

CLOSING THE GAP:  
Millennium Development Goals 8, 7, **6, 5, 4**, 3, 2, 1



**INTERNATIONAL NURSES DAY 2013**

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12 May 2013

Dear Colleagues,

It is our great pleasure to wish all nurses around the world a Happy International Nurses Day 2013. The theme that ICN has chosen for this year is *Closing the Gap: the Millennium Development Goals: 8, 7, 6, 5, 4, 3, 2, 1*. This slogan is intended to be a countdown to 2015, with an emphasis on the health related goals.

As the largest health care profession in the world, there is no doubt that nurses are key to the achievement of the Millennium Development Goals. Nurses are often the only health professionals accessible to many people in their lifetime. So nurses are particularly well placed and often the most innovative in reaching underserved and disadvantaged populations. Nurses are educated to understand the complex nature of maintaining health and wellness, and the impact of psychosocial and socio-economic factors such as poverty, unemployment and ethnicity. They see the context for wellbeing and accordingly act so as to reach beyond the immediate presenting problems.

Nurses have done much towards the achievement of the MDGs and to help shape and deliver sustainable goals and outcomes beyond 2015. And we can be proud of our achievements. Yet there is still more that we can – and must – do.

Nurses must engage in advocacy and lobbying. We must be involved in the development of any programme introduced to improve health services as it is nurses who have the practical knowledge of how health service delivery can be designed, coordinated and effectively implemented.

National nurses associations have an important role to play in informing, advising, encouraging and supporting nurses in their work. NNAs must continue to work with governments and others to strengthen health systems and create the conditions necessary to maximise the contribution of nurses.

The 2013 IND Kit provides a rich resource to national nursing associations as to how they can fulfil the important role of helping to achieve the MDGs. The countdown is on. The clock is ticking and we are running out of time. Each and every one of you can make a difference. In the words of UN Secretary General Ban Ki-Moon, *“There is no global project more worthwhile. ... Let us keep the promise.”*

Sincerely,

Rosemary Bryant  
President

David C. Benton  
Chief Executive Officer



## Executive summary

The adoption of the Millennium Declaration by the UN General Assembly in 2000 resulted in the creation of the Millennium Development Goal (MDG) framework, which has been used to galvanise development efforts, set global and national priorities, and focus attention, action and resources. Eight MDGs with a range of targets and indicators were developed and agreed. Taken together, these provide a holistic framework for sustainable poverty reduction and development. Three goals – numbers 4, 5 and 6 – are specifically related to health, and their achievement is closely linked to the other goals including those focused on poverty, hunger, gender equality and women's empowerment.

- **MDG 4 – Reduce child mortality** – has shown some significant success in the reduction of global deaths among children under the age of five. However, the majority of the 7.6 million child deaths that occur every year could be prevented using effective, affordable interventions. (WHO/UNICEF 2012, p.8). Neonatal mortality continues to be a major concern, as do infectious diseases and under-nutrition.
- **MDG 5 – Improve maternal health** – has resulted in an almost 50 percent decrease in the number of women who die during pregnancy or childbirth. There are still significant variations across regions, with women in sub-Saharan Africa at most risk with 56 percent of maternal deaths occurring there – a maternal mortality rate of 500. Delayed childbearing, increased access to skilled care during and after pregnancy coupled with safe, affordable, effective methods of contraception, and where necessary comprehensive post-abortion care are essential in improving maternal health.
- **MDG 6 – Combat HIV/AIDs, malaria and other diseases** – shows significant regional variation and also some successes with fewer people becoming infected with HIV in most regions and significant expansion of access to life-saving anti-retroviral therapy. While the numbers of reported cases of malaria and tuberculosis are falling, there is no room for complacency – there are increasing reports of resistance to artemisinins and insecticides for treating malaria and increasing reports of multi-drug resistant tuberculosis.

Progress towards the Goals is reported to the UN annually by individual countries and the results are collated in an annual UN Millennium Development Goals Report. Key successes include reductions in levels of extreme poverty, halving the proportion of people without access to drinking water, and increasing the numbers of girls enrolled in primary schools.

While there has been undoubted progress, there is still much to be achieved. Trends have been uneven within and across countries and regions, with the poorest and most marginalised continuing to be the most disadvantaged. As a result, one of the main criticisms of the MDGs has been the lack of focus on equity. Concerns have also been expressed about the low level at which some targets have been set and the omission of demographic changes such as the ageing population and the shift from rural to urban dwelling, as well as changes in the disease burden, especially the challenge of non-communicable diseases.

Nurses across the world have been actively engaged in local, national and regional efforts to tackle the MDGs. The International Council of Nurses (ICN) has worked with national nurses associations (NNAs) across the world to support and promote the achievement of the wider MDGs and the enhanced contribution of nurses in delivering the health-related MDGs. Successful initiatives include

the establishment of The Girl Child Education Fund, aimed at keeping orphaned daughters of nurses in Kenya, Swaziland, Uganda and Zambia in school. Working with the private sector, governments, NNAs and other partners, ICN has established five Wellness Centres for Health Care Workers (in Lesotho, Malawi Swaziland, Uganda and Zambia), and is in the process of establishing a sixth, . The ICN TB/MDR TB Project has informed, educated and supported tens of thousands of nurses, health workers and others in 13 countries. The work and contribution of nurses across African and other countries have been enhanced by access to information provided by ICN through the ICN MSD Nursing Mobile Libraries and the fact sheets and position statements available on the ICN website and included in communications with NNAs.

Nurses have also worked together and established groups and organisations spanning national borders to maximise their resources and their impact on particular health challenges such as HIV/AIDS – for example the Southern African Network of Nurses and Midwives (SANNAM). Reporting on the sub-national nursing contribution towards the achievement of the MDGs is somewhat of a challenge, mainly due to nurses’ seeming reluctance to publish and promote their work. Nurses across the world have developed services and delivered innovative care to children, women and those suffering from disease, contributing to the successes of the MDGs. They need encouragement and support to publish their successes.

The MDG Acceleration Framework (UNDP 2011), designed to galvanise progress at country level, includes recommended solutions and interventions, many of which are amenable to nursing action and could be used as a framework around which nurses can coalesce to shape and focus their continuing contribution to the MDGs.

There is concern that, in the coming few years, attention may be focused on the MDG successors, instead of pushing harder to meet the existing MDGs. A High-level Panel of 26 ‘eminent persons’ has been appointed to advise the UN secretary-general around the MDG successors and a UN Task Team has produced a Framework for Development linking the SDGs and MDGs. It is expected that whatever form is taken by the replacement for the MDGs, it must be measurable, include relative and absolute benchmarks and be subject to regular reporting. The new approach must reflect the lessons learned from the MDGs on the issue of equity and equality at national, community and family level, and the importance of consulting with a wide range of stakeholders including the most deprived members of the global community. It is also suggested that the new goals might incorporate an appropriate human rights based approach despite some of the challenges associated with that.

The changing global disease burden was acknowledged by the UN High-level Meeting on Prevention and Control of NCDs, held in 2011 (C3 Collaborating for Health 2011) and it is expected that any focus on health will include a focus on the growing burden of NCDs. One of the major challenges for the MDG successors is that they are being created during a serious global economic crisis, which is likely to reduce the amount of overseas development assistance available.

There are many uncertainties surrounding the development agenda post-2015, with many different concerns competing for inclusion. Nurses are encouraged to clarify their perspectives on what should follow and to find ways of engaging in the national and international consultations.

- NNAs are well placed to maintain the momentum, inform, advise, encourage and support nurses and to act as a conduit for the flow of information from grassroots to government. NNAs have an opportunity now to energise their members and focus their efforts on achieving the MDGs and seeking to influence the post-2015 agenda.
- NNAs are encouraged to align their priorities with existing frameworks and strategies and to forge partnerships, networks and alliances at every level with those who seek a common outcome. Nurses are encouraged to enhance their knowledge and skills so that they can



contribute effectively at every level from community engagement to international policy-making, including service delivery, education, research and management, as well as policy development and implementation.

- Nurses can engage in advocacy and lobbying from the personal/professional to the policy/systems levels. The international focus of the MDGs helps ensure that that nurses and others can strengthen links with appropriate international advocacy groups.
- The MDGs have provided a clear global focus for action and resource allocation. In contributing to their achievement, nurses have developed political skills to enable them to negotiate at every level and with various partners to shape and deliver appropriate services including for the most marginalised and underserved communities. Nurses have also shown great flexibility, innovation and courage in shaping and developing new roles and services.

In the run-up to 2015, nurses are encouraged to break through barriers and challenges to deliver the MDGs and meet the health needs of the poorest, most marginalised and underserved communities in the world. As they engage in the new agenda, it will be important to continue to work towards the achievement of all MDGs in every country and to ensure that the progress that has been made is not lost as the focus and resources shift. Regardless of the extent of the explicit focus on health in the new agenda, it is important to remember that health underpins future global development. The changing disease burden and the effects of climate change on health, development and environmental sustainability demand that nurses everywhere rise to the challenge and engage in shaping and delivering the new agenda for the health and wellbeing of the global community.



# Chapter 1

## Understanding the MDGs

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### Introduction to the MDGs

In 2000, the United Nations adopted the Millennium Declaration (UN 2000) – an affirmation of the commitment to the founding principles of the United Nations, and a rededication to a peaceful, equitable and environmentally sustainable world. Part III of the Declaration was entitled ‘Development and poverty eradication’ – and from this, the Millennium Development Goals were drawn up, and presented to the United Nations General Assembly in September 2001 (UN 2001).

The eight MDGs have come to represent an unprecedented level of consensus – even considered to be an ‘ethical imperative’ (Hulme and Fukuda-Parr 2009, p.3) – and were a turning point in the international community’s approach to poverty reduction. Unlike many earlier international development efforts, the MDGs take a holistic approach to reducing poverty – the Goals cover not only income poverty reduction per se, but also education, gender equality, health and environmental sustainability, and the need for a ‘global partnership for development’ that will facilitate the delivery of these aims. Without tackling all these angles simultaneously, sustainable reductions in poverty cannot be achieved. The MDGs are indicative of a shift towards a more people-centred (rather than purely economy-centred) approach to development, aided by the end of the Cold War, during which much international aid had been geo-politically motivated.

The MDGs consist of eight goals, backed up by 18 targets, and beneath that a set of indicators to measure the targets. The targets are quantitative, global and time bound – the aim was to achieve all the MDGs by 2015, taking 1990 levels as the baseline for progress. Three of the goals – numbers 4, 5 and 6 – are specifically related to health:

Goal 1: Eradicate extreme poverty and hunger

Goal 2: Achieve universal primary education

Goal 3: Promote gender equality and empower women

**Goal 4: Reduce child mortality**

**Goal 5: Improve maternal health**

**Goal 6: Combat HIV/AIDS, malaria and other diseases**

Goal 7: Ensure environmental sustainability

Goal 8: Develop a global partnership for development

In 2005, the cost of achieving the MDGs in all countries was estimated by the UN Millennium Project to be in ‘the order of \$121 billion in 2006, rising to \$189 billion in 2015’. (UN 2005, p.56).

### Example of Goal, targets and indicators

#### Goal 4:

Reduce **child mortality**

#### Target 4a:

Reduce by two-thirds the mortality rate among children under five

#### Indicators:

4.1 Under-five mortality rate

4.2 Infant mortality rate

4.3 Proportion of one-year-old children immunised against measles

## Linking the Goals

An important premise of the MDGs is that reducing poverty is dependent upon tackling a wide range of social issues, such as education, women's empowerment and environmental sustainability. These synergies between Goals are particularly relevant when addressing health. Focusing simply on Goals 4, 5 and 6 is not sufficient: the others all play a key role in improving the health of populations. For example, maternal and child health is linked with the education of girls (UN 2012a, p.28); good health cannot be achieved where there is limited access to clean water or where the environment is damagingly polluted; and children born into poverty are almost twice as likely to die before the age of five as those from wealthier families (UN 2012a, p.28).

## Progress on the MDGs

The MDGs have, in many ways, been strikingly successful. They superseded a number of earlier attempts to establish international development goals (for example, by the Organisation for Economic Co-operation and Development), and their simplicity, clarity, measurability and clear time horizon have led to their universal acceptance by international organisations, governments and NGOs. Annual reporting on progress is highlighted each year by the media, which can also be a driver of action: as Dr Margaret Chan, Director General of the World Health Organization, said in her inaugural address in 2007, 'What gets measured gets done.' (Chan 2007). The MDGs have acted as a rallying point for international donors, driving major development aid and investment. The United Nations continues to stress the importance of the MDGs – all member states strongly recommitted to achieving the Goals in 2010, and discussion is now beginning on a post-2015 framework (see chapter 4).

Progress towards the MDGs is reported to the UN annually by individual countries, and the results are collated in an annual UN *Millennium Development Goals Report*. There have been a number of successes:

- Estimates indicate that in 2010 the share of the world's population living on less than \$1.25 a day fell to less than half of its 1990 value – projected to be 883 million in 2015, compared with 1.4 billion in 2005 and 1.8 billion in 1990 (although 17 countries are far from reaching the Goal) (UN 2012a; World Bank 2011).
- The target to halve the proportion of people without access to drinking water has also been reached – falling from 24 percent in 1990 to 11 percent in 2010 (UN 2012a, p.52).

- Worldwide, there are now 97 girls enrolled in primary school for every 100 boys, up from 91 per 100 in 1999 – and enrolment of primary-school age children has risen significantly in sub-Saharan Africa, from 58 percent to 76 percent between 1999 and 2010 (UN 2012a, p17).

However, progress has been patchy: there are significant inequalities across and within regions and countries, and many of the MDGs are still to be achieved, with progress stalling – or even deteriorating – in some places. In sub-Saharan Africa, for example, the proportion of people living on less than \$1.25 remains at 47 percent, 27 percent are still undernourished, and both maternal and child mortality remain very high – child mortality has fallen by less than one third, significantly less than the two-thirds target (UN 2012a). Chapter 2 of this report highlights the variability in progress made in achieving the health MDGs.

In a positive sign, some countries have begun a ‘process to transform the MDGs into a floor instead of a ceiling for human development’ (UNDP 2005, p3) – explicitly building on the existing MDGs to foster further progress. Thailand, for example, which already achieved many of the MDG targets by 2004, has set new targets – such as extending the goal of universal education from primary to upper secondary education and reducing income poverty to less than 4 percent (Office of the High Commissioner on Human Rights OHCHR 2010, p.8). This demonstrates the capacity for extending, adapting and strengthening the areas covered and the targets set – this is particularly important where assistance has been so focused on achieving the MDGs that other areas (such as non-communicable diseases) may have received little attention (see section 1.4).

## Criticisms and challenges

The MDGs have brought coherence and unification to international development efforts – but they have also been criticised on a number of fronts.

One of the main criticisms has been the lack of focus on equity in the MDGs.

- There is huge variation between regions and countries – but the MDGs do not take account of this, as they are global goals. Seeing the MDGs as ‘one size fits all’ ignores the specific economic, geographical and political challenges faced by individual countries, and detract from what may have been very considerable progress, given the specific context.
- If a country sets a target to achieve the level of development set out in the MDGs, the incentive is to deal with the section of the population that is most easily helped to achieve the requisite level. This can leave the most deprived without the help they most need – a breach of the human right to an adequate standard of living for these most vulnerable populations (OHCHR 2010, p.10).
- There is risk of diversion of new resources away from issues not mentioned in the MDGs (often affecting the poorest), focusing only on areas that are specifically mentioned. For example, neglected tropical diseases have received little attention, with just 0.6% of overseas development aid for health being spent on these diseases, which affect one billion people (*The Lancet* 2010).

A further criticism is that targets may not have been set at the right level – notably the target on reducing the proportion of the population living on less than a dollar a day. This has been adjusted to \$1.25 – and the Goal may be reached globally. But \$1.25 is still extremely low, particularly given rises in oil and food prices in recent years (OHCHR 2010).

Demographic changes may also affect the Goals. For example, the target to improve the lives of at least 100 million slum dwellers has been reached – more than 200 million have improved water,

sanitation or housing (UN 2012a, p.56). However, more people than ever are living in slums: an estimated 863 million, up from 650 million in 1990 (UN 2012a, p.56). Changes in population demographics – such as ageing populations – and the shift from rural to urban dwelling are also affecting society in ways that impact upon poverty reduction and health.

The brevity of the MDGs means that a number of issues were omitted. Notably, MDG 6 specifies tackling only a small number of (infectious) diseases: HIV/AIDS, malaria and TB. However, the majority disease burden of many low- and middle-income countries has now dramatically shifted from infectious diseases to non-communicable diseases (NCDs) such as cardiovascular disease, cancer, diabetes and chronic lung disease – driven by changes in lifestyles and an ageing population. But because the major NCDs are not specifically mentioned, they are often sidelined by donors – even though a significant proportion of cases of diseases such as type 2 diabetes and heart disease could be prevented or delayed, and early detection and good treatment of NCDs can greatly reduce complications (UN 2011, p.5). Mental health is also not a specific focus of the health-related MDGs – yet mental health issues are estimated to cost the global economy \$16 trillion between 2010 and 2030 (WEF/Harvard 2011, Table 14, p.29) as well as the suffering it causes to individuals and families.

The omission of NCDs from the MDGs is crucially significant because the MDGs form the framework and goals for investment in international development’  
Dr Fiona Adshead, former director of chronic diseases and health promotion, WHO

In addition, there is no focus in the MDGs on countries’ governance, the functioning of which is essential for international development – for example, laws to ensure contract enforcement or to control corruption. There are no quantitative, time-bound targets in Goal 8 (on partnerships), which limits their effectiveness (Hulme and Fukuda-Parr 2009, p.23) – for example, no specific level set for development aid. Such explicit partnership targets could provide an opportunity for national nurses associations to engage in a more focused way and to influence other groups and organisations.

A recent challenge to the achievement of the MDGs has been the economic crisis and recession affecting much of the developed world, which has impacted upon the ability – and will – of some wealthier nations to provide aid to developing countries. The Dutch government, for example, cut its foreign aid from 0.8 percent of gross national income to 0.7 percent – and the effects of economic crises on aid levels have lasted for years in the past (World Bank 2011, p.128; World Bank 2009, p.9). The UN Secretary General in the *Millennium Development Goals Report 2012* focused particularly on the impact of the crisis on MDG 8 (establishing and maintaining partnerships): ‘The current economic crisis besetting much of the developed world must not be allowed to decelerate or reverse the progress that has been made.’ (UN 2012a, p.3)

## **2015: the Countdown**

The MDGs are time-bound: to be achieved by 2015. In just a couple of years, the MDGs will need either to be extended or replaced with a new set of Goals, targets and indicators. Whatever supersedes the existing MDGs should balance comprehensiveness and comprehensibility, and would do well to address criticism of the existing MDGs. Work on this has already begun, and is likely to be linked with efforts to develop a world-wide set of ‘sustainable development goals’ (see chapter 4).

## **Introduction**

While all eight of the MDGs have an impact on health, goals 4, 5 and 6 refer specifically to health issues. This chapter will consider the progress that has been made to date in meeting these goals, targets and indicators, highlight some of the strategies and identify some of the underlying challenges in efforts to achieve each goal.

## **MDG 4: Reduce child mortality**

**Target: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate.**

**Indicators:**

- Under-five mortality rate
- Infant mortality rate
- Proportion of one-year-old children immunised against measles

### **What progress has been made?**

The vast majority of all child deaths are attributable to a relatively small number of conditions: neonatal causes (40 percent); pneumonia (18 percent); diarrhoea (10 percent); malaria (10 percent); HIV/AIDS (2 percent); and measles (1 percent) – added to which, under-nutrition is a contributing factor in over 30 percent of child deaths globally. The leading causes of neonatal deaths are complications of preterm birth, intra-partum-related events, sepsis and meningitis, and stillbirths (WHO/UNICEF 2012, p.16).

And there have been significant successes. Despite population growth, there has been a huge reduction in global deaths among children under age five, from over 12 million in 1990 to 7.6 million in 2010. Progress in the developing world as a whole has accelerated, and the mortality rate declined by 35 percent, from 97 deaths per 1,000 live births in 1990 to 63 in 2010 (UN 2012a, p.26).

The chart below provides a regional assessment of progress towards the achievement of the Goal to reduce child mortality by two-thirds (UN 2012c). It works on two levels:

- the shade of the box indicates either whether the target will be met or exceeded by 2015 if trends continue (grey) or whether progress is insufficient to reach the target (white); and
- the words in each box indicate the current levels of mortality.\*

	Africa		Asia				Oceania	Latin America & Caribbean	Caucasus & Central Asia
	Northern	Sub-Saharan	Eastern	South-Eastern	Southern	Western			
<b>Reduce mortality of under-five-year-olds by two thirds</b>	Low mortality	High mortality	Low mortality	Low mortality	Moderate mortality	Low mortality	Moderate mortality	Low mortality	Moderate mortality

\* Low mortality indicates <40 deaths per 1,000 live births; moderate mortality 40–80; high mortality 80–150; very high mortality >150.

For example, Northern Africa has already achieved the target and Eastern Asia, too, has shown a significant decline. However, sub-Saharan Africa has achieved a reduction of only around 30 percent – less than half that required to reach the target: 82 percent of under-five deaths – 6.2 million – occur in sub-Saharan Africa and Southern Asia (UN 2012a, p.26).

There are also individual countries that have made significant progress between the baseline of 1990 and 2010, for example (UN 2012a, p.27):

- countries including Bangladesh, Nepal and Madagascar have recorded declines of at least 60 percent in deaths among the under-fives; and
- countries including Niger, Malawi and Sierra Leone have seen deaths per 1,000 live births brought down by over 100.

These successes help demonstrate that substantial progress really is possible.

### **What progress still needs to be made?**

A number of challenges remain.

- Particular attention needs to be focused on the increasing proportion of deaths occurring in the neonatal period, to ensure progress in reducing overall child mortality.
- Poverty continues to play a huge role in determining the survival rate in children under the age of five.
- Educating and empowering women and ensuring access to basic services as well as critical care services to the poor is essential to promote equity and reduce child mortality.
- Improved, skilled care at birth is an essential requirement to reduce preterm and intrapartum stillbirths; and the interventions to address these are also effective in improving other maternal and newborn outcomes (WHO/UNICEF 2012, p.17)

### **What strategies have been used?**

Nurses and good health care play a key role, as the majority of the 7.6 million child deaths that occur each year could be prevented using effective and affordable interventions. These interventions include: care for newborns and their mothers; optimal breastfeeding practices and adequate nutrition and immunisation; hand washing with soap and access to improved water and sanitation



facilities; malaria control; and prevention and care of HIV/AIDS. Lifesaving treatment options after a child becomes ill include case management of pneumonia (including antibiotics for bacterial pneumonia) and oral rehydration salts and zinc for diarrhoea. In countries with high mortality, these interventions could reduce the number of deaths by more than half – nurses are essential in advocating for, shaping and delivering these interventions (WHO/UNICEF 2012, p.18).

WHO promotes four main strategies that are complemented by interventions for maternal health – in particular, skilled care during pregnancy and childbirth, for example by family health nurses – an example of the integrated nature of the response required:

- appropriate home care and timely treatment of complications for newborns;
- integrated management of childhood illness for all children under five years old;
- expanded programme on immunisation (see box);
- infant and young child feeding.

#### **Progress: measles**

Improvements in immunisation have resulted in a 74 per cent reduction in global measles mortality, from an estimated 535,300 deaths in 2000 to 139,300 in 2010. Sub-Saharan Africa has made the most progress, with an 85 per cent drop in measles deaths during this period (UN 2012a, p.29). The increased proportion of one-year-olds immunised against measles was achieved through improvements in routine measles immunisation, large-scale immunisation campaigns and supplementary immunisation activities designed to reach children who do not have access to existing health services.

Other strategies include the development of a global action plan to scale up proven interventions and increase commitment to addressing diarrhoea and pneumonia (WHO/UNICEF 2012, p18).

#### **Underlying challenges**

##### *Neonatal mortality*

Mortality is not being reduced uniformly. Reductions in neonatal mortality – the first month after birth – lag behind survival gains among older children. Although, globally, neonatal deaths fell from 32 per 1,000 live births in 1990 to 23 in 2010, sub-Saharan Africa has recorded the least improvement over the last two decades, and suffers a higher neonatal mortality rate (35 deaths per 1,000 live births in 2010) than any other region (UN 2012a, p.27). Faster reductions in neonatal mortality are critical for achieving MDG 4 (WHO/UNICEF 2012, p.13).

##### *Inequity*

As discussed in chapter 1, one of the criticisms of the MDGs is that they are not equity focused so, for example, a country as a whole could achieve MDG 4, despite many of the most needy populations continuing to suffer from very high rates of childhood mortality. There are significant rural–urban disparities: children from rural areas in developing regions are less likely to live beyond their fifth year, and children from the poorest 20 percent of households are nearly twice as likely to die before their fifth birthday as children in the richest 20 percent of households.

In addition, mothers' education is a powerful determinant of inequity, with children of educated mothers – even mothers with only primary schooling – more likely to survive than children of

mothers with no education (UN 2012a, p.28). This also shows the importance of taking a holistic approach to achieving the MDGs – improving education and empowering women impacts upon the health of the next generation.

### *Infectious disease*

Pneumonia and diarrhoea are major killers of young children, across the developing world. Approximately 90 percent of deaths among children from these two diseases were in sub-Saharan Africa and South Asia, and the five countries in which the greatest number of deaths occurs are India, Pakistan, Nigeria, the Democratic Republic of the Congo and Ethiopia (WHO/UNICEF 2012, p.18).

Despite some progress (see box above), an estimated 19.1 million children – many of whom are the poorest and most marginalised, living in hard-to-reach areas – have not been immunised against measles: coverage levels in sub-Saharan Africa and Southern Asia have not yet reached 90 percent. Worryingly, reported measles cases, after decreasing from 2000 to 2008 and remaining stable in 2009, rose in 2010, with large outbreaks reported in Africa, the Eastern Mediterranean, Europe, Eastern and South-Eastern Asia, and Oceania (UN 2012a, p.29).

### *Under-nutrition*

Under-nutrition – inadequate energy or micronutrient intake – increases the risk of death and ill-health in the prenatal period and throughout infancy and childhood. Wasting (low weight for height) in children under five is a reliable indicator of acute food insecurity and a wasted child is at more immediate risk of death than a stunted child. Stunting (low height for age) prevalence is also a critical indicator of progress in child survival, reflecting long-term exposure to poor health and nutrition, especially in the first two years of life. In many developing countries, more than a third of children are stunted, particularly those in the poorest populations. This can also have serious implications in later life – when children are malnourished in their early years (particularly before the age of two), this can impact upon educational achievement, which can lead to lower income as an adult, perpetuating poverty across the generations.

## **MDG 5: Improve maternal health**

**Target: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio**

**Indicators:**

- Maternal mortality ratio
- Proportion of births attended by skilled health personnel

### **What progress has been made?**

The number of women who die during pregnancy or childbirth has decreased by nearly 50 percent globally since 1990 – from 543,000 to around 287,000. In developing regions, the number of maternal deaths per 100,000 live births – the maternal mortality ratio (MMR) – has fallen from 440 in 1990 to 240 in 2010: Eastern Asia had the lowest level in the developing regions, with an MMR of 37. But for every woman who dies, approximately 20 others suffer injuries, infections and disabilities (WHO/UNICEF 2012, p.13).

The chart below provides a regional assessment of progress towards the achievement of the Goal, focusing on the targets to reduce the maternal mortality ratio by three-quarters and increase access to reproductive health (UN 2012c). It works on two levels:

- the shade of the box indicates either whether the target will be met or exceeded by 2015 if trends continue (grey), whether progress is insufficient to reach the target (white), or whether data is insufficient (black); and
- the words in each box indicate the current levels of maternal mortality\* and access to reproductive health.\*\*

	Africa		Asia				Oceania	Latin America & Caribbean	Caucasus & Central Asia
	Northern	Sub-Saharan	Eastern	South-Eastern	Southern	Western			
Reduce maternal mortality by three quarters	Low mortality	Very high mortality	Low mortality	Moderate mortality	High mortality	Low mortality	Moderate mortality	Low mortality	Low mortality
Access to reproductive health	Moderate access	Low access	High access	Moderate access	Moderate access	Moderate access	Low access	High access	Moderate access

\* Low maternal mortality indicates <100 maternal deaths per 100,000 live births; moderate mortality 100–200; high mortality 200–500; very high mortality >500.

\*\* Low access to reproductive health (contraceptive prevalence rate – percentage of women aged 15–49, married or in union, using contraception) indicates <40%; moderate access 40–65%; high access >65%.

### What progress still needs to be made?

Very significant challenges remain in tackling maternal mortality.

- *Regional inequalities:* The MMR in developing regions remains 15 times higher than in developed regions: a woman in Chad has a 1 in 15 chance of dying from a maternal cause during her lifetime and a woman from Afghanistan has a 1 in 32 chance, compared with 1 in 3,800 for a woman in a developed country (WHO/UNICEF 2012, p.13).
- *Sub-Saharan Africa:* 85 percent of maternal deaths in 2010 were in just two regions: sub-Saharan Africa (with 56 percent of maternal deaths; an MMR of 500) and Southern Asia (29 percent): 245,000 in total. In addition, sub-Saharan Africa also had the largest proportion (10 percent) of maternal deaths attributed to HIV: over 90 percent of the 19,000 AIDS-related indirect maternal deaths annually are in sub-Saharan Africa (UN 2012a, p.31).

### What strategies have been used?

The antenatal and postnatal periods, as well as delivery, are important times for reaching women with interventions and information that promote health, wellbeing and survival of mothers as well as their babies. Skilled health professionals (doctors, nurses or midwives) can prevent and manage life-threatening complications such as heavy bleeding, or refer the patient to a higher level of care when needed.

- Antenatal coverage – at least one visit with a doctor, nurse or midwife – has progressively increased in developing regions from 63 percent in 1990 to 71 percent in 2000, and then to 80 percent in 2010 (UN 2012a, p.32).
- In developing regions overall, the proportion of deliveries attended by skilled health personnel rose from 55 percent in 1990 to 65 percent in 2010. However, fewer than half of births in sub-Saharan Africa and Southern Asia are attended by skilled health personnel.

Increased access to safe, affordable and effective methods of contraception has contributed to improvements in maternal and infant health by preventing unintended or closely spaced pregnancies. Use increased rapidly from 1990 to 2000 in many regions, but since then the pace of progress has tended to slow.

- More than half of all women aged 15 to 49 who were married or in a union were using some form of contraception in 2010 in all regions except sub-Saharan Africa and Oceania. Women in sub-Saharan Africa had the lowest level of contraceptive prevalence – just 25 percent, which is below the 1990 level of other regions (UN 2012a, p.35).

Where unsafe abortions occur (see below), comprehensive post-abortion care for women is important to address complications and ensure access to contraception. Skilled nurses and health workers, appropriate pain-control management, follow-up care including identification and treatment of bleeding or infection, removing health worker stigma for caring for women after an abortion, and increasing and improving family-planning counselling and services are all necessary components (WHO & UNICEF 2012, p.20).

- The WHO estimates that 75 percent of unsafe abortions could be avoided, were the need for family planning fully met (WHO/UNICEF 2012, p.19).

### **Underlying challenges**

Many of the underlying challenges to improving maternal health are exacerbated by a lack of family-planning services and obstetrical, antenatal and postnatal care challenges, which nurses are well placed to help address.

#### *Very early childbearing*

Very early childbearing is associated with extra health risks for mothers and their infants. In countries where marriage at a young age is relatively common, developing and implementing culturally sensitive programmes to delay the age at marriage and enacting and enforcing laws concerning a minimum age for marriage could assist in further reducing adolescent childbearing (UN 2012a, p.34).

In developing regions as a whole, the number of births per 1,000 women aged 15 to 19 years decreased between 1990 and 2000. Since that time, the rate of decline has slowed or even reversed in most regions. However, sub-Saharan Africa continues to have the highest birth rate among adolescents (120 births per 1,000 adolescent women), with little progress since 1990, and the adolescent birth rate also remains high in Latin America and the Caribbean.

### *Antenatal care*

Where marriage at a young age is relatively common, developing and implementing culturally sensitive programmes to delay the age at marriage and enacting and enforcing laws concerning a minimum age for marriage could assist in further reducing adolescent childbearing.

There has been progress in most regions in meeting the WHO recommendation of at least four visits for antenatal care (including, at a minimum, screening and treatment for infections and identification of warning signs during pregnancy). However, almost half of pregnant women in developing regions still did not have the recommended number of visits and the quality of care provided during visits needs attention (UN 2012a, p.33). In addition, there are significant differences in coverage within regions: Southern Africa reported almost universal coverage in 2010, but in West Africa about one third of pregnant women did not receive antenatal care visits.

### *Specific conditions*

Haemorrhage and hypertension together account for more than half of maternal deaths, and sepsis and unsafe abortion combined account for 17 percent. Obstructed labour and anaemia are classified by WHO as contributing factors rather than direct causes of death. Indirect causes, including deaths due to conditions such as malaria, HIV/AIDS and cardiac diseases, account for about 20 percent, which reinforces the need to take a comprehensive rather than a vertical approach in addressing health-related MDGs (WHO/UNICEF 2012, p.16).

### *Unsafe abortions*

Unsafe abortions (i.e. abortions performed by someone who lacks the necessary skill or in an environment that does not meet minimum standards) cause severe infections, bleeding and organ damage. Each year, unsafe abortions result in the deaths of 47,000 women, and temporary or permanent disability among an additional five million women, almost all in developing countries

According to the Inter-Agency Group for Safe Motherhood, 'Unsafe abortion is the most neglected – and most preventable – cause of maternal death-' (WHO/UNICEF 2012, p.20).

## **MDG 6: Combat HIV/AIDS, malaria and other diseases**

**Target: Have halted by 2015 and begun to reverse the spread of HIV/AIDS**

**Indicators:**

- HIV prevalence among pregnant women aged 15-24 years
- Condom use rate of the contraceptive prevalence rate
- Condom use at last high-risk sex
- Percentage of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS
- Contraceptive prevalence rate
- Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years

**Target: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it**

**Target: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases**

**Indicators:**

- Prevalence and death rates associated with malaria
- Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures
- Prevalence and death rates associated with tuberculosis
- Proportion of tuberculosis cases detected and cured under DOTS (internationally recommended TB control strategy)

### **What progress has been made?**

Although there is significant regional variation, there have been some successes in tackling the diseases in MDG 6.

#### *HIV/AIDS*

- Fewer people are becoming infected with HIV, with the rate of decline happening faster in some countries than in others. Annual new infections in 2010 – 2.7 million people, 390,000 of whom were children – were 21 percent lower than the 1997 peak and 15 percent lower than in 2001.
- At the end of 2010, an estimated 34 million people were living with HIV, up 17 percent from 2001 (UN 2012a, p.39). This persistent increase reflects the continued large number of new infections along with a significant expansion of access to life-saving antiretroviral therapy (ARV), which has transformed HIV from a death sentence to a manageable chronic disease, allowing people to lead full and active lives.
- The number of people dying of AIDS-related causes fell to 1.8 million in 2010, down from a peak of 2.2 million in the mid-2000s. A total of 2.5 million deaths have been averted in low- and middle-income countries since 1995 due to the introduction of ARV (UN 2012a, p.39). In 2010,

6.5 million people were receiving ARV, increasing by almost 20 percent to 8 million in 2011 (UNAIDS 2012, p.9) – but, as noted below, there is still a long way to go.

### *Malaria*

There have been significant reductions in the number of reported cases of malaria, with many countries achieving a reduction of over 50 percent between 2000 and 2010 (UN 2012a, p.42).

### **Tuberculosis**

Globally, incidence rates of tuberculosis peaked in 2002 and have been falling since then. The absolute number of new cases has also started to fall, although very slowly. If current trends continue, the world will achieve the target of halting the spread and beginning to reverse the incidence of the disease (UN 2012a, p.44).

The chart below provides a regional assessment of progress towards two aspects of achieving of the Goal: halting and reversing HIV/AIDS and tuberculosis (UN 2012c). It works on two levels:

- the colour of the box indicates either whether the target will be met or exceeded by 2015 if trends continue (grey), or whether progress is insufficient to reach the target (white), or whether there has been no progress or deterioration (black); and
- the words in each box indicate HIV incidence\* and TB mortality.\*\*

	Africa		Asia				Oceania	Latin America & Caribbean	Caucasus & Central Asia
	Northern	Sub-Saharan	Eastern	South-Eastern	Southern	Western			
Halt and begin to reverse the spread of HIV/AIDS	Low incidence	High incidence	Low incidence	Low incidence	Low incidence	Low incidence	Low incidence	Low incidence	Low incidence
Halt and reverse the spread of TB	Low mortality	High mortality	Low mortality	Moderate mortality	Moderate mortality	Moderate mortality	High mortality	Low mortality	Moderate mortality

\* Low HIV incidence indicates <0.05 new HIV infections per year per 100 people aged 15–49; intermediate incidence 0.05–0.25; high incidence >0.25.

\*\* Low TB mortality indicates <8 deaths per year per 100,000 population; moderate mortality 8–29; high mortality >29.

## HIV/AIDS

### *What progress still needs to be made?*

There are significant regional variations (UN 2012a, p.39).

- Sub-Saharan Africa accounted for 70 percent of new HIV infections in 2010, while it is home to just 12 percent of the global population. However, the rate here varies widely, as the epidemic continues to be most severe in Southern Africa.
- The Caribbean has the second-highest regional HIV incidence, although the growth of the epidemic has slowed considerably since the mid-1990s.
- HIV incidence and prevalence is substantially lower in Asia than in some other regions. But the absolute size of the Asian population means it has the second largest number of people living with HIV.
- In contrast to other regions, new HIV infections continue to grow in the Caucasus and Central Asia.

The proportion of women living with HIV has remained stable at 50 percent globally, although women are disproportionately affected in sub-Saharan Africa (59 percent of all people living with HIV) and in the Caribbean (53 percent) (UN 2012a, p.39).

The 2010 target of universal access to anti-retroviral therapy was missed. More than 50 percent of eligible people in sub-Saharan Africa are still not receiving anti-retroviral therapy (UN 2012a, p.42), although Botswana, Namibia and Rwanda have already attained universal access, covering at least 80 percent of the population in need (UN 2012a, p.42).

### *What strategies have been used?*

The main strategies to meet the goals and targets have included education and awareness raising, behaviour change, counselling and testing, improved care and increased access to treatment. Nurses have been actively involved in the delivery of these key strategies in collaboration with a wide variety of national and international partners. In many countries, the establishment of services to meet the HIV/AIDS epidemic has revolutionised accessibility and delivery of health services, with increased community involvement and task shifting across the health workforce.

Maternal health programmes are an important access point for women to testing and services and to the prevention of mother-to-child transmission. There are no comparable entry points for men. Without treatment, about one third of children born to women living with HIV will become infected in the womb, at birth or through breastfeeding, and the risk can be greatly reduced by treating an expectant mother with antiretroviral medicine.

Media campaigns and the use of new communication technologies have been successful in increasing knowledge and changing behaviour (including among adolescents), especially when complemented with sex education and through the use of novel communication techniques such as embedding messages in TV dramas.

### *Underlying challenges*

Accessibility and affordability: Accessibility and affordability of diagnosis and lifelong treatment remains a major challenge in many developing countries. As more people benefit from antiretroviral therapy, there is increasing concern about the possible increase in HIV drug resistance. HIV mutates



rapidly and, since treatment is intended to be lifelong, more drug-resistant strains of the virus seem likely to emerge.

Barriers to behaviour change: At the level of the individual, knowledge and understanding are key to behaviour change and uptake and use of HIV services including HIV testing. However, cultural and religious factors may determine the extent to which individuals, groups and populations are prepared to follow medical advice and change behaviour – for example in the use of condoms or monogamous relationships. Securing political commitment to address the epidemic has been more challenging in some countries than others. Also, where women are not empowered to take control of their own health, tackling the spread of HIV/AIDS can be particularly challenging – for example, where women do not have access to, or cannot insist on the use of, condoms.

Discrimination: Stigma and discrimination remain widespread and can manifest in different ways – inappropriate comments, breaches of patients' confidentiality, delay and refusal of testing and treatment, and social isolation. This can reduce the uptake of interventions such as counselling and testing, including among pregnant women, which further endangers the health of their babies. Nurses can make a significant contribution to fighting stigma and discrimination using the tools and techniques described in the ICN 2003 International Nurses Day Kit – *Nurses: Fighting AIDS Stigma, Caring for All* (ICN 2003).

## **Malaria**

*What progress still needs to be made?*

Despite the falls in malaria in many regions, it is insufficient to meet the MDG target. Africa continues to be most badly affected, accounting for 81 percent of malaria cases and 91 percent of malaria deaths. 86 percent of these deaths were among children under the age of five (UN 2012a, p.42).

*What strategies have been used?*

The main strategies to fight malaria include use of insecticide-treated mosquito nets (ITNs), indoor residual spraying (IRS), rapid diagnosis and increased access to artemisinin-based treatment. Successful implementation of these strategies has required significant education and behaviour change among families and health professionals – for example, in promoting the use of ITNs, particularly for children and pregnant women – and changing services to facilitate rapid diagnosis and access to appropriate treatment.

*Underlying challenges*

Despite the progress that has been made and the opportunities to achieve more successful outcomes, spending on malaria, domestically and internationally, is inadequate for prevention and control.

In addition, there is increasing concern about growing resistance to artemisinins and to insecticides. Without proper attention and management, this poses a grave threat to future progress.

## **Other diseases**

*Tuberculosis*

MDG 6 provided an opportunity to focus on other diseases as well as HIV/AIDS and malaria and, of these, tuberculosis has been subject to particular attention, not least because of its relationship with HIV/AIDS.

It is estimated that in 2010 there were 12 million people living with tuberculosis, 8.8 million people worldwide were newly diagnosed (including 1.1 million cases among people with HIV), and there were 1.4 million deaths (including 350,000 people with HIV) (UN 2012a, p.44).

Although, as noted above, the increase in incidence rates is slowing, there is clearly no room for complacency. It is estimated that more than one third of new cases still go unreported and over 84 percent of the estimated 290,000 cases of multi-drug-resistant tuberculosis in 2010 were not being diagnosed and treated according to international guidelines. Moreover, many tuberculosis patients do not know their HIV status, but may well be HIV-positive, and accordingly not yet accessing antiretroviral therapy. (UN 2012a, p.45)

### *Sidelined disease burdens*

Concerns have been raised that the specific focus of MDG 6 on HIV/AIDS, malaria and tuberculosis may have led to other equally pressing disease burdens being sidelined in terms of focus and access to resources. These include the neglected tropical diseases – a group of parasitic and bacterial infections that affect over 1.4 billion mainly poor people causing physical distress and impairment and making it impossible for many to escape the cycle of poverty (*The Lancet* 2010).

Another group of diseases that have not received the attention and resources they require are non-communicable diseases (NCDs), primarily cardiovascular disease, chronic lung disease, type 2 diabetes and cancer. The rise in these diseases, much of which is preventable, requires urgent attention, as this double disease burden of communicable and non-communicable diseases will place an unmanageable and unsustainable pressure on health systems across the developing and developed world. In recognition of this, a United Nations High-level Meeting on the Prevention and Control of Non-communicable Diseases – only the second such meeting to be held on the subject of disease (the first being in 2001 on HIV/AIDS) – was held in New York in September 2011 (C3 Collaborating for Health 2011). Mental health is also a cause of a large proportion of the global health burden, which also receives relatively little attention and funding, given the impact that it is projected to have on individual families, communities and economies (WEF/Harvard 2011).

## **Summary**

The health related MDGs have helped to focus attention on the need for health systems to be underpinned by robust financing mechanisms; a well-trained and adequately paid workforce; reliable information on which to base decisions and policies; well-maintained facilities; and logistics to deliver quality medicines and technologies. These are prerequisites if countries are to meet the needs of their populations and provide appropriate services when and where they are needed. National nurses associations may be well placed to contribute to and monitor progress within their health systems; to support and lobby for improvements where necessary; and to hold their governments to account.

In seeking to address the MDGs, indicators and targets, the importance of integrated services and a comprehensive approach has been emphasised – for example, providing a quality and appropriate service for a HIV-positive pregnant woman impacts on all three of the health-related MDGs and is also associated with many of the other MDGs. Similarly, it is possible to speed up the decline in under-five mortality by expanding interventions that target the main factors, along with ensuring education, empowering women, removing financial and social barriers to accessing basic services and making critical services more available to the poor.

Working together to achieve the MDGs also provided people from all sectors, including nurses, with opportunities to develop the knowledge and skills to engage in multi-sector, multi-partnership working.



### **The nursing contribution**

There have been major successes over the past decade in improving the knowledge and skills of nurses to enable them to make a significant contribution towards the achievement of the health-related MDGs. Nurses are often the only health professionals accessible to many people in their lifetime and across the care continuum, and so are particularly well placed and innovative in reaching underserved and disadvantaged populations. This chapter will highlight some of the contributions that nurses have made globally towards the achievement of the MDGs and will consider how the MDG Acceleration Framework (UNDP 2011) could be used by nurses to focus their activities and stimulate and guide further progress.

#### **International Council of Nurses**

The International Council of Nurses (ICN) has made a significant contribution towards achievement of the MDGs, not just those specifically related to health – a testament to the importance of adopting a holistic and comprehensive approach to global health, wellbeing and development. ICN has been actively engaged in influencing policies and programmes globally and has participated in decision-making forums as well as international meetings and events. ICN initiated the following programmes, all of which are described on ICN's website.

In collaboration with the Florence Nightingale International Foundation, ICN established The Girl Child Education Fund in 2005 aimed at keeping orphaned daughters of nurses in sub-Saharan Africa in school. To date, 316 girls in Kenya, Swaziland, Uganda and Zambia have benefited from this initiative, which as well as health benefits for the girls and their families also contributes to MDG 2 (achieve universal primary education) and MDG 3 (promote gender equality and empower women). Some of the benefits of educating girls include:

- greater participation in the work force and increased family incomes: for each additional year a girl is in school, her wages as an adult rise by approximately 15 percent;
- greater chance that their own children will be educated: children whose mothers have no education are more than twice as likely to be out of school as children whose mothers have some education;
- improved family planning;
- lower infant mortality: every day over 2,700 children under the age of five will die needlessly because their mothers were denied an education earlier in life;
- fewer maternal deaths in childbirth; and
- lower HIV/AIDS infection rates: rates are doubled among young people who do not finish primary school.

Working with governments, public- and private-sector partners and national nursing associations (NNAs) in the host countries as well as the NNAs in Sweden, Norway and Ireland, ICN has established six Wellness Centres for Health Care Workers, which provide HIV and TB prevention, treatment and care in a discreet setting, psychological counselling and stress management, non-communicable disease prevention and management, occupational safety training and continuing professional

development. As well as contributing to the achievement of MDG 6, this initiative has also contributed to the retention and support of the nursing workforce in Lesotho, Swaziland, Zambia, Uganda, Malawi and Ethiopia.

The ICN TB/MDR TB Project has made a vital contribution to MDG 6 by preparing over 1,000 nurses as trainers in 13 countries who, between them, have trained in the region of 30,000 other nurses and health workers, impacting on prevention, care and management globally. To complement this training, ICN offers an online programme 'Care, prevention and management of tuberculosis', which provides practical tools to nurses and those involved in caring for patients, families and communities affected by TB, including drug-resistant TB. The course is applicable for all settings, dealing with the challenges of providing care when resources are scarce and the workload is high. The course has a particular emphasis on providing good-quality patient-centred care in practice and is relevant to those wanting to update their knowledge as well as to experienced nurses working routinely with those affected by TB.

By providing updated nursing and health information to nurses in remote and rural areas, including those working with the poorest and most vulnerable in refugee settings, and those working in disaster-hit areas, the ICN/MSD Mobile Libraries have enabled thousands of nurses and health workers across sub-Saharan Africa and in other countries including Haiti and East Timor to provide appropriate care to children, mothers, families and communities, thereby helping to address MDGs 4, 5 and 6. To broaden the reach of the library, English, Portuguese and French versions have been established.

ICN has also developed and disseminated fact sheets, position statements and other publications to inform and guide nurses on related issues. These can be accessed via the ICN website: [www.icn.ch](http://www.icn.ch).

In contributing to the non-health-specific MDGs, ICN partnered with the private sector and NNAs in Kenya, Malawi and Uganda to promote access to safe water, a key issue in improving child health and achieving MDG 4.

In support of MDG 3 (promote gender equality and empower women), ICN lobbied actively as part of a wider campaign for the creation of a well-funded, dedicated UN agency to promote women's human rights and advance the worldwide struggle for gender equality, a campaign that saw the establishment in 2010 of UN Women.

As well as working together at the international level, nurses and midwives have also established regional groups to maximise their resources and input, such as the 15 countries who form the Southern African Network of Nurses and Midwives (SANNAM) and who have helped shape, inform and support the role of nurses in the prevention, care and management of HIV/AIDS across their region (see [www.sannam.org.za](http://www.sannam.org.za)).

In Northern Ghana, nurses were posted to community locations and helped reduce the childhood mortality rates by over half in three years. Nurses worked with chiefs and elders to help keep the customs of the traditional healers to increase the acceptance of more modern health technologies. This reduced parental health seeking delays and increased child survival. [Binka et al. 2007]

Nurses and community health workers in Malindi in Kenya reshaped outpatient clinic services to better meet the needs of HIV-positive patients who had also been diagnosed with tuberculosis, and a private nurse practitioner established a clinic in Kibera slum in Nairobi, where she provided a safe clean environment for delivery as well as providing ante natal and post natal and ongoing care to local mothers and children (ICN 2010)..

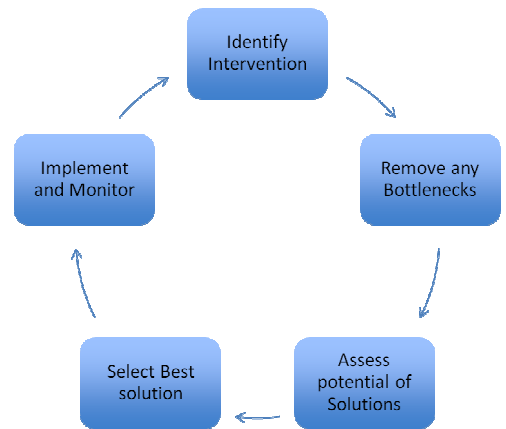
In Papua New Guinea, a nurse-led primary-health centre delivers services in a remote area with a high rate of HIV/AIDS. The nurses identified key local stakeholders (youth and women's groups and community leaders) in 14 villages to increase awareness about HIV/AIDS. They use shortwave radio services and community-based outdoors remote broadcasting systems and local newspapers to deliver health information and highlight services available. They also offer remote clinics in each village where they have set hours and days that they visit. They also conduct workshops on HIV/AIDS and work with the citizens on prevention and other health topics such as diabetes, hypertension, prenatal care and immunisations. (ICN 2008a)

Despite the wide-ranging contribution of nurses in many countries alluded to above and the many anecdotal descriptions of nursing activities, services and innovations designed to address the MDGs, the outcome of literature searches about the nursing contribution to the MDGs is disappointing and reinforces the importance of nurses promoting and publishing their work. This is not just in relation to the MDGs or nurses working in low-income countries. A recent Canadian Commission found that the value of nursing can be difficult to quantify and noted that even in systematic reviews and vigorous analyses, there tends to be too narrow a focus on the question 'does it work?' rather than 'who, with what characteristics, and under what circumstances, most benefits from nursing interventions...in what way do they benefit and at what cost?' That narrow 'does it work?' approach needs to be expanded to allow assessments of nursing that take into account all the factors that perpetuate problems or determine health (National Expert Commission 2012, p.31).

## **M**aximising future impact

The MDG Acceleration Framework (MAF) was developed in 2010 to provide a systematic framework which can be used collaboratively by a variety of stakeholders to help galvanise progress at country level with the MDGs which were not on track to be met by 2015 or where there was slow or uneven progress (UNDP 2011, p.5). The framework is based on the premise that with commitment, focus on the right interventions, and the right type and level of support the MDGs are achievable. It includes four systematic steps:

- 1) identify the interventions;
- 2) focus on the bottlenecks that are preventing the interventions from being implemented;
- 3) decide on the solutions; and
- 4) implement and monitor.



The Framework includes a comprehensive list of tested interventions and solutions that countries can adapt and use as they work their way through the four-step process. While the MAF was designed to complement and inform country plans, it could also be used by nurses to prioritise, focus, monitor and evaluate their activities and contribution towards achievement of the health-related MDGs.

The chart below includes some of the recommended solutions and interventions that are particularly amenable to nursing action and which are categorised here in terms of health systems strengthening; nursing practice; health promotion and disease prevention; and information sharing. These can be used by NNAs, nurse educators, service managers, and others to focus attention and energy and to link to existing initiatives and resources. Using an internationally recognised framework can help nurses articulate and describe their contribution to national and global health and development priorities.



	<b>MDG</b>	<b>Suggested interventions</b>
<b>Health systems strengthening</b>	4,5,6	Recruitment, reward, retention of health workers and protection of their health
	4,5,6	Education, training and capacity building for practice, management, research and development
	4,5,6	Monitoring and evaluation
<b>Nursing practice</b>	4	Integrated management of childhood illnesses
	4	Management of malnutrition and severe acute malnutrition
	4,6	Prevention, care and management of illnesses and diseases including diarrhoea, pneumonia, tuberculosis, malaria
	4,5	Antenatal, delivery, postnatal and neonatal care
	4	Breastfeeding promotion, support and education and support for safer infant feeding for HIV positive mothers
	4,5	Nutrition support and advice for infants, adolescents, pregnant women and nursing mothers, focusing particularly on local products
	4,5,6	Reproductive and sexual health services for men and women, including family planning
	4,6	Well baby checks and delivery of immunisation programmes including measles
	5	Emergency obstetric care and appropriate referral
	5	Abortion counselling to the extent permitted by law
	5	Skilled attendance, clean delivery, post-partum care
	5,6	Counselling – family planning, contraception, post-abortion, HIV
	5	Screening and treatment of sexually transmitted infections
	4,5,6	Prevention of mother to child transmission of HIV (PMTCT)
	4,5,6	Blood safety, injection safety, infection control and universal precautions
	6	HIV/AIDS care and treatment including palliative care
	6	Prevention, treatment, care and control of TB
	6	Integrated HIV/TB services
<b>Health promotion and disease prevention</b>	4,5,6	Behaviour change
	4,5,6	HIV counselling and testing
	4,5,6	Outreach health promotion and information programmes for disadvantaged populations (in terms of income, geography, gender, age, etc.)
	6	Information and education to address stigma and discrimination
	4,5,6	Age and culturally appropriate sex and reproductive health education and services
	6	Prevention and management of stigma and discrimination
	6	Promotion of the use of anti-mosquito bed nets
<b>Information sharing</b>	4,5,6	Monitoring of policies and practices
	4,5,6	Networking within and beyond the health sector
	4,5,6	Knowledge exchange
	4,5,6	Making content locally appropriate and accessible
	4,5,6	Appropriate use of new technologies



#### **The issue**

With two years to go before the MDGs reach their end, discussions as to their replacement are well under way – whether for an extension of the deadline, a new set of MDG-style goals, or a completely new system. The negotiations are already threatening to be highly complex, and their outcome is far from clear cut. There are potential dangers – that the new goals are overloaded (the new goals cannot be all things to all people); that they are too donor-centric (they are dominated by the priorities of actors from developed countries, rather than the priorities of those affected by the issues); or that they are too prescriptive (UN System Task Team 2012, p.33). However, this is a crucial opportunity to correct deficiencies in the existing MDGs and emphasise the priorities of the 21<sup>st</sup>-century world. Taking enough time – rather than rushing the process – will be essential if an acceptable, comprehensive solution is to be found.

#### **The ‘how?’: the process that will establish future Goals**

The United Nations is the body with the ‘impartiality, neutrality and global legitimacy’ to act as instigator and coordinator of the MDG successors (Vandemoortele 2012, p.14), so in 2011 the UN Secretary General began the task of assessing the MDG framework and investigating what should come next.

A UN System Task Team on the Post-2015 Development Agenda has been established, bringing together representatives of over 50 UN organisations and other international bodies (see Annex 3). The role of this Task Team includes the establishment of a ‘road map’ for establishing the post-2015 development agenda and, in particular, ensuring full input from stakeholders, including those in developing countries who are most affected by poverty and health issues of the MDGs. This is essential for legitimacy – the original Goals were criticised for having been largely designed behind closed doors, by experts. It is often the case the researchers and experts may ‘miss what matters to poor people’ (Sumner 2009) if their opinions are not canvassed. National consultations have already begun, and thematic consultations established (including on inequalities and on health), which will be key in developing the new framework.

In addition, a High-level Panel of 26 ‘eminent persons’ has been appointed – co-chaired by the UK prime minister and the presidents of Indonesia and Liberia – including representatives from developed and developing country governments, and civil society (UN 2012b). This Panel will advise the Secretary General, particularly around the process of developing Sustainable Development Goals (see below). (For a list of members, see Annex 3).

A further complication is that the discussions are taking place in the context of a much-changed world: developed countries are affected by economic crises, and there are global threats of climate change and human security – leading to the danger that the new framework will be ‘shock-driven’ (Green 2012). One suggestion is the inclusion of ‘a mechanism to review, and adjust, goals and targets mid-way to account for unforeseeable circumstances and ensure that goals remain relevant and appropriate’ (Overseas Development Institute 2012, p.9). Jan Vandemoortele, one of the architects of the original MDGs in 2001, has urged for combining the urgency of the issues with

caution in developing the MDG successors – what he describes as ‘hastening slowly’ (Vandemoortele 2009). Without getting the process right, the content will be irrelevant, as the Goals will fail to have the legitimacy they need to drive development into mid-century.

## **The ‘what?’: building on the lessons learned from the MDGs**

From the earliest days of the MDGs there has been discussion as to the issues that should, or could, be added to the development framework – and, despite criticism of the MDGs, building on them is seen as essential in setting targets beyond 2015. According to a recent UN Economic Commission for Africa survey in 32 African countries, the overwhelming majority of stakeholders agreed that the MDGs were ‘important development priorities’ for their countries and ‘should feature in the post-2015 agenda’ (Vandemoortele 2012, p.7). The strengths of the MDGs – their clarity, conciseness and measurability – should be retained to provide continuity, but there are also strong calls to integrate key issues that have been omitted.

### **Measuring progress**

Whatever form the replacement of the MDGs takes, progress must be measurable – ‘as long as disparities in human wellbeing are not adequately monitored and reported, societies are unlikely to address them’ (Vandemoortele 2012, p.35) – and governments must be held to account for failure to make progress. The timeline – probably with a data baseline of 2010 – must be long enough for achievement of real, transformative change – possibly 2030, or perhaps even 2050. The longer the timescale, the more achievable the goals – but this also weakens political will in the short and medium term, because the deadline is so far beyond the watch of current political leaders (UN System Task Team 2012, p.37). The setting of intermediate targets could help to overcome this ‘accountability deficit’ – perhaps acting as ‘quantitative goalposts’ on which world leaders would gather to report every five years (Vandemoortele 2012, p.28). Intermediate targets could also allow for adjustment or refinement of the long-term goals, to reflect changing global circumstances (such as climate change or new technologies).

One of the criticisms of the MDGs is that they have put a higher burden of achievement on countries with a low level of development – for example, cutting infant mortality by two-thirds has required the less-developed countries to make far greater absolute progress, as the initial baseline was so high. The recent report by the UN System Task Team has stated that a combination of relative and absolute benchmarks, allowing countries to demonstrate progress, even if they have not yet achieved the target itself, may be necessary to overcome this discrimination (UN System Task Team 2012, p.37). This would require a methodology that allows for the pace of progress to be measured, rather than just the level of achievement relative to the target (Fukuda-Parr 2012, p.13).

Regular reporting and accurate data will be required; data-gathering capacity needs to be strengthened in many parts of the world. Information also needs to be linked in better ways – for example, ‘development choices are often made without consideration of health effects’ (Haines 2012, p.2193). Improved data collection and assessment will enable progress towards health, sustainability and other goals to be better measured, and aid to be most effectively allocated. Although data availability has improved, it remains inadequate in many poor countries, and building capacity in those countries will require well-coordinated support from development partners and commitment of national government (UN 2012a, p.66).

## Equity

Among the most trenchant criticisms of the MDGs has been the failure of the goals – at macro (national or community) or micro (family) level – to take inequalities into account. Inequalities – and the ‘social determinants of health’ – have been increasingly highlighted in recent years, for example by the WHO’s Commission on the Social Determinants of Health, whose final report, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*, strongly called for action on inequality: ‘Achieving health equity within a generation is achievable, it is the right thing to do, and now is the right time to do it.’ (WHO 2008, p.iii).

Inequity can take different forms.

- At the national level, different countries have different starting points, but the MDGs are global, rather than local – hence, even where significant progress has been made in a country, the ‘failure’ to achieve a goal may be highlighted more than the relative (but significant) progress that has been made.
- At community level there is no incentive to prioritise the most underprivileged – among them the very poorest, slum dwellers, the unemployed, indigenous people and other ethnic minorities, and illiterate women (Vandemoortele 2012, p.11). Countries’ reports on their progress towards the MDGs often do not mention ethnic minorities: in 2007, ‘none of the MDG country reports gives consideration to minorities under each of the eight Goals’ (Human Rights Council 2007, p.2). Indeed, it has been argued that the MDGs may have served as an excuse to justify violations of human rights, such as forced evictions in slum clearance in South Africa. (The provincial law that led to this has since been struck down by the South African Constitutional Court) (OHCHR 2010, p.9).
- Inequalities may also be rife within families – for example, boys and men may be prioritised over girls and women when it comes to food distribution, and the way in which family income is spent may mask serious hardship among some family members. For example, in the Philippines, the poorest households spent more on tobacco in 2003 than on health, education and clothes combined (WHO 2009, p.6).

There are a number of proposed solutions to the failure to prioritise equity. Greater participation of disadvantaged groups in the negotiations on priorities for the future would be invaluable – as an example, the 1999 *Voices of the Poor* study (World Bank 1999) gathered feedback from over 60,000 poor people in 60 countries, and changed our understanding of poverty and its impact on people’s lives. This sort of participation can also help to tailor development targets to national and local circumstances. There is plenty of precedent for adapting the (global) MDGs to national realities – for example, Thailand has significantly extended the MDGs (‘MDG-Plus’) to include new targets and indicators (for example, on heart disease) as well as an explicit focus on inequality, which is now providing the framework for UN development work in the country (UNDP 2005). And there are other examples – Sri Lanka has set a goal for universal access to safe water by 2025, and Kenya and Malawi are introducing free primary education as a strategy (OHCHR 2010, p.11).

Disparities within countries are of increasing concern worldwide – the World Economic Forum now places ‘severe income disparity’ high on its list of Global Risk Factors (as a high risk to economies in terms both of likelihood and severity) (WEF 2012). Disaggregated monitoring of data can also highlight disparities in development within countries – data-collection techniques are improving, and could allow for this form of monitoring.

There is also an option for a separate target on inequality – although there is no single policy that can reduce inequality, so mainstreaming it throughout the development framework is more likely to be successful (Vandemoortele 2012, p.31) or global targets could focus specifically on the most

marginalised in society, for example, targets on reducing maternal mortality in the least-well-off quintile.

### **What is missing – and does it matter?**

One suggestion for bringing equity into the Goals is to incorporate human rights within the framework. Taking a ‘human rights approach’ (see e.g. Hamm 2001) to development would require governments and donors to consider everyone, particularly those at high risk of having their human rights abused. There are some rights that must apply to all (for example, the right to life), but others can be ‘progressively realised’, according to the capacities of the government – in other words, ratcheted up and not then allowed to slip backwards. The concern is that, currently, ‘If massive human rights violations are the method, no one is the wiser: the figures show “progress”.’ (Langford 2010, p.88).

Human rights are the subject of their own international treaties, which put non-discrimination at their heart, and cover ‘civil and political’ rights (such as the right to life and the right to a fair trial) and ‘economic, social and cultural’ rights (including rights to ‘the enjoyment of the highest attainable standard of physical and mental health’), with additional treaties for minorities and those at particular risk, such as children and women. There is considerable debate about which – if any – human rights should be explicitly brought into a new global development framework. The Millennium Declaration included issues around civil and political rights, for example, ‘promote democracy and strengthen the rule of law’ (UN 2000, para 24), but these were omitted from the MDGs. Indeed, some human rights seem to go further than the MDGs – such as the right to a free primary education (OHCHR 2010, p.3). Many human rights are linked, directly or indirectly, to health.

However, were all human rights to be explicitly included, there is a danger that the new set of targets will spiral out of control, becoming wholly unattainable in their effort to take all concerns into account. Human rights are already the subject of their own treaties, so perhaps it is better to see the targets and human rights as ‘complementary, not as substitutes’: ‘The overarching goals of the post-2015 agenda could be formulated using the language of human rights... Numerical targets could then be set as stepping stones towards the gradual realisation of these rights.’ (Vandemoortele 2012, p.27-8).

Human rights are not the only issue not incorporated within the MDG framework, and now clamouring for inclusion. For example, since 1990 the majority disease burden of many low- and middle-income countries has dramatically shifted from infectious diseases to non-communicable diseases. Between 2005 and 2015, in Africa it is estimated that deaths from NCDs will rise by 27 percent, and in SE Asia infectious disease deaths will fall by 16 percent and NCD deaths rise by 21 percent (WHO 2012). These diseases are driven by changes in lifestyle – unhealthy diets high in fat, salt and sugar; the harmful use of alcohol; low levels of physical activity; and smoking (WHO 2011, p.16). Much of the disease burden is preventable by tackling these risk factors – and, once the diseases have presented, there are many treatments available that can help to reduce the risk of complications. Good adult health is essential for economic development, and it is doubtful whether the MDGs could ever be achieved in their entirety without tackling this new burden of NCDs, when the economic, social and emotional consequences of the new epidemic are so great, and growing. And the biggest risk factor of all, tobacco use – estimated to have killed six million people in 2010, nearly 80 percent of whom live in low- and middle-income countries (American Cancer Society 2012, p.16) – is a clear candidate for a target. Some NNAs, including those in Malta, Panama, Slovenia and South Africa, are already informing and educating their members to address the NCD challenge (C3 Collaborating for Health 2010).

Other areas omitted from the MDGs include: free primary education, access to safe affordable water, explicit help for children orphaned by HIV/AIDS, reducing violence against women, fair trade, social

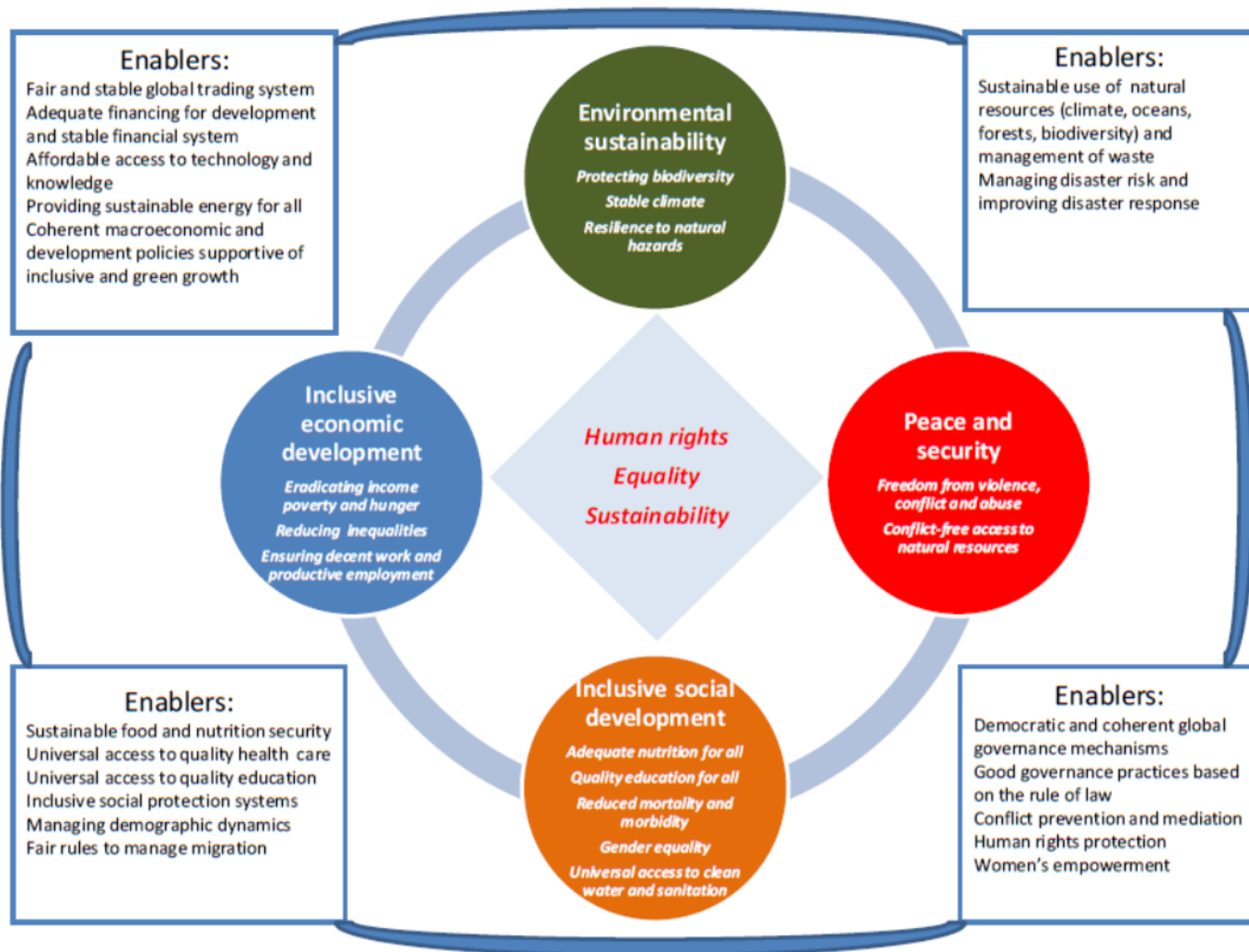
security, child labour (see, for example, Langford 2010, p.84). Some countries have already added targets to their MDG plans – Thailand has a target of universal upper secondary education by 2015, has an indicator around poverty in particularly deprived areas, and is measuring prevalence and death rates from heart disease (UNDP 2005, pp.8-9) – but the list of issues is seemingly endless, and is in danger of spiralling out of control. Within countries, nurses may have clear views about the gaps in the current Goals and the priorities for inclusion in the post-2015 Goals and NNAs can use national and international advocacy and lobbying and develop partnerships with other groups and organisations to ensure their voices are heard.

Finally, any new set of Goals will need to be future-proof. Demographics are changing fast, with rapidly ageing populations in many parts of the world and with the population heading for nine billion by 2050; food insecurity is becoming an increasing problem; insecurity and conflict – often driven by poverty and climate change – plagues much of the world, with threats of terrorism increasing; new technologies such as the internet lead to their own opportunities and challenges (lack of access to the internet is a new potential inequality); patterns of disease are changing, particularly towards non-communicable diseases and mental health issues; and finally climate change threatens fundamentally to change lifestyles and livelihoods of all on the planet. All these are calling for consideration in the new Goals.

## **Commitment: funding and partnership**

One of the major challenges for the MDG successors will be that they are being created during a serious global economic crisis. Even when economies were booming, pledges by developed countries have largely not been implemented – for example, a pledge made by the G8 countries in 2005 to double development aid to Africa (Fukuda-Parr 2012, p.5) was achieved by only a few countries. Overseas development assistance (ODA) remained at an average of just 0.31 percent of donor gross national income, despite a UN target of 0.7 percent – Africa received only about \$45 billion in 2010, \$16 billion less than the target (OHCHR 2010, p.15). There are continuing calls for this to increase, but it seems likely that the squeeze is going to get worse: previous banking crises have tended to see donor aid rising for a couple of years and then falling sharply, not returning to former levels for 15 years (World Bank 2009, p.9). This pattern may be being repeated – so it is unrealistic to expect a new set of development goals to be accompanied by substantial increases in ODA.

Perhaps, instead, it is time to look also at other ways of creating partnership and assistance, such as better reporting requirements, improved complaint mechanisms, better partnership with the private sector (building on MDG 8 on partnership), or new sources of revenue, such as increased royalties from natural resources or a financial transactions tax (Green 2012). As has been highlighted by the United Nations in relation to non-communicable diseases, development requires a ‘whole-of-society’ approach (UN 2011, para.33) – partnership across the board may be one of the most effective ways of delivering on the new commitments.



Although environmentalists were disappointed with the outcome from Rio (its notable failure to set a strong lead in tackling climate change), one positive outcome was that health was explicitly recognised in the outcomes document as ‘a precondition for, an outcome of, and indicator of ... sustainable development’ (Rio 2012, para.138). The ‘win-win’ of tackling health and environmental sustainability is increasingly recognised. For example, working to improve low-carbon technologies in developing countries could provide jobs and reduce pollution (both benefiting health), as well as leading to lower prices for energy, if an emissions-trading scheme on carbon is introduced (Institute of Development Studies 2009). Additionally, health benefits accrue from ensuring that cities facilitate ‘active travel’ (walking and cycling), which reduces pollution and increases physical activity (helping to reduce obesity and consequent non-communicable diseases).

An NGO – Beyond 2015 – is campaigning to influence the development of the post-2015 framework, including how the MDG successor goals link to the proposed SDGs (Beyond 2015 2012). It brings together over 300 civil-society organisations, and its website will be updated with the latest information, including on health issues, as negotiations progress: [www.beyond2015.org](http://www.beyond2015.org).



## **Conclusion: key challenges**

There are many uncertainties surrounding the development agenda post-2015 – not least how ‘sustainable development’ and ‘development’ will be brought together. Any new set of global goals must strike a balance between comprehensiveness and clarity – not so onerous as to be no longer credible, but not setting the bar so low as to be meaningless. The goals must be set in consultation with those who will be most affected, so participation of the most deprived must – as far as possible – be sought, and negotiations must be transparent and decisions accountable. Human rights language can help to frame the goals, and the human-rights concept of progressive realisation could be central. Finally, reporting mechanisms must allow for clear accountability, perhaps with interim targets set to ensure political will.

The task can seem vast and complex, requiring the juggling of many different, seemingly valid concerns, all competing for a place in a fast-changing, insecure post-MDG world. But this must not deter us from trying.



## Chapter 5

### Role of NNAs and nurses in achieving MDGs and for sustainability beyond 2015

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#### **M**aintaining the momentum

Nurses have done much – and can contribute even more – towards the achievement of the MDGs and to help shape and deliver sustainable goals and outcomes beyond 2015. From the individual nurse in a remote primary-care setting to leaders at national and international level, nurses work to deliver appropriate care and services, transform systems, environments and policies, and secure the resources and conditions necessary for improved health outcomes. To contribute to their full potential, nurses must be confident and bold in their contribution and willing to share, collaborate and build on progress and successes to date as well as learn from the initiatives, projects and programmes that have been less than successful, or indeed have had adverse or unintended outcomes.

National nurses associations (NNAs) are well placed to inform, advise, encourage and support nurses and act as a conduit for the free flow of information and communication from grassroots to government. NNAs provide a focus for nursing engagement within and beyond the health sector at national and international level. NNAs must continue to work with governments and others to strengthen health systems and create the conditions necessary to maximise the contribution of nurses including issues of understaffing, under-training and poor deployment.

The time is right for NNAs to re-energise their members and galvanise their efforts towards achieving the MDGs in the run-up to 2015, and to inform and position themselves to influence the post-2015 agenda.

#### **P**artnerships, networks and alliances

Too often nurses feel that their voices are not heard and that they are isolated and excluded from key structures, processes and decision making. However, the global, national and local focus on the MDGs provided many opportunities for partnership working and alliance building. ‘To avoid duplicative efforts and ensure sustainability of current progress, nurses need to align their strategies with the existing frameworks created by multilaterals such as the World Health Organization (WHO) and the UN.’ (Amieva and Ferguson 2012).

To enhance their offer in shaping policies, services and care NNAs are more likely to achieve successful, sustainable outcomes if they:

- work in partnership with other professions, groups and organisations and develop networks and strategic alliances;

- align with other frameworks and strategies locally, nationally and internationally to share a common focus, avoid overlap and highlight the synergies that can be achieved by combining activities towards a common outcome;
- use the WHO Nursing and Midwifery Services Strategic Directions 2011–2015 (WHO 2010) as a framework for broad-based collaborative action and to prioritise the areas in most need of technical assistance and capacity building within their countries to meet the MDGs, and collaborate with key partners and stakeholders to develop, implement, monitor and evaluate strategies and programmes of work;
- build on existing communication channels to keep members up to date on issues and developments and provide networking opportunities for them to share their efforts and experiences of improving care and services including solutions, successes, case studies of good practice and lessons learned;
- act as the focal point for international networking within the global nursing community and link grassroots members with national organisations and international agencies;
- encourage members to engage with global networks which promote exchange of information, ideas and experiences among the health community such as Health Information for All by 2015 (HIFA [www.hifa2015.org](http://www.hifa2015.org)) and Global Health Nursing and Midwifery ([www.ghdonline.org/nursing/](http://www.ghdonline.org/nursing/)); and
- create and take opportunities to work and partner with governments, NGOs, research and educational institutions and, where appropriate the private sector, donors and funders, as well as with other members of the multidisciplinary health team including midwives, doctors and community health workers, particularly as pressure increases to make as much progress as possible in achieving the MDGs by 2015.

## **Knowledge and skills**

For nurses to make an effective contribution, they need to know what to do and how to do it. This requires a wide range of knowledge, skills and competencies including skills in clinical practice and management; education and training; policy making, politics and influencing; research and development; and dissemination and use of evidence.

NNAs have an important role to play in addressing these issues and building the capacity and contribution of the nursing workforce. They can:

- interpret and disseminate information about MDG progress and priority actions in a local context, thus ensuring that nurses know about local and national progress and strategies and are enabled to engage appropriately;
- promote and develop innovative approaches to ensure that services are designed and delivered in sustainable ways that best meet the needs of local communities across the lifecycle and the care continuum, including those with disabilities who may have less access to health care services and more unmet health needs;
- make the best use of the available resources and workforce and expand the reach and coverage of nurses by appropriate task shifting and delivering services in new and different circumstances;
- collaborate with partners within and beyond their countries to develop and implement guidelines for evidence-based practice and demonstrate the impact by getting results on the ground;

- develop and implement competency-based education and training programmes at post-basic level, to address specific challenges related to achievement of the MDGs; and
- work with academic partners and others to contribute to the tracking and reporting of progress; generate evidence for health and policy options; and develop the evidence base on cost-effective nursing and midwifery services and their impact on the health-related MDGs.

## **Advocacy and lobbying**

Nurses can engage in advocacy and lobbying from personal/professional to policy change/system levels (ICN 2008b). The national and international attention that is focused on the MDGs provides many opportunities for nurses to take strategic actions to transform systems, processes and policies and influence decision-making by patients, communities, policymakers, governments and others. Furthermore, the international focus on the MDGs helps ensure that (even in countries where policy change is not likely to be achieved through direct advocacy by health professionals) nurses and others can strengthen links with appropriate international advocacy groups and seek to achieve change and improvement through such routes.

For any advocacy or lobbying activity to be effective, it is necessary to be clear about what the NNA is seeking to achieve, who it is trying to influence, as well as where and when NNA activities and approaches are most likely to have an impact.

The MAF referred to in chapter 3 identifies numerous specific clinical and non-clinical issues around which nurses and others can come together to implement and advocate. Advocacy campaigns can also address wider underpinning issues such as the social determinants of health including housing, education, water and sanitation, workforce shortages and imbalances within and between countries, whether due to economics, working conditions, security issues, training, migration or other causes. NNAs are particularly well placed locally and nationally to advocate and lobby for the resources required to carry out the work that needs to be done.

The ICN 10-step advocacy framework (ICN 2008b, p.11), which has been adapted below, can be used by NNAs, other nursing groups and individuals to help focus attention and secure progress on the achievement of particular goals, targets or indicators and can also be used to help influence the post-2015 agenda.

- 1) Take action – overcome obstacles to action; take on a variety of roles including representing, accompanying, empowering, mediating, modelling, negotiating and networking.
- 2) Select your issue – identify and draw attention to an issue that is important and achievable.
- 3) Understand the political context – identify the key people to influence; understand how and by whom decisions are made and how they are enforced, implemented and evaluated.
- 4) Build the evidence base – understand the issues and map the potential roles of relevant players including understanding supporters and opponents.
- 5) Engage others – win the support of key individuals/organisations; empower and support patients and communities to advocate on their own behalf.
- 6) Elaborate strategic plans – collectively identify goals and objectives and best ways to track progress and achieve them; secure small steps to achieve a long-term vision.
- 7) Communicate messages and implement plans – deliver simple, concise, tailored messages that include the action to be taken; counteract the efforts of opposing interest groups.

- 8) Seize opportunities – time interventions and actions for maximum impact; create or grasp opportunities.
- 9) Be accountable – monitor and evaluate progress and impact against clearly defined objectives.
- 10) Catalyse health development – build capacity throughout the process of strategic planning, networking, communicating, etc. to ensure sustainability.

## **C**onclusion

The MDGs have provided a clear global focus for action and resource allocation. In contributing to their achievement, nurses have developed political skills to enable them to negotiate at every level and with various partners to shape and deliver appropriate services including for the most marginalised and underserved communities. Nurses have also shown great flexibility, innovation and courage in shaping and developing new roles and services. While no system or approach is perfect – and some of the shortcomings of the MDGs have been discussed in earlier chapters – there are tremendous benefits to be gained from having a united focus.

In the run-up to 2015, nurses are encouraged to break through barriers and challenges to deliver the MDGs and meet the health needs of the poorest, most marginalised and underserved communities in the world.

As discussed in chapter 4, it is unclear what the post-2015 follow-up will look like. It will be important not just to engage in the new agenda but to continue to work towards the achievement of all MDGs in every country and to ensure that the progress that has been made is not lost as the focus and resources shift.

One thing is clear, however: health will be an essential element underpinning future global development, whether or not it is explicit in the new agenda. The changing disease burden and the effects of climate change on health, development and environmental sustainability demand that nurses everywhere rise to the challenge and engage in shaping and delivering the new agenda for the health and wellbeing of the global community.

### List of related ICN fact sheets

These can be found at [www.icn.ch/publications/fact-sheets/](http://www.icn.ch/publications/fact-sheets/)

- [Adherence to Long Term Therapy](#)
- [Antimicrobial Resistance](#)
- [Childhood Nutrition](#)
- [Going, Going, Gone: The Nursing Presence in the World Health Organization](#)
- [Health and Human Rights](#)
- [HIV/AIDS in the European Union](#)
- [Immunisation Safety: An Essential Nursing Function](#)
- [Immunisation Safety: Safe Waste Disposal Practices Save Lives](#)
- [Infection Control](#)
- [Mainstreaming a Gender Perspective into the Health Services](#)
- [Male Circumcision](#)
- [Maternal and Infant Nutrition](#)
- [Medication Errors](#)
- [Men's Health](#)
- [Mobilising Nurses for HIV/AIDS Prevention and Care](#)
- [The Nursing and Social Care Interface](#)
- [Nursing Sensitive Outcome Indicators](#)
- [Occupational Stress and the Threat to Worker Health](#)
- [Palliative Care](#)
- [The Paris Declaration](#)
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- [Positive Practice Environments](#)
- [Positive Practice Environments: Meeting the Information Needs of Health Professionals](#)
- [Poverty and Health: Breaking the Link](#)
- [Preventing Needlestick Injuries](#)
- [Provider-initiated HIV Testing and Counselling \(PITC\) in Health Care Facilities](#)
- [Selecting Safer Needle Devices](#)
- [Sexually Transmitted Infections](#)
- [Tuberculosis](#)
- [Tuberculosis Exposure in the Health Care Setting: Prevention of Occupational Transmissions](#)
- [The Vaccine Cold Chain: Maintaining Cool Links](#)
- [The WHO 'Treat 3 million by 2005' \(3x5\) Initiative](#)
- [Women's Health](#)





## List of related ICN Position Statements

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### A. Nursing roles in health care services

Antimicrobial resistance (2004)  
Breastfeeding (2004)  
Distribution and use of breast milk substitutes (2004)  
Elimination of female genital mutilation (2010)  
Health services for migrants, refugees and displaced persons (2006)  
HIV infection and AIDS (2008)  
Management of nursing and health care services (2000)  
Mental health (2008)  
Nurses' role in providing care to dying patients and their families (2006)  
Women's health (2012)

### B. Nursing profession

Assistive or support nursing personnel (2008)  
Continuing competence as a professional responsibility and public right (2006)  
Nursing research (2007)

### C. Socioeconomic welfare of nurses

Occupational health and safety for nurses (2006)  
Reducing the impact of HIV infection and AIDS on nursing and midwifery personnel (2008)  
Socioeconomic welfare of nurses (2010)

### D. Health care systems

Health human resources development (HHRD) (2007)  
Nurses and primary health care (2007)  
Nursing and development (2007)  
Participation of nurses in health services decision-making and policy development (2008)  
Patient safety (2012)  
Promoting the value and cost-effectiveness of nursing (2001)  
Publicly funded accessible health services (2012)

### E. Social issues

Falsified/Counterfeit medicines (2010)  
Health care waste: role of nurses and nursing (2010)  
Health information: protecting patient rights (2008)  
Informed patients (2008)  
Nurses, climate change and health (2008)  
Nurses and human rights (2011)  
Rights of children (2008)  
Universal access to clean water (2008)



## **The UN System Task Team on the Post-2015 Development Agenda and the High-level Panel of Eminent Persons**

### **UN System Task Team on the Post-2015 Development Agenda**

The UN System Task Team on the Post-2015 Development Agenda brings together representatives of over 50 UN organisations and other international bodies.

Its membership is:

- Department of Economic and Social Affairs (DESA), co-chair
- United Nations Development Programme (UNDP), co-chair
- Convention on Biological Diversity (CBD)
- Department of Public Information (DPI)
- Economic Commission for Africa (ECA)
- Economic Commission for Europe (ECE)
- Economic and Social Commission for Asia and the Pacific (ESCAP)
- Economic and Social Commission for Western Asia (ESCWA)
- Executive Office of the Secretary-General (EOSG)
- Food and Agricultural Organization of the United Nations (FAO)
- Global Environment Facility (GEF)
- International Atomic Energy Agency (IAEA)
- International Civil Aviation Organization (ICAO)
- International Fund for Agricultural Development (IFAD)
- International Labour Organization (ILO)
- International Maritime Organization (IMO)
- International Monetary Fund (IMF)
- International Organization for Migration (IOM)
- International Telecommunication Union (ITU)
- Joint United Nations Programme on HIV/AIDS (UNAIDS)
- Non-Governmental Liaison Service (NGLS)
- Office of the Deputy Secretary-General (ODSG)
- Office of the High Commission for Human Rights (OHCHR)
- Office of the High Representative for the Least Developed Countries, Landlocked Developing Countries and Small Island Developing States (OHRLLS)
- Office of the Special Advisor on Africa (OSAA)
- Peacebuilding Support Office (PBSO)
- United Nations Children's Fund (UNICEF)
- United Nations Conference on Trade and Development (UNCTAD)
- United Nations Convention to Combat Desertification (UNCCD)
- United Nations Educational, Scientific and Cultural Organization (UNESCO)
- United Nations Entity for Gender Equality and Empowerment of Women (UN Women)
- United Nations Environment Programme (UNEP)
- United Nations Framework Convention on Climate Change (UNFCCC)
- United Nations Fund for International Partnerships (UNFIP)
- United Nations Global Compact Office
- United Nations High Commissioner for Refugees (UNHCR)
- United Nations Human Settlements Programme (UN-HABITAT)

- United Nations Industrial Development Organization (UNIDO)
- United Nations International Strategy for Disaster Reduction (UNISDR)
- United Nations Institute for Training and Research (UNITAR)
- United Nations Millennium Campaign
- United Nations Office for Outer Space Affairs (UNOOSA)
- United Nations Office for Project Services (UNOPS)
- United Nations Office on Drugs and Crime (UNODC)
- United Nations Population Fund (UNFPA)
- United Nations Relief and Works Agency for Palestinian Refugees in the Near East (UNRWA)
- United Nations Research Institute for Social Development (UNRISD)
- United Nations System Chief Executives Board for Coordination Secretariat (CEB)
- United Nations University (UNU)
- United Nations Volunteers (UNV)
- United Nations World Tourism Organization (UNWTO)
- Universal Postal Union (UPU)
- World Bank
- World Food Programme (WFP)
- World Health Organization (WHO)
- World Intellectual Property Organization (WIPO)
- World Meteorological Organization (WMO)
- World Trade Organization (WTO)

Source: [www.un.org/millenniumgoals/pdf/Task%20Team%20member%20entities.pdf](http://www.un.org/millenniumgoals/pdf/Task%20Team%20member%20entities.pdf)

#### **High-level Panel of 26 'eminent persons'**

The High-level Panel of 26 'eminent persons' consists of:

Co-chairs:

- President Susilo Bambang Yudhoyono (Indonesia)
- President Ellen Johnson Sirleaf (Liberia)
- Prime Minister David Cameron (United Kingdom)

Other members:

- Fulbert Gero Amoussouga (Benin)
- Vanessa Petrelli Corrêa (Brazil)
- Yingfan Wang (China)
- Maria Angela Holguin (Colombia)
- Gisela Alonso (Cuba)
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- Gunilla Carlsson (Sweden)
- Emilia Pires (Timor-Leste)
- Kadir Topbas (Turkey)
- John Podesta (United States of America)
- Tawakel Karman (Yemen)
- Amina J. Mohammed, the Secretary-General's Special Adviser on Post-2015 Development Planning (ex-officio)

For biographical information on each, see the UN Secretary-General's Press Release, 31 July 2012:  
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