected by the disease(s)** are each an integral component of the health system, as is the **government sector**.

Applicants should therefore consider the broad range of non-government sector needs in any assessment of overall weaknesses and gaps in strategies to ensure increase demand for, and access to required services and/or care. As discussed in s.4.3. above, this assessment should consider the broad range of health system weaknesses that affect access to services by *key affected populations* (including the different needs of women and men, girls and boys), sexual minorities, and people who are not presently visible to service delivery providers due to stigma, discrimination, and other barriers to equal access.

B. Restrictions on including s.4B. in Round 9

- (a) A disease proposal cannot only include s.4B.1. – 4B.3. and have no other disease program activities described in s.4.5.1. **This is because HSS is not a separate component** for Global Fund funding.
- (b) All disease program activities (or pre-dominantly disease-specific) that may also benefit the health system must be included in s.4.5.1. and not s.4B. (*and described by objective, 'SDA', indicator and activity*). These cannot be included in s.4B.1. in any circumstance. → *For example, if the request is for laboratory equipment that is used*

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in a central laboratory that is specifically for HIV diagnosis, this should be included only in s.4.5.1. and not s.4B. Also see item 'D' below.

- (c) Applicants cannot duplicate requests for HSS support in s.4.5.1. and s.4B. of the same disease.

C. Possible indicators and tools available to guide applicants

Working with WHO, the Global Fund has released an update to the ['M&E toolkit'](#) to provide increased guidance on appropriate indicator selection (*including planned outputs and outcomes, and links to impact on the three diseases*).

Applicants are also encouraged to review ['WHO's Building Blocks for health systems'](#), and work with other in-country partners to consider country specific needs.

D. What health system strengthening interventions will the Fund support?

Experience confirms that it is not appropriate to define specific areas for allowable health systems strengthening funding. This is because priorities differ between countries and are best determined based on the analysis of weaknesses in the health system, and knowledge of current national health sector strategies and available resources.

Annex 3 of these Guidelines provides information on the types of support that can be requested of the Global Fund for *HSS cross-cutting interventions*. This material draws on WHO experience of the 'building blocks' for strong health systems.²⁴ It also provides a link between the Round 7 Guidelines for Proposals, and the 'HSS strategic actions' that were described in the 2007 material.

Importantly, the material in Annex 3 is illustrative and not exhaustive. Additional guidance, including links to partner websites, is available at: <http://www.theglobalfund.org/en/rounds/9/other/>

It is also suggested that:

- ➔ Responses to health system weaknesses and gaps should not be developed in isolation from existing national strategies. Rather, there must be a clear and logical justification given between the planned *HSS cross-cutting interventions*, the national health development plans or strategies, and improved outcomes for HIV, tuberculosis and/or malaria.
- ➔ Requests for support for *HSS cross-cutting interventions* (and any disease program activities in 4.5.1. that benefit the health system) be drawn from existing country-specific assessments of weaknesses and gaps in the health system (*whenever such assessments already exist*).

E. Community systems strengthening that benefit the three diseases

The Global Fund continues to support community systems strengthening initiatives, as part of the overall framework for improved outcomes for the three diseases.

Similar for other interventions, activities focused on strengthening underlying service delivery capacity (and reach) at the community level may also be included in s.4B. if the planned

²⁴ Based on the material entitled 'Everybody's Business: Strengthening health systems to improve health outcomes *WHO's Framework for Action, 2007* available at: http://www.who.int/healthsystems/strategy/everybodys_business.pdf

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interventions benefit more than one of the three diseases, and the result of the requested support will be a contribution to improved outcomes for the diseases.

As set out in s.4.7.1. of these Guidelines, commencing from Round 9, the Global Fund encourages applicants to include community systems strengthening measures on a routine basis in proposals to the Global Fund. Information on possible interventions, and how these may link to improved outcomes for the three diseases, is available in the updated M&E Toolkit available at [M&E toolkit](#).

F. *Completing the questions in s.4B.*

4B.1. Description of HSS cross-cutting interventions

Applicants may complete table 4B.1. for up to five *HSS cross-cutting interventions* which ensure achievement of disease outcomes for HIV, tuberculosis, and/or malaria.

For each '*HSS cross-cutting intervention*', applicants should provide:

- (i) A title, the disease(s) that benefit from the interventions, and the principle WHO "building block" from **Part D** in this section of the Guidelines above;
- (ii) In (a), up to a one page maximum summary of the relevant action, and how the action is essential to the intended disease-specific performance outcomes;
- (iii) in (b), a very short sentence that summarizes the overall planned outputs and outcomes that will be achieved in respect of the HSS cross-cutting intervention (e.g., '*improved cold storage of pharmaceuticals*', or '*strengthened national data collection and reporting*'); and
- (iv) in (c), (***as requested in the heading for each relevant column in the table in the Proposal Form***) information on the support that is available for the same *HSS cross-cutting intervention* from other sources (domestic or international). Also, information on the timeframe over which the support from those other sources will be provided.

4B.2. Engagement of HSS key stakeholders in Proposal Development

If *HSS cross-cutting interventions* are included in a proposal, the Global Fund expects that key health systems stakeholders will have been involved the proposal development process.

In order, the two sub-sections request:

- (a) information on the level of involvement of government and non-government (including the private sector) health system stakeholders, including representatives of key affected populations (including women and men), and sexual minorities, who can help identify where in the health system they can best be served; and
- (b) confirmation that budget, work plan and 'Performance Framework' materials have been attached to the proposal.
➔ *Applicants may include the HSS cross-cutting interventions in the same files or work books as the disease program interventions or separate files and work books. However, HSS is not a separate component and the material should still be included as part of the disease proposal that includes s.4B.*

4B.3. Strategy to mitigate unintended consequences

Applicants should describe any possible unintended consequences that may result from the

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HSS cross-cutting interventions set out in section 4B.1. (*For example, if support is requested for human resources funding, it may result in movement of human resources from one sector to another, or loss of services in another area*). Applicants should also provide a description of the country's proposed strategy for mitigating any potential unintended consequences.

G. TRP review of funding requests for HSS cross-cutting interventions in s.4B.

Where an applicant has included *HSS cross-cutting interventions* in a disease proposal as part of that 'disease component', the TRP is authorized to recommend, *subject to technical merit based on the criteria set out in Annex 2 to these Guidelines*:

(a) **Both** the disease specific interventions (s.4.5.1.) in that disease and necessary *HSS cross-cutting interventions* (s.4B. of that same disease);

or

(b) **Only** the disease-specific interventions;

or

(c) **Only** the HSS cross-cutting interventions.

This change was introduced at the 16th Board meeting. This decision supports the objective of applicants having flexibility in how they apply for funding to address health systems weaknesses that impact HIV, tuberculosis and malaria outcomes on a *cross-cutting* basis.

Annex 3 – What the Global Fund will support

Set out below is information on possible disease program interventions (s.4.5.1.) and interventions to strengthen health systems (as part of a disease program in s.4.5.1. or, separately, in s.4B. as *HSS cross-cutting interventions*).

Importantly, the material below **is not a exhaustive list** of all activities/interventions that may be funded. It represents a guide only for possible programming to support existing in-country knowledge of the disease(s).

Disease focused activities may include, but are not limited to, the following:

- Behavior change interventions, such as peer education;
- Activities to reduce girls' and women's vulnerability to the three diseases, such as equitable access to youth and social safety net programs, prevention and mitigation of sexual violence, and advocacy for legal change and enforcement;
- Community outreach, including preventive measures focusing on *key affected populations*;
- Blood safety and safe injection interventions to prevent medical transmission;
- Male circumcision, with the assurance of a comprehensive package of prevention messages and activities and access to counseling and testing services;
- Community-based programs aimed at alleviating the impact of the diseases, including programs directed at women, orphans, vulnerable children and adolescents; and alleviating the burden of care and support on, especially, women;
- Community systems strengthening to improve implementation and service delivery, including strengthening core institutional capacity through physical infrastructure development, and organizational and systems strengthening;
- Partnership building at the community level, focusing on the building of systematized relationships among and between community based organizations at the local level to improve coordination, build upon one another's skills and abilities, and enhance service delivery outcomes in respect of the disease(s);
- Operational research to improve program performance, including determining effective ways to increase demand for, and improve access to, quality services;
- Home and palliative care support;
- Interventions related to interactions between the three diseases, including providing access to prevention services through integrated health services, especially for women and adolescents through reproductive health care;
- Provision and/or scale up of critical health products and health equipment to prevent, diagnose, and treat the three diseases, including the introduction of previously unavailable treatments;
- Workplace programs for prevention, and to care for and/or treat employees, including policy development in regard to such programs;
- Co-investment schemes to expand private sector programs to surrounding communities; and
- The establishment and ongoing support of interventions managed by people living with and/or affected by HIV, tuberculosis and/or malaria, such as support groups, treatment literacy programs, and risk-reduction programs.

But not:

- Basic science research and clinical research aimed at demonstrating the safety and efficacy of new drugs and vaccines.³⁰; or
- Large scale capital investments such as building hospitals or clinics.

³⁰ Providing support, care, and treatment for people who become HIV-positive in the course of an HIV-related clinical trial would be an allowable activity, within the context of national policies for the provision of antiretroviral therapy.

Annex 3 – What the Global Fund will support

Provided that there is a clear and demonstrated link to improved HIV, tuberculosis and/or malaria outcomes, health systems strengthening areas of focus that may be relevant to be included in proposals (in s.4.5.1 as a disease specific response, or once only in s.4B as a cross-disease response) include:

- **Information** - Strengthening the monitoring of performance of health systems with special reference to the three diseases, through data collection and analysis on health system metrics - for example data on public and private sector service delivery using facility assessments; better workforce data using multiple data sources; or, building district data management capacity.
→ *To draw linkages between the Round 7 Call for Proposals and Round 9, applicants are advised that the following items from the Round 7 Guidelines for Proposals (page 24), are included in this area:*
 - *Monitoring and evaluation*
 - *Information systems*
- **Service delivery** - For effective, good quality personal and non-personal care for those living with or affected by HIV, tuberculosis and/or malaria, actions may be needed that strengthen public demand for services. These include actions that: strengthen supervision and management of resources and facilities; increase the involvement of community systems, and civil society and the private sector in the delivery of public health programs; and, strengthen diagnostic services and laboratories.
→ *To draw linkages between the Round 7 Call for Proposals and Round 9, applicants are advised that the following items from the Round 7 Guidelines for Proposals (page 24), are included in this area:*
 - *Infrastructure (but not large-scale investments such as building new hospitals or new large clinics)*
- **Medical products and technologies** - To achieve more equitable access to essential medicines and technologies for the three diseases, actions may be needed to strengthen: policies, standards and guidelines; capacity to set and negotiate prices; quality assessment of priority products; procurement, supply and distribution systems; and, support for rational use of medicines, health products, and health equipment.
→ *To draw linkages between the Round 7 Call for Proposals and Round 9, applicants are advised that the following items from the Round 7 Guidelines for Proposals (page 24), are included in this area:*
 - *Essential medicines and health products management;*
 - *Procurement systems;*
 - *Logistics, including storage, transport and communications; and*
 - *Technology management and maintenance.*
- **Financing** - To improve financial risk protection and coverage for those living with and/or affected by HIV, tuberculosis and/or malaria, and transparent and effective use of resources, actions that may be appropriate include: strengthening financial resource tracking systems for the three diseases; actions to improve financial access to services, such as improving or expanding sustainable social insurance schemes to ensure access by *key affected populations* to essential services.
→ *To draw linkages between the Round 7 Call for Proposals and Round 9, applicants are advised that the following items from the Round 7 Guidelines for Proposals (page 24), are included in this area:*
 - *Health management; and*
 - *Health financing.*
- **Health workforce** - For the workforce (government and non-government sectors) to be better able to deliver services to achieve improved outcomes in respect of the three diseases, actions that may be appropriate include: strengthening the production of health workers; their recruitment, distribution, retention or productivity. Actions may include, for example, new approaches to: pre- and in-service training;

Annex 3 – What the Global Fund will support

strengthening workforce management; appropriate incentives for distribution and retention; and task shifting.

→ *To draw linkages between the Round 7 Call for Proposals and Round 9, applicants are advised that the following items from the Round 7 Guidelines for Proposals (page 24), are included in this area:*

- *Health management; and*
- *Human resources.*

- **Leadership and governance** - To improve governance of health systems with special reference to HIV, tuberculosis and/malaria outcomes, actions that may be appropriate include: strengthening capacity to be effective advocates in respect of the three diseases; building coalitions with other sectors and with actors outside government including civil society; improving oversight and regulation of services; and supporting policy and systems research related to the three diseases.

→ *To draw linkages between the Round 7 Call for Proposals and Round 9, applicants are advised that the following items from the Round 7 Guidelines for Proposals (page 24), are included in this area:*

- *Governance; and*
- *Community and client involvement;*
- *Strategic planning and policy development; and*
- *Policy research.*

HSS cross-cutting interventions included in s.4B need not be limited to only health sector-related activities or only to the three diseases. Rather, they may also target other sectors including education, the workplace, and social services. However, under Global Fund policy, support for health systems strengthening is available where there is a demonstrated link to reducing the spread and impact of HIV, tuberculosis and/or malaria.

IV. Health Systems Strengthening

Programs to address HIV, tuberculosis, and malaria (HTM) require support from public and private organizations. These organizations rely on effective, efficient, sustainable and transparent systems to: provide pharmaceuticals and other health products; finance health services; assure the quality and efficiency of care; manage the health workforce; and generate information needed for effective policy, operations and programming decisions. Where system weaknesses are important obstacles to responding to the three diseases, the Global Fund will consider providing resources for Health Systems Strengthening (HSS).

Global Fund support for HSS is available where the funding requested:

1. Is essential to achieve planned outputs and outcomes for the three diseases;
2. Addresses general health systems weaknesses which are beyond a specific programme's mandate but will contribute to improved HTM outcomes;
3. Consistent with (where they exist) national policy directions, for example, a health sector development plan, a national financing strategy or a health workforce plan.

HSS proposed for funding will depend on the country-specific context but may generally belong to some or all of the following broad areas (HSS SDAs) (which are the same as the six building blocks in the WHO Framework for HSS Action²):

- Service delivery organization and management
- Health Workforce / Human resources
- Information
- Medical products, vaccines, technology (*procurement, supply management, etc*)
- Financing
- Leadership and governance.

Global Fund support for interventions within the HSS SDAs, like disease program interventions, is tied to output and outcome indicators to objectively measure performance.

Tables 15A and 15 provide a number of illustrative *examples* of HSS interventions and possible HSS output and outcome indicators by HSS SDA that applicants may wish to use to formulate their own indicators. The list is not exhaustive and additional indicators can be used. In many cases, it is important to disaggregate relevant indicators to enable monitoring of progress in achieving equity of access and coverage of essential services for underserved communities, regions or other prioritized or vulnerable population groups (gender, rural/urban, income based). Reviewing data collected from selected indicators at both national and sub-national levels helps to highlight internal disparities and assists to establish appropriate country-specific baselines and targets.

As far as possible, the Global Fund encourages the use of existing in-country indicators used to monitor health systems performance. For example, those specific indicators that are part of a program-based approach (including Sector-wide Approaches) performance matrix or other national strategic frameworks.

WHO is in the process of developing a "HSS Toolkit" which is anticipated to be available by mid-2008. It is expected to include other examples of indicators, their definitions and measurement methods as well as explanations of the various HSS blocks.

² Refer to WHO guidance at: <http://www.who.int/healthsystems/strategy/en/>

New: Table 15A: HSS SDAs and illustrative examples of interventions

HSS Service Delivery Areas	Illustrative examples HSS Interventions
Service Delivery	<p>Actions may be needed to improve how HIV/AIDS, tuberculosis and malaria prevention, treatment, and care and support services are organized and delivered, and to expand access to all services. Possible activities include actions to strengthen public demand for services; improving supervision and the management of resources and facilities; involving civil society and the private sector in public health service delivery; and strengthening laboratories and other diagnostic services including renovating or upgrading health facilities. Activities and targets must relate to the equity and access needs of vulnerable and deprived populations. <i>(Note that the Global Fund will not fund large infrastructure projects, such as the construction of hospitals).</i></p>
Health Workforce	<p>Actions may be needed to strengthen the production of health workers as well as their recruitment, distribution, retention, training and productivity. Actions may include, strengthening workforce management; improving incentives to address distribution or retention; or task shifting to less specialized health workers. The focus should not only be on clinical service providers but also management and support staff essential to keep a system running.</p>
Information Systems	<p>Actions may be needed to strengthen the generation and use of information/data needed to manage services and to account for results. This includes monitoring of health system inputs and service delivery coverage (health systems performance) with special reference to the three diseases, and cross-cutting priority areas. It may include strengthening the collection and quality of mortality statistics; and investing in the systematic use of evidence to guide decisions at the facility and district levels. Activities include improving data collection and analysis using multiple data sources such as surveys and building district and national data management capacity for M&E, operational research and surveys. It may also mean formulating and implementing clear national information policy and standards and expanding reporting by private-for-profit health service providers.</p>
Medical Products, Vaccines, Technology *	<p>To achieve more equitable access to essential medicines³ and technologies, actions may be needed to: strengthen policies, standards, and guidelines; and/or build capacity to set and negotiate prices; quality assessment of priority products; strengthen procurement systems, improve supply and distribution systems; and strengthen mechanisms to enforce rational use of medicines, commodities and equipment. <i>(Note that the Global Fund will not fund basic science research and clinical research aimed at demonstrating the safety and efficacy of new pharmaceuticals and vaccines).</i></p>
Financing	<p>Actions may be needed to improve financial risk protection and coverage for vulnerable groups in order to reduce the burden of out-of-pocket payments. Actions may also be needed to ensure the transparent and effective use of resources, including: strengthening financial resource tracking systems, (including HIV/AIDS, tuberculosis and malaria accountability and reporting through the institution of national sub-accounts); and improving financial access to essential services through development of sustainable financing plans as part of national financing strategies. Also, efforts to improve financial management at operational levels and by NGOs/civil society groups may be required to strengthen service delivery and increase coverage of prevention, treatment, and care and support services⁴. Other activities might involve developing ways of reducing household out of pocket payments; such as exemption mechanisms, vouchers and other demand side incentives, or to strengthen health insurance schemes for the benefit of key affected populations in respect of the three diseases.</p>
Leadership and Governance	<p>This involves improved governance of health systems with special reference to positive impact on of HIV/AIDS, tuberculosis and malaria service delivery and utilisation. Actions that may be needed include: strengthening advocacy capacity; building coalitions with other sectors and civil society; improving oversight and regulation of services provided by government and non-government providers; instituting regular performance reviews, and supporting policy and systems research.</p>

³ An Essential Medicines List is a government-approved selective list of medicines or national reimbursement list.

⁴ With indicators for effective financial management.

Revised Table 15: Examples of Health Systems Strengthening Indicators

HSS Service Delivery Areas	HSS Output indicators	HSS Outcome indicators	Disease Specific Output / Outcome/ Impact
Service Delivery	<p>Number (percentage) facilities and/or laboratories / renovated / upgraded to a specified standard and delivering a specific service package — by type, geographical area, and public/private</p> <p>Number (percentage) of facilities and/or laboratories (a) receiving supervisory visit in past 12 months, and (b) fulfilling basic quality assurance criteria — by type, geographical area, and public/private</p> <p>Number of Civil Society Organisations receiving support for organisational and system development providing public health services at community level including to vulnerable populations — by type of service, geographical area and group (e.g. vulnerable populations; Sexual Minorities, Internally displaced persons, Intravenous Drug users, commercial sex workers, indigenous groups, migrants/ refugees etc)</p>	<p>Number (percentage) of all facilities offering basic package of services (public/private)</p> <p>Proportion of population with access to basic services⁵ — by geographical area and other socio-demographic characteristics⁶ (e.g. vulnerable groups)</p> <p>Proportion of population with access to care and support services — by geographical area and other socio-demographic characteristics⁶ (e.g. vulnerable groups)</p>	Disease specific output / outcome / impact indicators should be included (e.g. see specific disease section)
Health Workforce	<p>Number of health workers recruited at primary health care facilities in past 12 months by cadre; e.g. as percentage of planned recruitment target</p> <p>Number of graduates of health training programmes in past 12 months, by cadre, urban/rural, gender, etc</p> <p>Number (percentage) of facility-based and/or community based health workers who reported receiving personal supervision in last six months</p> <p>Number (percentage) of senior staff at primary health care facilities who received in-service management training in past 12 months</p> <p>National strategy in place for training Civil Society Organisations for service provision</p>	<p>Health worker density per 1,000 population, (by cadre, urban/rural or other geographic delimitation)</p> <p>Percentage of PHC facilities meeting national approved staffing norms</p>	

⁵ Access as defined by the country itself.

⁶ Based on countries' own definitions of basic package, access and service availability etc.

HSS Service Delivery Areas	HSS Output indicators	HSS Outcome indicators	Disease Specific Output / Outcome/ Impact
	Information Systems ⁷	<p>Number of staff trained on monitoring and evaluation, surveillance, and operational research (per level including civil society)</p> <p>Percentage of registered private-for-profit facilities/civil society organisations reporting routine data according to national guidelines in past 12 months</p> <p>A nationally coordinated multi-year plan with a schedule for survey implementation and data analysis prepared</p> <p>Percentage of deaths covered by mortality civil registration system</p>	
Medical Products, Vaccines and Technology	<p>Number (percentage) of staff (by region) trained/recruited for procurement and supply management & quality assurance in past 12 months (as percentage of planned target)</p> <p>No. and percentage of facilities with staff trained for Procurement Supply Management and fully applying national regulations</p>	<p>Average stockout duration for a basket of medicines in the central and/or regional stores in the last year, out of average stockout duration for the same basket in the past three years</p> <p>Average stockout duration for a basket of medicines in a sample of remote facilities in the last year, out of average stockout duration for the same basket in the past three years.</p> <p>Average time between order and delivery from central store to remote facilities in the last year out of average time between order and delivery in the past three years</p>	
Financing	<p>Patient / household out of pocket expenditures of accessing or obtaining services</p> <p>Number and percentage of facilities meeting established national financial management criteria</p> <p>Number of Civil Society organisations with budget and accounting system in place</p>	<p>Out of pocket expenditure by households as percentage of Total Health Expenditure (or prepaid expenditure as percentage of Total Health Expenditure - where prepaid = tax plus insurance)</p>	
Leadership and Governance	<p>Health sector development strategic plan developed, agreed, implemented and reviewed annually</p> <p>Number of staff receiving training in past 12 months on strategic planning and policy development per level</p> <p>Private health sector policy developed and implemented, including existence of an up-</p>		

⁷ All the health system building blocks require information as part of their interventions, as well as for verification purposes and proposals should ideally have information requirements needed to support indicator measurements for other health system strengthening blocks.

HSS Service Delivery Areas	HSS Output indicators	HSS Outcome indicators	Disease Specific Output / Outcome/ Impact
	<p>to-date and accurate private provider registration system</p> <p>Number and percentage of Civil Society Organisations that work in partnership with a public/private provider in delivering services</p> <p>Frequency of other governance/ stewardship mechanisms - e.g. audits, reviews of performance against targets</p>		

Selected references/resources:

- Health Metrics Network, *Strengthening Country Health Information Systems: Assessment and Monitoring Tool (version 2.00)*, Geneva, 2007 [available on URL: <http://www.who.int/healthmetrics/support/tools> .
- Bossert, T. et al, *Assessing financing, education, management and policy context for strategic planning of human resources for health*, World Health Organization, Geneva, 2007.
- Management Sciences for Health and World Health Organization, *Tools for planning and developing human resources for HIV/AIDS and other health services*, Geneva, 2006, available at: <http://www.who.int/hrh/tools/planning>].
- WHO, 2007 *Everybody's Business, Strengthening Health Systems to Improve Health Outcomes*", available at: <http://www.who.int/healthsystems/strategy/en/>
- WHO, 2007, *World Health Statistics* available at: <http://www.who.int/healthinfo/statistics/en/>
- A Global Fund guide to procurement plans, with relevant indicators is available at: <http://www.theglobalfund.org/en/about/procurement/guides/#psm>
- WHO information on indicators to monitor in-country pharmaceutical situations is available at: <http://www.who.int/medicinedocs/collect/medicinedocs/index/assoc/s14101e/s14101e.pdf>

**5. GLOBAL FUND TO FIGHT AIDS, TB AND MALARIA.
SEPTEMBER 2008. GLOBAL FUND FACT SHEET SERIES, 5 OF 6: THE
GLOBAL FUND'S APPROACH TO HEALTH SYSTEMS STRENGTHENING.
GENEVA, SWITZERLAND.**

[http://www.theglobalfund.org/documents/rounds/9/CP_Pol_R9_FactSheet_5_HSS_en.pdf]

This factsheet includes an explanation of HSS in the context of the Global Fund's mandate. Applicants are encouraged to incorporate responses to Health System constraints and gaps within their proposals. The factsheet provides direction for applicants on how to clearly include HSS interventions in proposals and how to develop strong requests for funding. It also depicts the different ways in which HSS cross-cutting interventions can be included.

Fact Sheet: The Global Fund's approach to health systems strengthening

A. What is health systems strengthening in the context of the Global Fund's mandate?

A health system consists of all organizations, people, and actions whose primary intent is to promote, restore or maintain health. It involves the broad range of individuals, institutions, and actions that help to ensure the efficient and effective delivery and use of the spectrum of products and information for prevention, treatment, and care and support to people in need of these services.

The Global Fund recognizes the importance of supporting the strengthening of public, private and community health systems where weaknesses and gaps in those systems constrain the achievement of improved outcomes in reducing the burden of HIV, tuberculosis and malaria.

With a strong focus on ensuring linkages between and outcomes for the three diseases, the Global Fund remains committed to providing funding for health systems strengthening (HSS) within the overall framework of funding technically sound proposals.

B. Why is health systems strengthening important?

In order to function well, health systems must carry out a number of basic functions. The World Health Organization has categorized these functions into the following “essential building blocks”¹:

- Good health service delivery, i.e. the ability to efficiently deliver effective, safe, quality personal and non-personal interventions to those who need them;
- A well-performing health workforce that is responsive, fair and efficient in achieving the best health outcomes possible, given available resources and circumstances;
- A well-functioning health information system that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health systems performance and health status;
- A well-functioning system for providing equitable access to quality essential pharmaceutical and health products and technologies;
- Good health financing systems to raise adequate funds for health, and to ensure protection for financial risks; and
- Effective leadership and governance to ensure strategic policy frameworks exist and are combined with effective oversight, coalition-building, the provision of appropriate regulations and incentives, and accountability.

Inadequate health systems are one of the main obstacles to scaling-up interventions to secure better health outcomes for HIV, tuberculosis, and malaria. In the context of the Global Fund's mandate, HSS refers to activities and initiatives that improve the underlying health systems of countries in any of the six areas identified above, and/or manage interactions between them in ways that achieve more equitable and sustainable health services and health outcomes related to the three diseases.

¹ *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes (WHO's Framework for Action)*, Geneva, World Health Organization, 2007.

C. Including health systems strengthening in proposals

The Global Fund recognizes that health systems weaknesses and gaps that impact achievement of improved HIV, tuberculosis and malaria outcomes may be responded to through a disease specific program approach or a cross-disease approach that benefits more than one of the three diseases ('cross-cutting').

As in prior Rounds, the Global Fund encourages applicants, wherever possible, to integrate their responses to these health system weaknesses and gaps within the relevant disease component(s). This is encouraged whether the response is disease program specific, or cross-cutting (*refer to [diagram 1](#) and [diagram 2](#) below for options for including cross-cutting interventions into disease specific programming*).² When cross-cutting HSS requests are included in disease specific program descriptions, these requests will be assessed by the Technical Review Panel ('TRP') as an integral part of its review of the relevant disease component(s).

Consistent with the Global Fund's encouragement noted above, all responses to health systems weaknesses that are specific to only one disease must be included in the implementation strategy for that disease only.

However, the Global Fund also recognizes that certain cross-cutting responses may not always be easily included within disease program strategies. For example, difficulties may arise during attempts to apportion cross-cutting interventions between the diseases (*diagrams 1 and 2*). Where this is the case, applicants may request funding for the necessary HSS cross-cutting interventions through a distinct but complementary section (the 'cross-cutting HSS section'³) in only one of the disease components applied for in the proposal (*refer to [diagram 3](#) below*).

To ensure that Global Fund resources continue to be prioritized towards the achievement of improved outcomes for the three diseases, the information provided by applicants in the cross-cutting HSS section must clearly articulate how the interventions will address identified health systems constraints to improved HIV, tuberculosis and/or malaria outcomes (*although recognizing that interventions may benefit other disease outcomes also*).

When reviewing a disease proposal which contains a cross-cutting HSS section, the TRP may recommend for funding, subject to technical merit:

- the entire disease proposal including the distinct cross-cutting HSS section; or
- the disease proposal excluding the cross-cutting HSS section; or
- only the cross-cutting HSS section if the interventions in that section materially contribute to overcoming health systems constraints to improved HIV, tuberculosis and/or malaria outcomes.

To support the preparation of strong, appropriate requests for funding for HSS cross-cutting interventions, the Global Fund recommends that health systems and cross-disease focused in-country stakeholders are involved in the CCM and in proposal development. In particular, the Global Fund encourages applicants to include stakeholders who are involved in the planning, budgeting and resource allocation processes for the national disease programs and health system reform, and explain the role of these stakeholders in the proposal that is submitted.⁴ Applicants are also encouraged to draw on recent assessments of health system weaknesses and gaps (which may be broader than the three diseases, where they exist) when preparing their proposals.

² The interventions should be described in the disease specific program intervention strategy (section 4.5.1 in Round 9).

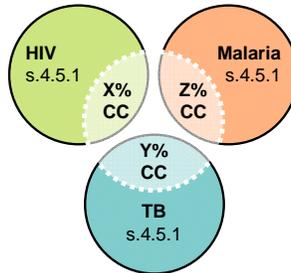
³ The relevant sections comprise section 4B and 5B, and are available from the Global Fund's call for proposals website.

⁴ By way of example, personnel from Ministries of Planning and/or Finance, and stakeholders involved in other proposal development processes for health systems support, including through the World Bank or GAVI.

Consistent with the Global Fund's focus on supporting the achievement of improved outcomes for the three diseases, funding for HSS is not available as a separate funding window in proposals submitted to the Global Fund. For this reason, proposals cannot be submitted where a disease proposal only requests funding of HSS cross-cutting interventions through the cross-cutting HSS distinct section.

Diagrams providing more information on the alternative approaches for inclusion of cross-cutting HSS interventions in Global Fund proposals are set out below.

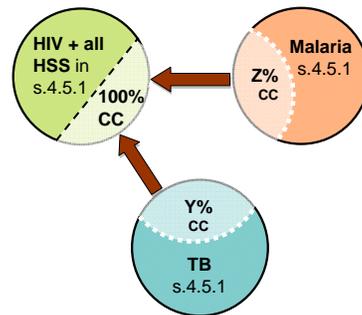
Diagram 1: Responses to cross-cutting health systems constraints apportioned between the diseases and integrated into the program description as for other program specific activities (s.4.5.1 by disease)



May be more appropriate where there is a desire to include HSS cross-cutting interventions as part of each disease proposal. *HSS cross-cutting interventions are described in the implementation strategy by disease with all other disease program interventions (s.4.5.1).*

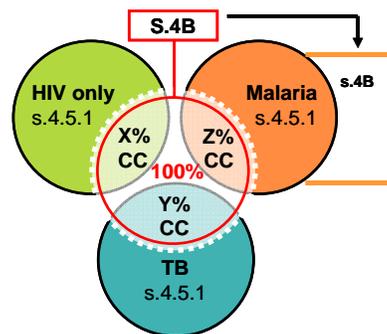
* 'CC' means HSS cross-cutting interventions

Diagram 2: Responses to cross-cutting health systems constraints included in one disease only, but integrated into the program description for that disease as for other program specific activities (s.4.5.1 in one of the disease proposals)



May be more appropriate where there are HSS cross-cutting interventions, but they are particularly relevant to one of the three diseases. *HSS cross-cutting interventions are described in the implementation strategy of that disease with all other disease program interventions (s.4.5.1). In this example, all HSS cross-cutting interventions are included in the HIV proposal.*

Diagram 3: Responses to cross-cutting health systems constraints included in the HSS cross-cutting section related to one disease only (s.4B in one disease only)



May be more appropriate where there are HSS interventions that are cross-cutting and which are more appropriately included as a holistic set of interventions *(in this example, all HSS cross-cutting interventions are included within the malaria proposal).* The TRP will review that section as a distinct part of the malaria proposal and can recommend (i) the malaria part and the cross-cutting part, or (ii) the malaria part only, or (iii) the HSS cross-cutting part only.

2. BACKGROUND ON HEALTH SYSTEMS STRENGTHENING

Compilation of selected publications to provide a background on HSS:

6. World Health Organization. 2007. *Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action*. Geneva, Switzerland.
7. Hunt, Paul. January 2008. *Promotion and protection of all human rights, civil, political, economic and cultural rights: Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. New York, NY: United Nations General Assembly.

6. WORLD HEALTH ORGANIZATION. 2007. EVERYBODY'S BUSINESS: STRENGTHENING HEALTH SYSTEMS TO IMPROVE HEALTH OUTCOMES: WHO'S FRAMEWORK FOR ACTION. GENEVA, SWITZERLAND.

[http://www.who.int/healthsystems/strategy/everybodys_business.pdf]

This document provides valuable background information on health systems, as it seeks to promote a common understanding of health systems and what constitutes health system strengthening. It defines and explains six building blocks of health systems, and provides insights into major health system challenges and opportunities. It also provides a framework for WHO's own current and increasing role in improving the performance of health systems.

EVERYBODY'S BUSINESS

STRENGTHENING HEALTH SYSTEMS TO IMPROVE HEALTH OUTCOMES

WHO'S FRAMEWORK FOR ACTION



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LIST OF ABBREVIATIONS

ACRONYM	FULL TITLE
AU	African Union
CCS	WHO Country Cooperation Strategies
EURO	WHO, Regional Office for Europe
GATS	General Agreement Trade in Services
GAVI	Global Alliance on Vaccines Initiative
GAVI-HSS	GAVI Health System Strengthening
GDP	Gross Domestic Product
GHPs	Global Health Partnerships
GOARN	Global Outbreak And Response Network
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome
HSAN	Health Systems Action Network
IMAI	Integrated Management of Adult Illness
IMCI	Integrated Management of Child Illness
LHW	Lady Health Worker
MDG	Millennium Development Goal
MOH	Ministry of Health
MTSP	Medium-Term Strategic Plan
NEPAD	New Partnership for Africa's Development
NGO	Non-Governmental Organization
OECD	Organisation for Economic Co-operation and Development
SARS	Severe Acute Respiratory Syndrome
TB	Tuberculosis
TTR	Treat, Train and Retain initiative
UN	United Nations
UNITAID	International Drug Purchasing Facility
WHO	World Health Organization

FOREWORD

The strengthening of health systems is one of six items on my Agenda for WHO. The strategic importance of Strengthening Health Systems is absolute.

The world has never possessed such a sophisticated arsenal of interventions and technologies for curing disease and prolonging life. Yet the gaps in health outcomes continue to widen. Much of the ill health, disease, premature death, and suffering we see on such a large scale is needless, as effective and affordable interventions are available for prevention and treatment.

The reality is straightforward. The power of existing interventions is not matched by the power of health systems to deliver them to those in greatest need, in a comprehensive way, and on an adequate scale.

This Framework for Action addresses the urgent need to improve the performance of health systems. It is issued at the midpoint in the countdown to 2015, the year given so much significance and promise by the Millennium Declaration and its Goals. On present trends, the health-related Goals are the least likely to be met, despite the availability of powerful drugs, vaccines and other tools to support their attainment.

The best measure of a health system's performance is its impact on health outcomes. International consensus is growing: without urgent improvements in the performance of health systems, the world will fail to meet the health-related Goals. As just one example, the number of maternal deaths has stayed stubbornly high despite more than two decades of efforts. This number will not fall significantly until more women have access to skilled attendants at birth and to emergency obstetric care.

As health systems are highly context-specific, there is no single set of best practices that can be put forward as a model for improved performance. But health systems that function well have certain shared characteristics. They have procurement and distribution systems that actually deliver interventions to those in need. They are staffed with sufficient health workers having the right skills and motivation. And they operate with financing systems that are sustainable, inclusive, and fair. The costs of health care should not force impoverished households even deeper into poverty.

This Framework for Action moves WHO in the right direction, on a course that must be given the highest international priority. WHO staff, working at all levels of the Organization, are its principal audience, but basic concepts, including the fundamental “building blocks” of health systems, should prove useful to policy-makers within countries and in other agencies.

Margaret Chan
Director-General



EXECUTIVE SUMMARY

It will be impossible to achieve national and international goals – including the *Millennium Development Goals* (MDGs) – without greater and more effective investment in health systems and services. While more resources are needed, government ministers are also looking for ways of doing more with existing resources. They are seeking innovative ways of harnessing and focusing the energies of communities, non-governmental organizations (NGOs) and the private sector. They recognize that there is no guarantee the poor will benefit from reforms unless they are carefully designed with this end in mind. Furthermore, they acknowledge that only limited success will result unless the efforts of other sectors are brought to bear on achieving better health outcomes. All these are health systems issues.

The World Health Organization (WHO) faces many of the same challenges faced by countries: making the health system strengthening agenda clear and concrete; creating better functional links between programmes with mandates defined in terms of specific health outcomes and those with health systems as their core business; ensuring that the Organization has the capacity to respond to current issues and identify future challenges; and ensuring that institutional assets at each level of the Organization (staff, resources, convening power) are used most effectively.

The primary aim of this Framework for Action is to clarify and strengthen WHO's role in health systems in a changing world. There is continuity in the values that underpin it from its constitution, the Alma Ata Declaration of Health For All, and the principles of Primary Health Care. Consultations over the last year have emphasized the importance of WHO's institutional role in relationship to health systems. The *General Programme of Work (2006-2015)* and *Medium-term Strategic Plan 2008-2013* (MTSP) focus on what needs to be done. While reaffirming the technical agenda, this Framework concentrates more on how the WHO secretariat can provide more effective support to Member States and partners in this domain.

There are four pillars to WHO's response, each with its set of strategic directions:

A single Framework with six building blocks

A key purpose of the Framework is to promote common understanding of what a health system is and what constitutes health systems strengthening. Clear definition and communication is essential. If it is argued that health systems need to be strengthened, it is essential to be clear about the problems, where and why investment is needed, what will happen as a result, and by what means change can be monitored. The approach of this Framework is to define a discrete number of "building blocks" that make up the system. These are based on the functions defined in World health report 2000. The building blocks are: **service delivery; health workforce; information; medical products, vaccines and technologies; financing; and leadership and governance (stewardship).**

The building blocks serve three purposes. First, they allow a definition of desirable attributes – what a health system should have the capacity to do in terms of, for example, health financing. Second, they provide one way of defining WHO's priorities. Third, by setting out the entirety of the health systems agenda, they provide a means for identifying gaps in WHO support.

While the building blocks provide a useful way of clarifying essential functions, the challenges facing countries rarely manifest themselves in this way. Rather, they require a more integrated response that recognizes the inter-dependence of each part of the health system.

THE SIX BUILDING BLOCKS OF A HEALTH SYSTEM

- Good **health services** are those which deliver effective, safe, quality personal and non-personal health interventions to those that need them, when and where needed, with minimum waste of resources.
 - A well-performing **health workforce** is one that works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances (i.e. there are sufficient staff, fairly distributed; they are competent, responsive and productive).
 - A well-functioning **health information** system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status.
 - A well-functioning health system ensures equitable access to essential **medical products, vaccines and technologies** of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use.
 - A good **health financing** system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. It provides incentives for providers and users to be efficient.
 - **Leadership and governance** involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system-design and accountability.
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Health systems and health outcome programmes: getting results

WHO's involvement in all aspects of health and health systems constitutes a comparative advantage. Nevertheless, it is clear that, in too many instances, WHO's support can be fragmented between advice focusing on particular health conditions (that may not always take systems or service delivery issues into account) and advice on particular aspects of health systems provided in isolation. While there are good examples of how both streams of activity can work together, the challenge is to develop a more systematic and sustained approach that responds better to the needs of Member States.

Several productive relationships have been established, bringing together “programme” and “systems” expertise. These include work on costing and cost-effectiveness; the *Treat, Train and Retain (TTR)* initiative linking systems work on health service staffing with improving access to HIV/AIDS care and treatment, and the work across WHO stimulated by the Global Alliance on Vaccines Initiative (GAVI) Health Systems Strengthening window.

Three complementary directions to a more strategic response are proposed: extending existing interactions; better and more systematic communication and awareness among all WHO staff on how to think systematically about health system processes, constraints and what to do about them; greater consistency, quality and efficiency in the production of methods, tools and data reporting across WHO. Attention to institutional incentives is also needed.

A more effective role for WHO at country level

Countries at different levels of development look for different forms of engagement with WHO as they seek to improve their health systems' performance. Some are primarily interested in exchanging ideas and experiences in key aspects of policy (such as health worker migration); getting wider international exposure for important domestic agendas (such as patient safety or the health of indigenous populations); and developing norms and standards for measuring performance. Countries at all levels of development look to WHO for comparative experience in relation to different aspects of reform. But it is countries at a lower level of income – as evidenced increasingly in WHO Country Cooperation Strategies (CCS) – that seek more direct involvement in overall policy and health systems development.

Four strategic directions are proposed. First, there is a need to improve capacity to diagnose health systems constraints. Second, WHO should seek more active and consistent engagement in overall sector policy processes and strategies. In this context, engagement in key policy events should involve all levels of the Organization. Third, WHO's efforts should be directed towards building national capacity in policy analysis and management. Lastly, tracking trends in health systems performance needs to be geared first and foremost towards national decision making.

The role of WHO in the international health systems agenda

In addition to supporting health systems strengthening in individual Member States, WHO has an international role. The international health environment is increasingly crowded. There are three main directions for WHO. First, the Organization continues to produce global norms, standards and guidance. These include health systems concepts, methods and metrics; synthesizing and disseminating information on “what works and why”, and building scenarios for the future. The second direction concerns the building or shaping of international systems that impact on health. These include systems and networks for identifying and responding to outbreaks and emergencies. They also include WHO's role as a key actor in influencing aid architecture as it affects health systems. The third direction concerns how WHO is working more directly with other international partners on their support for health systems strengthening. This can be through global health partnerships (GHPs), such as the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria and GAVI, the larger philanthropic foundations, the World Bank and regional development banks and bilaterals, as well as stakeholders in the non-government and corporate sector.

Success will depend on how well WHO uses its institutional assets and instruments. WHO must make greater use of existing staff: by strengthening their capacity in health sector policy and strategy development; by developing a professional network of staff working on health systems; and by getting a better match between supply and demand in specific policy areas. It must look at the business rules that govern planning and budgeting, and explore ways in which the integrity of WHO's MTSP can be maintained, while promoting joint work across different programmes. Several health systems specific partnerships have been launched in the last two years, including the Global Health Workforce Alliance and the Health Metrics Network. WHO needs to leverage the benefits these partnerships offer to countries and international partners, and negotiate ways for partnerships to support WHO core functions. In terms of judging results, the MTSP defines specific results for WHO's activities in health systems development.



INTRODUCTION

Health outcomes are unacceptably low across much of the developing world, and the persistence of deep inequities in health status is a problem from which no country in the world is exempt. At the centre of this human crisis is a failure of health systems. Much of the burden of disease can be prevented or cured with known, affordable technologies. The problem is getting drugs, vaccines, information and other forms of prevention, care or treatment – on time, reliably, in sufficient quantity and at reasonable cost – to those who need them. In too many countries the systems needed to do this are on the point of collapse, or are accessible only to particular groups in the population. Failing or inadequate health systems are one of the main obstacles to scaling-up interventions to make achievement of internationally agreed goals such as the MDGs a realistic prospect.

There is widespread acceptance of the basic premise underlying this Framework – that only through building and strengthening health systems will it be possible to secure better health outcomes. The key question is what does this mean in practice? The growing recognition of the importance of health systems increases the urgency of this question.

Objectives

- **Promote common understanding**
We need a common understanding of what a health system is, and what activities are included in health systems strengthening – in countries at different levels of development and with different social, institutional and political histories.
- **Address new challenges and set priorities**
Health systems worldwide are having to cope with a changing environment: epidemiologically, in terms of changing age structures, the impact of pandemics and the emergence of new threats; politically, in terms of changing perceptions about the role of the state and its relation with the private sector and civil society; technically, in terms of the growing awareness that health systems are failing to deliver – that too often they are inequitable, regressive and unsafe, and so constitute one of the rate limiting factors to achieving better development outcomes; institutionally, especially in low-income countries, in having to deal with an increasingly complex aid architecture. Some of the main challenges and priorities, both old and new, are discussed in the next section.
- **Address questions of health system financiers**
For those who finance healthcare – from the general public, through national ministries of finance, development banks, bilateral agencies and global funds – the issue is not just one of refining definitions and concepts. If health systems are to be strengthened, where is more spending most needed? How and by whom should it be financed and how can that financing be sustained? How can financiers monitor the progress of change? What indeed are the characteristics of a “strengthened system” and how can they be measured?
- **Strengthen WHO’s role in health systems, in a changing world**
There is a growing demand for WHO to do more in health systems. While this may include greater levels of investment, it will also require a consideration of whether WHO could use its resources more effectively, either through different patterns of allocation or different ways of working.

The importance of health systems as part of the global health agenda and in terms of WHO’s response is reflected in the *11th General Programme of Work (2006-2015)* and the *Medium-term Strategic Plan (2008-2013)*. This Framework spells out in more detail the policy challenges faced by countries, and the steps for a more effective institutional response by the WHO Secretariat.

How will the Framework for Action add value to WHO's work? Support for health systems strengthening is the most frequently mentioned priority in WHO Country Cooperation Strategies¹ (CCSs). Two sorts of expertise are wanted from WHO: first, in specific technical areas of health systems; second, in strategic support to governments as they strive to reconcile competing priorities and sources of advice. That said, however, establishing WHO's position as a key provider of health systems support at country level – given the many actors in this area – needs to be based on a clear understanding of priorities, capacity and comparative advantage.

Several regional offices have defined regional health systems strategies and/or technical strategies in specific areas such as health financing. Similarly, several technical programmes in WHO are developing work programmes on systems strengthening. This document sets them within a Framework for Action for the Organization as a whole.

The Framework is about ways of working in WHO. Two sets of issues are particularly important. How can we develop more synergistic working relationships between the technical programmes, which focus on particular health outcomes, and the specialist health systems groups in the organization? And, how can we ensure better links between WHO's engagement in policy processes at country level and the health systems strengthening activities that flow from them? The importance of working in new ways gives the Framework for Action its title. **Health systems strengthening is “everybody's business”**.

Health system basics

Any strategy for strengthening health systems needs a basic shared perception of what a health system is, what it is striving to achieve, and how to tell if it is moving in the desired direction.

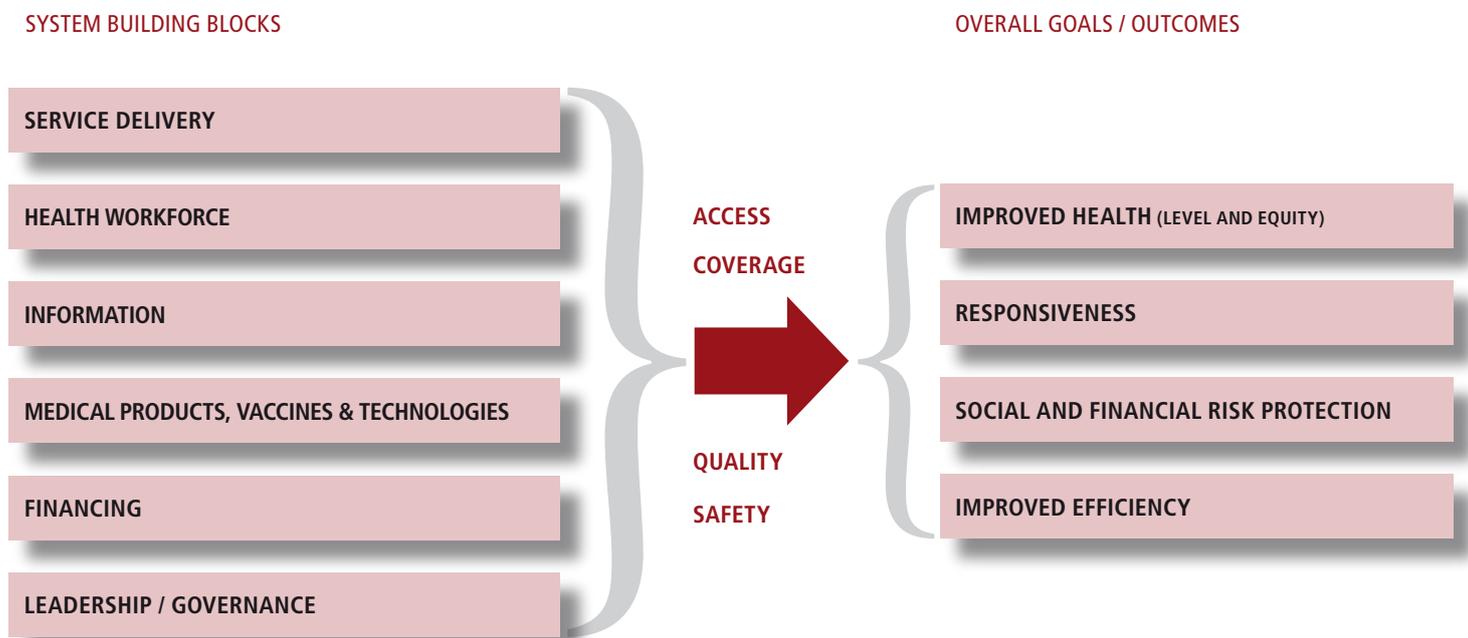
- **What is a health system?**
A health system consists of all organizations, people and actions whose *primary intent* is to promote, restore or maintain health². This includes efforts to influence determinants of health as well as more direct health-improving activities. A health system is therefore more than the pyramid of publicly owned facilities that deliver personal health services. It includes, for example, a mother caring for a sick child at home; private providers; behaviour change programmes; vector-control campaigns; health insurance organizations; occupational health and safety legislation. It includes inter-sectoral action by health staff, for example, encouraging the ministry of education to promote female education, a well known determinant of better health.
- **Guiding values and principles**
The directions set out for WHO in this document are determined by the values and goals enshrined in the **Alma Ata Declaration**; WHO's commitments on gender and human rights³ and the World health report 2000.
- **Health system goals**
Health systems have multiple goals. The World health report 2000 defined overall health system outcomes or goals as: improving health and health equity, in ways that are responsive, financially fair, and make the best, or most efficient, use of available resources. There are also important intermediate goals: the route from inputs to health outcomes is through achieving greater access to and coverage for effective health interventions, without compromising efforts to ensure provider quality and safety.

1 WHO Country Presence 2005: CCSs provide the medium-term strategic framework for WHO's work at country level.

2 This is an expanded version of the definition given in the World health report 2000 Health Systems: Improving Performance.

3 Declaration of Alma Ata, 1978; Universal Declaration on Human Rights 1948; WHO Gender Policy 2002. The Right to Health and other human rights instruments institutionalise in law many aspects of Primary Health Care.

THE WHO HEALTH SYSTEM FRAMEWORK



THE SIX BUILDING BLOCKS OF A HEALTH SYSTEM: AIMS AND DESIRABLE ATTRIBUTES

- Good **health services** are those which **deliver** effective, safe, quality personal and non-personal health interventions to those who need them, when and where needed, with minimum waste of resources.
- A well-performing **health workforce** is one which works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances. I.e. There are sufficient numbers and mix of staff, fairly distributed; they are competent, responsive and productive.
- A well-functioning **health information system** is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health systems performance and health status.
- A well-functioning health system ensures equitable access to essential **medical products, vaccines and technologies** of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use.
- A good **health financing** system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them.
- **Leadership and governance** involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition-building, the provision of appropriate regulations and incentives, attention to system-design, and accountability.

- **Health system building blocks**
To achieve their goals, all health systems have to carry out some basic functions, regardless of how they are organized: they have to provide services; develop health workers and other key resources; mobilize and allocate finances, and ensure health system leadership and governance (also known as stewardship, which is about oversight and guidance of the whole system). For the purpose of clearly articulating what WHO will do to help strengthen health systems, the functions identified in the World health report 2000 have been broken down into a set of six essential 'building blocks'. All are needed to improve outcomes. This is WHO's health system framework.
- **Desirable attributes**
Irrespective of how a health system is organized, there are some desired attributes for each building block that hold true across all systems.

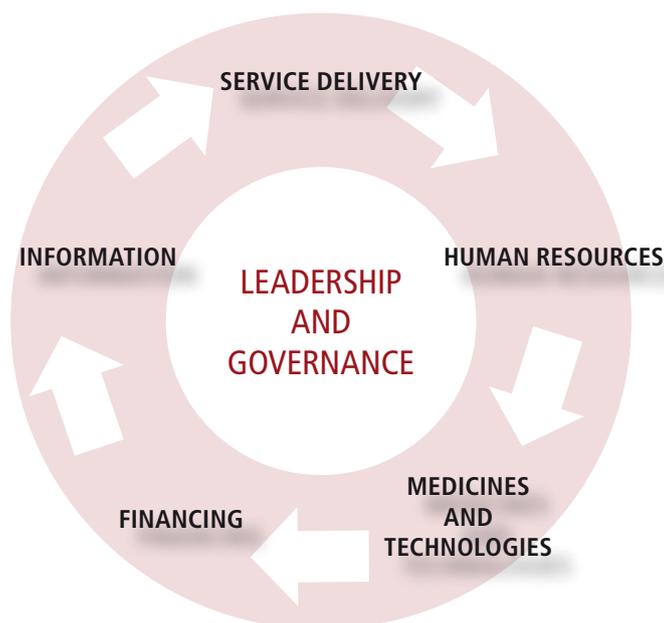
- **Multiple, dynamic relationships**
A health system, like any other system, is a set of inter-connected parts that must function together to be effective. Changes in one area have repercussions elsewhere. Improvements in one area cannot be achieved without contributions from the others. Interaction between building blocks is essential for achieving better health outcomes.
- **Health system strengthening**
Is defined as improving these six health system building blocks and managing their interactions in ways that achieve more equitable and sustained improvements across health services and health outcomes. It requires both technical and political knowledge and action.
- **Access and coverage**
Since notions of improved access and coverage lie at the heart of this WHO health system strengthening strategy, there has to be some common understanding of these terms.
- **Is progress being made?**
A key concern of governments and others who invest in health systems is how to tell whether and when the desired improvements in health system performance are being achieved. Convincing indicators that can detect changes on the ground are needed.

'ACCESS' AND 'COVERAGE': UNDERSTANDING CURRENT USAGE

Throughout the world, countries try to protect the health of their citizens. They may be more or less successful, and more or less committed, but the tendency is one of trying to make progress, in three dimensions. First, countries try to broaden the range of benefits (programmes, interventions, goods, services) to which their citizens are entitled. Second, they extend access to these health goods and services to wider population groups, and ultimately to all citizens: the notion of universal access to these benefits. Finally, they try to provide citizens with social protection against untoward financial and social consequences of taking up health care: of particular interest is protection against catastrophic expenditure and poverty. In health policy and public health literature the shorthand for these entitlements of universal access to a specified package of health benefits and social protection is universal coverage.

The words access and coverage are also used to denote measurable targets, as well as aspirational goals. For example, many epidemiologists and

disease control programme managers use the term "coverage" to measure the proportion of a target population that benefits from an intervention. On the other hand, when policy makers or health economists in Thailand, France or the USA talk about moving towards universal coverage, they are striving for access to a broadening range of benefits, for all citizens without exclusion, and with the necessary social protection. Depending on the context, the accent may be primarily on broadening the package; or on extending coverage in excluded groups; or on improving social protection. In all cases though, what is at stake is the public responsibility for ensuring all citizens' entitlements to the protection of their health – the political idea that led WHO to promote Health For All. These differences in usage are a fact of life in the multi-disciplinary field of health. What is important is that the differences are understood.



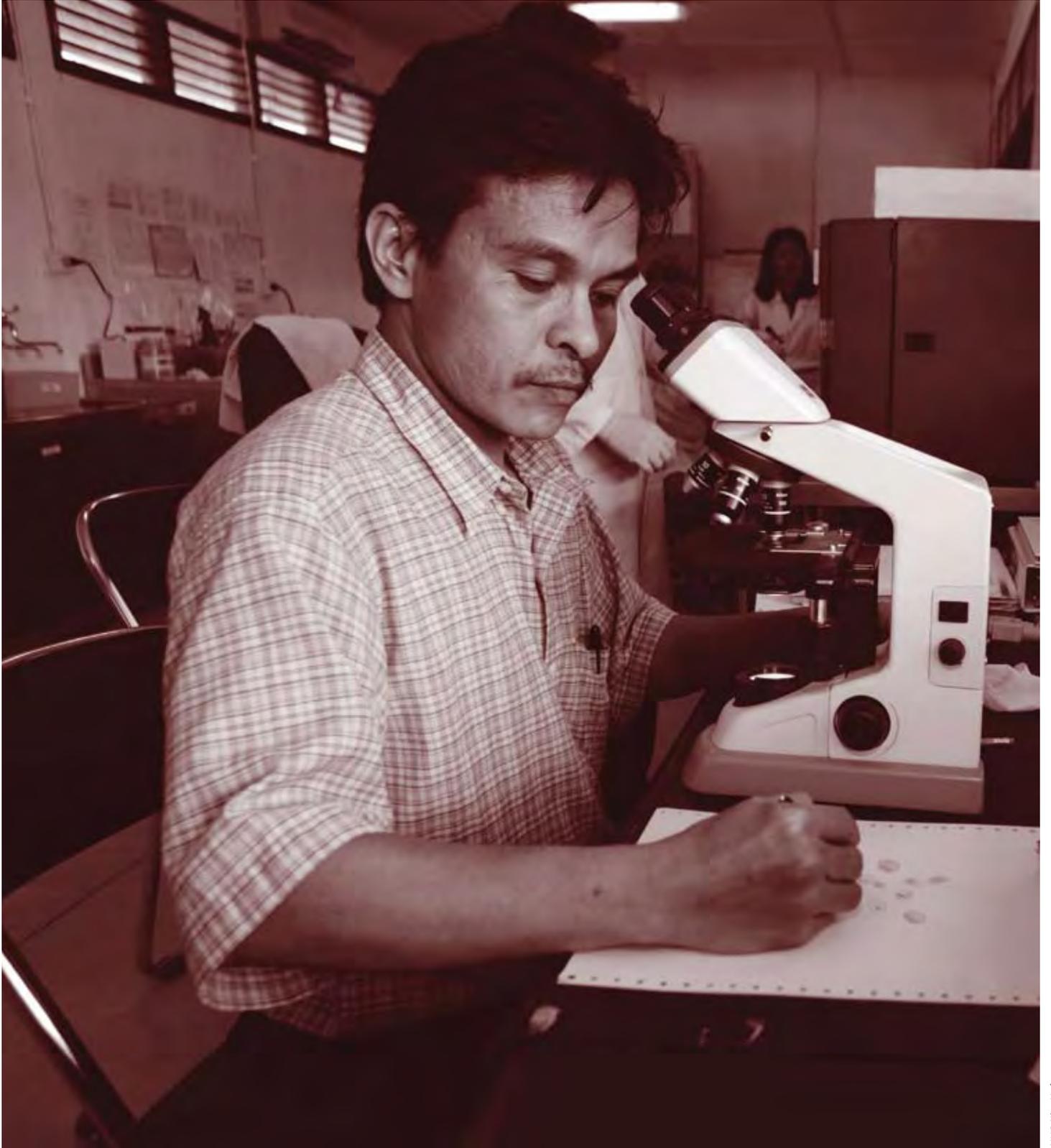
WHAT CAN WE LEARN FROM THE PRIMARY HEALTH CARE VALUES AND APPROACH?

Primary Health Care, as articulated in the **Alma Ata Declaration** of 1978, was a first international attempt to unify thinking about health within a single policy framework. Developed when prospects for growth in many countries were bright, Primary Health Care remains an important force in thinking about health care in both the developed and developing world. Although often honoured more in the breach than in the observance, its **underpinning values – universal access, equity, participation and intersectoral action** – are central to WHO's work and to health policies in many countries today. The Primary Health Care approach also emphasizes the importance of health promotion and the use of appropriate technology. As the non-communicable disease burden rises and the menu of diagnostic and therapeutic technologies expands, these principles – backed up by an increasing body of evidence on intervention cost-effectiveness – are as important for health policy makers to keep in mind today as they were thirty years ago.

The term Primary Health Care is important in a second way. The term signifies an important approach to health care organization in which the **primary, or first contact, level** – usually in the context of a health district – acts as a driver for the health care delivery system as a whole. Again, while the language may have changed – for example the term 'close-to-client' care is

also used, and a wide range of service delivery models have evolved – the principle of providing as much care as possible at the first point of contact **effectively backed up by secondary level facilities that concentrate on more complex care**, remains a key aim in many countries. The concept of **integrated** Primary Health Care is best viewed from the perspective of the individual: the aim being to develop service delivery mechanisms that encourage continuity of care for an individual across health conditions, across levels of care, and over a lifetime.

The values and principles of Primary Health Care remain constant, but there are lessons from the past, which are particularly important when looking ahead. First, despite increased funding, resources for health will always be limited, and there is a responsibility to achieve the maximum possible with available resources. Second, past efforts to implement a Primary Health Care approach focused almost exclusively on the public sector. In reality, for many people – poor, as well as rich – private providers are the first point of contact, and responsible health system oversight involves taking account of private as well as public providers. Third, while keeping its focus on the community and first contact care, Primary Health Care needs to recognize the problems associated with relying on voluntarism alone.



HEALTH SYSTEMS CHALLENGES AND OPPORTUNITIES

Health systems have to deal with many challenges. As the spectrum of ill-health changes, so health systems have to respond. Their capacity to do so is influenced by a variety of factors. Some operate at a national or sub-national level, such as the availability of financial and human resources, overall government policies in relation to decentralization and the role of the private sector. Some operate through other sectors. Increasingly, however, national health systems are subject to forces that affect performance, such as migration and trade factors, operating at an international level.

Some health policy challenges are primarily of concern to low-income countries. However, despite national differences, *many policy issues are shared across remarkably different health systems*. Concerns such as the impact of aging populations, the provision of chronic care or social security reform are no longer the concern of industrialized countries alone. Similarly, the threat posed by new epidemics, such as avian or human pandemic influenza, requires a response from all countries rich and poor. The differences lie in the relative severity of challenges being faced, the way a particular health system has evolved, and the economic, social and political context – all of which determine the nature and effectiveness of the response.

Given the size of global spending on health and concerns about health systems performance, the question is, “Why aren’t health systems working better?”

Managing multiple objectives and competing demands

In the face of fierce competition for resources, governments worldwide have to manage multiple objectives and competing demands. As they strive for greater efficiency and value for money, they must seek ways to achieve more equity in access and outcomes and to reduce exclusion. They are under pressure to ensure that services are effective, of assured quality and safe, and that health providers are responsive to patients’ demands. Progress in one direction may mean compromise in another. For example, the pressure to increase access to HIV/AIDS care and treatment, which has helped bring visibility to the human resources crisis in Africa, brings its own pressures on the capacity of the health system to handle other causes of ill-health. Progress in increasing staff retention in the public sector through better pay packages may mean compromise in containing costs.

Competition for resources may be between hospitals and primary level care; between prevention and treatment; between professional groups; between public and private sectors; between those engaged in efforts to treat one condition versus another; between capital and recurrent expenditures. This means health system strengthening requires careful judgement and hard choices. It can be better informed by evidence and by the use of technical tools, but ultimately it is a political process and reflects societal values.

A national health sector strategy is one way to reconcile multiple objectives and competing demands. To be robust, a sector strategy requires sound logic and sufficient support. Plans need to be costed; budgets have to balance ambition with realism. The necessary processes have to be managed in an inclusive way, and linked with national development planning processes such as poverty reduction strategies. These, together with transparent systems to track effects, are the key to unlocking more resources.

A significant increase in funding for health

Health systems are a means to the end of achieving better health outcomes. In many countries, resources for health have increased from both domestic budgets and, in lower- and middle-income countries, from external development partners as well.

There is growing interest in the array of domestic financing mechanisms that can be drawn upon to move towards universal coverage, including tax-based funding, social health insurance, community or micro-insurance, micro-credit and conditional cash transfers. All of these mechanisms make major demands on managerial capacity. On the other hand, where providers depend largely on out-of-pocket payments for their income, there is over-provision of services for people who can afford to pay, and lack of care for those who cannot.

Much of the increase in investment by external partners has focused on particular diseases or health conditions. The global health landscape has been transformed in the last ten years with the emergence of multiple, billion-dollar global health partnerships such as the Global Fund and the GAVI Alliance. These have helped generate growing political support for increasing access to care and treatment for many critical health conditions, and have also thrown a spotlight on longstanding systems issues such as logistics, procurement and staffing. Moreover the growing demands for provision of lifelong treatments highlights the need for policies that protect people from catastrophic spending.

'Scaling-up' is not just about increasing spending

It is increasingly recognized that scaling-up is not just about increasing investment. Close scrutiny of what is involved points to a set of health systems challenges, most of which are equally pertinent in higher as well as low-income settings.

Countries both rich and poor are looking for ways of doing more with existing resources. In many health systems, existing health workers could be more productive if they had access to critical material and information resources, clearly defined roles and responsibilities, better supervision and an ability to delegate tasks more appropriately. Changes in overall intervention-mix and skill-mix could create efficiencies.

In many instances, extending coverage or quality cannot be achieved simply by replicating existing models for service delivery or focusing only on the public sector. In addition, decision-makers seek innovative ways to engage with communities, NGOs and the private sector. Promising experiences, such as working with informal providers to expand TB care, the social marketing of bed-nets or contracting with NGOs, need to be shared. It is important to take note of what did and did not work in the past. Careful analysis is needed about which local initiatives are genuinely amenable for replication and expansion. Multiple barriers cannot all be addressed or overcome at once. Judgements have to be made between pushing to quickly get specific outcomes and building systems and institutions. Managing the tension between saving lives and livelihoods and starting the process of re-building the state is a particular challenge in fragile states.

There is no guarantee that the poor will benefit from reforms unless they are carefully designed with this end in mind. It is well-known that the child health MDG target can be reached with minimal gains among the poorest. And in many countries, groups such as the poor – and too often women more than men – migrants and the mentally ill are largely invisible to decision-makers. These require specific attention, but introducing strategies that promote equity rather than the converse is not straightforward, as the debates around rapidly scaling-up HIV/AIDS treatment showed. Demand-side factors also determine use, so understanding the incentives and disincentives for seeking care is also important.

HEALTH SYSTEMS: A SHORT HISTORY

Health systems of some sort have existed as long as people have tried to protect their health and treat disease, but organized health systems are barely 100 years old, even in industrialized countries. They are political and social institutions. Many have gone through several, sometimes parallel and sometimes competing, generations of development and reform, shaped by national and international values and goals. **Primary Health Care** as articulated in the **Alma Ata Declaration** of 1978 was a first attempt to unify thinking about health within a single policy framework. Developed when prospects for growth in many countries were bright, Primary Health Care remains an important force in thinking about health care in both the developed and developing world. The financial optimism of the 1970s was soon dispelled in many parts of the world by a combination of high oil prices, low tax revenues and economic adjustment. Countries seeking to finance essential health care were faced with two difficult prescriptions: focus public spending on interventions that are both cost-effective and have public good characteristics (the message of the World Development Report 1993), and boost financing through charging users for services. Whilst many governments started to levy fees, most recognized the political impossibility of focusing spending on a few essential interventions alone. The results were predictable. The poor were deterred from receiving treatment and user fees yielded limited income. Moreover, maintaining a network of under-resourced hospitals and clinics, while human and financial resources were increasingly pulled into vertical programmes, increased pressures on health systems sometimes to the point of collapse.

As the crisis in many countries deepened in the 1990s, so many governments looked to the wider environment for new solutions. If the health district was

not working well it was because insufficient power was decentralized within government. If health workers were unproductive, then look to civil service reform. If hospitals were a drain on the budget, reduce capacity in the public sector. Infused with ideas from market-based reforms in Europe's public services, and with new experiences emerging from transitional economies, **health sector reform** focused above all on doing more for less. Efficiency remained the watchword. It was not until towards the end of the decade that the international community started to confront the reality that running health systems on \$10 per capita or less is just not a viable proposition. In this regard, the work of the Commission on Macroeconomics and Health and costing the global response to the HIV/AIDS pandemic finally broke the mould, making it acceptable to talk more realistically about resource needs.

In the first decade of the 21st Century, many of the pressures remain. In the developed world, the public looks for signs that increased spending delivers results, while planners look nervously at the impact of ageing populations. In the developing world, there are more resources for health but most are linked to specific programmes. But there are also signs of change. There is a wider recognition of inter-dependence and the importance of wider policy choices on health systems, particularly the impact of migration and trade. Similarly, it is clear that governments do not have all the answers. Productive relations with the private sector and voluntary groups are both possible and desirable. Governments have a much wider range of policy levers at their disposal. The challenge for WHO as their adviser, is to understand the whole menu and know when and how to mix the right combination of ingredients.

HEALTH SYSTEM CHALLENGES: A FEW FACTS AND FIGURES

- Globally, health is a US\$3.5 trillion industry, or equal to 8% of the world's GDP.
 - Large health inequalities persist: even within rich countries such as USA and Australia, life expectancy still varies across the population by over 20 years.
 - Recent essential medicines surveys in 39 mainly low- and low-middle-income countries found that, while there was wide variation, average availability was 20% in the public sector, and 56% in the private sector.
 - Each year, 100 million people are impoverished as a result of health spending.
 - Extreme shortages of health workers exist in 57 countries; 36 of these are in Africa.
 - In over 60 countries, less than a quarter of deaths are recorded by vital registration systems.
 - An estimated 50% of medical equipment in developing countries is not used, either because of a lack of spare parts or maintenance, or because health workers do not know how to use it.
 - Private providers are used by poor as well as rich people. For example, in Bangladesh, around ¾ of health service contacts are with non-public providers.
 - In 2000, less than 1% of publications on Medline were on health services and systems research.
 - Globally, about 20% of all health aid goes to support governments' overall programmes (i.e. is given as general budget or sector support), while an estimated 50% of health aid is off budget.
 - There has been a rapid increase in global health partnerships. More than 80 now exist, of which WHO houses over 30.
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Success will be limited unless efforts of other sectors are brought to bear on achieving health outcomes. Scaling-up requires the following: working with ministries of finance to justify budget demands in the context of macroeconomic planning, and ensuring health is well reflected in poverty reduction strategies and medium-term expenditure frameworks; working with ministries of labour, education and the civil service on issues of pay, conditions, health worker training and retention; working with ministries of trade and industry around access to drugs and other supplies; and, with increasing decentralization, working with local government. Attention to health determinants must be maintained, as investments in education, housing, transport, water and sanitation, improved governance or environmental policy can all benefit health. Actions by other sectors can also have adverse effects on health, something that is recognized by the growing requirement for health impact assessments.

The health systems agenda is not static

Patterns of disease, care and treatment are changing. Eighty per cent of non-communicable disease deaths today are in low- and middle-income countries. Systems for managing the continuum of care – be it for HIV/AIDS or hypertension – pose different demands from those needed for acute intermittent care. New delivery strategies may create new demands on the health system. For example, the shift from traditional birth attendants to skilled birth attendants has implications for staffing, for referral systems, and in terms of upgrading facilities to deliver emergency obstetric care. New approaches to mental health and non-communicable diseases emphasize primary prevention, community care and well informed patients, all of which entail shifts from the traditional focus of institutional care.

The introduction of new drugs, vaccines and technologies have an impact on staffing and training, but equally on health financing and service delivery. For example, some hospital-based treatments can now be delivered through day care centres. This is leading to a reappraisal of traditional service delivery models and strategies for increasing efficiency.

Health systems are at the heart of how countries respond to new disease threats such as Severe Acute Respiratory Syndrome (SARS), avian flu, pandemic human influenza. International networks for identifying and responding to such security threats depend for their effectiveness on the 'weakest link'. Accordingly, disease control efforts must be internationally coordinated. As well as testing the alert and response capacity of weak health systems, the attention such outbreaks generate presents important opportunities to catalyse and orchestrate support for improving them: by building epidemiological and laboratory capacity in the context of revised International Health Regulations, addressing patents and intellectual property rights, improving supply chain management and so forth.

An estimated 25 million people are displaced today as a result of conflict, natural or man-made disasters. In such situations, local health systems become rapidly over-whelmed and multiple agencies often move in to assist. This leads to the paradoxical situation in which leadership is weaker than usual because it has been disrupted or divided, but the need for leadership is even greater. The continuing search for ways to strengthen leadership at such times includes emergency preparedness programmes, norms and standards, creating contingency funds and more interaction between UN agencies and other actors.

Changes in public policy and administration, particularly decentralization, makes new demands on local authorities and may change fundamentally the role of central ministries. After years of relative inattention, there is now a resurgent interest in the role of the state. However, the emphasis is on 'good governance' and effective stewardship, rather than a return to earlier 'command and control' models. The public in most countries no longer accepts a passive role and rightly demands a greater say in how health services are run, including how health authorities are held accountable for their work. The information technology revolution has accelerated this change.

There is a major emphasis on demonstrating results and value for money, not just in terms of health outcomes but also in being able to demonstrate progress in systems strengthening. There is also greater focus on corruption in the health sector, with distinctions being made between grand larceny, mismanagement and behaviours such as salary supplementation through informal payments.

Development partners have their impact on health systems

Development partners impact health systems through support for the new global health partnerships – as well as through measures that can increase the predictability of aid – ideally making it easier for finance ministries to finance the long-term recurrent costs of salaries or life-saving medicines.

Perhaps most importantly, the barriers to more rapid progress at country level observed by GHPs have helped to dispel the simple notion that health systems can be built around single diseases or interventions. At the same time, the emergence of new funds has highlighted challenges already faced by countries in managing multiple sources of finance. Multiple parallel policy processes or reporting systems have led to unnecessarily high transaction costs, and a concern that narrowly focused support is drawing scarce personnel away from other essential services and compromising a healthy balance of health services. As a result, many GHPs, along with bilateral agencies, are searching for ways to better harmonize and align their activities with national policies and systems.

In short, countries face many challenges: making the case for more effective investment in health systems in a competitive funding environment; creating better functional links between programmes with mandates defined in terms of specific health outcomes and those with health systems as their core business; ensuring capacity to respond to current issues and identify future challenges; and ensuring that resources are used as effectively as possible. WHO faces these same challenges.

REDUCING HEALTH INEQUALITIES IN THAILAND

Between 1990 and 2000, Thailand significantly reduced its level of child mortality and at the same time halved inequalities in child mortality between the rich and the poor. These impressive results can be explained partly by substantial economic growth and reduced poverty over this period. However there were a number of other important strategies that contributed, many of which began to be put in place before 1990 but which were extended and maintained. These include improved insurance coverage and more equitable distribution of primary health care infrastructure and intervention coverage.

From the 1970s onwards, a series of pro-poor health insurance schemes improved health service coverage. The initial step was to waive user charges

for low-income families. This was followed by subsidized voluntary health insurance, then the extension of the government welfare scheme in the 1990s to all children under 12, the elderly and disabled, and to universal coverage from 2001. Also from the 1970s, health infrastructure and services were scaled up with a particular focus on Primary Health Care and community hospitals targeting the poorer, rural populations. Increased production, financial incentives and educational strategies led to a more equitable allocation of doctors in rural areas in the 1980s. This combination led to increased utilization of health services. For example, vaccination coverage rose from 20%-40% in the early 1980s to over 90% in the 1990s; skilled birth attendance rose from 66% to 95% between 1987 and 1999.

Sources (see Annex 2, References): Vapattanawong P et al, 2007; Tangcharoensathien V et al 2004.



WHO'S RESPONSE TO HEALTH SYSTEMS CHALLENGES

The analysis of challenges in the previous section provides some clear messages. WHO needs to communicate about health systems, in plain language, to the increasing range of actors involved in health. Health systems are clearly a means to an end, not an end in themselves. There needs to be a focus on providing support to countries in ways that better respond to their needs. Lastly, there is a major role for WHO at the international level. These messages determine the four inter-connected pillars of WHO's response:

- A. A single framework with six clearly defined building blocks**
- B. Health systems and programmes: getting results**
- C. A more effective role for WHO at country level**
- D. The role of WHO in the international health systems agenda**

As the UN technical agency in health, WHO draws on its core functions in addressing these challenges. Some of the functions are not unique to WHO: other agencies are actively involved in, for example, developing tools or technical support. However, WHO's mandate, neutral status and near-universal membership give it unique leverage and advantage. Indeed, having so many players active in health today does not reduce but rather accentuates the importance of WHO's role in strengthening health systems.

- WHO is involved in all aspects of health and health systems. It is therefore well-placed to understand how health system strengthening affects service delivery on the ground.
- WHO is perceived by governments as a trusted adviser in a value-laden area because it is directly accountable to its Member States, and because it is not a major financier, so its advice is independent of loans or grants.
- In addition to its normative role, WHO's network of 144 country and six regional offices puts it in a strong position to link national and international policy and strategy.
- Continuous country presence makes WHO well-placed to support rapid responses to crises and also longer-term interventions needed for sustained improvement in health systems.

In WHO's key strategy documents, health systems are a priority. The General Programme of Work, "Engaging for Health", provides the broad agenda for WHO in health systems development. The draft Medium-term Strategic Plan 2008-2013 has two strategic objectives explicitly concerned with health systems. However, other strategic objectives (listed in Annex 1) also include activities designed to strengthen health systems. As such, all WHO programmes are involved in some aspect of systems development. This reinforces a central principle of this health system strengthening Framework – it is "everybody's business."

WHO's involvement in all aspects of health and health systems is a strength and, too often, an under-utilized resource. Advice on health systems strengthening must be informed by: an understanding of what is needed to make sure that clinic staff address major causes of child or adult mortality; recognizing that the way hospitals deal with major accidents or complicated deliveries determines whether people are impoverished by the catastrophic cost of treatment; taking experience of the HIV/AIDS community in getting governments to work more effectively with private providers and those living with the disease. At the same time, of course, one cannot advise on health systems financing from the perspective of malaria or child health alone.

WHO needs to set priorities. However, WHO cannot focus on one aspect of health systems development at the expense of another. Indeed, adopting a more holistic approach is a priority in itself. This section provides a broad view of where the main focus will be for each pillar of the strategy. The last section then sets out some of the implications that implementing the four pillars will have for the way WHO works.

A. A SINGLE FRAMEWORK WITH SIX CLEARLY DEFINED BUILDING BLOCKS AND PRIORITIES

As previously mentioned, a health system, like any other system, is a set of inter-connected parts that have to function together to be effective. This pillar summarizes the main directions of WHO's work in each of the health system building blocks, and where there are important linkages between them.

PRIORITIES BY BUILDING BLOCK

- 1 **Service delivery:** packages; delivery models; infrastructure; management; safety & quality; demand for care
 - 2 **Health workforce:** national workforce policies and investment plans; advocacy; norms, standards and data
 - 3 **Information:** facility and population based information & surveillance systems; global standards, tools
 - 4 **Medical products, vaccines & technologies:** norms, standards, policies; reliable procurement; equitable access; quality
 - 5 **Financing:** national health financing policies; tools and data on health expenditures; costing
 - 6 **Leadership and governance:** health sector policies; harmonization and alignment; oversight and regulation
-

1. SERVICE DELIVERY

In any health system, good health services are those which deliver effective, safe, good quality personal and non-personal⁴ care to those that need it, when needed, with minimum waste. Services – be they prevention, treatment or rehabilitation – may be delivered in the home, the community, the workplace or in health facilities.

Although there are no universal models for good service delivery, there are some well-established requirements. Effective provision requires trained staff working with the right medicines and equipment, and with adequate financing. Success also requires an organizational environment that provides the right incentives to providers and users. The service delivery building block is concerned with how inputs and services are organized and managed, to ensure access, quality, safety and continuity of care across health conditions, across different locations and over time. Attention is needed on the following:

- Demand for services. Raising demand, appropriately, requires understanding the user's perspective, raising public knowledge and reducing barriers to care – cultural, social, financial or gender barriers. Doing this successfully requires different forms of social engagement in planning and in overseeing service performance.
- Package of integrated services. This should be based on a picture of population health needs; of barriers to the equitable expansion of access to services, and available resources such as money, staff, medicines and supplies.
- Organization of the provider network. The purpose of an organized provider network is to ensure close-to-client care as far as possible, contingent on the need for economies of scale; to promote individual continuity of care where needed, over time and between facilities; and to avoid unnecessary duplication and fragmentation of services. This means considering the whole network of providers, private as well as public; the package of services (personal, non-personal); whether there is over – or under – supply; functioning referral systems; the responsibilities of and linkages between different levels and types of provider including hospitals; the suitability of different delivery models for a specific setting; and the repercussions of changes in one group of providers on other groups and functions (e.g. on staff supervision or information flows).

⁴ Non-personal services are also called population-based services.

- **Management.** The aim is to maximize service coverage, quality and safety, and minimize waste. Whatever the unit of management (programme, facility, district, etc.) any autonomy, which can encourage innovation, must be balanced by policy and programme consistency and accountability. Supervision and other performance incentives are also key.
- **Infrastructure and logistics.** This includes buildings, their plant and equipment; utilities such as power and water supply; waste management; and transport and communication. It also involves investment decisions, with issues of specification, price and procurement and considering the implications of investment in facilities, transport or technologies for recurrent costs, staffing levels, skill needs and maintenance systems.

WHO is strongest in defining which health interventions should be delivered, with associated guidelines, standards and indicators for monitoring coverage. Most of this work is carried out on a programme-by-programme basis (e.g. for malaria, maternal or mental health). Increasingly, however, it is evident that there is a need to be sure that health systems in countries with differing levels of resources can accommodate the ideals that these norms imply. A further strength of many individual programmes is in exploring innovative models of service delivery, for example, involving private providers in the care of TB. Initiatives such as the Integrated Management of Child, or Adult, Illness (IMCI, IMAI) are responding to increasing interest in delivering packages of care.

Priorities

Building on the above, WHO will increase its attention to the challenges associated with delivering packages of care (prevention, promotion and treatment for acute and chronic conditions). The aim is to help develop mechanisms for integrated service delivery where possible, that is to say, mechanisms that encourage continuity of care for an individual where needed across health conditions and levels of care and over a lifetime. Priorities are as follows:

- **Integrated service delivery packages**
WHO will continue to produce and disseminate cost-effectiveness data for prevention and treatment, and define service standards and measurement strategies for tracking trends and inequities in service availability, coverage and quality. It will help define integrated packages of services, and the roles of primary and other levels of care in delivering the agreed packages, as part of its health policy development support.
- **Service delivery models**
WHO will increase efforts to capture experience with models for delivering personal and non-personal services in different settings, including fragile states. It will consider the whole network of public and private providers in order to enhance equitable access, quality and safety. It will synthesize and share experience of the costs, benefits and conditions for success of strategies to improve service delivery. These may include community health workers, task shifting, outreach, contracting, accreditation, social marketing, uses of new technologies such as telemedicine, hospital service organization and management, delegation to local health authorities, other forms of decentralization, etc. It will concentrate especially on lessons from those strategies that have been implemented on a large scale, and that have helped to improve services for the poor and other disadvantaged groups. It will consider the stewardship and governance implications of different service delivery models, for example, legislation for non-communicable diseases, approaches to regulating private providers and the consequences for health services of decentralization to local government.
- **Leadership and management**
WHO will support Member States to improve management of health services, resources and partners by health authorities, as a means to expand coverage and quality. This will be done through: promoting tools for analysing barriers to care, and management weaknesses; generating and sharing knowledge on strategies to improve management, often in the context of decentralization; developing local resource institutions' capacity to support local health managers; and developing methods to monitor progress.

SERVICE
DELIVERY

- **Patient safety and quality of care**
WHO will continue its focus on patient safety, and systems and procedures that improve safety. Related work on quality will foster approaches that take account of the full spectrum of interventions needed: treatment protocols and clinical management schedules; supportive supervision and performance assessment; training and continuing education; procedures for registration, licensing and inspection; and fora for dialogue and motivating providers.
- **Infrastructure and logistics**
The challenge of how to handle major capital investment decisions, such as hospitals, deserves more attention by WHO. Currently the effectiveness of its contributions in, for example, complex emergencies is limited. WHO will review current work on infrastructure and logistics, both investment decisions and developing sustainable infrastructure and logistics systems, identifying the gaps, what other agencies are doing and how WHO should position itself.
- **Influencing demand for care**
WHO will communicate international agreements on rights and responsibilities of citizens with regard to their health, and support their incorporation into national policy and practice. It will encourage effective use of the media in promoting health and the engagement of civil society organizations in service delivery planning and oversight, as a means to provide all those who need care, especially the poor and other vulnerable groups, with the confidence that they will be treated decently, fairly and with dignity.

STRENGTHENING PRIMARY HEALTH CARE IN LAO PEOPLE'S DEMOCRATIC REPUBLIC

A comprehensive Primary Health Care programme has been in place in the remote Sayaboury province since 1991. It has achieved impressive results. Between 1996 and 2003 health facility utilization tripled, maternal mortality dropped 50%, and by 2003 infant and child mortality were less than one-third the national average. These impressive changes are the result of a suite of interventions, coupled with modest but sustained support. Key interventions included: provincial and district management strengthening (training; regular supervision and performance assessment); training

and regular supervision of dispensary staff village health volunteers and traditional birth attendants; construction and upgrading of dispensaries; staff development opportunities and incentives such as free medical treatment for volunteers; provision of essential equipment and seed capital for the revolving drug fund. Technical and financial support were provided throughout the 12 years. The external financial investment, roughly US\$4 million, was equivalent to US\$1 per person per year.

Source (see Annex 2, References): Perks C et al 2006.

2. HEALTH WORKFORCE

HEALTH WORKFORCE

Health workers are all people engaged in actions whose primary intent is to protect and improve health. A country's health workforce consists broadly of health service providers and health management and support workers. This includes: private as well as public sector health workers; unpaid and paid workers; lay and professional cadres. Countries have enormous variation in the level, skill and gender-mix in their health workforce. Overall, there is a strong positive correlation between health workforce density and service coverage and health outcomes.

In any country, a "well-performing" health workforce is one which is available, competent, responsive and productive. To achieve this, actions are needed to manage dynamic labour markets that address *entry* into and *exits* from the health workforce, and improve the distribution and performance of *existing health workers*. These actions address the following:

- How countries plan and, if needed, scale-up their workforce asking questions that include: What strategic information is required to monitor the availability, distribution and performance of health workers? What are the regulatory mechanisms needed to maintain

quality of education/training and practice? In countries with critical shortages of health workers, how can they scale-up numbers and skills of health workers, in ways that are relatively rapid and sustainable? Which stakeholders and sectors need to be engaged (e.g. training institutions, professional groups, civil service commissions, finance ministries)?

- How countries design training programmes so that they facilitate integration across service delivery and disease control programmes.
- How countries finance scaling-up of education programmes and of numbers of health workers in a realistic and sustainable manner and in different contexts.
- How countries organize their health workers for effective service delivery, at different levels of the system (primary, secondary, tertiary), and monitor and improve their performance.
- How countries retain an effective workforce, within dynamic local and international labour markets.

Traditionally, much of WHO's focus in countries has been on training, especially in-service training. More recently, WHO has mobilized greater international awareness of health workforce shortages and performance challenges, especially in Africa, and has been instrumental in creating the Global Health Workforce Alliance, a partnership intended to tackle them in a more coherent way. It has also shed light on the available but still limited knowledge base on workforce policy options through its World health report 2006.

Priorities

- **International norms, standards and databases**
WHO will maintain and strengthen the Global Atlas on the health workforce. It will facilitate the generation and exchange of information on health workforce availability, distribution and performance by supporting regional workforce observatories.
- **Realistic strategies**
WHO will increase its support for realistic national health workforce strategies and plans for workforce development. These will consider the range, skill-mix and gender balance of health workers (health service providers and management and support workers) needed to deliver the agreed package of services across priority programmes. They will address workforce education, recruitment, retention and performance and define regulatory options to improve quality of practice, such as licensing and accreditation.
- **Crisis countries**
In countries with a workforce crisis, WHO will act on the basis of agreed multi-stakeholder health workforce strategies (such as the Treat, Train, Retain Initiative) and best knowledge to take rapid action. Workforce strategies will be developed in collaboration with priority programmes and with key stakeholders in other sectors as needed.
- **Costing**
WHO will generate knowledge about the financial costs of scaling-up and then maintaining the expanded health workforce, as well as ways to address financial sustainability, and use this in dialogue with international financing institutions.
- **Training**
WHO will support the redesign of training programmes to produce the spectrum of health workers (service providers and management and support workers) to deliver health services. It will explore and document ways to maximise the use of priority programme training initiatives, and mechanisms such as accreditation to assure quality of training programmes.
- **Evidence**
WHO will synthesize and disseminate evidence on the following: ways to organize the health workforce for more effective service delivery and improved health worker performance;

strategies to better retain health workers that include attention to both salaries and working conditions and differential effects on male and female staff; and ways to monitor health worker performance.

- **Advocacy**
International and regional advocacy will focus on: developing strategies to manage migration, such as the International Code of Practice; promoting better understanding of the implications of international labour markets for developing countries; and ways to mobilize better technical support to countries. It will facilitate agreements between agencies on more effective financing mechanisms for workforce development.
- **Working with international health professional groups**
Such as the International Council of Nursing, the World Medical Association, the Federation of International Pharmacists and the World Federation of Medical Education, WHO will maintain its function in setting norms and standards for the health workforce, including the development of internationally agreed definitions, classification systems and indicators.

DEVELOPING NEW CADRES: LADY HEALTH WORKERS IN PAKISTAN

In 1994, the Government of Pakistan launched the National Family Planning and Primary Care Programme, to prevent and treat common ailments at the community level in a cost-effective manner. The lynch pin of this programme was the "Lady Health Worker" (LHW). These are salaried community health workers with eight years of schooling, who receive a 15-month training session followed by one year of field practice.

By the end of 2006, there were 96,000 LHWs, and another 14,000 LHWs will be deployed by end 2008. Each LHW serves a population of 1000-1500, of whom 75% live in rural areas. Each LHW is attached to a government health facility, from which they receive regular in-service training and medical supplies. They are supervised by LHW supervisors. Their annual salary is around US\$343. The cost of the programme for the first eight years

was US\$155 million, and the approved budget for 2003-2008 is US\$357 million. Government is the main funder, with 11% coming from external sources. The overall yearly cost of one LHW is approximately US\$745. This gives an average cost per person per year of less than 75 cents.

Evaluations of this programme have found significant impact on health knowledge and health service utilization, especially in rural areas. For example, in areas with LHWs, there are a higher proportion of births attended by a skilled attendant; more babies exclusively breast-fed; more mothers who know about oral rehydration, and who give it to children with diarrhoea; and more children fully vaccinated, compared with areas without LHWs.

Sources (see Annex 2, References): Oxford Policy Management, 2002; Arif GM Asian Development Bank, 2006. Desplats M, et al, Médecine Tropicale, 2004.

3. INFORMATION

INFORMATION

The generation and strategic use of information, intelligence and research on health and health systems is an integral part of the leadership and governance function. In addition, however, there is a significant body of work to support development of health information and surveillance systems, the development of standardized tools and instruments, and the collation and publication of international health statistics. These are the key components of the Information building block. This is increasingly more than just a national concern. As part of efforts to create a more secure world, countries need to be on the alert and ready to respond collectively to the threat of epidemics and other public health emergencies.

A well functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely health information by decision-makers at different levels of the health system, both on a regular basis and in emergencies. It involves three domains of health information: on health determinants; on health systems performance; and on health status. To achieve this, a health information system must:

- Generate population and facility based data: from censuses, household surveys, civil registration data, public health surveillance, medical records, data on health services and health system resources (e.g. human resources, health infrastructure and financing);
- Have the capacity to detect, investigate, communicate and contain events that threaten public health security at the place they occur, and as soon as they occur;
- Have the capacity to synthesize information and promote the availability and application of this knowledge.

WHO supports countries in developing and applying different data collection and data management tools, from personal medical records to population data records, and in analysing the data produced. It develops tools and standards, such as the International Classification of Diseases, maintains the global mortality and causes of death database, and produces regular reports on health statistics, disaggregated where appropriate by age and sex. It supports the development of strong public health surveillance systems, as part of an inter-connected global system to collectively reduce international vulnerability to public health threats.

Priorities

- **National information systems**
Support improved population and facility-based information systems, so that they can generate, analyse and use reliable information from multiple data sources, in collaboration with partners (e.g. UN, other agencies, the Health Metrics Network partnership, the Institute of Health Metrics and Evaluation).
- **Reporting**
Avoid parallel reporting systems where possible, and promote single reporting to development partners. WHO will support the use of new data collection and data management technologies where appropriate.
- **Stronger national surveillance and response capacity**
Public health systems that are equipped with up-to-date technologies and dedicated personnel and are able to detect, investigate, communicate and contain threats to public health security, and be part of an unbroken international line of defence against such threats.
- **Tracking performance**
Establish a set of core and additional health system metrics to track health system performance for use by countries and external agencies financing investments in health systems.
- **Standards, methods and tools**
These include the International Classification of Diseases, Global Burden of Disease updates, MDG monitoring tools; development and measurement of Health System Metrics; and standards for electronic medical records. A key role will be played by expert groups, including the Advisory Committee for Health Monitoring and Statistics.
- **Synthesis and analysis of country, regional and global data**
This includes comprehensive WHO databases populated with more uniform data, disaggregated as needed by age and sex; regular publication of World Health Statistics.

INFORMATION

HEALTH SYSTEM STRENGTHENING: MONITORING PROGRESS

Securing more investment in health system strengthening will depend on being able to demonstrate progress. Moreover, agreement on consistent ways of measuring change in key dimensions of the health system can guide resource allocation to where it is needed most and will improve accountability. A monitoring system for health systems strengthening needs to capture trends in health system inputs and outputs, supported by coverage data with a small

set of indicators. Progress can be summarized with a country “dashboard” that includes key indicators for these core areas and describes progress on an annual or bi-annual basis. The dashboard should also provide contextual information such as the country health situation in relation to its level of economic development or health expenditure.

http://www.who.int/healthinfo/health_system_metrics_glion_report.pdf

Source: Health systems strengthening: Monitoring progress: Proposed indicators and data collection strategies. T Boerma, WHO 2007.

4. MEDICAL PRODUCTS, VACCINES AND TECHNOLOGIES

MEDICAL PRODUCTS, VACCINES AND TECHNOLOGIES

A well-functioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use.

To achieve these objectives, the following are needed:

- National policies, standards, guidelines and regulations that support policy;
- Information on prices, international trade agreements and capacity to set and negotiate prices;
- Reliable manufacturing practices and quality assessment of priority products;
- Procurement, supply, storage and distribution systems that minimize leakage and other waste;
- Support for rational use of essential medicines, commodities and equipment, through guidelines, strategies to assure adherence, reduce resistance, maximize patient safety and training.

WHO has a strong track record in helping countries frame national policies. It promotes evidence-based selection of medicines, vaccines and technologies by developing international standards, norms and guidelines through WHO's Expert Committees and consultation processes. WHO/UN pre-qualification programmes for priority vaccines, medicines and diagnostics will be boosted significantly by the establishment of UNITAID, the new international drug purchase facility. WHO provides information on medicine and vaccine prices and supports the development of systems for post-marketing surveillance. It promotes equitable access and rational use, for example, through essential medicines lists, clinical guidelines, strategies to assure adherence and safety, training and working with consumer organizations. It also supports technology assessments and policy development.

Priorities

- **Establish norms, standards and policy options**
Set, validate, monitor, promote and support implementation of international norms and standards to promote the quality of medical products, vaccines and technologies, and ethical, evidence-based policy options and advocacy.
- **Procurement**
Encourage reliable procurement to combat counterfeit and substandard medical products, vaccines and technologies, and to promote good governance and transparency in procurement and medicine pricing.

- **Access and use**
Promote equitable access, rational use of and adherence to quality products, vaccines and technologies through providing technical and policy support to health authorities, professional networks, consumer organizations and other stakeholders.
- **Quality and safety**
Monitor the quality and safety of medical products, vaccines and technologies by generating, analysing and disseminating signals on access, quality, effectiveness, safety and use.
- **New products**
Stimulate development, testing and use of new products, tools, standards and policy guidelines, emphasizing a public health approach to innovation, and on adapting successful interventions from high-income countries to the needs of lower-income countries, with a focus on essential medicines that are missing for children and for neglected diseases.

5. SUSTAINABLE FINANCING AND SOCIAL PROTECTION

A good health financing system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. Health financing systems that achieve universal coverage in this way also encourage the provision and use of an effective and efficient mix of personal and non-personal services.⁵

Three interrelated functions are involved in order to achieve this: the collection of revenues – from households, companies or external agencies; the pooling of pre-paid revenues in ways that allow risks to be shared – including decisions on benefit coverage and entitlement; and purchasing, or the process by which interventions are selected and services are paid for or providers are paid. The interaction between all three functions determines the effectiveness, efficiency and equity of health financing systems.

Like all aspects of health system strengthening, changes in health financing must be tailored to the history, institutions and traditions of each country. Most systems involve a mix of public and private financing and public and private provision, and there is no one template for action. However, important principles to guide any country's approach to financing include:

- Raising additional funds where health needs are high, revenues insufficient, and where accountability mechanisms can ensure transparent and effective use of resources;
- Reducing reliance on out-of-pocket payments where they are high, by moving towards pre-payment systems involving pooling of financial risks across population groups (taxation and the various forms of health insurance are all forms of pre-payment);
- Taking additional steps, where needed, to improve social protection by ensuring the poor and other vulnerable groups have access to needed services, and that paying for care does not result in financial catastrophe;
- Improving efficiency of resource use by focusing on the appropriate mix of activities and interventions to fund and inputs to purchase, aligning provider payment methods with organizational arrangements for service providers and other incentives for efficient service provision and use including contracting, strengthening financial and other relationships with the private sector and addressing fragmentation of financing arrangements for different types of services;
- Promoting transparency and accountability in health financing systems;
- Improving generation of information on the health financing system and its policy use.

SUSTAINABLE FINANCING AND SOCIAL PROTECTION

5 Resolution WHA58.33 on «Sustainable health financing, universal coverage and social health insurance» defined universal coverage as ensuring that the population has access to needed services without the risk of financial catastrophe.

**SUSTAINABLE
FINANCING
AND SOCIAL
PROTECTION**

The most pressing challenge is to provide technical advice to the large number of countries seeking support to develop their financing systems to move more quickly towards universal coverage. Key global public goods produced by WHO include standardized tools and guidelines, for example, for costing, cost-effectiveness analysis and national health accounts. In addition, WHO provides information to countries and works with them to improve their own data collection and to incorporate it into policy development, including analysis of health expenditures and catastrophic spending. Emerging issues relate to using debt relief and medium-term expenditure frameworks to raise more funds for health, and the need to collaborate with priority health programmes, many of which are seeking to develop sustainable financing plans for their particular country-level activities.

Priorities

- **Health financing policy option**
Assess and disseminate information about what works and what does not work in health financing strategies; facilitating the sharing of country experience in various types of health financing reforms; sharing of key information required by country policy makers; and the development of tools, norms and standards including those required to assist countries to generate and use information in their own settings.
- **Improve or develop pre-payment, risk pooling**
and other mechanisms to reduce the extent of financial catastrophe and impoverishment due to out-of-pocket payments, and to extend financial and social protection.
- **Ensure adequate funding from domestic sources**
In some countries, the ministry of health has the potential to attract a higher share of government funding. In others, the health sector can become engaged in debates about fiscal policies that directly affect health (e.g. taxes on products that are harmful to health), as well as by ensuring that health activities are included in poverty reduction strategy papers and medium-term expenditure frameworks. Funding might also be increased through financial arrangements between the government and non-government sectors. Various mixes of tax funding with social, community and private health insurance, provide the alternative institutional frameworks for such arrangements. WHO will support countries to make the case for health funding, as well as to develop new sources of finance.
- **Used funds**
Ensure available funds are used equitably and efficiently, by appropriate provider payment mechanisms, aligning financing and service delivery incentives; addressing fragmented financing systems; appropriate use of tools, such as contracting, to achieve appropriate balance between activities, programmes, inputs, capital versus recurrent expenditures, and ensuring protection of vulnerable population groups.
- **Promote international dialogue**
to increase funding for health in poor countries from domestic and external sources, ensure the predictability of funding, and ensure that new external sources contribute to the development of sustainable domestic financial institutions.
- **Increase availability of key information**
for use by country policy makers in areas such as how much is spent on health, by whom, whether it results in financial catastrophe and who benefits. This also requires information on the costs of scaling-up interventions and the impact on population health of doing so, as well as the costs and impact of reducing system constraints to scaling-up.

EXTENDING SOCIAL AND FINANCIAL PROTECTION IN COLOMBIA

Colombia's national health insurance scheme was part of a package of health reforms introduced nation-wide in 1993, with the aim of improving service access, efficiency and quality. Two insurance schemes were created that targeted different populations. First, a compulsory contributory regime that included all formal sector employees and independent workers able to pay, plus their families. This was largely financed from payroll taxes. Second, a subsidized regime targeted the poor by subsidizing their insurance premiums using dedicated public resources and cross subsidies from the 'contributory regime'. The benefit package for the subsidized regime was initially limited to essential clinical services, a few surgeries plus the treatment of catastrophic diseases, but gradually made more generous as more resources became available. By 2004, the subsidized regime benefit package covered a wider

range of inpatient care, but was still smaller than that of the contributory regime.

The subsidized regime played a key role in increasing coverage for the poor and people living in rural areas. Insurance coverage rose from 3% to 57% for the poorest quintile between 1995 and 2005. In rural areas insurance coverage increased from 6% to 46%. Total impoverishment due to health spending (using Florez and Hernandez's comprehensive definition) declined from 18% to 8% over six years between 1997 and 2003. Access to and use of health services increased in rural areas over 15 years up to 2000: for example, there was a 49% increase in pre-natal care, and a 66% increase in assisted deliveries.

Sources (see Annex 2, References): Florez and Hernandez, 2005; Pinto D and Hsiao W, 2007.

6. LEADERSHIP AND GOVERNANCE

The leadership and governance of health systems, also called *stewardship*, is arguably the most complex but critical building block of any health system. It is about the role of the government in health and its relation to other actors whose activities impact on health. This involves overseeing and guiding the whole health system, private as well as public, in order to protect the public interest. It requires both political and technical action, because it involves reconciling competing demands for limited resources, in changing circumstances, for example, with rising expectations, more pluralistic societies, decentralization or a growing private sector. There is increased attention to corruption, and calls for a more human rights based approach to health. There is no blueprint for effective health leadership and governance. While ultimately it is the responsibility of government, this does not mean all leadership and governance functions have to be carried out by central ministries of health. Experience suggests that there are some key functions common to all health systems, irrespective of how these are organized.

LEADERSHIP AND GOVERNANCE

- Policy guidance. Formulating sector strategies and also specific technical policies; defining goals, directions and spending priorities across services; identifying the roles of public, private and voluntary actors and the role of civil society.
- Intelligence and oversight. Ensuring generation, analysis and use of intelligence on trends and differentials in inputs, service access, coverage, safety; on responsiveness, financial protection and health outcomes, especially for vulnerable groups; on the effects of policies and reforms; on the political environment and opportunities for action; and on policy options.
- Collaboration and coalition building. Across sectors in government and with actors outside government, including civil society, to influence action on key determinants of health and access to health services; to generate support for public policies, and to keep the different parts connected - so called 'joined up government'.
- Regulation. Designing regulations and incentives and ensuring they are fairly enforced.
- System design. Ensuring a fit between strategy and structure and reducing duplication and fragmentation.
- Accountability. Ensuring all health system actors are held publicly accountable. Transparency is required to achieve real accountability.

LEADERSHIP AND GOVERNANCE

An increasing range of instruments and institutions exist to carry out the range of functions required for effective leadership and governance. Instruments include sector policies and medium-term expenditure frameworks; standardised benefit packages; resource allocation formulae; performance-based contracts; Patient's Charters; explicit government commitments to non-discrimination and public participation; public fee schedules. Institutions involved may include other ministries, Parliaments and their committees, other levels of government, independent statutory bodies such as professional councils, inspectorates and audit commissions, NGO 'watch dogs' and a free media.

WHO's tendency at present is to focus on the development of specific technical health policies. This is important, but the added challenge for governments is to provide vision and direction for the whole health system, and oversee implementation of agreed health policies through systems that are faced with critical governance and stewardship challenges. These include: reconciling competing demands for resources; working across government to promote health outcomes; managing growing private sector provision; tackling corruption, responding to decentralization; engaging with an increasingly vocal civil society, and a growing array of international health agencies. This is an area in which WHO needs to enhance its capacity to support ministries of health.

Priorities

All governments are faced with the challenge of defining their role in health in relation to other actors. For many this is changing, for example, with decentralization. Any approach to leadership and governance must clearly be contingent on national circumstances. WHO will help governments as follows:

- **Develop health sector policies and frameworks**
that fit with broader national development policies and resource frameworks, and are underpinned by commitments to human rights, equity and gender equality. As part of this, it will promote international debate on the central but changing role of governments in health.
- **Regulatory framework**
Design, implement and monitor health related laws, regulations and standards, especially in the areas of International Health Regulations; regulation of medical products, vaccines and technologies; regulation concerning occupational health and workplace safety. WHO will also engage in trade debates in areas affecting health systems.
- **Accountability**
Support greater accountability through the Organization's work on monitoring health system performance as set out in the building block on information.
- **Generate and interpret intelligence**
and research on policy options⁶. At the international level, it will facilitate access to knowledge on approaches to policy and systems development: by promoting a more systematic health systems research agenda; through the Alliance on Health Policy and Systems Research; by building capacity in regional observatories or their equivalent; and by increasing access to and use of new knowledge management technologies. It will work to strengthen national capacity in health policy analysis and links to policy decision-making.
- **Build coalitions**
across government ministries, with the private sector and with communities: to act on key determinants of health; to protect workers' health; to ensure the health needs of the most vulnerable are properly addressed; to anticipate and address the health impact of public and commercial investments.
- **Work with external partners**
to promote greater harmonization and alignment with national health policies.

6 Research for Health: a Position Paper on WHO's Roles and Responsibilities in Health Research. WHO 2006.

OECD-WHO REVIEW OF THE SWISS HEALTH SYSTEM

At the request of the Swiss Federal Office of Public Health, WHO and Organisation for Economic Co-operation and Development (OECD) jointly undertook an independent review of the Swiss health care system in 2005–2006. The review assessed institutional arrangements and the performance of the health system against key policy goals of effectiveness and quality,

access and responsiveness, efficiency and financial sustainability. It discussed factors affecting performance, future system challenges, and potential areas for reform. Findings were discussed at a national seminar of Swiss health experts from the public and private sector.

STRENGTHENING INSTITUTIONAL CAPACITY FOR POLICY ANALYSIS IN KYRGYZSTAN

The WHO Health Policy Analysis Project was launched in Kyrgyzstan in 2000. It was designed to support the government's Manas Health Care Reform Programme, whose goal was to improve the sustainability, efficiency and quality of the Kyrgyz health system. The project had four types of activities: policy analysis; linking evidence to policy; capacity building for policy analysis and evidence based policy design; and dissemination of results.

Capacity building in monitoring and evaluation of health system performance, and in policy analysis more broadly, has been carried out in four ways. There were frequent interactions with senior policy makers to present findings and implications of studies, to demonstrate their political usefulness and stimulate demand. Round table discussions on key health policy topics were a way to inject technical input and build political consensus. The Ministry of Health (MOH) health management courses targeted at managers of primary care and inpatient facilities were a crucial way to inform and engage health

care managers in health policy issues. The health policy courses for Central Asia and Caucasus in collaboration with the World Bank Institute and WHO European Region allowed cross-country learning for a large number of Kyrgyz policy makers. Lastly, a group of young health policy analysts have been mentored through the six years to become independent researchers providing continuous support to the MOH.

These core activities have now been institutionalised through the creation of a Department of Strategic Planning and Reform Implementation within the MOH, which has taken on core health system performance monitoring, and a Centre for Health System Development, which is an autonomous public entity created by the MOH to support policy development and implementation through knowledge generation and training. Support to these two young institutions will continue until at least 2010.

Source: Box prepared by WHO/EURO, 2007, based on the Manas Health Care Reform Programme.

B. HEALTH SYSTEMS AND PROGRAMMES: GETTING RESULTS

WHO's involvement in all aspects of health and health systems constitutes a real comparative advantage. It is better placed than many other international agencies to identify competing demands across health priorities, and to understand how efforts to strengthen health systems affect services on the ground.

There is a growing body of experience with cross-departmental relationships that bring together 'programme' and 'system' expertise. Much existing collaboration focuses on 'normative' issues, such as costing of programme scale-up, estimates of disease burden or the dense network of relationships between those concerned with pharmaceutical policy and technical departments with a stake in essential drug lists, pre-qualification of manufacturers and treatment guidelines.

Collaboration on more operational aspects of health systems strengthening is less common. Many technical departments operate their own country support networks through which they provide independent advice on service delivery and systems issues. Sometimes, awareness of parallel efforts is lacking. This is beginning to change. Examples include the TTR initiative linking systems work on health service staffing with improving access to HIV/AIDS care and treatment; the Taskforce on TB control and health system strengthening; joint work on HIV/AIDS and TB scale-up in the Baltic countries, and work across WHO stimulated by the opening of the GAVI Health System Strengthening window.

Nevertheless it is clear that, in too many instances, WHO's support remains fragmented between advice focusing on particular health conditions (which may not always take account of systems or delivery issues) and advice on particular aspects of health systems provided in isolation. While there are good examples of how both streams can work together, the challenge is to develop a more systematic and sustained approach that responds better to the needs of Member States.

Improve and extend existing interactions

Learning from TTR, GAVI, etc., WHO will establish more systematic ways to work together to ensure priority programme policies and delivery strategies are designed in ways that can take account of a country's overall health system organization and resources that can identify whether appropriate solutions to barriers to care lie in or outside programme control, and that ensure gains in coverage do not occur at the expense of other health priorities. Much of this work has to happen at country level. However, there is room for more interaction at other levels of WHO. In this regard, there is interesting work as part of the new Stop TB Strategy. Guiding principles are being developed for national TB programmes and partners, to contribute to health system strengthening without losing gains made in TB control (known as the 'do's, don'ts and non-negotiables'). Work will also involve exploring how to build on packages of care such as the Integrated Management of Childhood Illness.

More pro-active engagement is needed across Strategic Objectives on approaches to service delivery (for example, to ensure continuing personal care for diabetes and HIV; service delivery in emergencies, or the delivery of non-personal services). These will help identify and exploit common systems requirements across interventions, and promote joint learning.

More active engagement is also needed in the area of health systems with global health partnerships concerned with HIV, TB, malaria and maternal, neonatal and child health.

Create better and more systematic communication

A pragmatic view of the basic relationship between systems and programmes is that outcome-oriented programmes – in WHO and in countries – will continue to exert a certain dominance because of their capacity to attract resources. This means that health system specialists have to be prepared to be responsive and act in advisory mode. They must also be opportunistic, and use programme requests such as costing as entry points to identify issues such as financing policy that cannot be adequately addressed on a programme by programme basis. WHO needs a strong group of staff and consultants able to adapt the analytic approach to health systems for country support.

A 'DIAGONAL' APPROACH TO HEALTH SYSTEM STRENGTHENING

- Taking the desired health outcomes as the starting point for identifying health systems constraints that «stop» effective scaling-up of services;
- Addressing health systems bottlenecks in such a way that specific health outcomes are met while system-wide effects are achieved and other programmes also benefit;
- Addressing primarily health systems policy and capacity issues;
- Encouraging the development of national health sector strategies and plans, and reducing investment in isolated plans for specific aspects of health systems;
- Robust monitoring and evaluation frameworks.

Altogether, better communication is needed to think systematically about health system processes, constraints and what to do about them.

Achieve greater consistency, quality and efficiency

We must ensure greater consistency, quality and efficiency in the production of methods, tools and data reporting across WHO, building on current work in areas such as programme costing or the reporting of health statistics. This is covered further in the specific building blocks.

Other actions are listed here, and discussed further in the last section. For example, improved health system awareness among all WHO staff – in other words, a basic familiarity with health system issues – needs to be combined with improved 'outcome literacy' among systems staff, plus the establishment of a professional network for health systems staff in all parts of WHO. Better relationships also require careful thought about incentives, and top-level managerial support.

SELECTED SYSTEM CONSTRAINTS AND POSSIBLE DISEASE-SPECIFIC AND HEALTH-SYSTEM RESPONSES

Constraint	Possible disease-specific response	Possible health system response
Financial access difficult e.g. inability to pay, informal fees	Payment exemptions for an individual, for a specific disease	Pooling pre-paid funds (from households, external agencies, companies) in ways that allow risks to be shared, and decrease individual payments when sick
Physical access difficult e.g. distance to facility	Out-reach for specific diseases; engage private providers	Revising plans for the location, construction or upgrading of health facilities
Knowledge and skills low (public and private providers)	Workshops and other continuing education for specific diseases	Revised pre-service training curricula; systems for licensing, accreditation, supervision
Staff are poorly motivated	Staff get financial incentives to deliver specific services	Clear job descriptions; performance and salary review; fair, transparent promotion procedures
Weak leadership and management	Workshops to develop skills in managing staff, budgets etc. (e.g. in public and NGO facilities)	Additional actions such as giving managers more control over resources; more accountability for results
Ineffective intersectoral action and partnership	Disease-specific cross-sectoral committees, usually national level	Building local government systems with cross-sector representation, and explicit procedures for public accountability

Source (see Annex 2, References): Adapted from Travis et al, 2004.

C. A MORE EFFECTIVE ROLE FOR WHO AT COUNTRY LEVEL

Countries at different levels of development look to engage with WHO as they seek to improve their health systems. Some countries are primarily interested in exchanging ideas and experiences in key aspects of policy (such as health worker migration), in getting wider international exposure for important domestic agendas (such as patient safety or the health of indigenous populations), or in the development of norms and standards for measuring performance. All countries look to WHO for comparative experience in relation to different aspects of reform in areas such as health financing, and for WHO's convening role where action may be needed across countries.

However, it is countries at a lower level of income – as evidenced increasingly in WHO CCSs – that seek more direct involvement in overall policy and health systems development, often in conjunction with other partners such as the World Bank. This area, above others, requires improvement. In states recovering from emergencies or emerging from conflict, WHO may also be called on to act as the coordinator of the many organizations concerned with health work; to ensure that health remains central to the security and humanitarian agenda and to advise on reconstruction of the health system as a whole.

Improved capacity to diagnose and act on health system constraints

There are many different entry points to the analysis of health system weaknesses and barriers to improving service delivery. The purposes, depth and quality of analyses may vary widely. Some are done as part of broad sector review processes by ministries and partners. Some are done as part of an external agency's individual strategy development⁷. Some are done for specific programmes or for specific aspects of the health system such as the health workforce. Programme-specific diagnostic tools are being developed by many agencies. Consultations suggest that WHO needs to improve capacity to diagnose and act on health system constraints.

- WHO will support the use of consistent approaches to identifying health system constraints, that incorporate a system-wide perspective, but are sufficiently flexible to be used by programme and systems groups with different entry points. These approaches need to be able to inform major planning exercises, medium-term expenditure frameworks, the health components of poverty reduction strategies, etc. WHO will work to ensure that core technical frameworks inform the assessment of health system challenges and priorities.
- To reduce duplication, WHO will undertake diagnostic exercises preferably through MOH-led reviews and, where appropriate, jointly with other development partners. It may also undertake independent reviews if requested.

More intensive engagement in sector policy processes and investment strategies

Helping a country decide on the best ways to invest in order to strengthen health systems requires two interconnected responses: having an over-arching vision and strategy for the health sector, and the development of more detailed policies and investment plans in specific technical areas.

As stated in the building block on leadership and governance, WHO's work at country level will be significantly enhanced if it engages more effectively with partners in overall policy processes. Many of WHO's senior interlocutors at country level (ministers, permanent secretaries, directors-general) seek support in assessing overall sectoral needs or on how to deal with varying advice on policy issues from different partners. This function – “helping to sort the wood from the trees” and putting technical advice in a political context – is an area of potentially great comparative advantage and influence.

In specific policy areas, demand from countries for WHO advice nearly always exceeds supply. For example, in health financing – one of the most common areas in which advice is sought

⁷ For example, the WHO CCS process provides some information on constraints but is not designed to do this in sufficient detail for national policy purposes.

– WHO has well-recognized strengths in costing, in national health accounts and in analysing financial catastrophe and impoverishment. It is less well equipped at present to support countries on domestic financing policy. The same is true in other specific areas.

WHO will increase its engagement in high level policy dialogue. It will:

- support the development of evidence-based health sector strategies and costed plans linked to the macro-economic framework. This will entail more active and consistent engagement in key policy events by all levels of the Organization;
- increase its capacity for policy advice in specific aspects of systems, such as health workforce strategies and investment plans, health financing policies, etc.;
- work with development partners, GHPs and funding agencies to improve harmonization and alignment with national health policies and systems, through harmonization plans, mutual accountability Memoranda of Understanding, institutional performance contracts, etc.
- assist governments in the implementation of International Health Regulations, international agreements on trade, human rights and gender, by identifying their implications for the national health system.

Build national capacity, especially in policy analysis and management

WHO will focus on building national capacity in health policy analysis and management, recognizing that the Organization itself needs greater capacity in these areas. Policy analysis involves analysing problems from several standpoints: the problem, and who is affected; possible solutions; and the political and institutional feasibility as well as technical desirability of implementing any of them. Management is about managing services, resources and partners. Aid management is a particularly important and difficult task in many poorer countries. It is about tracking aid flows and managing external partners - and the funds and technical assistance they provide - in ways that maximise their contribution to national strategies with minimum transaction costs.

WHO's focus will be on the development of *institutional* not just *individual* capacity. Actions will include:

- catalysing structured discussions by different stakeholders on key policy concerns, and making independent appraisals of experience with use of different tools for policy analysis and management available;
- sustained technical support to dedicated policy 'think-tanks' or 'observatories', to identify problems of national concern, gather intelligence, and generate policy options for debate. This includes promoting different forms of informal and formal 'experience-exchange' in managing specific policy challenges across countries.
- support national approaches to develop managerial capacity, through networks of resource institutions, a greater WHO role in harmonizing development partners support to management strengthening and linking activities to national instruments such as poverty reduction strategy papers. This includes helping managers tackle difficult management issues such as workforce productivity and performance, budgeting and procurement, and taking advantage of vehicles such as the Global Health Workforce Alliance and GAVI HSS.
- supporting national mechanisms for tracking aid flows and managing partners. In exceptional circumstances, such as countries emerging from conflict or health emergencies, it may involve temporarily taking on the role of co-ordinator of external health aid organizations.

Support countries' monitoring of trends in health systems and performance

The generation and use of information is at the heart of WHO's mandate. A major part of its work must be to support health ministries to track trends in their health systems' performance, in ways that are geared primarily to national decision-making, but also to enable them to make comparisons with, and learn from, other countries. For greatest positive effect, this requires

consistent approaches shared and supported by all levels of WHO. And it requires engagement with other international players, especially the Health Metrics Network. Priorities, below, here link with those in the information building block..

- Effective communication of internationally agreed concepts, language and metrics on health systems.
- Improved country data collection systems that capture health system inputs, services and outcomes, using validated tools, at national and sub-national level.
- Greater joint monitoring by external agencies, using nationally led processes and systems.

CAPACITY BUILDING: WHAT IS KNOWN ABOUT GOOD PRACTICE?

Capacity building in practical terms involves ensuring that a combination of the **tools, skills, staff and support systems** required for chosen functions are available and operational. There is no blueprint on how to build capacities in policy and strategy development, but there are some clear lessons from past efforts. The demand for tools for policy analysis is longstanding, with expectations of what they can achieve often exceeding experience on the ground. Available tools vary widely in purpose and scope; more are focused on assessing specific system components than on assisting political analysis. Key tools for aid management are credible policies and

costed plans. One important way of building skills in, for example, analysing how different interest groups are positioned, or brokering agreements between them, is through on-the-job practice coupled with exchanges of experience between individuals and institutions. Another lesson is that tools and skills alone are not enough to improve performance: attention to improving any required support systems (such as for tracking aid flows) may be needed. Lastly, attention to creating demand for staff with these capabilities may be needed, and a long-term view for any support provided is essential.

D. THE ROLE OF WHO IN THE INTERNATIONAL HEALTH SYSTEMS AGENDA

WHO's international work complements and supports its more direct engagement in countries, through the production of global public goods such as norms, standards, policies and guidance. In addition, WHO's international work has a value in its own right, through increasing the effectiveness of international systems such as the surveillance and response network, or through shaping international health aid architecture.

Produce global public goods: norms, standards, policies and guidance

WHO needs to respond to the consistent demand from countries and development partners for a common language to describe the components of health systems and the actions needed to make them function more effectively. Although there is progress, more remains to be done to simplify and communicate health systems terminology to a wider variety of audiences. The development of standardized methods and tools, such as for national health accounts in low and middle-income countries, will also continue to be core business of WHO.

There is a need for a more systematic approaches to research and learning. Evidence on effective strategies for health systems strengthening is scarcest where need is greatest.

Each reform and innovation constitutes a learning opportunity⁸. The question is how we best learn about what works and why. Broader social, political and institutional factors need to be taken into account as we amass evidence either from one-off case studies or in the ongoing work of emerging health systems observatories. Knowledge Networks of the Commission for Social Determinants on Health are amassing evidence on critical determinants and effective ways of influencing country policy and practice.

The 2008 World health report will draw on three decades of experience with PHC principles and practices and show how these may inform pathways to improve health in the 21st Century. Health systems will be prominent in the new health research agenda being prepared by WHO⁹. The Alliance for Health Policy and Systems Research has a new ten-year strategy that focuses on stimulating the generation, synthesis and use of policy relevant health systems knowledge. WHO will also support approaches to more informal learning and sharing tacit knowledge, taking advantage of progress in information technology, and leveraging e-health networks within and between countries.

To make the case that health systems strengthening merits greater investment, a key priority is to agree on a set of measurements that can capture the status of a health system and demonstrate whether its performance is improving (see box 13). The purpose of such health system metrics is twofold: for comparing systems one to another, but more importantly to enable decision makers and investors to track progress of their own health system over time and take action as needed.

It is also important to forecast trends and look ahead and consider the implications for health systems and health equity of aging populations, developments in medical therapies, information technologies, etc., and at how these changes will affect the interaction between health systems and human health security. An important part of WHO's global stewardship function is to generate awareness and informed debate on future policy challenges and options.

Coherent international systems for better health

A core function of WHO is to use its convening power effectively to work with global and regional systems for better health. Of growing importance in strengthening country support are the networks of regional institutions of which WHO is an integral part. In Africa, for example, WHO will work towards ensuring consistent health systems messages from the New Partnership for

8 Frenk J, Bridging the divide: global lessons from evidence-based health policy in Mexico. *Lancet*, 2006.

9 Research for Health: a Position Paper on WHO's Roles and Responsibilities in Health Research. WHO 2006.

Africa's Development (NEPAD) and the African Union (AU), the Regional Economic Commissions, and the newly reorganized African Development Bank.

There is also an important relationship between how aid for health is organized and how health systems develop. The principles agreed by countries and development partners at the High-level forum on Aid Effectiveness in Paris (to which WHO was a signatory) aim for greater *ownership* by government, *alignment* with national priorities, and *harmonization* between development partners. Greater *predictability* in aid finance makes it more likely that finance ministries will budget for the long term recurrent costs that all functioning health systems need. WHO will continue to work with the OECD Development Assistance Committee and others to increase development partner accountability in health, focusing on ways in which applying the Paris Principles support health systems development.

WHO is also evolving the way it works with GHPs, such as Stop TB and Roll Back Malaria, in order to bring the Paris 'best practice' Principles to bear, recognizing the importance of GHPs for strengthening health systems as well as accelerating achievement of health outcomes.

The development of systems for a more secure world includes, but is not limited to, systems for epidemic outbreak surveillance and response such as the Global Outbreak And Response Network (GOARN). It includes systems for predicting and preventing exposure to environmental health hazards. In addition, health systems contribute to human security, as poor health and the lack of health services can trigger instability (conversely, in many conflicts health facilities and health workers become the target of warring parties). A robust health system is a vital part of any governments' response, to avoid a vicious cycle of deteriorating health leading to deteriorating security. WHO's role in health security is addressed in the World health report 2007.

Work with partners

Given its critical role for health systems development, strengthened coordination with the World Bank is a priority. WHO will aim to leverage the capacity of other development banks and bilateral agencies to pursue health outcomes through investments in other sectors. WHO will work with the Bretton Woods Institutions and finance ministries to ensure health is properly reflected in national development planning and expenditure frameworks.

The major health financing partnerships have recognized the need to engage in health systems strengthening and are doing so in different ways. The Global Fund is currently developing its systems strengthening approach. GAVI has targeted funds for a new health systems strengthening window. WHO is committed to working with GAVI and the Global Fund to operationalize those opportunities in a way that will provide effective financing for health systems development.

WHO will draw on the strengths of international NGOs with an interest in health systems. Two groups are of particular concern. A first emerging group is the international lobby for health systems development. Previously the province of a few international NGOs, a new Health Systems Action Network (HSAN) has been formed. Activist members are beginning to ensure that health systems messages are heard in major developmental fora. Their demand for clarity in messaging, costing and impact is something to which WHO will respond. Second, is the growing number of organizations responding to demands for technical support. WHO will seek to engage them. Where appropriate, WHO can play a role in creating technical support networks and ensuring their quality through accreditation of individuals or institutions.

International agreements between governments impact on health systems. Prominent among these are interactions – both bilateral and through the World Trade Organization – that have influenced the price of and access to pharmaceuticals. Public health is an area in which innovation and Intellectual Property Rights will play an increasingly prominent role¹⁰. Other trade agreements likely to influence health systems, such as the General Agreement Trade in Services (GATS), have

10 Public Health Innovation and Intellectual Property Rights. Report of the Commission on Intellectual Property Rights, Innovation and Public Health. World Health Organization, 2006.

received less attention. Their potential impact, through liberalization of insurance markets and granting access to foreign private providers of health care, may be significant in many countries. International agreements will also influence the management of migration both of health workers and those seeking care. How these issues are handled between countries will have a lasting impact on health sector effectiveness.

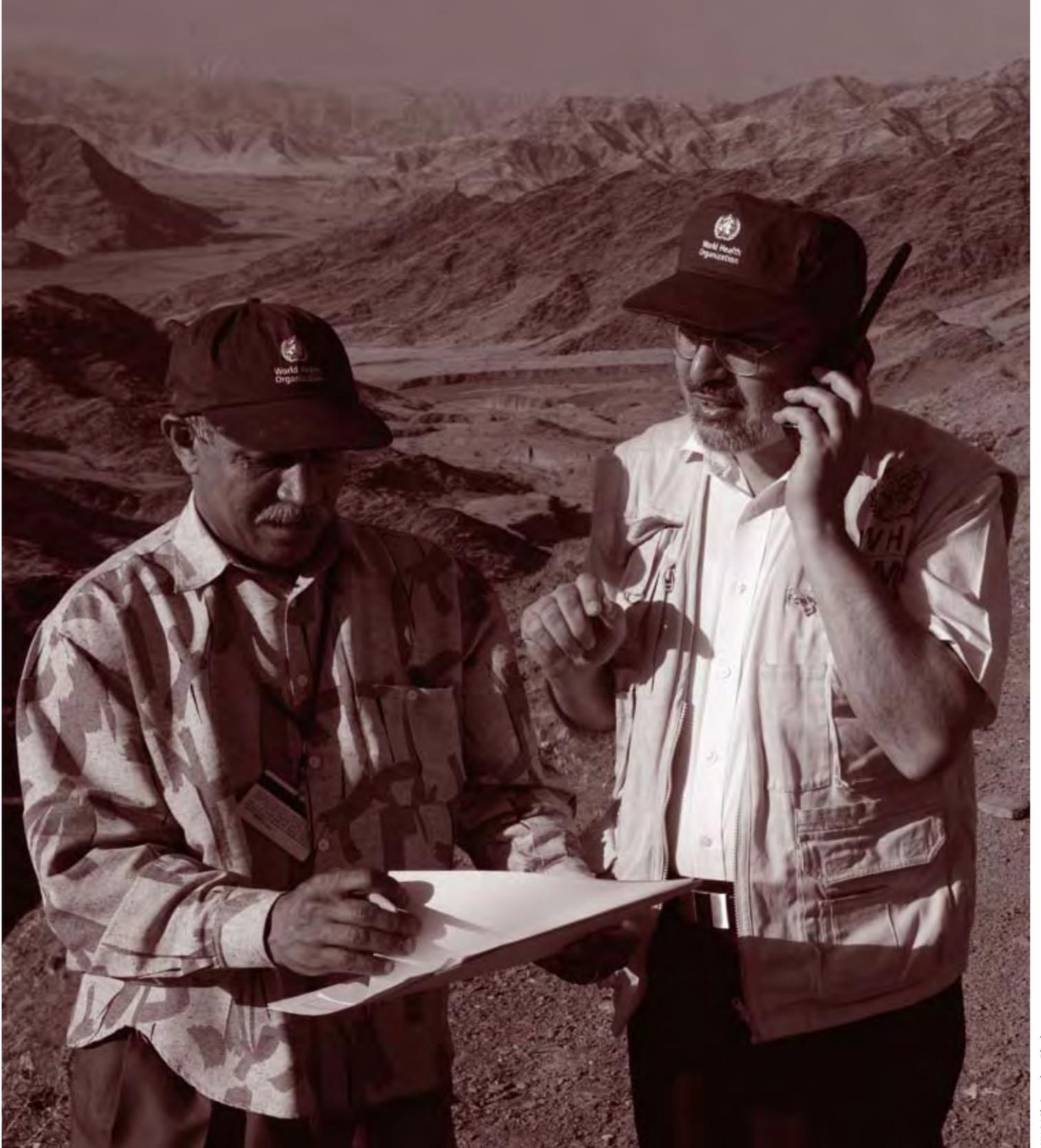
Over the last three years, partly stimulated by having a UN Special Rapporteur of the Commission on Human Rights on the right to health, there has been increasing interest in how a focus on the realization of this right can be used to focus on the need for investment in health workers and health systems.

WHO will work to influence international agreements that impact on health and health systems. It will help in making linkages across governments (for instance between ministries of trade and health); and it will help ministries of health anticipate and act on changes that will come about as a result of international agreements.

GAVI AND HEALTH SYSTEM STRENGTHENING (GAVI-HSS)

Since the GAVI Board decision in December 2005 to earmark US\$500 million for health system strengthening (HSS), the GAVI-HSS window has developed rapidly. Applications for funds are expected to address health system barriers known to impede the demand for and delivery of immunization and other child and maternal health services. Three priority areas are identified,

focusing on the district level and below: health workforce mobilization, distribution and motivation; organization and management of health services; supply, distribution and maintenance systems for drugs, equipment and infrastructure. Three proposal rounds have now been completed, with a total of US\$266 million approved.



IMPLICATIONS FOR THE WAY WHO WORKS

HEALTH SYSTEM STRENGTHENING: WHO'S FRAMEWORK FOR ACTION

- **A single framework with six clearly defined building blocks**
- **Systems and programmes: getting results**
- **A more effective role on systems for WHO at country level**
- **The role of WHO in the international health systems agenda**

“Everybody’s Business” is a framework that signals directions and priorities in the health systems agenda for the whole of WHO, so that it can provide more effective support, directly and indirectly, to Member States. It is not a detailed implementation plan. Indeed an implementation plan in the conventional sense would not be appropriate, given that it has Organization-wide implications.

The Framework can be used in a number of ways, for example, as the basis for dialogue with partners, to inform internal staff development and learning, or as an input into operational planning at all levels. More detailed guidance on the ways in which it can be used will be ready by end 2007.

The Framework’s success will depend on how well WHO uses its institutional assets and instruments. Its translation into action will involve a wide range of WHO structures and processes, to ensure that planning, management, staff skill mix, etc. are geared to achieving the outcomes that are set out here.

This section outlines some of the implications of the Framework for Action for the way WHO works. It signals where innovation is already occurring, and where further, more detailed work is planned in the coming months to make the Framework operational. It focuses on three key areas.

New ways of working across the Organization

The previous section argued for the need to bridge the gap between programmes and systems departments, and the need for a more coherent approach to country support involving all levels of WHO. There are several ways of doing this. The first involves working within existing arrangements.

- Improved communication on what is meant by health system strengthening, better documentation of actual experience, convincing metrics for tracking improvements in health systems and clear deliverables will create greater confidence that health systems strengthening involves clear strategies, specific actions and gets results.
- Developing acceptable criteria for prioritizing country support: to strike the elusive ‘right balance’ between responding to demands from a large number of countries and ensuring impact through focusing on a few.
- Building on opportunities for collaboration, and ensuring a prompt response. There are already a number of examples. The cluster of Family and Child Health is involved in two major, well-resourced initiatives (GAVI and the Oslo Initiative to achieve MDGs 4 and 5).

These have recognized health systems constraints as major obstacles to scaling-up, and are prepared to commit significant funds to overcome them. By engaging early on, with several departments working together, WHO has been able to shape the new policies and funding windows these initiatives are developing. The volume of funds disbursed to countries for HIV/AIDS means that here, too, there are real opportunities to strengthen health systems, and collaboration needs to be intensified.

- Reappraisal of the use of expert guidance and external scrutiny, and experience with instruments such as expert advisory committees.

The second route involves organizational changes to create stronger incentives for joint work. Here, there are some interesting regional developments. WHO European Region has introduced significant changes to its country support planning and budgeting system, to make it more responsive to country needs. WHO African Region is introducing sub-regional offices, to bring technical support closer to the country level. WHO will review the organization-wide relevance of structural changes already happening in some regional offices.

Enhancing staff competencies and capacity

More analysis of WHO's health system workforce is needed but even without it, WHO will review how to do better with existing staff.

- **Strengthen capacity in health sector policy and strategy development**
As mentioned previously, much of the responsibility for sector policy dialogue with senior policy makers falls to WHO Representatives and Liaison Officers. The challenge is to ensure that they have adequate back-up support and advice from regional offices and headquarters, and to consider where such a function should be located and how it should be resourced. It also requires a more responsive approach to country requests for support (e.g. participation in joint health system reviews). This has implications for how WHO plans, as it runs counter to the current system of advance planning.

WHO will increase its capacity and skill base so that it has more staff equipped to respond to senior policy makers. Building on existing activities of WHO regional offices, and the WHO Learning Committee (including the Core Functions workshop), it will define the competencies required more precisely, decide what form of staff development is necessary and consider how staff with these capabilities can fit into WHO's strategic objective/departmental structure.

- **Develop a professional network of staff working on health systems**
The key change in recent years is that there are rising numbers of health system professionals in technical programmes.

WHO will work to build up a network of health system professionals across the Organization, to improve communication and share experience on health systems issues. The network will not replace independent work on specific issues. It will foster informal and more formal interactions, based on a review of existing staff, their level, distribution and skill-mix. Activities could include seminar series, cross-cluster groups or facilitated electronic debates on key topics, and possibly some form of health systems 'help desk'. It will build on past and current experience, such as the informal cross-cluster group on non-state providers that has been established.

- **Make a better match between supply and demand in specific areas.**
WHO is looking at ways to better respond to requests for specific policy advice. To expand its response capability, it will investigate the potential of WHO accredited support networks.

Strengthen WHO's convening role, and role in health system partnerships

- **Maintain its convening role**
WHO has immense convening power. A key role for WHO is to detect and raise visibility for neglected or critical health systems issues that affect many countries, or those which require a trans-national response. WHO will continue to do this through informal meetings or through expert committees.
- **Address opportunities and challenges of health system partnerships**
The various emerging partnerships referred in previous sections are giving prominence to a wide range of health systems issues that might not have been possible in other ways. WHO will work to leverage the benefits that these partnerships offer to countries and international partners. It will clearly define its roles on a case-by-case basis and negotiate ways for partnerships to support WHO in its core functions.
- **Work with UN partners**
As part of the UN family, WHO will be active in promoting a more coherent UN presence at country level. Working as part of the UN country team, WHO will seek to ensure a clear division of responsibilities among UN partners in responding to national needs for health systems support.

Next steps

The Framework for Action will be judged by the extent to which it is made operational. Based on the outline provided above, over the next months it will be complemented by additional documents to elaborate how this will be done.

Like all such documents, this Framework for Action is introduced into a complex and continually changing world. It should, therefore, be regarded as a 'living document' that sets direction but makes course corrections as needed.

In terms of judging results, this is a corporate Framework for Action. The Medium-term Strategic Plan defines specific results for WHO activities in health systems development and will be the main instrument used for tracking progress.

MATCHING SERVICES TO NEEDS: A NEW APPROACH TO COUNTRY SUPPORT

Work at country level throughout the European Region is characterized in terms of its influence on, or contribution to, four basic health systems functions. The Bi-ennial Collaborative Agreements between EURO and individual Member States contain the joint priorities for co-operation by the Ministry of Health and WHO. For each priority (or Strategic Objective), they identify expected

results, the products under each expected result and set out how the budget is allocated. Each product – regardless of which technical unit is responsible – is categorized according to one or more health system functions: health policy and stewardship; health system financing; health system resource generation; health service delivery.

 ANNEX 1

WHO Core Functions as defined in the 11th General Programme of Work

- **Providing leadership; engaging in partnerships where joint action is needed**
- **Stimulating knowledge generation, translation and dissemination**
- **Setting norms and standards**
- **Articulating ethical and evidence-based policy options**
- **Providing technical support; catalysing change; building sustainable institutional capacity**
- **Monitoring and assessment of trends**

WHO's Medium-term Strategic Objectives

- S01 To reduce the health, social and economic burden of communicable diseases
- S02 To combat HIV/AIDS, tuberculosis and malaria
- S03 To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries
- S04 To reduce morbidity and mortality and improve health during key stages of life, including pregnancy; childbirth; neonatal period; childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals
- S05 To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact
- S06 To promote health and development, and prevent or reduce risk factors for health conditions associated with tobacco, alcohol, drugs and other psychoactive substance use, unhealthy diets, physical activity and unsafe sex
- S07 To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive and human-rights based approaches
- S08 To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health
- S09 To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development
- S010 To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research
- S011 To ensure improved access, quality and use of medical products, vaccines and technologies
- S012 To provide leadership, strengthen governance and foster partnership and collaboration in engagement with countries, the United Nations system, and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the 11th General Programme of Work
- S013 To develop and sustain WHO as a flexible, learning Organization, enabling it to carry out its mandate more efficiently and effectively

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USEFUL WEBLINKS**Africa health workforce observatory:**

<http://www.afro.who.int/hrh-observatory>

European Observatory on health systems and policies

www.euro.who.int/observatory

Global Observatory for eHealth:

<http://www.who.int/goe>

Global atlas of the health workforce:

<http://www.who.int/globalatlas/default.asp>

The global health library:

<http://www.who.int/ghl>

GTZ-ILO-WHO Consortium on Social Health Protection in Developing Countries:

<http://www.socialhealthprotection.org/>

Health systems

www.who.int/healthsystems

Health Evidence Network:

<http://www.euro.who.int/HEN>

The health academy:

<http://www.who.int/healthacademy>

Health InterNetwork Access to Research Initiative:

<http://www.who.int/hinari>

Knowledge management for public health:

<http://www.who.int/km4ph>

Latin America and Caribbean Observatory of Human Resources:

<http://www.observatoriorh.org/eng/index.html>

Management for Health Services Delivery (MAKER):

<http://www.who.int/management/en>

Patient safety:

http://www.who.int/topics/patient_safety

Service Availability Mapping:

<http://www.who.int/healthinfo/systems/serviceavailabilitymapping/en>

WHO-CHOICE = CHOosing Interventions that are Cost-Effective:

<http://www.who.int/choice/en/>

WHO European Ministerial Conference on Health Systems 2008:

<http://www.euro.who.int/healthsystems2008>

World Health Statistics:

<http://www.who.int/healthinfo/statistics>

WHO Eastern Mediterranean Regional Health System Observatory:

<http://gis.emro.who.int/HealthSystemObservatory/Main/Forms/Main.aspx>

Health Systems and Services (HSS)
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1211 Geneva 27
Switzerland

<http://www.who.int/healthsystems>



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7. HUNT, PAUL. JANUARY 2008. PROMOTION AND PROTECTION OF ALL HUMAN RIGHTS, CIVIL, POLITICAL, ECONOMIC AND CULTURAL RIGHTS: REPORT OF THE SPECIAL RAPPORTEUR ON THE RIGHT OF EVERYONE TO THE ENJOYMENT OF THE HIGHEST ATTAINABLE STANDARD OF PHYSICAL AND MENTAL HEALTH. NEW YORK, NY: UNITED NATIONS GENERAL ASSEMBLY.

The right to the highest attainable standards of health provides important guidance on developing an effective and integrated health system. There is an increasing acknowledgement that strong health systems are essential to a healthy and equitable society. Taking into account good health practices as well as the right to the highest attainable standards of health, this report identifies general approaches to strengthening health systems. These approaches should be applied consistently and systemically across a set of "building blocks," which together constitute a functioning health system.



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Agenda item 3

**PROMOTION AND PROTECTION OF ALL HUMAN RIGHTS, CIVIL,
POLITICAL, ECONOMIC, SOCIAL AND CULTURAL RIGHTS**

**Report of the Special Rapporteur on the right of everyone to the enjoyment of
the highest attainable standard of physical and mental health, Paul Hunt**

Summary

At the heart of the right to the highest attainable standard of health lies an effective and integrated health system, encompassing health care and the underlying determinants of health, responsive to national and local priorities, and accessible to all.

The Human Rights Council, in its decision 2/108, requested the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health to identify and explore the key features of an effective, integrated and accessible health system from the perspective of the right to health, bearing in mind the level of development of countries. This report is a response to that request.

There is a growing recognition that a strong health system is an essential element of a healthy and equitable society. In any society, an effective health system is a core social institution, no less than a fair justice system or democratic political system. However, according to a recent publication of the World Health Organization, health systems in many countries are failing and collapsing.

The report briefly identifies some of the historical landmarks in the development of health systems, such as the Declaration of Alma-Ata on primary health care (1978). Taking into account health good practices, as well as the right to the highest attainable standard of health, the report identifies a general approach to strengthening health systems (chap. II, sect. C). This general approach should be applied, consistently and systematically, across the numerous elements - or “building blocks” - that together constitute a functioning health system. By way of illustration, the report takes the general approach outlined in the report and begins to apply it to two of the health system “building blocks” (chap. II, sect. E).

Section F signals how the right to a fair trial has helped to strengthen court systems and argues that, in a similar way, the right to the highest attainable standard of health can help to strengthen health systems.

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I. INTRODUCTION

1. The Human Rights Council, in its resolution 6/29, extended the mandate of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (“right to the highest attainable standard of health” or “right to health”) set out in the Commission on Human Rights resolutions 2002/31 and 2004/27. The present report is submitted in accordance with that resolution.
2. The Special Rapporteur submitted an interim report to the General Assembly (A/62/214) at its sixty-second session in October 2007, in which three issues were considered. The first is how to prioritize health interventions, given that budgets are finite. Second, the report outlines a right-to-health impact assessment methodology. Third, it highlights the vital importance of underlying determinants of health, with particular reference to safe water and adequate sanitation. The report also includes an overview of the Special Rapporteur’s activities between November 2006 and July 2007.
3. Between July and December 2007, the Special Rapporteur undertook two missions - to Colombia (in September), focusing on aerial sprayings of illicit coca crops along the border with Ecuador, and India (in November) on maternal mortality. Reports thereon will be submitted to the Human Rights Council in September 2008.
4. In August 2007, as part of the John D. and Catherine T. MacArthur Foundation International Lecture Series on Population Issues, the Special Rapporteur gave a lecture on “The Millennium Development Goals and the Right to the Highest Attainable Standard of Health”, in Abuja, Nigeria.
5. On 19 September 2007, the draft Human Rights Guidelines for Pharmaceutical Companies in relation to Access to Medicines were launched, initiating a lengthy process of public consultation. In the light of this ongoing process, the revised final draft Guidelines will be published in 2008.
6. While at the University of Toronto, the Special Rapporteur also gave a public lecture on the right to the highest attainable standard of health. During the same month, he also addressed a London conference organized by Action for Global Health.
7. In October 2007, the Special Rapporteur was a keynote speaker at the 8th International Health Impact Assessment Conference, which took place in Dublin, Ireland. The Special Rapporteur also held a consultation, hosted by the British Medical Association, on accountability and the right to health. In New York, the Special Rapporteur met with the Open Society Institute to discuss his work on HIV/AIDS. Furthermore, he participated in a consultation, organized by the Brazilian Permanent Mission to the United Nations, on the draft Human Rights Guidelines for Pharmaceutical Companies in relation to Access to Medicines. Also in October, the Special Rapporteur spoke at the launch, which took place at the Women Deliver Conference in London, of the International Initiative on Maternal Mortality and Human Rights.

8. In November, the Special Rapporteur co-organized with the United Nations Population Fund (UNFPA) a workshop on mainstreaming sexual and reproductive health rights into the work of the United Nations human rights system. The workshop was hosted by the Office of the United Nations High Commissioner for Human Rights (OHCHR) in Geneva.
9. In December, the Special Rapporteur gave the first annual lecture on malaria and human rights, co-organized by the UK Coalition against Malaria and the European Alliance Against Malaria.
10. Throughout the reporting period, the Special Rapporteur had a number of consultations, in addition to those already mentioned, on the draft Human Rights Guidelines for Pharmaceutical Companies in relation to Access to Medicines, including with the International Federation of Pharmaceutical Manufacturers and Associations (IFPMA) and the pharmaceutical company Novo Nordisk.
11. The Special Rapporteur is extremely grateful to all those who have given him the benefit of their advice, support and time.

II. HEALTH SYSTEMS AND THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH

12. The last six decades of international and domestic policy and practice have confirmed that health is not only a human rights issue but also a fundamental building block of sustainable development, poverty reduction and economic prosperity. Recently, there has also been growing recognition that a strong health system is an essential element of a healthy and equitable society. In any society, an effective health system is a core institution, no less than a fair justice system or democratic political system.¹
13. Yet according to a recent publication of the World Health Organization (WHO), health systems in many countries are failing and collapsing. “In too many countries” health systems “are on the point of collapse, or are accessible only to particular groups in the population”.² Too often health systems “are inequitable, regressive and unsafe”. “Health outcomes are unacceptably low across much of the developing world, and the persistence of deep inequities in health status is a problem from which no country in the world is exempt. At the centre of this human crisis is a failure of health systems.”³

¹ L. Freedman, “Achieving the MDGs: Health systems as core social institutions”, *Development* 2005, vol. 48, No. 1, p. 19-24 (available at <http://www.palgrave-journals.com/development/journal/v48/n1/pdf/1100107a.pdf>).

² *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes*, WHO, 2007, p. 1 (available at http://who.int/healthsystems/strategy/everybodys_business.pdf).

³ Ibid.

14. WHO also confirms that sustainable development depends on effective health systems: “It will be impossible to achieve national and international goals - including the Millennium Development Goals - without greater and more effective investment in health systems and services.”⁴

15. At the heart of the right to the highest attainable standard of health lies an effective and integrated health system, encompassing health care and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all. Without such a health system, the right to the highest attainable standard of health can never be realized.

16. Thus, it is only through building and strengthening health systems that it will be possible to secure sustainable development, poverty reduction, economic prosperity, improved health for individuals and populations, as well as the right to the highest attainable standard of health.

17. In decision 2/108, the Human Rights Council requested the Special Rapporteur, when presenting his report, to consider the possibility of identifying and exploring “the key features of an effective, integrated and accessible health system”. He was asked to undertake this task “bearing in mind the level of development of countries and from the perspective of the right to the highest attainable standard of physical and mental health”.

18. This report looks at health systems from the perspective of the right to the highest attainable standard of health, drawing on numerous consultations, as well as consideration of extensive literature from the fields of both medicine and public health.⁵ Crucially, the chapter is informed by an understanding of health good practices, as well as the right to the highest attainable standard of health. All of the features and measures identified here are already found in some health systems, recognized in some international health instruments (such as the Declaration of Alma-Ata) or advocated in the health literature. But they are not usually recognized as human rights issues.

19. The report outlines how the right to the highest attainable standard of health underpins and reinforces an effective, integrated, accessible health system - and why this is important.

A. Health systems: some historical landmarks⁶

20. Health systems of some sort have existed as long as people have tried to protect their health and treat diseases, but organized health systems are barely 100 years old, even in industrialized countries. They are political and social institutions, and usually include the State,

⁴ Ibid., p. v.

⁵ This report has been enriched by consultations in the United Kingdom of Great Britain and Northern Ireland, the United States of America, New Zealand, Australia, Switzerland, Italy and Zimbabwe. The consultations have included a wide range of stakeholders from developing and developed countries, including indigenous people. The Special Rapporteur is very grateful to all those who organized, and participated in, these meetings.

⁶ This section draws extensively on *Everybody's Business ...* (note 2 above), p. 9.

private and voluntary sectors. Many health systems have gone through several, sometimes parallel and competing, generations of development and reform, shaped by national and international values and goals.

21. One of the first attempts to unify thinking about health within a single policy framework was embodied in the Declaration of Alma-Ata on primary health care, agreed by Ministers of Health from throughout the world and adopted on 12 September 1978 at the International Conference on Primary Health Care. This seminal Declaration does not seek to address health systems in their entirety;⁷ instead, it focuses on some vital components of an effective health system and still remains very relevant to health systems strengthening.

22. The Declaration begins by affirming that the attainment of the highest possible level of health is a fundamental human right. Several principal themes recur throughout the Declaration, all of which are relevant to health systems in both developed and developing countries:⁸

- (a) The importance of equity;
- (b) The need for community participation;
- (c) The need for a multisectoral approach to health problems;
- (d) The need for effective planning;
- (e) The importance of integrated referral systems;
- (f) An emphasis on health-promotional activities;
- (g) The critical role of suitably trained human resources;
- (h) The importance of international cooperation.

23. In addition to these themes, the Declaration highlights a number of essential health interventions:

- (a) Education concerning prevailing health problems;
- (b) Promotion of food supply and proper nutrition;
- (c) Adequate supply of safe water and basic sanitation;

⁷ For a broader approach, see *The World Health Report 2000 - Health Systems: Improving Performance*, WHO, 2000.

⁸ This passage draws extensively on A. Green, *An Introduction to Health Planning for Developing Health Systems*, Oxford University Press, 2007, pp. 63-64.

- (d) Maternal and child health care, including family planning;
- (e) Immunization against major infectious diseases;
- (f) Prevention and control of locally endemic diseases;
- (g) Appropriate treatment of common diseases and injuries;
- (h) Provision of essential drugs.

24. Since 1978, a number of other issues - such as gender, the environment, disability, mental health, traditional health systems, the role of the private sector, and accountability - have been increasingly recognized as important. When revisiting the Declaration, they need to be taken into account.

25. One of the most striking characteristics of the Declaration is that it encompasses the interrelated domains of medicine, public health and human rights. For example, it includes medical care, such as access to essential drugs, and public health, such as community participation and access to safe water, all of which are major preoccupations of the right to the highest attainable standard of health. The Declaration is situated on the common ground between medicine, public health and human rights. This convergence is reinforced by Committee on Economic, Social and Cultural Rights general comment No. 14 (2000) on the right to the highest attainable standard of health (art. 12), paragraph 43, according to which “the Declaration of Alma-Ata provides compelling guidance on the core obligations arising from” the right to the highest attainable standard of health.

26. Since its adoption, some of the elements of the Declaration have developed. The Ottawa Charter for Health Promotion (1986), for example, laid the foundations of modern health promotion. Looking beyond a curative-oriented health sector, the Charter emphasizes the vital role of multisectoral prevention and promotion in relation to many health problems.

27. For the most part, however, the central messages of the Declaration of Alma-Ata were obscured in the 1980s and 1990s. For a variety of reasons, there was a shift towards vertical (or selective) biomedical interventions. Driven by neoliberal economics, structural adjustment programmes led to reduced health budgets and the introduction of user fees. As WHO recently observed: “The results were predictable. The poor were deterred from receiving treatment and the user fees yielded limited income. Moreover, maintaining a network of under-resourced hospitals and clinics, while human and financial resources were increasingly pulled into vertical programmes, increased pressures on health systems sometimes to the point of collapse.”⁹

28. This quotation is astonishing - and shaming. International and national policies were introduced that - predictably - brought health systems “to the point of collapse”.

⁹ *Everybody's Business ...* (note 2 above), p. 9.

29. As the health crisis deepened, efficiency became the watchword and health sector reform “focused above all on doing more for less”.¹⁰ It was only around the turn of the century that the international community started to confront the reality that running health systems on US\$ 10 per capita, or less, is simply not a viable proposition.

30. In the last few years, there has been a significant increase in the amount of international funding available to health. Some States have also increased their domestic health funding. Much of the increase in investment by external partners, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, as well as the GAVI Alliance (GAVI), has focused on specific diseases and conditions. However, these initiatives exposed (some would say aggravated) the degraded state of many health systems. There has been a dawning realization that these specific initiatives cannot thrive without effective, strengthened health systems. Recent years have also seen a growing appreciation of the seriousness of the health workforce crisis, including the skills drain from low-income to high-income countries, a perverse subsidy from the poor to the rich.¹¹

31. In 2005, recognizing that inadequate health systems were impeding progress towards improved immunization coverage, GAVI decided to support health system strengthening with an initial commitment of US\$ 500 million for 2006-2010.¹² Launched in 2007, the International Health Partnership - a global compact for achieving the health Millennium Development Goals - aims to build health systems in some of the poorest countries in the world. It is hoped that the Partnership will go beyond making better use of existing aid and also generate additional resources.

32. As increased resources are invested in health systems, the timeliness of the Human Rights Council’s decision 2/108 becomes apparent. It is important to clarify the relationship between health systems and the right to the highest attainable standard of health. In this way, the right to the highest attainable standard of health, informed by health good practices, can help to make a practical, constructive contribution to health system strengthening.

33. Additionally, States have a legal duty to comply with their binding international and national human rights obligations. Identifying the features of a health system that arise from the right to the highest attainable standard of health can help States ensure that their policies and practices are in conformity with their legally binding human rights duties.

B. Definitions

34. There are countless competing definitions of health systems. In an important publication brought out by WHO in 1991, Tarimo defines a health system as “the complex of interrelated elements that contribute to health in homes, educational institutions, workplaces, public places and communities, as well as in the physical and psychological environment and the health and

¹⁰ Ibid.

¹¹ For the Special Rapporteur’s report on the skills drain, see A/60/348, paragraphs 18-89.

¹² See http://www.gavialliance.org/resources/HSS_Background.pdf.

related sectors”.¹³ In 2007, WHO adopted a narrower definition: “A health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health.”¹⁴ The literature reveals many other definitions, each with carefully nuanced differences.

35. For present purposes, there is no need to favour one definition over another because all the features and measures identified in this report should be part of any health system, however defined.

C. In general terms, a right-to-health approach to strengthening health systems

36. International human rights law signals the content and contours of the right to the highest attainable standard of health. In the last decade or so, States, international organizations, international and national human rights mechanisms, courts, civil society organizations, academics and many others have begun to explore what this human right means and how it can be put into practice. Health workers are making the most decisive contribution to this process.

37. Drawing on this deepening experience, and informed by health good practices, this section outlines the general approach of the right to the highest attainable standard of health towards the strengthening of health systems. Because of space constraints, this outline can only be brief and introductory.

1. At the centre: the well-being of individuals, communities and populations

38. A health system gives rise to numerous technical issues. Of course, experts have an indispensable role to play in addressing these technical matters. But there is a risk that health systems will become impersonal, “top-down” and dominated by experts. Additionally, as a recent WHO publication observes, “health systems and services are mainly focused on disease rather than on the person as a whole, whose body and mind are linked and who needs to be treated with dignity and respect.”¹⁵ The publication concludes, “health care and health systems must embrace a more holistic, people-centred approach”.¹⁶ This is also the approach required by the right to the highest attainable standard of health. Because it places the well-being of individuals, communities and populations at the centre of a health system, the right to health can help to ensure that a health system is neither technocratic nor removed from those it is meant to serve.

¹³ E. Tarimo, *Towards a Healthy District. Organizing and Managing District Health Systems Based on Primary Health Care*, WHO, 1991, p. 4.

¹⁴ *Everybody’s Business...* (note 2 above), p. 2.

¹⁵ *People at the Centre of Health Care: Harmonizing Mind and Body, Peoples and Systems*, WHO, 2007, p. v.

¹⁶ *Ibid.*, p. vii.

2. Not only outcomes, but also processes

39. The right to the highest attainable standard of health is concerned with both processes and outcomes. It is not only interested in what a health system does (e.g. providing access to essential medicines and safe drinking water), but also how it does it (e.g. transparently, in a participatory manner, and without discrimination).

3. Transparency

40. Access to health information is an essential feature of an effective health system, as well as the right to the highest attainable standard of health. Health information enables individuals and communities to promote their own health, participate effectively, claim quality services, monitor progressive realization, expose corruption, hold those responsible to account, and so on. The requirement of transparency applies to all those working in health-related sectors, including States, international organizations, public private partnerships, business enterprises and civil society organizations.

4. Participation

41. All individuals and communities are entitled to active and informed participation on issues relating to their health. In the context of health systems, this includes participation in identifying overall strategy, policymaking, implementation and accountability. The importance of community participation is one of the principal themes recurring throughout the Declaration of Alma-Ata. Crucially, States have a human rights responsibility to establish institutional arrangements for the active and informed participation of all relevant stakeholders, including disadvantaged communities.¹⁷ These issues have been explored in several of the Special Rapporteur's reports, including on Uganda and mental disability.¹⁸

5. Equity, equality and non-discrimination

42. Equality and non-discrimination are among the most fundamental elements of international human rights, including the right to the highest attainable standard of health. A State has a legal obligation to ensure that a health system is accessible to all without discrimination, including those living in poverty, minorities, indigenous peoples, women, children, slum and rural dwellers, people with disabilities, and other disadvantaged individuals and communities. Also, the health system must be responsive to the particular health needs of women, children, adolescents, the elderly, and so on. The twin human rights principles of equality and non-discrimination mean that outreach (and other) programmes must be in place to ensure that disadvantaged individuals and communities enjoy, in practice, the same access as those who are more advantaged.

¹⁷ See H. Potts, *Human Rights in Public Health: Rhetoric, Reality and Reconciliation*, PhD thesis, Monash University, Melbourne, Australia, 2006.

¹⁸ E/CN.4/2006/48/Add.2 and E/CN.4/2005/51.

43. Equality and non-discrimination are akin to the critical health concept of equity. There is no universally accepted definition of equity, but one sound definition is “equal access to health care according to need”.¹⁹ All three concepts have a social justice component. In some respects, equality and non-discrimination, being reinforced by law, are more powerful than equity. For example, if a State fails to take effective steps to tackle race discrimination in a health system, it can be held to account and required to take remedial measures. Also, if a health system is accessible to the wealthy but inaccessible to those living in poverty, the State can be held to account and required to take remedial action.

6. Respect for cultural difference

44. A health system must be respectful of cultural difference. Health workers, for example, should be sensitive to issues of ethnicity and culture. Also, a health system is required to take into account traditional preventive care, healing practices and medicines. Strategies should be in place to encourage and facilitate indigenous people, for example, to study medicine and public health. Moreover, training in some traditional medical practices should also be encouraged.²⁰ Of course, cultural respect is right as a matter of principle. But, additionally, it makes sense as a matter of practice. As Thoraya Ahmed Obaid, Executive Director of UNFPA, observes: “cultural sensitivity ... leads to higher levels of programme acceptance and ownership by the community, and programme sustainability”.²¹

7. Medical care and the underlying determinants of health

45. The health of individuals, communities and populations requires more than medical care. For this reason, international human rights law casts the right to the highest attainable standard of physical and mental health as an inclusive right extending to not only timely and appropriate medical care but also the underlying determinants of health, such as access to safe water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, access to health-related education and information, including on sexual and reproductive health, and freedom from discrimination.²² The social determinants of health, such as gender, poverty and social exclusion, are major preoccupations of the right to the highest attainable standard of health. In his work, for example, the Special Rapporteur has

¹⁹ *An Introduction to Health Planning ...* (note 8 above), p. 64.

²⁰ For the Special Rapporteur’s reflections on indigenous peoples and the right to the highest attainable standard of health see, for example, A/59/422 and E/CN.4/2005/51/Add.3.

²¹ *Culture Matters - Working with communities and faith-based organizations: Case studies from country programmes*, UNFPA, 2004, p. v.

²² See, for example, article 24 of the Convention on the Rights of the Child: Health care includes dental care.

consistently looked at medical care and the underlying determinants of health, including the impact of poverty and discrimination on health. In short, the right to the highest attainable standard of health encompasses the traditional domains of both medical care and public health. This is the perspective that the right to the highest attainable standard of health brings to the strengthening of health systems.

8. Progressive realization and resource constraints

46. The right to the highest attainable standard of health is subject to progressive realization and resource availability. In other words, it does not make the absurd demand that a comprehensive, integrated health system be constructed overnight. Rather, for the most part, human rights require that States take effective measures to progressively work towards the construction of an effective health system that ensures access to all. The disciplines of medicine and public health take a similar position; the Declaration of Alma-Ata, for example, is directed to “progressive improvement”.²³ Also, the right to health is realistic: it demands more of high-income than low-income States, that is to say, implementation of the right to health is subject to resource availability.

47. These two concepts - progressive realization and resource availability - have numerous implications for health systems, some of which are briefly explored later in this chapter. For example, because progressive realization does not occur spontaneously, a State must have a comprehensive, national plan, encompassing both the public and private sectors, for the development of its health system. The crucial importance of planning is recognized in the health literature, the Declaration of Alma-Ata and Committee on Economic, Social and Cultural Rights general comment No. 14 (2000) on the right to the highest attainable standard of health (for more on planning, see section E below).

48. Another implication of progressive realization is that an effective health system must include appropriate indicators and benchmarks; otherwise, there is no way of knowing whether or not the State is improving its health system and progressively realizing the right to the highest attainable standard of health. Moreover, the indicators must be disaggregated on suitable grounds, such as sex, socio-economic status and age, so that the State knows whether or not its outreach programmes for disadvantaged individuals and communities are working. Indicators and benchmarks are already commonplace features of many health systems, but they rarely have all the elements that are important from a human rights perspective, such as disaggregation on appropriate grounds.²⁴

²³ Paragraph VII (6).

²⁴ For a human rights-based approach to health indicators, see the Special Rapporteur’s report E/CN.4/2006/48.

49. A third implication arising from progressive realization is that at least the present level of enjoyment of the right to the highest attainable standard of health must be maintained. This is sometimes known as the principle of non-retrogression.²⁵ Although rebuttable in certain limited circumstances, there is a strong presumption that measures lowering the present enjoyment of the right to health are impermissible.

50. Finally, progressive realization does not mean that a State is free to choose whatever measures it wishes to take so long as they reflect some degree of progress. A State has a duty to adopt those measures that are most effective, while taking into account resource availability and other human rights considerations.

9. Duties of immediate effect: core obligations

51. Although subject to progressive realization and resource availability, the right to the highest attainable standard of health gives rise to some core obligations of immediate effect. A State has “a core obligation to ensure the satisfaction of, at the very least, minimum essential levels” of the right to the highest attainable standard of health.²⁶ What, more precisely, are these core obligations? Some are discussed later in this report. Briefly, they include an obligation to:

- (a) Prepare a comprehensive, national plan for the development of the health system;
- (b) Ensure access to health-related services and facilities on a non-discriminatory basis, especially for disadvantaged individuals, communities and populations; this means, for example, that a State has a core obligation to establish effective outreach programmes for those living in poverty;
- (c) Ensure the equitable distribution of health-related services and facilities, e.g. a fair balance between rural and urban areas;
- (d) Establish effective, transparent, accessible and independent mechanisms of accountability in relation to duties arising from the right to the highest attainable standard of health.

52. Also, a State has a core obligation to ensure a minimum “basket” of health-related services and facilities, including essential food to ensure freedom from hunger, basic sanitation and adequate water, essential medicines, immunization against the community’s major infectious diseases, and sexual and reproductive health services including information, family planning, prenatal and post-natal services, and emergency obstetric care. Some States have already identified a minimum “basket” for those within their jurisdiction. Some international

²⁵ Committee on Economic, Social and Cultural Rights general comment No. 14 (2000), para. 32.

²⁶ *Ibid.*, paras. 43-45.

organizations have also tried to identify a minimum “basket” of health services. This is a difficult exercise, not least because health challenges vary widely from one State to another, which means that in practice, the minimum “basket” may vary between countries. In some countries, the challenge is undernutrition, elsewhere it is obesity.

53. Much more work has to be done to help States identify the minimum “basket” of health-related services and facilities required by the right to the highest attainable standard of health. However, that vital task is not the purpose of this report. This report is not attempting to provide a list of essential services and facilities that are needed for a well-functioning health system. Rather, the report is seeking to identify a number of additional, and frequently neglected, features arising from the right to the highest attainable standard of health, and informed by health good practices, that are required of all health systems. These include, for example, access on the basis of equality and non-discrimination, an up-to-date health plan, effective accountability for the public and private health sector, and so on.

10. Quality

54. Health services and facilities must be of good quality. For example, a health system must be able to ensure access to good quality essential medicines. If medicines are rejected in the North because they are beyond their expiry date and unsafe, they must not be recycled to the South. Because medicines may be counterfeit or tampered with, a State must establish a regulatory system to check medicine safety and quality. The requirement of good quality also extends to the manner in which patients and others are treated. Health workers must treat patients and others politely and with respect.

11. A continuum of prevention and care with effective referrals

55. A health system should have an appropriate mix of primary (community-based), secondary (district-based) and tertiary (specialized) facilities and services, providing a continuum of prevention and care. The system also needs an effective process when a health worker assesses that a client may benefit from additional services and the client is referred from one facility to another. Referrals are also needed, in both directions, between an alternative health system (e.g. traditional practitioners) and “mainstream” health system. The absence of an effective referral system is inconsistent with the right to the highest attainable standard of health.

12. Vertical or integrated?

56. There is a long-standing debate about the merits of vertical (or selective) health interventions, which focus on one or more diseases or health conditions, and a comprehensive, integrated approach. By drawing off resources, vertical interventions can jeopardize progress towards the long-term goal of an effective health system. They have other potential disadvantages, such as duplication and fragmentation. However, in some circumstances, such as during a public health emergency, there may be a place for a vertical intervention. When these circumstances arise, the intervention must be carefully designed, so far as possible, to strengthen and not undermine a comprehensive, integrated health system.

13. Coordination

57. A health system, as well as the right to the highest attainable standard of health, depends on effective coordination across a range of public and private actors (including non-governmental organizations) at the national and international levels. The scope of the coordination will depend on how the health system is defined. But however it is defined, coordination is crucial. For example, a health system and the right to the highest attainable standard of health demand effective coordination between various sectors and departments, such as health, environment, water, sanitation, education, food, shelter, finance and transport. They also demand coordination within sectors and departments, such as the Ministry of Health. The need for coordination extends to policymaking and the actual delivery of services.

58. In the Special Rapporteur's experience, health-related coordination in many States is very patchy and weak. Alone, the Cabinet is an insufficient coordination mechanism for health-related issues. Other coordination mechanisms are essential.

14. Health as a global public good: the importance of international cooperation²⁷

59. Public goods are goods that benefit society as a whole. The concept of "national public goods", such as the maintenance of law and order, is well established. In an increasingly interdependent world, much more attention is being paid to "global public goods". They address issues in which the international community has a common interest. In the health context, global public goods include the control of infectious diseases, the dissemination of health research, and international regulatory initiatives, such as the WHO Framework Convention on Tobacco Control. Although it remains very imprecise, the concept of "global public goods" confirms that a health system has both national and international dimensions.

60. The international dimension of a health system is also reflected in States' human rights responsibilities of international assistance and cooperation. These responsibilities can be traced through the Charter of the United Nations, the Universal Declaration of Human Rights, and several more recent international human rights declarations and binding treaties.²⁸ They are also reflected in the outcome documents of several world conferences, such as the Millennium Declaration, as well as numerous other initiatives, including the Paris Agenda on Aid Effectiveness (2005).

61. As a minimum, all States have a responsibility to cooperate on transboundary health issues and to "do no harm" to their neighbours. High-income States have an additional responsibility to provide appropriate international assistance and cooperation in health for low-income countries.

²⁷ This section draws extensively on *Health is Global: Proposals for a UK Government-Wide Strategy*, Department of Health, 2007, especially at p. 46.

²⁸ See S. Skogly, *Beyond National Borders: States' Human Rights Obligations in International Cooperation*, Antwerp/Oxford, Intersentia, 2006.

They should especially assist low-income countries with the fulfilment of their core obligations arising from the right to the highest attainable standard of health. Equally, low-income States have a responsibility to seek appropriate international assistance and cooperation to help them strengthen their health systems.

62. The relationship between health “global public goods” and the human rights responsibility of international assistance and cooperation in health demands further study.

15. Striking balances

63. Few human rights are absolute. Frequently, balances have to be struck between competing human rights. Freedom of information, for example, has to be balanced with the right to privacy. Moreover, there are often legitimate but competing claims arising from the same human right, especially in relation to those numerous rights that are subject to resource availability. In the context of health systems, finite budgets give rise to tough policy choices. Should the Government build a new teaching hospital, establish more primary health-care clinics, strengthen community care for people with disabilities, improve sanitation in the capital’s slum, improve access to antiretrovirals, or subsidize an effective but expensive cancer drug? A preliminary report of the Special Rapporteur submitted to the United Nations General Assembly addressed these challenging issues (A/62/214). Human rights do not provide neat answers to such questions, any more than do ethics or economics. But human rights require that the questions be decided by way of a fair, transparent, participatory process, taking into account explicit criteria, such as the well-being of those living in poverty, and not just the claims of powerful interest groups.

64. Because of the complexity, sensitivity and importance of many health policy issues, it is vitally important that effective, accessible and independent mechanisms of accountability are in place to ensure that reasonable balances are struck by way of fair processes that take into account all relevant considerations, including the interests of disadvantaged individuals, communities and populations.

16. Monitoring and accountability

65. Rights imply duties, and duties demand accountability. Accountability is one of the most important features of human rights - and also one of the least understood. Although human rights demand accountability this does not mean that every health worker or specialized agency becomes a human rights enforcer. Accountability includes the monitoring of conduct, performance and outcomes. In the context of a health system, there must be accessible, transparent and effective mechanisms of accountability to understand how those with responsibilities towards the health system have discharged their duties. The crucial role of accountability is explored further in section E below.

17. Legal obligation

66. The right to the highest attainable standard of health gives rise to legally binding obligations. A State is legally obliged to ensure that its health system includes a number of the features and measures signalled in the preceding paragraphs. The health system must have, for example, a comprehensive, national plan; outreach programmes for the disadvantaged;

a minimum “basket” of health-related services and facilities; effective referral systems; arrangements to ensure the participation of those affected by health decision-making; respect for cultural difference; and so on. Of course, these requirements also correspond to health good practices. One of the distinctive contributions of the right to the highest attainable standard of health is that it reinforces such health good practices with legal obligation and accountability.

D. The “building blocks” of a health system

67. Informed by health good practices, the preceding section outlines the general approach of the right to the highest attainable standard of health towards the strengthening of health systems. This general approach has to be consistently and systematically applied across the numerous elements that together constitute a functioning health system.

68. What are these functional elements of a health system? The health literature on this issue is very extensive. For its part, WHO identifies “six essential building blocks” which together make up a health system:²⁹

(a) Health services. “Good health services are those which deliver effective, safe, quality personal and non-personal health interventions to those who need them, when and where needed, with minimum waste of resources.” Non-personal health interventions include, for example, safe water and adequate sanitation;

(b) Health workforce. “A well-performing health workforce is one which works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances, i.e. there are sufficient numbers and mix of staff, fairly distributed; they are competent, responsive and productive”;

(c) Health information system. “A well-functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health systems performance and health status”;

(d) Medical products, vaccines and technologies. “A well-functioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use”;

(e) Health financing. “A good health financing system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them”;

(f) Leadership, governance, stewardship. This “involves ensuring strategic policy frameworks exist and are combined with effective oversight coalition-building, the provision of appropriate regulations and incentives, attention to system-design, and accountability”.

²⁹ *Everybody’s Business ...* (note 2 above), p. 3.

69. Although some of these formulations may be subject to debate, for the purposes of this report these “building blocks” are a useful way of looking at a health system. Of course, each “building block” has generated a huge literature over many years.

70. For present purposes, three short points demand emphasis. First, these are not only “building blocks” for a health system, they are also “building blocks” for the right to the highest attainable standard of health. Like a health system, the right to health requires health services, health workers, health information, medical products, financing and stewardship.

71. Second, in practice, the “building blocks” might not have all the features required by the right to the highest attainable standard of health. For example, a country might have a health information system, one of the WHO “building blocks”. But the information system might not include appropriately disaggregated data, which is one of the requirements of the right to health. In short, an essential “building block” might be in place, but without all the features required by international human rights law.

72. Third, the crucial challenge is to apply - or integrate - the right to the highest attainable standard of health, as well as other human rights, across the six “building blocks”. The general approach outlined in the preceding section has to be consistently and systematically applied to health services, health workers, health information, medical products, financing and stewardship - all the elements that together constitute a functioning health system.

73. The systematic application of the right to health to the six “building blocks” is likely to have a variety of results. In some cases, the right to health will reinforce existing features of the “building blocks” that routinely receive the attention they deserve. In other cases, the application of the right will identify existing features of the “building blocks” that tend to be overlooked in practice and that require much more attention, such as the disaggregation of data on appropriate grounds. It is also possible that the application of the right may identify features that, although important, are not usually regarded as forming any part of the six “building blocks”.³⁰

E. Applying the general approach: some specific measures for health system strengthening

74. Because of space constraints, it is not possible in this report to apply the right to the highest attainable standard of health across the “building blocks” that together constitute a health system. Such an ambitious undertaking must be the subject of further studies. However, the present section begins to apply the right to the highest attainable standard of health to two “building blocks” of WHO: (i) a health workforce and (ii) leadership, governance and stewardship. Although this is a brief application of the right to the highest attainable standard of health, it gives a sense of the practical implications of the general approach outlined in section C above in relation to the health system “building blocks” signalled in section D above.

³⁰ Such as ex ante impact assessments (see paragraphs below on planning).

1. A health workforce

75. While human resources in health have attracted increasing attention in recent years, the human rights dimensions of the issue rarely receive significant consideration. If the general approach outlined in section C were applied to health workers, the following points would be among those that need detailed examination.

76. A State should have an up-to-date development plan for human resources in preventive, curative and rehabilitative health; it should encompass physical and mental health.

77. When planning, the State should consider providing a role for mid-level providers, such as assistant medical officers and surgical technicians, as well as public health workers. Described as a key strategy to uphold the fundamental human right to health, mid-level providers are already an essential part of the health systems in some countries, such as Mozambique.³¹

78. Recruitment of health workers must include outreach programmes to disadvantaged individuals, communities and populations, such as indigenous peoples.³²

79. Effective measures are required towards achieving a gender balance among health workers in all fields.

80. The State should ensure that the number of domestically trained health workers is commensurate with the health needs of the population, subject to progressive realization and resource availability. In this context, appropriate balances must be struck between, for example, the number of health workers at the community or primary level and specialists at the tertiary level.

81. The number of health workers should be collected, centralized and made publicly available. The data should be broken down by category, e.g. nurse, public health professional and so on. The various categories should be disaggregated, as a minimum, by gender.

82. Health workers' training must include human rights, including respect for cultural diversity, as well as the importance of treating patients and others with courtesy. This issue is explored in the Special Rapporteur's report on health workers and human rights education.³³

83. After qualifying, all health workers must have opportunities, without discrimination, for further professional training.

³¹ See *Health Systems Strengthening for Equity (HSSE): The Power and Potential of Mid-Level Providers* at www.midlevelproviders.org

³² "Health workers" include all those developing, managing, delivering, monitoring and evaluating preventive, curative and rehabilitative health in the private and public health sectors, including traditional healers.

³³ A/60/348.

84. Health workers must receive domestically competitive salaries, as well as other reasonable terms and conditions of employment. Their human rights must be respected, for example, freedoms of association, assembly and expression. They must be provided with the opportunity of active and informed participation in health policymaking. The safety of health workers, who are disproportionately exposed to health hazards, is a major human rights issue.

85. There should be incentives to encourage the appointment, and retention, of health workers in underserved areas. When considering the situation of health workers in Uganda, this was one of the issues considered by the Special Rapporteur.³⁴

86. The skills drain raises numerous human rights issues, including in relation to the right to the highest attainable standard of health in countries of origin. Where relevant, both sending and receiving States must have policies in place to address the skills drain. In an earlier report, the Special Rapporteur examined the skills drain through the right-to-health lens.³⁵

2. Leadership, governance, stewardship

87. This is “arguably the most complex but critical building block of any health system”.³⁶ It encompasses many elements, including planning and accountability.

(a) Planning

88. In the Special Rapporteur’s experience, this is one of the weakest features of the development and strengthening of health systems. With a few honourable exceptions, the record of health planning is poor, while the history of health planning is surprisingly short. Many States do not have comprehensive, up-to-date health plans. Where they exist, plans “often fail to be implemented and remain grand designs on paper. Elsewhere plans may be implemented but fail to respond to the real needs of the population.”³⁷

89. However, from the perspective of the right to the highest attainable standard of health, effective planning is absolutely critical. Progressive realization and resource availability - two inescapable components of the international right to health - cannot be addressed without planning.³⁸

³⁴ E/CN.4/2006/48/Add.2.

³⁵ A/60/348.

³⁶ *Everybody’s Business...* (note 2 above), p. 23.

³⁷ *An Introduction to Health Planning...* (note 8 above), p. 18.

³⁸ See section C above on progressive realization and resource availability.

90. Recognizing the critical role of effective planning, the Committee on Economic, Social and Cultural Rights designated the preparation of a health “strategy and plan of action” a core obligation arising from the right to the highest attainable standard of health. The Committee also encouraged high-income States to provide international assistance “to enable developing countries to fulfil their core ... obligations”, including the preparation of a health plan.³⁹

According to the Declaration of Alma-Ata: “All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors.”⁴⁰

91. Health planning is complex and many of its elements are important from the perspective of the right to the highest attainable standard of health, including the following.

92. The entire planning process must be as participatory and transparent as possible.

93. It is very important that the health needs of disadvantaged individuals, communities and populations are given due attention. Also, effective measures must be taken to ensure their active and informed participation throughout the planning process. Both the process and plan must be sensitive to cultural difference.

94. Prior to the drafting of the plan, there must be a health situational analysis informed by suitably disaggregated data. The analysis should identify, for example, the characteristics of the population (e.g. birth, death and fertility rates), their health needs (e.g. incidence and prevalence by disease), and the public and private health-related services presently available (e.g. the capacity of different facilities).

95. The right to the highest attainable standard of health encompasses an obligation on the State to generate health research and development that addresses, for example, the health needs of disadvantaged individuals, communities and populations. Health research and development includes classical medical research into drugs, vaccines and diagnostics, as well as operational or implementation research into the social, economic, cultural, political and policy issues that determine access to medical care and the effectiveness of public health interventions. Implementation research, which has an important role to play with a view to dismantling societal obstacles to health interventions and technologies, should be taken into account when drafting the national health plan.

96. The plan must include certain features such as clear objectives and how they are to be achieved, time frames, indicators and benchmarks to measure achievement, effective coordination mechanisms, reporting procedures, a detailed budget that is attached to the plan, financing arrangements (national and international), evaluation arrangements, and one or more accountability devices. In order to complete the plan, there will have to be a process for prioritizing competing health needs.

³⁹ General comment No. 14 (see note 25 above), paragraphs 43-45.

⁴⁰ Paragraph VIII.

97. Before their finalization, key elements of the draft plan must be subject to an impact assessment to ensure that they are likely to be consistent with the State's national and international legal obligations, including those relating to the right to the highest attainable standard of health. For example, if the draft plan proposes the introduction of user fees for health services, it is vital that an impact assessment is undertaken to anticipate the likely impact of user fees on access to health services for those living in poverty. If the assessment confirms that user fees are likely to hinder access, the draft plan must be revised before adoption; otherwise, it is likely to be inconsistent with the State's obligations arising from the right to the highest attainable standard of health.⁴¹

98. Of course, planning is only the means to an end: an effective, integrated health system that is accessible to all. The main task is implementation. Evaluation, monitoring and accountability can help to ensure that all those responsible for implementation discharge their duties as planned, and that any unintended consequences are swiftly identified and addressed.

(b) Monitoring and accountability

99. As already discussed, monitoring and accountability have a crucial role to play in relation to human rights and health systems. Accountability provides individuals and communities with an opportunity to understand how those with responsibilities have discharged their duties. Equally, it provides those with responsibilities the opportunity to explain what they have done and why. Where mistakes have been made, accountability requires redress. But accountability is not a matter of blame and punishment. It is a process that helps to identify what works, so it can be repeated, and what does not, so it can be revised. It is a way of checking that reasonable balances are fairly struck.

100. In the context of health systems, there are many different types of accountability mechanisms, including health commissioners, democratically elected local health councils, public hearings, patients' committees, impact assessments, judicial proceedings, and so on. An institution as complex and important as a health system requires a range of effective, transparent, accessible, independent accountability mechanisms. The media and civil society organizations have a crucial role to play.

101. Accountability in respect of health systems is often extremely weak. Sometimes the same body provides health services, regulates and holds to account. In some cases, accountability is little more than a device to check that health funds were spent as they should have been. Of course, that is important. But human rights accountability is much broader. It is also concerned with ensuring that health systems are improving, and the right to the highest attainable standard of health is being progressively realized, for all, including disadvantaged individuals, communities and populations.

⁴¹ With Gillian MacNaughton, the Special Rapporteur co-authored a report on impact assessments, poverty and the right to the highest attainable standard of health; for an outline see A/62/214 from paragraph 33. The full report is available from the website of Essex University, Human Rights Centre, Right to Health Unit (http://www2.essex.ac.uk/human_rights_centre/rth/projects.shtm).

102. In some States, the private health sector, while playing a very important role, is largely unregulated. Crucially, the requirement of human rights accountability extends to both the public and private health sectors. Additionally, it is not confined to national bodies; it also extends to international actors working on health-related issues.

103. Accountability mechanisms are urgently needed for all those - public, private, national and international - working on health-related issues. The design of appropriate, independent accountability mechanisms demands creativity and imagination. Often associated with accountability, lawyers must be willing to understand the distinctive characteristics and challenges of health systems, and learn from the rich experience of medicine and public health.

104. The issue of accountability gives rise to two related points.

105. First, the right to the highest attainable standard of health should be recognized in national law. This is very important because such recognition gives rise to legal accountability for those with responsibilities for health systems. As is well known, the right is recognized in the Constitution of WHO, as well as the Declaration of Alma-Ata. It is also recognized in numerous binding international human rights treaties, including the Convention on the Rights of the Child, which has been ratified by every State in the world, except for two (the United States of America and Somalia). The right to the highest attainable standard of health is also protected by numerous national constitutions. It should be recognized in the national law of all States.

106. Second, although important, legal recognition of the right to the highest attainable standard of health is usually confined to a very general formulation that does not set out in any detail what is required of those with responsibilities for health. For this reason, a State must not only recognize the right to health in national law but also ensure that there are more detailed provisions clarifying what society expects by way of health-related services and facilities. For example, there will have to be provisions relating to water quality and quantity, blood safety, essential medicines, the quality of medical care, and numerous other issues encompassed by the right to the highest attainable standard of health. Such clarification may be provided by laws, regulations, protocols, guidelines, codes of conduct and so on. WHO has published important standards on a range of health issues. Obviously, clarification is important for providers, so they know what is expected of them. It is also important for those for whom the service or facility is intended, so they know what they can legitimately expect. Once the standards are reasonably clear, it is easier (and fairer) to hold accountable those with responsibilities for their achievement.

3. Conclusion

107. In summary, there is a legal obligation arising from the right to the highest attainable standard of health to ensure that there is an up-to-date development plan for human resources in health; programmes to recruit from disadvantaged populations; an adequate number of domestically trained health workers (subject to progressive realization and resource availability); domestically competitive salaries for health workers; incentives to work in underserved areas; and so on. In the context of health planning, there is a legal obligation to ensure that the process is participatory and transparent; addresses the health needs of disadvantaged individuals,

communities and populations; and includes a situational analysis. Before finalization, key elements of the draft plan must be subject to an impact assessment and the final plan must include certain crucial features.

108. These (and other) features are not just a matter of health good practice, sound management, justice, equity or humanitarianism. They are a matter of international legal obligation. Whether or not the obligations are properly discharged should be subject to review by an appropriate accountability mechanism.

F. The right to health helps to establish a health system in the same way as the right to a fair trial helps to establish a court system

109. How does it help to recognize that the right to the highest attainable standard of health underpins and reinforces the features and measures required to establish an effective, integrated, accessible health system? One way of answering this question is by using the analogy of a court system and the right to a fair trial.

110. Just as every State must have a health system, it must also have an effective court system. The key features of an effective court system include independent, impartial judges. A case must come to trial without undue delay. All parties to a case must be given an opportunity to give their version of events, call witnesses and make a legal argument. In serious cases, an impecunious defendant must be provided with legal aid. In some cases, an interpreter must be provided. The judge must give reasons for his or her decision. There must be an appeal process in case the judge makes a mistake. Usually, the hearing should be in public.

111. The human right to a fair trial requires a court system to have all these features. Significantly, many of these features have major budgetary implications.

112. States have designed a range of mechanisms and measures to ensure that these features of a court system are available in law and fact. For example, judicial independence must be protected by a carefully constructed process of judicial appointment and dismissal and by judges enjoying reasonable terms and conditions of employment.

113. Of course, a State could construct an effective court system without any express reference to the right to a fair trial. Indeed, policymakers in the Ministry of Justice could construct an effective court system without even thinking about human rights. And if they do, so be it. What is important is that there is an effective court system, with the key human rights features, dispensing justice without fear or favour.

114. But the record shows that many court systems do not possess all the key human rights features and do not dispense justice. In practice, some right-to-a-fair-trial features are overlooked or compromised. In this context, human rights play a number of important roles, including the following two.

115. First, the right to a fair trial provides guidance to policymakers in the Ministry of Justice. Human rights law reminds them what are the key features of a court system that must always be respected. Also, if officials in the Ministry of Justice are under political pressure to introduce unfair trials, they can explain that the State has minimum, legally binding, human rights

obligations that cannot be compromised. In this way, human rights discourage backsliding. Sometimes human rights can stop the Government from introducing misconceived reforms to the justice system.

116. Human rights have a second function. Anticipating that policymakers and others sometimes make mistakes, human rights require an effective mechanism to scrutinize important decisions. As already discussed, they require that those responsible be held to account - at the national and international levels - so that if there is an error, it can be identified and corrected. On countless occasions, human rights have been used to challenge policymakers and others about unjust court systems. Crucially, human rights have been used to expose unfair systems of justice - and they have led to welcome reforms.

117. Of course, sometimes human rights law fails and an unfair court system is uncorrected and unreformed. Sometimes policymakers reject the guidance provided by human rights, and accountability mechanisms prove too weak to provide redress. Human rights are only tools - and flawed tools to boot - and do not always work. But sometimes they do. Indeed, human rights have worked on many occasions and helped to establish court systems that are fairer and more just than they would otherwise have been.

118. By analogy, these arguments also apply to a health system.

119. From the perspective of the right to the highest attainable standard of health, as well as health good practices, an effective health system must include a number of features and measures, some of which are signalled in this report. There must be, for example, an up-to-date health plan; outreach programmes for disadvantaged groups; publicly available data that is appropriately disaggregated; a minimum “basket” of health-related services and facilities; an up-to-date, national essential medicines list; meaningful regulation and effective accountability of the public and private health sector; and so on.

120. Of course, it is possible to build a health system that has these features without any express reference to human rights, even without taking human rights into account. But the record shows that very many health systems do not, in fact, have these (and other) features that are required by the right to the highest attainable standard of health, and suggested by health good practices.

121. In this context, the right to the highest attainable standard of health can play a similar role in relation to the health system as the right to a fair trial plays in relation to a court system. The right to health can provide guidance to health policymakers, reminding them what features of a health system must always be respected. If there is national or international pressure to introduce reforms that will hinder access to health services for children or those living in poverty, officials can explain that the State has minimum, legally binding human rights obligations that cannot be compromised in this way.

122. Also, because health policymakers and others sometimes make mistakes, the right to the highest attainable standard of health requires an effective mechanism to review important health-related decisions. Under the right to health, those with responsibilities should be held to account so that misjudgements can be identified and corrected. Accountability can be used to expose problems and identify reforms that will enhance health systems for all.

123. Recent history is littered with misguided reforms that have brought many health systems “to the point of collapse”.⁴² While the right to health is not a panacea, it can help to stop the introduction of such ill-conceived health reforms. Just as the right to a fair trial has been used to strengthen systems of justice, so the right to health can be used to strengthen health systems.

III. CONCLUSIONS

124. **Health systems and human rights is a very large and complex topic. In a report of this length, it is impossible to address all of the important issues, such as the role of the State in relation to the private health sector. Elsewhere, the Special Rapporteur has looked at (and continues to examine) one dimension of this issue: pharmaceutical companies and access to medicines.**⁴³

125. **The report has identified urgently needed research, including detailed studies that consistently and systematically apply the general approach outlined in section C of the present report to all six of the WHO health system “building blocks” signalled in section D above.**

126. **In resolution 60/251, the General Assembly has mandated the Human Rights Council to “promote the effective coordination and the mainstreaming of human rights within the United Nations system”. All those responsible for strengthening health systems should recognize the importance of human rights. Moreover, they should embark on the integration of the right to the highest attainable standard into their work. This applies equally to those focusing on a component of health systems, such as the health workforce.**

127. **Today, there are numerous health movements, perspectives and approaches, including health equity, primary health care, health promotion, social determinants, health security, continuum of care, gender, development, biomedical, macroeconomic and so on. All are very important. The right to the highest attainable standard of health recurs throughout them all. It is the only perspective that is both underpinned by universally recognized moral values and reinforced by legal obligations. Properly understood, the right to the highest attainable standard of health has a profound contribution to make towards building healthy societies and equitable health systems.**

⁴² *Everybody’s Business...* (note 2 above), p. 1.

⁴³ A/61/338.

3. COMMUNITY SYSTEMS STRENGTHENING AND THE GLOBAL FUND

Compilation of selected publications about community systems strengthening and the Global Fund:

8. Global Fund to Fight AIDS, TB and Malaria. September 2008. *Global Fund Fact Sheet Series, 2 of 6: Community systems strengthening*. Geneva, Switzerland.
9. International HIV/AIDS Alliance. 2008. *A framework for analysing and organising data regarding community system strengthening in Round 8*. Brighton, United Kingdom.
10. Global Fund to fight AIDS, TB and Malaria and International HIV/AIDS Alliance. September 2008. *Civil society success on the ground: community systems strengthening and dual-track financing*. Geneva, Switzerland and Brighton, United Kingdom.

**8. GLOBAL FUND TO FIGHT AIDS, TB AND MALARIA.
SEPTEMBER 2008. GLOBAL FUND FACT SHEET SERIES, 2 OF 6:
COMMUNITY SYSTEMS STRENGTHENING. GENEVA,
SWITZERLAND.**

[http://www.theglobalfund.org/documents/rounds/9/CP_Pol_R9_FactSheet_2_CommunitySystems_en.pdf]

'Community systems strengthening' (CSS) refers to initiatives that contribute to the development and/or strengthening of community-based organizations in order to improve knowledge of, and access to, improved health service delivery. The mounting scale of HIV, TB and malaria, and the more recent availability of significant financial resources to respond to these diseases, has increased pressure on national systems to scale-up and improve the quality of implementation efforts. Scaling up the response to the three diseases will not be successful without strengthened community systems. The Global Fund encourages applicants to include measures to strengthen community systems relevant to in-country contexts on a routine basis in proposals for new and continuing funding. This factsheet provides a basic overview of community systems strengthening, its importance, and how to incorporate CSS into Global Fund proposals.

Fact Sheet: Community Systems Strengthening

A. What is community systems strengthening?

Community systems strengthening refers to initiatives that contribute to the development and/or strengthening of community-based organizations in order to improve knowledge of, and access to improved health service delivery. Specifically in the context of applications to the Global Fund, community systems strengthening initiatives are encouraged to achieve improved outcomes for HIV, tuberculosis and malaria prevention, treatment, and care and support programs.

Community systems strengthening areas of activity may include a focus on:

- **Building capacity** of the core processes of community-based organizations to provide an increased range, or quality of services, through, for example:
 - > Physical infrastructure development, including obtaining and retaining office space, holding bank accounts, and improving communications technology
 - > Organizational systems development, including improvements in the financial management of community-based organizations, and the development of strategic planning, monitoring and evaluation, and information management capacities
- **Building partnerships** at the local level to improve coordination, enhance impact, and avoid duplication of service delivery.
- **Sustainable financing**, including a focus on supporting initiatives to plan for and achieve predictability of resources over a longer period of time with which to work for improved impact and outcomes for the disease(s).

B. Why is community systems strengthening important?

The mounting scale of the three epidemics of HIV, tuberculosis and malaria, and the more recent availability of significant financial resources to respond to the diseases, has increased pressure on national systems to scale-up and improve the quality of implementation efforts. Scaling up the response to the three diseases will not be successful without strengthened community systems.

Contributing to ensuring a broader, multi-sectoral approach to national HIV, tuberculosis, and malaria program implementation, an increasing number of community based organizations have evolved to fill service delivery gaps at the community level. However, many of the emerging community based organizations are located in rural or remote areas, operate with limited human resources, and are often staffed by volunteers. Many also lack sufficient experience and systems to access resources that could strengthen their underlying management systems, thereby improving their operational and implementation effectiveness in service delivery for (and beyond) the three diseases.

The Global Fund recognizes that the presence of strong, sustainable community-based organizations is an important element of ensuring program impact, sustainability, and results for HIV, tuberculosis, and malaria prevention, treatment, and care and support efforts.

Whilst recognizing the important role of government and quasi-government community-based organizations in service delivery, community systems strengthening initiatives are of particular importance to the full range of non-government organizations that support and/or extend service delivery to, especially, *key affected populations*¹, including people who may not be visible to existing service access points due to geographic, social or other factors. Community systems strengthening initiatives may therefore be required to support the work of a broad range of non-governmental organizations, including home-based care organizations; support organizations for people living with and/or affected by the diseases; faith-based organizations, women's organizations, youth organizations, and community centers, and private sector organizations.

C. Incorporating community systems strengthening into Global Fund proposals

The Global Fund supports community systems strengthening initiatives as part of the overall framework for improving health outcomes for HIV, tuberculosis and malaria. The Global Fund encourages applicants to include measures to strengthen community systems relevant to in-country contexts on a routine basis in proposals for new and continuing funding.

Applicants are encouraged to consider community systems strengthening needs in:

- Their assessment of disease programs and health system weaknesses and gaps, to ensure that identification of program needs considers the community systems that are necessary to improve the scope and quality of service delivery, particularly to those without current access; and
- The overall program implementation strategy, including strengthening of sub-recipient or other implementing partner systems and capacities to improve the quality and sustainability of services delivered throughout the community.

How community systems strengthening initiatives may support efforts to ensure a gender sensitive approach to service delivery and overall program implementation in the context of Global Fund proposals is also encouraged through reference to the Global Fund's Fact Sheets entitled 'Ensuring a Gender Sensitive Response' and 'Sexual Minorities in the context of HIV epidemics' available through the Global Fund's website.

The Global Fund's revised Guidelines for Proposals include a non-exhaustive reference to areas of work that may be supported by the Global Fund to improve access to and/or the quality of services, such as:

- Initiatives to improve community-based program implementation and service delivery, including strengthening core institutional capacity through physical infrastructure development, and organizational and systems strengthening; and
- Partnership building at the community level, focusing on the building of systematized relationships among and between community-based organizations to improve coordination.

Where the planned initiatives benefit more than one of the three diseases supported by the Global Fund, it may be appropriate to apply for community systems strengthening through an approach that cuts across the three diseases. Information on this possibility is provided in the Guidelines for Proposals, within the description of 'health systems cross-cutting interventions'.

¹ The Global Fund adopts the UNAIDS definition of *key affected populations*.

9. INTERNATIONAL HIV/AIDS ALLIANCE. 2008. A FRAMEWORK FOR ANALYSING AND ORGANISING DATA REGARDING COMMUNITY SYSTEM STRENGTHENING IN ROUND 8. BRIGHTON, UNITED KINGDOM.

This framework aims to help with assessing community systems strengthening (CSS) needs and organizing data and costs for integrating CSS into proposals. The Global Fund has given a broad description of CSS and this framework provides focus for consultation and planning by proposing further details of core processes that may be considered for strengthening.

A framework for analysing and organising data regarding community system strengthening in Round 8

Overview

The framework aims to help with assessing community systems strengthening needs and organizing data and costs for integration into Round 8 proposal development. It is based on existing Global Fund and other tools for assessing and planning capacity building with civil society organisations (CSOs).

The framework is in 4 parts: 1) gap analysis; 2) prioritization; 3) objective setting; 4) operational planning

The Global Fund has provided a broad description of CSS and this framework aims to provide a focus for consultation and planning by proposing more details of the core processes that may be considered for strengthening. These core processes may be defined in different ways with regard to different types of organizations and different roles that they may play in Global Fund grant management and implementation. The framework may therefore be adapted as necessary. However, it will be important to maintain focus during consultations as time is short and where there are so many actors involved in such a broad area of CSS there is a real risk of losing track of the purpose of the exercise. The framework provides a structure for facilitating consultations and organising findings.

CSS in the Round 8 proposal form

It is important to read the Global Fund guidelines regarding CSS to better understand what to write about CSS and where to include CSS analysis and planning in the form. It is also important to read the Global Fund fact sheet on CSS. The relevant excerpt of the guidelines is annexed to this document.

Note that support for community systems strengthening initiatives may be requested either through a disease-specific approach (e.g., included in s.4.5.1.) OR where appropriate to the weaknesses and gaps identified a proposal may include initiatives for community systems strengthening within the framework of the HSS cross-cutting interventions optional additional section (s.4B).

There is no single section of the proposal that addresses CSS. It is therefore important to build and follow the logic of what is being proposed for CSS by considering what should be included about CSS in each section of the proposal. It is advisable to ensure that CSS is mentioned to a greater or lesser extent in all relevant sections. The main sections to consider are:

Section 4.3 – Major constraints and gaps

- sections 4.3.2 and 4.3.3 provides an opportunity to make the link between the health system and CSS

Section 4.4 – Round 8 priorities

- gaps in the coverage of CSS activities can be mentioned here

Section 4.5 – Implementation strategy

- CSS-related goals, impact/outcome indicators and objectives should be included in section 4.5.1
- lessons learned from implementation experience related to CSS should be included in section 4.5.3
- CSS-related strategies and plans to enhance social and gender equality should be included in section 4.5.4
- Plans for partnerships with the private sector regarding CSS should be included in section 4.6.3

Section 4.7 – Program sustainability

- CSS is mentioned explicitly under section 4.7.1, Strengthening capacity and processes to achieve improved HIV outcomes – it is very important to describe clearly how investment in CSS will contribute to improved HIV outcomes
- Section 4.8 – Measuring impact
- CSS plans to strengthen monitoring and evaluation systems should be included in section 4.8.3

Section 4.9 – Implementation capacity

- CSS strategies and plans for improving coordination between implementers and for strengthening implementation capacity should be included in sections 4.9.5 and 4.9.6

Section 5 – Funding request

- Gaps in CSS funding should be included in section 5.1 and details of CSS budgeting in 5.2 (note that sub-sub-recipients' budgets are mentioned explicitly in the form)
- When organizing the costs of CSS activities, take note of the 13 GF Round 8 cost categories that are most relevant to each activity (these categories are annexed to this document)

Step 1: Gap analysis

CSS areas	Core processes	Key capacities/skills/processes to consider	Main gaps
Capacity building	Governance, leadership and strategy	Clarity of mission and strategic planning Effective organizational governance and leadership Clarity of structure and responsibilities, transparent decision making, and internal accountability systems	
	Financial management and systems	Recording transactions and balances Disbursing funds to sub-recipients and suppliers in a timely, transparent and accountable manner ¹ Maintaining an adequate internal control system Supporting the preparation of regular reliable financial statements including for internal management purposes Safeguarding organisational assets	
	Programme management and arrangements	Legal status and authority to enter into agreements ² Project cycle management, work planning, internal reporting and coordination Adequate HIV/AIDS and cross functional expertise (e.g. project cycle management, finance, procurement, legal, M&E) Effective systems for undertaking assessments of implementing partners, planning, delivery/management and monitoring of technical support for capacity building of implementing partners	
	Monitoring and evaluation	Collecting and recording programmatic data with appropriate indicators and quality control measures Preparing regular reliable programmatic reports Making data available for the purpose of internal programme management, evaluations and other studies	

¹ The relevance of this process depends on the type of organisation, e.g. is relevant to a lead SR working with SSRs

² This may not be relevant to all organisations, e.g. grassroots self-help groups

Step 1: Gap analysis contd.

CSS areas	Core processes	Key capacities/skills/processes to consider	Main gaps
Capacity building contd.	Human and material resources	Adequate staffing for leadership, management, administration, implementation and technical support Systems for human resources (staff and volunteers) development management and motivation including access to knowledge and skills in HIV programming, technical support and grant management (training, exchange, mentoring etc.) Adequate infrastructure and information systems to support implementation including logistics and administration	
Building partnerships	Networking & advocacy	Awareness and working relationships with others Research, documentation, and external communication Consultation with partners/stakeholders, synthesis and representation of information and interests, accountability and feedback	
	Collaboration with health system entities ³	Degree of meaningful engagement with relevant local and national health systems entities – to contribute to policy and planning, and improve access, uptake and quality of services ⁴	
	Coordination	Degree of meaningful engagement with local and national coordinating bodies – to contribute to planning, assessment, programme design and oversight, referral, resource allocation, and decision making	
Sustainable financing	Planning for financial requirements	Costed strategic and annual plans (budgeting) Resource mobilisation strategy and plans, diversifying funding bases, income generation Financial risk identification and management	
	Institutional relations	Strategic partner identification and mobilisation Development and maintenance of donor relations Donor and other partner reporting	

³ Entity = policy and planning authorities and service providers

⁴ Particularly with key affected populations - UNAIDS defines affected populations as follows: women and girls, youth, men who have sex with men (MSM), injecting and other drug users, sex workers, people living in poverty, prisoners, migrant laborers, people in conflict and post-conflict situations, refugees and internally displaced persons. This definition relates, in principle, to vulnerable groups affected by HIV and AIDS but may be extended to tuberculosis and malaria, whereby youths, particularly infants, migrants and people living in poverty are considerably susceptible to the two diseases, whether directly or indirectly.

Step 2: Prioritisation

CSS areas	Core processes	Main constraints and gaps	Priorities
Capacity building	Governance, leadership and strategy	... From step 1...	... to identify...
	Financial management and systems		
	Programme management and arrangements		
	Monitoring and evaluation		
	Human and material resources		
Building partnerships	Networking & advocacy		
	Collaboration with health system entities ⁵		
	Coordination		
Sustainable financing	Planning for financial requirements		
	Institutional relations		

⁵ Entity = policy and planning authorities and service providers

Step 3: Objective setting

CSS areas	Core processes	Priorities	Objectives
Capacity building	Governance, leadership and strategy	... From step 2...	... to identify...
	Financial management and systems		
	Programme management and arrangements		
	Monitoring and evaluation		
	Human and material resources		
Building partnerships	Networking & advocacy		
	Collaboration with health system entities ⁶		
	Coordination		
Sustainable financing	Planning for financial requirements		
	Institutional relations		

⁶ Entity = policy and planning authorities and service providers

Step 4: Operational planning

CSS areas	Core processes	Objectives	Activities	Indicator targets	Lead organisation	Budget
Capacity building	Governance, leadership and strategy	... from step 3...	... to identify...	... to identify...	... to identify...	... to calculate...
	Financial management and systems					Refer to R8 cost categories
	Programme management and arrangements					
	Monitoring and evaluation					
	Human and material resources					
Building partnerships	Networking & advocacy					
	Collaboration with health system entities ⁷					
	Coordination					
Sustainable financing	Planning for financial requirements					
	Institutional relations					

⁷ Entity = policy and planning authorities and service providers

Annex 1: Excerpt of the Round 8 guidelines on CSS (see section 4.7.1)

The Global Fund recognizes that strong service delivery is required throughout the health system to have an impact on the three diseases.

This question therefore seeks information on how the activities/interventions to be undertaken strengthen overall service delivery. (*s.4.9.6. asks specifically what management and technical assistance is requested during the proposal term to support implementation*).

When responding to this question, applicants should not limit their responses to the government sector. Rather, focus should also be given to the capacity strengthening of the private sector and/or the broad range of non-government sectors referred to in other parts of these Guidelines.

In particular, applicants are encouraged to include *community systems strengthening* activities/interventions in their proposals where the planned activities/interventions respond to weaknesses and gaps that have been identified as barriers to increasing demand for, and access to, services at the local level for *key affected populations* (including women and girls), sexual minorities, and people who are not covered with services due to stigma, discrimination and other social factors.

Community systems strengthening initiatives may include (but are not limited to):

- **Capacity building** of the core processes of community based organizations (CBOs) through: *physical infrastructure development* - including obtaining and retaining office space, holding bank accounts, strengthening communications technology; or *organizational systems development* - including improvements in the financial management of CBOs (and identification and planning for recurrent costs); development of strategic planning, M&E, and information management capacities;
- **Systematic partnership building** at the local level to improve coordination, enhance impact, avoid duplication, build upon one another's skills and abilities and to maximize service delivery coverage for the three diseases; and/or
- **Sustainable financing**: creating an environment for more predictable resources over a longer period of time with

provided that the support requested is demonstrated to be linked to improved service delivery and outcomes for the three diseases.

Support for community systems strengthening initiatives may be requested through a disease-specific approach (e.g., included in s.4.5.1.). In addition, where appropriate to the weaknesses and gaps identified in s.4.3., a proposal may include initiatives for community systems strengthening within the framework of the HSS cross-cutting interventions optional additional section (s.4B). Refer back to the community systems strengthening fact sheet in Part A1 of these Guidelines.

As explained in s.4.5. of these Guidelines, applicants who believe it appropriate to their in-country setting, may apply for funding for 'HSS cross-cutting interventions' in a distinct section in one disease, where the interventions benefit more than one of the three diseases. (Refer to the Board's decision entitled, 'Global Fund's strategic approach to health systems strengthening', GF/B16/10).

Additional Guidance from Aidspace

Section 4.7.1 is asking you to describe how the activities included in this proposal will contribute to strengthening the government and non-government sectors. It is a general question, related to the broad range of initiatives in the proposal. Later, in [Section 4.9.6](#), you will have an opportunity to describe what management and technical assistance activities have been included in the proposal.

In its guidance above, the Global Fund describes the types of community systems strengthening activities that can be included in your proposals. An increased emphasis on community systems strengthening is one of the new features of Round 8 (see "[Community Systems Strengthening](#)" in Chapter 2: What's New for Round 8). Applicants should therefore read the guidance provided above **before** designing their implementation strategy for this proposal.

Annex 2: Round 8 cost categories

Activities identified for strengthening community systems will vary with regard to which GF cost category to use. For example, the costs of a 'home-based care' intervention may be broken down into the following activities and cost categories:

Description	Cost Category for table 5.4
<i>Community-based agents</i>	<i>Human Resources</i>
<i>Travel to communities</i>	<i>Planning and Administration</i>
<i>Testing kits</i>	<i>Health Products and Health Equipment</i>
<i>Provision of medicines for treatment</i>	<i>Pharmaceutical Products (Medicines)</i>
<i>Vehicle for agent</i>	<i>Infrastructure and Other Equipment</i>

Round 8 Cost Categories:

	Category	Expenditure examples
1	Human Resources	Salaries, wages and related costs (pensions, incentives and other employee benefits, etc.) relating to all employees (including field personnel), and employee recruitment costs.
2	Technical and Management Assistance	Costs of all consultants (short or long term) providing technical or management assistance, including consulting fees, travel and per-diems, field visits and other costs relating to program planning, supervision and administration (including in respect of managing sub-recipient relationships, monitoring and evaluation, and procurement and supply management).
3	Training	Workshops, meetings, training publications, training-related travel, including training per-diems. <i>Do not include employee training-related human resources costs that should be included under the Human Resources category).</i>
4	Health Products & Health Equipment	Health products such as bed nets, condoms, lubricants, diagnostics, reagents, test kits, syringes, spraying materials and other consumables. Health equipment such as microscopes, x-ray machines and testing machines (including the 'Total Cost of Ownership' of this equipment such as reagents, and maintenance costs). (Total cost of ownership' includes the cost of reagents and other consumables, and annual maintenance to ensure that the equipment operates effectively.) <i>Do not include other types of non-health equipment, as these costs should be included under the Infrastructure and Other Equipment category below.</i>
5	Pharmaceutical products (<i>medicines</i>)	Cost of antiretroviral therapy, medicines for opportunistic infections, anti-tuberculosis medicines, anti-malarial medicines, and other medicines. <i>Do not include insurance, transportation, storage, distribution or other like costs. These costs should be included in Procurement and Supply Management costs below.</i>
6	Procurement & Supply Management costs	Transportation costs for all purchases (equipment, commodities, products, medicines) including packaging, shipping and handling. Warehouse, PSM office facilities, and other logistics requirements. Procurement agent fees. Costs for quality assurance (including laboratory testing of samples), and any other costs associated with the purchase, storage and delivery of items. <i>Do not include staff,</i>

	Category	Expenditure examples
		<i>management or technical assistance, IT systems, health products or health equipment costs, as these costs should be included in the categories above.</i>
7	Infrastructure and Other Equipment	This includes health infrastructure rehabilitation and renovation and enhancement costs, non-health equipment such as generators and beds, information technology (IT) systems and software, website creation and development. Office equipment, furniture, audiovisual equipment, vehicles, motorcycles, bicycles, related maintenance, spare parts and repair costs.
8	Communication materials	Printed material and communication costs associated with program-related campaigns, TV spots, radio programs, advertising, media events, education, dissemination, promotion, promotional items.
9	Monitoring & Evaluation	Data collection, surveys, research, analysis, travel, field supervision visits, and any other costs associated with monitoring and evaluation. <i>Do not include personnel, management or technical assistance or IT systems costs, as these costs should be included in the categories above.</i>
10	Living support to clients/target populations	Monetary or in-kind support given to clients and patients E.g.: school fees for orphans, assistance to foster families, transport allowances, patient incentives, grants for revenue-generating activities, food and care packages, costs associated with supporting patients charters for care.
11	Planning and Administration <i>Do not include CCM support costs in the Round 8 proposal**</i>	Office supplies, travel, field visits and other costs relating to program planning and administration (including in respect of managing sub-recipient relationships). Legal, translation, accounting and auditing costs, bank charges etc. Green Light Committee contributions (refer to s.4.10.7). <i>Do not include human resources costs here - they should be included under the Human Resources category above.</i>
12	Overheads <i>Do not include CCM support costs in the Round 8 proposal**</i>	Overhead costs such as office rent, utilities, internal communication costs (mail, telephone, internet), insurance, fuel, security, cleaning. Management or overhead fees.
13	Other <i>Do not include CCM support costs in the Round 8 proposal**</i>	Significant costs which do not fall under the above-defined categories. Specify clearly the type of cost. Applicants are able to add additional rows to this table should there be other national budget cost categories that are not covered by the above categories.

** Commencing from November 2007, CCM (and Sub-CCM) support costs are provided through a separate budget from the Secretariat, and not through grant funds. Applications for this support are made through a separate form, and subject to review, those costs will be provided through a separate Secretariat budget. Information on those costs is available at: <http://www.theglobalfund.org/en/apply/call8>

10. GLOBAL FUND TO FIGHT AIDS, TB AND MALARIA AND INTERNATIONAL HIV/AIDS ALLIANCE. SEPTEMBER 2008. CIVIL SOCIETY SUCCESS ON THE GROUND: COMMUNITY SYSTEMS STRENGTHENING AND DUAL-TRACK FINANCING. GENEVA, SWITZERLAND AND BRIGHTON, UNITED KINGDOM.

[http://www.aidsalliance.org/custom_asp/publications/view.asp?publication_id=326]

This report aims to increase understanding of the range of ways in which the Global Fund can support – and has supported – civil society activities, including those of community-based organizations. To outline the many different models of community systems strengthening, this report includes case studies from civil society organizations in Cambodia, India, Mongolia, Peru, Senegal, Somalia, Thailand, Ukraine and Zambia. All nine case studies examine HIV grants, but the examples are also illustrative of tuberculosis and malaria grants. The report also illustrates a range of examples of dual track financing, and addresses topics including civil society activities to integrate HIV services with sexual and reproductive health services.



CIVIL SOCIETY SUCCESS ON THE GROUND

Community
Systems
Strengthening
and Dual-track
Financing:
Nine Illustrative
Case Studies



Investing in our future

The Global Fund
To Fight AIDS, Tuberculosis and Malaria

International
HRV/AIDS

Alliance

List of Terms & Abbreviations

Alliance	International HIV/AIDS Alliance
ACER	ART Community Education and Referral (Zambia)
ANCS	Alliance Nationale Contre le SIDA (Senegal)
ART	antiretroviral treatment
CBO	community-based organization
CCM	Country Coordinating Mechanism
CHAZ	Churches Health Association of Zambia
CISS	Coordination of International Support to Somalis
CSS	community systems strengthening
IDU	injecting drug user
DFID	Department for International Development (UK)
DTF	dual-track financing
HCT	home-care team
HSS	health systems strengthening
ICP	Integrated Care and Prevention Program (Cambodia)
IDU	injecting drug user
IEC	information/education/communication
JICA	Japan International Cooperation Agency
KHANA	Khmer HIV/AIDS NGO Alliance
LGBT	lesbian/gay/bisexual/transgender
M&E	monitoring and evaluation
MSM	men who have sex with men
NAF	National AIDS Foundation (Mongolia)
NGO	nongovernmental organization
OI	opportunistic infections
OVC	orphans and vulnerable children
PEPFAR	President's Emergency Plan for AIDS Relief (U.S.)
PLWHA	people living with HIV/AIDS
PMTCT	prevention of mother-to-child transmission
PR	Principal Recipient
STI	sexually-transmitted infection
TB	tuberculosis
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VCT	voluntary counseling and testing
ZNAN	Zambia National AIDS Network

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THE GLOBAL FUND ENCOURAGES PROPOSALS DESIGNED TO REACH KEY AFFECTED POPULATIONS WHO OFTEN DON'T HAVE A STRONG VOICE, SUCH AS WOMEN, YOUNG GIRLS AND SEXUAL MINORITIES.

About This Publication



PROGRAMS TO COMBAT MALARIA AIM TO SAVE THE LIVES OF THOSE MOST VULNERABLE, PARTICULARLY CHILDREN UNDER FIVE AND PREGNANT WOMEN, WHOSE BODIES ARE UNABLE TO EFFECTIVELY FIGHT THE DISEASE.

Many would recognize that the Global Fund to Fight AIDS, Tuberculosis and Malaria is a continually developing institution, evolving as a result of feedback from its key stakeholders. The organization's eighth funding round, launched in March 2008, and its impending Round 9 to be launched in October 2008 represent the culmination of a number of mechanisms to harness and enhance the role of civil society in the implementation of Global Fund grants. This publication has been designed to serve as a tool to support countries in understanding these mechanisms and what they mean practically at country level, including the types and kinds of partnerships as well as the possible interventions the Global Fund supports.

Through the use of country-level case studies, the publication highlights examples of substantial civil society involvement in all aspects of Global Fund processes from grant management to service delivery. The case studies are not intended to provide in-depth, step-by-step guidelines for interested organizations and stakeholders. Instead, they aim solely to show the range of innovative options that many civil society groups have already identified and implemented within their specific contexts.

This publication was coordinated jointly by the International HIV/AIDS Alliance and the Global Fund. The Open Society Institute provided financial support. Of the nine case studies, five (Cambodia, India, Mongolia, Senegal and Ukraine) focus specifically on the involvement of Alliance linking organizations in those countries. The other four (Peru, Somalia, Thailand and Zambia) consider civil society engagement as it would pertain to management and oversight of existing Global Fund grants.

Although these nine case studies examine grants for HIV/AIDS programs, the guidelines and policies discussed are applicable across the three diseases.

Introduction

1 The Global Fund has adopted the United Nations definition of civil society: “The associations of citizens (outside their families, friends and businesses) entered into voluntarily to advance their interests, ideas and ideologies. The term does not include profit making activity (the private sector) or governing (the public sector). Of particular relevance to the United Nations are mass organizations (such as organizations of peasants, women or retired people), trade unions, professional associations, social movements, indigenous people’s organizations, religious and spiritual organizations and academic and public benefit nongovernmental organizations.”

Civil society¹ has been an important and vital partner to the Global Fund since the financing mechanism was first conceived. Civil society organizations contributed to the design and structure of the Global Fund, and subsequently they have encouraged governments to commit more resources to support its work.

Civil society has not just been an advocate for the Global Fund; it has also played an essential role in the oversight and implementation of Global Fund grants. A look at one key indicator demonstrates the strong role of this sector in implementation. As calculated by the Global Fund, year-end figures from 2006 show that 83 percent of programs with civil society Principal Recipients (PRs) received one of the two highest ratings (“A” or “B1”). Only two percent of such programs received a “C” rating, a lower proportion than programs without civil society PRs.

These results highlight the impact and importance of having civil society implementers. Moreover, they have achieved these successes through several different and innovative models. Some have implemented alongside governments in a mechanism now known as dual-track financing (DTF), under which the Global Fund strongly encourages countries to nominate at least one government and one non-government PR to lead program implementation. (Additional details about DTF may be found in the Glossary of Key Terms section.) Other examples of civil society engagement have included multiple-PR models (with more than one civil society PR), which is a form of DTF, and where civil society has acted as the sole PR. At least one of each of the above-mentioned PR models involving civil society is discussed in the case studies that follow.

It is not just as implementers that civil society has a major impact. Nongovernmental organizations (NGOs) regularly serve as sub-recipients and (where they exist) sub-sub-recipients. Experience indicates that local NGOs are especially effective in reaching those in need when it comes to actual hands-on service delivery. That is because many of them not only serve the community, but actually reflect the community too. Networks of people living with HIV/AIDS (PLWHA) are assuming key roles in treatment literacy and adherence, as well as continuing valuable and essential support for education and prevention initiatives. These networks fill an invaluable void in ensuring that social support and care interventions are effective and stretch to hard-to-reach communities, in particular vulnerable and marginalized populations.

Such local groups and networks are often small and lack the capacity to deliver the quantity and quality of services needed, especially as programs are scaled up. The Global Fund's response is to support smaller implementing organizations to help them become stronger and more effective implementers, not just in the short term but over the long term too. To fulfill this goal, the Global Fund encourages the Country Coordinating Mechanism (CCM) members to identify national gaps and constraints to scale-up within the context of developing the capacities of community-based organizations (CBOs). These interventions, known as community systems strengthening (CSS), are increasingly becoming a core part of the Global Fund's preferred strategy across its programs. More and more civil society groups are receiving not only financial support but also crucial technical support in areas including accounting and monitoring and evaluation (M&E). Such CSS activities are vital for the long-term sustainability of organizations providing essential prevention, treatment and care services.

In April 2007, the Board developed the following decision point to ensure that the role of civil society and the private sector in the work of the Global Fund is maximized:

“The Board believes that civil society and the private sector can, and should, play a critical role at all levels of the architecture and within every step of the processes of the Global Fund, at both the institutional and the country levels. This includes their critical roles in the development of policy and strategy, and in resource mobilization at the Global Fund Board level, and in the development of proposals and the implementation and oversight of grants at the country level. The Board further expresses its desire for strengthened and scaled-up civil society and private sector involvement at both the country and Board levels, while recognizing the respective strengths and roles of the two sectors.”

As noted previously and in the case studies that follow, the Global Fund has and will continue to support measures in proposals that are designed to increase civil society engagement and participation. The Global Fund is committed to doing so at all levels of its architecture, from being a member of a country CCM to supporting proposal development to directly servicing grant implementation. However, despite the strong leadership from the Global Fund to support the role of civil society stakeholders, not all governments recognize the valuable support civil society can bring to scale-up. Stakeholders, including governments, may not know how to reach out to or include civil society organizations or, in many cases, may be reluctant to include them due to the often wary or critical nature of the government-civil society interface.

In many countries, government reluctance to work with civil society has been a significant barrier to the effective design of proposals and, equally, to the managing of bottlenecks and challenges in grants. However, even those barriers are less significant overall than the lack of knowledge and awareness among civil society, particularly at the local level, of the possibilities available for support, funding and participation through the Global Fund. Civil society groups with the appropriate information and support can point to the clear Global Fund guidelines regarding the increased direct engagement of civil society.

For example, it is important for all members of a CCM – including civil society – to understand the call for Global Fund proposals, both in terms of the type of funding and the mechanism for approving funding. One particularly common occurrence is that CCM members believe there are funding ceilings applicable to each country, and thus the CCM designs and submits a less ambitious country proposal. By acting so cautiously, a CCM can seriously limit the amount of assistance that could theoretically be available to civil society partners (especially service deliverers) and people in need. However, according to the Global Fund Secretariat there are i) no funding ceilings and ii) the Secretariat is often disappointed by the size and ambitiousness of applications.

Ultimately, the responsibility for increasing civil society engagement lies within civil society itself. For example, if NGOs in some countries are not ready to serve as PRs, then they can work with CCMs to apply for increased funding for CSS to strengthen their capacities in the medium term. This will enable them to become stronger sub-recipients, and eventually capable PRs of Global Fund resources.

The case studies in this publication aim to increase awareness of the areas where civil society can engage across Global Fund processes. Each context is different, so countries must determine the most suitable solution for their national context. However, the relatively wide range of models is likely to offer something for all potentially interested stakeholders.

As civil society continues to engage in Global Fund processes – including proposal development and grant implementation – other stakeholders, including governments, will increasingly come to recognize the comparative advantage these organizations bring, in particular to reaching vulnerable and marginalized populations. The Global Fund can offer this leadership; however, it is also important for civil society organizations to coordinate and develop networks to increase their representation within these processes. The strength of the relationships they have with their governments will not be an organic process in every setting, and in some contexts will require time to nurture. These funding opportunities for civil society represent key opportunities to strengthen these relationships as well as to pave the path for sustainable responses to AIDS, TB and malaria in the long term.

Glossary of Key Terms

This section includes detailed descriptions and explanations of some of the major concepts and terms discussed in the case studies. Readers who are not familiar with the Global Fund or its recent policy decisions are recommended to review this section prior to reading the case studies.

COMMUNITY SYSTEMS STRENGTHENING

Community systems strengthening (CSS) refers to the provision of financial, technical and other kinds of support to organizations and agencies that work directly with and in communities. From the Global Fund's perspective, most entities in need of such support are local NGOs that comprise and/or provide services to people living with HIV/AIDS (PLWHA), TB or malaria, members of vulnerable populations and individuals who otherwise have sub-standard access to vital health services. Both civil society and government can and do provide CSS currently in Global Fund grants.

CSS has been an element of most grant programs over the first seven rounds. It is only recently, however, that the Global Fund Secretariat and Board have signaled how and why it should be a priority across all disease components. In particular, the Board now recommends "the routine inclusion, in proposals for Global Fund financing, of requests for funding of relevant measures to strengthen community systems necessary for the effective implementation of Global Fund grants." Applicants are therefore specifically encouraged to include CSS activities in their proposals where these interventions support increased demand for and access to service delivery at the local level for "key affected populations" - including women and girls, sexual minorities and people who are not reached with services due to stigma, discrimination and other social factors.

The Global Fund has identified three interconnected areas of need that can be addressed as part of efforts to strengthen community organization responses to HIV/AIDS: predictable financing, training and capacity building and coordination, alignment and advocacy. As specified in the Global Fund's Round 8 Guidelines, released in March 2008, CSS initiatives may include (but are not limited to):

- > **Capacity building of the core processes of CBOs through:**
 - > physical infrastructure development - including obtaining and retaining office space, holding bank accounts, strengthening communications technology; or
 - > organizational systems development - including improvement in the financial management of CBOs (and identification and planning for recurrent costs); development of strategic planning, M&E, and information management capacities;
- > **Systematic partnership building at the local level to improve coordination, enhance impact, avoid duplication, build upon one another's skills and abilities and maximize service delivery coverage for the three diseases; and/or**
- > **Sustainable financing: creating an environment for more predictable resources over a longer period of time with which to work.**

The Global Fund's final stipulation was that inclusion of such initiatives is appropriate "provided that the support requested is demonstrated to be linked to improved service delivery and outcomes for the three diseases."

DUAL-TRACK FINANCING

At its Fifteenth Meeting in 2007, the Global Fund Board approved a set of measures under the heading of "Strengthening the Role of Civil Society and the Private Sector in the Global Fund's Work." As part of this decision, the Board approved the recommended, routine use of **dual-track financing (DTF)**, whereby both government and non-government PRs are included in proposals to the Global Fund. The new guidelines are not a requirement. However, they do include the following caveat: "If a proposal does not include both government and non-government PRs, it should contain an explanation of the reason for this."

According to the Board's decision, the "possible benefits of DTF" include:

- > increased absorption capacity (from taking full advantage of implementation capacity of all domestic sectors, both governmental and non-governmental);
- > accelerated implementation and performance of grants; and
- > the strengthening of weaker sectors.

PRINCIPAL RECIPIENT

The term **Principal Recipient (PR)** means principal implementer/manager of program interventions. The PR is responsible to the Global Fund for reporting on programmatic and financial performance during the program term. In country, the role is to oversee and ensure timely, outcome-focused service delivery by other key implementing partners under the Global Fund grant.

SUB-RECIPIENT

Sub-recipients are program implementers that deliver services under the leadership and management of the PR. Sub-recipients have a direct contractual relationship with the PR and can be selected from a broad range of possible implementing partners, including:

- > NGOs and CBOs
- > networks of PLWHA
- > the private sector
- > faith-based organizations (FBOs)
- > academic/educational institutions
- > government (including ministries of health, as well as other ministries involved in a multisectoral response to the diseases, such as education, agriculture, youth, women's affairs, information, etc.); and
- > multi-/bilateral development partners (but ideally only where no national recipient is available).

SEXUAL AND REPRODUCTIVE HEALTH INTEGRATION

In the context of the Global Fund, **sexual and reproductive health integration** usually refers to efforts to more fully coordinate and integrate reproductive health and HIV/AIDS services. Many grant implementers already consider this a priority when soliciting proposals and selecting sub-grantees. However, it is only in the past couple of years that the Global Fund Board has taken steps that greatly increase the ability and inclination of CCMs to submit proposals that specifically outline sexual and reproductive health integration strategies. The most important are the following:

- > **The passage of a gender decision point, which places gender as a high priority for efforts to address HIV/AIDS, tuberculosis and malaria. It defines gender broadly to include not only women and girls but also sexual minorities, including people who identify as male, female, and transgender.**
- > **A heightened recognition of the importance of funding health systems strengthening (HSS) initiatives. The primary principle of HSS is that activities should have a positive impact on the entire health system. Under Global Fund guidelines, such activities may relate specifically to any one of the three diseases - and if so, they should be included within the disease component under which a proposal is submitted. If, however, the activities are not specific to one of the diseases but are likely to benefit more than one, then they may also be included in a proposal as a separate cross-cutting initiative.**
- > **Stronger efforts to push CCMs to include more members of vulnerable groups and to guarantee that they can participate meaningfully.**

Cambodia

KEY ELEMENTS OF CIVIL SOCIETY ENGAGEMENT

- > community systems strengthening
- > care and support
- > prevention programs for vulnerable populations

ORGANIZATION INVOLVED

Khmer HIV/AIDS NGO Alliance

COUNTRY BACKGROUND

POPULATION

14 million

INCOME LEVEL CLASSIFICATION

Low income (as per latest World Bank data)

ADULT HIV PREVALENCE

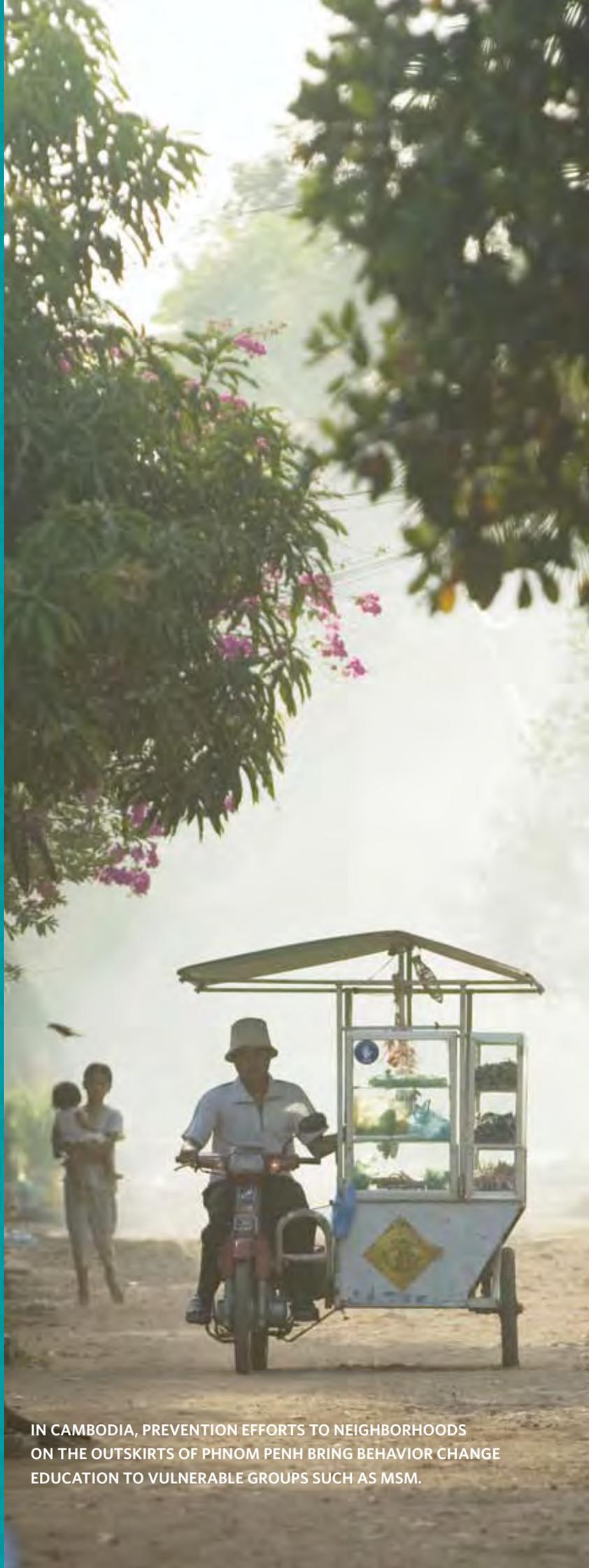
0.9% (as per 2007 estimates from Cambodia's National Center for HIV/AIDS, Dermatology and STDs)

POPULATIONS MOST AT RISK

Sex workers, IDUs, MSM

NOTABLE TRENDS

Overall HIV prevalence in Cambodia has declined over the past few years, from an estimated high exceeding 3% in the late 1990s to less than 1% in 2007. The decline is attributed to strong awareness-raising and prevention efforts by the government with support from bilateral and multilateral donors and civil society. Prevention efforts are thought to have been least successful among the most stigmatized populations, including IDUs and MSM. KHANA estimated in 2006, for example, that between 37% and 45% of IDUs in Cambodia were HIV-positive. Recent trends also indicate that half of new infections are among married women.



IN CAMBODIA, PREVENTION EFFORTS TO NEIGHBORHOODS ON THE OUTSKIRTS OF PHNOM PENH BRING BEHAVIOR CHANGE EDUCATION TO VULNERABLE GROUPS SUCH AS MSM.

BACKGROUND, ACTIVITIES AND STRATEGIES OF KHANA

The Khmer HIV/AIDS NGO Alliance (KHANA), established in 1997, was a project of the International HIV/AIDS Alliance; it became an independent organization and an Alliance linking organization in 1999. Over the years, KHANA has maintained close links to the Alliance and continues to receive some financial and technical support. At the same time, KHANA funding sources have expanded and currently include USAID, the Bill & Melinda Gates Foundation, the European Union and the Global Fund. Past donors have included the United Nations Population Fund (UNFPA), the World Bank and the Japan International Cooperation Agency (JICA).

As an NGO support organization, KHANA does not provide direct service delivery. Instead, it offers financial, technical and capacity-building support to community-based civil society partners that are directly involved in such activities. In March 2008, Global Fund assistance in particular was underpinning KHANA support to nearly 70 local partners in 17 Cambodian provinces. These partners implement focused HIV prevention activities, provide care and support (with a longstanding focus on home-based care) to PLWHA and their families and carry out advocacy activities to reduce stigma and improve the lives of PLWHA.

KHANA's interactions with its partners represent a direct example of CSS at all stages of establishing and maintaining working relationships, from identifying partners to working with those who eventually come on board.

IDENTIFYING PARTNERS AND STRENGTHENING NGOS' APPLICATION PROCESSES

The typical process for KHANA is as follows:

- 1 As it seeks to identify potential new community-based partners, KHANA holds meetings across the country to which local civil society groups are invited. Some have previously worked on HIV issues; others have not but have expressed an interest in becoming involved. The organizations are selected according to experience in community mobilization, organizational capacity and demonstrated commitment to participatory development and service provision.**
- 2 Members of CBOs and NGOs are then trained in the basics of HIV and sexually-transmitted infection (STI) prevention and treatment and in carrying out community needs assessments.**
- 3 Once the needs assessments have been completed, KHANA then supports these organizations to develop a proposal for a project based on the assessment.**
- 4 After review by a proposal review committee, the CBO or NGO may be supported by KHANA using funds available, for example as a Global Fund sub-recipient.**

Once a partnership has been developed with a community group, and a grant is awarded, it is usual for this relationship to continue over many years as the NGO or CBO refines its project to meet the changing needs of the community and KHANA continues to provide technical support. During the development of proposals for Global Fund-supported programs, KHANA either mobilizes new partners using the process described above or else identifies existing partners whose capacity and focus are relevant for the priorities of that Global Fund round (as defined by the CCM). In addition to these specific application-oriented processes, KHANA is also involved in other activities that increase awareness among local civil society groups as to the availability of and ways to acquire additional resources.

KHANA'S INTEGRATED CARE AND PREVENTION PROGRAM

KHANA's Integrated Care and Prevention Program (ICP) supports PLWHA and affected families through the provision of comprehensive home-based care services. These services are provided by KHANA's partners through home-care teams (HCTs). Each team consists of representatives from KHANA's partner NGO, a representative from the local health center and volunteers. During home visits, the teams provide basic medical treatment and referrals to vital health services including opportunistic infections (OI), STI and tuberculosis (TB) treatment, as well as access to prevention of mother-to-child transmission (PMTCT), voluntary counseling and testing (VCT) and antiretroviral treatment (ART) services. They also provide psychosocial support, prevention education, food and nutritional support, school materials and encouragement for orphans and vulnerable children (OVC) to complete basic education and facilitate access to income-generation opportunities.

HCTs encourage people living with HIV to access local self-help groups for mutual support. Additionally, the ICP program reaches out to the general population through community education activities and provides capacity-building opportunities for the government partners and PLWHA networks that work with KHANA.

ONGOING TECHNICAL ASSISTANCE TO SELECTED PARTNERS

Technical assistance continues to be an important and ongoing part of KHANA's support after partner NGOs are on board. Such support focuses on both programmatic and organizational development: technical assistance is provided in the form of training workshops on a variety of themes such as home-based care for PLWHA, strategies for supporting OVC in local communities, M&E, financial management and fundraising.

Each partner organization faces a different set of challenges and has identified unique capacity-building needs. Therefore KHANA seeks to be as hands-on as possible when providing technical support. Staff provide one-to-one technical support during regular field visits to partner organizations with the goal of building the capacity of those organizations in specific technical and organizational areas according to individual partners' needs. These visits also offer an opportunity for KHANA to monitor program activities. The network organizes (and encourages participation in) exchange visits among partners. Such direct engagement increases the sharing of useful and effective ideas and strategies.

KHANA has long recognized that building local partner M&E capacity must be a crucial component of its technical assistance efforts. This core element of comprehensive CSS has the dual effect of improving the quality and scope of service delivery among those in need while at the same time helping ensure longer-term sustainability. The process ensures partners are able to meet key requirements of other current and potential donors. Members of the KHANA M&E team help the partners to collect and present data according to set indicators and targets. Partners report quarterly, and reported data is collated in the KHANA central Monitoring and Reporting System database. Data can then be presented according to the requirements of each donor in a clear and timely manner.

The benefit of KHANA's strong community systems means that in addition to supporting communities, KHANA has played an increasingly important role at the national level by taking part in policy development and inputting into the national strategic plans for the country. Through its understanding of and ability to represent the needs of people living with HIV and of vulnerable populations, KHANA is able to represent them or act as a bridge. This helps ensure that the views and voices of community are heard at the decision-making table and, hopefully, listened to.

GLOBAL FUND INVOLVEMENT

KHANA staff have worked with government and CCM officials planning and drafting all Global Fund proposals. The organization obtained funds as a sub-recipient for two HIV/AIDS grants (Rounds 1 and 5) and will again through Round 7, contingent upon the grant being signed.

For Round 1, KHANA focused primarily on what their areas of success at the time: home-based care (also known as community-based care) for PLWHA and OVC. Both of those have remained core priorities for KHANA through subsequent grant proposals. At the same time, the organization has recognized and responded to other urgent priorities as they have become apparent.

The HIV epidemic in Cambodia has continued to disproportionately strike members of certain vulnerable sub-populations, notably injecting drug users (IDUs), men who have sex with men (MSM) and sex workers. KHANA has encouraged the CCM and other leading in-country Global Fund stakeholders to provide more targeted assistance for members of these groups. For example, in the lead up to the Round 6 HIV/AIDS proposal, KHANA prepared a report highlighting the results of assessments that showed how stigma, discrimination, and lack of access to essential services were driving a new and little-recognized HIV epidemic among IDUs. That report and KHANA's direct involvement in proposal preparation contributed to the inclusion of measures and target indicators aimed at HIV prevention and care among IDUs.

Cambodia's Round 6 HIV/AIDS proposal ultimately was not approved. KHANA and its partner allies nevertheless determined to advocate for similar measures and indicators focusing on drug users for the Round 7 proposal. KHANA has broadened its efforts on behalf of vulnerable populations by recommending a project focusing on prevention for MSM. In the end, KHANA's four main projects for the Round 7 proposal (which will be implemented contingent upon signing) included those two new focus areas – prevention among IDUs and MSM – and two longstanding areas – home-based care for PLWHA and OVC risk reduction – where it had demonstrated effectiveness.

For IDUs, KHANA included the following priority activities in the Round 7 proposal:

- > **supporting NGOs to implement drug-related HIV activities in seven provinces;**
- > **initiating ten projects for risk reduction with amphetamine users that include outreach, peer education, life skills development, HIV/AIDS/STI education, condom distribution, assisted referral to STI/VCT/HIV care, and referral to drug treatment/rehabilitation;**
- > **initiating five harm reduction projects for IDUs over three years. Such projects would include similar services to those for amphetamine users (noted in the bullet point above) as well as needle and syringe exchange;**
- > **expanding socioeconomic support for IDUs through drop-in centers, income-generating activities, community-based support through teams for families and individuals and self-help groups; and**
- > **creating NGO-led rehabilitation and detoxification services at two sites by the end of three years, each of which would also provide opioid substitution therapy.**

For MSM, KHANA included the following in the Round 7 proposal:

- > **supporting seven NGOs to implement comprehensive MSM/HIV prevention and care in four provinces;**
- > **expanding socioeconomic support by supporting NGOs to provide MSM-specific drop-in centers or “safe spaces”;**
- > **initiating HIV prevention activities with a particular focus on increasing condom use rates and improving reduction in STIs transmission and better health-seeking behavior in relation to STIs. Specific efforts in this area include expanded outreach and peer education, life skills development, condom distribution, assisted referral to STIs and VCT sites, and integrating drop-in centers with STIs clinics;**
- > **ensuring full access to non-discriminatory care for HIV-positive MSM. Specific efforts would include assisted referral to appropriate services for HIV care, including ART and treatment for opportunistic infections; and**
- > **supporting the development of the first national MSM network.**

CAPACITY BUILDING

Through its many years of work with local NGOs, KHANA has observed how important it is for applicants to recognize the amount of additional systems, restructuring and expertise that are required to make an application to be a PR. They need to discuss with the CCM which elements of the PR or sub-recipient role are manageable and decide if the expectations of the CCM are appropriate or might take them beyond current capacity. However, a desire to become a recipient can provide a clear set of goals in terms of developing internal capacity to take on GF responsibilities in the future. One of the key objectives of the recent focus of the Global Fund on investing in CSS is to enable CBOs, civil society organizations, networks and NGOs to build their capacity to play a greater and more competent role in scaling up services that help to reverse HIV, TB and malaria epidemics.

LESSONS LEARNED

The availability of Global Fund financing has enabled KHANA, its partners and the government to scale up responses across the country. Such expanded programs have contributed to the overall decline in HIV prevalence. Continued success will depend on expanding and sustaining direct engagement with CBOs that have proved effective in supporting, if not leading, the HIV prevention and care efforts in Cambodia.

Other notable lessons learned from KHANA's experience in Cambodia include the following:

- > **Ongoing partnership-building with key government agencies can provide an entry point for meaningful engagement in Global Fund processes. KHANA has been proactive in engaging in technical working groups and other forums at the national level where there is an opportunity to establish mutually-respectful working relationships with government counterparts and feed into national strategies and policies. By making itself visible and establishing its reputation and expertise in this way, KHANA is well positioned to influence the agenda when Global Fund priorities and programs are being discussed.**
- > **Building complementarity with government based on comparative strengths can help establish a role for civil society in implementing Global Fund programs. In Cambodia, for example, approaches such as the continuum of care for PLWHA have been built on the complementarity of public sector and civil society. While the Ministry of Health has focused on facility-based clinical services, KHANA and its partners have worked in the community to provide home care, referral, positive prevention, psychosocial support, adherence follow-up and socioeconomic support including livelihoods, education, nutrition and protection of OVC.**
- > **Civil society organizations, which can link experience at the community level to the national level, can play a significant role in voicing the needs of vulnerable people during Global Fund processes. KHANA has been able to bring learning from its partners at the community level to the national level, where it has already established its voice and influence. For example, KHANA has encouraged the inclusion of activities targeting IDUs and MSM in Global Fund proposals based on its partners' experience of working closely with these relatively hard-to-reach groups.**
- > **Civil society needs to build on existing coordination mechanisms so that NGOs can bring a unified voice to Global Fund processes. In Cambodia, the NGO sector is large and diverse, which can have both positive and negative repercussions. To reduce the negative impacts, intermediary organizations like KHANA can play a role in helping improve coordination among civil society.**



KHANA ENGAGES BUDDHIST MONKS IN EFFORTS TO PROVIDE SOLIDARITY AND A SUPPORTIVE ENVIRONMENT FOR PLWHA.

India

KEY ELEMENTS OF CIVIL SOCIETY ENGAGEMENT

- > community systems strengthening
 - > sexual and reproductive health integration
 - > dual-track financing
-

ORGANIZATION INVOLVED

India HIV/AIDS Alliance

COUNTRY BACKGROUND

POPULATION

1.1 billion

INCOME LEVEL CLASSIFICATION

Low income (as per latest World Bank data)

ADULT HIV PREVALENCE

0.36% (as per latest UNAIDS data)

POPULATIONS MOST AT RISK

IDUs, sex workers, MSM, transgender individuals, internal migrants (commonly referred to in India as "single migrants").

NOTABLE TRENDS

The estimated number of PLWHA in India was reduced significantly in 2007 under new UNAIDS methodology. Even so, the new estimate (2.5 million) remains the highest in Asia, although prevalence is far lower than in many other nations in the region due to the sheer size of India's population. The HIV epidemic in India also varies substantially by region. In the north east, for example - most notably in the states of Manipur and Nagaland - HIV is concentrated among IDUs; elsewhere the main transmission route is unprotected sex. There is a wide range of responses across the 35 states of India. Awareness is higher in southern states where the epidemic has been most visible as well as where the response has been strongest.



GOOD LEADERSHIP HELPS ENCOURAGE OTHERS TO TAKE THE INITIATIVE TO COUNSEL AND RAISE AWARENESS OF DISEASE PREVENTION AND TREATMENT. TRAINING PEOPLE TO TRAIN OTHERS IS AN EFFECTIVE WAY OF SPREADING HEALTH TIPS THROUGHOUT THE ENTIRE COMMUNITY.

BACKGROUND, ACTIVITIES AND STRATEGIES OF FOCUS ORGANIZATION

Established in 1999, the India HIV/AIDS Alliance is a partnership of organizations supporting effective, sustainable and comprehensive responses to HIV and meeting the challenges of AIDS in India. Supported by a national secretariat in Delhi, it comprises linking organizations, state partners and their networks of more than 110 community-focused organizations in six states: Andhra Pradesh, Delhi, Maharashtra, Manipur, Punjab and Tamil Nadu.

In 2007, the Alliance in India supported more than 120 community-based projects to prevent HIV infection, improve access to HIV treatment, care and support and lessen the impact of HIV/AIDS, including reducing stigma and discrimination. Particular emphasis was placed on working with and for the most vulnerable and marginalized communities, such as sex workers, MSM, IDUs, and adults and children living with HIV.

In 2007, the Alliance and its partners served an estimated 146,000 people, including some 43,000 sex workers; 28,000 PLWHA; 26,000 affected family members; 25,000 MSM and hijra/transgender community; 22,000 children affected by HIV/AIDS and 2,400 IDUs.

COMMUNITY SYSTEMS STRENGTHENING THROUGH SEXUAL AND REPRODUCTIVE HEALTH ACTIVITIES

The India HIV/AIDS Alliance sexual and reproductive health and HIV/AIDS integration program is the most recent of the three core programming streams. Initiated in 2006 with support from the Department of International Development (DFID), it was implemented across six states (the five states in which the Alliance continues to work as well as Orissa). The services were provided through four Alliance linking organizations, one lead state partner organization and 16 implementing NGO partners.

The overall goal of the program was to respond effectively to the “feminization” of the HIV epidemic in India. Moreover, it was designed to fit within the longer-term strategic context of the National AIDS Control Program’s new strategic framework. In practice this means that the Alliance’s primary objective is to strengthen and develop community-centered approaches to meet the sexual and reproductive health and HIV-related needs of women in low-income settings.

The Alliance in India developed information, education and communication (IEC) materials regarding sexual and reproductive health and HIV. These materials include information about HIV transmission and care, reproductive health, care during pregnancy, childcare, personal hygiene, condom usage, STIs and nutrition. The IEC materials, backed up by a rigorous system of training, were provided directly to Alliance implementing partners to support outreach workers and other community workers and volunteers. Those individuals organized sessions with community members and disseminated appropriate information related to sexual and reproductive health. Such capacity-building efforts constitute significant CSS activity.

In late 2007, the Alliance in India reported the following outcomes (as of mid-2007) of its sexual and reproductive health/HIV integration program:

- > **nearly 1,000 support groups of vulnerable women were formed and are meeting regularly;**
- > **more than 100 women PLWHA groups were created;**
- > **more than 20,000 information and discussion sessions were conducted in group meetings. Topics ranged from condom negotiation, ART, STIs, contraception and pregnancy to legal and policy issues;**
- > **approximately 14,000 home visits were conducted by outreach workers offering sexual and reproductive health/HIV information;**
- > **more than 2,000 referrals were made to STI and reproductive health services; and**
- > **nearly 200 women were supported by NGOs in obtaining legal advice; more than half received free legal support services.**

The focus, strategies, results and impact of this DFID program were so promising – and were achieved within a very short period of time (the project was only funded for 14 months) – that the Alliance decided that sexual and reproductive health/HIV integration would be a strategic priority for the next three years. Based on demand from the communities and findings of various end-of-project reports, the Alliance decided to broaden the definition of sexual and reproductive health to include males at risk and ensure greater male involvement. This umbrella category includes: single migrant men living in urban slums; HIV-positive men; MSM and hijra/transgender community and male IDUs. The Alliance is keen to offer targeted sexual and reproductive health/HIV services to such individuals. This is because they tend to be particularly difficult to reach; are disproportionately vulnerable to contracting HIV; have little awareness of sexual and reproductive health/HIV issues; have limited access to appropriate services and/or face significant stigma and discrimination that restricts their ability or inclination to seek social and health services.

2 Additional information about the Avahan initiative may be found on the Gates Foundation website: www.gatesfoundation.org/GlobalHealth/Pri_Diseases/HIVAIDS/HIVProgramsPartnerships/Avahan/

However, a major challenge to the expansion of the sexual and reproductive health/HIV integration program for marginalized male populations is the lack of comprehensive information about them and their unmet sexual and reproductive health needs. In order to address this challenge, the Alliance supported a comprehensive survey among representatives of male marginalized groups in 2007. Key areas of focus included awareness of HIV and STI risk behaviors (and inclination or ability to take preventive measures based on awareness), access to and use of condoms and uptake of available NGO and government services. Across all groups, the initial results demonstrated that there are gaps in the health system as far as men are concerned – and that the public health machinery has become disproportionately focused on women. Consequently, even when men make a decision to participate in and access services, there tends to be a limited scope or enabling environment for them to do so.

These findings are expected to guide the development of new Alliance programming on comprehensive sexual and reproductive health for males, including convergence with HIV.

OTHER COMMUNITY SYSTEMS STRENGTHENING EXAMPLES

The current focus on sexual and reproductive health/HIV integration is high-profile, but it is not the only pathway through which the Alliance in India facilitates CSS. Another important – and complementary – focus is on populations considered most vulnerable to HIV transmission, so-called key populations, including MSM, IDUs and sex workers.

The India HIV/AIDS Alliance has developed several CSS implementation models for working with these populations, all within the context of “focused prevention”. Focused prevention relies on supporting the behavior change of communities at risk (key populations) through providing peer education and supporting services in a selected area. The goal is to saturate the specific geographic area so that all (or nearly all) residents have access to HIV prevention and care information and resources.

One such effort was initiated recently in the state of Andhra Pradesh, one of five Indian states where the Alliance currently works. The effort is part of a larger community-driven prevention program supported by the Bill & Melinda Gates Foundation’s Avahan initiative, which currently reaches more than 50,000 key population community members in that state.²

The model emphasized the Alliance working with community members in selected areas to develop a strategy that would address the challenges faced by them and their peers in terms of police harassment and stigma and discrimination as well as access to essential social and health services. The result was the evolution of the Core Advocacy Group concept, a model for involving community members at all levels in building their skills and empowering them to take responsibility for addressing these challenges. The model places priority on leadership from members of the affected communities themselves and has been introduced not only to Alliance implementing NGO partners but also to other groups working on similar issues.

GLOBAL FUND INVOLVEMENT

The Alliance is already serving – with distinction – as one of two civil society PRs for the India Round 6 HIV/AIDS grant. Its engagement at that level is a solid example of the utility and effectiveness of the DTF model, which was adopted in India long before it was specifically encouraged by the Global Fund.

The Round 6 grant focuses on scaling up care and support services for children living with and/or affected by HIV. As PR, the Alliance focuses on CSS: building the capacity of local NGOs to provide community-based services efficiently, consistently and at the high standards required by the Global Fund. The official start date of the Round 6 grant was 1st June 2007. By the end of the year, the India HIV/AIDS Alliance had initiated the following activities, most of which focused on project start-up (itself a vital part of CSS):

- > **staff recruitment and initial training/orientation at the national level for Alliance sub-recipients;**
- > **setting up detailed M&E and financial systems;**
- > **writing project operational guidelines;**
- > **conducting child-profiling/mapping and participatory situation analysis at all field sites; and**
- > **technical support and monitoring visits to sub-recipients by the Alliance, as well as joint visits with sub-recipients to implementing NGOs (known as sub-sub-recipients) to oversee staff capacity building and outline project compliance guidelines.**

More recently, the Alliance in India has been asked to serve as PR of a proposal submitted for a Round 8 HIV/AIDS grant. The request was based on Alliance experience as PR in Round 6, its work supporting sexual and reproductive health/HIV integration and its history of building the capacity of community groups (including NGOs) to effectively respond to the epidemic in India. The Round 8 proposal focuses on CSS for sexual minorities as a key part of efforts to increase access to HIV prevention and care services among MSM and members of the hijra/transgender communities. The proposal seeks to achieve these and other goals by strengthening the management of relevant health system resources and increasing the involvement of community-based groups.

2. LACK OF CAPACITY AND AWARENESS IN THE CIVIL SOCIETY SECTOR

The CCM received a reported 700 responses to its call for proposals, the majority of which came from NGOs seeking to serve either as PRs or sub-recipients for Round 6. Of those, only about 20 (less than three percent) came close to meeting the necessary criteria. Such results point to the lack of awareness among local civil society groups as to the relevant Global Fund processes and expectations. They also highlight crucial gaps in capacity within the sector. In advance of upcoming rounds, the Alliance has partnered with several other civil society players, including the other non-governmental PR (Population Foundation of India), to try to address this lack of awareness. The groups involved are leading a series of meetings with civil society organizations across the country to outline the process and expectations of being a PR or an sub-recipient – and to share experiences of organizations that have already held such roles. There has also been some participation from government agencies in this effort, including the National AIDS Control Organization.

LESSONS LEARNED

The following are three of the numerous lessons learned by the Alliance from its work in India over the past several years:

- > **Effective DTF can occur even in environments where the government remains somewhat suspicious of the civil society sector. Proof of this comes from the Alliance's strong performance as co-PR for the Round 6 HIV/AIDS grant. Such useful work has helped prompt the government to recognize the value of civil society not only in Global Fund processes, but also more broadly.**
- > **It may seem as though CSS would have a limited effect in large and populous countries with thousands of local civil society groups of greatly varying quality, experience and interests. The Alliance in India has shown that a useful strategy in such a situation is to keep the focus limited to a few targeted areas and districts at first. The effective CSS model that emerges from that strategy can then be adapted and expanded elsewhere in the country. In many cases, as with the Bill & Melinda Gates Foundation Avahan initiative, partnerships can be formed with other international, national and local civil society groups to fund, design and implement such models elsewhere.**
- > **Effective sexual and reproductive health/HIV integration requires the involvement of men as well as women. Services in particular need to be expanded to men and sexual minorities, since women are targeted in many reproductive and child health projects of government. Programs and strategies targeted at men – who in some environments remain underserved – are often best designed and implemented by civil society. The most appropriate efforts are those that seek guidance and engagement from community groups with relevant experience and an interest in reaching out to men.**

As specified in the Round 8 proposal, some of the major capacity-building needs of sexual minority groups include institution-building of CBOs, project cycle management and financial management. Also deemed important are efforts to address relevant non-HIV needs of community members, such as mental health, trauma and violence response and family crisis-support programs. Notable activities in the Round 8 proposal include community mobilization and organization in the form of CBOs, capacity building of organizations, sensitization training and quality assurance for service providers, and advocacy for legal and social reforms. The proposal also includes lesser-studied areas such as spouse and partner coverage, linkages and services for MSM and hijras/transgenders living with HIV and HIV prevention for married men as learning and advocacy initiatives.

The Global Fund had yet to announce its Round 8 decisions at the time research for this case study was collected. Moreover, program implementation of the Round 6 grant is so new – the official start date was in mid-2007 – that outcomes, impacts and observations are somewhat limited. However, by early 2008 the following two challenges and obstacles had been identified by India HIV/AIDS Alliance staff as being especially noteworthy:

1. WORKING WITH GOVERNMENT: AN EVOLVING RELATIONSHIP

The national government's strong and significant role in the CCM is a critical factor governing participation by and from civil society. The sector's participation has been further influenced by the continued vacancies of several CCM seats reserved for civil society. As a co-PR, the Alliance has "special invitee" status only on the CCM. In that role as observer, it is not permitted to vote and can only contribute informally to discussions and questions upon request of the CCM membership or office bearers (including occasional presentations to the CCM on results and performance).

The result is a situation where civil society is poorly represented and implementing organizations such as the Alliance cannot contribute. This situation, coupled with many government agencies' critical view of the capacities and governance of civil society organizations in general, has had a negative impact on the ability of civil society to be considered equal and/or significant players to date for the Global Fund. The result continues to be missed opportunities for effective communication and engagement.

Mongolia

KEY ELEMENTS OF CIVIL SOCIETY ENGAGEMENT

- > community systems strengthening
- > sexual and reproductive health integration

ORGANIZATION INVOLVED

National AIDS Foundation

COUNTRY BACKGROUND

POPULATION

2.7 million

INCOME LEVEL CLASSIFICATION

Low income (as per latest World Bank data)

ADULT HIV PREVALENCE

Less than 0.1% (as per latest UNAIDS data)

POPULATIONS MOST AT RISK

MSM, sex workers

NOTABLE TRENDS

The total number of PLWHA in Mongolia is estimated to be about 1,000. However, although HIV cases are rare to date, numerous social, health and economic indicators point to the possibility of substantial increases in the future. Among those factors are:

- > rising rates of STIs, poverty, unemployment, and alcohol and substance abuse;
- > growing numbers of sex workers and street children;
- > a young population (50% of Mongolians are below the age of 23);
- > increasing internal and external migration;
- > surging HIV epidemics in neighboring nations;
- > limited access to health services for vulnerable populations; and
- > high levels of HIV-related stigma and discrimination.



CBOs HELP TO RELIEVE THE PRESSURE ON HOSPITALS AND CLINICS BY PROVIDING BASIC HEALTH CARE AND EXTENDING MEDICAL SERVICES THROUGHOUT THE COMMUNITY.

BACKGROUND, ACTIVITIES AND STRATEGIES OF FOCUS FOR THE NATIONAL AIDS FOUNDATION

Established in 1998, the National AIDS Foundation (NAF) is the Mongolian linking organization of the International HIV/AIDS Alliance. It is also a member of Mongolia's National AIDS Committee. NAF's main activities over the years have included providing financial and technical support to local NGOs, conducting research and needs assessments, documenting the work of its local partners and identifying best practices and participating in policy-making and advocacy aimed at improving the national HIV/AIDS response.

THE GLOBAL FUND AND THE NATIONAL AIDS FOUNDATION

Mongolia is the Global Fund's smallest program. It is also unusual in that the (relatively) few recorded cases of HIV in the country means that treatment needs – which dominate grants in many other nations – are quite low. The Global Fund's efforts in Mongolia are therefore focused on prevention, especially among vulnerable populations, and on reducing stigma and discrimination.

Mongolia has been awarded HIV/AIDS grants from the Global Fund in Rounds 2, 5 and 7 – provisionally with regard to the most recent. (As of May 2008, the Round 7 grant had yet to be signed. The total request over five years was for US\$ 2.95 million) The Ministry of Health is sole PR for all three grants, with NAF acting as one of the main sub-recipients in each case. NAF also sits on the CCM, thereby guaranteeing a strong and engaged civil society presence. The organization has worked closely with – and maintains good relations with – the Ministry of Health and other relevant government agencies. Its work in recent years as a sub-recipient is considered not only competent but efficient and innovative.

As one of the main sub-recipients, NAF has been developing its own organizational capacity including financial management, onward granting, and M&E, all with the support of the Alliance. The Global Fund's new emphasis on DTF and CSS implies further capacity building of civil society organizations, particularly those acting as sub-recipients. NAF is a good example of a sub-recipient with the potential to achieve the qualities needed to be a co-PR in the future. The possible step up in responsibility would undoubtedly bring new challenges; however, the early signs are that NAF is gaining the expertise and experience to effectively serve as co-PR.

SEXUAL AND REPRODUCTIVE HEALTH WITHIN GLOBAL FUND WORK

All three HIV/AIDS grants contain several specific sexual and reproductive health indicators. The Round 2 grant, for example, included indicators aimed at reducing syphilis prevalence and improving STI diagnosis and treatment. Additional indicators and targets – including some focusing on specific vulnerable populations – were included in subsequent grants. The Global Fund’s partners have therefore from the very beginning seized the opportunity to facilitate greater integration of sexual and reproductive health and HIV services.

As a sub-recipient, NAF is a crucial part of this ongoing integration. Its work through the Global Fund is also a consistent source of CSS across Mongolia. NAF has funded and provided technical assistance to local NGOs offering a wide range of HIV prevention and sexual and reproductive health-related services including condom promotion, mobile VCT, drop-in centers, legal support, basic medical care and referrals, peer education (focusing on both HIV and sexual and reproductive health issues) and community outreach. NAF selects, funds and supports NGOs that are able and willing to reach some or all of the following key populations: sex workers, MSM, mobile traders, migrant workers (including miners working in the country illegally), IDUs and vulnerable children.

The Round 7 proposal represented the most far-reaching effort to increase Global Fund support for sexual and reproductive health and, by extension, improve sexual and reproductive health/HIV integration. Even more so than in previous proposals, it also allocated significant resources to building capacity among local groups to deliver such services. Local NGOs will receive ongoing training, including through regular field visits from NAF and other stakeholders. The training will focus on (among other areas) accounting and bookkeeping, M&E, and HIV prevention and care. This example of Global Fund-supported CSS was strongly backed by NAF and the Alliance.

NAF, moreover, was directly involved in drafting the Round 7 proposal. The elements of sexual and reproductive health integration to be addressed and supported include the following:

- > **linking and adapting outreach and peer education programs with sexual and reproductive health education for sex workers;**
- > **including treatment and counseling for STIs in all VCT services;**
- > **training and educating as to the utility of condoms as dual protection;**
- > **increasing referrals, for example, by considering prenatal clinics to be major entry points to sexual and reproductive health/HIV services; and**
- > **seeking to meet standards set by WHO and UNAIDS on issues such as one-stop care services for prenatal care, controlling syphilis to help decrease HIV transmission risk, private-sector quality improvement and laboratory quality control and transport.**

In the lead up to Round 7, NAF also identified strategies and activities to reach and improve services among key vulnerable populations. The organization specifically identified its intent to support partners in providing mobile STI and VCT services to both sex workers and MSM, for example. It also planned to train outreach workers to provide information, education and skills to illegal miners with the goal of establishing five total sites and reaching 25,000 people by the final year of the grant. Separately, it called for training staff to provide a range of crucial care interventions – including VCT, STI diagnosis and treatment and counseling – for illegal miners via mobile services for six months every year.

The following were among the other notable integrated HIV/sexual and reproductive health prevention activities included in the Round 7 proposal:

- > **organizing education workshops and sessions on HIV and STIs for sex workers detained at facilities in Ulaan Bataar. Detention center staff would also be a focus of education outreach. These efforts would include the development of training manuals for NGO staff overseeing the sessions; and**
- > **offering education and training on HIV prevention and communication skills to police officers who are in regular contact with members of vulnerable groups. Such efforts would focus on six districts of Ulaan Bataar.**

CHALLENGES TO SEXUAL AND REPRODUCTIVE HEALTH/HIV INTEGRATION

NAF itself has identified several challenges to the effective implementation and sustainability of programs and strategies to increase sexual and reproductive health/HIV integration. The two main broad challenges include:

- > **inadequate human, financial, technical and M&E capacity among local NGOs, many of which have traditionally focused on more specific, segmented elements of care; and**
- > **lack of knowledge and understanding about sexual and reproductive health/HIV integration, including why it might improve health delivery.**

The organization plans to address such challenges by expanding the scope and scale of technical assistance it offers NGO partners. It has received assistance from the Alliance to help develop appropriate training models in advance. CSS is and will continue to be directly enhanced by the flow of ideas, information and resources from the Alliance to NAF to local partners. In return, the local partners will act as the eyes and ears at the grassroots level so that NAF and the Alliance receive guidance and suggestions as to the most important priorities.

LESSONS LEARNED

The following are three of the more notable lessons learned from NAF's work in Mongolia over the past several years:

- > **Civil society organizations often lead the way in identifying and implementing innovative strategies and initiatives that are included in Global Fund programs. Civil society's ability to influence Global Fund proposals is best achieved when one or more organizations, such as NAF, are directly involved in drafting Global Fund applications. Among NAF's most important influences has been to focus attention and resources on sexual and reproductive health integration, which was a little-known and poorly-funded health objective prior to the Global Fund's engagement.**
- > **HIV-related stigma and discrimination are persistent, widespread and debilitating obstacles to public health, even in countries with low HIV prevalence. These point to the continued urgent need to expand and improve HIV education and awareness initiatives in such environments. The effectiveness of such initiatives is enhanced when civil society and government collaborate closely.**
- > **NAF's experience in Mongolia perfectly illustrates how CSS can be implemented among organizations and partners of widely varying sizes and expertise. NAF itself is a beneficiary of CSS from its international partner, the Alliance, and it in turn serves the same role with many smaller NGOs across the country. Such a multi-layered structure is often particularly effective at the grass-roots level because national and local organizations are far more likely than international ones (or bilateral donors) to provide training and information in ways that are culturally, economically and politically appropriate.**

Peru

KEY ELEMENTS OF CIVIL SOCIETY ENGAGEMENT

- > civil society as sole Global Fund Principal Recipient
- > community systems strengthening

ORGANIZATION INVOLVED

CARE Peru

COUNTRY BACKGROUND

POPULATION

28 million

INCOME LEVEL CLASSIFICATION

Lower-middle income (as per latest World Bank data)

ADULT HIV PREVALENCE

0.6% (as per latest UNAIDS data)

POPULATIONS MOST AT RISK

Sex workers, MSM

NOTABLE TRENDS

HIV prevalence is several times higher among key vulnerable groups - an estimated 10% among MSM and more than 2% among female sex workers, for example - yet HIV prevention and education services reportedly reach fewer than half of individuals in such groups. TB is another important factor, because Peru reportedly has the continent's second-largest burden of that disease, which is the single most common killer of HIV-positive people worldwide.



IN PERU, THE GOVERNMENT AND CIVIL SOCIETY HAVE COME TOGETHER TO PREPARE A MULTISECTORAL NATIONAL STRATEGY TO FIGHT HIV/AIDS, WHICH INCLUDES MEASURES TO PREVENT MOTHER-TO-CHILD TRANSMISSION OF HIV.

THE “NO-GOVERNMENT” MODEL: AN NGO AS SOLE PRINCIPAL RECIPIENT

As of March 2008, the Global Fund had approved a total of five grants for Peru, three for HIV/AIDS and two for TB. Uniquely, no government agency is involved as PR: all grants are overseen and implemented by the same civil society organization, CARE Peru. (The organization is affiliated with CARE International, but is formally separate and operates independently with local staff.)

Peru's case is unusual for the Global Fund because the government did not insist on one or more of its agencies serving as PR. That made it easier for the CCM to appropriately honor and respond to the results of the public tenders associated with each grant. In all five cases, CARE Peru's proposals were evaluated as the strongest by an independent review committee.

These decisions were not only accepted, but generally welcomed. From the chair downwards, government representatives of the CCM have noted the importance and value of civil society involvement in all Global Fund processes and programs.

To some extent the government's attitude reflects the historic strength of and respect for civil society that is seen throughout much of Latin America. More directly in the case of HIV and TB, however, it results from the belief that effective prevention and treatment activities should not be just community-based but also community-run. In particular, NGOs are believed to have greater success, once properly supported, in identifying and reaching the most vulnerable populations. Many individuals in those groups tend to be wary of government structures because they engage in behavior that is either illegal or highly stigmatized (or both).

The CCM and the government have openly signalled their backing for such an overall decentralized strategy by selecting a civil society PR and publicly announcing how and why the two sectors (public and non-governmental) are expected to cooperate in terms of HIV and TB service provision.

COMMUNITY SYSTEMS STRENGTHENING AS CORE PRIORITY

CSS is an integral part of all five Global Fund grant programs in Peru, with specific focus on groups run by people living with and/or directly affected by one or both of the diseases. For example, each program objective outlined in the HIV/AIDS grants is tackled by a consortium of NGOs working together. Through its sub-recipients – which include both civil society groups and government entities – CARE provides these local groups with financial and technical support over a wide range of areas, such as:

- > **improving basic management skills (including helping legalize PLWHA groups as NGOs);**
- > **training PLWHA groups and advocates on how to effectively work and advocate within the public health system;**
- > **training MSM and sex workers to serve as peer educators and counselors in all issues related to HIV prevention and treatment. Particular attention is paid to giving them the skills and confidence to promote condom usage, STI screening and care and treatment adherence. The educators also assist their peers in navigating care systems; and**
- > **helping PLWHA networks set up income-generating microenterprises as part of an effort to improve the livelihoods of HIV-positive people.**

The peer educator approach now used in all HIV/AIDS grants was modelled on the one pioneered in the TB programs. Through the TB grants, CARE sub-recipients create and support local TB organizations at the community level. These groups encourage testing, educate patients and their families on adherence and prevention and deliver services directly if needed. Many, for example, conduct home visits to bring medicines to patients. A major priority of CARE is to help ensure that these organizations are able to continue their activities once Global Fund support ends. Training is therefore offered in financial management, applying for grants and forming partnerships with government agencies and other NGOs.

LESSONS LEARNED

The following are among the noteworthy lessons learned from the Global Fund's experience to date in Peru:

- > **Governments do not need to be directly involved in the design and management of Global Fund programs for them to be efficient and effective. None of the five Global Fund programs approved for Peru have PRs from the public sector. That does not stem from any particular perceived or real lack of capacity among government agencies; instead, it is based on agreement among all stakeholders (including those in government) that civil society would likely do a better job.**
- > **Global Fund programs may be implemented more smoothly when each sector's responsibilities are clear from the very beginning. Civil society and the government are both involved in HIV and TB service provision in Peru through the Global Fund. Yet potential confusion and mistrust regarding funding and roles have largely been avoided because all stakeholders have always been aware of what can be expected of them in their focus areas.**
- > **The peer educator approach can be an important part of effective strategies to increase uptake of vital prevention, care and treatment services. As seen in Peru, such an approach can work across all disease components if tailored and implemented properly.**

Senegal

KEY ELEMENTS OF CIVIL SOCIETY ENGAGEMENT

- > dual-track financing
- > community systems strengthening

ORGANIZATIONS INVOLVED

- > Alliance Nationale Contre le SIDA (Senegalese National HIV/AIDS Alliance), or ANCS
- > Observatoire de la réponse au VIH/SIDA au Sénégal (Watchdog of the response to HIV/AIDS in Senegal), or Observatoire

COUNTRY BACKGROUND

POPULATION

12 million

INCOME LEVEL CLASSIFICATION

Low income (as per latest World Bank data)

ADULT HIV PREVALENCE

0.9% (as per latest UNAIDS data)

POPULATIONS MOST AT RISK

Sex workers, migrant laborers, MSM

NOTABLE TRENDS

HIV prevalence in Senegal has long been among the lowest of all countries in sub-Saharan Africa. Its success in holding back the epidemic stems from the government's early and relatively consistent efforts to raise awareness and provide HIV and STI prevention information and materials (including condoms) throughout the country. The government also implemented one of the first national initiatives in the region to provide ART. Civil society has played a vital role in supporting the government's comprehensive efforts and advocating for improvements when deemed necessary.



JAMRA IS A PRIMARY SCHOOL FOR CHILDREN WHOSE LIVES ARE AFFECTED BY HIV/AIDS, DRUGS OR POVERTY.

3 Much of the information in this case study about the Observatoire, including impact, conclusions and lessons learned, was adapted from a 2007 Alliance report, *Leadership in action: A case study of the 'Observatoire', a group of NGOs in Senegal*. Written by Ralf Jürgens and Dr. Fatim Louise Dia, it offers a more in depth discussion of the Observatoire.

BACKGROUND: THE ROAD TO DUAL-TRACK FINANCING IN SENEGAL

Founded in 1995, Alliance Nationale Contre le SIDA (ANCS) is the linking organization in Senegal for the International HIV/AIDS Alliance. It receives financial and technical support from the Alliance on a regular basis and has provided similar assistance to numerous NGOs engaged in the HIV/AIDS response at the local level.

ANCS is one of five NGOs comprising the Observatoire, an informal network whose members first met in 2003.³ The Observatoire's important and decisive impact on the HIV/AIDS response in Senegal is based on the fact that not only did it identify problems, but it also proposed solutions. Its members also agreed from the very beginning that government and civil society must consider themselves partners, not adversaries, in all elements of a comprehensive response. DTF in the Global Fund context was a crucial outcome of these efforts.

The impetus behind the Observatoire's establishment was growing recognition that key government agencies – notably the National AIDS Council – were having difficulty managing projects funded by the World Bank and the Global Fund (through Round 1). Also, NGOs were discouraged that civil society was not being consulted and thus could have little impact on decision-making.

Observatoire members decided that they needed clear evidence for their concerns to be taken seriously. They agreed to conduct research on Senegal's response to HIV/AIDS and use the information to identify solutions and advocate for appropriate policy and management change. The result was a paper presented at a highly-publicized press conference in January 2005. Among the findings – all of which pointed to the possibility of a more extensive epidemic – were the following:

- > **surveys of pregnant women indicated that HIV infection rates had risen recently in more than half of Senegal's 12 regions;**
- > **access to HIV testing and ART remained limited, despite government commitment to reach all in need; and**
- > **few programs were in place to provide services for OVC and members of some vulnerable populations, including MSM.**

More specifically, the report concluded that the National AIDS Council had not developed clear, transparent guidelines for managing Global Fund and World Bank assistance. The quality and effectiveness of newly-funded, established programs were also questioned. Moreover, the civil society sector was found to be insufficiently represented on the Global Fund CCM and, more broadly, limited in its ability to participate in the national response. The report included several recommendations, most of which focused on increased transparency and restructuring so that program activities could be more closely reviewed and influenced by non-governmental stakeholders.

The Observatoire's report reinforced similar concerns at the Global Fund Secretariat that the targets identified in the grant would not and could not be met. In April 2005, the Global Fund Board threatened to withdraw the grant if administration and implementation problems were not addressed within three months.

The threat prompted government officials to engage directly with key civil society organizations. The main result of the discussions was an agreement to split the Global Fund grant into separate government and civil society components and to appoint an NGO to serve as PR for the civil society component beginning with Phase 2. This early example of DTF was confirmed when ANCS, by consensus the best prepared of local NGOs, was appointed to be co-PR.

ACTIVITIES AND STRATEGIES OF ANCS

ANCS worked with six sub-recipients through the Round 1 grant. They provide the following services at the community level: support and referrals for PMTCT services; community mobilization; care and support for PLWHA; care and support for OVC; prevention among sex workers and MSM and VCT services. As part of an effort to ensure integrated care, all services are provided in partnership with government agencies at the local level. For example, sub-recipients offer adherence and social support to PLWHA receiving ART at public-sector health facilities.

ANCS also keeps in mind one major issue highlighted in the Observatoire's report – that the government was not as transparent as it should be. Thus, ANCS pays close attention to ensuring transparency in all its activities. It set up an advisory committee comprising representatives from civil society networks, UN agencies, CCM members and government agencies to focus on strengthening transparency and ownership of the program. Now, for example, sub-recipients are selected by merit in an open process that begins with a nationwide call for proposals via the media. An independent committee then reviews applications and selects the most promising ones.

Strong support of CSS by ANCS is exemplified by the scale and scope of technical assistance it provides to sub-recipients. The first step is usually a capacity analysis to determine what each sub-recipient needs most. All have at the very least received in-depth training on finance and accounting and – given the Global Fund's strict requirements – on M&E activities. Additional assistance has been offered in areas ranging from human resources management to quality control. ANCS also makes it a priority to review sub-recipient systems and progress on an ongoing basis through regular site visits. It steps in with advice and support if and when problems are identified.

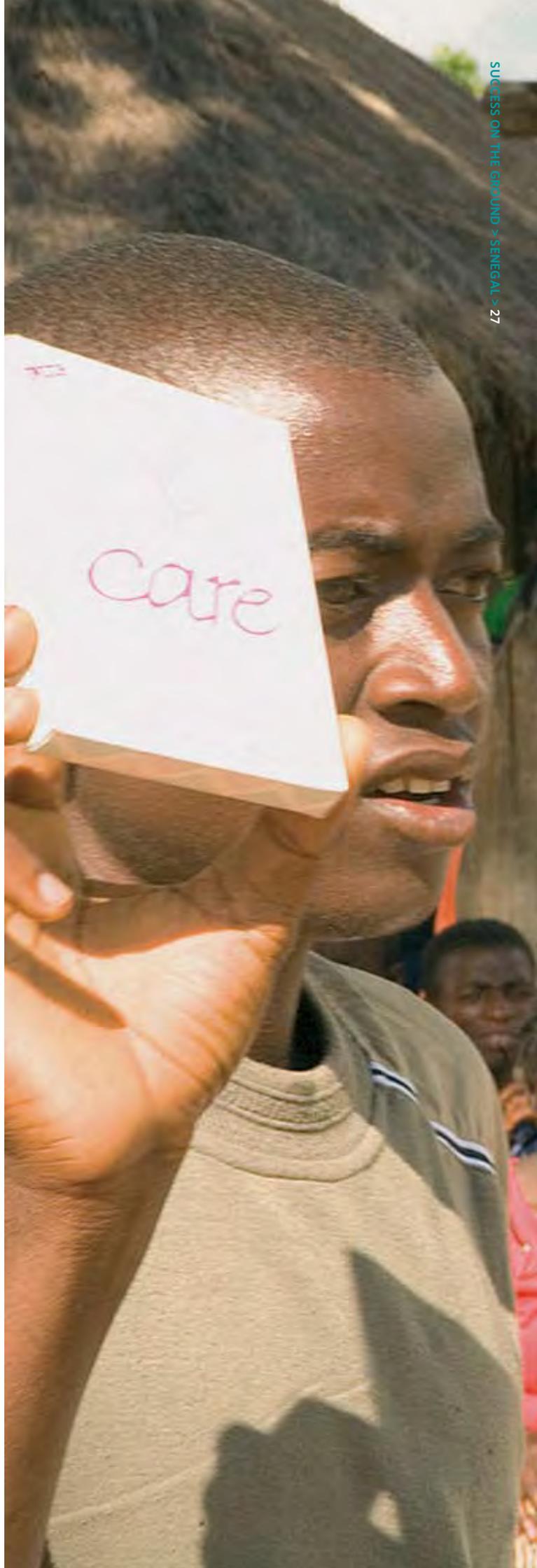
The PR's close working relationship with its sub-recipient partners has greatly assisted the latter in efforts to achieve longer-term sustainability. Among the most notable CSS impact to date has been the fact that sub-recipients have used the same systems when dealing with other donors, including USAID.

KEY SUCCESSES, OUTCOMES AND CHALLENGES

The DTF arrangement has been remarkably successful in Senegal. The majority of sub-recipients supported by ANCS in the Round 1 grant have exceeded their targets, and the others have at least met them. The Global Fund's own evaluation of Senegal's grant was mostly positive, with implicit support for ANCS's performance as PR. The success of the DTF structure prompted the CCM to replicate it – with the National AIDS Council and ANCS serving as PRs for the government and civil society components, respectively – in Senegal's successful Round 6 HIV/AIDS proposal. A total of US\$ 4.47 million was approved for Phase 1 of that second grant.

With such success comes a major challenge, however. ANCS recognizes that maintaining its high level of performance throughout the Round 6 grant may be difficult because the number of sub-recipients it oversees is expected to at least double (from six). The organization has itself sought capacity-building support from the Alliance as it prepares to scale up its engagement.

The work of ANCS and, by extension, the watchdog activities of the Observatoire have also ensured that civil society is more fully and meaningfully involved in all aspects of the national response to HIV/AIDS. One important example of the positive impact of such engagement is that most of the recommendations in the Observatoire's landmark report have subsequently been adopted. As a result, most observers agree that access to HIV testing and treatment have improved; programs have been initiated with the goal of reaching more MSM and other vulnerable populations and more aggressive efforts have been undertaken to reduce HIV-related stigma and discrimination.



LESSONS LEARNED

The following are among the lessons learned from the ongoing and direct efforts by the Observatoire and ANCS to improve the HIV/AIDS response in Senegal:

- > **civil society organizations can more effectively influence government policy if they build coalitions and work together;**
- > **national responses can be greatly improved when civil society effectively recognizes and exploits its crucial “watchdog” function. Such efforts are best approached with the goal of proposing solutions and soliciting the support of funders;**
- > **local NGOs can manage funds and programs carefully, efficiently and effectively. The performance to date of ANCS sub-recipients offers proof that targeted support reaps major benefits;**
- > **ongoing reviews of sub-recipients’ performance can help identify gaps and problems early on and enable them to be fixed promptly. This can help ensure that targets and goals are ultimately met; and**
- > **close collaboration and partnerships between government and civil society can be a successful model. The model works when government recognizes the inherent value of civil society engagement and NGOs have the capacity to deliver quality outcomes.**

Somalia

KEY ELEMENTS OF CIVIL SOCIETY ENGAGEMENT

- > community systems strengthening
- > non-Country Coordinating Mechanism proposal

ORGANIZATION INVOLVED

Coordination of International Support to Somalis (CISS)

COUNTRY BACKGROUND

POPULATION

8.3 million

INCOME LEVEL CLASSIFICATION

Low income (as per latest World Bank data)

ADULT HIV PREVALENCE

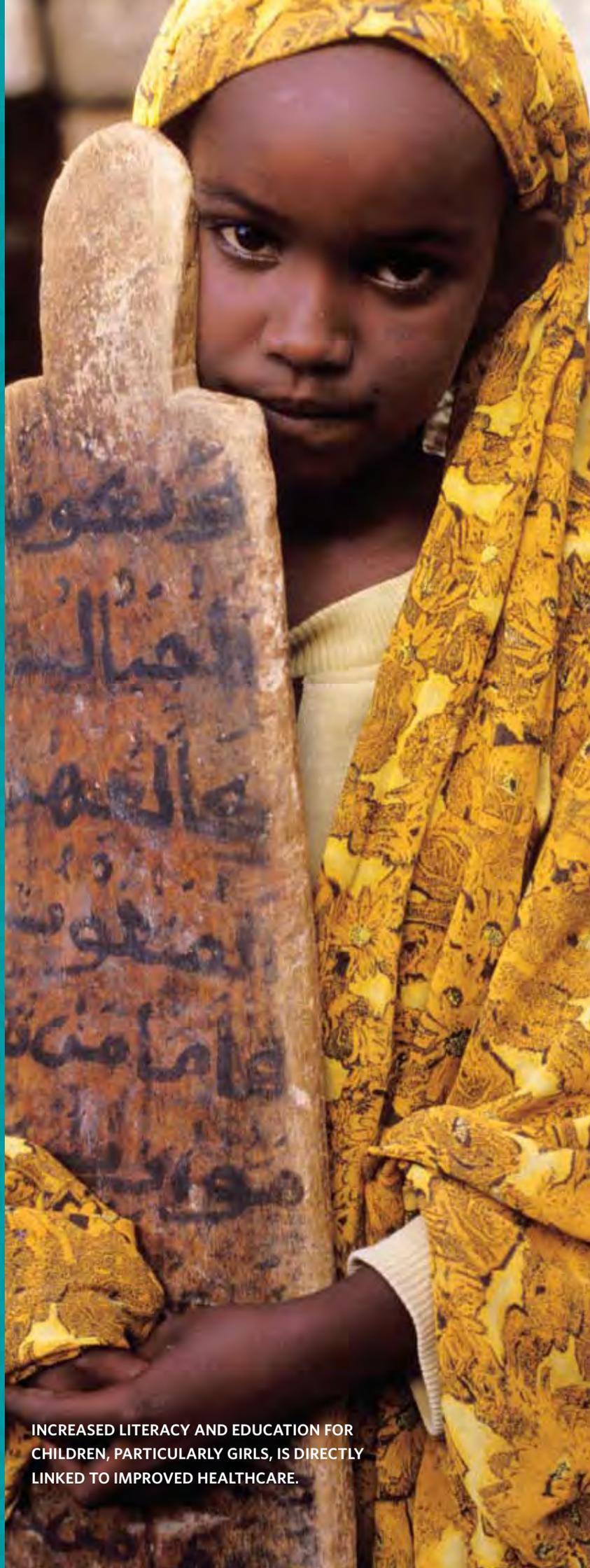
0.9% (as per latest UNAIDS data)

POPULATIONS MOST AT RISK

Internally-displaced people and other mobile populations, young people

NOTABLE TRENDS

The lack of reliable data from Somalia regarding all health issues - not just HIV - greatly limits the ability to identify epidemiological trends. Most observers believe there is a significant TB/HIV co-infection problem, given that Somalia is one of the world's high-burden TB countries.



INCREASED LITERACY AND EDUCATION FOR CHILDREN, PARTICULARLY GIRLS, IS DIRECTLY LINKED TO IMPROVED HEALTHCARE.

OVERARCHING OBSTACLE: ABSENCE OF CENTRALIZED AUTHORITY

Somalia has been considered a “failed state” since the early 1990s, when the most recent national government fell amid tribal and clan-based conflict. The international community has worked to help re-establish central authority, but various efforts over the years have not proved successful. The country instead has been divided into three separate regions, each of which has its own administrative bodies. However, the governments of two of the regions, Puntland and Somaliland, are not recognized abroad, and neither they nor the national government based in Mogadishu in the south have more than a tenuous reach throughout their territory. The situation currently is most challenging in the south, where persistent conflict, poverty, and hunger have forced hundreds of thousands of Somalis to flee their homes. The majority remain in camps for internally-displaced people run by the UN and other international organizations.

Although conditions are marginally better in Puntland and Somaliland, the political chaos over the years has been accompanied by near-total collapses in Somalia’s nationwide economy and its education and health systems. Illiteracy rates have continued to rise while life expectancy worsens. Awareness about HIV is extremely low, which – as it does in most other societies – contributes to high levels of HIV-related stigma and discrimination. Another important factor behind such high levels is a deeply conservative culture that often stigmatizes and ostracizes individuals who contract HIV due to the real or perceived behaviors leading to transmission.

BACKGROUND TO GLOBAL FUND INVOLVEMENT

Although Somalia is considered a failed state, the experience of the Global Fund is that such states should not necessarily be equated with poor performance in implementation. Applications from Somalia have been approved and funded – including one that focuses on HIV/AIDS through Round 4.

The Global Fund’s inherent flexibility has been the major underlying reason for its ability and inclination to provide support in challenging environments. For instance, it is true that the Global Fund generally encourages national governments to be directly involved in establishing a CCM and overseeing Global Fund activities, including grant applications, through that body. No central government exists in Somalia; therefore, forming one government-level CCM was impossible with three separate governing authorities. A group of international organizations (including UN agencies) formed the Coordination of International Support to Somalis (CISS) to submit non-CCM proposals to the Global Fund. This option was acceptable because the Global Fund’s guidelines specifically state that it will consider such proposals from nations where a viable central government does not exist.

CISS is an unusual model for numerous reasons. Not only is it not considered a CCM, but originally it was composed entirely of representatives of international organizations. At the time that CISS was being formed its members believed that no local organizations – civil society or public sector – had the capacity to or were prepared to represent themselves. Original CISS members also were concerned that including local representatives would exacerbate competing interests throughout the highly-charged domestic political environment. Because of the importance it places on national ownership, the Global Fund Secretariat was not satisfied with that decision. It strongly urged CISS members to devise a solution to ensure that Somalis were directly represented. In the wake of negotiations with authorities of the three separate regions, the coalition agreed to include at least one representative from each region.

Another unusual feature is that CISS is not based in Somalia but in neighboring Kenya (in Nairobi). That decision was based on security concerns and on close consideration of the political complications of seeking to work across all three regions of Somalia. CISS members recognized that a potential base in Somalia would mean having to choose one of the three regions. The two regions not chosen might then have barred all or some forms of Global Fund assistance in response.

The lack of local capacity is also the reason that an international agency, the United Nations Children’s Fund (UNICEF), was selected as PR for the HIV/AIDS grant, *Implementing the Strategic Framework of Prevention and Control of HIV/AIDS and STIs within Somali Populations*. The total funding request was for US\$ 24.9 million.

UNICEF manages the grant from Nairobi, although it retains a persistent presence in Somalia through focal points in all three regions, in conjunction with regular site visits by key staff. To the fullest extent possible, the agency and its implementing partners seek to coordinate and integrate similar activities within the framework of the different HIV/AIDS strategies and programs devised by authorities in the three regions. One success has been the establishment and utilization in all three regions of a single M&E framework with common reporting tools.

COMMUNITY SYSTEMS STRENGTHENING THROUGH THE GLOBAL FUND

CSS is one of the major, if not the most important, Global Fund activities undertaken to date through the Round 4 HIV/AIDS program in Somalia. The rationale was lack of awareness and capacity among local NGOs to even apply for Global Fund grants, let alone provide appropriate services. The first year of the grant was almost exclusively oriented toward intensive training of civil society groups (and, to some extent, public sector entities) in all aspects of organizational administration and service provision. The priority skills included basic M&E skills, blood safety measures, VCT, and anti-stigma and behavior-change strategies. As of February 2008, approximately 20 NGOs had been accredited (deemed prepared to serve as sub-recipients).

UNICEF has been assisted in these CSS efforts by other international NGOs, including Oxfam. That organization's local branch has received Global Fund support for a project in which local "trainee consultants" are given three months of training in organization development and then "attached" to selected NGOs for six months, during which time they in turn train that group's staff and serve as mentors. Such a CSS model is particularly effective because the ultimate hands-on training of NGOs is provided by local experts.

According to a Global Fund scorecard prepared and released in 2007, the program "has achieved some significant results." Among the most notable in terms of exceeding targets were the following:

- > **580 people receiving VCT services (290 percent of target);**
- > **227 PLWHA had received adequate treatment and/or prophylaxis for OIs (151 percent of target);**
- > **70 PLWHA in need had received ART (77 percent of target); and**
- > **9,782 people had been reached by CBOs each year with HIV prevention, treatment and care services (217 percent of target).**

Global Fund staff also note that reporting (M&E) is of particularly high quality among sub-recipients in Somalia. That achievement would seem to be a direct result of the concentrated and extensive focus on CSS from the very start of the grant.

CURRENT AND POTENTIAL CHALLENGES TO GLOBAL FUND ACTIVITIES

The successes demonstrated to date in Somalia should not be underestimated, but it is important to note that significant challenges remain for all stakeholders involved in the HIV/AIDS response. Among them are the following:

- > **Whether viewed collectively or by individual regions, Somalia is one of the poorest societies in the world. Few domestic resources are therefore available to contribute to an effective HIV/AIDS response. The lack of resources and capacity within governing bodies could prove problematic for the long-term sustainability of HIV/AIDS and other key health programs.**
- > **Very little is known about the HIV epidemic in Somalia. Most observers believe HIV prevalence remains relatively low, especially in comparison with some neighboring countries, but no reliable data currently exist. Collecting such information country-wide will always be difficult with the existing political structure as well as with the ongoing conflict in certain regions.**
- > **Direct and consistent engagement by Somalis in decision-making is hindered by the fact that both CISS and the PR are based in Kenya.**
- > **Reports to date indicate that although prevention activities are expanding into all parts of the country, they have reached only a small number of people in key high-risk groups (including sex workers, IDUs and army personnel). Comprehensive prevention efforts have also been hindered by the slow progress of condom distribution. One reason cited for that shortfall is concern on the part of PR staff of potential reprisals against service providers by socially-conservative opponents of such interventions.**
- > **CISS, the PR and their local implementing partners have had little success in getting PLWHA involved in any capacity building, let alone in taking leadership roles. They point to persistently strong HIV-related stigma and discrimination, including examples in which HIV-positive individuals have been shunned by or experienced physical abuse from family members, friends and other community members.**



LESSONS LEARNED

The following are two complementary and important overall lessons to be learned from the mostly-positive impact and outcomes of the Global Fund's HIV/AIDS grant in Somalia:

- > **The Global Fund's guidelines are flexible and adaptable enough for it to be directly engaged in even the most complex, resource-constrained and politically challenging environments.**
- > **Local civil society groups can be effective service providers and partners in challenging environments as well, provided i) they receive appropriate, targeted support as early as possible, and ii) they themselves demonstrate a strong degree of commitment and coordination.**

Thailand

PEER EDUCATION AND CLEAN NEEDLE EXCHANGE PROGRAMS FOR IDUs HAVE MADE SIGNIFICANT INROADS IN THE SPREAD OF NEW INFECTIONS IN THAILAND.

KEY ELEMENTS OF CIVIL SOCIETY ENGAGEMENT

- > leadership by vulnerable population
- > non-Country Coordinating Mechanism proposal
- > community systems strengthening

ORGANIZATION INVOLVED

Raks Thai Foundation

COUNTRY BACKGROUND

POPULATION

65 million

INCOME LEVEL CLASSIFICATION

Lower-middle income (as per latest World Bank data)

ADULT HIV PREVALENCE

1.4% (as per latest UNAIDS data)

POPULATIONS MOST AT RISK

IDUs, sex workers, MSM

NOTABLE TRENDS

In the 1980s, Thailand was one of the first Asian countries to face a severe HIV epidemic. In the following decade, its government was also one of the first among high-burden countries - not only in the region, but worldwide - to initiate comprehensive prevention and treatment programs. Those steps were successful in stabilizing the epidemic, although the intensity and quality of the government's prevention efforts in recent years have been criticized as inadequate.



INJECTING DRUG USERS: THE MOST VULNERABLE OF THE VULNERABLE

HIV prevalence in Thailand continues to be several times higher among the most vulnerable groups than the general population. Individuals most at risk are IDUs, MSM and sex workers, of which Thailand has a particularly large number, due to its domestic sex industry. In 2000, the health minister estimated that nearly half of IDUs were HIV-positive. That share is thought to have declined, but more recent estimates – that perhaps one-third of active IDUs are living with HIV – offer clear signs of a still-raging epidemic.

The stigma and discrimination experienced by Thailand's IDUs, estimated to number at least 200,000, were starkly displayed during a high-profile anti-drugs campaign launched by the government in 2003. Over the course of several months, police detained tens of thousands of people and killed as many as 3,000 of them, almost all extra-judicially. The government claimed that those killed were drug dealers, but many independent observers said the majority were simply users. The resulting international uproar prompted the government to scale back the campaign, but calls for re-escalation continue to be made from time to time by various officials.

The Thai government's indifference toward IDUs has long been evident in terms of HIV services also. Even though authorities recognized that IDUs were a particularly vulnerable population by 2000, they had not implemented measures to address the specific HIV prevention and care needs of drug users. Instead drug-related policies focused on punishment by emphasizing incarceration, mandatory drug treatment and violations of confidentiality. Given such conditions, it was not surprising that most IDUs were unable or unwilling to seek access to vital HIV services. Moreover, the risks of contracting HIV remained high because no syringe exchange or substitution treatment programs existed in Thailand, even though a handful of pilot projects had been evaluated as successful and effective.

BACKGROUND TO GLOBAL FUND INVOLVEMENT

According to the experiences of some of the NGOs, the government's attitudes toward IDUs carried over to the CCM, the majority of whose members are from government agencies. For example, a group of civil society organizations – including the Raks Thai Foundation – was stymied when it approached the CCM with proposals to integrate the needs of IDUs into Thailand's first Global Fund HIV/AIDS grant application. CCM members reportedly said that working with IDUs would be "too complicated". A second effort was similarly rebuffed, with some CCM members stating that a proposal to the Global Fund with specific targets and services for IDUs was "not necessary" and would "not merit funding".

Raks Thai and its civil society allies, including organizations of drug users, therefore decided to bypass the CCM and submit their own proposal. The main reason for this was based on the CCM refusal to consider their proposal, which the Global Fund guidelines specifically mention as an appropriate rationale for submitting a non-CCM proposal (see box on following page).

In its proposal, Raks Thai listed the following other reasons for **not** submitting a proposal through the CCM:

- > **The government of Thailand and Thai society [do] not currently recognize the value of harm reduction [to reduce HIV transmission risk among IDUs].**
- > **Although there are public health officials in government positions who support harm reduction, they are currently unable to express this support publicly given the current policy environment.**
- > **Harm reduction programming is urgently needed in Thailand. However, in light of the current official drug policies, it is drug users themselves who are in the best position to deliver harm reduction programming. Their peers may be reluctant to participate in similar government-initiated programs because participation could be perceived to carry the risk of harassment, arrest, and mandatory treatment and HIV testing. They also fear for their privacy, given that health-care facilities and the police regularly share information about drug users.**
- > **The [applicant] does, however, firmly believe that the Thai government will permit the proposed pilot project to proceed. That is because the government had officially recognized drug use as a health issue; it had previously allowed pilot studies of harm reduction programs, including syringe exchange and methadone maintenance; the project is consistent with several of the stated objectives in the current National HIV/AIDS Plan; and the proposed project has the support of recognized NGOs and academic partners who will independently and rigorously monitor and evaluate the project.**

CIVIL SOCIETY STRENGTH IN THAILAND

The Raks Thai Foundation's ability to apply for and receive Global Fund support points to a notable domestic factor: civil society is fairly strong and influential in Thailand in general. The HIV/AIDS sphere is no exception. At the time the proposal was submitted, the Thai NGO Coalition on AIDS reportedly represented some 170 local NGOs focusing on HIV issues throughout the country, and the Thai Network of People Living with HIV (TNP+) had a network of nearly 600 local PLWHA organizations.

These groups help strengthen members' ability to identify and respond to needs at the community level. They also serve as developers and incubators of appropriate strategies that might be useful at higher levels, including policy-makers at the national level. For example, such groups' advocacy efforts for improved treatment access prompted the government in 2006 to adopt a policy to provide free ART to all in need.

The proposal, *Preventing HIV/AIDS and Increasing Care and Support for Injecting Drug Users in Thailand*, was approved in Round 3. It was a small grant, with just US\$ 1.3 million requested over three years (in comparison with the standard five-year grant). Three civil society implementing partners were involved: the Thai Drug Users' Network, the Thai Treatment Action Group and Alden House.

The main objectives of the grant, listed below, were designed to fill a gap left by the Thai government's reluctance to engage fully in HIV prevention and treatment services for IDUs:

- > **dissemination among IDUs of education and awareness information regarding how to prevent HIV infection and other health-related harms;**
- > **increasing uptake of health-care services among IDUs by providing information on where and how to get such services;**
- > **increasing uptake of VCT among IDUs;**
- > **reducing AIDS deaths among IDUs;**
- > **increasing the capacity of policy-makers to create public health policies specific to injection drug use and HIV/AIDS; and**
- > **increasing awareness and capacity among health-care providers, police and prison staff as to how and why to provide and support comprehensive HIV prevention, care, treatment and support to IDUs.**

The grant offers a rich example of CSS aimed specifically at members of vulnerable populations. Through capacity-building activities, grant implementers focused on training peer leaders within IDU communities. Those participating could be either current or former drug users. Approximately 50 peer leaders were trained under a model that involved formal partnerships among, and regular input from i) public health experts and health researchers from Thailand and abroad and ii) four dynamic and effective drug users' organizations from abroad.

After being trained, the individuals provided peer-based outreach, education, and counseling and referral in four communities, including in local prisons and youth detention centers. Their activities were organized and coordinated through harm reduction centers (small office spaces with drop-in centers) established with grant funds. Support for HIV testing and ART adherence were two of the more specialized activities in which they were trained. Grant implementers and their partners also provided regular training updates for all participants.

GLOBAL FUND GUIDELINES FOR SUBMITTING NON-CCM PROPOSALS

LESSONS LEARNED

The following are among the notable lessons learned from this unique Global Fund program in Thailand:

- > The Global Fund guidelines on non-CCM proposals are taken seriously by the Global Fund Board and proposal review committees (such as the Technical Review Panel). Although the Global Fund does prefer proposals to come from CCMs, there are exceptional cases based on set criteria for accepting non-CCM proposals. Assuming they meet the relevant criteria, non-CCM proposals are considered carefully and potentially funded.
- > Civil society organizations, notably those comprising members of vulnerable communities, need not necessarily be large or experienced for their non-CCM proposals to be considered. As proved by the Raks Thai Foundation in its successful proposal, it is more important that they be able to identify significant obstacles to the delivery of services to those in need, have developed a plan to respond and can demonstrate a commitment to carry out their objectives.
- > Funding from the Global Fund can be used for capacity-building activities within the applicant organization. This is especially important when a non-CCM application is made, because in such instances government expertise and resources are less likely to be available to implementers.
- > Local and international NGOs are often willing and able to help their civil society compatriots in drafting proposals (non-CCM and otherwise); training staff and volunteers and helping build implementation capacity. Such assistance played a critical role in all aspects of the civil society-led, non-CCM grant in Thailand.

According to Global Fund guidelines, proposals from non-CCMs are eligible if they satisfactorily explain that they originate from:

- > countries without a legitimate government (such as governments not recognized by the UN); or
- > countries in conflict, facing natural disasters, or in complex emergency situations; or
- > countries that suppress or have not established partnerships with civil society and NGOs.

In the first two criteria, non-CCM proposals are eligible because it is likely that CCMs have not been established. That is the case with Somalia.

The third criterion is more pertinent to countries where CCMs do exist, as in Thailand. As the Global Fund guidelines further state, non-CCM proposals are eligible when a CCM “unreasonably fails to consider a proposal that has been submitted though the CCM’s advised processes for proposal consideration.” Such a failure on the part of the CCM may be related to the fact that it “i) did not review the proposal; ii) did not review it within a reasonable timeframe; or iii) unreasonably refused to include it (or some part) in the CCM’s own proposal to the Global Fund.”

The successful non-CCM proposal from Thailand included extensive documentation, as required, that convinced grant evaluators that the CCM had in fact unreasonably refused to include proposals related to prevention and care among IDUs.

Ukraine

KEY ELEMENTS OF CIVIL SOCIETY ENGAGEMENT

- > community systems strengthening
- > leadership by vulnerable populations

ORGANIZATIONS INVOLVED

- > International HIV/AIDS Alliance in Ukraine
- > All-Ukrainian Network of People Living with HIV

COUNTRY BACKGROUND

POPULATION

46 million

INCOME LEVEL CLASSIFICATION

Lower-middle income (as per latest World Bank data)

ADULT HIV PREVALENCE

1.4% (as per latest UNAIDS data)

POPULATIONS MOST AT RISK

IDUs, sex workers, MSM, prisoners, street children

NOTABLE TRENDS

Ukraine is home to the highest HIV rate in Europe and one of the world's fastest-growing epidemics in recent years. One of the main reasons the epidemic has yet to show signs of stabilizing is that prevention programs still reach only relatively small proportions of the most at-risk populations, notably IDUs, sex workers and MSM. As in most other countries of the former Soviet Union, the epidemic in Ukraine has long been concentrated among IDUs. Although their share of new infections has dropped below 50% recently, they are still by far the most heavily-affected group.



IN UKRAINE, VOLUNTEERS AND PROFESSIONAL COUNSELORS ATTEND A WORKSHOP ON MOTIVATIONAL COUNSELING WHICH INCORPORATE TRUST-BUILDING EXERCISES.

BACKGROUND AND OBJECTIVES OF FOCUS ORGANIZATIONS: CSS AT THE CORE

Established in 2000, the International HIV/AIDS Alliance in Ukraine is in some respects the largest NGO in Ukraine. Its current size stems primarily from the appointment, in March 2004, of the UK-based International HIV/AIDS Alliance as PR of the country's Round 1 HIV/AIDS grant. (The Alliance in Ukraine is implementing the Global Fund program on behalf of its parent organization.) The Alliance had not sought the PR responsibility when the grant proposal was first submitted; it became directly involved only after the Global Fund Board suspended the grant in January 2004 amid concerns over the original PRs' mis-management and slow disbursement of funds.

The Alliance in Ukraine also serves as co-PR of the Round 6 HIV/AIDS grant, sharing responsibilities with another civil society group, the All-Ukrainian Network of People Living with HIV (the Network). Through its work with the Global Fund and the USAID SUNRISE project, the Alliance has provided financial and technical support to about 150 NGOs and national institutions, enabling them to deliver appropriate and high-quality services and information. The full range of technical support includes treatment awareness, project design, service provision to vulnerable communities, budget planning, strategic planning, M&E, financial management, development of information and resource materials, partnership building, advocacy and resource mobilization.

The Alliance's effective oversight of the Round 1 grant has been particularly notable given the difficult circumstances under which it became involved. It succeeded in speeding up overall implementation to efficient levels, achieved more widespread and rapid scale-up of ART enrollment and identified and removed many of the obstacles hampering effective introduction of substitution treatment. One important factor behind the Alliance's success in Ukraine has been that it has from the beginning been able to rely on the expertise of the Alliance Secretariat in the UK. The technical and capacity-building support provided by the Secretariat proved invaluable in enabling the Ukraine linking organization to step into the PR role relatively quickly and efficiently.

The Network is a homegrown entity that was started a decade ago by a small group of PLWHA, many of whom had experience in self-help groups. At the time, there was almost a complete lack of treatment and care services available for HIV-positive people. Most of the rapidly-growing number of PLWHA were isolated and alone, vulnerable to legal, social and economic discrimination. Ignorance about HIV was widespread and the few prevention services available rarely targeted the most at-risk individuals (then, as now, IDUs). The Network grew to become the primary advocacy and support group for PLWHA in Ukraine. It has reached some 20,000 PLWHA across the country through community centers where local volunteers and members provide care and support services to their HIV-positive peers.

With the assistance of several international NGOs, the Network has gained the ability to provide direct technical support and training for PLWHA, social workers and counselors on how to manage the local centers and deliver comprehensive services at the community level. The Global Fund has also played a direct role in such CSS activities. Not only is the Network co-PR of the Round 6 HIV/AIDS grant, but it is a sub-recipient for the Round 1 grant. It therefore has long received financial and technical support through the Global Fund to help strengthen and expand its activities on the ground.

GLOBAL FUND ROUND 6: DUAL CIVIL SOCIETY PRINCIPAL RECIPIENTS

In the wake of the problems with the Round 1 grant, the original Ukrainian CCM was disbanded and replaced with a new one, the National Coordination Council, in 2005. The following year, the council led the development of a successful Round 6 HIV/AIDS proposal that included a maximum amount of US\$ 151 million over five years, the largest grant ever approved for Eastern Europe.

The newer grant is even more unusual than its Round 1 predecessor because it not only has two PRs, but both are civil society organizations. This is not an example of DTF per se (because no government body is involved). It is more accurately viewed as a multiple-PR model in which an experienced organization (the Alliance) simultaneously shares responsibility with and helps build the grant-management capacity of another group with which it has long been partnered (the Network). This is a formal arrangement where, as part of the program, the Network has been contracted with the Alliance to provide technical assistance in developing its procedures so that it can effectively meet its PR responsibilities. The lesson learned by this structure is that the Global Fund is willing to consider numerous options in order to help raise committed local NGOs to leadership positions.

The Alliance oversees most prevention and M&E activities funded through the Round 6 grant. The Network, alternatively, focuses on treatment, care and support and building supportive environments. The PRs' responsibilities overlap to some extent in certain areas, given that prevention and care are not mutually exclusive. For example, the provision of substitution treatment for IDUs is both a vital (particularly in Ukraine) HIV prevention service and also an important treatment one because it is often the first step towards IDUs accessing regular care and support.

ROUND 6 STRATEGIC PRIORITIES, OBJECTIVES AND SERVICE DELIVERY AREAS

Staff from the Alliance and the Network were among the civil society stakeholders involved in developing the proposal for the Round 6 HIV/AIDS grant.

THE ROAD TO NGO PROVISION OF SUBSTITUTION TREATMENT IN UKRAINE

Nearly all local and international NGOs – as well as independent observers – agree that Ukraine’s HIV epidemic can only be addressed effectively when IDUs have more extensive and consistent access to a full range of harm reduction services. Many of those interventions, including syringe exchange and opiate substitution treatment, remain controversial, however. Opponents of substitution treatment, for example, believe that providing drug users with orally-ingested medicine to wean them off of injecting heroin is merely an example of swapping one addictive drug for another. They either do not see or do not care about the most important impact: the dramatic reduction in HIV transmission risk.

Advocates’ efforts to increase access to substitution treatment in Ukraine have spanned more than a decade. Their efforts have not been in vain, as similar efforts have been in neighboring Russia, where methadone and similar medicines used in substitution treatment remain banned for any purpose. However, powerful drug-control officials in Ukraine have thrown up one roadblock after another, even after the government formally acknowledged the internationally-recognized effectiveness of substitution treatment in reducing HIV transmission and treating opiate addiction.

The debate has been going on for nearly five years. As far back as December 2003, the Alliance in Ukraine’s executive director, Andriy Klepikov, emphasized the need for substitution treatment during hearings in the Ukrainian parliament. Four months later, the prime minister signed a new National HIV/AIDS Program that specifically provided for substitution treatment implementation.

No further action was taken for a full year. Finally, in April 2005 the health minister issued the first order on implementation of substitution treatment programs in six Ukrainian cities. However, law enforcement authorities launched a campaign to ban the medical use of methadone, the cheapest and most widely-used (internationally) substitution treatment medicine.

Advocates, including the Alliance and the Network, used Global Fund assistance to help successfully counter the banning effort. Even so, the number of IDUs able to access either methadone or its less controversial counterpart, buprenorphine, remained limited. Part of the problem was lack of funds; other obstacles included various customs and drug-scheduling regulations that effectively limited supply.

Advocates continued to meet with government officials and parliamentarians to explain the evidence-based rationale for substitution treatment and urge them to facilitate its access as a vital public health intervention. Finally, the Ukrainian government in November 2007 included funds in the national budget to treat patients with substitution treatment. The following month, the president issued a decree aimed at eliminating existing barriers to the scale-up of substitution treatment. The first batch of methadone to be used for substitution treatment arrived by the end of the year.

The most recent outcome is likely to have the most far-reaching positive impact on drug users’ health. In January 2008, an amended version of the national drug law took effect. It not only stresses the concept of drug-related harm reduction as one of the key strategies of the government drug policy, but also cancels the government’s monopoly on the use of narcotic drugs for medical purposes. That means civil society groups are now allowed to implement substitution treatment programs on their own. The new law is a major triumph for civil society stakeholders in Ukraine and the culmination of many years’ effort.

Because the grant is so large and ambitious, they created a system in which the following four main strategic priorities constituted the overall guidelines of the grant:

- > **coordinating services to increase efficiency;**
- > **expanding prevention services for the most at-risk populations;**
- > **scaling up treatment, care and support for most affected populations to redress inequities; and**
- > **sustaining and enhancing the key achievements of the Round 1 program.**

These four main strategic priorities were the basis from which five key objectives were determined. In turn, 15 service delivery areas were identified from those five objectives.

- > **IDUs are at the center of one key objective and several service delivery areas, all of which are overseen by the two PRs. The basic package of services for IDUs around the country is being enhanced by establishing drop-in centers and improving access to social and vocational support, mobile HIV testing, TB detection, STI detection and treatment and structured referral to treatment, care and support. Much of this work is being done through a community outreach model that is driven by local NGOs, particularly those comprising drug users themselves. The capacity of local organizations is being strengthened through the formation of peer groups, with special focus on underserved small towns and villages. These new groups are expected to be among the most important advocates for policy change at the local and national levels, especially with regard to HIV prevention and treatment among IDUs.**

Other service delivery areas focus specifically on the three other populations considered to be the most vulnerable in Ukraine:

- > **Grant funds are being used by local organizations to create and sustain self-help groups for MSM, an often-neglected but highly-stigmatized population. Financial and technical support are also being provided to strengthen the capacity and reach of a newly formed lesbian/gay/bisexual/transgender (LGBT) coalition. Leaders of this coalition, which is modelled to some extent on the Network, are seeking to boost their ability to conduct effective advocacy on behalf of MSM at local and national levels. The main advocacy goals include reducing stigma and discrimination and helping to improve access by MSM to essential HIV prevention and care services.**
- > **Communities of female sex workers and the NGOs that work with them are being strengthened through training and the formation of peer groups to conduct effective outreach. As with the MSM and IDU communities, one key goal is to increase sex workers' direct participation in HIV-related service delivery to their peers. This involves soliciting input from and training sex workers in areas including project design, planning, implementation and M&E.**

- > **Prevention services for prisoners are being scaled up, with a goal of reaching some 50,000 inmates by the end of the grant. Prison staff and local NGOs are providing prisoners with information about HIV transmission and care as well as about TB (which is a huge health problem in Ukraine's penitentiaries). Projects are also being designed to provide basic commodities, including condoms and bleach (to help clean injecting materials). In a possible indication of a long-term strategy, at least one prison pilot substitution treatment project is being developed.**

All of these service delivery activities include substantial CSS elements, given the high priority placed on involving local civil society groups. To facilitate this overall effort, the grant proposal calls for the establishment of two regional resource centers to provide wide-ranging technical assistance to NGO sub-grantees. These centers are intended to bolster the capacity of civil society to contribute to the national response to HIV/AIDS by offering individual counseling and advice on technical, legal and organization development issues; financial management schemes; strategic planning and advocacy for promoting efficient models and civil society mobilization.

LESSONS LEARNED

As of March 2008, the Round 6 grant had been operating for less than a year; thus it is not yet possible to draw firm conclusions about its impact. It is possible, however, to list a few important observations related to the process to date:

- > **Civil society groups are often willing, able and committed to support each other in ensuring the success of Global Fund grants. In Ukraine and elsewhere, bonds between nongovernmental groups are generally stronger than those between NGOs and government bodies due to more closely-shared objectives and operating mechanisms. Therefore, CSS is manageable and effective even when both the provider and recipient of technical support have similar high-level responsibilities.**
- > **The enthusiasm, motivation and commitment of members of vulnerable communities should not be underestimated. Even if on paper they may not have the appropriate capacity or expertise to manage programs and services, they should be given special attention because of their potential and likelihood of remaining engaged and identifying new strategies. In Ukraine, the direct engagement of HIV-positive individuals through the Network has greatly invigorated HIV prevention and treatment initiatives begun by the Alliance and other stakeholders.**
- > **Even if government-controlled, CCMs are often willing to support civil society taking the lead in Global Fund projects. This is especially true if the organizations specifically stress that their activities are in line with the national HIV/AIDS programs and they present themselves as collaborators, not adversaries. The Alliance in Ukraine offers a good example of how to walk that line deftly and appropriately – as both partner to the government and advocate seeking to encourage policy change.**

Zambia

KEY ELEMENTS OF CIVIL SOCIETY ENGAGEMENT

- > dual-track financing with multiple PRs
- > community systems strengthening

ORGANIZATIONS INVOLVED

- > Zambian National AIDS Network
- > Churches Health Association of Zambia

COUNTRY BACKGROUND

POPULATION

12 million

INCOME LEVEL CLASSIFICATION

Low income (as per latest World Bank data)

ADULT HIV PREVALENCE

17% (as per latest UNAIDS data)

POPULATIONS MOST AT RISK

Everyone (generalized epidemic)

NOTABLE TRENDS

With nearly one in five people between the ages of 15 and 49 living with HIV, Zambia's epidemic is one of the most generalized in the world. Nearly all individuals are at risk of contracting HIV, which has spread for the most part through unprotected sex and mother-to-child transmission. External assistance, particularly from the Global Fund and the President's Emergency Plan of AIDS Relief (PEPFAR), has helped increase access to treatment and bolster prevention programs.



A PEER EDUCATOR IN ZAMBIA LEADS A SESSION WHICH IS PART OF A CAMPAIGN ENTITLED "YOUNG, HAPPY, HEALTHY AND SAFE" WHICH PROVIDES INFORMATION ABOUT AND RAISES AWARENESS OF HIV/AIDS.

GLOBAL FUND INVOLVEMENT

Zambia's CCM successfully applied to the Global Fund HIV/AIDS component for Rounds 1 and 4. From the very beginning, it considered civil society to be an equal partner to the government, specifically in terms of grant management and implementation. For both Rounds 1 and 4, the CCM's proposal called for four PRs, two from the government sector (the Ministries of Finance and Health) and two from the civil society sector (the Zambian National AIDS Network (ZNAN); and the Churches Health Association of Zambia (CHAZ)).

The Zambian example is unusual because the multiple-PR model was adopted so early in the Global Fund's history – with the very first round of grants. The CCM was the key driving force behind that model. It was determined to take whatever appropriate steps were necessary to address its national HIV epidemic effectively and quickly, and it concluded that getting money to community-based NGO implementers through civil society itself would be the most effective means for the specific Zambian context.

The model also stemmed from the CCM's recognition that the most efficient strategy would be to hold different stakeholders responsible for different aspects of implementation. The four PRs were selected for their ability to implement programs, manage resources efficiently and effectively, harness community support and ensure accountability. Each PR was given responsibility for different parts of the grant (although some responsibilities overlap in part).

ZNAN and CHAZ, the two civil society PRs, oversee all civil society sub-recipients and program activities. The two ministries focus on overall coordination, as well as large-scale logistical activities in which public-sector negotiations are ongoing (such as ARV procurement).

ONE CIVIL SOCIETY PRINCIPAL RECIPIENT'S RANGE OF FUNDED ACTIVITIES

One notable outcome from the multiple-PR model is that more than one stakeholder nearly always means that a greater number and wider range of activities and options will be considered. That point is illustrated by the type of activities funded in Round 4 by ZNAN, for example.

Improving access to HIV treatment is one of the two main responsibilities ZNAN has as PR. (The other refers more directly to prevention education and service provision.) The organization realized that several different strategies could be used to fully achieve the one HIV treatment objective. In some cases, the organization emphasized existing best practice, while in others it developed new projects.

One best practice identified by ZNAN is an innovative and successful community-engagement project that exemplifies CSS. That project, known as ART Community Education and Referral (ACER), was launched by the International HIV/AIDS Alliance and has been implemented in partnership with numerous local NGOs and community groups (see box, next page). ACER focuses on training and employing PLWHA to help support those in need and link them with appropriate treatment services. ZNAN supported the project through the Global Fund to expand from four sites to more than ten.

ZNAN has also sought to increase the involvement of the private sector in the country's HIV/AIDS response. The organization signalled this priority immediately after the Round 4 grant was signed. It announced through the media (including newspapers and radio) that it would be supporting the development and expansion of HIV/AIDS workplace programs through the Global Fund. The announcement included a public call for proposals – with relevant criteria clearly outlined – from private companies and organizations involved or interested in setting up such programs.

After reviewing all submissions, ZNAN chose the Zambian AIDS Business Coalition to be the main sub-grantee for that private-sector initiative. The PR assessed the coalition's capacity needs and provided support where necessary, including staff training, improved transportation options and upgraded technology (including better computer access). This type of capacity-building support is similar to – and ultimately complements – the CSS activities offered by ZNAN to civil society sub-grantees in its role as PR.

ACER PROJECT: A COMMUNITY-ENGAGEMENT MODEL FOR THE GLOBAL FUND

The Global Fund in Zambia recently agreed to support the innovative project ACER, begun by the International HIV/AIDS Alliance in 2004. The decision by ZNAN, one of the PRs of a large HIV/AIDS grant, was in recognition of the success of the project and the expectation that it would expand. It also serves as an indication of the type and scope of projects that are funded through the Global Fund.

The underlying idea behind ACER was to explore how an integrated community-engagement approach can support the government ART program, increase uptake of HIV testing and ART and contribute to better HIV prevention and health-seeking behavior. To that end, ACER focuses on linking existing community organizations - including home-based care providers, church groups, traditional healers and PLWHA groups - with government health services. Those partner groups provide community education on ART, VCT, HIV prevention and stigma reduction. They also help develop and sustain a two-way referral system between the community and the health system (including other treatment supporters), thereby helping ensure that individuals are followed up and supported when they return to the community.

Another key element of ACER is the direct involvement of PLWHA in all stages of its design and implementation. For example, based on the belief that peer support is a highly-effective strategy in reaching people in need, the project trains people openly living with HIV as treatment support workers. They promote uptake of treatment, support treatment adherence and help enhance prevention efforts in community and clinic settings. All treatment support workers are full-time employees, which not only guarantees them and their families a livelihood but also creates a committed and experienced staff.

In addition, the Network of Zambian People Living with HIV/AIDS (NZP+) was involved in the two formative assessments, known as "community consultations" held prior to the project's launch. Those consultations were essential for project designers to recognize and understand individual and community perceptions as well as residents' knowledge and experiences of HIV/AIDS and its related treatment. NZP+ and its HIV-positive members continue to be key partners in the ongoing implementation of this model.

As of the beginning of 2008, the project was reaching more than 120,000 people at a total of four sites in Zambia, two each in Ndola and Lusaka. With recently-announced Global Fund assistance, totaling at least US\$ 1 million, the project will be scaled up to 13 districts. That will lead to a large increase in the number of treatment support workers; perhaps as many as 500 will ultimately be needed.

The project's success in helping increase uptake in VCT and treatment services has also prompted the Zambian Ministry of Health to use the ACER community-engagement approach in the scale-up of its treatment services. And finally, there are significant and noteworthy CSS elements to the project. For example, local partner organizations are learning from their involvement in the ACER project and utilizing their new skills to build capacity for other activities.

IMPACT AND LESSONS LEARNED

Serving as a PR, even for only part of a grant, is a major responsibility for any entity. The challenges are arguably greater for civil society groups because they are nearly always smaller and have less direct access to resources than government agencies. ZNAN, however, has been relatively successful to date:

- > According to a 2007 grant scorecard issued by the Global Fund, ZNAN progress has been mostly positive. It was noted in particular that the program “has performed well in its key activity of putting HIV/AIDS patients on ART (579 patients, 125 percent of target). There are also good results for people receiving sensitization and education on ART (90 percent of target) and health- and home-based care facilities receiving support (114 percent of target).”
- > The number of patients on ART had more than doubled less than one year after the release of the 2007 Global Fund scorecard. According to ZNAN, in April 2008 nearly 1,420 patients were on ART through the program.

The most notable lesson learned from the experience in Zambia is that a multiple-PR model can indeed be effectively structured and implemented. The success to date serves as a clear counterweight to critics’ arguments that such a model is unwieldy to administer and creates a competitive environment among the various PRs. As has become clear in Zambia, such potential problems can be avoided when:

- > civil society’s voice and influence in the CCM are strong and respected by all stakeholders;
- > the CCM as a whole recognizes the comparative advantage of each of the sectors (public, civil society and private) in specific elements of service delivery;
- > each PR’s responsibilities are identified and highlighted from the very beginning; and
- > the program continues to be implemented in a spirit of mutual respect and cooperation among all PRs involved.



AMONG OTHER TYPES OF SUPPORT, VOLUNTEER TRADITIONAL BIRTH ATTENDANTS IN ZAMBIA ADVISE PREGNANT WOMEN TO GO FOR VCT FOR HIV. WITH PROPHYLACTIC USE OF ARVS, MANY MOTHERS WHO TEST POSITIVE GIVE BIRTH TO BABIES WHO ARE HIV-NEGATIVE.





Established in 1993, the International HIV/AIDS Alliance (the Alliance) is a global partnership of nationally-based organizations working to support community action on AIDS. These national partners help local community groups and other NGOs to take action on AIDS, and are supported by technical expertise, policy work and fundraising carried out at the UK-based international secretariat and across the Alliance.

In addition to community and country-based programs, the Alliance also has extensive regional programs and works on a range of international activities such as support for South-South cooperation, operations research, training and good practice development, as well as policy analysis and advocacy.

This publication is based on an extensive literature review and interviews among staff at the Secretariat of the International HIV/AIDS Alliance (Brighton, UK) and the Global Fund Secretariat (Geneva, Switzerland). Staff from Alliance linking organizations in specific countries also provided information, observations and insights.

Interviews were conducted with the following individuals affiliated with the International HIV/AIDS Alliance or its linking organizations at local levels: Fiona Barr, Altantsetseg Batsukh, Joanna Doricott, Carolyn Green, Sunita Grote, Christopher Kangale, Anton Kerr, Alaine Manouan, Siobhan O'Dowd and Hiroko Takasawa.

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IT IS NEEDED, OFTEN RIGHT INTO PEOPLE'S HOMES.**

4. HUMAN RESOURCES FOR HEALTH (HRH)

Compilation of selected publications about Human Resources for Health:

11. Adano, Ummuro and James McCaffery. October 2008. *Global Fund Round 9 Opportunity to Build Human Resource Management Capacity: the central pillar in health systems strengthening initiatives*. Washington DC: Capacity Project (funded by USAID).
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**11. ADANO, UMMURO AND JAMES MCCAFFERY. OCTOBER 2008.
GLOBAL FUND ROUND 9 OPPORTUNITY TO BUILD HUMAN
RESOURCE MANAGEMENT CAPACITY: THE CENTRAL PILLAR IN
HEALTH SYSTEMS STRENGTHENING INITIATIVES. WASHINGTON
DC: CAPACITY PROJECT (FUNDED BY USAID).**

Many countries do not have adequate capacity to manage their current health workforce, let alone to effectively manage increased numbers of health workers and new funding for human resources, or to effectively develop and implement health workforce strategies and policies.. Round 9 of the Global Fund provides an opportunity to build human resource management capacity to enable countries to effectively use expanding funds for the health workforce and to successfully implement health workforce strategies and policies at national, district, and facility level. This short document outlines ways in which the Global Fund can be used to build this capacity.

Global Fund Round 9 Opportunity to Build Human Resource Management Capacity: the central pillar in health systems strengthening initiatives

Ummuro Adano, Management Sciences for Health, Capacity Project, USAID

James McCaffery, Training Resource Group, Capacity Project, USAID

October, 2008

Context

As human resources for health (HRH) issues continue to dominate the global health agenda, it is evident that donor funding is expanding to help address this challenge. The international community is planning to more than double its funding for health beginning in 2009, and nested within these funds will be more resources available to address HRH issues and meet the overall goal of increasing the health care workforce, thus enhancing both quality and access. This is a critical goal, but the increased resources will put more pressure on already overburdened health sector leaders to manage systems to produce and use well a range of new health care workers. Moreover, a portion of these new financial resources will undoubtedly be targeted towards studies and other documentation activities that are likely to generate reports and guidelines. The intent is that these products and promising practices will be taken up, utilized or implemented by HR professionals in the target countries to inform HRH policy and practice.

This is fine in theory; however, in fact, most ministries of health have inadequate capacity to manage their current HRH situation to say nothing about managing an increase in health care workers to undertaking new initiatives. The fact of the matter is that professionally qualified HR managers mostly do not actually exist and where they do, they have no training, qualification or preparation to succeed in their roles, let alone absorb and make sense of the complex technical resources or guidelines that donor funded projects continue to provide. This approach has to change and some of the available financial resources – including the Global Fund to Fight AIDS, TB and Malaria – should be specifically programmed to support directly the development of human resource management (HRM) capacity in these countries, especially the strategic role of HR Directorates in ministries of health.

It is important to stress that these governments have been managing HRH badly for years, until almost all facets of HRM systems are inadequate at best, and almost drive health workers from the system at worst. Problems exist at every level, from sector-wide planning and policy-making to managing a facility-level work environment. These problems in turn create obstacles at every stage of HR management, and serve to impede effective health worker production, recruitment, hiring, deployment, productivity and retention. Moreover, it is these rickety HRM systems—weak, understaffed by people with little or no background, often unsupported within their own ministries—who will be expected to be the key to absorbing and making effective use of the rapidly expanding donor funding.

Round 9 of the Global Fund presents an opportunity for governments and other partners to begin to reverse the mismanagement of HR and underinvestment in HRM systems, and to build the capacity that will enable the effective use of increased donor funding for HRH. This is an opportunity not to be missed.

Strategic Actions to Strengthen the HRM Function

Health workers are the heart of any viable national health system or service delivery organization that is able to meet its goals. And good HR management with certain core functions is the glue that holds all the internal parts of an organization together, contributes to a positive work climate and supports high-quality services.

Given the severity of the HRM challenges in most countries, there needs to be a wide range of practical actions taken by donors and country governments to make serious progress in the area of workforce management and support. As long as basic requirements around the Global Fund and Health System Strengthening are met, in particular demonstrating the link between Health System Strengthening interventions and improved outcomes for AIDS, TB, and/or malaria, the Global Fund can be used to support these actions. And given the pressing nature of the HRH crisis and the bottleneck that HR management represents in addressing the crisis, as relevant to their situations applicants **should** use the Global Fund to support these actions.

These actions include:

- *Establish, staff and strengthen HR Units or Directorates* in ministries of health to raise their profile and visibility and ensure that they have a reasonable budget and are more strategically placed within the organizational hierarchy to contribute ideas and decisions to meet the goals of the national health system.
- *Recruit and provide salary support for professional HR Managers to work in HR Directorates and Planning Departments:* These managers will plan and lead programs of work that aim to strengthen sector wide HR professional leadership for the effective planning and management of human resources in the health sector. For this to happen, a new cadre of HR managers will need to be trained and enabled to have real input into operational and strategic decisions about HRM. This may involve a bundle of integrated and complementary strategies and actions, such as:
 - *Establish a partnership at the country level* wherein HRH function managers and staff—both at the central and district levels—have access to articulated training, coaching, mentoring and problem-solving follow-up over a two-year period. This can be done with a consortium of international and country-level partners (this is already under discussion among the Global Health Workforce Alliance, WHO/AFRO and the Capacity Project). Combine this approach with donor and government agreement to recruit and fund a sufficient number of HRM managers and leaders (not necessarily clinicians) so that capacity can be built and sustained. Make certain that a large proportion of these potential leaders are not clinicians, as draining doctors and nurses away from actual practice represents a significant current loss. This “sufficient number” would have to be large enough to allow for some leakage, as—when skills and competencies are enhanced—there will likely be jobs available within the private and NGO health communities.
 - *Provide sound readily-available HRM consulting support* to HR staff working at different levels of the system. This is especially important in settings where the HR role and functions have been decentralized to regions and districts.

- *Work with local and regional management training institutions* to support a serious and substantive HRM short degree program at one or more institutions in sub-Saharan Africa that agree to produce HRM leaders and practitioners (not just academics). This program should be closely aligned with ministries of health and other related nongovernmental agencies, and should include some sort of work-based, integrated practicum to assure relevance and operational reality.
- *Develop performance-based indicators that measure HRM progress* so that the HRM function and leaders can more easily be held accountable. It is also important to link the training, education, coaching and mentoring to these indicators.
- *Develop and deploy HR managers* to all high-volume facilities and larger clinics and, in decentralized systems, establishing provincial and district HR focal point persons. In some cases, this may require the hiring of new HR qualified staff, but in most cases it may just involve the recalibration of the role of existing staff, especially Health Administration Officers where they exist, and giving them additional HRM training and support to begin assuming a fuller HR-specific role.

Without this kind of HRM focused health system strengthening (HSS) work, the capacity of the health sector to produce, deploy and manage an increase in health care workers is seriously in question, as is the ability to undertake new and necessary HR initiatives and reforms that will emerge from the increase in attention to HSS.

Global Fund applicants seeking additional advice on how to include the types of HRM capacity building activities described above in their Round 9 proposals should contact James McCaffery (jmccaffery@capacityproject.org) and/or Ummuro Adano (uadano@intrahealth.org).

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**12. COOPER, MAGGIE AND ERIC A. FRIEDMAN. AUGUST 2008.
THE RIGHT TO HEALTH AND HEALTH WORKFORCE PLANNING: A
GUIDE FOR GOVERNMENT OFFICIALS, NGOS, HEALTH WORKERS AND
DEVELOPMENT PARTNERS. WASHINGTON, DC: PHYSICIANS FOR
HUMAN RIGHTS.**

[<http://physiciansforhumanrights.org/library/documents/reports/health-workforce-planning-guide-2.pdf>]

The health workforce, improved health outcomes, and human rights are inextricably linked. Not only is a strong health workforce needed for improved health and fulfilling human rights, but human rights are needed to develop the workforce that can lead to overall better health. This guide explains why it is necessary to ground health workforce planning in human rights, and how to develop a plan that does just that. Health and other government ministry officials, civil society, health workers, and development partners can use this tool as they develop or revise health workforce plans. The strategies contained in this guide can also inform interventions, approaches, and priorities in health workforce development that can be incorporated into Global Fund proposals.

The Right to Health and Health Workforce Planning

**A Guide for Government Officials, NGOs,
Health Workers and Development Partners**

Health
Action AIDS

PHR

Physicians for
Human Rights

Physicians for Human Rights

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PHYSICIANS FOR HUMAN RIGHTS

Physicians for Human Rights (PHR) mobilizes health professionals to advance health, dignity, and justice and promotes the right to health for all. Harnessing the specialized skills, rigor, and passion of doctors, nurses, public health specialists, and scientists, PHR investigates human rights abuses and works to stop them. Since 1986, PHR has exposed human rights violations and called for accountability on a range of issues, including trauma inflicted on civilians during conflict; lack of access to healthcare due to racial, ethnic and gender discrimination; violence against women; torture and inhuman treatment of detainees, and poor health stemming from vast inequities in societies. As a founding member of the International Campaign to Ban Landmines, PHR shared the 1997 Nobel Peace Prize.

Health Action AIDS, a campaign of PHR, mobilizes health professionals to support a comprehensive AIDS strategy and advocates for funds to combat the disease. It develops ways for US health professionals to support colleagues and activists around the world and researches the connection between human rights and HIV/AIDS.

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I find this document impressive, accessible, and groundbreaking. When one reads the document one can't but be amazed by the intense and intensive, broad and detailed consultations that have gone into this unique publication. It should be a pocket book to every health professional, a bible to every Minister of Health, a guiding star for every health and human rights expert and novice.

**— Maxwell V. Madzikanga
(Msc Disease Control, EMMB magna cum laude)
Senior HIV/AIDS Researcher to the
UN Special Rapporteur on the
Right to Health**

EXECUTIVE SUMMARY

The purpose of this guide is to explain why it is necessary to ground health workforce planning in human rights, and how to develop a plan that does just that.

After years of insufficient investment, inadequate attention, and ill-advised policies, global attention is now focused on the health workforce. Without a skilled, motivated, and well-equipped health workforce accessible to everyone, health goals will go unrealized and the human right to the highest attainable standard of health unfulfilled. Indeed, the health workforce, improved health outcomes, and human rights are inextricably linked. Not only is a strong health workforce needed for improved health and fulfilling human rights, but human rights are needed to develop the workforce that can lead to overall better health.

The World Health Organization, the Global Health Workforce Alliance, and most significantly, national-level alliances are poised to develop strategies to meet health workforce needs in developing countries — and much work towards this end is already underway. The aim of this guide is to explain and explore how human rights, especially the right to health, can and should inform national health workforce strategies.

Policymakers, health workers, NGOs, technical agencies, and others involved in developing and implementing health workforce plans can adapt the principles and examples contained in this guide to their own situation to ensure that human rights are incorporated into national health workforce strategies.

Indeed, an overriding message of this guide is that human rights are not merely add-ons or luxuries that only a few countries may be able to afford. Rather, human rights must be integral to the process and content of developing health workforce strategies in all countries, and only when this is the case will the dignity of everyone — including the poorest and most marginalized and socially disadvantaged members of society — be respected and upheld.

Incorporating human rights into health workforce planning begins with the process of developing the plan. The views of all segments of society should be taken into account from the beginning of developing the plan

— not only as an afterthought, or to seek affirmation or buy-in into a plan that has already been developed. The government, which will generally spearhead the planning process, should especially ensure that marginalized or otherwise disadvantaged members of society — such as people living in rural areas, people with HIV/AIDS, and people with disabilities — are involved in developing the plans, and that adequate resources are available to allow them to meaningfully engage in the planning process. Health workers themselves must also be fully involved in the planning process.

Another key human rights principle, accountability, also starts at the beginning of the planning process, and continues through the development and implementation of the plan. Plans should be accountable to human rights obligations and other health goals and commitments, such as the Millennium Development Goals and the global commitment to universal access to HIV services by 2010. Broad participation in developing the plan will help ensure that it is accountable to the needs, priorities, and rights of the population. Continued accountability entails making the health workforce plan readily accessible; engaging in effective monitoring and evaluation; involving communities in the monitoring process; and providing mechanisms to address complaints, including complaints about the violation of patients' rights. Donors, too, are accountable in designing their support to promote local processes and plans, and avoid unintended consequences, such as may occur through health programs that are isolated from other parts of the health sector.

Human rights principles put heavy emphasis on ensuring that any health workforce strategy promotes equality and avoids discrimination. One example of the principle of equality is how the workforce is distributed, and the importance of a comprehensive approach to strengthening the workforce in rural and other underserved areas to fulfill the right to health for everyone.

To fulfill the right to equal access to health care, planners may need to provide financial and non-financial incentives for health workers. They may need to improve health infrastructure in certain areas; utilize the education system to help recruit, train, and retain health workers for rural areas (through curricula reform, scholarships,

and local recruitment in rural areas); find ways to foster a skills mix that values workers who serve in rural areas; establish community services requirements, and ensure that health workers in rural areas — and indeed, everywhere — feel valued. Special training for health workers and appropriate policies are needed to ensure that health workers themselves do not discriminate against women, people with AIDS, and others. Within the workforce, special concerns that women may have should be addressed, and gender equality ensured.

The response to the health workforce crisis should be comprehensive, covering aspects of the workforce such as numbers, distribution, quality of training, productivity, management, and information systems. The health workforce plan cannot be developed in isolation, but should be linked to broader health development strategies, which will be required to ensure that health workers have the medicines, supplies, and other tools needed to do their job, and that information systems are in place to ensure that health workers and planners alike have accurate and timely information. It should also support improvements in underlying determinants of health, such as clean water, sanitation, and adequate nutrition. The plan should respond to the range of health workers needs, including material, professional, and psychosocial needs, and should ensure confidential health services for health workers, including comprehensive HIV services. The plan should also be comprehensive in its reach, covering both the public sector and the multi-faceted private sector (including not-for-profit institutions, NGOs, and for-profit businesses). It should consider as well the range of health workers whose services could be used to rapidly scale up health services, including unemployed health workers, retired workers, and the diaspora.

Even as the health workforce will require rapid expansion in many countries, this should not occur at the expense of quality. For example, increased

production of health workers should occur in concert with sufficient trainers and other measures needed to ensure their quality; plans should address the need for supportive supervision; health workers should be trained in ethical standards; and the government has a responsibility to ensure the quality of the private sector health workforce.

A well-designed health workforce plan is only meaningful if it is implemented, which will require sufficient funding, often more — sometimes significantly more — than is presently being spent. To meet their human rights obligations, countries must prioritize health and other spending required to fulfill these rights. Following human rights law, countries should seek funds from all available sources, including increasing the share of the budget that goes to health, examining ways to increase overall resources available for public investment, and seeking external funding to fill the gap. Wealthy nations, in turn, are obliged to cooperate in ensuring that such funding is available.

Finally, health workforce strategies must be sustainable, so that countries provide their populations ever-improving levels of health services, and maintain and enhance commitments to equality. This requires setting priorities that will ensure that essential health services, including those in underserved areas, can continue even if there are funding shortfalls beyond the country's control. Health workers themselves are central to sustaining a strong health workforce and health sector, and ensuring that human rights principles continue to inform the health system. This requires that health workers understand and can promote human rights through their work in treating patients, through policymaking roles, and through advocacy. All health workers should be trained in human rights, including the right to health.

INTRODUCTION

The massive shortage of health workers in Africa and elsewhere, combined with greatly increased national and international attention to the health workforce over the past few years, creates a unique opportunity to re-envision and develop that workforce. If governments and development partners are genuinely committed to achieving Universal Access to HIV/AIDS treatment, prevention, care, and support by 2010, the Millennium Development Goals, and other health goals, then significant investments in the health workforce are required, as are national health workforce strategies. This workforce should not simply be an expanded version of the present workforces. Rather, countries have the opportunity — and the obligation — to create a new type of health workforce, where health workers are trained in human rights, including the right to health; a health workforce that is equitably distributed; and a health workforce that has the tools required to provide their populations with the highest attainable standard of health.

The impact on health outcomes of the shortage and poor distribution of health care workers in developing countries, especially those in sub-Saharan Africa, has recently received substantial international attention. The World Health Organization's *World Health Report 2006: Working Together for Health* estimated that sub-Saharan Africa is suffering a shortage of more than 800,000 doctors, clinical officers, nurses, and midwives, and an overall shortfall of nearly 1.5 million health workers.¹ The decimating impact of HIV/AIDS has also thrown into harsh light the extraordinary need for health workers and health systems to administer and monitor antiretroviral treatment regimes, provide palliative care and voluntary counseling and testing services, prevent mother-to-child transmission, and handle increased hospital admissions due to HIV-related

illnesses.² The lack of sufficient numbers of accessible, well-trained health workers has also been cited as a primary barrier to reducing high rates of maternal mortality³ and blamed for many other preventable deaths from other causes.

The shortage of doctors and nurses in our hospital has led to one nurse attending to 40 patients at time. This is a nightmare for patients who require urgent attention, such as those suffering from acute asthma or acute diabetes (keto-acidosis). This had led to the loss of patients who would otherwise be stabilised. The quality of service is highly compromised and bordering on unethical practice. This is inhuman treatment of fellow human beings.

— **Medical laboratory technologist,
Kenyatta National Hospital,
Nairobi, Kenya⁴**

Countries and international partners are realizing that to adequately meet current health needs, and achieve universal access to HIV services by 2010 and the health-related Millennium Development Goals (MDGs), let alone to prepare for possible future health scenarios (an outbreak of SARS or avian influenza, for instance), they must create strategic, forward-thinking and comprehensive plans to produce, retain and manage the people that constitute the health workforce. These people are not limited to doctors and nurses, but also include midwives, physical and occupational therapists, clinical officers, physician and nursing assistants, psychiatrists and other mental health providers, laboratory technicians, nutritionists,

¹ World Health Organization, *World Health Report 2006: Working Together for Health* (2006), at 8, 12-13. Available through: <http://www.who.int/whr/2006/en/index.html>. Other estimates of the number of additional doctors, nurses, and midwives Africa needs are even higher. See Joint Learning Initiative, *Human Resources for Health: Overcoming the Crisis* (2004), at 28. Available through: <http://www.globalhealthtrust.org/Report.html>.

² Olive Shisana, et al. (Human Sciences Research Council, Medical University of South Africa & South Africa Medical Research Council), *The Impact of HIV/AIDS on the Health Sector. National Survey of Health Personnel, Ambulatory and Hospitalised Patients and Health Facilities, 2002* (2003). Available for free download at: <http://www.hsrcpress.ac.za/product.php?mode=search&page=1&freedownload=1&productid=1986>.

³ Marge Kobinsky, et al., "Going to Scale with Professional Skilled Care." *Lancet* (Oct. 14, 2003) 368:1377-1386, at 1379-1380.

⁴ Personal communication with Raphael Gikera, Medical Laboratory Technologist, Kenyatta National Hospital, Nairobi, Kenya, July 18, 2006.

social workers, managers and logistical personnel, traditional healers, community health workers and many other cadres of health workers.

Countries such as Eritrea, Kenya, Lesotho, Malawi, South Africa, Swaziland and Zambia have already generated strategic plans for their respective health workforces, though turning them into concrete plans of action and implementing those plans have in some cases been patchy and beset by difficulties.⁵ In 2005, African Union Ministers of Health committed themselves to "... prepare and implement costed human resources for health development plans."⁶ And the African Health Strategy 2007-2015, adopted by African Union health ministers in April 2007, commits countries to "Develop costed national human resources development and deployment plans, including revised packages and incentives, especially for working in disadvantaged areas."⁷ These plans must be informed not only by technical considerations, but also human rights principles and obligations, including the right to the highest attainable standard of health.

⁵ Ummuro Adano (Capacity Project), *Collection and Analysis of Human Resources for Health (HRH) Strategic Plans* (Dec. 2006). Available at: http://www.capacityproject.org/images/stories/files/resourcepaper_strategicplans.pdf.

⁶ Gaborone Declaration on a Roadmap Towards Universal Access to Treatment and Care, 2nd Ordinary Session of the Conference of African Ministers of Health (CAMH2), Gaborone, Botswana, Oct. 10-14, 2005, at 2(v). Available at <http://www.physiciansforhumanrights.org/library/documents/reports/gaborone-declaration.pdf>. Earlier, the Fourth Ordinary Session of the Assembly of the African Union, meeting in January 2005, urged Member States to "Prepare inter-ministerial costed development and deployment plans to address the Human Resources for Health Crisis." Assembly of the African Union, Fourth Ordinary Session, Jan. 30-31, 2005, Abuja, Nigeria, *Decision on the Interim Report on HIV/AIDS, Tuberculosis, Malaria and Polio*. Available at: <http://www.africa-union.org/summit/jan2005/Assembly/Assembly%20Decisions%2055%20-%2072.doc>.

⁷ Africa Health Strategy 2007-2015, at para. 56. Adopted at the Third Session of the African Union Conference of Ministers of Health, Johannesburg, South Africa, April 9-13, 2007. Available at: http://www.africa-union.org/root/UA/Conferences/2007/avril/SA/9-13%20avr/doc/en/SA/AFRICA_HEALTH_STRATEGY_FINAL.doc.

Why a Rights-Based Approach to Health and Health Workforce Planning?

Health rights, like other human rights, are not to be viewed as unreasonable demands. They are entitlements borne out of specific obligations that individuals claim from states. People do not simply have a 'need' for the goods, services and conditions that promote health. They have a 'right' to claim that these be provided by their governments based on the inherent dignity of all human beings, and a legal world order that recognizes that protecting and preserving this dignity is the first job of governments.⁸ A rights-based approach recognizes and insists that states are accountable for incorporating human rights principles, such as equity and non-discrimination, into policy formulation and implementation.⁹

Human rights assume a special concern for rectifying historical and other imbalances and meeting the needs and rights of poor, disadvantaged and marginalized individuals and populations.¹⁰ These groups are mostly likely to suffer from the effects of ill health, due in large part to having the least reliable access to adequate health services and healthy living conditions, often as a result of neglect or discrimination. A rights-based approach to health can uphold and reinforce public health goals by seeking to redress these disparities.

⁸ "Human rights and fundamental freedoms are the birthright of all human beings; their protection and promotion is the first responsibility of Governments." Vienna Declaration, World Conference on Human Rights, Vienna, June 14 — 25, 1993, U.N. Doc. A/CONF.157/24 (Part I) at 20 (1993), at para. 1. Available at: <http://www1.umn.edu/humanrts/instree/l1viedec.html>.

⁹ UN Millennium Project, *Final Task Force Paper on Child Health and Maternal Health: Who's got the power? Transforming health systems for women and children* (2005), at 35. Available at <http://www.unmillenniumproject.org/documents/TF4Childandmaternalhealth.pdf>.

¹⁰ Audrey R. Chapman (American Association for the Advancement of Science), *Exploring a Human Rights Approach to Health Care Reform* (1993), at 23.

I. THE PURPOSE OF THIS GUIDE

The primary purpose of this manual is to guide the development and evaluation of national health workforce plans that are based on human rights, drawing especially on obligations critical to realizing and upholding the right to health. Human rights standards should be integral to, rather than add-ons to, health workforce policies.

It should serve as a technical guide to inform ministry of health and education officials, health workforce experts, health workers, NGOs, and anyone else involved in developing a national health workforce strategy of factors that they should consider to ensure that the plan and the planning process itself are in accord with human rights standards, and should be used to evaluate such plans. More generally, this guide should inform anyone interested in how countries should respond to the health workforce crisis about certain critical, rights-based elements of that response, as well as contributing rights-based principles into the national and global dialogues around health workforce. If the World Health Organization, the Global Health Workforce Alliance, or another entity develops standard criteria for what makes for a sound health workforce plan, human rights principles must be part of those criteria.

Equally important, this guide aims to expand knowledge of the right to health more generally. The right to health can only be invoked effectively if people are aware of it and know what it means in relation to their own lives.¹¹ If individuals, groups, policymakers and advocates are empowered to demand an inclusive and accountable process of health workforce planning, these plans will be more likely to be more effective, equitable and sustainable in their implementation.

¹¹ Judith Asher, *The Right to Health: A Resource Manual for NGOs* (2004), at 4. Available at: http://shr.aaas.org/pubs/rt_health/rt_health_manual.pdf.

This guide should not be viewed as a blueprint for incorporating human rights into the health workforce planning process. There is no single form for a plan. Every health workforce plan should be a living strategy that responds to the unique and changing circumstances faced by each country and, ideally, be subject to regular re-evaluation to ensure that these are being adequately addressed. Countries should not be dissuaded from adopting a human rights approach to health workforce planning even though limited capacity may constrain them from immediately implementing every aspect of such an approach in full.

The development of a comprehensive, rights-based health workforce plan should not divert attention from attending to short-term operational issues that are vital to functional health services, such as the effort to scale up laboratory capacity to respond to TB and HIV epidemics. Deferring such interventions until such a plan is in place also has human rights implications, especially as the poor and marginalized are most likely to be affected by such delays.¹²

This guide is confined to a discussion of a rights-based approach to health workforce planning; therefore, it does not attempt to discuss other important variables that affect national health workforces. For this reason, discussion of health systems more broadly, international migration or “brain drain” of health workers, and the impact of macroeconomic policies (such as those prescribed or influenced by the International Monetary Fund) on national health sectors, will be limited to their relevance to health workforce planning.

¹² UN Millennium Project, *Final Task Force Paper on Child Health and Maternal Health: Who's got the power? Transforming health systems for women and children* (2005), at 35. Available at <http://www.unmillenniumproject.org/documents/TF4Childandmaternalhealth.pdf>.

II. INTRODUCTION TO THE RIGHT TO HEALTH

Philosophical and Legal Background on the Right to Health

By their nature, human rights are universal because they are derived from the inherent dignity of each individual person.¹³ A variety of human rights are implicated in a rights-based approach to health workforce planning because realizing the right to health is dependent upon attaining other human rights, for example, the rights to food, housing, work, access to information and freedom of movement, among others.¹⁴ This manual focuses primarily on the right to health because it is fundamental to the exercise of other human rights and because the right to health depends on a qualified, motivated, and accessible health workforce.

The right to health can be construed as (1) a right to health care and (2) a right to conditions that promote good health. This is not a right to be healthy. Individual genetics, choices and susceptibility all affect health.¹⁵ Rather, in its most common formulation, it is the right to the *highest attainable standard of health*.

Individuals and communities are “rights holders” — they hold or claim the right to health; states or public authorities are “duty bearers” — they are duty bound to provide for the realization of the right to health in practice. The right to health is applicable to all people, in every country. It is a universal entitlement that is non-negotiable. Governments must take action to progress towards realizing this right, whether or not they

have ratified treaties that invoke the right to health, even though certain specific obligations pertaining to this right are affected by whether a country has ratified the relevant treaties.¹⁶ Most countries, including many of the poorest, have ratified pertinent treaties.¹⁷

The central statement of the right to health in international human rights law can be found in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR).¹⁸ Here, the right to health is defined in Article 12(1):

1. “The States Parties to the present Covenant recognize the right of everyone to the enjoyment of *the highest attainable standard of physical and mental health*.”

Article 12(2) delineates several specific government obligations:

2. “The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
 - (a) The provision for the reduction of the still birth rate and of infant mortality and for the healthy development of the child;
 - (b) The improvement of all aspects of environmental and industrial hygiene;
 - (a) The prevention, treatment and control of

¹³ Audrey R. Chapman (American Association for the Advancement of Science), *Exploring a Human Rights Approach to Health Care Reform* (1993), at 22. Some people have questioned the universality of human rights, or of particular rights. International law, however, is unequivocal on the universality of human rights. See, e.g., Vienna Declaration, World Conference on Human Rights, Vienna, June 14 — 25, 1993, U.N. Doc. A/CONF.157/24 (Part I) at 20 (1993), at para. 1 (“The universal nature of these rights and freedoms is beyond question”). Available at: <http://www1.umn.edu/humanrts/instree/l1viedec.html>.

¹⁴ 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 3. Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

¹⁵ Judith Asher, *The Right to Health: A Resource Manual for NGOs* (2004), at 17. Available at: http://shr.aaas.org/pubs/rt_health/rt_health_manual.pdf.

¹⁶ *Id.* at 4. See also Vienna Declaration, World Conference on Human Rights, Vienna, June 14 — 25, 1993, U.N. Doc. A/CONF.157/24 (Part I) at 20 (1993), at para. 5 (“All human rights are universal, indivisible and interdependent and interrelated. The international community must treat human rights globally in a fair and equal manner, on the same footing, and with the same emphasis. While the significance of national and regional particularities and various historical, cultural and religious backgrounds must be borne in mind, it is the duty of States, regardless of their political, economic and cultural systems, to promote and protect all human rights and fundamental freedoms.”). Available at: <http://www1.umn.edu/humanrts/instree/l1viedec.html>.

¹⁷ Audrey R. Chapman (American Association for the Advancement of Science), *Exploring a Human Rights Approach to Health Care Reform* (1993), at 7.

¹⁸ International Covenant on Economic, Social and Cultural Rights, G.A. res.2200A (XXI), 21 U.N.GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993, U.N.T.S. 3, entered into force Jan. 3, 1976, at art. 12 (emphasis added). Available at: <http://www1.umn.edu/humanrts/instree/b2esc.htm>.

epidemic, endemic, occupational and other diseases;

- (b) The creation of conditions which would assure to all medical services and medical attention in the event of sickness.

A far more detailed elaboration on the right to health can be found in *General Comment 14 on the right to the highest attainable standard of health* (General Comment 14). This document is an interpretation of Article 12 by the Committee on Economic, Social and Cultural Rights.¹⁹ It provides an authoritative explanation of obligations that governments must fulfill and clarifies that the right to health encompasses both the right to health care and to the “underlying determinants of health,” those socio-economic conditions, including food and nutrition, housing, potable water and sanitation, safe working conditions and a healthy environment, that are essential to living a healthy life.²⁰

States are obliged to ensure that the rights in the ICESCR are incorporated into their domestic legal systems, through “the precise method by which” they do so is for each State to decide.²¹ In some countries, national law (generally the Constitution) automatically gives force to international human rights treaties. Other countries pass new legislation that contains the rights included in the ICESCR or amend existing legislation to be consistent with these rights. Some countries have done nothing to incorporate the ICESCR into their national law, which poses particular challenge enforcing the rights in the ICESCR in court.²² National law might itself contain a right to health, and judges should (though not always will) use international legal obligations when interpreting the government’s human rights obligations.²³ Domestic courts may decide to interpret the rights differently from the Committee on Economic, Social and Cultural Rights. The rulings of the Constitutional Court of South Africa, a country whose own Constitution contains a right to

health provision, have made clear that that court does not view the General Comments of the Committee on Economic, Social and Cultural Rights as binding law in South Africa.²⁴

Individual dignity underpins the right to health, which consists of both freedoms and entitlements. Freedoms include the right of each person to control one’s health and body and the right to be free from non-consensual medical treatment and experimentation. Each individual is also entitled to access an equitable system of health care. According to General Comment 14, the right to health must be understood as a “right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the achievement of the highest attainable standard of health.”²⁵

The Right to Health: Benchmarks for Governments

Several essential and interrelated benchmarks exist to discern whether or not a state is progressing towards the meaningful achievement of the right to health:

- **Availability:** Health care and public health facilities, goods and services must be both functional and available in sufficient quality within a country, taking into consideration a country’s level of development.
- **Accessibility:** Health facilities, goods and services must be accessible to everyone. Accessibility encompasses non-discrimination, physical accessibility, economic accessibility (affordability) and access to information.
- **Acceptability:** Health facilities, goods and services must respect medical ethics and patient dignity. They must also respect the culture of individuals, minorities, people and communities, and be sensitive to gender and life-cycle requirements. Health facilities, goods and services must protect confidentiality and be designed to improve the health status of all concerned.
- **Quality:** Health facilities, goods and services must be scientifically and medically appropriate and of good quality. This requires, among other things, skilled

¹⁹ 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). Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

²⁰ *Id.* at para 4.

²¹ Committee on Economic, Social and Cultural Rights, *General Comment 9, The domestic application of the Covenant* (Nineteenth session, 1998), U.N. Doc. E/C.12/1998/24 (1998), at para. 5. Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom9.htm>.

²² *Id.* at para. 6.

²³ Rakeb Messele, *Enforcement of Human Rights in Ethiopia* (2002), at 16. Available at: <http://www.apapeth.org/Docs/ENFORCEMENT%20OF%20HR.pdf>.

²⁴ *Minister of Health v. Treatment Action Campaign (No. 2)* (2002), Constitutional Court of South Africa, CCT 8/02A, at paras. 26-39 (rejecting the concept of core minimum obligations, promulgated in General Comment 3 of the Committee on Economic, Social and Cultural Rights, as a self-standing and independent right under the South African Constitution). Available through: <http://www.constitutionalcourt.org.za/>.

²⁵ 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. 9. Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

health personnel, scientifically approved and unexpired drugs and functional equipment, safe, potable water and adequate sanitation.

The human rights standards invoked in Article 12 and expanded upon in General Comment 14 are directly relevant to any health planning process because they serve as criteria by which potential plans or programs can be assessed.²⁶ NGOs, advocates and policymakers can refer to these criteria to determine whether or not the process, substance and implementation of health planning are consistent with rights-based obligations.

Obligations of Governments

These obligations can be broken down into three broad categories, encompassed under the headings respect, protect and fulfill.

- States are obligated to *respect* the right to health by refraining from inhibiting equal access to health care for all persons or from upholding discriminatory policies or coercive practices that interfere with achieving the right to health, for example, by withholding or misrepresenting health-related information.
- States are also required to *protect* individuals and communities from harmful measures by third parties that would interfere with the right to health, for example, through regulating and enforcing standards of practice for medical personnel and upholding environmental standards.
- States are bound to *fulfill* the right to health through adopting policies and laws that recognize and prioritize realization of this right. The obligation to fulfill the right to health specifies that states must “*adopt a national health policy with a detailed plan for realizing the right to health.*”²⁷

The right to the “highest attainable standard of health” takes into account differing levels of available resources, and recognizes that countries vary in development status, health profiles, financial means and social conditions. The International Covenant on Economic, Social and Cultural Rights requires that each State “take steps, individually and through international assistance and co-operation... to the maximum of its available resources, with a view to

achieving progressively the full realization of the rights recognized in the present Covenant...”²⁸ States are therefore obligated to use the maximum of their available resources to work towards full realization of the right to health and other economic, social and cultural rights.

Is a Country Meeting Its Obligations?

The test of whether states are meeting their obligations regarding the level of resources they devote towards fulfilling the right to health is therefore not one of the absolute level of resources or how the current level of resources compares to previous levels — though both of these measures may be indicative — but rather whether they are prioritizing the right to health and other rights such that they are spending the *maximum* available resources towards their fulfillment. General Comment 14 explains that where resource constraints prevent a state from fully complying with its obligations under the Covenant, the state “has the burden of justifying the every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, the obligations outlined above.” States that fail to do so are violating their obligations under the right to health.²⁹

Even states spending the maximum available resources will have very different levels of resources available. In recognition of this reality, the concept of *progressive realization* is applied to the right to health. It acknowledges that countries, particularly developing countries, may have limited capacity to actually implement their obligations under the right to health and allows for flexibility in the manner and timing of implementation as befits each individual country.³⁰ Progressive realization, however, does not provide an excuse for inaction; states must “move as expeditiously and effectively as possible towards” full realization of the right to health.³¹

²⁶ Judith Asher, *The Right to Health: A Resource Manual for NGOs* (2004), at 29. Available at: http://shr.aaas.org/pubs/rt_health/rt_health_manual.pdf.

²⁷ 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. 36 [emphasis added]. Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

²⁸ International Covenant on Economic, Social and Cultural Rights, G.A. res.2200A (XXI), 21 U.N.GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993, U.N.T.S. 3, entered into force Jan. 3, 1976, at art. 2. Available at: <http://www1.umn.edu/humanrts/instreetree/b2esc.htm>.

²⁹ 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. 47. Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

³⁰ Judith Asher, *The Right to Health: A Resource Manual for NGOs* (2004), at 22-23. Available at: http://shr.aaas.org/pubs/rt_health/rt_health_manual.pdf.

³¹ Committee on Economic, Social and Cultural Rights, *General Comment 3, The nature of States parties' obligations* (Fifth session, 1990), U.N. Doc. E/1991/23, annex III at 86 (1991), at para 10. Available

What Are Core Obligations?

Core obligations are not subject to progressive realization — they must be met immediately, regardless of scarce resources,³² because they are minimum standards of essential health care needed for good health and to prevent “avoidable mortality.”³³ According to the Committee on Economic, Social and Cultural Rights, without such minimum core obligations, the Covenant “would be largely deprived of its *raison d’être*.”³⁴ All states have an immediate duty to move deliberately towards implementing these obligations through, for example, legislative, policy and regulatory measures, with sufficient resources accorded to make these measures meaningful.³⁵

at: <http://www1.umn.edu/humanrts/gencomm/epcomm3.htm>.

³² “It should be stressed, however, that a State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations . . . which are non-derogable.” 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. 47. Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>. This is a stronger stance than the Committee on Economic, Social and Cultural Rights took in its General Comment 3 on state party obligations. “In order for a State party to be able to attribute its failure to meet at least its minimum core obligations to a lack of available resources it must demonstrate that every effort has been made to use all resources that are at its disposition in an effort to satisfy, as a matter of priority, those minimum obligations. The Committee wishes to emphasize, however, that even where the available resources are demonstrably inadequate, the obligation remains for a State party to strive to ensure the widest possible enjoyment of the relevant rights under the prevailing circumstances.” Committee on Economic, Social and Cultural Rights, *General Comment 3, The nature of States parties’ obligations* (Fifth session, 1990), U.N. Doc. E/1991/23, annex III at 86 (1991), at paras. 10-11. Available at: <http://www1.umn.edu/humanrts/gencomm/epcomm3.htm>. The change followed the adoption of the Maastricht Guidelines in 1997. The Maastricht Guidelines state, “Such minimum core obligations apply irrespective of the availability of resources of the country concerned or any other factors and difficulties.” Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, Maastricht, January 22-26, 1997, at para. 9. Available at: http://www1.umn.edu/humanrts/instree/Maastrichtguidelines_.html.

³³ Judith Asher, *The Right to Health: A Resource Manual for NGOs* (2004), at 50. Available at: http://shr.aaas.org/pubs/rt_health/rt_health_manual.pdf.

³⁴ Committee on Economic, Social and Cultural Rights, *General Comment 3, The nature of States parties’ obligations* (Fifth session, 1990), U.N. Doc. E/1991/23, annex III at 86 (1991), at para 10. Available at: <http://www1.umn.edu/humanrts/gencomm/epcomm3.htm>.

³⁵ Judith Asher, *The Right to Health: A Resource Manual for NGOs* (2004), at 50. Available at: http://shr.aaas.org/pubs/rt_health/rt_health_manual.pdf.

To meet their core obligations, governments must:

- Ensure the right of access to health facilities, goods and services, especially for vulnerable and marginalized groups;
- Ensure access to nutritionally adequate and safe food;
- Ensure access to basic shelter, housing, sanitation and potable water;
- Provide essential drugs;
- Ensure equitable distribution of health facilities, goods and services; and
- Adopt a national health strategy and plan of action.³⁶

Governments are also obligated to:

- Ensure reproductive, maternal and child health care;
- Provide immunization against major infectious diseases;
- Take steps to prevent, treat and control epidemic and endemic diseases;
- Provide health education and access to information regarding major health problems in the community; and
- Provide appropriate training for health personnel, including education on health and human rights.³⁷

A National Workforce Plan: A Right to Health Necessity

Creating and implementing a national health workforce plan is an essential measure towards fulfilling the right to health, particularly if the health workforce is insufficient for meeting a population’s essential and evolving health needs. A state’s minimum core obligation to fulfill the right to health includes the obligation “...to adopt and implement a national public health strategy and plan of action.”³⁸ Since the health workforce is central to the success of any overall health strategy and plan of action, any meaningful public health strategy must incorporate

³⁶ 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. 43. Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

³⁷ *Id.* at para 44.

³⁸ *Id.* at para. 43 (f).

a health workforce plan. For this reason, creating and implementing a national health workforce plan must take precedence within state agendas.

The process by which such a plan is developed is critical to its success.³⁹ A plan developed without a rights-based approach will be unlikely to result in the sustainable health improvements for poor, marginalized or vulnerable groups or address the needs and concerns identified by health workers themselves. Fidelity to a rights-based approach within the planning process itself, including adhering to the principles of participation, equity and non-discrimination, will help ensure that the criteria of

availability, accessibility, acceptability and quality are built into the plan.

The next two sections will discuss the key human rights principles of participation, equity and non-discrimination in relation to health workforce planning, which are essential to effectively promoting and protecting the right to health.⁴⁰

³⁹ Charles O. Oyaya & Susan B. Rifkin, "Health Sector Reforms in Kenya: An Examination of District Level Planning." *Health Policy* (2003) 64: 113-127.

⁴⁰ Virginia Leary, "The Right to Health in International Law." *Health and Human Rights* (1994) 1(1). Available at: <http://www.hsph.harvard.edu/fixcenter/V1N1leary.htm>.

III. PARTICIPATION: WHO IS INVOLVED IN DEVELOPING THE PLAN?

Participation is a vital feature of the right to the highest attainable standard of health. The right to health not only attaches importance to reducing the burden of ill health, it also emphasizes the importance of democratic and inclusive processes by which this objective is to be achieved.

—Paul Hunt,
UN Special Rapporteur on the Right to Health⁴¹

The right to health concerns not only the content of a health strategy and how it is implemented, but also the process by which it is developed. That process should not be one in which government authorities simply dictate what the policies will be. Rather, it must be a participatory process, where the people whose rights will be affected by these policies — in the case of health workforce plans, everyone — have a meaningful opportunity to be involved in developing and evaluating these policies. This does not mean that every citizen will be involved in drafting the strategy, which is clearly not practical. It does mean, however, that the plan genuinely addresses the concerns and needs of the population, which have not simply been surmised, but rather directly gathered. This may happen through a variety of measures such as having an inclusive team of people to drive the strategy's development; holding community and national forums open to members of the public to discuss the plan; holding consultations with NGOs, health professional associations, and other entities that represent certain interests and perspectives; conducting surveys of ordinary health system users and marginalized populations about their perspectives and needs, and health workers about theirs; and providing opportunities for written input and feedback.

One model for participation, particularly noteworthy because it places considerable authority in civil society

and health workers themselves, are democratically elected health councils, which are present in many countries and provide civil society a voice in health planning. In some cases, these councils have decision-making powers, which may include approving plans and budgets and providing complaint mechanisms. Municipal health councils in Brazil, for example, have binding authority to approve health plans and budgets, with half their membership drawn from civil society, and the other half a mix of health workers, government officials, and contracted-out service providers. Monthly meetings are open to the public.⁴² In the health workforce planning context, the teams that develop the plan, like these health councils, should include various sectors of government, civil society representatives, and health workers.

This obligation has particular relevance in relation to countries' health planning processes. General Comment 14 highlights "participation of the population in all health-related decision-making at the community, national and international levels" as "...a further important aspect of the right to health."⁴³ Moreover, the Committee determined that popular "participation in political decisions related to the right to health taken at both the community and national levels" is an important aspect of creating conditions that assure access to health facilities, goods and services.⁴⁴ General Comment 14 identifies participatory health planning as an essential component of the right to health. State parties are obligated to:

...adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health system concerns of

⁴¹ Paul Hunt, *Some Closing Remarks on Participation and the Right to the Highest Attainable Standard of Health*, Third National Health Conference, Peru: Civil Participation and the Right to Health, July 12, 2006. Available at: http://www2.essex.ac.uk/human_rights_centre/rth/docs/PH's%20draft%20for%20July%202006%20Peru.doc.

⁴² Helen Potts, *Accountability and the Right to the Highest Attainable Standard of Health* (2008), at 22. Available at: http://www2.essex.ac.uk/human_rights_centre/rth/docs/HRC_Accountability_Mar08.pdf.

⁴³ 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. 11. Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

⁴⁴ *Id.* at para. 17.

the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process...⁴⁵

The Value of Participation

As a critical dimension of the right to health, participation is valuable in a number of ways.

- Participation is necessary to secure health services that actually meet the requirements of the communities that they serve through offering people an opportunity to voice their needs and expectations. People who are receiving or providing health services are in the best position to indicate whether their needs are being met, and what it will take to meet them.
- Health worker participation will also help ensure that the plans take into account the needs of the health workers themselves. A Kenyan physician points out the disheartening disjuncture between expectations of quality care in the context of severe resource constraints:

There is nothing more demotivating to a worker than being in an office without any resources to do the work. Many of us have worked in hospitals where we were recycling gloves in this era of HIV. We have worked in labour wards and operating theatres where autoclaves could be broken for days, yet we are expected to provide safe motherhood services.

- Physician, Kenya⁴⁶

Including the perspectives of health workers is crucial to ensure that resources are directed where they can support health workers' ability to do their jobs, which is key to motivating and retaining them.

- Participation cannot be divorced from other fundamental rights, including equity and non-discrimination. The nature and level of participation influences whether these rights will be realized within the plan being devised.⁴⁷ By participating in the planning process, communities are also able to exercise influence over resources and ultimately access to health care. Participation helps to direct attention towards inequitable or insufficient resource provision and

ensure that planning processes are undertaken and implemented in an equitable and non-discriminatory manner. When marginalized populations — people with disabilities, for example — have the opportunity to participate in planning for the workforce that will — or will not — meet their needs, these needs are more likely to be taken into account in the planning process, and met in the health strategy that emerges.

- The contribution to the planning process and education that comes from participation means people know what to expect of health services and can better judge whether these expectations are being met, and to take measures through their community and government representatives, media, and other measures to seek to rectify any deficiencies.
- This process of participation also serves to empower people and communities by giving them a voice and allowing them to contribute to life-affecting processes.
- Understanding community health needs and implementing programs to successfully address them is a necessary measure to build or re-build trust between the public and the health sector. The World Health Organization (WHO) recognizes that this relationship of trust is essential for building functioning and responsive health systems. The WHO explicitly calls for the design and implementation of a health workforce plan that fosters trust between citizens and health workers, including through the “[establishment] of decision-making processes that are seen as fair and inclusive.”⁴⁸ Through this participation, community members will interact with health workers, will understand the constraints and challenges that health workers and the larger health system face, and will know that they have had a genuine opportunity to develop a health workforce that is not antagonistic to their needs, but rather designed around meeting those needs.
- Involving the general public in health workforce planning, and in health sector planning more generally, is needed to enable plans to address community involvement in health promotion and health systems.⁴⁹

⁴⁵ *Id.* at para. 43 (f).

⁴⁶ Personal communication with Dr. Burton Wagacha, Health Coordinator, GTZ Refugee Kenya Country Program, Kenya, July 6, 2006.

⁴⁷ Barbara Klugman, *Accountability and Participation in Africa* (2006), at 1.

⁴⁸ World Health Organization, *World Health Report 2006: Working Together for Health* (2006), at 121. Available at: <http://www.who.int/whr/2006/en/index.html>.

⁴⁹ Africa Health Strategy 2007-2015, at para. 74-78. Adopted at the Third Session of the African Union Conference of Ministers of Health, Johannesburg, South Africa, April 9-13, 2007. Available at: <http://www.africa-union.org/root/UA/Conferences/2007/avr/>

For example, what role will the health workforce have in promoting health literacy among the general population? What will be the linkages between communities and the formal health sector to ensure a continuity of care, including between health services and community-based social services, and how can the plan ensure health workers' knowledge about these community-based services? How can it ensure that health workers are responsive to local needs and concerns? How can health workers support informal caregivers?

- Participation and who is allowed or encouraged to participate tells us a lot about society. Ensuring participation is a positive commitment that demonstrates that people's input and opinions matter. This is particularly true with respect to poor and marginalized groups, who are often left out of decision-making related to their health service provision.

What Does Participation Entail?

Participation must not just be tokenism,⁵⁰ a symbolic or 'check the box' approach that may be used to give the appearance of participation or help to legitimize a particular project or policy. It should also be representative, so that a wide range of people and perspectives have the opportunity to contribute, and not large numbers of people but all drawn from a narrow segment of society.

It is important to ascertain that community and stakeholder views are not only sought out, but are also being respected and incorporated into decision-making processes. Participation is usefully defined as:

*Involving genuine and voluntary partnerships between different stakeholders from communities, health services and other sectors; based on shared involvement in, contribution to, ownership of, control over, responsibility for and benefit from agreed values, goals, plans, resources and action around health.*⁵¹

SA/9-13%20avr/doc/en/SA/AFRICA_HEALTH_STRATEGY_FINAL.doc.

⁵⁰ UNICEF, *Fact Sheet: The Right to Participation*, <http://www.unicef.org/crc/files/Right-to-Participation.pdf>. Last modified Dec. 15, 2005.

⁵¹ Rene Loewenson (EQUINET/TARSC), *Report of the TARSC/Equinet Regional Meeting on Public Participation in Health, in cooperation with IDRC (Canada) and WHO (AFRO/HSSD), Equinet Policy Series No. 5* (2000).

For participation to extend beyond mere consultation into a more reciprocal process, it must be 1) meaningfully informed and 2) adequately resourced.

Participation Should Be Meaningfully Informed

I'd say [health] policies are usually imposed (not the nicest word to use but the reflection of a reality of a hand[ful] of de-contextualised experts placing/suggesting solutions for the problems of the 'others'). That's the process of policy making to my view.

— Dr. Jaime Miranda,
Civil Association for Health and Human
Rights Education (EDHUCASalud),
Lima, Peru⁵²

While participation may be formally endorsed and adopted in policy terms, its practical implementation in health planning or policymaking is often very limited. Achieving the right to participation requires that all stakeholders are meaningfully informed and, where necessary, helped to understand how technical decisions have an impact on health. Participation in health planning has historically been a particularly top-down process, characterized by a hierarchical, clinically-oriented approach to decision-making that may exclude poor and marginalized groups altogether.

A re-thinking of participation in health planning will recognize and value community input, rather than disregarding it as unscientific and uninformed, as has too often been the case.⁵³ Policymakers have a responsibility to ensure that community participation is informed, and that communities have the capacity, the organization, the information and the "language" to effectively engage in health policy and planning discussions.⁵⁴ This may require provision of key documents in advance, directly explaining impact of technical sounding decisions and policies on real life, and encouraging questions through creating an open, non-intimidating, non-judgmental atmosphere that encourages questions and allows time for community members to express their views. This will allow community representatives to take a more active, informed and effective role in health workforce planning and better represent the interests of their communities.

⁵² Personal communication with Dr. Jaime Miranda, Civil Association for Health and Human Rights Education (EDHUCASalud), Lima, Peru.

⁵³ Rene Loewenson, *Participation and Accountability in Health Systems: The Missing Factor in Equity*. (2000), at 10. Available at <http://www.equinet africa.org/bibl/docs/partic&account.pdf>.

⁵⁴ *Id.*

For their part, health workers and policymakers may not be attuned to the value of citizen participation in health-related decision making or what it entails. Making this kind of informed engagement possible may require steps to:

- Educate health professionals, technical experts and policymakers about the right to health in the context of other economic, social and cultural rights, and specifically, about the right of people to participate in health-related decision-making.
- Inform citizens, both as health consumers and health providers, of their right to provide input to and demand accountability of health workforce strategies.
- Offer “technical empowerment”⁵⁵ to allow community members and community representatives to understand and influence workforce planning and service delivery.

Resources To Ensure That Participation Is Possible

Enabling meaningful participation requires that resources be specifically allocated for this purpose. Participation in health planning is unlikely to be enacted spontaneously. It requires political will and resource commitment to enable stakeholders to engage in all stages of the health workforce planning process, including plan development, implementation and monitoring. The process of facilitating participation will necessarily vary, but without making and adhering to explicit political and budgetary commitments, participation will not work.

Representing Diverse Perspectives

*The actual capacity of communities to participate in defining and implementing health agendas has been limited by resource constraints, entrenched professional and social hierarchies, and public health models focused on individual behaviors and curative biomedical interventions. Gender, race and class discrimination also play a role.*⁵⁶

— World Health Organization

⁵⁵ Carmen Baez & Peter Barron, *Community Voice and Role in District Health Systems in East and Southern Africa: A Literature Review. EQUINET Discussion Paper 39* (June 2006), at 35. Available at: <http://www.equinetafrica.org/bibl/docs/DIS39GOVbaez.pdf>.

⁵⁶ World Health Organization, *World Health Report 2004: Changing History*. Available at: <http://www.who.int/whr/2004/chapter3/en/print.html>.

Participation in health systems takes place at many levels and reflects relationships of power and influence within and between communities. Local elites or more powerful medical interest groups may benefit from policy reforms at the expense of less well organized or more marginalized populations, such as people living in poverty, youth, rural communities or people with disabilities.⁵⁷

WHO and others recognize that a multi-stakeholder and multi-sectoral approach must serve as a guiding principle for formulating national health workforce strategies. An inclusive process must involve relevant ministries (e.g., ministries of health, finance and education) and interest groups such as NGOs, patient groups, professional associations and donor coordinating committees in the planning process.⁵⁸

It is also crucial to take steps to conscientiously identify groups that are usually marginalized from health planning process and to build up their capacity to participate in the development, substance and implementation of these strategies.⁵⁹ Including ordinary citizens and vulnerable groups, such as those below, in health workforce planning is both essential for realizing the right to health and to developing sustainable, successful health services that meet the needs of communities.⁶⁰

People Living with HIV/AIDS (PLWHA)

The involvement of people living with or affected by HIV/AIDS underpins ethical and effective interventions against HIV/AIDS⁶¹ and demands that people living with HIV/AIDS (PLWHA) be involved at every level of decision-making. PLWHA are best placed to inform decision-making processes and represent their own needs. Yet stigma and lack of explicit provisions to ensure participation can preclude PLWHA from taking part in health decision-making processes,

⁵⁷ Rene Loewenson, *Participation and Accountability in Health Systems: The Missing Factor in Equity*. (2000), at 6. Available at <http://www.equinetafrica.org/bibl/docs/partic&account.pdf>.

⁵⁸ Mario R. Dal Poz, et al. “Addressing the Health Workforce Crisis: Towards a Common Approach.” *Human Resources for Health* (August 3, 2006) 4:21 at 3. Available at: <http://www.human-resources-health.com/content/4/1/21>.

⁵⁹ Barbara Klugman, *Accountability and Participation in Africa* (2006), at 21.

⁶⁰ Carmen Baez & Peter Barron, *Community Voice and Role in District Health Systems in East and Southern Africa: A Literature Review. EQUINET Discussion Paper 39* (June 2006), at 3. Available at: <http://www.equinetafrica.org/bibl/docs/DIS39GOVbaez.pdf>.

⁶¹ UNAIDS, *Greater Involvement of People Living with HIV and AIDS — GIPA*, http://www.unaids.org/en/Issues/Affected_communities/gipa.asp, visited Feb. 8, 2008.

thereby affecting the chances of having their rights and needs addressed.⁶² The organization of the health workforce, its distribution, community-level health services, and the roles of different health workers will have a tremendous impact on the full spectrum of HIV-related health services.

HIV-positive health professionals: Involvement in health planning is a way to assert the role and rights of PLWHA, but it is also particularly important to crafting national human resources for health strategies that integrate and recognize the role that HIV-positive health providers play in providing health services. The dire lack of trained health workers combined with the high rates of HIV infection among the existing health workforce in sub-Saharan Africa (one study estimates that nearly 16% of South Africa's health professionals are HIV-positive⁶³) means that the contributions of HIV-positive health workers are essential for service delivery. The retention of these workers will depend in large part on whether their needs are met (e.g., for confidential medical and support services and flexible schedules to accommodate doctor visits) and whether or not they experience enabling and non-discriminatory workplace environments. The participation of HIV-positive health workers in national HRH planning processes is essential to facilitate overt consideration of these important issues.

Ordinary Health System Users, Particularly Rural Poor and Other Marginalized Groups

From the health users' point of view, the success of a national health workforce strategy will be measured by whether they as individuals receive competent, timely and appropriate health care. National health workforce plans must extend beyond managerial and technical considerations to encompass the perspectives of health consumers,⁶⁴ particularly the rural poor and other marginalized populations such as ethnic minorities. These groups are often the most disadvantaged in

⁶² Madeleen Wegelin-Schuringa & Evelien Kamminga, "Water and Sanitation in the Context of HIV/AIDS: The Right of Access in Resource-Poor Countries." *Health and Human Rights* (2006) 9:152-172, at 163.

⁶³ Olive Shisana, et al. (Human Sciences Research Council, Medical University of South Africa & South Africa Medical Research Council), *The Impact of HIV/AIDS on the Health Sector. National Survey of Health Personnel, Ambulatory and Hospitalised Patients and Health Facilities, 2002* (2003), at 34. Available for free download at: <http://www.hs-rcpress.ac.za/product.php?mode=search&page=1&freedownload=1&productid=1986>.

⁶⁴ World Health Organization, *World Health Report 2006: Working Together for Health* (2006), at 120. Available at: <http://www.who.int/whr/2006/en/index.html>.

terms of accessing health services, and their voices are least likely to be heard in policy and planning processes. Participation of health system users can take various forms, including focus groups, community meetings and inclusion on leadership teams, but there must be an understanding that input gathered through these forums has a legitimate role in actually shaping the health workforce plan. Because participation necessarily cannot include every individual, NGOs (such as health consumer organizations) and other civil society representatives have an important role to play. Their participation can help ensure that the concerns and perspectives of individual health care users are reflected in the health workforce plans.

Front Line Health Providers

Health services providers are best placed to voice what tools and conditions are necessary for them to deliver high quality, timely care to their patients:

*Our capacity to deliver health services would be improved by a conducive working environment with adequate basic infrastructure, proper medical supply management, better and regular remuneration and opportunities for continuing education and training.*⁶⁵

— Doctor, Meru, Kenya

Health workers from various cadres and at different stages in their careers should be involved in order to gather a variety of perspectives. For example, junior doctors will have different perspectives and experiences than senior doctors. Given that many doctors migrate early in their careers, the input of new doctors to health workforce planning is especially valuable.

Home Caregivers and Community Health Workers

UNAIDS recently estimated that 90% of care for people living with AIDS is provided in the home.⁶⁶ Certainly a need, and often even a preference,⁶⁷ for home- and community-based care exists, but instead of being integrated into

⁶⁵ Personal communication with Dr. Bactrin M. Killingo, Meru Hospice, Meru, Kenya, July 13, 2006.

⁶⁶ UNAIDS, *2004 Report on the Global AIDS Epidemic* (2004), at 118. Available through: http://www.unaids.org/bangkok2004/GAR2004_html/GAR2004_00_en.htm.

⁶⁷ According to VSO, 90% of Zambians expressed a preference for home- or community-based care over that provided within a clinical setting. Voluntary Service Overseas (VSO), *Reducing the Burden of HIV and AIDS Care on Women and Girls. VSO Policy Brief* (2006), at 5. Available at http://www.vso.org.uk/Images/RBHACWG_tcm8-8415.pdf.

and recognized by formal health systems, community carers — whether community health workers, volunteers or family members — are instead compensating for the failure of public health systems to provide health services to their citizens. Yet because these care providers are not integrated into formal health systems, policies designed to improve conditions of service, enhance compensation and extend training opportunities and other benefits to health workers will not necessarily reach community care providers.⁶⁸ To counteract this invisibility, community caregivers must be included in health workforce planning. This is crucial to uphold the rights of both caregivers and their patients — for example, by providing necessary training, supervision and equipment (such as home-based care kits and basic medicines) to enable compliance with established standards of care,⁶⁹ which may also have to be developed as part of the workforce planning process.

Practitioners of Traditional Medicine

An estimated 80% of people in Africa use traditional medicine, yet few national policies exist to regulate its practice or incorporate it into other aspects of health systems.⁷⁰ Traditional healers play important roles within communities — the high utilization of their services indicates an established level of trust and their inclusion in health workforce planning offers an opportunity to gain greater understanding of local beliefs and practices around health. Given such extreme shortages of health workers, traditional practitioners are important human resources and can have a synergistic relationship with formal health services, such as by referring patients to formal health services and providing counseling or other services.⁷¹ Additionally, the dialogue that results from participation by traditional practitioners within health workforce planning may also provide an opportunity to learn about and help influence traditional practices that are harmful to health.

⁶⁸ *Id.* at 17.

⁶⁹ *Id.* at 3.

⁷⁰ New Partnership for Africa's Development (NEPAD), *Human Resource Development Program — NEPAD Health Strategy (Draft 10)* (2003), at 4. Citing WHO/AFRO, *Promoting the Role of Traditional Medicine in Health Systems: A Strategy for Africa* (1999). Available at: <http://www.nepad.org/2005/files/documents/115.pdf>.

⁷¹ The Ugandan NGO Traditional Healers and Modern Practitioners Together Against AIDS (THETA) is one example of such collaboration. See Uganda AIDS Commission, *Country Responses — THETA*, http://www.aidsuganda.org/response/govt_sectors/cso_programs/theta.htm, visited Dec. 8, 2007.

Women

Women's under-representation or exclusion from health care-related decision-making structures may lead to omission of important qualitative issues from health workforce planning. For example, female health workers may have distinct needs in terms of balancing professional and home responsibilities, returning to work and updating skills following pregnancy and child-rearing leave, or security and workplace violence concerns. Rather than regarding these needs as inefficiencies, health workforce planning should consider ways to accommodate these needs in order to optimize the contributions of female health staff and support their retention.

Children, Youth and the Elderly

Children, youth and the elderly have the right to participate in decision-making that affects their lives. This is especially relevant to health workforce planning within the context of the HIV/AIDS crisis, which has forced young people (including many orphans) and the elderly to take on the role of care providers in their families and communities. Yet evidence points to the exclusion of child- or grandparent-headed households from decision-making processes or bodies due to stigma surrounding AIDS.⁷² As with home and community caregivers, it is important that health workforce plans acknowledge the care roles played by children and older adults so that they can better account for their needs. For example, child- or elder-headed households may have greater difficulty in accessing clinics themselves or bringing a family member to a facility due to transportation, financial and physical constraints. Health workforce plans may be able to accommodate some of these by, for example, making provision for health outreach workers and mobile clinics.

People with Disabilities

People with physical and mental disabilities are among the poorest and most marginalized of all groups. Disabled people have limited access to education, employment, and basic health care, often live in dire poverty, and experience profound economic and social exclusion. Social attitudes, stigma, discrimination and lack of accommodation play an important role in limiting the opportunities of disabled people and their participation in public life. Health services facilities are often

⁷² Madeleen Wegelin-Schuringa & Evelien Kamminga, "Water and Sanitation in the Context of HIV/AIDS: The Right of Access in Resource-Poor Countries." *Health and Human Rights* (2006) 9:152-172, at 163.

unavailable or inaccessible to people with disabilities and rehabilitation services are scarce, particularly in rural areas.⁷³ Prevention and treatment guidelines for common diseases rarely take into account special needs of people with disabilities.⁷⁴

In order to overcome such exclusion, health workforce planning must include people with disabilities, their family members, disability advocacy groups and disability service providers to ensure that the needs of people with disabilities — 10% of the world's population, 80% of whom live in developing countries — are both identified and appropriately addressed.⁷⁵ Are disability-related service requirements, such as rehabilitation services and community-based care facilities, fully integrated into national health workforce planning? Is disability awareness training integrated into health training curricula? Do health training institutions offer mental health nursing or psychiatric specializations, and do adequate numbers of people enroll in these programs? Are people with disabilities able to pursue health-related training or employment? These and other questions need to be considered throughout the health workforce planning process.

Participation and Positive Outcomes

Participation can lead to policies that are not only more inclusive, but more effective, robust, sustainable, and meaningful to those living in poverty.

**- Paul Hunt,
UN Special Rapporteur on the
Right to Health⁷⁶**

⁷³ World Bank, *Disability and HIV/AIDS at a Glance* (Nov. 2004). Available at <http://siteresources.worldbank.org/INTPHAAG/Resources/AAGEngDisabilityHIVr4.pdf>. For example, UNICEF estimates that only 3% of all people with disabilities receive rehabilitation services that meet their needs. *Id.* In Ethiopia, fewer than 5% of people with disabilities receive rehabilitation services. Landmine Survivors Rehabilitation Services Database, *Ethiopia*, http://www.lsndatabase.org/country_rehab.php?country=ethiopia. Accessed Jan. 13, 2008. In Namibia, 15% of people with disabilities living in urban areas receive rehabilitation services, but only 2% of those in rural areas do. Ronald Wiman, Einar Helander & Joan Westland, *Meeting the Needs of People with Disabilities—New Approaches in the Health Sector* (2002), at 4. Available at: <http://siteresources.worldbank.org/DISABILITY/Resources/280658-1172610662358/MeetingNeedsWiman.pdf>.

⁷⁴ Personal communication, Jean Thomas Nouboussi, Handicapped International, Jan. 15, 2008.

⁷⁵ World Bank, *Disability and HIV/AIDS at a Glance* (Nov. 2004). Available at <http://siteresources.worldbank.org/INTPHAAG/Resources/AAGEngDisabilityHIVr4.pdf>.

⁷⁶ Paul Hunt, "Some Closing Remarks on Participation and the Right to the Highest Attainable Standard of Health." Third National Health

Participation of communities and other stakeholders in public health planning helps ensure sustainability and effectiveness of policies and programs that result by building trust and support within the community for the plan and by fostering a deeper understanding of policy and program intentions.⁷⁷ For instance, health care providers and health care consumers can offer invaluable assessments of whether health workforce policies are meeting their needs in practice. Informed policy decisions based on such input, including how to prioritize limited resources, can have markedly positive outcomes, as in the case of Ondo State, Nigeria.

Ondo State in southwest Nigeria has a population of 4 million people, making it the same size of some entire countries in sub-Saharan Africa. In 2003, a new administration came into office with a comprehensive development agenda, seeking to turn around what was then a very troubled state. In the area of health, the government surveyed health providers to learn their needs, and found that the overwhelming need — the priority of 62% of health workers — was to have adequate medicines, supplies, and equipment. The government focused on improving these basic requirements for a functioning health system, including by improving working conditions in rural health facilities, which were in the worst condition.

The results have been dramatic. Before these efforts, only 28% of nurses practiced in rural areas of this primarily rural state. This figure has jumped to 66%.⁷⁸ Improvement in working conditions in rural health facilities appears to be a major factor in this change. There are at least two lessons here. One, finding solutions to the health worker crisis requires listening to health workers themselves. The government sought health workers' views, and acted based on these views. Two, strengthening the health workforce is intimately linked to other health system improvements. The health workforce cannot be looked at in isolation from wider health system failings such as inadequate supplies of medicines and equipment. Creating conditions where health workers are able to

Conference, Peru: Civil Participation and the Right to Health, July 12, 2006. Available at: http://www2.essex.ac.uk/human_rights_centre/rth/docs/PH's%20draft%20for%20July%202006%20Peru.doc.

⁷⁷ Helen Potts, *A Right to Participation in Public Health Strategy Development* (2005). Available at: <http://www.engagingcommunities2005.org/abstracts/Potts-Helen-final.pdf>.

⁷⁸ Powerpoint presentation by Commissioner for Health, Ondo State, Nigeria & CHESTRAD International, Nigeria, Ondo State, Nigeria: Evidence, Learning & Action for Human Resources for Health, presented Aug, 2006, in Akure, Ondo State, Nigeria, at slides 10, 30.

be healers will encourage their retention.⁷⁹

But full participation in health workforce planning also has intrinsic value of its own. The process

⁷⁹ Other development activities, including building roads to areas previously only accessible by boat, likely also contributed to the increased number of nurses serving in rural areas. Ondo States is presently seeking funds to expand and consolidate these improvements. Personal communication, Dr. Lola Dare, Executive Secretary, African Council for Sustainable Health Development (ACOSHED), Jan. 14, 2008.

of involving people in decision-making helps both individuals and communities to become effective agents in their own lives and to ask questions, seek solutions and pursue accountability.⁸⁰

⁸⁰ UN Millennium Project, *Final Task Force Paper on Child Health and Maternal Health: Who's got the power? Transforming health systems for women and children* (2005), at 35. Available at <http://www.unmillenniumproject.org/documents/TF4Childandmaternalhealth.pdf>.

IV. NON-DISCRIMINATION AND EQUALITY

[AIDS treatment programs are] focused on urban areas. The rural areas are left behind. Patients can't afford transit. I've had five patients die quietly in the last six months because they didn't have access to AIDS treatment...There's no electricity where I work, the roads are bad, there's no equipment. If I get a needle puncture, there's no prophylaxis. I'm on my own. I'm on call 24 hours; this leads to fatal errors. This is a classic case of marginalization.

— Physician,
Niger State, Nigeria⁸¹

An Explanation of the Principles of Non-Discrimination and Equity

Non-discrimination is one of the most fundamental principles in international human rights law and is absolutely central to a human rights approach to health.⁸² All states, regardless of resource constraints, must immediately comply with this obligation, which forbids:

*...any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health.*⁸³

⁸¹ Personal communication with Dr. Chukwumanya Igboekwu, Health Program Associate for Physicians for Social Justice (PSJ) and practicing physician based in Kontagora, Niger State, Nigeria, Nov. 2006.

⁸² Judith Asher, *The Right to Health: A Resource Manual for NGOs (2004)*, at 53. Available at: http://shr.aaas.org/pubs/rt_health/rt_health_manual.pdf.

⁸³ 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>.

States are required not simply to refrain from discriminatory policies or actions, but also to affirmatively move towards equitable arrangements that guarantee minimum essential health standards for all. In this context, non-discrimination and equity are two distinct yet related concepts. Equity is at the heart of realizing the right to health: states have an immediate obligation to work towards promoting equity and to rectify the collective effects of past or current discrimination. This means that states are actively required to take steps to achieve health equity among all population segments.

The right to health has a particular concern for ensuring access to health facilities, goods, and services for “vulnerable or marginalized groups.”⁸⁴ This is a core obligation, which means that all states, regardless of resource availability or level of development, are required to take specific, targeted actions to ensure that all vulnerable or marginalized groups have access to minimum standards of essential health care services.

To be consistent with this rights requirement, health workforce plans should explicitly consider how health workers shortages and poor distribution restrict vulnerable or marginalized groups from accessing health services to which they are entitled. These groups, such as women, refugees, asylum seekers or migrants, people with disabilities or indigenous populations, may each have distinct challenges in accessing health care that meets minimum standards.

They are also the least likely to have benefited from overall advances in health status and are most likely to suffer a disproportionate burden of ill health due to either overt discrimination or to neglect. In some instances, a person's health status itself — for example, living with HIV/AIDS or a physical or mental disability — may foster discrimination or stigma, further reinforcing their exclusion and vulnerability.⁸⁵ Discrimination also inhibits

⁸⁴ *Id.* at para 43(a).

⁸⁵ Paul Hunt, *The right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, Report of the Special Rapporteur. U.N. Doc. E/CN.4/2003/58 (Feb. 13, 2003), at para. 59. Available at: <http://www2.essex.ac.uk/human%5Frights%5Fcentre/>

effective public health responses — populations that are stigmatized and discriminated against have greater difficulty in accessing and are more reluctant to avail themselves of health services.⁸⁶

The health workforce shortage reflects and amplifies patterns of global inequity. The developed world, despite a lower burden of disease, claims the majority of the world's health workers. The imbalances are most severe in sub-Saharan Africa, which accounts for 24% of the world's disease burden, while claiming only 3% of the world's health workforce and 1% of global health financing. In contrast, the Americas region, including the United States and Canada, possesses 37% of the world's health workforce, despite only suffering 10% of the global health disease burden, and accounts for at least 50% of global health expenditures.⁸⁷ This discrepancy in coverage is reflected in health outcomes, such as markedly higher rates of maternal mortality in developing countries, which is strongly associated with lack of access to qualified health workers.⁸⁸ A woman in sub-Saharan Africa has a one in 16 chance of dying due to pregnancy-related complications; a woman in the developed world has only a one in 2,800 chance of dying as a result of pregnancy; in fact, less than 1% of maternal deaths occur in high-income countries.⁸⁹

The hospital where I work, which serves 100,000 people in the district, averages 2-3 maternal deaths per week due to delayed operations. The two medical officers cannot adequately cope since they have to attend to other emergencies and referrals from the neighbouring districts.

— Nurse,
Homa Bay, Kenya⁹⁰

rth/docs/CHR%202003.pdf.

⁸⁶ *Id.* at paras. 59-63; Judith Asher, *The Right to Health: A Resource Manual for NGOs* (2004), at 57. Available at: http://shr.aas.org/pubs/rt_health/rt_health_manual.pdf.

⁸⁷ World Health Organization, *World Health Report 2006: Working Together for Health* (2006), at 8. Available at: <http://www.who.int/whr/2006/en/index.html>.

⁸⁸ Carla AbouZahr, "Maternal Mortality: Helping Mothers Live." *OECD Observer* (Dec. 2000). Available at: <http://www.oecdobserver.org/news/fullstory.php/aid/374>.

⁸⁹ World Health Organization, *World Health Report 2005: Make Every Mother and Child Count* (2005), at 11. Available at: <http://www.who.int/whr/2005/en/>.

⁹⁰ Personal communication with Fredrick Omiah, practicing nurse, Homa Bay District Hospital, and honorary national secretary, National Nurses Association of Kenya, Homa Bay, Kenya, July 6, 2006.

These disparities are replicated within countries as well as between them. Urban centers contain greater proportions of health workers than rural areas, making health services less accessible to rural residents and contributing to disparate health outcomes. For example, as of 2004, Ghana's capital, Accra, and the surrounding area had 30 times more doctors and four times more nurses, relative to population, than the rural Northern Region.⁹¹ This lopsided arrangement has resulted in very poor health outcomes for rural residents. According to UNICEF, the infant mortality rate in the rural north of the country is twice as high as that in the capital region.⁹²

Communities in rural Uganda have a difficult time accessing a health worker. For example, at outpatient facilities upcountry, there may be 200 people per day who show up seeking care, but only one health worker and one clinic for 25km. You may see a doctor or a nurse, but quality of care is unsure. It's different seeing a patient first thing in the morning versus after many, many patients — my judgment may be impaired after so many consultations.

— Medical student,
Kampala, Uganda⁹³

Many of these disparities can be attributed in large measure to inappropriate and inequitable distribution of resources. Disproportionate investment in "expensive curative health services that are often accessible only by a small, privileged fraction of the population, rather than [in] primary and preventative health care benefiting a far larger part of the population"⁹⁴ is a form of discrimination.

A concerted, collaborative effort by different levels of government may be required to overcome such disparities. For example, in Nigeria, the federal government is responsible for tertiary facilities, provincial governments for provincial hospitals, and local governments for district hospitals and local health facilities. Absent a joint

⁹¹ Drawn from presentation by Dr. Yaw Antwi-Boasiako, Director, Human Resources for Health Department, Ministry of Health, Ghana, at the Oslo Consultation: Human Resources for Health, Oslo, Norway, Feb. 24-25, 2005.

⁹² UNICEF, *At a Glance: Ghana — The Big Picture*, http://www.unicef.org/infobycountry/ghana_1878.html, visited Feb. 8, 2008.

⁹³ Personal communication with Nixon Niyonzima, medical student, Makerere University, Kampala, Uganda, July 12, 2006.

⁹⁴ 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. 19. Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

strategy to improve the distribution of resources, tertiary facilities might be well-resourced due to funds from the federal government, but primary facilities could remain severely deprived.

Redressing disparities may require redistributing authority across levels of government, or reconsidering their roles. To increase the numbers of health workers recruited from rural areas, Ghana's health ministry is urging district assemblies to sponsor students, who are then expected to return to serve in their districts.⁹⁵

Groups that are particularly prone to experiencing discrimination — such as people with disabilities, minorities and the poor — are most frequently deprived of their right to enjoy the highest attainable standard of health because of insufficient resource allocation, in addition to other overt types of discrimination. For instance, the small budgetary allocations allotted to mental health by many countries means that many people with mental disabilities are unable to realize their right to health on an equal basis with other population groups.⁹⁶

A rights-based national health workforce plan offers an opportunity to correct existing inequalities and promote more equitable health outcomes within a country. This requires prioritizing poor, vulnerable and marginalized groups when drafting and implementing a health workforce plan. This is essential in order to move towards realizing equitable health care for all population groups, to realize public health priorities and to comply with immediate obligations to prevent discrimination in access to health care services or to the underlying determinants of health such as access to clean water.⁹⁷ The failure to take such concerted, deliberate and targeted action — accompanied by meaningful allocation of resources — amounts to a violation of the obligation to fulfill the right to health.⁹⁸

While in Tororo district, a rural district in Eastern Uganda, I was witness to the plight of a woman with a threatened miscarriage. There was not a single doctor in a radius of about 10km — we being only medical students. We stabilized the woman and referred her to a higher level health facility on a bicycle, more than 10km away.

— Medical student, Uganda⁹⁹

Possible Strategies to Enhance Equity

States are obligated to “take measures to reduce the inequitable distribution of health facilities, goods and services.”¹⁰⁰ In order to progress towards eliminating these inequities, a health workforce plan should consider why gaps in coverage occur, how they impact the ability of vulnerable and marginalized groups to access health services, and develop priorities accordingly. For example:

- Are health budgets inequitable, prioritizing curative, tertiary-level services at the expense of primary health care?
- What is the balance of training generalists and specialists, the latter likely to be based in urban areas and tertiary health facilities?
- Do health workers have reliable access to essential supplies and basic infrastructure in rural areas?
- Which groups face particular difficulty in accessing health services, even in areas where services are available?

As part of this process, health data focused on rural or urban location and gender should be used as much as possible in order to help health workforce planners identify existing discrimination or disparities.¹⁰¹ This

⁹⁵ Ministry of Health, Republic of Ghana, *Dealing with the Human Resource Crisis in the Health Sector: Draft Policy on the Way Forward Towards a Sustainable Human Resource Development* (Sept. 2005), at 9. Available at: http://www.interchurch.org/resources/uploads/files/292Addressing_the_HR_crisis_Mld_level_care.doc. See also World Health Organization, *Mental Health Profile (Ghana) 2003* (c. 2003), at 34. Available at: http://www.who.int/countries/gha/publications/MENTAL_HEALTH_PROFILE.pdf.

⁹⁶ Paul Hunt, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. U.N. Doc. E/CN.4/2005/51 (Feb. 11, 2005), at para. 58. Available at: <http://www2.essex.ac.uk/human%5Frights%5Fcentre/rth/docs/CHR%202005.pdf>.

⁹⁷ Judith Asher, *The Right to Health: A Resource Manual for NGOs* (2004), at 53. Available at: http://shr.aaas.org/pubs/rt_health/rt_health_manual.pdf.

⁹⁸ 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. 52 Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

⁹⁹ Personal communication with Nixon Niyonzima, medical student, Makerere University, Kampala, Uganda, Jan. 23, 2008.

¹⁰⁰ 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. 52 Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

¹⁰¹ Paul Hunt, *The right of everyone to the enjoyment of the highest attainable standard of physical and mental health: Report of the Special Rapporteur, Mission to Mozambique*, U.N. Doc. E/CN.4/2005/51/Add.2 (Jan. 4, 2005), at para. 38. Available at: <http://www2.essex.ac.uk/human%5Frights%5Fcentre/rth/docs/mozambique.pdf>. Data should, for instance, be disaggregated by gender and other prohibited grounds of discrimination. *Id.*

may assist countries in setting priorities that will allow for distribution, training and management of the health workforce in a manner that will reinforce, rather than undermine, equitable and accessible health care.

Improving Inequitable Health Services in Rural and Underserved Areas

The skewed distribution of health workers in favor of urban areas and at the expense of rural and other underserved areas (such as poor areas on the outskirts of cities) significantly affects the ability of these populations to access health services. Rural health posts remain unfilled for a variety of reasons, including lack of essential supplies, inadequate infrastructure, poor working conditions and accommodation options for health workers, social and professional isolation, and restricted employment and educational opportunities for spouses and children. Governments must actively move to address these vast disparities in order to comply with their obligations to fulfill the right to health.

Since staff shortages constitute perhaps the biggest challenge to providing quality and accessible care in rural and underserved areas, national health workforce plans should pay particular attention to issues that undermine recruitment and retention of health workers in these areas, bearing in mind that multi-sectoral cooperation will be required to effectively address many of these factors. Several areas, such as professional development and training and recruitment strategies, are situated soundly within the purview of health workforce planning and should be considered in light of equity and non-discrimination requirements.

Incentives for Working in Disadvantaged Areas

The Africa Health Strategy 2007-2015 directs countries to develop packages and incentives for working in disadvantaged areas.¹⁰² A wide range of financial and non-financial incentives can encourage health workers to serve in rural areas, including hardship allowances, housing, support for children's education, vehicle loans, telecommunications equipment, travel allowances, and preference for training slots. Zambia has used a combination of many of these incentives to encourage physicians to serve in rural areas. At least 66 physicians in Zambia are

serving or have served on a three-year contract in rural areas, receiving a hardship allowance, an accommodation allowance, an education allowance for the doctors' children, eligibility and some funding for post-graduate training, and eligibility for a loan.¹⁰³ South African health professionals receive a special allowance for working in rural areas, with the exact amount varying by profession and on the particular area's designation.¹⁰⁴ The Christian Health Association of Malawi is reportedly successful in retaining upper-skilled health workers in rural areas through several allowances, including a car allowance and hardship allowance, that effectively double take-home pay.¹⁰⁵

While incentives are becoming more common, they are hardly universal. In Niger State, Nigeria, a physician in a rural area reports that he is paid less than his urban counterparts.¹⁰⁶ Such a payment scheme, which discourages service in rural areas, is inconsistent with right to health obligations.

Basic Infrastructure

The often dilapidated state of health facilities in rural areas serves as a disincentive for patients to come to these facilities and health workers to serve in them. As detailed above, Ondo State, Nigeria has succeeded in increasing the proportion of nurses serving in rural areas in part by focusing on improving the supplies of medicine, equipment, and supplies in these facilities. As part of its efforts to retain health workers in rural areas, Zambia will receive support from GAVI to bring clean water and power to rural health facilities.¹⁰⁷ Part of the compre-

¹⁰² Africa Health Strategy 2007-2015, at para. 56. Adopted at the Third Session of the African Union Conference of Ministers of Health, Johannesburg, South Africa, April 9-13, 2007. Available at: http://www.africa-union.org/root/UA/Conferences/2007/avril/SA/9-13%20avr/doc/en/SA/AFRICA_HEALTH_STRATEGY_FINAL.doc.

¹⁰³ "Rural doctor s number soars — Chitwo." *Times of Zambia*, July 28-Aug. 4, 2005. Available at: <http://www.times.co.zm/news/viewnews.cgi?category=4&id=1122582782>; Jaap Koot et al., *Supplementation Programme Dutch Medical Doctors 1978–2003 Lessons learned; Retention Scheme Zambian Medical Doctors 2003–2006 Suggestions: Final Report* (Dec. 2003), at 27.

¹⁰⁴ Public Health & Welfare Sectoral Bargaining Council, *Resolution 2 of 2004: Revised Non-Pensionable Recruitment Allowances, Referred to "The Recruitment Allowance": Public Sector Health Professionals Working in Hospitals/Institutions as Managed by the Health Employer in ISRDS Nodes; and Rural Areas* (Jan. 2004). Available at: http://www.doh.gov.za/docs/misc/resolution2_2004.pdf.

¹⁰⁵ Yoswa M. Dambisya, *A review of non-financial incentives for health worker retention in east and southern Africa* (2007), at 18. Available at: <http://www.equinet africa.org/bib/docs/DIS44HRdambisya.pdf>.

¹⁰⁶ Personal communication with Dr. Chukwumuanya Igboekwu, Health Program Associate for Physicians for Social Justice (PSJ) and practicing physician based in Kontagora, Niger State, Nigeria, Jan. 12, 2008.

¹⁰⁷ Personal communication with Lisa Oldring, Special Advisor, Realizing Rights: The Ethical Globalization Initiative, Nov. 1, 2007.

hensive approach Partners In Health took to retaining health workers in rural central Haiti was to rehabilitate the facilities in which it worked, including stocking them with essential medicines.¹⁰⁸

Professional Development

Rural health practitioners' fear of getting left behind or passed over for promotions compared to colleagues in "more prestigious" urban positions¹⁰⁹ is exacerbated by a lack of training and professional development opportunities for health workers in rural and remote areas. This suggests that health workforce plans should place particular priority on ensuring that rural health professionals (including, but not limited to, doctors) are able to upgrade their skills and remain in contact with the broader medical field in order to allow them to achieve their professional goals, interact with colleagues, and develop as practitioners.

Rural district hospital doctors interviewed in South Africa's Western Cape Province emphasized that they are called upon to tap into a wide range of skills and knowledge on a regular basis due to the variety of medical problems that they encounter. They cited the recurrent need for trauma management, as well as general surgical, obstetric and anesthetic skills. The doctors, however, indicated that limited opportunity to perform other, more unusual procedures, combined with unreliable referral capacities, led to skills attrition: "But because if you do something wrong here and it goes seriously wrong, it's too far from town B (secondary hospital) to take the risk. And then you slowly unlearn some of the skills that you did know." They emphasized that skills development was crucial and highlighted rotations through secondary or tertiary hospitals as especially useful, expressing a preference for hands-on learning as opposed to lectures. Outreach visits by visiting specialists were also highly regarded as a very helpful way to supplement in-service learning from more experienced colleagues (as long as such visits were coordinated with district hospital needs). The doctors also stressed the need for more consistent feedback on cases that were referred up the chain of care: "About referring to (secondary) hospital X — it's

¹⁰⁸ Maggie Cooper (Physicians for Human Rights), *Bold Solutions to Africa's Health Worker Shortage* (2006), at 6. Available at: <http://physiciansforhumanrights.org/library/documents/reports/report-boldsolutions-2006.pdf>.

¹⁰⁹ Giles Dussault & Maria Cristina Franceschini, "Not Enough There, Too Many Here: Understanding Geographical Imbalances in the Distribution of the Health Workforce." *Human Resources for Health* (May 27, 2006) 4:12. Available at: <http://www.human-resources-health.com/content/4/1/12>.

like sending stuff into the Bermuda triangle. They never come back with summaries, we never found out what happened to them, there's no interconnection between the two."¹¹⁰

Training and Recruitment

National health workforce plans must also take into account that governments are obligated to provide "appropriate training for health personnel"¹¹¹ in order to "[address] the health needs of the whole population."¹¹² Appropriate training will ensure that health staff are able to "recognize and respond to the specific needs of vulnerable and marginalized groups."¹¹³ Appropriate training also implies that health personnel will be well-equipped to provide services such as reproductive, maternal and child health care, immunizations, and disease prevention and health education activities,¹¹⁴ many of which will generally be provided within primary health care settings.¹¹⁵

This means that both pre-service and in-service training must place a particular priority on the provision of primary health care within rural and under-resourced settings. It is likely to be a rude and disheartening awakening to practice in a remote setting with limited resources when one's training took place in a tertiary facility with access to resources, referral capacity and collegial interaction:

...it is frustrating because I have skills, which I cannot really use. I refer patients that I think need examination to the doctor. This frustrates me because in some cases I know what has to be done but lack the equipment and space to do it.

— South African primary health care nurse¹¹⁶

¹¹⁰ M. De Villiers & P. De Villiers, "Doctors' views of working conditions in the rural hospitals in the Western Cape", *South African Family Practice* (2004) 46(3): 21-26.

¹¹¹ 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. 44(e). Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

¹¹² *Id.* at para. 43f.

¹¹³ *Id.* at para. 37.

¹¹⁴ *Id.* at para. 44.

¹¹⁵ Physicians for Human Rights, *An Action Plan to Prevent Brain Drain: Building Equitable Health Systems in Africa* (June 2004), at 116. Available at: <http://physiciansforhumanrights.org/library/documents/reports/report-2004-july.pdf>.

¹¹⁶ Petrida Ijumba, "'Voices' of Primary Health Care Facility Workers." *In Health Systems Trust* (Petrida Ijumba, ed.), *South African Health Review 2002* (2002), at 184. Available at: <http://www.hst.org.za/>

Health workers are also frustrated because their training has ill-prepared them for tasks that their jobs in primary care settings require: for example, training for primary health care workers in South Africa, especially nurses, remains largely entrenched within urban academic hospital settings and neglects day-to-day competency needs that primary care nurses are called upon to address, including cultural sensitivity, community mobilization and participation, and inter-sectoral collaboration.¹¹⁷

Appropriate training may also contribute to a more equitable distribution of health workers by producing health professionals who have had exposure to rural and under-served settings and are prepared to work in these areas.¹¹⁸ It may also raise health workers' awareness of health inequalities that result from the poor conditions that characterize many rural health services.

Through its "Community Based Education and Service" (COBES) program, Uganda's Makerere University offers its health sciences students the opportunity to gain experience working in underserved rural communities. Medical, nursing, dental, pharmacy and radiography students are divided into teams and given four-to-six week placements at rural district health centers, where they continue with classes and interact closely with the community through providing health education and other community service activities. According to Dr. Andrew Mwanika, head of COBES, this exposure to the realities of rural practice is intended to "acclimatize students to rural work conditions so that they might be better prepared and more willing to locate in remote areas." Dr. Mwanika emphasized that COBES has resulted in substantial yields since its inception in 2003: "The service coverage at the facilities, homes, schools and communities increases whenever the students are in the districts. The relationship between the students and the communities is excellent — gone are the reservations to learn in rural communities. The students show a high understanding of the health needs of the communities compared to before COBES...The potential is immense, especially around the issue of partnerships, shaping the attitudes of students for rural practice, community

research and projects."¹¹⁹ One student participant said of his rural experiences, "The facilities there are not enough. There's a shortage of drugs and equipment; many people can't afford drugs and treatment. This changes your perspective and makes you think about the health system in Uganda. Seeing this motivates you to change the situation. We — my colleagues and myself — want to do something. We could change a lot if we were properly empowered."¹²⁰

In addition to integrating exposure to underserved communities into training programs, health workforce plans should consider investing in scholarship schemes and other directed incentives and recruitment strategies to encourage students of rural origin, which has been shown to be the "most significant predictor" of future rural practice,¹²¹ to pursue health professional careers. This particular focus on educating rural students has implications for providing more equitable health coverage since students of rural origin are more likely to return to practice in rural areas, three to eight times more likely according to one study of medical students in South Africa.¹²²

In order to attract and retain trained health professionals in a deprived rural area of Kwa-Zulu Natal, South Africa, the Mosvold Hospital started a scholarship program exclusively for students from the local area, who are far more likely to return to practice in their rural district than their urban peers. Started in 1998, the scholarship provides funding for books, tuition, accommodation & food; in return, each student signs a year-for-year work back contract with Mosvold Hospital. By 2005, fourteen students completed degrees in areas such as medicine, nursing, pharmacy, optometry and radiography. All returned to their rural district. Another 46 students were enrolled in degree schemes to allow them to study for health sciences degrees. Mosvold's success has led to its replication in other areas of South Africa, inspiring a similar program at the University of the Witwatersrand, the Wits Initiative for Rural Health Education. Twenty students from rural communities in North West and Limpopo provinces are receiving schol-

uploads/files/chapter10.pdf.

¹¹⁷ *Id.* at 182-183.

¹¹⁸ Physicians for Human Rights, *An Action Plan to Prevent Brain Drain: Building Equitable Health Systems in Africa* (June 2004), at 116. Available at: <http://physiciansforhumanrights.org/library/documents/reports/report-2004-july.pdf>.

¹¹⁹ Personal communication with Dr. Andrew Mwanika, Makerere University Medical School, Kampala, Uganda, July 24, 2006.

¹²⁰ Personal communication Nixon Niyonzima, medical student, Makerere University, Kampala, Uganda, July 12, 2006.

¹²¹ Elma de Vries & Steve Reid, "Do South African medical students of rural origin return to rural practice?" *South African Medical Journal* (May 2003): 93 789-793. Available at: <http://www.ajol.info/viewarticle.php?jid=1&id=6552>.

¹²² *Id.*

arship support to study health sciences at Wits Medical School; afterwards, they will return to their rural homes to work in local hospitals. The success of the Mosvold initiative has also prompted provincial departments of health to disperse scholarship funding at the district level in order to better link recipients with rural health facilities in their own communities.

Skills Mix

Different types of health workers may be more or less likely to work in rural areas. For example, clinical officers and other non-physician clinicians — health workers with three to four years of training in many of the competencies of a physician — are much more likely than physicians to serve in rural areas.¹²³ Certain types of nurses, such as community nurses, might be trained specifically for deployment in rural areas.¹²⁴ Ghana developed a new cadre of health workers, Community Health Officers, who were nurses with two years of training (including a six-month internship), and deployed them to deprived areas of rural districts. They spend much of their time visiting communities, and also operate small, community-based clinics.¹²⁵

Community health workers can provide certain basic health services in rural areas, and are being increasingly looked to as part of a strategy to scale up HIV and other health services.¹²⁶ Community health workers can help extend care into rural and other hard-to-reach areas, though will require adequate supervision and support, and should be integrated into an effective referral system.

Efforts to develop or increase numbers of community health workers may well need to happen in concert with other strategies to increase the number of health workers in rural areas, not only because of the limited range of services community health workers can provide, but also to ensure that they have proper supervision and support. Malawi, for example, which is working towards having one

community health worker (Health Surveillance Assistant) per 1,000 population, is simultaneously recruiting and deploying more than 1,000 nurses to rural villages as community nurses, in part to improve supervision and support for the Health Surveillance Assistants.¹²⁷

Other staffing and skills mix decisions will also impact the availability of health care for underserved populations. These include staffing levels at different types of health facilities and the degree of specialization with the health professions. How does the plan distribute health workers across primary, secondary, and tertiary health facilities? Are there plans for enough health workers at the primary level, and strategies (including those discussed elsewhere in this section) to recruit them to these facilities? What is the balance between generalists and specialists? Specialists are more likely to be based at tertiary facilities in urban areas, which have the population base to support them.

Community Service Requirement

Countries may require health workers to spend their initial year or years of service in community service placements, which may be targeted to rural areas. Indeed, the Africa Health Strategy 2007-2015 recommends that African Union members “ensure that health workers trained using public funds offer compulsory community service for a given time as a means of paying back to society.”¹²⁸ South Africa, for example, requires doctors, dentists, pharmacists and other health professionals to serve one year in the public sector before they are fully registered with professional councils,¹²⁹ with the requirement for nurses beginning in January 2008.¹³⁰ This can be an important way to ensure that trained health workers are available to serve in rural areas,¹³¹ though this method of

¹²³ Fitzhugh Mullan & Seble Frehywot, “Non-physician clinicians in 47 sub-Saharan African countries.” *Lancet* (Dec. 22, 2007) 370: 2158-2163, at 2161.

¹²⁴ Personal communication with Isabella Mbai, Head, Department of Nursing Sciences, School of Medicine, Moi University, Eldoret, Kenya, Oct. 10, 2006.

¹²⁵ Seth Acquah, Graeme Frelick & Richard Matikanya, *Providing Doorstep Services to Underserved Rural Populations: Community Health Workers in Ghana* (Oct. 2006). Available at http://www.capacityproject.org/images/stories/files/community_health_workers_ghana.pdf.

¹²⁶ World Health Organization, *Task Shifting: Rational Redistribution of Tasks among Health Workforce Teams: Global Recommendations and Guidelines* (2008). Available at: http://www.who.int/entity/healthsystems/TTR_TaskShifting.pdf.

¹²⁷ Government of Malawi, Round 5 Health System Strengthening proposal (Health Systems Strengthening and Orphan Care and Support) (June 2005), at 62-63. Available at: http://www.theglobal-fund.org/search/docs/5MLWH_1142_0_full.pdf

¹²⁸ Africa Health Strategy 2007-2015, at para. 56. Adopted at the Third Session of the African Union Conference of Ministers of Health, Johannesburg, South Africa, April 9-13, 2007. Available at: http://www.africa-union.org/root/UA/Conferences/2007/avril/SA/9-13%20avr/doc/en/SA/AFRICA_HEALTH_STRATEGY_FINAL.doc.

¹²⁹ Africa Working Group of the Joint Learning Initiative on Human Resources for Health & Development, *The Health Workforce in Africa: Challenges and Prospects* (Sept. 2006), at 41-42. Available at: http://www.who.int/hrh/documents/HRH_Africa_JLreport.pdf.

¹³⁰ “South Africa: Nursing Students Set to Challenge Manto.” *Cape Argus* (Cape Town, South Africa), Nov. 22, 2007. Available at: <http://allafrica.com/stories/200711230381.html>.

¹³¹ The reality is sometimes less than the promise. At least as of 2001,

placing health workers in rural areas both raises concerns about inadequate supervision for the newly trained health professionals and high rates of turnover.¹³²

Valuing Health Workers

Countries may find other ways to encourage health workers to serve in rural areas, such as by demonstrating to the health workers that their countries and communities value their service. For example, health workers hired to serve in rural areas as part of Kenya's Emergency Hiring Program underwent a two-week training and orientation course, followed by an inspirational graduation ceremony. The program also utilized a rapid, fair, and transparent recruitment process.¹³³ Such approaches can be important supplements to other measures to create an equitable distribution of the health workforce. Indeed, they may contribute to retention and improved health worker motivation nationally.

Countering Discrimination by Health Workers

Even where health workers are available, stigma and ignorance among health workers themselves can limit some people's access to quality, acceptable health care. It is important to be quite frank about this so that a health workforce plan can incorporate programs and allocate budgetary resources in order to combat discriminatory practices on the part of health workers.

Discrimination in the forms of exclusion and maltreatment inhibits effective public health interventions.

Clinic staff were reluctant to test me because they didn't think older people like myself were at risk, but the results came back positive. I have accepted the disease as it is there and I can't do anything about it.

— 62-year old South African grandmother¹³⁴

three-quarters of community service doctors in South Africa were serving in urban areas. Rural Doctors Association of Southern Africa, *Position Paper: Crisis in Staffing of Rural Hospitals* (Jan. 2001), at 1. Available at: http://www.rudasa.org.za/download/crises_staffing.doc.

¹³² See *id.* Also, newly health professionals have less experience, and so lack the additional skills and knowledge that come with experience.

¹³³ Ummuro Adano (Capacity Project), *Reflections on the Emergency Hiring Plan* (Sept. 2006). Available at: http://www.capacityproject.org/index.php?option=com_content&task=view&id=132&Itemid=147.

¹³⁴ Help Age International, *One in Fourteen People Living with HIV are Over 50 and Millions More Older People are at Risk* (Nov. 29,

Frequently, disabled people report that they are told to go home by clinical staff, who assure them that disabled people "cannot get AIDS." Where AIDS medications are scarce and where services and support for individuals with HIV or AIDS are limited, individuals with pre-existing disabilities report being placed last on the list of those entitled to care.¹³⁵

Patients will not avail themselves of health services if they experience discriminatory and demeaning treatment when they interface with the health system/health workers.

Unfortunately the nurse I met knew that I was HIV positive; she refused to touch my wound and gave me the bandage to stop the bleeding myself. This attitude aroused suspicion among the other nurses. She did not tell them my status to my knowledge but I knew they suspected I was positive. I felt very bad. I have not been to that hospital again.

— Person with HIV/AIDS, Nigeria¹³⁶

Discriminatory practice often reflects a lack of knowledge and training on the part of health workers. For example, inaccurate information and insufficient training, in addition to inadequate support services, encourages stigma and often leads to isolation or the unnecessary institutionalization of people with mental disabilities, and at times even to unconscionable practices.¹³⁷ A doctor in Serbia advised parents of a newborn against an often life-saving surgery for a child with hydrocephalus "since she would die anyway."¹³⁸

My job is made difficult by the negative attitude people have to mental health....Some of my colleagues

2006). Available at: <http://www.helppage.org/News/Mediacentre/Pressreleases/wSGB>.

¹³⁵ World Bank, *Disability and HIV/AIDS at a Glance* (Nov. 2004). Available at <http://siteresources.worldbank.org/INTPHAAG/Resources/AAGEngDisabilityHIVr4.pdf>.

¹³⁶ Physicians for Human Rights, *Nigeria: Access to Health Care for People Living with HIV and AIDS* (2006), at 36. Available at: <http://physiciansforhumanrights.org/library/documents/reports/nigeria-access.pdf>.

¹³⁷ Paul Hunt, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. U.N. Doc. E/CN.4/2005/51 (Feb. 11, 2005), at paras. 53-55. Available at: <http://www2.essex.ac.uk/human%5Frights%5Fcentre/rth/docs/CHR%202005.pdf>.

¹³⁸ Mental Disability Rights International, *Torment not Treatment: Serbia's Segregation and Abuse of Children and Adults with Disabilities* (2007), at vii. Available at: <http://www.mdri.org/projects/serbia/Serbia-rep-english.pdf>.

describe mental patients as 'your people' as if they do not have anything to do with them. We are trying to remove that culture.

— **Psychiatric nurse,
Eastern Cape Province, South Africa**¹³⁹

Health workers in India — from senior professionals to ward staff — were shown to carry out discriminatory practices towards HIV-positive patients. Ward staff displayed the most discriminatory attitudes towards patients.¹⁴⁰ In Nigeria, 59% of health professionals surveyed believed that people living with AIDS should be placed in a separate ward, while 40% believed that a person's appearance was indicative of HIV status.¹⁴¹ Approximately 12% of health workers surveyed in Kenya in 2006 reported providing different levels of care for HIV-positive and HIV-negative individuals, while a higher proportion of health workers reporting discriminatory attitudes.¹⁴²

[Health care professionals] live in a milieu that has negligible understanding of the disease. Many [health care professionals] are learning on the job and have no formal training on HIV. Most have no opportunity to have continuing education or retraining on HIV and lack access to current information about HIV and AIDS.

— **Nigerian policymaker**¹⁴³

These examples illustrate the importance of including pre-service and in-service education and training related to HIV/AIDS, physical and mental disability, stigma and patients' rights within health workforce planning (and budgeting), and human rights as an integral part

of training and professional development for health workers at all levels, not as an afterthought subject to elimination when budgets are tight. This is critical to promoting non-discrimination and ensuring equal access to care for all patients.

Discrimination against patients also results from fear of infection or injury linked to poor working conditions and lack of essential supplies such as gloves. For example, lack of protective supplies appears to be a major contributor to discrimination by Nigerian health workers against people with or perceived to have HIV.¹⁴⁴

*How can one talk of the ethical duty of a nurse to provide care unless the nurse is enabled to do so without the constant risk of injury?*¹⁴⁵

In order to help diminish discriminatory practices by health workers, training on universal precautions must be coupled with adequate resources to ensure that health workers are able to protect themselves and their patients against occupational hazards. A plan should consider whether health workers have reliable access to and training in infection control measures. If access to universal precautions, such as gloves and puncture-proof containers for disposal of needles, is restricted or unavailable, both health workers and their patients are endangered. Moreover, a lack of such precautions is in direct contradiction to a state's obligation to take measures to minimize occupational health hazards¹⁴⁶ and act to "[prevent, treat] and control...epidemic, endemic, occupational and other diseases."¹⁴⁷

Health workers must also be sensitized to the rights and needs of other often marginalized groups, including special health risks and concerns that may affect certain populations, including people with disabilities, gays and lesbians, and other people who often suffer from societal discrimination, but must not pervade the health sector. Health workers must be at the vanguard of respecting human rights; their discrimination can kill. Explained Kasia Malinowska-Sempruch of the

¹³⁹ Kerry Cullinann, "Voice of a nursing Sister: Gugu Majola of Gateway Clinic at Mary Theresa's Hospital." In Health Systems Trust (Petrida Ijumba & Peter Barron, eds.), *South African Health Review* (2005), at 160-161. Available at: http://www.hst.org.za/uploads/files/sahr05_voices5.pdf.

¹⁴⁰ Horizons Program/Population Council, Sharan & Institute of Economic Growth, *Reducing AIDS-related Stigma and Discrimination in Indian Hospitals* (2006), at 24-27. Available at: <http://www.popcouncil.org/pdfs/horizons/inplhafriendly.pdf>.

¹⁴¹ Physicians for Human Rights, *Nigeria: Access to Health Care for People Living with HIV and AIDS* (2006), at 51. Available at: <http://physiciansforhumanrights.org/library/documents/reports/nigeria-access.pdf>.

¹⁴² Kenya Treatment Action Movement (with financial support from USAID Health Policy Initiative Task Order 1), *Measuring Facility/Provider Index of Stigma and Discrimination in Kenya* (2007), at 9, 20.

¹⁴³ Physicians for Human Rights, *Nigeria: Access to Health Care for People Living with HIV and AIDS* (2006), at 51. Available at: <http://physiciansforhumanrights.org/library/documents/reports/nigeria-access.pdf>.

¹⁴⁴ *Id.* at 24.

¹⁴⁵ Shreedevi Balachandran, "Nurses and the Occupational Risks of Blood-Borne Infections." *Indian Journal of Medical Ethics* (Oct.-Dec. 2004). Available at: www.ijme.in/104di088.html.

¹⁴⁶ 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. 36. Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

¹⁴⁷ International Covenant on Economic, Social and Cultural Rights, G.A. res.2200A (XXI), 21 U.N.GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993, U.N.T.S. 3, entered into force Jan. 3, 1976, at art. 12(2)(c). Available at: <http://www1.umn.edu/humanrts/instr/b2esc.htm>.

Open Society Institute, referring to the injection drug-driven HIV epidemic in Eastern Europe and Central Asia, “Governments tell drug users to act responsibly and not to infect others, but the clinics shut the doors in the faces of those seeking to take care of themselves....The message sent is that some people with HIV are good and pure, and others deserve to die.”¹⁴⁸

Equity for all populations also requires special attention to groups in the population who might not speak the dominant language, or who speak local, indigenous languages. The quality and meaningful availability of health services will likely be compromised when health workers and their patients have difficulty communicating due to language barriers. Health workers from local communities and who speak local languages are also more likely to be attuned to the local culture, and can provide care that is both scientifically and culturally acceptable.¹⁴⁹ Special attention should be given in recruiting students for health professional training to having sufficient numbers of health professionals who speak local languages, and to training health workers in these languages in the interim, if recruitment alone proves insufficient.

Gender Equity

Human rights imperatives coincide with practical rationales for integrating a gender perspective into health workforce planning and creating equitable arrangements for women who work in the health sector.

In order to combat gender-based discrimination and ensure that women are able to enjoy the right to health on an equal basis with men, states are obligated to: “... integrate a gender perspective in their health-related policies, planning, programs and research in order to promote better health for both women and men. A gender-based approach recognizes that biological and socio-cultural factors play a significant role in influencing the health of men and women.”¹⁵⁰

¹⁴⁸ “XVI International AIDS Conference: HIV Treatment Programs FAIL Drug Users in Asia and the Former Soviet Union, Experts Warn.” *PLANetWIRE.org*, Aug. 16, 2006. Available at: <http://www.planetwire.org/details/6580>.

¹⁴⁹ See Physicians for Human Rights, *Deadly Delays: Maternal Mortality in Peru* (2007), at 131-132. Available at: <http://www.physiciansforhumanrights.org/library/documents/reports/maternal-mortality-in-peru.pdf>.

¹⁵⁰ 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. 30. Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

Such a perspective is all the more critical given women’s extraordinarily important role in providing health care services in both formal and informal settings worldwide, accounting for up to 80% of the health workforce in some countries.¹⁵¹

- In sub-Saharan Africa, women have established themselves as a major proportion of formal health sector employees, in contrast to other fields where they are not so well represented numerically.¹⁵²
- Women now form a majority of enrolled students in South African undergraduate medical programs.¹⁵³
- Women and girls are more likely to provide care for family members who are ill. The duties of providing home- or community-based care for people living with HIV/AIDS also fall primarily to women.

It is important that health workforce plans explicitly recognize that qualitative factors related to gender impact occupational choices, work practices and career paths, so that they can promote recruitment strategies, retention schemes and conditions of employment that are sensitive to women’s needs and preferences to encourage effective deployment and retention of the health workforce.¹⁵⁴ For example, women working in the health sector must often balance professional and home responsibilities and tend to place a high value on flexible working hours, child care availability and housing arrangements in addition to salary concerns. Women working in remote areas also express concerns regarding adequate security measures and transportation options.¹⁵⁵

¹⁵¹ International Labour Organization & World Health Organization, *Joint ILO/WHO guidelines on health services and HIV/AIDS* (2005), at 9. Available at: http://www.who.int/hiv/pub/prev_care/who_ilo_guidelines.pdf.

¹⁵² Hilary Standing, “Gender — A Missing Dimension in Human Resource Policy and Planning.” *Human Resources for Health Development Journal* (Jan.-April 2000) 4:27-43, at 36.

¹⁵³ Mignon Breier & Angelique Wildschut, “The feminisation of medical schools in South Africa.” *HSRC (Human Sciences Research Council) Review* (Nov. 2006) 4(4): 10-12. Available at: http://www.hsrc.ac.za/HSRC_Review_Article-44.phtml.

¹⁵⁴ Hilary Standing, “Gender — A Missing Dimension in Human Resource Policy and Planning for Health Reforms.” *Human Resources Development Journal* (Jan.-April 2000) 4:27-43. Available at: http://www.who.int/hrh/en/HRDJ_4_1_04.pdf.

¹⁵⁵ Hilary A. Brown & Laura Reichenbach, *Increasing Health Systems Performance: Gender and the Global Health Workforce* (Oct. 2004), presented at the Global Forum for Health Research Forum 8, Mexico, Nov. 2004. Available at: <http://www.globalforumhealth.org/Forum8/Forum8-CDROM/OralPresentations/Reichenbach%20L%20Brown%20H%20F8-544.doc>.

Taking steps to address discrimination is also imperative because numerical parity has not translated into equitable working arrangements. Women are likely to experience discrimination or mistreatment in their capacity as health workers. This may take the form of low wages and inequitable pay, unequal access to professional development opportunities, sexual harassment, workplace violence, or a combination of any of the above,¹⁵⁶ all of which contribute to women's attrition from the health sector.

Women remain more likely to be concentrated in specific occupations within the health sector, such as nursing, and to be under-represented at senior professional, managerial or decision-making levels within the health sector. In Bangladesh, for instance, women occupy a majority of nursing positions, but are very under-represented within the ranks of dentists, medical assistants, pharmacists, managers and doctors.¹⁵⁷ This under-representation of women within upper health professional ranks is not confined to developing countries. The Royal College of Nursing reports that while 93% of the UK's nursing staff are women, men fill approximately 45% of senior management positions and take up a similar proportion of professional development or education opportunities.¹⁵⁸ Health workforce planning offers an opportunity to investigate obstacles to women being employed in senior positions and to take steps to overcome these and redress the situation.

Personal security is another serious concern for women working in healthcare settings and the feminization of health workforce necessitates urgent attention to safety and workplace violence issues.¹⁵⁹ For example, nurses in South Africa (a predominantly female profession) are three times more likely to experience violence in the workplace than members of any other health occupation group.¹⁶⁰ Health workforce

plans should explicitly seek input from women employed within the health sector about their workplace security worries and set aside resources necessary to implement measures to improve security. For example, in response to security concerns, a nurse in charge of a rural health facility in Zimbabwe had lighting installed in the facility's parking lot, and organized a bus to take health workers home.¹⁶¹

Gender-based discrimination has negative implications for the distribution, motivation and retention of female health workers and for the provision of available, accessible, acceptable and quality health services. A rights-based approach to health workforce planning will consider how to better ensure the creation of safe, supportive and equitable working environments for women employed in the health sector. Such an approach is necessary to correct health workforce imbalances within a country and to provide accessible, acceptable and sustainable health services to all segments of the population.

Equitable Treatment for Health Workers

The provision of equitable health facilities, goods and services for health users is closely linked to upholding the rights of health workers and ensuring that they, too, benefit from equal treatment and fair conditions. A health workforce plan that adheres to the principles of human rights will consider whether and how health workers experience inequitable treatment or discrimination and the resulting impact on their motivation and retention, and, hence, on the availability of health services.

Inequitable Wage Structures

One scenario that can result in inequitable health care is a two-tier salary structure. This occurs when health workers attached to disease-specific programs (many of which are donor funded), especially HIV/AIDS programs, are paid wages or financial incentives that are untenable for the public sector to provide for its employees who also provide essential services, such as obstetric nurses.¹⁶² In and of itself, wage differentials between programs are not necessarily an instance of rights-related discrimination;

¹⁵⁶ James McCaffrey (The Capacity Project), *Global Health Technical Briefs: Addressing the Crisis in Human Resources for Health* (Nov. 2006). Available at: <http://www.maqweb.org/techbriefs/tb37capacity.pdf>.

¹⁵⁷ Pascal Zurn, Mario R. Dal Poz, Barbara Stilwell & Orvill Adams, "Imbalance in the health workforce." *Human Resources for Health* (2004) 2:13. Available at: <http://www.human-resources-health.com/content/2/1/13#B77>.

¹⁵⁸ International Council of Nurses, *Fact Sheet: Equal Opportunity: Gender issues*, http://www.icn.ch/matters_equalop.htm. Accessed Jan. 24, 2008.

¹⁵⁹ World Health Organization, *World Health Report 2006: Working Together for Health* (2006), at 11. Available at: <http://www.who.int/whr/2006/en/index.html>.

¹⁶⁰ Petrida Ijumba, "'Voices' of Primary Health Care Facility Workers."

In Health Systems Trust (Petrida Ijumba, ed.), South African Health Review 2002 (2002), at 193. Available at: <http://www.hst.org.za/uploads/files/chapter10.pdf>.

¹⁶¹ Personal communication with Barbara Stillwell, Human Resources for Health Department, World Health Organization, Feb. 10, 2006.

¹⁶² World Health Organization, *World Health Report 2006: Working Together for Health* (2006), at 21. Available at: <http://www.who.int/whr/2006/en/index.html>.

wage differentials exist in every employment sector and, in this case, public sector or primary care health workers do not automatically have a “right” to salaries identical to, for example, health workers employed by AIDS programs.¹⁶³ The danger here is that wage differentials may result in fewer health workers and therefore fewer primary health services available in the public sector, which poor people rely on. Inequitable wage structures can disproportionately harm poor and rural populations by drawing health workers away from the public sector to more lucrative positions elsewhere, by disadvantaging health workers who practice in rural district hospitals or primary settings compared to their urban or tertiary practice colleagues, or by causing discord among professions, thereby potentially harming motivation and retention and reducing quality and availability of care.¹⁶⁴

Uneven Allowances

Another practice that may fuel more uneven service provision occurs when hardship or scarce skills allowances target a particular class of health worker, such as doctors or specialized categories of hospital-based nurses, and omit others working under similarly harsh conditions, such as nurses practicing in rural district hospitals or primary health care settings.¹⁶⁵ This occurred in Ghana, where the large disparity in the extra pay doctors and

nurses received through Ghana’s Additional Hours Duty Allowance (ADHA) caused nurses in Ghana to feel that their efforts were not appreciated. This led to de-motivation and appears to have contributed to a significant increase in the number of nurses who sought to migrate after the ADHA was introduced.¹⁶⁶

*Salarywise, we are not paid as professionals. There is the scarce [skills] allowance. But this is mostly going to doctors. Nurses should be considered for this allowance because nurses are often the ones who orientate the doctors.*¹⁶⁷

- Mental health nurse, Eastern Cape, South Africa

These practices risk devaluing the contributions of nurses and other skilled workers, and fuel alienation, loss of morale and further departures. Health workforce plans should carefully consider whether such allowances will facilitate retention in underserved areas or whether they will prove to be divisive and demotivating.¹⁶⁸ Allowances and wage structures need to be well thought-out, transparent and faithful to equity considerations that value the provision of a broad spectrum of competent care in very deprived environments as well as more specialized skills. Neglecting these considerations within the planning process can lead to unforeseen and negative consequences for health worker motivation and retention that are ultimately borne by poor or underserved populations.

Increased Utilization

Planning for increased utilization of services is also important to ensure equitable access to health services as financial and other access barriers decrease. For example, it is well documented that user fees are the most regressive form of health financing and block

¹⁶³ It is important, however, that health workforce plans recognize that the low and unreliable wages that public sector employees often receive do indeed have human rights implications. For example, they may violate health workers’ rights to an adequate standard of living and their labor rights for fair remuneration. These violations have also have consequences for motivation and retention, leading to more restricted, less equitable health care services.

¹⁶⁴ A collaboration of Northern and Southern NGOs are developing a code of practice directed at international NGOs working in developing countries to provide guidelines on practices such NGOs should follow to contribute to enhanced health workforce capacity, and avoid distorting the workforce. The code (draft at time of publication) is available through: <http://ngocodeofconduct.org/>.

¹⁶⁵ The South African Health Review reported that the departures of professional nurses from district hospitals, both abroad and to urban areas, was a serious crisis that was potentially even more significant than the migration of doctors. The Review pointed to the restrictive nature of scarce skills allowances, which were limited to a few, specialized categories of nurses not often found in district hospitals, as a major factor promoting the exodus. The Review also noted that scarce skills allowances were more often targeted at hospital-based health workers, signaling to primary health care nurses that they were not valued as much as their hospital-based colleagues. Ian Couper, Marietjie de Villiersii & Nontsikelelo Sondzabai, “Human Resources: District Hospitals.” *In* Health Systems Trust (Petrida Ijumba & Peter Barron, eds.), *South African Health Review* (Aug. 2005), at 126. Available at: http://www.hst.org.za/uploads/files/sahr05_chapter9.pdf.

¹⁶⁶ James Buchan & Delanyo Dovlo, *International Recruitment of Health Workers to the UK: A Report for DFID* (Feb. 2004), at 21, 23. Available at: http://www.dfidhealthrc.org/Shared/publications/reports/int_rec/int-rec-main.pdf.

¹⁶⁷ Kerry Cullinann, “Voice of a nursing Sister: Gugu Majola of Gateway Clinic at Mary Theresa’s Hospital.” *In* Health Systems Trust (Petrida Ijumba & Peter Barron, eds.), *South African Health Review* (2005), at 160. Available at: http://www.hst.org.za/uploads/files/sahr05_voices5.pdf.

¹⁶⁸ Nzapfurundi Chabikuli, Duane Blaauw, Lucy Gilson & Helen Schneider, “Human Resource Policies: Health Sector Reform and the Management of PHC Services in SA.” *In* Health Systems Trust (Petrida Ijumba & Peter Barron, eds.), *South African Health Review* (Aug. 2005), at 110. Available at: http://www.hst.org.za/uploads/files/sahr05_chapter8.pdf.

access to health services for the poorest households.¹⁶⁹ User fees undermine equity of access to health services and infringe on the right to economic accessibility:

*Health facilities, goods and services must be affordable for all...Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.*¹⁷⁰

Elimination of user fees, especially for essential health services, is in keeping with — and indeed demanded by — a rights-based approach to health. The unplanned removal of these fees, however, may result in an increased uptake of services that overwhelms the capacity of existing health workers and diminishes further the quality of care that patients receive.¹⁷¹ Governments should abolish user fees if they still exist, while devising

other, more equitable funding mechanisms, while the health workforce plan should recognize the role that user fees may have played in health financing and how they impact access to services. The plans should consider how the abolition of user fees will increase demand on health services, with the attendant need for more health workers, as well as other health goods and supplies, including medicines. If user fees have played a role in supplementing health worker salaries, the health workforce plan will need to find other ways to ensure that health workers receive a living wage.

¹⁶⁹ Lucy Gilson & Di McIntyre, "Removing user fees for primary care in Africa: the need for careful action." *BMJ* (Oct. 1, 2005) 331:762-765. Available at: <http://www.bmj.com/cgi/content/full/331/7519/762.pdf>.

¹⁷⁰ 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. 12(b). Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

¹⁷¹ "Zambia overwhelmed by free health care." *BBC News Online*, April 7, 2006. Available at: <http://news.bbc.co.uk/2/hi/africa/4883062.stm>. See also Lucy Gilson & Di McIntyre, "Removing user fees for primary care in Africa: the need for careful action." *BMJ* (Oct. 1, 2005) 331:762-765. Available at: <http://www.bmj.com/cgi/content/full/331/7519/762?ecoll>.

V. COMPREHENSIVE RESPONSE

Practical and Human Rights Reasons for Need for Comprehensive Response

Both practical and human rights considerations inform the need for a comprehensive approach to health workforce planning. Each country's health workforce is embedded within broader health and social systems, and is shaped and influenced by many factors, including education and training structures, labor markets (both national and international), disease burdens, changing demographics, and government regulations. These external factors should be explicitly recognized within health workforce strategies, even if it is not practicable to address them all at the same time.¹⁷²

From a practical perspective, a comprehensive approach is necessary to address the numerous factors that characterize the health workforce crisis in many countries, such as:

1. **Shortage:** Due to, for instance, migration, AIDS deaths, and an insufficient number of training slots;
2. **Inequitable distribution:** Exacerbated by poor rural or public sector conditions;
3. **Low productivity:** Linked to poor policies and lack of tools;
4. **Poor quality of services:** Related to poor training, lack of continuous education and lack of supportive supervision.

Addressing all of these aspects of the crisis will be necessary for a country to have an available, accessible, acceptable and good-quality health workforce. Many of these shortcomings also contribute to the overseas migration of health workers, so a more comprehensive approach is also more likely to have positive results in terms of stemming brain drain and encouraging retention.

The World Health Report 2006: Working Together for Health proposes a common technical framework as a way to assist countries in adopting a comprehensive

approach to health workforce planning.¹⁷³ This Human Resources for Health (HRH) Action Framework is based around the six interlocking components of policy, finance, education, partnerships and leadership, all centered around health workforce management systems. The HRH Action Framework highlights that addressing the health workforce crisis in a fragmented manner “may be counter-productive and fail to result in sustainable change. While one intervention may concentrate on one or two of the components initially, it is crucial that a comprehensive plan be developed to integrate challenges in all six components.” The Framework also emphasizes the need to link human resources for health to other health system elements in order to achieve desired health outcomes.¹⁷⁴

A human rights approach will also facilitate a more comprehensive approach to health workforce planning that will better address the complex political, social and economic contexts that influence the production, retention and distribution of a country's health workforce. By its nature, the right to health takes a comprehensive view of health, including, as it does, consideration of both health services and the conditions necessary for enjoyment of a healthy and dignified life.

Priorities must be set within a comprehensive approach to health workforce planning. The minimum core obligations identified within General Comment 14 offer an excellent starting point for providing a basis upon which to identify these.

In particular, one core obligation¹⁷⁵ specifies that states

¹⁷³ World Health Organization, *World Health Report 2006: Working Together for Health* (2006), at 137. Available at: <http://www.who.int/whr/2006/en/index.html>.

¹⁷⁴ The HRH Action Framework was crafted with input from representatives of multilateral and bilateral agencies, donor and partner countries, non-governmental organizations (NGOs) and the academic community who convened at a consultation in Washington, DC, sponsored by the WHO and USAID. Mario Dal Poz, Estelle Quain, Mary O'Neil, et al. “Addressing the health workforce crisis: towards a common approach.” *Human Resources for Health* (2006) 4:21. Available at: <http://www.human-resources-health.com/content/4/1/21>.

¹⁷⁵ Committee on Economic, Social and Cultural Rights, *General Comment 14, The right to the highest attainable standard of health*,

¹⁷² Vasant Narasimhan, Hilary Brown, Ariel Pablos-Mendez, et al., “Responding to the global human resources crisis.” *Lancet* (May 1, 2004) 363:1469-1472.

are obligated “to adopt and implement a national public health strategy and plan of action, on the basis of”:

- “epidemiological evidence”: A comprehensive health workforce plan should be evidenced-based to the extent possible.¹⁷⁶
- “a participatory and transparent process”: A comprehensive health workforce plan should be developed in a genuinely inclusive manner that encourages broad stakeholder involvement.

Plans shall also include:

- “right to health indicators and benchmarks”: A comprehensive health workforce plan should permit monitoring to ascertain whether it is promoting the achievement of the essential elements of the right to health; namely, availability, accessibility, acceptability and good quality.

Both the process and content of plans shall:

- “give particular attention to all vulnerable or marginalized groups”: A comprehensive health workforce plan should give particular priority to extending health services to those populations and areas that suffer the most severe shortages of qualified health workers, whether as a result of geographical poor distribution, historical neglect or discrimination.

Ultimately, a comprehensive, rights-based health workforce plan should be judged in large part by whether it protects and promotes the health of poor and marginalized groups,¹⁷⁷ who are least likely to have available, accessible, acceptable and good quality health services.

Links to the Broader Health System

Strengthening the workforce very much depends on linking health workforce planning to the broader health system elements that directly affect the ability of health workers to do their jobs.

The right to health demands that states ensure that “functioning health facilities, goods and services [and]

programs” are “available in sufficient quantity within the State party.” While varying in their precise composition based upon a state’s particular situation and development level, these will “include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Program on Essential Drugs.”¹⁷⁸

Achieving the right to health in practice depends upon the interplay of care and conditions that are essential to living a healthy life. Equipping health care workers to perform their jobs is necessary to achieve the highest attainable standard of health. While individual providers may be at the heart of quality health service provision, their ability to perform their jobs in a competent, safe and acceptable manner will be severely circumscribed by insufficient resources and inadequate essential services. If, for example, health workers do not have tools to deliver services or their salary is partially dependent upon point-of-service fees for basic health services,¹⁷⁹ then insufficient or inappropriate resources have been allocated to the health workforce. Either way, this is inconsistent with the right to good-quality and accessible health care: Inadequate resources have been dedicated to providing health workers with the tools they need to deliver good-quality services or money is being collected in a way that reduces access to health services.

Health workers have pointed to the constraints that the lack of functioning equipment and infrastructure, medical supplies and drugs impose on their ability to effectively treat patients as a major factor influencing their decisions to migrate. Respondents to a Zimbabwean survey cited their inability to provide adequate care as a consequence of these shortages as a primary reason for leaving their government health posts.¹⁸⁰ Shortages of supplies and malfunctioning equipment often preclude

U.N. Doc. E/C.12/2000/4 (2000), at para. 43(f). Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

¹⁷⁶ Epidemiological evidence also includes anticipated changes disease patterns and emerging health issues, such as changes in disease patterns and the increase in natural disasters that are resulting from climate change. Personal communication, Dr. Erica Franks, President, Physicians for Social Responsibility, Jan. 10, 2008.

¹⁷⁷ Audrey R. Chapman (American Association for the Advancement of Science), *Exploring a Human Rights Approach to Health Care Reform* (1993), at 23.

¹⁷⁸ 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. 12(a). Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

¹⁷⁹ This was previously the case in Uganda. Lucy Gilson & Di McIntyre, “Removing user fees for primary care in Africa: the need for careful action.” *BMJ* (Oct. 1, 2005) 331:762-765. Available at: <http://www.bmj.com/cgi/content/full/331/7519/762.pdf>.

¹⁸⁰ Regional Network for Equity in Health in Southern Africa (EQUINET), Health Systems Trust (South Africa) and MEDACT (UK), *Health Personnel in Southern Africa: Confronting Maldistribution and Brain Drain* (2003) at 17. Available at: <http://www.equinet africa.org/bibl/docs/healthpersonnel.pdf>.

health workers from carrying out the basic duties that are imperative to functioning health services, and impede achievement of their own personal goals,¹⁸¹ leading to a demoralized and frustrated health workforce. Nurses in Kenya relate that patients' relatives are often asked to bring bed linens, detergents and gloves when they accompany a sick family member to a health facility because of severe shortages of basic supplies.¹⁸² A South African pharmacist spoke of being unable to visit clinics to deliver drugs or check on stocks due to unreliable transport, impeding reallocation of resources from areas of surplus to those of shortage.¹⁸³ Health workers in Tanzania compared their treatment of patients to gambling: Their treatment decisions were based on guesswork because they lacked access to medical laboratories. One female lab worker likened making a diagnosis without a microscope to a game of chance: "You are not sure if you are treating malaria or typhoid or both. I do feel hurt more than the patient himself. This is really discouraging for us working in these dispensaries."¹⁸⁴

These poor working conditions and a growing health worker shortage reinforce one another and also further impoverish the quality of services — inadequate supplies and deprived conditions prompt departures, overwhelming remaining health staff and compromising care, while a dearth of trained staff also forces health facilities to restrict services and admissions.¹⁸⁵

¹⁸¹ In the words of a young doctor working in a public hospital in South Africa: "The lack of equipment and drugs is very frustrating and depressing. You cannot do quality work. I have not yet lived up to my own ideal." Inke Mathauer & Ingo Imhoff (GTZ), *Staff Motivation in Africa: The Impact of Non-Financial Incentives and Quality Management Tools. A Way to Retain Staff?* (2003), at 5. Available at <http://www2.gtz.de/migration-and-development/download/mathauer.pdf>.

¹⁸² Katie Nguyen, "Underpaid and Undervalued: Kenyan Nurses Lured Away." *The Boston Globe*, March 3 2006. Available at http://www.boston.com/news/world/europe/articles/2006/03/03/underpaid_and_undervalued_kenyan_nurses_lured_away/.

¹⁸³ Petrida Ijumba, "'Voices' of Primary Health Care Facility Workers." In Health Systems Trust (Petrida Ijumba, ed.), *South African Health Review 2002* (2002), at 194–195. Available at: <http://www.hst.org.za/uploads/files/chapter10.pdf>.

¹⁸⁴ Rachel Manongi, Tanya Marchant & Christian Bygbjerg, "Improving Motivation Among Primary Health Care Workers in Tanzania: A Health Worker Perspective." *Human Resources for Health* (March 7, 2006) 4:6. Available at <http://www.human-resources-health.com/content/4/1/6>.

¹⁸⁵ Even South African specialist hospitals such as Groote Schuur, site of the world's first heart transplant in 1967, and the Red Cross Children's Hospital, the only comprehensive paediatric hospital in southern Africa, report having to close beds within intensive care units due to a shortage of nurses and doctors qualified to handle

I work for a private institution which often finds itself unable to cope with disasters because there is no fall back plan due to a shortage of professionals. We often turn patients away when we cannot cope. Public health institutions' accident and emergency departments are manned by one officer where there is a requirement of six. The cholera outbreak has led to deaths because there is not enough man-power to carry out effective control measures.

**- Physician,
Harare, Zimbabwe¹⁸⁶**

There are also serious implications for vertical treatment programs as hospitals and clinics restrict patient enrollment due to shortages of ARVs and tuberculosis drugs.¹⁸⁷ The inability to treat patients due to drug shortages is profoundly demoralizing for health workers, leaving them feeling powerless to do little more than manage the effects of AIDS on their patients¹⁸⁸ or helpless to watch as a patient dies while on the waiting list for ARV treatment: "It is emotional and feels terrible but there is nothing we can do because we rely on the resources available to us."¹⁸⁹

A comprehensive health workforce plan will consider these broader health system and development issues, such as supply chain and equipment management, basic infrastructure provision and health financing, all of which directly impact the health workforce and are critical to the achievement of the right to health. Health workforce planning should happen in concert with broader health sector planning, and should be incorporated into that larger plan. Malawi, for example, is implementing its

ICU cases. See Dominique Herman, "Nursing shortage forces more ICU closures." *IOL (South Africa)*, Nov. 4, 2005. Available at: <http://www.healthlink.org.za/news/20041007>.

¹⁸⁶ Personal communication with Dr. Douglas Gwatidzo, Harare, Zimbabwe, March 1, 2006.

¹⁸⁷ The head of the Anti-Retroviral Treatment clinic at Harare Central hospital reported that they stopped accepting new patients due to a shortage of ARVs. A total of 20,000 people were allotted to participate in the clinic's treatment program by the end of 2005, but only 2,050 patients were enrolled as of November 2005. "Harare Hospital Faces Closure." *Daily Mirror*, Nov. 21, 2005. Available at: http://www.queensu.ca/samp/migrationnews/article.php?Mig_News_ID=2078&Mig_News_Issue=11&Mig_News_Cat=11.

¹⁸⁸ Petrida Ijumba, "'Voices' of Primary Health Care Facility Workers." In Health Systems Trust (Petrida Ijumba, ed.), *South African Health Review 2002* (2002), at 196. Available at: <http://www.hst.org.za/uploads/files/chapter10.pdf>.

¹⁸⁹ "Focus on Health Workers." *Equal Treatment (Treatment Action Campaign)*, Dec. 2005, Issue 18, at 13.

Emergency Human Resource Programme in conjunction with its Essential Health Package, which should strengthen the health system beyond the workforce.¹⁹⁰

Links to Underlying Determinants of Health

Just as the health workforce is linked to and dependent upon other health system elements, health workers also have the potential to impact the underlying conditions of health through their work, including malnutrition, unsafe water and poor hygiene, and personal safety. For example, health workers have an important role in detecting and treating malnutrition, as well as preventing it in the first place through education and referring patients to nutrition programs. Or health workers might be able to directly prescribe malnutrition therapy, such as nutrient-dense ready-to-use food, which is easy to store and has proven highly effective at treating malnutrition.¹⁹¹ A program in Kenya trains nurses on a water-treatment product called WaterGuard, which the nurses prescribe to patients suffering from diarrhea.¹⁹² Health workers should be trained in recognizing and responding to sexual violence, including by providing prophylactic anti-retroviral drugs and referring patients to appropriate social and legal services.

Community-based health workers may have an especially important role to play in promoting health literacy, including educating community members about nutrition, proper hygiene and other forms of environmental sanitation. They may have responsibilities that go beyond education, for example, helping to build

latrines or improve access to clean water.¹⁹³

While largely beyond the scope of plans, health workers also have an important role to play as community leaders who are aware that many of the health conditions they address are directly or indirectly linked to underlying determinants of health. Health workers can raise awareness or advocate in the community and in the political system about the impact that malnutrition, pollution and other factors can have on health.

Comprehensive Response to Health Worker Needs

A comprehensive, rights-based approach to planning will also take into account the rights of health workers. It is not much of a stretch to attribute significant attrition within the health workforce to a denial of health worker rights in the workplace, as was highlighted in the section of this guide on equity and non-discrimination. For example, a recent assessment of the health workforce in Swaziland concluded that nurses and midwives (“the backbone of the health system”) feel distinctly undervalued, pointing to a combination of poor working conditions, low pay, lack of support and low status as factors that are prompting their departure from the country.¹⁹⁴ Thandie Nhlengetfwa, a Swazi nurse, described reasons why many of her colleagues were leaving to take up positions in South Africa:

*Nurses are quitting — not because they are not dedicated, but because we feel we are not appreciated. We are not given the salary increases — 97% of nurses are women, and I guess the authorities feel that this is women’s work and it isn’t important. We don’t have supplies at the hospital: a baby comes, it’s bleeding — there are no gloves for protection against HIV. You can’t let the baby bleed, you must take her, and treat her. All the nurses are demoralized.*¹⁹⁵

¹⁹⁰ Debbie Palmer, “Tackling Malawi’s Human Resources Crisis.” *Reproductive Health Choices* (2006) 14: 27–39, at 33, 35.

¹⁹¹ Médecins Sans Frontières, *Food is not enough – Without essential nutrients, millions of children will die*, Oct. 10, 2007. Available at: http://www.msf.org/msfinternational/invoke.cfm?objectid=88BFF62D-15C5-F00A-2541FCBC25DD29EA&component=toolkit.article&method=full_html. See also Médecins Sans Frontières, *Treating malnutrition: The RUF revolution*, Oct. 10, 2007. Available at: http://www.msf.org/msfinternational/invoke.cfm?component=article&objectid=88C80C10-15C5-F00A-257AF64DC3C4940F&method=full_html. Currently, inadequate production of this nutritious, ready-to-use food limits its availability. See Médecins Sans Frontières, *Increasing and ensuring the supply of therapeutic RUF*, Oct. 10, 2007. Available at: http://www.msf.org/msfinternational/invoke.cfm?component=article&objectid=88CC9A04-15C5-F00A-25B3558F7E632BDB&method=full_html.

¹⁹² U.S. Centers for Disease Control and Prevention, *Working to Make Water Safe to Drink*. <http://www.cdc.gov/about/stateofcdc/everwhere/water.htm>, visited Jan. 16, 2008.

¹⁹³ Uta Lehmann, Irwin Friedman & David Sanders, *Review of the Utilisation and Effectiveness of Community-Based Health Workers, JLI Working Paper 4-1* (Feb. 2004), at 7. Available at: <http://www.webcitation.org/query.php?url=http://www.globalhealthtrust.org/doc/abstracts/WG4/LehmannFINAL.pdf&refdoi=10.1186/1475-2875-6-11>.

¹⁹⁴ World Health Organization/Ministry of Health & Social Welfare of the Government of Swaziland, *A Situation Analysis of the Health Workforce in Swaziland* (April 2004), at 11.

¹⁹⁵ This issue of low status is particularly pronounced in Swaziland, given that women are legally and culturally regarded as minors. See “Swaziland: Nurses’ Strike Impacts on Health Care.” *IRIN*, Feb. 25, 2004. Available at <http://www.irinnews.org/report>.

It appears that nurses' rights to "just and favourable conditions of work," including "safe and healthy working conditions," and "fair wages and equal remuneration"¹⁹⁶ for all workers, including equal conditions of work and equal pay for men and women, are being violated here. This comment certainly raises issues of equity, but it also points to the need for a comprehensive response to dissuade nurses from migrating: nurses perceive that they are being discriminated against because they are women; they work without adequate supplies and they are unable to protect themselves; they are poorly compensated for their hard work and they feel undervalued.¹⁹⁷ These kinds of violations have a direct and detrimental impact on health worker retention and, consequently, on the provision of adequate health services to the population. A comprehensive health workforce plan must address these violations of health worker rights, whether they impact all workers or particular cadres, to be effective in improving retention and morale among health workers. It should also make psychosocial support available to health workers, such as through peer support groups in which participation is confidential.¹⁹⁸

Comprehensive Services for Health Workers — HIV/AIDS Services

In addition to addressing issues such as gender equity and workplace safety to protect and uphold health workers' rights, comprehensive health workforce plans should explicitly seek to alleviate the massive detrimental impact that HIV/AIDS is having on the health sector. This requires action on a number of fronts and

aspx?reportid=48745.

¹⁹⁶ International Covenant on Economic, Social and Cultural Rights, G.A. res.2200A (XXI), 21 U.N.GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993, U.N.T.S. 3, entered into force Jan. 3, 1976, at arts. 7, 7(b), 7(a)(i). Available at: <http://www1.umn.edu/humanrts/instreet/b2esc.htm>.

¹⁹⁷ Similarly, a survey of four countries found that among the reasons for that health personnel offered in explaining their attention to migrate were poor remuneration, the decline of health services, and the desire for a safer environment, all of which have human rights implications. M. Awases, A. Gbary, J. Nyoni & R. Chatora (World Health Organization, Regional Office for Africa), *Migration of Health Professionals in Six Countries: A Synthesis Report* (2004), at 43. Available at: <http://www.afro.who.int/dsd/migration6countriesfinal.pdf>.

¹⁹⁸ Physicians for Human Rights, *An Action Plan to Prevent Brain Drain: Building Equitable Health Systems in Africa* (June 2004), at 44. Available at: <http://physiciansforhumanrights.org/library/documents/reports/report-2004-july.pdf>.

will also require sustained commitments on the part of health ministries, national governments and donors over many decades.

The provision of HIV/AIDS services to health care workers presents a challenging issue that requires consideration in developing a national health workforce plan. Health workers, like everyone else, have a right to access respectful and confidential health services.¹⁹⁹ In the case of HIV-positive health workers, this right is often abridged. HIV-positive health workers in Zimbabwe report widespread stigmatization: Colleagues often refuse to share toilet facilities and bring their own utensils to avoid any potential overlap through using cafeteria utensils.²⁰⁰ Médecins Sans Frontières staff at several HIV/AIDS project sites in southern Africa have reported stories of "health workers who would rather die than disclose their HIV status to a colleague."²⁰¹ Health workers have also reported that they are deterred from seeking AIDS services at the same facilities where they see patients: "stand[ing] in the same queue" is a barrier to accessing HIV testing and treatment.²⁰²

The development of separate health centers for health workers is one option that has been proposed to alleviate these barriers. Swaziland has opened such a facility, an HIV and TB Wellness Center for HIV-positive health workers and their immediate families that serves about 6,000 people in Manzini, the country's largest urban area.²⁰³ In Botswana, the Tshedisa Institute provides

¹⁹⁹ 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 paras. 12(b), 12(c). Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

²⁰⁰ "Zimbabwe: HIV Positive Health Workers form Union." *IRIN PlusNews*, Feb. 16, 2007. Available at: <http://www.plusnews.org/report.aspx?reportid=70230>.

²⁰¹ Katharina Kober & Wim Van Damme, "Scaling Up Access to Antiretroviral Treatment in South Africa: Who Will Do the Job?" *Lancet* (July 3, 2004) 364:103-107, at 105.

²⁰² International Council of Nurses press release, *Healthy and Valued Health Workers are Essential to Save Health Systems in Sub-Saharan Africa* (Dec. 1, 2005). Available at www.intlnursemigration.org/news.shtml#3.

²⁰³ *Id.*; Maggie Cooper (Physicians for Human Rights), *Bold Solutions to Africa's Health Worker Shortage* (2006), at 8. Available at: <http://physiciansforhumanrights.org/library/documents/reports/report-bold-solutions-2006.pdf>. Run under the auspices of the Swaziland Nurses Association, with support from the Danish Nurses Organization, this center will provide comprehensive HIV and TB treatment, health services and training. Such centers are to be expanded throughout the country as a key part of the Swaziland National AIDS Programme. International Council of Nurses press release, *Healthy and Valued Health Workers are Essential to Save Health Systems in Sub-Saharan*

holistic care for HIV infected and affected health workers in the capital Gaborone.²⁰⁴

Yet because the right to health also emphasizes “equality of access to health care and health services,”²⁰⁵ opening separate facilities for health workers raises issues that also need to be addressed within health workforce and broader health sector planning. If separate facilities are made available to health workers, a simultaneous effort must also be undertaken to reduce HIV stigma and discrimination among health workers who access these facilities. This should be part of the aim of these facilities and should also be part of a larger de-stigmatization effort that is integrated into health workforce planning, so that health workers treat all patients with full and equal respect, and so health workers can become community leaders in contributing to the reduction and elimination of stigma.

Health workers in Uganda, for example, are raising awareness among their colleagues about the harm caused by AIDS-related stigma and the need to eliminate it. A health and human rights organization in Uganda that spearheads a national network of health professionals, the Action Group for Health, Human Rights and HIV/AIDS, has developed an anti-stigma task force, which has trained 150 health workers in four districts on stigma and what they can do to prevent it.²⁰⁶

The development of these separate health centers raises broader issues of access to HIV and other health services for all marginalized populations. Health care workers do indeed have special, legitimate concerns related to HIV that may require special responses (e.g., separate facilities), but so, too, do other populations, such as rural people, people with disabilities, injecting drug users, and prisoners, all of whom may face great stigma and lack access to confidential, good-quality HIV/AIDS treatment services.

An example of an integrated HIV program for health workers can be found at McCord hospital in Durban, South

Africa, where staff are provided with free, on-site HIV care in a general practice staff clinic. Measures are taken to protect confidentiality: HIV-related blood tests are coded; blood tests and counseling are provided by a doctor; HIV and CD4 results are not attached to a personnel file. The clinic aims to normalize HIV by integrating HIV care into a general practice setting within the workplace and demonstrating that HIV can be treated. Stigma, fear and denial remain acknowledged barriers to accessing care, but the in-house program seeks to raise awareness and combat stigma, especially by having HIV-positive health workers educate other staff members.²⁰⁷ The program has led to growing openness, with a number of staff disclosing their status to encourage others to undergo HIV testing.²⁰⁸

The unique impact of HIV/AIDS on health workforce attrition through a combination of absenteeism, burnout, sickness and death must also be considered.²⁰⁹ Shoring up health systems in countries heavily impacted by the pandemic may depend upon providing HIV-positive health workers with rapid and reliable access to treatment so that they may remain in their jobs and provide critical health services. Conversely, continued attrition of health workers due to HIV/AIDS in heavily-impacted countries presages health system collapse. In Botswana, for example, an estimated 17% of health care worker deaths between 1999 and 2005 were attributable to HIV/AIDS.²¹⁰

Whether a decision is made to provide separate HIV/AIDS services for health workers or to integrate these within existing health facilities in a confidential and respectful way, health workforce plans must provide

Africa (Dec. 1, 2005). Available at www.intlnursemigration.org/news.shtml#3

²⁰⁴ Kerry E. Uebel, Jenny Nash & Ava Avalos, “Caring for the Caregivers: Models of HIV/AIDS Care and Treatment Provision for Health Care Workers in Southern Africa.” *Journal of Infectious Diseases* (2007) 196 (Suppl 3): S500-S504, at S502.

²⁰⁵ 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 paras. 19. Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

²⁰⁶ Physicians for Human Rights, *AGHA: Inspiring Results*, <http://www.physiciansforhumanrights.org/hiv-aids/partnerships-in-africa/uganda/agma-inspiring-results.html>, visited Dec. 10, 2007.

²⁰⁷ Powerpoint presentation by Kerry Uebel, Providing HIV care for Health Workers, Oct. 7, 2006, McCord Hospital, Durban, South Africa. Available at: <http://www.hms.harvard.edu/aids/images/saworkshop-pp-addressing-uebel.ppt>. See also Dan J. Ncayiyana, “Doctors and nurses with HIV and AIDS in sub-Saharan Africa,” editorial. *BMJ* (Sept. 11, 2004) 329: 584-585. Available at: <http://bmj.bmjournals.com/cgi/content/full/329/7466/584>.

²⁰⁸ Kerry E. Uebel, Jenny Nash & Ava Avalos, “Caring for the Caregivers: Models of HIV/AIDS Care and Treatment Provision for Health Care Workers in Southern Africa.” *Journal of Infectious Diseases* (2007) 196 (Suppl 3): S500-S504, at S501-S502.

²⁰⁹ Delanyo Dovlo, “Wastage in the Health Workforce: Some Perspectives from African Countries.” *Human Resources for Health* (Aug. 10, 2005) 3:6. Available at <http://www.human-resources-health.com/content/3/1/6>.

²¹⁰ International Labour Organization press release, *ILO/WHO to Develop Joint Guidelines on Health Services and HIV/AIDS* (April 19, 2005). Available at http://www.ilo.org/global/About_the_ILO/Media_and_public_information/Press_releases/lang--en/WCMS_005158/index.htm.

for universal precautions and workplace education and prevention programs that include practical exercises as well as information sharing.²¹¹ These programs must include all employees of health facilities, from doctors and nurses to auxiliary workers, such as maintenance staff, clerks and gardeners, who are not charged with patient care but who may face some degree of occupational risk.²¹² The programs are more likely to succeed when family members are included.²¹³

Workplace HIV education and prevention programs must also focus specifically on reducing stigma. This is essential both to ensure that quality of patient care is not compromised due to health worker fears and misgivings, but also to foster a supportive workplace environment so that health care workers feel that they can be tested without fear of losing their jobs or incurring the censure of their colleagues. An assessment conducted during 2003 revealed that only 2% of Malawian health care workers who died between 1996 and 2002 had been tested for HIV, a frightening statistic in view of the fact that 80% of these deaths were HIV-related. Such a scenario demonstrates the serious role that stigma and discrimination play in discouraging counseling and testing.²¹⁴

In addition to considering how best to provide HIV/AIDS services to health workers, health workforce plans should also seek to incorporate workplace policies that support HIV-positive health workers so that they can continue to work as long as possible. This may require introducing or expanding flexible working hours to accommodate necessary appointments or to allow for part-time work, long-term sick leave and early retirement.²¹⁵ Opportunities for HIV testing can be incorporated into other health care for health workers, such as an annual physical exam or during hepatitis B vaccination. Senior management should be encouraged to support early HIV testing among health workers and make clear that test results are anonymous and not associated with employment prospects.²¹⁶

Utilizing a Range of Health Workers to Ensure a Timely Response

While prioritizing principles such as participation, evidence base and equity, comprehensive health workforce plans must also prioritize a timely response to the health worker crisis. This might suggest consideration of alternative means of building and supporting a country's health workforce. One way, as discussed above, is supporting and acknowledging the role that existing, trained HIV-positive health workers can play and facilitating their retention through providing supporting workplace environments and access to confidential services.

Comprehensive plans should also consider the contribution that a variety of cadres can make to reducing a country's disease burden. For example, increased utilization of community health workers could extend the coverage of basic health services and health support services in a relatively rapid manner, particularly for poor and remote populations, who often face the most barriers to accessing health care. The use of community health workers to deliver health service can reduce health inequities by reaching out to these marginalized

²¹¹ A study of health workers in South Africa found that only about one-third of health care workers surveyed received training on transmission of HIV, care for those infected with HIV, or universal precautions against transmission. The remainder received only verbal or written information. Olive Shisana, et al. (Human Sciences Research Council, Medical University of South Africa & South Africa Medical Research Council), *The Impact of HIV/AIDS on the Health Sector. National Survey of Health Personnel, Ambulatory and Hospitalised Patients and Health Facilities, 2002* (2003), at 76-77. Available for free download at: <http://www.hspress.ac.za/product.php?mode=search&page=1&freedownload=1&productid=1986>.

²¹² For instance, 38% of hospital related injuries in South Africa happened to cleaners who were responsible for disposing of medical materials. Stephen Kinoti, "The Impact of HIV/AIDS on the Health Workforce." Presentation at the World Bank, Feb. 25, 2003. Available at <http://info.worldbank.org/etools/bSPAN/presentation-View.asp?EID=289&PID=590>.

²¹³ Ensuring that health workers' partners have access to HIV services will help in HIV prevention efforts for the partners, which will in turn help protect the health workers from contracting HIV. And when family members are able to access HIV treatment, health workers will not divide their medication between themselves and HIV-positive family members, which would significantly impair the effectiveness of AIDS treatment. Personal communication, June Fisher, Training for the Development of Innovative Control Technology (TDICT) project, Nov. 16, 2007.

²¹⁴ Commonwealth Regional Health Community Secretariat, U.S. Agency for International Development, Bureau for Africa & Support for Analysis and Research in Africa (SARA) Project, *Challenges Facing the Malawian Health Workforce in the Era of HIV/AIDS* (2004), at 9-10. Available at: <http://www.crhcs.org.tz/modules.php?op=modload&name=UpDownload&file=index&req=getit&lid=81>.

²¹⁵ Physicians for Human Rights, *An Action Plan to Prevent Brain Drain: Building Equitable Health Systems in Africa* (June 2004), at 42. Available at: <http://physiciansforhumanrights.org/library/documents/reports/report-2004-july.pdf>; Regional Network for Equity in Health in Southern Africa (EQUINET) and Oxfam (Great Britain) (Jean-Marion Aitken and Julia Kemp), *HIV/AIDS, Equity and Health Sector Personnel in Southern Africa* (Sept. 2003), at 14, 34-35. Available at: <http://www.equinet africa.org/bibl/docs/hivpersonnel.pdf>.

²¹⁶ Kerry E. Uebel, Jenny Nash & Ava Avalos, "Caring for the Caregivers: Models of HIV/AIDS Care and Treatment Provision for Health Care Workers in Southern Africa." *Journal of Infectious Diseases* (2007) 196 (Suppl 3): S500-S504, at S503.

populations.²¹⁷ Community health workers, mid-level cadres, such as clinical officers, and professionals all offer a variety of skills that can be harnessed to extend timely and competent care in a manner that supports greater equity in access to health services. For example, Malawi, Mozambique and Tanzania are utilizing mid-level health workers such as clinical officers and assistant medical officers to deliver much of the emergency obstetric care provided in those countries.²¹⁸

The African diaspora also offers a wealth of expertise and resources that could be used to strengthen health systems in their home countries. Members of the diaspora may not have sufficient information about the current health needs in their home countries and may be unaware of national health priorities.²¹⁹ Diaspora representation within the health workforce planning process, for example through participation of unions, professional groups or diaspora organizations, can facilitate both cooperation and knowledge-sharing between diaspora health professionals and their in-country colleagues, including health ministry officials. Members of the diaspora may be well-placed, given their linguistic and cultural connections, to temporarily return to their countries of origin to supplement service provision and boost training capacity or to contribute their skills by telephone or internet.²²⁰

The use of foreign medical staff is another option that merits consideration in terms of boosting a country's capacity to rapidly respond to the health workforce shortage and extend coverage of good-quality care. For example, Malawi's Emergency Human Resource Programme includes a focus on using international volunteer doctors to fill critical coverage gaps while more Malawians are being trained. Again, though, this approach requires an examination of local factors to determine what is locally tenable. Malawi's program

also relies on international nurses tutors, but stopped short of recruiting expatriates to fill nursing posts due to a concern that this would spark industrial action by Malawian nurses, as had previously occurred.²²¹ A comprehensive approach to health workforce planning should recognize that use of expatriate personnel must be done in a sensitive manner that builds capacity concomitantly with providing services.

Covering the Full Health Sector, Including Private Sector

Health workers are employed within a "pluralistic market"²²² of health institutions, which includes government, private for-profit (commercial), and private not-for-profit health services providers. The not-for-profit sector itself includes several types of entities, including NGOs, faith-based health services, and social franchises. In many cases, private providers supply a significant proportion of health services, often filling gaps in public health facility coverage.²²³ For example, church missions in Zimbabwe provide nearly 70% of rural hospital beds and missions run 40% of Tanzania's hospitals.²²⁴ Private providers may also target a certain portion of the population, such as providing private services for people with higher incomes, or an NGO-run health program might focus on a particular disease.

The health worker shortage and the fact that large segments of the population in most countries use the private sector demand that health workforce plans

²¹⁷ Andy Haines, David Sanders, Uta Lehmann, et al. "Achieving Child Survival Goals: Potential Contributions of Community Health Workers." *Lancet* (June 23, 2007) 369: 2121-2131.

²¹⁸ Systems Strengthening for Equity (HSSE): The Power and Potential of Mid-Level Providers, *The Approach*, <http://www.midlevelproviders.org/approach.php>, visited Dec. 10, 2007.

²¹⁹ Mattias Creffier, "Congo: Turning Brain Drain into Brain Gain." *Africa News EN* (Oct. 23, 2006). Available at: <http://www.africa-interactive.net/index.php?PageID=1960>.

²²⁰ See, e.g., African Leadership and Progress Network, *The African Leadership & Policy Brief: Addressing Africa's Humiliation: 'Brain Gain'/'Brain Circulation' Diaspora Networks for African Progress* (March 1, 2006). Available at: http://www.africanprogress.net/brain_gain_network.htm.

²²¹ Debbie Palmer, "Tackling Malawi's Human Resource Crisis", *Reproductive Health Matters* (2006) 14: 27-39, at 32-33.

²²² Vasant Narasimhan, Hilary Brown, Ariel Pablos-Mendez, et al., "Responding to the global human resources crisis." *Lancet* (May 1, 2004) 363:1469-1472, at 1470.

²²³ One study of 22 countries in sub-Saharan Africa that examined care for children under five-years-old found that a substantial majority of the children received care in the private sector. Ndola Prata, Dominic Montagu & Emma Jefferys, "Private Sector, Human Resources and Health Franchising in Africa." *Bulletin of the World Health Organization* (2005) 83: 274-279, at 275-276. Available at: <http://www.who.int/bulletin/volumes/83/4/274.pdf>. The World Bank estimates that upwards of half of health care provision in sub-Saharan Africa occurs through the private sector. International Finance Corporation, World Bank Group, *The Business of Health in Africa: Partnering with the Private Sector to Improve People's Lives* (2007), at vii. Available at: <http://www.ifc.org/ifcext/healthinfrica.nsf/Content/FullReport>.

²²⁴ Paolo Ferrinho, Wim Van Lerberghe, Inês Fronteira, et al. "Dual practice in the health sector: review of the evidence." *Human Resources for Health* (2004) 2:14. Available at: <http://www.human-resources-health.com/content/2/1/14>.

explicitly consider the role of the private health care providers within the country. Indeed, addressing the interplay between the public and private health workforces may highlight new opportunities for cooperation and improved efficiency using a country's existing human resources, which may in turn facilitate better, swifter, and more accessible health care. Private sector providers may serve as important resources for governments to partner with, regulate, and even learn from in national efforts to provide essential health services for everyone.

Ideally, health workforce plans should consider where private sector providers are located, how many there are, and who they are serving, recognizing that limited information is a serious obstacle to understanding the full scope of the role that private sector health providers play in many countries. This is part of a larger need to base health workforce plans on as accurate as possible an understanding of the current health workforce and trends, such as numbers of health workers, their distribution, health worker migration patterns, their skills, their ages (which will affect retirement), and the number of unemployed health workers.

Coordination between public and private sectors is key to avoid unwittingly undermining critical health services. For instance, anecdotal evidence reports that public health sector salary increases in Tanzania drew staff away from faith-based organizations, which provide many of the health services in rural areas of the country, perversely leading to a reduction in rural health services.²²⁵

The importance of coordination to avoid different health providers working at cross purposes is also particularly important for donors and internationally supported NGOs, especially those with programs focused on a single disease, such as HIV/AIDS. These NGOs may be able to pay health workers more than the public sector can, and so draw health workers away from the public sector. Without a concerted strategy to ensure that these NGO programs are provided in a way that will have broader positive impact, the programs could cause an internal brain drain that is detrimental to some primary health services.²²⁶ Countries — and development

partners — have a responsibility to implement strategies that will avoid internal brain drain, such as by integrating HIV/AIDS programs in existing primary health centers, rather than developing vertical programs.

Health workers move between these various sectors due to personal choice and new opportunities, but also in response to violations of their rights, such as a lack of basic supplies at public sector facilities, such as gloves, which infringe on health workers' rights to "safe and hygienic working conditions."²²⁷ Public sector salaries that are not "domestically competitive"²²⁸ and that do not permit health workers to achieve an adequate standard of living for themselves or their families will prompt workers to depart from the public sector entirely or adopt a survival strategy of dual practice or "moonlighting" within both public and private sectors to augment these poor salaries and working conditions.²²⁹

Such dual practice activities have implications for the availability of health care services, especially for poor and vulnerable populations. For instance, public sector clinic staff may only be nominally available 'full time'; in reality, hours spent in a public clinic decrease as uptake of private, often fee-for-service, employment increases. This effectively diminishes the ability of low-income people to receive health care services.²³⁰ There may be benefits to formalizing dual practices, such as enabling health workers to supplement their income and remain in the country rather than emigrating, by creating clear expectations that enable informed decision-making by public sector health facilities and patients, and by reducing informal payments often charged in the public sector.²³¹ Formalization might, however, simply serve to perpetuate a practice that undermines the public health service and avoid dealing with low pay and inadequate

particularly those related to national human resource settings"). Available at: <http://www.ncseonline.org/NLE/CRSreports/07Oct/RL34192.pdf>.

²²⁷ 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 paras. 15. Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

²²⁸ *Id.* at para. 12a.

²²⁹ Paolo Ferrinho, Wim Van Lerberghe, Inês Fronteira, et al. "Dual practice in the health sector: review of the evidence." *Human Resources for Health* (2004) 2:14. Available at: <http://www.human-resources-health.com/content/2/1/14>.

²³⁰ *Id.*

²³¹ International Finance Corporation, World Bank Group, *The Business of Health in Africa: Partnering with the Private Sector to Improve People's Lives* (2007), at 31. Available at: <http://www.ifc.org/ifcext/healthinfrica.nsf/Content/FullReport>.

²²⁵ Presentation by Dr. Adeline Kimambo, Director, Christian Social Services Commission (Tanzania), *The Health Care Worker Shortage: Impact on the Tanzania Health Care System*. Washington, DC, Aug. 30, 2005.

²²⁶ See, e.g., Tiaji Salaam-Blyther (Congressional Research Service), *CRS Report for Congress: PEPFAR: From Emergency to Sustainability* (Sept. 2007), at 14 (quoting an Institute of Medicine report: "PEPFAR's HIV/AIDS activities have sometimes negatively affected other aspects of public health systems and exacerbated resource constraints,

working conditions that lead public sector workers to seek supplementary employment.

The movement of health workers out of the public sector also may well have negative human rights implications for the availability of many basic health services for poor, vulnerable and rural populations, who are most hurt by the internal “brain drain” of health workers from public to private (both for-profit and non-profit) sector health employers and to urban areas. For example, the expansion of ARV roll-out programs in South Africa has meant stiff competition for professionals who are needed to provide these services. Advertisement aimed at doctors, nurses, pharmacists and dieticians have drawn these professionals out of the general pool of public sector health workers, instead of introducing new people into the health system. At the same time, some South African district hospitals report staff shortages of up to 50% in rural areas, resulting in untenable workloads for remaining staff, high levels of absenteeism and low morale.²³² Of course, it is critically important to roll out ARV programs, which are central to people’s right to receive AIDS treatment,²³³ but as far as possible, AIDS treatment programs should be integrated into other essential health services to avoid drawing health workers away. Health workforce plans should seek to have a frank, participatory discussion about the ways to minimize harm that results from such trade-offs and try for positive synergies between AIDS programs and primary care, as, for example, undertaken by Partners

In Health in rural Haiti, Rwanda, and Lesotho.²³⁴

Health workforce plans may consider opportunities to utilize private sector resources including to support capacity building within the public sector, to supplement staff in public health facilities in the short term through contract arrangements, or to train, contract services to, or otherwise engage private sector providers to better enable them to contribute to increased access to equitable essential health services.

Rural district hospital doctors in South Africa’s Limpopo province suggested utilizing private practitioners on a part-time basis in order to reduce their workloads.²³⁵ A study of rural hospitals in the Western Cape Province also recommended developing a model for public-private partnerships that would use private practitioners to supplement after-hours duty rosters. This is an urgent matter: an excessive workload was cited one of the biggest factors prompting doctors to leave district hospitals.²³⁶

A comprehensive health workforce plan will acknowledge the interplay between these various actors and will solicit input from stakeholders in both the public and private sectors. The private health sector, while having no monopoly on good practices, may offer examples of interventions or possibilities for coordination that could assist countries in bolstering their public health sectors and supporting their health workers.²³⁷

²³² Ian Couper, Marietjie de Villiers & Nontsikelelo Sondzaba, “Resources: District Hospitals.” In Health Systems Trust (Petrida Jumba & Peter Barron, eds.), *South African Health Review* (2005), at 125, 127. Available at: http://www.hst.org.za/uploads/files/sahr05_chapter9.pdf.

²³³ See UN Human Rights Commission, *Access to medication in the context of pandemics such as HIV/AIDS*, Commission on Human Rights resolution 2002/32 (2002), at para. 1 (“Recognizes that access to medication in the context of pandemics such as HIV/AIDS is one fundamental element for achieving progressively the full realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”). Available at: http://ap.ohchr.org/documents/E/CHR/resolutions/E-CN_4-RES-2002-32.doc; Office of the United Nations High Commissioner on Human Rights/UNAIDS, *International Guidelines on HIV/AIDS and Human Rights* (2006), at 18 (“States should also take measures necessary to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality goods, services and information for HIV prevention, treatment, care and support, including antiretroviral and other safe and effective medicines, diagnostics and related technologies for preventive, curative and palliative care of HIV and related opportunistic infections and conditions.”). Available at: http://data.unaids.org/Publications/IRC-pub07/JC1252-InternGuidelines_en.pdf.

²³⁴ See Partners In Health, *The PIH model of care — partnering with poor communities to combat disease and poverty*, <http://www.pih.org/what/PIHmodel.html>, visited Dec. 10, 2007. For a discussion on integrating HIV and other disease-specific health services with the broader health services, see Physicians for Human Rights, *Guide to Using Round 7 of the Global Fund to Fight AIDS, Tuberculosis and Malaria to Support Health Systems Strengthening* (2007), at 10-11. Available at: <http://physiciansforhumanrights.org/library/documents/reports/round7-gf-hss-guide.pdf>.

²³⁵ Theunis Kotzee & Ian Couper, “What interventions do South African qualified doctors think will retain them in rural hospitals of the Limpopo province of South Africa?” *Rural and Remote Health Journal* (2006) 6: 581. Available at: <http://www.rrh.org.au/articles/subviewafro.asp?ArticleID=581>.

²³⁶ M. De Villiers & P. De Villiers, “Doctors’ views of working conditions in the rural hospitals in the Western Cape.” *South African Family Practice* (2004) 46(3): 21-26.

²³⁷ For example, PEPFAR used a private firm to recruit 830 Kenyan health workers as part of an Emergency Hiring Plan. Health workers reported surprise and pleasure at the speed and transparency of the process, compared to Ministry of Health recruitment. Capacity Project, *Kenya’s Health Care Crisis: Mobilizing the Workforce in a New Way*, http://www.capacityproject.org/index.php?option=com_content&task=view&id=133&Itemid=108, visited Jan. 8, 2008. Public sector recruitment could benefit if the Ministry of Health adopted these practices.

VI. QUALITY

Quality and Right to Health

In addition to being available, accessible and acceptable, health facilities, goods and services must also be of good quality in order to fulfill the right to health. General Comment 14 defines the element of quality as it applies to the right to health:

“As well as being culturally appropriate, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, among other things, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.”²³⁸

This element of quality has implications for health workforce planning. Health workers are at the heart of providing good-quality health services. Without a sufficient number of trained health workers who are equitably distributed and provided with medicine, equipment, supplies, infrastructure and supervision to allow them to perform their jobs according to established standards of care, the quality of health care provision will be compromised.

Issues Related to Quality

The right to health recognizes that the application of quality standards will vary depending upon the resources and conditions that prevail in an individual country.²³⁹ While states are obligated to “ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct,”²⁴⁰ this obligation should be fulfilled with an eye to prevailing health conditions within a country. This is immensely important for education and training, which

should be designed with the ultimate goal of meeting the actual health needs of the whole population.²⁴¹

Pre-Service Training

Pre-service training must be made relevant to country needs. In the case of resource-poor countries with lack of access to health facilities, health workers should emerge from their training well-prepared to provide primary health care services and address health problems, such as HIV/AIDS, malaria, tuberculosis and malnutrition. This requires re-shaping health education so that exposure to providing primary care and working in deprived settings becomes an integral part of pre-service training. This is necessary to equip health workers to address common health conditions and to meet the needs of poor and marginalized populations. At present, most undergraduate-level health training takes place in tertiary care settings and does not adequately prepare students for the realities of practice in under-resourced environments.²⁴²

In-Service Training and Professional Development

Ongoing training for practicing health workers is also necessary in order to maintain and upgrade skill levels. This is essential so that health workers can adequately respond to new diseases, such as HIV/AIDS. It will also assure the public that they are receiving care that meets or exceeds minimum established standards.²⁴³

In-service training should also be tailored to meet health needs within a particular country, and conducted as part of a coherent program of professional development. Whenever possible, training should take place at clinical

²³⁸ 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. 12[d]. Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

²³⁹ 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. 12. Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

²⁴⁰ *Id.* at para 35.

²⁴¹ Richard Cash, “Ethical Issues in Health Workforce Development.” *Bulletin of the World Health Organization* (April 2005) 83(4): 280-284, at 281.

²⁴² Fatu Yumkella, “Retention: Health Workforce Issues and Response Actions in Low-Resource Settings.” *Capacity Project Resource Paper* (August 2005), at 9. Available at: <http://www.equinet africa.org/bibl/docs/DIS44HRdambisya.pdf>.

²⁴³ Richard Cash, “Ethical Issues in Health Workforce Development.” *Bulletin of the World Health Organization* (April 2005) 83(4): 280-284, at 282.

locations to minimize the difficulties associated with moving people from their workplace; namely, reduced staff capacity, increased burdens on colleagues, and travel time and expense. In addition to being less disruptive, on-site and interactive training for health workers is far more likely to result in the application of new skills within their workplace.²⁴⁴

Supervision and Standards

For education and training to be successfully applied, health workers must have supportive supervision within a context of standards that are agreed upon, adhered to and clearly communicated by supervisors to their staff. The presence of standards alone or the threat of punitive action will not be enough to ensure acceptable health care. Health workers should be recognized and possibly rewarded for their good work. This requires discernable career paths and clear expectations that supervisors and workers alike understand so that individual health workers know where they stand.²⁴⁵

Some of the short term international projects that have started here in Nigeria are recruiting health workers here and provide very interesting and challenging working environments. These organizations also provide goal-oriented and performance-based supervision, which is better than the work environment in the public sector environment that is limited by bureaucracy.

— Pharmacist,
Abuja, Nigeria²⁴⁶

Health workforce plans must also consider how to better support supervisory functions, such as through providing in-service training to supervisors, and resources such as vehicles and computer systems to allow for more regular supervisory visits and organized record keeping. The importance placed on goal-oriented and performance-based supervision by health workers indicates that health workforce plans should prioritize training health workforce supervisors in the public sector to fulfill their roles in ways that are transparent and

linked to results, such as through clearly communicating performance appraisal criteria to their staff.²⁴⁷

The development and implementation of performance-based standards must also take care to avoid creating perverse incentives. For example, if health workers fear being fired if they are associated with a maternal death, they might choose to deny care for a mother with a high-risk pregnancy, rather than risking her death in their care.²⁴⁸ They should also be carefully evaluated to ensure that the standards are having their intended impact. In Rwanda, mothers are encouraged to give birth in health facilities. Yet because of the shortage of health workers, many of these mothers are not being attended by a skilled health worker even when they give birth at the health facility.²⁴⁹

Quality and Ethics

While objective, performance-based standards are crucial, they should not be allowed to conflate numbers or outcomes with quality of care. This requires a nuanced approach to what constitutes 'good' performance and incorporating ethical standards into health education, training and practice. Health workforce plans offer an opportunity to more fully integrate ethical guidelines into both pre-service and in-service training so that practitioners are more attuned to their obligations to treat their patients with respect and dignity. Training in ethics, while not providing formal sanctions like laws or regulations do, can create an atmosphere where health workers are aware that they will be judged by their peers and patients and may encourage adherence to standards of quality care.²⁵⁰

Community Health Workers and Quality Assurance

As with health professionals and paraprofessionals who receive formal education and training, quality

²⁴⁴ World Health Organization, *World Health Report 2006: Working Together for Health* (2006), at 82. Available at: <http://www.who.int/whr/2006/en/index.html>.

²⁴⁵ Elizabeth Molyneux & Martin Weber, "Applying the Right Standards to Improve Hospital Performance in Africa." *Lancet* (Oct. 30, 2004) 364:1560-61, at 1561.

²⁴⁶ Personal communication with Tony Anammah, Pharmacist, Gede Foundation, Abuja, Nigeria, June 23, 2006.

²⁴⁷ Rachel Manongi, Tanya Marchant & Christian Bygbjerg, "Improving Motivation Among Primary Health Care Workers in Tanzania: A Health Worker Perspective." *Human Resources for Health* (March 7, 2006) 4:6. Available at: <http://www.huna-resources-health.com/content/4/1/6>.

²⁴⁸ Physicians for Human Rights, *Deadly Delays: Maternal Mortality in Peru* (2007), at 73. Available at: <http://www.physiciansforhumanrights.org/library/documents/reports/maternal-mortality-in-peru.pdf>.

²⁴⁹ Personal communication with Dr. Steven Rulisa, Obstetrician/Gynecologist, Vice President, Rwanda Medical Association, Kigali, Rwanda, Nov. 8, 2007.

²⁵⁰ Richard Cash, "Ethical Issues in Health Workforce Development." *Bulletin of the World Health Organization* (April 2005) 83(4): 280-284, at 283.

assurance measures are also required for community health workers. Health workforce plans should formally recognize community health workers, link them to the broader health workforce, and budget both their initial and recurrent costs. This is necessary to ensure that community workers receive proper training, supervision, material support and fair compensation, that they are utilized in appropriate and well-defined roles, and that they have career pathways. Moreover, defining the roles of community health workers relative to facility-based health workers is important to allow for harmonized training, mutual respect and understanding of roles and responsibilities, and consistent referral and practice guidelines,²⁵¹ all of which are essential to achieving and sustaining good quality health services.

Private Sector Regulation

States are responsible for promulgating and enforcing guidelines of practice for private health care providers. The right to health requires that states ensure that health personnel “meet appropriate standards of education, skill and ethical codes of conduct” and “ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability or quality of health facilities, goods or services.”²⁵²

Health workforce plans should consider how private health providers, who may be located within for-profit, NGO, mission-based or informal sectors, influence the quality of services available. In many cases, the ability of low-income countries to effectively monitor and regulate the standards of private practitioners may be quite limited.²⁵³ The health workforce planning process offers an opportunity to evaluate private sector health worker education and the extent to which private providers are accredited according to uniform standards that also apply to the public sector. Private practitioners and professional associations should be involved in standard setting and monitoring to enhance cooperation and compliance.

²⁵¹ Andy Haines, David Sanders, Uta Lehmann, et al. “Achieving Child Survival Goals: Potential Contributions of Community Health Workers.” *Lancet* (June 23, 2007) 369: 2121-2131, at 2127.

²⁵² 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. 35. Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

²⁵³ Ruairi Brugha & Anthony Zwi, “Improving the quality of private health sector delivery of public health services: challenges and strategies.” *Health Policy & Planning* (1998) 13(2): 107-120. Available at: <http://heapol.oxfordjournals.org/cgi/reprint/13/2/107>.

A Kenyan Physician’s Perspective

Education

“Many health workers, especially doctors, landed in this career by virtue of the fact that they passed exams well and medicine takes only the top cream. After the basic training, there is no system for further training and development and the health workers are left alone to shape their specialty through thick and thin.”

Training

“African governments should look at their needs and have a training and human development policy based on these. A challenge to this need-tailored approach is encroachment by a western education system...which does not address the real needs.”

Supervision And Performance Appraisal

“I left a job which was better paying than what I earn now simply because my boss never appreciated anything. My current bosses appreciate what I do and though the salary is less, I am more motivated. There is never enough money to keep you working, but an appraisal system that objectively evaluates the achievement of each staff member cannot be over-emphasized. It is this lack of appraisal system that makes health workers have a “don’t care” attitude — after all, you will get the same pay, etc. whether you work hard or not.”

Human Resource Policy

“No system exists to address grievances. What is the hiring and firing process? Who decides on transfers and to what extent is this used to settle grudges? How are promotions and appointments handled? How are staff files handled and can you get it easily when the need arises? I know of some workers who looked for their files for over one year with no trace. This situation is demotivating to committed [health workers] who eventually leave the country.”²⁵⁴

²⁵⁴ Personal communication with Dr. Burton Wagacha, Health Coordinator, GTZ Refugee Kenya Country Program, Kenya, July 6, 2006.

VII. FUNDING

Human Rights Requirement

International law is clear that funding levels are central to human rights obligations. The International Covenant on Economic, Social and Cultural Rights requires a state to use the “maximum of its available resources” from all sources at its disposal to move towards achieving the highest attainable standard of health, as well as toward achieving other economic, social, and cultural rights.²⁵⁵ This means that state budgets should reflect a commitment to meeting obligations under the right to health. A state that is unwilling to allocate funds in this way violates its obligations to the right to health. For example, it is highly doubtful that a state that declines to provide essential primary health interventions for its population while concurrently investing in significant military expenditures is making “every effort”²⁵⁶ to satisfy its core obligations.

This unwillingness is distinct from a state’s inability to comply with right to health obligations due to limited resources. The right to health recognizes that resource constraints may preclude a state’s full compliance with these obligations. This is consistent with the understanding that the right to health is subject to progressive realization. Governments, however, must demonstrate that they are moving towards achieving the right to health in practice through continual and significant efforts to progress towards the right to health,²⁵⁷ moving “as expeditiously and effectively as possible towards” the full realization of the right to health.²⁵⁸

²⁵⁵ International Covenant on Economic, Social and Cultural Rights, G.A. res.2200A (XXI), 21 U.N.GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993, U.N.T.S. 3, *entered into force* Jan. 3, 1976, at art. 2(1). Available at: <http://www1.umn.edu/humanrts/instr/b2esc.htm>.

²⁵⁶ 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. 47. Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

²⁵⁷ Judith Asher, *The Right to Health: A Resource Manual for NGOs* (2004), at 42. Available at: http://shr.aaas.org/pubs/rt_health/rt_health_manual.pdf.

²⁵⁸ Committee on Economic, Social and Cultural Rights, *General Comment 3, The nature of States parties’ obligations* (Fifth session, 1990), U.N. Doc. E/1991/23, annex III at 86 (1991), at para. 9. Available

This confers some special importance on allocating resources towards health workforce planning as a component of a larger national health strategy, one of the core right to health obligations that all governments must fulfill.²⁵⁹ Health workforce planning has not received adequate attention, and in countries where plans have been developed, arrangements for implementation, monitoring and evaluation have generally been insufficient and funding has often fallen short.²⁶⁰ If countries hope to seriously address the health workforce crisis that impedes progress against diseases such as HIV/AIDS and tuberculosis, while denying people access to basic essential health services, then resources must be made available to draft comprehensive, costed plans according to human rights principles.

Funding the Planning Process

Developing an evidence-based plan requires resources to support technical components, such as data collection, that are essential to craft a comprehensive plan and to monitor and evaluate the plan once it is enacted. However, support for the technical aspects of drafting and implementing a health workforce plan must be balanced by a participatory process that invites and utilizes input from a diverse range of stakeholders, including government agencies, NGOs, professional groups, the education and training sector, and health service providers and consumers. This is critical both as a matter of upholding people’s right to participate in decisions affecting their own health,²⁶¹ and to develop an

at: <http://www1.umn.edu/humanrts/gencomm/epcomm3.htm>.

²⁵⁹ 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 paras. 43(f), 47. Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

²⁶⁰ Giles Dussault & Maria Cristina Franceschini, “Not Enough There, Too Many Here: Understanding Geographical Imbalances in the Distribution of the Health Workforce.” *Human Resources for Health* (May 27, 2006) 4:12, at 5. Available at: <http://www.human-resources-health.com/content/4/1/12>.

²⁶¹ 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. 11. Available at: <http://www1.umn.edu/humanrts/gencomm/epcomm3.htm>.

understanding among stakeholders of the contribution that planning can make to achieving more accessible and effective health services and better health outcomes. Investment in an inclusive process of health workforce planning is crucial to creating and sustaining support for a plan; absent genuine participation, the sustained commitment from the range of stakeholders necessary to defend and support implementation of a health workforce plan is unlikely to be achieved.²⁶² Moreover, dedicated financial resources are also required to ensure that participation does not stop after the drafting process, but feeds into monitoring and evaluation to ensure that strategies, once enacted, progress towards meeting the needs of all stakeholders, especially health service users and frontline care providers.

Funding the Plan

Sufficient funding is necessary to allow for development and implementation of a costed health workforce plan that uses an evidence-based approach to consider what distribution and mix of staff is necessary to provide accessible health care of good quality to all population segments within a country. For example, health workforce plans must allocate funding not just to develop and maintain direct health service providers, but also to train and support the management and support workers who are essential to running a functioning health system.²⁶³ A commitment to expand the capacity of health training institutions to expand student enrollment must be matched by a commitment to support additional faculty to ensure that the quality of instruction is not diminished as student numbers increase. This will require explicit budget allocations to cover more health teaching positions, including competitive salaries and benefits.

Health workforce plans must also prioritize equity as they allocate funding. In particular, health workforce plans should give preference to quickly providing health services to poor and marginalized populations who are most directly and negatively affected by a lack of trained, accessible health workers. A 'trickle down' approach of investing in the health workforce at large will not achieve equitable outcomes.

www1.umn.edu/humanrts/gencomm/escgencom14.htm.

²⁶² Ummuro Adano [Capacity Project], *Collection and Analysis of Human Resources for Health (HRH) Strategic Plans* (Dec. 2006), at 3, 6. Available at: http://www.capacityproject.org/images/stories/files/resourcepaper_strategicplans.pdf.

²⁶³ World Health Organization. *Fact Sheet No. 302: The global shortage of health workers and its impact* (April 2006). Available at: <http://www.who.int/mediacentre/factsheets/fs302/en/index.html>.

Without specifically costing these elements and including them in a budget attached to the health workforce plan, it is unlikely that they will be acted upon in a meaningful way. This means that governments must be prepared to allocate their own domestic funds by increasing health sector spending, at least when governments are not already spending the maximum of available resources towards fulfilling the right to health and other human rights obligations. African governments should meet their pledge in the *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases* (2001) to devote at least 15% of annual budgets to health.²⁶⁴ As of 2005, only about one-third of sub-Saharan countries were allocating even 10% of their budgets to health spending.²⁶⁵ As of 2007, only two countries in Africa had achieved the 15% minimum.²⁶⁶ Increased resource generation can also lead to more money for the health sector.²⁶⁷

In addition, governments may be able to find resources through greater efficiencies and improved financial management. For example, when a new state administration took office in Ondo State, Nigeria in 2003, the government re-negotiated contracts, cutting one-third to one-half the cost of many contracts, including saving 7 billion naira on road construction.²⁶⁸ This money could then be put towards development.

²⁶⁴ *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases*, Organization of African Unity summit, adopted April 27, 2001, Abuja, Nigeria, at para. 26. Available at: <http://www.uneca.org/adf2000/Abuja%20Declaration.htm>.

²⁶⁵ Chris Atim, *Economic Viewpoint: Health Financing in Africa - Further Thoughts on Abuja* (Aug. 2006). Available at: <http://go.worldbank.org/RYOQ50AYL0>.

²⁶⁶ Africa Health Strategy 2007-2015, at para. 14. Adopted at the Third Session of the African Union Conference of Ministers of Health, Johannesburg, South Africa, April 9-13, 2007. Available at: http://www.africa-union.org/root/UA/Conferences/2007/avril/SA/9-13%20avr/doc/en/SA/AFRICA_HEALTH_STRATEGY_FINAL.doc.

²⁶⁷ Rwanda Country Coordinating Mechanism, Round 5 Health System Strengthening proposal (Assuring Access to Quality Care: The Missing Link to Combat AIDS, Tuberculosis and Malaria in Rwanda) (June 2005), at 54 ("In concordance with the insight of the WHO Commission on Macroeconomics and Health, the project anticipates increased population wealth through improving health"). Available at: http://www.theglobalfund.org/search/docs/5RWNH_1199_0_full.pdf.

²⁶⁸ Presentation by Olusegun Agagu, Governor, Ondo State, Nigeria, Three Years Along the Road to Progress, in Akure, Ondo State, June 23, 2006. At 2007 exchange rates, 7 billion Nigerian naira is equivalent to nearly \$60 million.

Seek Funds From All Available Sources

In addition to meeting the Abuja commitment, at least in Africa, governments must also be prepared to seek resources in support of health workforce planning and implementation from all available international sources of funding, including from multilateral sources such as GAVI²⁶⁹ and the Global Fund to Fight AIDS, Tuberculosis and Malaria,²⁷⁰ as well through bilateral mechanisms such as the President's Emergency Plan for AIDS Relief (PEPFAR) and the Millennium Challenge Accounts (MCA).²⁷¹ This may require advocacy on the part of governments to ensure that international development

²⁶⁹ In 2005, GAVI (formerly the Vaccine Fund) decided to make funds available for health systems strengthening, and committed an initial \$500 million towards that purpose. One focus area for this funding is the health workforce. See GAVI Alliance, *Health Systems Strengthening*, <http://www.gavialliance.org/vision/policies/hss/index.php>. Accessed Jan. 16, 2008.

²⁷⁰ The Global Fund has supported health systems, including the health workforce, in varying ways during its existence, including by funding a portion of Malawi's Emergency Human Resources Programme. In November 2007, the Fund's Board set out the Fund's strategic position on health system strengthening, which will guide the Fund over the next several years. It stated that "[t]he Global Fund shall allow broad flexibility regarding [Health Systems Strengthening] actions eligible for funding, such that they can contribute to system-wide effects and other programs can benefit." These actions must contribute to improved AIDS, tuberculosis, or malaria outcomes. Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria, *Decision Points of 16th Board Meeting* (Nov. 2007), at 11 [Strategic Approach to Health Systems Strengthening: Decision Point GF/B16/DP10]. Available at: <http://www.theglobalfund.org/en/files/board-meeting16/GF-BM16-Decisions.pdf>. More information about the Global Fund and health systems strengthening is available through Physicians for Human Rights, *Guide to Using Round 7 of the Global Fund to Fight AIDS, Tuberculosis and Malaria to Support Health Systems Strengthening* (March 2007). Available through: <http://physicians-forhumanrights.org/library/report-2007-03-17.html>. Note that this guide applies to Round 7 of the Global Fund; each Round has slightly different guidelines. Guidelines for Round 8, which launches on March 1, 2008, will be available through the Global Fund's website: <http://www.theglobalfund.org>.

²⁷¹ The Millennium Challenge Corporation (MCC) is a U.S government program established in 2004 to assist governments in supporting economic growth and reducing poverty. Countries must meet requirements concerning governance and rule of law, economic freedom and investing in health and education in order to be eligible to apply for development grants under this program. See Millennium Challenge Corporation, *Indicators*, <http://www.mcc.gov/selection/indicators/index.php>. Accessed June 25, 2008. The MCC accepts proposals for projects that are designed to improve health conditions within a country, including developing human resources for health. See Millennium Challenge Corporation, *Preliminary Guidance for Countries Considering Health Sector Activities*, Nov. 2006. Available at: <http://www.mcc.gov/countries/tools/2007/compact/english/tools-2007-25-guidelinesforcountriesproposinghealthsectorprograms.pdf>.

partners include health workforce strengthening among the areas that they fund both bilaterally and through other international funding mechanisms.²⁷²

Governments' efforts to secure financial resources necessary to support the development and implementation of a comprehensive health workforce plan should be matched by a willingness on the part of international donors to channel a portion of foreign aid funding towards this endeavor, and to the health sector overall.

The donor community needs to change some of its policies concerning remuneration. Most donors do not fund salaries, which I find self-defeating. Take the example of a donor choosing only to fund medical supplies without considering how the supplies will be dispensed and by whom. Donors need to scale up in investing in human resources, especially in health care workers.

- Physician, Meru, Kenya²⁷³

Economically developed states are obligated to provide international assistance necessary to achieve realization of economic, social and cultural rights, including the right to health.²⁷⁴ This is a legal obligation that stems from multiple international agreements,²⁷⁵ including the UN Charter, which stipulates that member states are obliged

²⁷² The Millennium Challenge Corporation has committed \$140 million to build and rehabilitate health facilities. Approximately 600 health workers will be needed to staff these facilities, but this funding does not cover these posts. *Médecins Sans Frontières, Help Wanted: Confronting the health worker crisis to expand access to HIV/AIDS treatment: The MSF experience in southern Africa* (May 2007), at 11. Available at: http://www.msf.org/source/countries/africa/southafrica/2007/Help_wanted.pdf.

²⁷³ Personal communication with Dr. Bactrin M. Killingo, Meru Hospice, Meru, Kenya, July 13, 2006.

²⁷⁴ Paul Hunt, *The right of everyone to the enjoyment of the highest state attainable standard of physical and mental health*, U.N. Doc. A/60/348 (Sept. 12, 2005), at paras. 59-65. Available at: <http://www2.essex.ac.uk/human%5Frights%5Fcentre/rth/docs/GA%202005.pdf>.

²⁷⁵ For example, the Universal Declaration on Human Rights also confirms that states are obliged to assist one another: "Everyone... is entitled to realization, through national effort and international cooperation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity...." Universal Declaration of Human Rights. G.A. resolution 217 A (III), UN Doc. A/810 at 71, Dec. 10, 1948, at art. 22. Available at: <http://www1.umn.edu/humanrts/instree/b1udhr.htm>. With regard to implementing economic, social and cultural rights, parties to the Convention on the Rights of Child have "shall undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international co-operation." Convention on the Rights of the Child, G.A. res. 44/25, annex, 44 U.N. GAOR Supp. (No. 49) at 167, U.N. Doc. A/44/49 (1989), entered into force Sept. 2, 1990, at art. 4. Available at: <http://www1.umn.edu/humanrts/instree/k2crrc.htm>.

to “take joint and separate action” to achieve “solutions of economic, health, social and related problems” and to promote “universal respect for, and observance of, human rights and fundamental freedoms.”²⁷⁶

The ICESCR reiterates and expands upon this obligation, stating that all parties are obliged to “take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant,” which includes the right to the highest attainable standard of health.²⁷⁷

²⁷⁶ UN Charter, arts. 55 and 56. Available at: <http://www1.umn.edu/humanrts/instreet/aunchart.htm>.

²⁷⁷ International Covenant on Economic, Social and Cultural Rights,

Health workers, as service providers, “play an indispensable role in the realization of the right to health.”²⁷⁸ Because of this, donors must consider the serious obligation upon them to include explicit health workforce support within their international assistance packages.

G.A. res.2200A (XXI), 21 U.N.GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993, U.N.T.S. 3, *entered into force* Jan. 3, 1976, at arts. 2(1), 12(1). Available at: <http://www1.umn.edu/humanrts/instreet/b2esc.htm>.

²⁷⁸ Paul Hunt, *The right of everyone to the enjoyment of the highest state attainable standard of physical and mental health*, U.N. Doc. A/60/348 (Sept. 12, 2005), at para. 8. Available at: <http://www2.essex.ac.uk/human%5Frights%5Fcentre/rth/docs/GA%202005.pdf>.

VIII. ACCOUNTABILITY

...rights and obligations demand accountability: unless supported by a system of accountability, they can become no more than window dressing.”

**-Paul Hunt,
Special Rapporteur on the Right to Health²⁷⁹**

Accountability and Human Rights Framing

Funding obligations related to health workforce planning are closely tied to accountability. Accountability mechanisms are necessary to ensure that states do not use progressive realization (the legal recognition that states may not be able to fully realize economic, social and cultural rights in a short period of time)²⁸⁰ and resource constraints to excuse lack of progress related to the right to health generally and, in this case, to adopting and implementing a health workforce plan.²⁸¹ Accountability reinforces the compact underlying human rights: that states are obligated to fulfill certain responsibilities and conduct themselves in an acceptable manner and that rights-holders (the public, health consumers, health workers) are entitled to claim these rights

and receive remedies if their rights are violated. This necessitates independent, accessible and effective accountability measures, enacted and monitored by bodies such as independent review and standard-setting bodies, patients' rights groups and national human rights organizations, in some cases possibly supported by legal recourse.²⁸² It also requires that members of the public know their rights as they relate to the health workforce and to health more generally, that they understand that they are entitled to these rights, and that they know the ways they can pursue these rights if they are not being fulfilled.

Accountability is not simply about establishing blame and redressing grievances. It is also a process by which determinations may be made about what is working and what could be improved upon.²⁸³ This more expansive understanding conceives of accountability as a tool to move towards realizing the right to health in practice.

Accountability to Existing Obligations

Governments have obligations under the right to health and through other commitments they have made that should form the basis of health workforce plans. Many right to health obligations are discussed elsewhere; the health workforce plan and associated policies must give life to these obligations. There are other obligations that will affect the workforce as well. For example, as part of their responsibility to eliminate discrimination against women, countries must have as “[a] major goal...

²⁷⁹ Paul Hunt, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. U.N. Doc. E/CN.4/2005/51 (Feb. 11, 2005), at para. 67. Available at: <http://www2.essex.ac.uk/human%5Frights%5Fcentre/rth/docs/CHR%202005.pdf>. For a valuable resource on accountability, see *Accountability and the Right to the Highest Attainable Standard of Health* (2008), at 15-16. Available at: http://www2.essex.ac.uk/human_rights_centre/rth/docs/HRC_Accountability_Mar08.pdf. See also Judith Asher, *The Right to Health: A Resource Manual for NGOs* (2004), at 4. Available at: http://shr.aaas.org/pubs/rt_health/rt_health_manual.pdf.

²⁸⁰ Committee on Economic, Social and Cultural Rights, *General Comment 3, The nature of States parties' obligations* (Fifth session, 1990), U.N. Doc. E/1991/23, annex III at 86 (1991), at para 9. Available at: <http://www1.umn.edu/humanrts/gencomm/epcomm3.htm>.

²⁸¹ Paul Hunt, *Implementation of General Assembly Resolution 60/251 of 15 March 2006 Entitled "Human Rights Council," Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. U.N. Doc. A/HRC/4/28 (Jan. 11, 2007), at para. 87. Available at: <http://www2.essex.ac.uk/human%5Frights%5Fcentre/rth/docs/council.pdf>.

²⁸² 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. 59. Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>; Paul Hunt, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. U.N. Doc. E/CN.4/2005/51 (Feb. 11, 2005), at paras. 70-71. Available at: <http://www2.essex.ac.uk/human%5Frights%5Fcentre/rth/docs/CHR%202005.pdf>.

²⁸³ Paul Hunt, *Implementation of General Assembly Resolution 60/251 of 15 March 2006 Entitled "Human Rights Council," Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. U.N. Doc. A/HRC/4/28 (Jan. 11, 2007), at para. 46. Available at: <http://www2.essex.ac.uk/human%5Frights%5Fcentre/rth/docs/council.pdf>.

reducing women's health risks, particularly lowering rates of maternal mortality and protecting women from domestic violence."²⁸⁴ Among other implications, this means that the workforce strategy should enable 24-hour per day/365 day per year basic and emergency obstetric care, and train health workers to recognize and respond to domestic violence.²⁸⁵

More generally, a variety of aspects of the right to health establish and reinforce its universality, creating the obligation that countries work towards ensuring access to health services for *everyone*, including priority services such as reproductive, maternal, and child care; immunizations, nutrition, safe water and adequate sanitation facilities; preventing and treating epidemic and endemic diseases; making available essential medications; and addressing other major health concerns of the whole population, based on epidemiological evidence.²⁸⁶

Beyond the right to health — and helping to give the rights requirements specific timelines and benchmarks — countries have made a number of health-related commitments that depend on a motivated, equitably distributed, and adequately sized health workforce for their achievement. These include the health-related Millennium Development Goals,²⁸⁷ universal access to

HIV services by 2010,²⁸⁸ universal access to reproductive health by 2015,²⁸⁹ and an African Union commitment to a package of essential health services by 2015.²⁹⁰

These commitments can be translated, at least approximately, into how many health workers are needed, how those health workers should be distributed, and what skills they will require. For example, what are the interventions required to deliver a comprehensive package of HIV services, how many people will need to receive these services to achieve universal access, what type of health workers will provide these different services, and how many health workers will be needed to deliver the required level of service? While the health workforce plan cannot be developed through a simple formula — productivity, motivation, and other aspects of the health system will all affect the level of services that health workers can deliver, for example — it is doubtful that countries will be able to achieve health obligations without a concerted effort to determine the level of services required to meet these obligations, and the health workforce that must be developed to provide them.

Indeed, a current frequent shortcoming in the health workforce planning process is that the link is weak between health ministry human resources for health departments and health priority programs, limiting the extent to which human resource plans reflect projected need.²⁹¹

More positively, the health sector planning process in Ethiopia, which has one of the world's most severe shortages of health workers, included an MDGs Needs

²⁸⁴ 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. 59. Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>; Paul Hunt, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. U.N. Doc. E/CN.4/2005/51 (Feb. 11, 2005), at para. 21. Available at: <http://www2.essex.ac.uk/human%5Frights%5Fcentre/rth/docs/CHR%202005.pdf>.

²⁸⁵ See Physicians for Human Rights, *Deadly Delays: Maternal Mortality in Peru* (2007), at 50, 133-134. Available at: <http://www.physiciansforhumanrights.org/library/documents/reports/maternal-mortality-in-peru.pdf>.

²⁸⁶ International Covenant on Economic, Social and Cultural Rights, G.A. res.2200A (XXI), 21 U.N.GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993, U.N.T.S. 3, *entered into force* Jan. 3, 1976, at art. 12. Available at: <http://www1.umn.edu/humanrts/instree/b2esc.htm>; 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 paras. 14-17, 21, 43-44. Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

²⁸⁷ These goals include reducing maternal mortality by three-quarters by 2015 compared to 1990, and reducing child mortality by two-thirds over the same years, and reversing the spread of AIDS, malaria, and other major diseases. See United Nations Statistics Division, *Millennium Development Goals Indicators: The Official United Nations Site for the MDG Indicators*, <http://unstats.un.org/unsd/mdg/Host.aspx?Content=Indicators/OfficialList.htm>, visited Jan. 3, 2008. A strong case can be made that most (if not all) of the MDGs have achieved the status of customary international law. See Philip

Alston, *A Human Rights Perspective on the Millennium Development Goals* (2004), at paras. 40-42. Available at: http://www.hurilink.org/tools/HRSPerspectives_on_the_MDGs--Alston.pdf.

²⁸⁸ Political Declaration on HIV/AIDS, UN Doc A/Res/60/262, adopted by the UN General Assembly, June 15, 2006, at para. 20. Available at: http://data.unaids.org/pub/Report/2006/20060615_HLM_PoliticalDeclaration_ARES60262_en.pdf.

²⁸⁹ U.N. World Summit Outcome, U.N. Doc. A/60/1 (60th sess.) (2005), at para. 57(g). Available at: <http://daccessdds.un.org/doc/UNDOC/GEN/N05/487/60/PDF/N0548760.pdf?OpenElement>.

²⁹⁰ "[We hereby] commit ourselves to the achievement of Universal Access to Prevention, Treatment and Care by 2015 through the development of an integrated health care delivery system based on essential health package delivery close-to-client . . ." *Gaborone Declaration on a Roadmap Towards Universal Access to Prevention, Treatment and Care*, 2nd Ordinary Session of the Conference of African Ministers of Health, Gaborone, Botswana, Oct. 10-14, 2005, at para. 2. Available at: http://www.africa-union.org/root/au/Conferences/Past/2006/March/SA/Mar6/GABORONE_DECLARATION.pdf

²⁹¹ Personal communication, Jennifer Nyoni, Division of Health Systems & Services Development, WHO Regional Office for Africa, April 25, 2008.

Assessment to calculate the funding needed to achieve the Millennium Development Goals by 2015. The calculations considered five steps of expanded coverage needed to achieve the MDGs. At each step, the assessment addressed the human resource implications for the additional progress towards achieving the MDGs, in particular the degree to which additional health workers of a given type were required (for example, expanding comprehensive emergency obstetrical care would require an eleven-fold increase in the number of BA level nurse-midwives and a six-fold increase in the number of health officers), implications for production, and in the case of BA level nurse-midwives and health officers, the need for a hardship allowance for health workers serving in rural areas. These human resource needs were incorporated into the calculation of the increase in funding required to achieve the MDGs.²⁹²

Accountable to Whom? The Need for Monitoring, Evaluation and Participation

Holding states — and others responsible for upholding the right to health — accountable demands the inclusion of indicators and benchmarks within a national health workforce plan.²⁹³ A rights-based approach to health workforce planning requires that such plans be reviewed and critiqued by a variety of stakeholders, and re-worked, if necessary. Provisions for monitoring and evaluation must be built into national health workforce plans, including capacity to revise plans if they do not successfully support the creation and maintenance of a health workforce that is progressively providing available, accessible, acceptable and good quality health services on a more equitable basis.

Effective and inclusive monitoring and evaluation requires making the plan publicly available and genuinely accessible to the population. One way to make the plan available is to post it on the Internet. Much more, though, will be needed to enable the large portions of the population without regular Internet access to access the plan. For example, the plan could be communicated

through radio and newspaper, and also made available locally in hard copy. The plan should also be translated into minority languages.

Monitoring and evaluation is important in order to determine not only whether benchmarks are being achieved but also for whom. Drafting and implementing a health workforce plan must be accompanied by a serious, sustained and transparent examination of its resulting impact on the health outcomes. Following the implementation of a plan, are health outcomes improving, especially among poor and marginalized groups? For this reason, collecting disaggregated data is critical to ensure that the implementation of health workforce plans is leading to progressively improved services for vulnerable groups, within the context of the overall population.²⁹⁴

Qualitative examination of health workforce plans is equally important, particularly from the perspective of health system users and frontline health workers at all levels, whose participation is critical to assessing the impact on health service provision in practice. Once health workforce plans have been implemented, for example, are people progressively finding it easier to access health services? Are levels of trust between patients and health providers improving and are expectations of quality of care being met? People who are receiving services should be positioned at the center of systems of accountability; ultimately, it is their needs and rights that will be met or remain unfulfilled. This will require empowering health consumers and educating them on the particulars of their entitlements under the health workforce plan, including what types of and how many health workers should be staffing their local health facilities, the hours the facilities should be open, and their right to be treated respectfully and without discrimination. Various sectors of society can drive this education and empowerment around health workforce planning, including the government, media, and civil society organizations. Partnerships among these sectors may enhance their impact.

These efforts should be tied to a broader campaign to educate people on their rights. With this combined strategy, and supported by civil society organizations, people may also be able to question whether even the specific entitlements under their workforce plan fall short of their rights and their government's responsibilities, and can challenge these deficiencies.

²⁹² Ethiopia Federal Ministry of Health, *Health Sector Strategic Plan (HSDP-III) 2005/6-2009/10* (2005), at 100-105. Available through: http://www.moh.gov.et/index.php?option=com_remository&Itemid=47&func=fileinfo&id=192.

²⁹³ 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 paras. 57. Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

²⁹⁴ Paul Hunt, *The right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Report of the Special Rapporteur*. U.N. Doc. E/CN.4/2003/58 (Feb. 13, 2003), at para. 51. Available at: <http://www2.essex.ac.uk/human%5Frights%5Fcentre/rth/docs/CHR%202003.pdf>.

Indeed, achieving accountability requires that individuals and communities are aware of both their rights and what they can do if their rights are not being met. Avenues of redress could include using formal reviews of the health workforce plan's implementation to voice concerns or bringing concerns to other structures, such as health councils, human rights commissions, courts, and administrative bodies. Civil society organizations or other institutions (such as a health ombudsman's office) may need to facilitate individuals' participation in these structures, which may otherwise be prohibitively complicated and intimidating, even as these structures should be designed to ease people's interactions with them.

Furthermore, health consumers can seek accountability by participating in political processes and by bringing their experiences to the media. They can bring their concerns directly to their political representatives, and work within their particular settings to ensure that politicians understand that they will be judged, at least in part, on progress or lack of progress in advancing the right to health. The media can create pressure on government officials to respond to failures in ensuring the right to health. The media can also help advance this right by disseminating examples of and information on how these rights can be fulfilled, such as by reporting on instances elsewhere in the country that are making progress, thereby demonstrating the possibilities for success.

The health system itself is an important forum for educating patients about their rights. For example, health facilities should post lists of patients' rights and avenues of redress if patients believe that their rights are not being fulfilled. Health workforce plans should include a strategy to inform people of their rights under the plan and of the mechanisms that exist to protect these rights.

Accountability to the people most immediately impacted by the health workforce plan, namely health system users and health workers, will be facilitated if their views are actively sought (such as through interviews and surveys) and publically reported as part of the formal monitoring of the plan's implementation. In India, for example, the People's Health Movement - India (Jan Swasthya Abhiyan) has begun to periodically audit rural public health services in seven states, interviewing health staff, including village-based health workers, patients, and other people in the community. Questions address the accessibility, availability, and quality of health services, as well as problems health workers face and the profile of the village health workers. The survey results are included in reports that are meant to raise

public awareness on the implementation of the National Rural Health Mission, launched in 2005, and to pressure the government to be accountable to the promises of this effort to improve the public health system.²⁹⁵ The National Rural Health Mission also has community-based monitoring built into its framework. This monitoring will be implemented as a partnership between civil society and the government, and will include meetings and interviews with villagers and health workers, as well as facility observation. Village and facility scorecards will be one output of the monitoring process.²⁹⁶

Monitoring and evaluation is needed at multiple levels, not only for the overall health workforce plan — possibly in the context of an evaluation of the health system more broadly — but also for the more detailed policies that might be developed as a result of the plan. For example, a study in Kenya found that all 62 public health facilities surveyed had policies meant to protect people living with HIV/AIDS from stigma and discrimination, following ministry of health guidelines. However, only five of the facilities were fully implementing the policies, such as by providing recourse for HIV-positive clients who had their rights violated.²⁹⁷

Levels of Accountability: Governments, Donors and Frontline Workers

Accountability operates on several levels. Governments are accountable for providing a plan that upholds the rights of the public to obtain available, accessible, accept-

²⁹⁵ Helen Potts, *Accountability and the Right to the Highest Attainable Standard of Health* (2008), at 15-16. Available at: http://www2.essex.ac.uk/human_rights_centre/rth/docs/HRC_Accountability_Mar08.pdf. The National Rural Health Mission also has

²⁹⁶ National Secretariat on Community Action – NRHM (Population Foundation of India & Centre for Health and Social Justice), *Community Based Monitoring of Health Services Under NRHM First Phase 2007* (pamphlet) (Aug. 2007). Available at: http://mohfw.nic.in/NRHM/Community_monitoring/Pamphlets/Community%20based%20monitoring%20English.pdf; National Secretariat of Advisory Group on Community Action (Population Foundation of India & Centre for Health and Social Justice), *Community Monitoring of Health Services Under NRHM* (poster) (c. 2007). Available at: http://mohfw.nic.in/NRHM/Community_monitoring/Posters/CM_framework.pdf. For more information on the community-based monitoring of the India's National Rural Health Mission, see Task force on Community Monitoring of Advisory Group on Community Action, *Manual on Community based Monitoring of Health services under National Rural Health Mission* (c. 2007). Available at: http://mohfw.nic.in/NRHM/Community_monitoring/Implementers_Manual.pdf.

²⁹⁷ Kenya Treatment Action Movement (with financial support from USAID Health Policy Initiative Task Order 1), *Measuring Facility/ Provider Index of Stigma and Discrimination in Kenya* (2007), at 6-7.

able health services of good quality, and for prioritizing resources accordingly. Health workers are accountable for providing appropriate treatment of good quality and respecting the rights of their patients; therefore, in addition to clinical skills, health workforce plans must build in resources and provide training to ensure that health workers are aware of their ethical obligations, including non-discrimination.

Procedures should be in place to compensate patients and discipline health workers if workers do violate patients' rights.²⁹⁸ Complaint mechanisms should be developed at individual health facilities, as well as through medical and nursing councils, which should have patient advocates and ensure legal representation for patients. Patients whose rights have been violated may also use the judicial system to seek redress. Judges and other legal professionals should be trained on patients' rights and other aspects of the right to health.²⁹⁹

Donors are accountable for ensuring that their programs and funding do not disregard national strategies or impede the right to health by creating duplicative or vertical programs that undermine the public health system. Such efforts may advance the right to health in some respect, by making certain services more available than before — though to a lesser degree than if such services were integrated into the public health system. In fact, donors that work outside national strategies and existing health structures may also counter wealthy

country responsibilities to respect the right to health, because they may reduce the availability of other health services by drawing health workers away from them. By directly supporting national health strategies and ensuring that their programs are integrated into the public health system, donors can keep their effect on the right to health positive, while helping ensure the sustainability of their efforts.

Ultimately, systems of accountability will allow for adjustments to be made to health workforce plans, leading to more sustainable implementation and building stronger, more responsive health systems that meet the actual and evolving health needs within a country. Accountability will also encourage continuing progress, and will avoid stagnation and the diversion of resources away from health services. A commitment to accountability will also foster consideration of how health workforce capacity will be built and sustained, forcing priority setting and linking health workforce plans to budgeting and other planning processes.

²⁹⁸ 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. 59. Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

²⁹⁹ Center for Reproductive Rights & Federation of Women Lawyers — Kenya, *Failure to Deliver: Violation of Women's Human Rights in Kenyan Health Facilities* (2007), at 10. Available at: http://www.reproductiverights.org/pdf/pub_exec_failurecover.pdf.

IX. SUSTAINABILITY

Sustainability and Human Rights — Continuing Progress

The right to health provides a solid platform on which to build sustainable, workable health workforce plans. Emphasizing, as it does, both “progressive realization” and avoiding “retrogressive measures” (moving forward continuously and not sliding backwards), the right to health is inherently concerned with ensuring sustainable, accessible and equitable health provision. For a health workforce plan to be faithful to human rights, and the right to health in particular, it must take as a non-negotiable principle that its implementation will result in health services that are progressively of higher quality and increasingly available to all population groups. Such continuing progress is consistent with human rights obligations. Commitments made by both national governments and international donors must reflect this understanding and account for the fact that once services have been implemented, withdrawing them is a violation of people’s right to health. This must be borne in mind when setting up programs and proposing funding so that initial investments are considered in light of the principle of non-retrogression. Backsliding is not an option.³⁰⁰

Planning for Sustainability

Principles of progressive realization and non-retrogression demand constant progress, which means that efforts to strengthen the workforce should be sustainable. This, in turn, requires setting priorities. Infusions of cash to

the health workforce sector, no matter how large, are unlikely to provide for all needs.³⁰¹ Planning for sustainability means that difficult but important questions must be asked about donor and national government commitments to the health workforce. For instance:

- Are donors willing to commit to long-term investments that are supportive of the health workforce as a whole as opposed to particular disease ‘silos’?
- What is the country capacity to sustain health interventions if these outside commitments are not forthcoming or are withdrawn?
- How will electoral changes impact long-term planning and resource allocation dedicated to the health workforce?

As a practical matter, this implies that health workforce should be a priority within national budgets, so that health services can continue even if outside funding dries up or is withdrawn.³⁰² Within the health workforce plan, the need for sustainability and the right to health offers a potential framework for priority setting, starting with the obligation of immediate effect to ensure non-discrimination and equity in health service provision,³⁰³ which must be a driving force behind any rights-based approach to health workforce planning. These plans must seek to promote achievement of human rights obligations in light of health needs on the ground. This may lead to prioritizing investment in nursing programs and community health workers ahead of increasing medical training slots in the event that adequate funding for all levels of training

³⁰⁰ “As with all other rights in the [International Covenant on Economic, Social and Cultural Rights], there is a strong presumption that retrogressive measures taken in relation to the right to health are not permissible. If any deliberately retrogressive measures are taken, the State party has the burden of proving that they have been introduced after the most careful consideration of all alternatives and that they are duly justified by reference to the totality of the rights provided for in the Covenant in the context of the full use of the State party’s maximum available resources.” 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. 32. Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

³⁰¹ Paul Hunt, *The right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, U.N. Doc. A/62/214 (Aug. 8, 2007), at paras. 16-17. Available at: <http://www2.essex.ac.uk/human%5Frights%5Fcentre/rth/docs/GA%202007.pdf>.

³⁰² For a wealthy country that is providing development assistance to end or reduce its support to countries that cannot provide quality health services to everyone using their own resources, without a plan to ensure that these resources are available from another sources, would itself raise serious questions about whether that international partner is meeting its own human rights obligations.

³⁰³ 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. 30. Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

is not forthcoming. It may require significantly boosting salaries for health sciences faculty in order to attract and retain excellent candidates or investing in scholarships and funding for health students from rural areas. It may mean dedicating resources to training more laboratory technicians and investing in remote lab facilities in order to provide timely and accessible services to HIV and TB patients in rural regions.

Ultimately, prevailing health conditions within a country in tandem with a commitment to ensuring that human rights obligations are met can guide priority setting while formulating a health workforce plan to ensure that essential health services, including for poor and marginalized populations, can continue even if the financing situation deteriorates.³⁰⁴ And such priorities should also be incorporated into the country's legal and policy framework to minimize the chance that changing political winds will cause a country to regress on its right to health obligations. A culture of human rights within the health community — and ideally, the broader community — can also help serve as a bulwark against regression.

Linking Sustainability to Budgeting and Planning Processes

Setting priorities also means recognizing that the health workforce does not stand in isolation from other sectors or planning processes. Health ministries and other health sector actors should engage with national budgeting and planning processes, such as Poverty Reduction Strategy Papers (PRSPs), to ensure that the health workforce is not overlooked when funding is allo-

cated and benchmarks are set. This may mean challenging previous inadequate health expenditures and advocating for substantial increases for health workforce funding within new government budgets. It may mean participating in — and possibly challenging — decisions on macroeconomic policies that have traditionally been in the hands of the ministry of finance, central bank, and the IMF. Policies in such areas as fiscal deficits, inflation targets, and taxes will affect the total resources available for public investment, including in the health sector, and in many countries are overly restricting funds available for such investments.³⁰⁵ NGOs and other members of civil society, including health workers, can be instrumental in providing detailed information and analysis that can be used to support health ministries' arguments for increased budget allocations.

To promote sustainability, it may well be useful to plan multiple budget scenarios within the national health workforce (and overall national health sector) to minimize disruption of health services in case the necessary external support is not forthcoming.³⁰⁶

Countries should in any case spend the maximum of their own available resources towards fulfilling the right to health along with other rights, and should aim to achieve the plan and attendant budget scenario that is consistent with the overall right to health obligations and related commitments, such as the MDGs. And they should make every effort to mobilize whatever additional external resources will be required to do so. Countries should also encourage donors to follow practices that would minimize the risk that unfulfilled funding commitments could lead to a disruption of health funding, such as by developing a collective assurance system with other donors. The International Health Partnership, an

³⁰⁴ It will be extremely difficult to provide essential health services for everyone if funding levels are too low. In 2001, the Commission on Macroeconomics and Health estimated that at least \$34 per capita by 2007 (increasing to \$38 per capita by 2015) might be regarded, "very roughly, as the minimum per capita sum needed to introduce the essential health interventions." Commission on Macroeconomics and Health, *Macroeconomics and Health: Investing in Health for Economic Development* (Dec. 2001), at 54-55. Available at: <http://libdoc.who.int/publications/2001/924154550X.pdf>. These benchmarks likely understate the funding needed to provide essential health services to everyone, as they do not incorporate additional health workforce funding needs, as well as for other reasons. See Commission for Africa, *Our Common Interest: Report of the Commission for Africa* (2005), at 195. Available through: <http://www.commissionforafrica.org/english/report/introduction.html>. A failure to provide sufficient resources to move as rapidly as feasible towards enabling everyone to access essential health services, and to maintaining this universal access once achieved, would suggest that countries are not providing the maximum of their available resources towards securing the right to health and other human rights, wealthier nations not living up to their obligations to provide international assistance and to cooperate in achieving universal observance of human rights, or a combination of both.

³⁰⁵ See Center for Global Development, *Does The IMF Constrain Health Spending in Poor Countries? Evidence and an Agenda for Action* (2007). Available through: http://www.cgdev.org/section/initiatives/_active/imfprograms/; Independent Evaluation Office of the IMF, *The IMF and Aid to Sub-Saharan Africa* (2007), at 7-10, 42 (finding that in 1999-2005, only 27% of increases in foreign assistance to sub-Saharan African countries with IMF programs was spent, with the rest being used to pay down domestic debt and build up foreign reserves). Available at: <http://www.ieo-imf.org/eval/complete/pdf/03122007/report.pdf>.

³⁰⁶ The African Health Strategy 2007-2015 calls for countries to develop several funding scenarios, and smartly insists that "[t]hese plans must include ways of bridging any possible resource gaps in the short, medium and long term." Africa Health Strategy 2007-2015, at para. 56. Adopted at the Third Session of the African Union Conference of Ministers of Health, Johannesburg, South Africa, April 9-13, 2007. Available at: http://www.africa-union.org/root/UA/Conferences/2007/avril/SA/9-13%20avr/doc/en/SA/AFRICA_HEALTH_STRATEGY_FINAL.doc.

initiative that launched in 2007 to support national health plans and help achieve the MDGs, and which involves a number of wealthy countries, developing countries, and health agencies, is taking a positive step in this direction. As of June 2008, the compact that Ethiopia was developing with the International Health Partnership included a process to “coordinate collective action to ensure that the shortfall is made up by additional commitments from one or more of the signatories” to the compact, should a donor report that its disbursements are likely to be less than it had previously committed to providing.³⁰⁷

Promoting Sustainability — Training Health Workers In Human Rights

Sustainability is also crucially linked to increasing health workers’ awareness of and commitment to human rights. Health workers have a unique capacity to “operationalize” the right to health, both in their daily practice and in their roles as advocates on behalf of their patients. Health professionals play a key role in setting health sector policy in most countries and their engagement with human rights, in tandem with their particular knowledge of health issues, is critical to realizing the right to health.³⁰⁸ Unfortunately, the prevailing situation often

reflects a serious lack of knowledge about human rights within the health sector.

A concerted commitment to educating health workers (including those in non-clinical positions) about human rights is required to overcome barriers of ignorance and suspicion. Health workers can use the right to health as a tool to complement clinical care, to enhance patient well-being, to secure improved funding for the health sector and to improve conditions under which health workers do their jobs. Human rights education will also enhance health workers’ efforts to improve accountability in the health sector. By embracing the right to health, health workers can advocate for more equitable health policies and work to ensure that health remains a high priority on the national agenda and is reflected within budget allocations. Advocacy by health workers to secure their own rights, such as safe working conditions and reliable stocks of medicines and supplies, also uphold their patients’ rights to quality care.

Health workforce plans offer an opportunity to formally integrate human rights, particularly the right to health, into education, curricula and training for health workers at all levels, from the undergraduate level to specialist and continuing education programs. This is critically important not only to create future advocates, but also to better ensure that ethical and human rights standards guide conditions of practice.³⁰⁹ Human rights education will better enable health workers to serve as stewards of the right to the best attainable standard of physical and mental health. They will be better equipped to positively incorporate human rights, such as non-discrimination, confidentiality and informed consent, into their own practice, as well as to address violations of human rights, such as instances of domestic or sexual violence, that they encounter in their professional role.

An awareness of human rights also offers a chance for health workers to feel themselves a part of a broader endeavor, which can itself prove to be a force for motivation and retention, particularly when working with or on behalf of deprived communities. For example, Partners In Health (PIH)/Zanmi Lasante has had notable success in retaining doctors at its remote clinic sites in Haiti. Out of 60 to 70 doctors that PIH employs there, only a very few

³⁰⁷ Ethiopia Federal Ministry of Health, *Compact Between the Government of Ethiopia and Development Partners on Scaling Up for Reaching the Health MDGs* (draft) (June 2008), at para. 41. The compact describes several ways in which these shortfalls could be covered: “Consideration needs to be given to how best to ensure shortfalls can be made up, including the feasibility of one of the development banks (that manage themselves on a commitment basis) acting as the ‘swing donor’, or the feasibility of establishing a specific fund to underwrite the risk.” *Id.* “In the event that the shortfall can not be made up within the financial year in which it occurs, the donor signatories will inform [the Federal Ministry of Health] and [Ministry of Finance and Economic Development] of the composition of the additional commitments that will be forthcoming in the subsequent year. This gives [the Ministry of Finance and Economic Development] the option to maintain public expenditure by temporarily drawing on foreign exchange reserves, to be replenished by the additional aid in the following year.” *Id.* at para 42.

³⁰⁸ Paul Hunt, *Implementation of General Assembly Resolution 60/251 of 15 March 2006 Entitled “Human Rights Council,” Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. U.N. Doc. A/HRC/4/28 (Jan. 11, 2007), at paras. 38-47. Available at: <http://www2.essex.ac.uk/human%5Frights%5Fcentre/rth/docs/council.pdf>. The report states: “Health professionals can use health-related rights to help them devise more equitable policies and programmes; to place important health issues higher up national and international agendas; to secure better coordination across health-related sectors; to raise more funds from the Treasury; to leverage more funds from developed countries to developing countries; in some countries, to improve the terms and conditions of those working in the health sector; and so on. It is crucial that many more health

professionals come to appreciate that the right to the highest attainable standard of health is not just a rhetorical device, but also a tool that can save lives and reduce suffering, especially among the most disadvantaged.” *Id.* at para. 44.

³⁰⁹ Judith Asher, *The Right to Health: A Resource Manual for NGOs* (2004), at 73. Available at: http://shr.aaas.org/pubs/rt_health/rt_health_manual.pdf.

have moved on within the past two years. According to Dr. Evan Lyon, who divides his time between PIH in Haiti and Brigham and Women's Hospital in Boston, "We've had a very, very high retention level and very few departures due to doctors leaving the profession, which is a problem in Haiti, or going into private practice in the city." Dr. Lyon attributes high retention in part to the reasonable salaries (higher than the public sector, but lower than the private sector) and the provision of housing, food, and periodic transport back to the cities by PIH to visit family. Doctors also have reliable access to supplies and medicine, as well as access to the internet, which assists with clinical research and communication. "[Having] the capacity and tools to do their jobs is also a factor that promotes retention among the doctors here," he says.

Dr. Lyon explains that in spite of their isolated, rural locations, a post at a PIH clinic has become the most sought-after residency site in Haiti, attracting and retaining the top medical graduates. Yet, he also emphasizes that "Out of 60-70 doctors, I only know of three who distinctly like working in rural areas...It's so exciting to watch people change from elite, quasi-cynical professionals to becoming advocates." He attributes this change to working within a mission-driven organization that seeks to provide high-quality medical and social care in solidarity with poor communities. "We watch as point of view and language change, as consciousness is raised. The dynamics of why people stay are so complex. There are no clubs here, no social life. There's something much bigger at work here."³¹⁰

I have come to realize that using a human rights framework makes you go beyond the field of clinical medicine to look into broader issues of public health sector accountability and governance issues that contribute in shaping the health policy process. A deep understanding of human rights compels one to stand in solidarity with marginalized groups who suffer discrimination in terms of access to healthcare service delivery.

³¹⁰ Personal communication with Dr. Evan Lyon, Partners in Health, July 17, 2006.

From my own experience of serving poor communities in rural Mashegu, northern Nigeria, I constantly find myself compelled by my knowledge of what the 'right to health' means to go beyond being just a clinician to become both an activist and advocate in demanding equity and good stewardship on the part of duty bearers. My overall goal has always been to ensure affordable access to healthcare for all members of the community irrespective of their socioeconomic status."

**— Physician,
Kontagora, Nigeria³¹¹**

Human rights education changes your perception from seeing medicine as an employment — where you can make some money — to a service to humanity. Is it not a violation of human rights that people cannot access healthcare? When you begin to feel these things as a physician, then you appreciate your service to the community more. You appreciate your role. It is imperative that while human rights should be incorporated into health workforce planning, numbers and all, health workers too ought to study human rights.

**— Medical student,
Kampala, Uganda³¹²**

³¹¹ Dr. Chukwumuanya Igboekwu, Health Program Associate for Physicians for Social Justice and practicing physician based in Kontagora, Niger State, Nigeria.

³¹² Personal communication with Nixon Niyonzima, medical student, Makerere University, Kampala, Uganda, Jan. 23, 2008.

X. CONCLUSION

Countries have much to gain from basing their health workforce plans on both technical considerations and human rights principles. Human rights principles will help ensure that health workers reach underserved areas and populations, that retention strategies succeed, and that the plan contributes to the significant progress many countries require to achieve their health goals.

Moreover, as part of their obligation to achieve the highest attainable standard of health for their populations, countries are obliged to adhering to these principles. Human rights criteria, no less than technical criteria,

should be factored into the development of health workforce plans and used to evaluate them. Ministries of health, the World Health Organization, the Global Health Workforce Alliance, and major development partners and technical agencies, should all incorporate these principles into their planning processes. Health workers themselves should assert their rights and those of the people they serve, and insist that the plans and strategies that will affect their fate and the fate of their nations are grounded in human rights.

APPENDIX: TECHNICAL RESOURCES

Human Resources for Health (HRH) Action Framework

The HRH Action Framework assists countries develop and implement a comprehensive response to their health workforce needs. It is a web-based resource that provides health workforce tools in six areas: human resource management systems, leadership, planning, finance, education, and policy. It is an initiative of the Global Health Workforce Alliance, and was developed through collaboration between the World Health Organization and USAID. It is available at: <http://www.capacityproject.org/framework/index.php>.

HRH Tool Compendium

The human resources for health tools included in this collection include a description and have been reviewed and tested by people with human resource expertise. It is available at: <http://hrhcompendium.com.test.ibiblio.org/>.

HRH Global Resource Center

This is a collection of papers, presentations, and other material related to the health workforce. The documents can be organized by subject, as well as by geographic focus and resource type. It is available at: <http://www.hrresourcecenter.org/>.

Global Health Workforce Alliance

Resources available through the Global Health Workforce Alliance website (<http://www.ghwa.org>) include a report on scaling up health worker education (http://www.who.int/entity/workforcealliance/documents/Global_Health%20FINAL%20REPORT.pdf) and guidelines on incentives to help recruit, retain, and motivate health workers (<http://www.who.int/entity/workforcealliance/news/incentives-guidelines/en/index.html>).

World Health Organization Human Resources for Health Department

WHO's Human Resources for Health Department website offers tools and guidelines in areas including human resources for health situation analysis, policies, planning, management, and education and training. They are available through: <http://www.who.int/hrh/tools/>.

Health Workforce Advocacy Initiative (HWAI)

The Health Workforce Advocacy Initiative (<http://www.healthworkforce.info/HWAI/>) is a civil society-led network affiliated with the Global Health Workforce Alliance. Documents including guiding principles on health workforce planning (which cover many of the concepts included in the present guide) and an advocacy toolkit for health worker advocates are available through: <http://www.healthworkforce.info/HWAI/Materials.html>.

13. ASSOCIATION OF NURSES IN AIDS CARE & PHYSICIANS FOR HUMAN RIGHTS. 2008. STATEMENT ON THE RIGHTS OF NURSES TO HEALTH AND SAFETY – A GLOBAL CALL TO ACTION. AKRON, OH AND WASHINGTON, DC.

[http://actnow-phr.org/campaign/nurses_health_rights]

This statement is a global call to action which draws attention to the need for workplace health and safety measures for nurses and other health care workers. It has been widely endorsed by organizations and individuals from around the world. Global Fund applicants should consider how they might incorporate these measures into their proposals.

STATEMENT ON THE RIGHTS OF NURSES TO HEALTH AND SAFETY– A GLOBAL CALL TO ACTION

Whereas nurses and all health care workers are essential to the health and well-being of all communities, and to the prevention of and scale-up of treatment for current global health crises including HIV, TB, and malaria pandemics, and to securing for all people the right to the highest attainable standard of health;

Whereas there is a global crisis related to shortages of nurses and health care workers directly impacting on achievement of Millennium Development Goals for health, raising the importance of retention of current workers and recruitment of new workers into the health workforce;

Whereas nurses and other health care workers face occupational health and safety risks in caring for persons with infectious illnesses including bloodborne and respiratory infections, including HIV and TB;

Whereas HIV-related illness is a leading cause of death, illness and absence from work for nurses and health care workers in regions heavily affected by the HIV epidemic, and the loss of this workforce directly impacts the ability to ensure health services to populations in need of prevention, care and treatment;

Whereas nurses and health care workers routinely face a lack of access to *confidential*, accessible, and affordable healthcare services, specifically in accessing HIV prevention, testing and care services;

We call upon all government leaders, bilateral and multilateral development donors and partners to adopt the following principles and incorporate them in implementation of all current and future programs supporting the delivery of HIV prevention, care and treatment services;

- **Provision of standard infectious disease precautions** for the protection of the health, safety, and well-being of ALL nurses and other health care workers in their work environments, with concrete policies, regulations and management directives that deliver these protections for these essential and valuable health personnel, including rapid access to post-exposure prophylaxis in the event of potential exposures to HIV and adequate supplies of protective equipment;
- **Provision of measures ensuring safe workplace conditions**, respecting the physical safety of nurses and health care workers in the course of traveling to or carrying out their duties;
- **Provision of accessible, confidential, and affordable access to healthcare services**, including HIV testing, prevention and care, for nurses and other health care workers;
- **Provision of a supportive environment** for nurses and health care workers engaged in health service delivery, recognizing the high rates of burnout and fatigue among health professionals dealing with life-threatening illnesses on a daily basis, enhancing their ability to care for their patients as well as themselves.

14. HEALTH WORKFORCE ADVOCACY INITIATIVE. 2008. GUIDING PRINCIPLES ON NATIONAL HEALTH WORKFORCE STRATEGIES.

[http://www.healthworkforce.info/advocacy/HWAI_Principles.pdf]

The guidelines are intended primarily for the policymakers and other people involved in developing and evaluating these plans, including ministry of health officials, health workers, civil society advocates, development partners, and technical advisors. What should these plans – which should be country-developed and country-led – contain? How should they be developed to give them the best chance of significantly improving health outcomes and moving countries as rapidly as possible towards universal access to essential health interventions? The guidelines should serve as overarching principles that will promote the success of health workforce plans, while ensuring that they are consistent with human rights.

Guiding Principles for National Health Workforce Strategies



Photo credits (left to right): WHO/C. Black, WHO/M. Kokic, WHO/G. Gaggero, WHO/M. Kokic

Developed by
the Health Workforce Advocacy Initiative

The Health Workforce Advocacy Initiative
is the civil society-led network of
the Global Health Workforce Alliance.

Guiding Principles for National Health Workforce Strategies

The Health Workforce Advocacy Initiative is the civil society-led network of the Global Health Workforce Alliance

With global targets for major health improvements fast approaching, including universal access to HIV services by 2010 and achieving the health-related Millennium Development Goals by 2015, and the recognition that these goals cannot be achieved without building health workforce capacity, many countries are developing or re-assessing national health workforce plans. The development of health workforce plans, as well as broader health sector strategies, is receiving particular attention through such regional and global initiatives as the Africa Health Strategy 2007-2015 and the International Health Partnership, as well as the Global Action Plan on Human Resources for Health.

The following guidelines are intended primarily for the policymakers and other people involved in developing and evaluating these plans, including ministry of health officials, health workers, civil society advocates, development partners, and technical advisors. What should these plans – which should be country-developed and country-led – contain? How should they be developed to give them the best chance of significantly improving health outcomes and moving countries as rapidly as possible towards universal access to essential health interventions? The guidelines should serve as overarching principles that will promote the success of health workforce plans, while ensuring that they are consistent with human rights. The right to the highest attainable standard of physical and mental health requires that these plans adhere to principles including equity, participation, and accountability, that they are based on major health needs of the population, that they make quality health care available, affordable, and accessible for everyone, that they represent continued progress towards filling this right, and that states spend the maximum of available resources towards meeting this and other human rights.

These principles begin with key considerations for the health workforce plan itself. The principles conclude with the context in which the plan should be developed and implemented, including financing and coordination with a broader health sector strategy. Many of the principles – such as those related to participation, monitoring and evaluation, and targets – also apply to that broader health strategy.

Targets

- ❖ **Aim for goals:** The health workforce plan should be aimed at ensuring that all people, in all places, have access to a skilled health worker who is equipped, motivated, and supported. Further, the plan should be targeted towards achieving health goals, commitments, and obligations, including the health-related MDGs and universal access to HIV/AIDS treatment, care, prevention, and support by

2010¹. This entails calculating the levels of services required to achieve these goals, determining what cadres (registered nurses, enrolled nurses, nurse practitioners, midwives, doctors, clinical officers, pharmacists, nutritionists, social workers, laboratory technicians, community health workers, etc.) of health workers will provide these services, the knowledge and skills these health workers will require, and how many of these workers will be needed, and then developing a plan that will develop, sustain, and equitably distribute these health workers. As a general rule, plans should both be ambitious – aiming to achieve these goals – and feasible, so with adequate support, they can in fact be implemented.

Comprehensive approach

- ❖ **Cover all aspects:** A comprehensive health workforce plan should address and, as appropriate to country circumstances, take measures to improve:
 - 1) health workforce finance (such as salaries and incentives and the total budget for health workforce);
 - 2) policy (such as the scope of practice for different types of health workers, guidelines on health workplace safety, and accountability of health workers, including management);
 - 3) education (including pre-service and in-service health worker training);
 - 4) partnership (including community mobilization and linkages between public and private sectors);
 - 5) leadership (including leadership skills among HRH managers and leadership to ensure full implementation of the health workforce strategy), and;
 - 6) human resource management systems (including systems for the collection and use of accurate information on the health workforce, supportive supervision, and improved productivity).These are elements of the Global Health Workforce Alliance/World Health Organization HRH Action Framework.
- ❖ **Cover all cadres:** The health workforce plan should cover all cadres of health workers, both clinical staff, such as nurses, doctors, midwives, and pharmacists, and non-clinical staff, such as managers and support staff, and including all members of the care providing team, including nutritionists, social workers, and mental health professionals.
- ❖ **Cover all sectors:** The health workforce plan should cover all recognized health care providers, including public, NGO/faith-based, and private for-profit, and seek to utilize all providers in ways to achieve equitable, quality health services for all and that creates an integrated and coordinated health sector. It should also, as relevant, recognize the significant role that traditional healers play, and identify ways to effectively engage them, such as through counseling and referrals.
- ❖ **Link to broader development strategy:** The plan should incorporate ways that the health systems and health workers can contribute to broader development goals (such as through health workers educating communities on clean water, sanitation, and nutrition).

¹ Health-related MDGs include reducing maternal mortality by three-quarters between 1990 and 2015, reducing child mortality by two-thirds between 1990 and 2015, and combating HIV/AIDS, malaria, and other major diseases. Other commitments include the African Union commitment to a package of essential health services for prevention, care, and treatment by 2015. The right to health has additional and complementary requirements, including creating the conditions to make medical services available to all, and focusing on certain health priorities such as maternal and child health.

Equality and non-discrimination

- ❖ **Equitable distribution:** The health workforce plan should prioritize a more equitable distribution of health workers. The plans and planning process should assess the various aspects of the plan from perspective of equity and, wherever possible, incorporate measures to strengthen the health workforce in underserved areas, including through incentives; developing or expanding cadres of community-based health workers (including nurses and community health workers) and other cadres most likely to practice in rural areas (e.g., clinical officers/nurse practitioners); using the education system to enhance equity, such as through recruitment strategies, scholarships, and curricula, and; focusing resources on improving health infrastructure in rural areas.

Along with prioritizing equitable geographic distribution, the plan should promote a distribution of health workers among different levels of health facilities (health centers, district hospitals, referral hospitals, etc.) and professional practice areas (e.g., generalists, specialists) in ways that will enhance equity. Well-staffed primary level health facilities and adequate numbers of generalists are particularly important for reaching underserved populations.
- ❖ **Marginalized populations:** The health workforce plan should be aimed at meeting the needs of often marginalized groups, including women, youth, elderly people, migrants, refugees and internally displaced people, gay, lesbian, and transgender people, people with physical and mental disabilities (including developing and retaining sufficient number of mental health workers, ensuring marginalized populations' participation in developing the plan, and training health workers on the rights of people with disabilities, impoverished people, people living with HIV/AIDS, and rural dwellers).
- ❖ **Combating stigma and discrimination:** Programs should be developed and human resources assigned to address the stigma and discrimination within the health sector itself against marginalized populations, including people living with HIV/AIDS, injecting drug users, sex workers, and health workers providing care to stigmatized populations.
- ❖ **Gender:** The plan should be address physical and sociocultural gender differences, including harms that may particularly affect women such as inequitable pay, unequal access to professional development opportunities, sexual harassment, and workplace violence.

Workplace health, safety, supplies, and infrastructure

- ❖ **Health worker health and safety:** The plan should secure health workers' health and safety, including through measures to ensure consistent use of universal precautions as well as other forms of infection prevention and control, to provide health care to health workers including comprehensive HIV services, to provide for health workers' physical safety, and to meet health workers' psychosocial needs. Measures to identify and treat HIV-positive health workers should be taken in recognition of special confidentiality concerns that health workers face.
- ❖ **Adequate supplies and basic infrastructure:** The overall national health sector strategy in which the health workforce strategy is embedded should include measures to ensure that health workers have the medicines, supplies, and equipment they require to do their job, and that health facilities have meet basic infrastructure requirements, such as having electricity and clean water.

Compensation and support, including for community health workers

- ❖ **Living wages:** Health workers in all cadres should receive an adequate package of salary and benefits, including those at the community level such as community health workers. Different health worker cadres should be treated equitably.
- ❖ **Retention incentives:** Plans should include financial and/or non-financial incentives (such as housing allowances, lunch allowances, car loans, child care facilities, and increased recognition) and other strategies to improve retention (as addressed elsewhere), including attention to supportive supervision, good and safe working conditions, professional development, and respect of workers' rights. Incentives should be designed to avoid unintended distortions, which may happen when they cover a particular disease area or segment of the workforce.
- ❖ **Home-based and community health workers:** The plans should include measures to support home-based and other informal caregivers, as well as community health workers (e.g., HIV peer counselors, adherence support counselors). Community health workers should be compensated for their work, and should receive ongoing training, adequate supervision, supplies, and other support.

Education and training

- ❖ **Human rights and ethics education:** The health workforce plan should incorporate human rights education into pre-service training curricula for health workers. This education should include health workers' role in advancing these rights and should promote non-discrimination and respect for the rights of the diverse populations that health workers will serve. Health education should also address professional ethics including confidentiality, patients' rights, and other such issues.
- ❖ **Task distribution:** The health workforce plan should address task-distribution and task-shifting in a manner that will ensure quality while increasing service delivery. Task-shifting may include creating or expanding new non-physician clinicians/clinical officers and community/lay health worker cadres, and, if so, it must strengthen related supervision and referral systems. Health-related education should address any resulting redistribution and mix of required skills and competencies. One consequence of task-shifting and the development of strong referral systems may be the need to expand the workforce to deal with newly identified patients with more complex needs. The plan should address recruitment, training, and retention of this additional workforce.
- ❖ **Pre-service education:** Pre-service education planning should be aimed at producing enough health workers, in conjunction with other measures, to achieve MDGs, Universal Access, and other health goals and commitments. Training should be aimed at national health needs, including primary health needs, and countries should consider innovative methods that might be used to accelerate expansion of pre-service training, if needed.
- ❖ **In-service training:** The health workforce plan should strengthen in-service training mechanisms so that health workers can be adequately informed and skilled to provide high quality care, including mechanisms to ensure training, especially on-site training, for health workers in rural areas (including possible use of information technology). The in-service training should contribute to continuing professional development.

Supervision and referral systems

- ❖ **Supportive supervision:** The plan should include measures to ensure that all health workers receive supportive supervision which in turn requires well-trained and well-prepared supervisors. The plan should address the resources required to provide regular supervision and to do so on site whenever possible. Supportive supervision is one way of providing quality assurance.
- ❖ **Connections to higher-level health services:** The plan should ensure that there is a highly functional, transparent, and dependable referral system that permits health workers to diagnose patients' health care needs, and then know how and to whom to refer patients promptly for more specialized or expert care when it is needed. This will be impacted by the skills mix and service delivery models, as well as factors like transportation and communications, which will likely be beyond the health workforce plan, and part of the broader health sector strategy.

Re-engaging health workers

- ❖ **Unemployed and retired health workers:** The plans should identify measures and policies that may be able to draw non-practicing health workers back into the workforce, including unemployed, underemployed, and retired health workers, and where appropriate to engage the country's health professional diaspora.

Ensuring quality

- ❖ **Quality in education:** As health worker pre-service education is scaled up, as required in many countries, measures should be taken to ensure quality.
- ❖ **Regulating private sector:** Plans should include regulation of private health providers to ensure that they are delivering quality health services.

Ready to implement

- ❖ **Specific steps:** The health workforce plan should provide specific actions and timeframes for those actions that will be needed to implement the plan. If the health workforce plan does not have such specificity, a separate action plan should be developed.
- ❖ **Costing:** The health workforce plan should be costed. It may include several levels of costing, in the event that external resources that may be required are not forthcoming. If several costing scenarios are included, one should be the resources required to fully implement the plan and achieve health goals. All aspects of the plan should be costed, unless accompanied by a fully costed plan of action.

PROCESS OF DEVELOPING AND IMPLEMENTING NATIONAL HEALTH WORKFORCE PLAN

Participation

- ❖ **Broad participation:** The health workforce plan should be developed in a genuinely participatory and transparent manner, involving informed and wide participation of stakeholders that include

NGOs, health workers, patient/health consumer groups, and representatives of often marginalized populations, such as women, youth, migrants, refugees and internally displaced people, people with physical and mental disabilities, people living with HIV/AIDS, impoverished people, sex worker and sexual minorities, and rural dwellers. This participation should inform the development of the plan.

- ❖ **Multi-sector collaboration:** The plan should be developed through multi-sector collaboration, including ministries of health, education, finance, and public service.
- ❖ **Communication with health workers:** Along with their participation in developing the plan, health workers should be widely educated about the health workforce plan and how it will impact them and their work.

Evidence base and flexibility

- ❖ **Best available evidence:** Planning should take into account the best available evidence. Evidence should include the nature of the existing health workforce – including current numbers, migration patterns, and workloads – as well as disease burdens, including expected trends and the impact of emerging health issues like climate change. The effect of HIV/AIDS, including on health workers themselves, on workloads, on the need for chronic care, and on health workers’ tasks, should be taken into account.
- ❖ **Gather evidence:** The planning process should include activities to gather more evidence where current evidence is inadequate.
- ❖ **Flexibility:** Mechanisms should exist to revise the plan as necessary. As new evidence is developed, the plans should be adjusted based on the best available evidence.

Monitoring and evaluation

- ❖ **Monitoring and evaluation:** The health workforce plan should incorporate a monitoring and evaluation (M&E) process to monitor the plan’s implementation, to determine obstacles to implementation, to determine the effectiveness of the plan and its various elements (e.g., is the retention strategy working?), and to determine how the plan may need to be revised to improve its effectiveness in achieving its goals and improving health outcomes.
- ❖ **Information systems:** The plan should strengthen health information systems if they are not presently adequate to allow for effective M&E (and are one of the building blocks of health systems in their own right), as well as to gather evidence that will inform the plans.
- ❖ **NGO and health worker involvement in M&E:** NGOs and health workers should be meaningfully involved in the monitoring and evaluation process. Funds should be provided to enable broad stakeholder participation in both the initial planning process and in the subsequent monitoring and evaluation of the plan. People involved in other sectors related to the health workforce, such as education and agriculture, should also participate in M&E.
- ❖ **Public availability and accessibility:** The health workforce plan should be made publicly available and accessible to all, including by communicating it through accessible media and translating it into minority languages.

- ❖ **Link to right to health indicators:** The plan should include right to health indicators and benchmarks that permit monitoring to ascertain whether it is promoting the achievement of the essential elements of the right to health, namely, availability, accessibility, acceptability, and quality, and addressing both preventative and curative health services.

Connection to broader health strategy to meet population's health needs

- ❖ **Linkages between overall health sector plan and health workforce strategy:** The health workforce plan should be linked to and harmonized with a broader health sector strategy (e.g., national health sector strategic plans). The connection to other health sector improvements is needed to help ensure that health workers will have the training, supportive supervision, and referral systems, and the medicines, supplies, equipment, and other tools that they require to effectively perform their responsibilities. Changes in other areas of the health sector should be factored into the health workforce plan, such as the impact the abolition on user fees will have on increased utilization of the health services. The priorities, goals, and service delivery models in the health sector strategies will also impact the health workforce plan. For example, integration of health services will maximize the ability of health workers to contribute to comprehensively meet people's health needs.

Financing

The health workforce plan and the broader health sector strategy will have to be fully funded. The following are benchmarks, strategies, and policies that should guide this financing.

- ❖ **Increased domestic financing:** The national health sector plan should receive the maximum available domestic financing, including at least 15% of the government budget, as African governments have committed themselves to spending on the health sector. In many cases international financing will be required to supplement domestic resources, but such increases in domestic financing are a necessary step towards achieving full financing for the health workforce plan and national health sector strategy. An increase in domestic financing should not come through inequitable strategies that impede access to health services, such as point-of-service payments (user fees) on basic health services. Sustainable financing schemes should be designed to enable all people, including the poor, access to quality health services.
- ❖ **International financing:** Countries should coordinate their health sector and health workforce strategies and domestic funding with funding from bilateral and multilateral development partners (e.g., the Global Fund, GAVI). Development partners should commit to sustained funding that is predictable, long-term, rooted in national health strategies, and in conjunction with domestic resources, sufficient for full implementation of the health sector and workforce strategies. Development partners should also commit to paying recurrent costs.
- ❖ **Reformed macroeconomic policies:** The national health sector plan should be developed in concert with an evaluation and revision of existing macroeconomic policies, such as wage ceilings, deficit targets, and inflation targets, which may unnecessarily restrict the government's overall fiscal space, thus limiting necessary investments and spending of domestic and donor resources.

Growth evidence demonstrates that a wide range of policies are consistent with macroeconomic stability. Country reviews of macroeconomic policy should present the range of possible alternative policies, and include an honest assessment of the risks and benefits of each possibility. Countries should choose those policies that will enable them to maintain macroeconomic stability while making the investments in health, education, and other sectors as required to achieve the MDGs and fulfill governments' human rights obligations. Civil society members should be actively involved in these discussions.

5. COUNTRY SPECIFIC EXAMPLES

Compilation of selected publications about Human Resources for Health:

15. Lesotho Country Coordinating Mechanism. 2008. *Summary of Cross-Cutting Activities from Lesotho's Proposal from Round 8.*

15. LESOTHO COUNTRY COORDINATING MECHANISM. 2008. SUMMARY OF CROSS-CUTTING ACTIVITIES FROM LESOTHO'S PROPOSAL FROM ROUND 8.

This is a short summary of the cross-cutting health systems strengthening activities that Lesotho included as part of its Round 8 HIV/AIDS proposal. This summary illustrates ways that HSS activities can be integrated into proposals. The Technical Review Panel has recommended this proposal for approval.

**Please see reference #3 for additional country examples from Tanzania, Malawi, Kenya, and Rwanda from [http://www.who.int/healthsystems/gf_hss.pdf].*

Summary of the Cross-cutting HSS Section from Lesotho's Round 8 HIV/AIDS Proposal

Below is a summary of the cross-cutting health systems strengthening activities that Lesotho included as part of its Round 8 HIV/AIDS proposal, illustrating ways that HSS activities can be integrated into proposals. This proposal has been recommended for approval by the Technical Review Panel.

The cross-cutting HSS section of Lesotho's Round 8 HIV proposal includes strategies to address four components of its health system: strengthening the health workforce to support service delivery, addressing health service delivery to improve outcomes at the primary health care level, strengthening the management information system, and strengthening the procurement and supply management system.

In the area of human resources, activities are focused on the recruitment and distribution of health personnel, retention, development of health personnel capacity, and health personnel productivity. The proposal aims to recruit additional health workers in primary health care (PHC) facilities, including 165 PHC community counselors and 50 retired local health workers on a short-term contract basis. Retention strategies proposed include provision of salary complements to 1,222 health workers at all levels (and not only those specifically working on HIV and TB) and mountain hardship allowances to 391 health professionals in primary care clinics in rural and hard-to-reach areas. The salary complements will be taken over by the Lesotho government at the end of the grant period. The hardship allowances will expand and help sustain an existing incentive program for health workers at remote clinics. The proposal also strengthens district level human resource management by recruiting, remunerating, and equipping ten new assistant human resource officers.

The teaching capacity at local training institutions will be strengthened through provision of salaries for 27 new tutors, salary complements for 30 senior tutors and 40 existing tutors, and through implementation of pre-service training of health care professionals in all training institutions. The proposal will also strengthen professional counseling services at health facilities by continuing to remunerate 63 existing facility-based professional counselors and recruit and remunerate 48 new facility-based professional counselors.

The proposal includes a mix of activities to address various issues that affect quality health service as Lesotho undertakes health sector reform and a decentralization process. Activities include updating the policy framework for service delivery regulations and mechanisms for implementation, including as the framework relates to public-private partnerships; establishing a clinical mentoring program; providing outreach to underserved communities including by procuring mobile clinics and an ambulance, and hiring drivers; strengthening supervision of district health management teams; conducting leadership training for senior staff at primary health centers; improving the safety at district hospital radiology facilities, and; improving primary health care in prisons.

To strengthen the national health management information system, Round 8 activities include developing a data quality management system; strengthening data collection at the district level by recruiting, training, and equipping data clerks for 65 health facilities and installing the Internet at 24 hospitals and clinics; developing the national capacity of all service providers in health management information systems through in-service training on monitoring and evaluation tools and principles for 150 public and private provider partners, and; conducting surveys of health facility accreditation and service availability.

Activities to strengthen the procurement and supply management system include training health workers in forecasting and supplies management; training various personnel responsible for logistics, procurement, and supply management; hiring key staff; procuring several vehicles and other equipment, and; supporting quality control testing for procured drugs.

These activities are in support of Lesotho's transition to decentralized health services. As noted in the proposal, support to the decentralization process is critical if the Government of Lesotho is to achieve optimum public health outcomes and, in particular, those for HIV and TB.

6. ADDITIONAL WEBSITE REFERENCES

In addition to the materials included in the toolkit, please refer to the following websites for additional references to support inclusion of health systems strengthening activities in Round 9 proposals.

- **Capacity Project. Accessed October 10, 2008.**

<http://www.capacityproject.org/framework/>

The HRH Action Framework has been developed as an initiative of the Global Health Workforce Alliance (GHWA) and represents a collaborative effort between the U.S. Agency for International Development (USAID) and the World Health Organization (WHO). The HRH Action Framework provides a way to comprehensively conceptualize and address the health workforce by engaging in six main areas (Human Resource Management Systems, Leadership, Partnership, Finance, Education and Policy). The website provides links to numerous tools in these areas to support country action.

- **Support for the Global Fund Round 9 call on health system strengthening (HSS) – specific resources on HSS:**

http://www.who.int/healthsystems/gf_round9/en/index.html

This WHO website lists a number of resources that provide helpful technical guidance for preparing health system strengthening (HSS) activities as part of a proposal to the Global Fund, Round 9.

- **WHO and UNAIDS resource kit for writing Global Fund HIV proposals for round 8 (includes several HSS resources)**

<http://www.who.int/hiv/pub/toolkits/GF-Round8/en/index1.html>

This resource kit was jointly developed by WHO and UNAIDS to provide specific guidance in planning for and writing Global Fund HIV proposals for Round 8. The kit is primarily intended for use by WHO, UNAIDS and other UN staff and consultants as they support country teams in developing Round 8 HIV proposals. The resource kit consists of technical guidance notes, reference documents, practical tools for proposal development, GFATM Round 8 forms, guidelines and key tools and Aidsplan Round 8 guides.

- **The Aidsplan Guide to Round 8 Applications to the Global Fund – Volumes 1 and 2:**

<http://www.aidsplan.org/index.php?page=guides>

This guide provide extensive information to support Global Fund applicants, including extensive analysis of the strengths and weaknesses of proposals submitted in previous rounds of funding and a step-by-step guide on filling out the Round 8 proposal form (much of which is identical to the Round 9 proposal form).

