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Physicians for
Human Rights

The Right to Health and Health Workforce Planning

A Guide for Government Officials, NGOs,
Health Workers and Development Partners



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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
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The Right to Health and Health Workforce Planning

A Guide for Government Officials, NGOs,
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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 as 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 ensure 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 services by 2010, the Millennium Development Goals, and other health goals, 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 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

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.

unethical practice. This is inhuman treatment of fellow human beings.

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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, 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.

⁴ Personal communication with Raphael Gikera, Medical Laboratory Technologist, Kenyatta National Hospital, Nairobi, Kenya, July 18, 2006.

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/I1viedec.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 tool 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.

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

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.

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>.

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.

II. Philosophical and Legal Background on the Right to Health

By their nature, human rights are universal because they are derived from inherent dignity of each individual person.¹³ A variety of human rights are implicated in a right-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

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/I1viedec.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/I1viedec.html>.

¹⁷ Audrey R. Chapman (American Association for the Advancement of Science), *Exploring a Human Rights Approach to Health Care Reform* (1993), at 7.

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;
 - (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
 - (d) 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

The ICESCR and domestic law States are obliged to ensure that their national laws give effect to the rights contained in the ICESCR, though "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 in those

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>.

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>.

countries particular challenge to 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

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>.

III. 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 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.

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.

IV. 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

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/instatee/b2esc.htm>.

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

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

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 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 follows 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/instate/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.

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

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

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.

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.

V. 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 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 right-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 right-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

³⁸ *Id.* at para. 43 (f).

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/xfbcenter/V1N1leary.htm>.

VI. 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 who 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, and providing opportunities for written input and feedback.

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."⁴² 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.⁴³ 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 the whole population; the strategy and plan of action shall be devised, and

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 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>.

⁴³ *Id.* at para. 17.

*periodically reviewed, on the basis of a participatory and transparent process...*⁴⁴

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, Kenya*⁴⁵

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.⁴⁶ 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

⁴⁴ *Id.* at para. 43 (f).

⁴⁵ Personal communication with Dr. Burton Wagacha, Health Coordinator, GTZ Refugee Kenya Country Program, Kenya, July 6, 2006.

⁴⁶ Barbara Klugman, *Accountability and Participation in Africa* (2006), at 1.

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.”⁴⁷ 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.⁴⁸ 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 know 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,⁴⁹ 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

⁴⁷ 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>.

⁴⁸ 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/avril/SA/9-13%20avr/doc/en/SA/AFRICA_HEALTH_STRATEGY_FINAL.doc.

⁴⁹ UNICEF, *Fact Sheet: The Right to Participation*, <http://www.unicef.org/crc/files/Right-to-Participation.pdf>. Last modified Dec. 15, 2005.

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.*⁵⁰

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, Peru*⁵¹

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.⁵² 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.⁵³ 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

⁵⁰ 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).

⁵¹ Personal communication with Dr. Jaime Miranda, Civil Association for Health and Human Rights Education (EDHUCASalud), Lima, Peru.

⁵² 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>.

⁵³ *Id.*

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.

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”⁵⁴ 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.*⁵⁵

- World Health Organization

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

⁵⁴ 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.equinet africa.org/bibl/docs/DIS39GOVbaez.pdf>.

⁵⁵ World Health Organization, *World Health Report 2004: Changing History*. Available at: <http://www.who.int/whr/2004/chapter3/en/print.html>.

organized or more marginalized populations, such as people living in poverty, youth, rural communities or people with disabilities.⁵⁶

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.⁵⁷

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.⁵⁸ 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.⁵⁹

a. People living with HIV/AIDS (PLWHA)

The involvement of people living with or affected by HIV/AIDS underpins ethical and effective interventions against HIV/AIDS⁶⁰ 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, thereby affecting the chances of having their rights and needs addressed.⁶¹ 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

⁵⁶ Rene Loewenson, "Participation and Accountability in Health Systems: The Missing Factor in Equity." (2000), at 6. Available at <http://www.equinet africa.org/bibl/docs/partic&account.pdf>.

⁵⁷ 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>.

⁵⁸ Barbara Klugman, *Accountability and Participation in Africa* (2006), at 21.

⁵⁹ 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.equinet africa.org/bibl/docs/DIS39GOVbaez.pdf>.

⁶⁰ 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.

⁶¹ 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.

Africa's health professionals are HIV-positive⁶²) 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.

b. 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,⁶³ particularly the rural poor and other marginalized populations such as ethnic minorities. These groups are often the most disadvantaged in 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.

c. 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.*⁶⁴

- Doctor, Meru, Kenya

⁶² 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.hsrbpress.ac.za/product.php?mode=search&page=1&freedownload=1&productid=1986>.

⁶³ 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>.

⁶⁴ Personal communication with Dr. Bactrin M. Killingo, Meru Hospice, Meru, Kenya, July 13, 2006.

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.

d. Home caregivers and community health workers

UNAIDS recently estimated that 90% of care for people living with AIDS is provided in the home.⁶⁵ Certainly a need, and often even a preference,⁶⁶ for home- and community-based care exists, but instead of being integrated into 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.⁶⁷ 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,⁶⁸ which may also have to be developed as part of the workforce planning process.

e. 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.⁶⁹ 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.⁷⁰ Additionally, the dialogue that

⁶⁵ UNAIDS, *2004 Report on the Global AIDS Epidemic* (2004), at 118. Available through: http://www.unaids.org/bangkok2004/GAR2004_html/GAR2004_00_en.htm.

⁶⁶ 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.

⁶⁷ *Id.* at 17.

⁶⁸ *Id.* at 3.

⁶⁹ 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>.

⁷⁰ 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*,

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.

f. 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.

g. 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.⁷¹ 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.

h. 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 unavailable or inaccessible to people with disabilities and rehabilitation services are scarce, particularly in rural areas.⁷² Prevention and treatment guidelines for common diseases rarely take into account special needs of people with disabilities.⁷³

http://www.aidsuganda.org/response/govt_sectors/cso_programs/theta.htm, visited Dec. 8, 2007.

⁷¹ 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.

⁷² 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

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 who live in developing countries - are both identified and appropriately addressed.⁷⁴ 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 Health⁷⁵

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.⁷⁶ 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

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>.

⁷³ Personal communication, Jean Thomas Nouboussi, Handicapped International, Jan. 15, 2008.

⁷⁴ World Bank, *Disability and HIV/AIDS at a Glance* (Nov. 2004). Available at <http://siteresources.worldbank.org/INTPHAAG/Resources/AAGEngDisabilityHIVr4.pdf>.

⁷⁵ 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.

⁷⁶ Helen Potts, *A Right to Participation in Public Health Strategy Development* (2005). Available at: <http://www.engagingcommunities2005.org/abstracts/Potts-Helen-final.pdf>.

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%.⁷⁷ 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 be healers will encourage their retention.⁷⁸

But full participation in health workforce planning also has intrinsic value of its own. The process 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.⁷⁹

⁷⁷ 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.

⁷⁸ 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.

⁷⁹ 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>.

VII. 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, Nigeria*⁸⁰

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.⁸¹ 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.*⁸²

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."⁸³ 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

⁸⁰ Personal communication with Dr. Chukwumuanya Igboekwu, Health Program Associate for Physicians for Social Justice (PSJ) and practicing physician based in Kontagora, Niger State, Nigeria, Nov. 2006.

⁸¹ 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.

⁸² 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>.

⁸³ *Id.* at para 43(a).

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.⁸⁴ Discrimination also inhibits 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.⁸⁵

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.⁸⁶ 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.⁸⁷ 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.⁸⁸

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.

⁸⁴ 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/rth/docs/CHR%202003.pdf>.

⁸⁵ *Id.* at paras. 59-63; Judith Asher, *The Right to Health: A Resource Manual for NGOs* (2004), at 57. Available at: http://shr.aaas.org/pubs/rt_health/rt_health_manual.pdf.

⁸⁶ 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>.

⁸⁷ Carla AbouZahr, "Maternal Mortality: Helping Mothers Live." *OECD Observer* (Dec. 2000). Available at: <http://www.oecdobserver.org/news/fullstory.php/aid/374>.

⁸⁸ 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/>.

- Nurse, Homa Bay, Kenya⁸⁹

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.⁹⁰ 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.⁹¹

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, Uganda⁹²

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"⁹³ 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 strategy to improve the distribution of resources, tertiary facilities might be well-resourced due to resources from the federal government, but primary facilities could remain severely under-resourced.

Redressing disparities may require redistributing authority across levels of government, or reconsidering their roles. To increase the numbers of health workers

⁸⁹ 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.

⁹⁰ 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.

⁹¹ UNICEF, At a Glance: Ghana - The Big Picture, http://www.unicef.org/infobycountry/ghana_1878.html, visited Feb. 8, 2008.

⁹² Personal communication with Nixon Niyonzima, medical student, Makerere University, Kampala, Uganda, July 12, 2006.

⁹³ 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>.

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.⁹⁴

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.⁹⁵

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.⁹⁶ 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.⁹⁷

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, Uganda⁹⁸

⁹⁴ 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.

⁹⁵ 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>.

⁹⁶ 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.

⁹⁷ 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>.

⁹⁸ Personal communication with Nixon Niyonzima, medical student, Makerere University, Kampala, Uganda, Jan. 23, 2008.

Possible strategies to enhance equity

States are obligated to “take measures to reduce the inequitable distribution of health facilities, goods and services.”⁹⁹ 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.¹⁰⁰ This 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

⁹⁹ 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>.

¹⁰⁰ 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.*

soundly within the purview of health workforce planning and should be considered in light of equity and non-discrimination requirements.

a. Incentives for working in disadvantaged areas

The Africa Health Strategy 2007-2015 directs countries to develop packages and incentives for working in disadvantaged areas.¹⁰¹ 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.¹⁰² 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.¹⁰³ 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.¹⁰⁴

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.¹⁰⁵ Such a payment scheme, which discourages service in rural areas, is inconsistent with right to health obligations.

b. 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,

¹⁰¹ 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.

¹⁰² "Rural doctor s number soars - Chituwo." *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.

¹⁰³ 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.

¹⁰⁴ 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/bibl/docs/DIS44HRdambisya.pdf>.

¹⁰⁵ 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.

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.¹⁰⁶ Part of the comprehensive 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.¹⁰⁷

c. Professional development

Rural health practitioners' fear of getting left behind or passed over for promotions compared to colleagues in "more prestigious" urban positions¹⁰⁸ 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 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."¹⁰⁹

d. Training and recruitment

¹⁰⁶ Personal communication with Lisa Oldring, Special Advisor, Realizing Rights: The Ethical Globalization Initiative, Nov. 1, 2007.

¹⁰⁷ 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>.

¹⁰⁸ 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>.

¹⁰⁹ 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.

National health workforce plans must also take into account that governments are obligated to provide “appropriate training for health personnel”¹¹⁰ in order to “[address] the health needs of the whole population.”¹¹¹ Appropriate training will ensure that health staff are able to “recognize and respond to the specific needs of vulnerable and marginalized groups.”¹¹² 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,¹¹³ many of which will generally be provided within primary health care settings.¹¹⁴

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 nurse¹¹⁵

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.¹¹⁶

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.¹¹⁷ It may also raise health workers’ awareness of health inequalities that result from the poor conditions that characterize many rural health services.

¹¹⁰ 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>.

¹¹¹ *Id.* at para. 43f.

¹¹² *Id.* at para. 37.

¹¹³ *Id.* at para. 44.

¹¹⁴ 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>.

¹¹⁵ 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/uploads/files/chapter10.pdf>.

¹¹⁶ *Id.* at 182-183.

¹¹⁷ 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>.

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 reservation 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.”¹¹⁸ 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.”¹¹⁹

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,¹²⁰ 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.¹²¹

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.

¹¹⁸ Personal communication with Dr. Andrew Mwanika, Makerere University Medical School, Kampala, Uganda, July 24, 2006.

¹¹⁹ Personal communication Nixon Niyonzima, medical student, Makerere University, Kampala, Uganda, July 12, 2006.

¹²⁰ 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>.

¹²¹ *Id.*

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 (WIRHE). Twenty students from rural communities in North West and Limpopo provinces are receiving scholarship 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.

e. 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.¹²² Certain types of nurses, such as community nurses, might be trained specifically for deployment in rural areas.¹²³ 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.¹²⁴

Community health workers can provide certain basic health services in rural areas, and are being increasingly looked to as part of a strategy to scaling up HIV and other health services.¹²⁵ 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.¹²⁶

¹²² Fitzhugh Mullan & Seble Frehywot, "Non-physician clinicians in 47 sub-Saharan African countries." *Lancet* (Dec. 22, 2007) 370: 2158-2163, at 2161.

¹²³ Personal communication with Isabella Mbai, Head, Department of Nursing Sciences, School of Medicine, Moi University, Eldoret, Kenya, Oct. 10, 2006.

¹²⁴ Seth Acquah, Graeme Frellick & 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.

¹²⁵ 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.

¹²⁶ 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.theglobalfund.org/search/docs/5MLWH_1142_0_full.pdf

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.

f. 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.”¹²⁷ 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,¹²⁸ with the requirement for nurses beginning in January 2008.¹²⁹ This can be an important way to ensure that trained health workers are available to serve in rural areas,¹³⁰ though this method of placing health workers in rural areas both raises concerns about inadequate supervision for the newly trained health professionals and high rates of turnover.¹³¹

g. 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.¹³² Such approaches can be important

¹²⁷ 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.

¹²⁸ 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_JLIreport.pdf.

¹²⁹ “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>.

¹³⁰ The reality is sometimes less than the promise. At least as of 2001, 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.

¹³¹ See *id.* Also, newly health professionals have less experience, and so lack the additional skills and knowledge that come with experience.

¹³² Ummuro Adano (Capacity Project), *Reflections on the Emergency Hiring Plan* (Sept. 2006). Available at:

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 grandmother¹³³

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.¹³⁴

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.

- HIV/AIDS patient, Nigeria¹³⁵

Discriminatory practice often reflects a lack of knowledge and training on the part of health workers. For example, inaccurate information and insufficient training, in

http://www.capacityproject.org/index.php?option=com_content&task=view&id=132&Itemid=147.

¹³³ Help Age International, *One in Fourteen People Living with HIV are Over 50 and Millions More Older People are at Risk* (Nov. 29, 2006). Available at:

<http://www.helpage.org/News/Mediacentre/Pressreleases/wSGB>.

¹³⁴ World Bank, *Disability and HIV/AIDS at a Glance* (Nov. 2004). Available at <http://siteresources.worldbank.org/INTPHAAG/Resources/AAGEngDisabilityHIVr4.pdf>.

¹³⁵ 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>.

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.¹³⁶ 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.”¹³⁷

My job is made difficult by the negative attitude people have to mental health....Some of my colleagues 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 Africa¹³⁸

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.¹³⁹ 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.¹⁴⁰ 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.¹⁴¹

[Health care professionals] live in 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 policymaker¹⁴²

¹³⁶ 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>.

¹³⁷ 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>.

¹³⁸ 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.

¹³⁹ 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>.

¹⁴⁰ 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>.

¹⁴¹ 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.

¹⁴² 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>.

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.¹⁴³

*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?*¹⁴⁴

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 hazards¹⁴⁵ and act to "[prevent, treat] and control...epidemic, endemic, occupational and other diseases."¹⁴⁶

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 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."¹⁴⁷

¹⁴³ *Id.* at 24.

¹⁴⁴ 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.

¹⁴⁵ 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>.

¹⁴⁶ 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/instree/b2esc.htm>.

¹⁴⁷ "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:

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 meaning 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 cultural acceptable.¹⁴⁸ 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."¹⁴⁹

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.¹⁵⁰

- 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.¹⁵¹
- Women now form a majority of enrolled students in South African undergraduate medical programs.¹⁵²

<http://www.planetwire.org/details/6580>.

¹⁴⁸ 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>.

¹⁴⁹ 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>.

¹⁵⁰ 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.

¹⁵¹ 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.

¹⁵² Mignonne 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.

- 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, working 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.¹⁵³ 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.¹⁵⁴

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,¹⁵⁵ 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.¹⁵⁶ 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.¹⁵⁷ 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.

¹⁵³ 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.

¹⁵⁴ 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>.

¹⁵⁵ 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>.

¹⁵⁶ 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>.

¹⁵⁷ International Council of Nurses, *Fact Sheet: Equal Opportunity: Gender issues*, http://www.icn.ch/matters_equalop.htm. Accessed Jan. 24, 2008.

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.¹⁵⁸ 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.¹⁵⁹ 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.¹⁶⁰

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.

a. 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.¹⁶¹ In and of itself, wage differentials between programs are not necessarily an instance of rights-related discrimination; 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

¹⁵⁸ 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>.

¹⁵⁹ 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>.

¹⁶⁰ Personal communication with Barbara Stillwell, Human Resources for Health Department, World Health Organization, Feb. 10, 2006.

¹⁶¹ 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>.

salaries identical to, for example, health workers employed by AIDS programs.¹⁶² 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.¹⁶³

b. 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.¹⁶⁴ 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.¹⁶⁵

Salarywise, we are not paid as professionals. There is the scarce [skills] allowance. But this is mostly going to doctors. Nurses should be considered

¹⁶² 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.

¹⁶³ 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/>.

¹⁶⁴ 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 Villiers & 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.

¹⁶⁵ 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.

*for this allowance because nurses are often the ones who orientate the doctors.*¹⁶⁶

- 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.¹⁶⁷ 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 access to health services for the poorest households.¹⁶⁸ 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.*¹⁶⁹

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.¹⁷⁰ Governments should abolish user fees if they still exist, while devising other, more equitable funding mechanisms, while the health workforce plan

¹⁶⁶ 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.

¹⁶⁷ 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.

¹⁶⁸ 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>.

¹⁶⁹ 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>.

¹⁷⁰ "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>.

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.

VIII. 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.¹⁷¹

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.¹⁷² 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.¹⁷³

¹⁷¹ Vasant Narasimhan, Hilary Brown, Ariel Pablos-Mendez, et al., "Responding to the global human resources crisis." *Lancet* (May 1, 2004) 363:1469-1472.

¹⁷² 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>.

¹⁷³ 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

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 obligation¹⁷⁴ specifies that states 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.¹⁷⁵
- "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,¹⁷⁶ who are least likely to have available, accessible, acceptable and good quality health services.

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>.

¹⁷⁴ 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>.

¹⁷⁵ 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.

¹⁷⁶ Audrey R. Chapman (American Association for the Advancement of Science), *Exploring a Human Rights Approach to Health Care Reform* (1993), at 23.

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.”¹⁷⁷

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,¹⁷⁸ 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 imposes 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.¹⁷⁹ Shortages of supplies and malfunctioning equipment often preclude health workers from carrying out the basic duties that are imperative to functioning

¹⁷⁷ 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>.

¹⁷⁸ 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>.

¹⁷⁹ 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 services, and impede achievement of their own personal goals,¹⁸⁰ 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.¹⁸¹ 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.¹⁸² 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."¹⁸³

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.¹⁸⁴

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, Zimbabwe¹⁸⁵

¹⁸⁰ 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>.

¹⁸¹ 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/.

¹⁸² 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>.

¹⁸³ 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>.

¹⁸⁴ 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 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>.

¹⁸⁵ Personal communication with Dr. Douglas Gwatidzo, Harare, Zimbabwe, March 1, 2006.

There are also serious implications for vertical treatment programs as hospitals and clinics restrict patient enrollment due to shortages of ARVs and tuberculosis drugs.¹⁸⁶ 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 patients¹⁸⁷ 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."¹⁸⁸

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 Emergency Human Resource Programme in conjunction with its Essential Health Package, which should strengthen the health system beyond the workforce.¹⁸⁹

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 programs that can help meet their food and nutrition needs. A program in Kenya trains nurses on a water-treatment product called WaterGuard, which the nurses prescribed to patients suffering from diarrhea.¹⁹⁰ 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

¹⁸⁶ 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.

¹⁸⁷ 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>.

¹⁸⁸ "Focus on Health Workers." *Equal Treatment (Treatment Action Campaign)*, Dec. 2005, Issue 18, at 13.

¹⁸⁹ Debbie Palmer, "Tackling Malawi's Human Resources Crisis." *Reproductive Health Choices* (2006) 14: 27-39, at 33, 35.

¹⁹⁰ U.S. Centers for Disease Control and Prevention, *Working to Make Water Safe to Drink*. <http://www.cdc.gov/about/stateofcdc/everywhere/water.htm>, visited Jan. 16, 2008.

responsibilities that go beyond education, for example, helping to build latrines or improve access to clean water.¹⁹¹

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.¹⁹² 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.*¹⁹³

It appears that nurses' rights to “just and favourable conditions of work,” including “safe and healthy working conditions,” and “fair wages and equal remuneration”¹⁹⁴ 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

¹⁹¹ 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>.

¹⁹² 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.

¹⁹³ 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.aspx?reportid=48745>.

¹⁹⁴ 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/instree/b2esc.htm>.

poorly compensated for their hard work and they feel undervalued.¹⁹⁵ 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.¹⁹⁶

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 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.¹⁹⁷ 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.¹⁹⁸ 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."¹⁹⁹ 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.²⁰⁰

¹⁹⁵ 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>.

¹⁹⁶ 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>.

¹⁹⁷ 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>.

¹⁹⁸ "Zimbabwe: HIV Positive Health Workers form Union." *IRIN PlusNews*, Feb. 16, 2007. Available at: <http://www.plusnews.org/report.aspx?reportid=70230>.

¹⁹⁹ 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.

²⁰⁰ 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.

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.²⁰¹ In Botswana, the Tshedisa Institute provides holistic care for HIV infected and affected health workers in the capital Gaborone.²⁰²

Yet because the right to health also emphasizes "equality of access to health care and health services,"²⁰³ 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.²⁰⁴

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.

²⁰¹ *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-boldsolutions-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 Africa* (Dec. 1, 2005). Available at www.intlnursemigration.org/news.shtml#3

²⁰² 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.

²⁰³ 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>.

²⁰⁴ 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.

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.²⁰⁵ The program has led to growing openness, with a number of staff disclosing their status to encourage others to undergo HIV testing.²⁰⁶

The unique impact of HIV/AIDS on health workforce attrition through a combination of absenteeism, burnout, sickness and death must also be considered.²⁰⁷ 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, it is estimated that 17% of health care worker deaths between 1999 and 2005 were attributable to HIV/AIDS.²⁰⁸

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 for universal precautions and workplace education and prevention programs that include practical exercises as well as information sharing.²⁰⁹ These programs must include all employees of health facilities,

²⁰⁵ 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>.

²⁰⁶ 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.

²⁰⁷ 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>.

²⁰⁸ 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.

²⁰⁹ A study of health workers in South African 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.hsrbpress.ac.za/product.php?mode=search&page=1&freedownload=1&productid=1986>.

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.²¹⁰ The programs are more likely to succeed when family members are included.²¹¹

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.²¹²

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.²¹³ 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.²¹⁴

²¹⁰ 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/presentationView.asp?EID=289&PID=590>.

²¹¹ 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.

²¹² 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.or.tz/modules.php?op=modload&name=UpDownload&file=index&req=getit&id=81>.

²¹³ 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>.

²¹⁴ 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.

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 particular 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 populations.²¹⁵ 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.²¹⁶

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.²¹⁷ Diaspora representation, for example, through participation of unions, professional groups or diaspora organizations, within the health workforce planning process 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.²¹⁸

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

²¹⁵ 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.

²¹⁶ 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.

²¹⁷ 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>.

²¹⁸ 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.

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.²¹⁹ 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"²²⁰ 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.²²¹ For example, church missions in Zimbabwe provide nearly 70% of rural hospital beds and missions run 40% of Tanzania's hospitals.²²² 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 give explicit consideration to 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

²¹⁹ Debbie Palmer, "Tackling Malawi's Human Resource Crisis", *Reproductive Health Matters* (2006) 14: 27-39, at 32-33.

²²⁰ 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.

²²¹ 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/healthin africa.nsf/Content/FullReport>.

²²² 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>.

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 salaries raises 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.²²³

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.²²⁴ 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."²²⁵ Public sector salaries that are not "domestically competitive"²²⁶ 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.²²⁷

²²³ 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.

²²⁴ 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, particularly those related to national human resource settings"). Available at: <http://www.ncseonline.org/NLE/CRSreports/07Oct/RL34192.pdf>.

²²⁵ 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>.

²²⁶ *Id.* at para. 12a.

²²⁷ 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>.

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.²²⁸ 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.²²⁹ Formalization might, however, simply serve to perpetuate a practice that undermines the public health service and avoid dealing with low pay and inadequate 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.²³⁰ Of course, it is critically important to roll out ARV programs, which are central to people's right to receive AIDS treatment,²³¹ 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-

²²⁸ *Id.*

²²⁹ 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/healthin africa.nsf/Content/FullReport>.

²³⁰ Ian Couper, Marietjie de Villiers & Nontsikelelo Sondzaba, "Resources: District Hospitals." *In* Health Systems Trust (Petrida Ijumba & Peter Barron, eds.), *South African Health Review* (2005), at 125, 127. Available at: http://www.hst.org.za/uploads/files/sahr05_chapter9.pdf.

²³¹ 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.

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.²³²

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.²³³ 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.²³⁴

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.²³⁵

²³² 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>.

²³³ 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>.

²³⁴ 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.

²³⁵ 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.

IX. 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."²³⁶

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.²³⁷ While states are obligated to "ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct,"²³⁸ 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.²³⁹

a. 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

²³⁶ 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>.

²³⁷ 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>.

²³⁸ *Id.* at para 35.

²³⁹ Richard Cash, "Ethical Issues in Health Workforce Development." *Bulletin of the World Health Organization* (April 2005) 83(4): 280-284, at 281.

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.²⁴⁰

b. 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.²⁴¹

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 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.²⁴²

c. 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.²⁴³

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, Nigeria²⁴⁴

Health workforce plans must also consider how to better support supervisory functions, such as through providing in-service training to supervisors, and resources

²⁴⁰ 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.equinetafrica.org/bibl/docs/DIS44HRdambisya.pdf>.

²⁴¹ Richard Cash, "Ethical Issues in Health Workforce Development." *Bulletin of the World Health Organization* (April 2005) 83(4): 280-284, at 282.

²⁴² 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>.

²⁴³ Elizabeth Molyneux & Martin Weber, "Applying the Right Standards to Improve Hospital Performance in Africa." *Lancet* (Oct. 30, 2004) 364:1560-61, at 1561.

²⁴⁴ Personal communication with Tony Anammah, Pharmacist, Gede Foundation, Abuja, Nigeria, June 23, 2006.

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.²⁴⁵

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.²⁴⁶ 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.²⁴⁷

d. 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.²⁴⁸

e. Community health workers and quality assurance

As with health professionals and paraprofessionals who receive formal education and training, quality 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

²⁴⁵ 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>.

²⁴⁶ 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>.

²⁴⁷ Personal communication with Dr. Steven Rulisa, Obstetrician/Gynecologist, Vice President, Rwanda Medical Association, Kigali, Rwanda, Nov. 8, 2007.

²⁴⁸ Richard Cash, "Ethical Issues in Health Workforce Development." *Bulletin of the World Health Organization* (April 2005) 83(4): 280-284, at 283.

workers is important to allow for harmonized training, mutual respect and understanding of roles and responsibilities, and consistent referral and practice guidelines,²⁴⁹ all of which are essential to achieving and sustaining good quality health services.

f. 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, good or services.”²⁵⁰

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.²⁵¹ The health workforce planning process offer 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.

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.”

²⁴⁹ 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.

²⁵⁰ 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>.

²⁵¹ 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>.

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 make 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."²⁵²

²⁵² Personal communication with Dr. Burton Wagacha, Health Coordinator, GTZ Refugee Kenya Country Program, Kenya, July 6, 2006.

X. 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.²⁵³ 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”²⁵⁴ 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,²⁵⁵ moving “as expeditiously and effectively as possible towards” the full realization of the right to health.²⁵⁶

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.²⁵⁷ 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.²⁵⁸ 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

²⁵³ 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/instree/b2esc.htm>.

²⁵⁴ 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>.

²⁵⁵ 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.

²⁵⁶ 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>.

²⁵⁷ 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>.

²⁵⁸ 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>.

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,²⁵⁹ and to develop an 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.²⁶⁰ 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.²⁶¹ 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.

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

²⁶⁰ 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.

²⁶¹ 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>.

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.

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 who are signatories to the *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases* of April should strive to meet their pledge to devote 15% of annual budgets to health.²⁶² As of 2005, only about one-third of sub-Saharan countries were allocating even 10% of their budgets to health spending.²⁶³ As of 2007, only two countries in Africa had achieved the 15% minimum.²⁶⁴ Increased resource generation can also lead to more money for the health sector.²⁶⁵

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.²⁶⁶ This money could then be put towards development.

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 GAVI²⁶⁷ and the Global Fund to Fight AIDS, Tuberculosis

²⁶² *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>.

²⁶³ Chris Atim, *Economic Viewpoint: Health Financing in Africa - Further Thoughts on Abuja* (Aug. 2006). Available at: <http://go.worldbank.org/RYOQ50AYL0>.

²⁶⁴ 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.

²⁶⁵ 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.

²⁶⁶ 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.

²⁶⁷ 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

and Malaria,²⁶⁸ as well through bilateral mechanisms such as the President's Emergency Plan for AIDS Relief (PEPFAR) and the Millennium Challenge Accounts (MCA).²⁶⁹ This may require advocacy on the part of governments to ensure that international development partners include health workforce strengthening among the areas that they fund both bilaterally and through other international funding mechanisms.²⁷⁰

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

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.

²⁶⁸ 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/boardmeeting16/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://physiciansforhumanrights.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>.

²⁶⁹ 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 <http://www.mcc.gov/selection/indicators/index.php>. 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>.

²⁷⁰ 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.

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, Kenya²⁷¹

Economically developed states are obligated to provide international assistance necessary to achieve realization of economic, social and cultural rights, including the right to health.²⁷² This is a legal obligation that stems from multiple international agreements,²⁷³ including the UN Charter, which stipulates that member states are obliged 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.”²⁷⁴

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.²⁷⁵

Health workers, as service providers, “play an indispensable role in the realization of the right to health.”²⁷⁶ Because of this, donors must consider the serious obligation upon them to include explicit health workforce support within their international assistance packages.

²⁷¹ Personal communication with Dr. Bactrin M. Killingo, Meru Hospice, Meru, Kenya, July 13, 2006.

²⁷² 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>.

²⁷³ 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/instreetree/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/instreetree/k2crc.htm>.

²⁷⁴ UN Charter, arts. 55 and 56. Available at: <http://www1.umn.edu/humanrts/instreetree/aunchart.htm>.

²⁷⁵ 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. 2(1), 12(1). Available at: <http://www1.umn.edu/humanrts/instreetree/b2esc.htm>.

²⁷⁶ 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>.

XI. 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 health²⁷⁷

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)²⁷⁸ 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.²⁷⁹ 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.²⁸⁰

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.²⁸¹ This more expansive understanding conceives of accountability as a tool to move towards realizing the right to health in practice.

²⁷⁷ 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>.

²⁷⁸ 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>.

²⁷⁹ 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>.

²⁸⁰ 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>.

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.

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...reducing women's health risks, particularly lowering rates of maternal mortality and protecting women from domestic violence.”²⁸² 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.²⁸³

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.²⁸⁴

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,²⁸⁵ universal access to HIV services by 2010,²⁸⁶ universal access to

A/HRC/4/28 (Jan. 11, 2007), at para. 46. 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 para. 21. Available at:

<http://www2.essex.ac.uk/human%5Frights%5Fcentre/rth/docs/CHR%202005.pdf>.

²⁸³ 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>.

²⁸⁴ 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/instr/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>.

²⁸⁵ 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*,

reproductive health by 2015,²⁸⁷ and an African Union commitment to a package of essential health services by 2015.²⁸⁸

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.

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.²⁸⁹ A right-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

<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.

²⁸⁶ 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.

²⁸⁷ 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>.

²⁸⁸ "[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

²⁸⁹ 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>.

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.²⁹⁰

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.

Monitoring and evaluation is needed at multiple levels, not only for the overall plan, 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.²⁹¹

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, acceptable 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.

²⁹⁰ 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>.

²⁹¹ 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.

Procedures should be in place to compensate patients and discipline health workers if workers do violate patients' rights.²⁹² 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.²⁹³

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.

²⁹² 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>.

²⁹³ 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.

XII. 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.²⁹⁴

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.²⁹⁵ 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

²⁹⁴ “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>.

²⁹⁵ 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>.

or is withdrawn.²⁹⁶ 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,²⁹⁷ 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. 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. 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 allocated 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.²⁹⁸ NGOs

²⁹⁶ 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.

²⁹⁷ 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>.

²⁹⁸ 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

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.²⁹⁹ 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.

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.³⁰⁰ 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

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>.

²⁹⁹ 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.

³⁰⁰ 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.

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.³⁰¹ 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 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

³⁰¹ Judith Asher, *The Right to Health: A Resource Manual for NGOs* (2004), at 73. Available at: http://shr.aas.org/pubs/rt_health/rt_health_manual.pdf.

of why people stay are so complex. There are no clubs here, no social life. There's something much bigger at work here."³⁰²

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.

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, Nigeria³⁰³

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, Uganda³⁰⁴

³⁰² Personal communication with Dr. Evan Lyon, Partners in Health, July 17, 2006.

³⁰³ Dr. Chukwumuanya Igboekwu, Health Program Associate for Physicians for Social Justice and practicing physician based in Kontagora, Niger State, Nigeria.

³⁰⁴ Personal communication with Nixon Niyonzima, medical student, Makerere University, Kampala, Uganda, Jan. 23, 2008.

XIII. 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/>.