

# id21 insights

communicating international development research

## Responding to the health workforce crisis

**The shortage of health workers with the right expertise and experience has reached crisis levels in many developing countries. The ability of health services to deliver care depends on the knowledge, skills and motivation of health workers. Without enough skilled staff in the right place at the right time health systems cannot function effectively and populations are left without the treatment and support they need.**

The human resources (HR) crisis is now firmly on the international policy agenda. The work of the **Joint Learning Initiative** and the High Level Forum on Health has described the magnitude of the HR challenge, identified the key contributory factors and defined some of the potential solutions. As **Gilles Dussault** highlights in this issue of id21 insights, without coordinated action to address the HR crisis, health systems will not deliver the care required to meet the Millennium Development Goals (MDGs). There is an urgency to expand and upgrade the health care workforce through a rapid increase in staff numbers, skill enhancement and improvements in productivity.

### Challenges

The main challenges facing developing countries are familiar to any health sector manager or policymaker:

- The health sector workforce is large and diverse and comprises separate occupations often represented by powerful professional associations or trade unions who pursue their members' interests.
- Health systems tend to be characterised by a broad

range of active stakeholders, such as professional associations and different government departments, with a high level of direct and indirect governmental and regulatory intervention, and 'top-down' attempts at reform.

- Health is labour intensive. The proportion of the total expenditure spent on staff, at 60 to 80 percent, is much higher in health than in most manufacturing industries, and in many service industries.

Pressures on under-resourced health sector workforces are heightened by the impact of HIV/AIDS. Health workforces in parts of sub-Saharan Africa are hit by HIV related increases in workload, higher stress levels and increasing death and absenteeism rates.

### Responses

The workforce is the most important but also the least predictable aspect of planning and managing health systems. HR permeates every aspect of health care delivery, but has often been overlooked in health policy making – in the past it has often been an afterthought. This has now changed. The big challenge is no longer to advocate and demonstrate that HR is important, it is to implement HR policies that deliver more effective care.

Not all HR policy solutions will work equally effectively. For example, decentralisation is not in itself the answer. It brings with it the increased need for better management, as noted by **Tim Martineau**. Some solutions are only relevant for specific occupations or professions, while others may work in one health organisation, system or culture, but be inappropriate or ineffective in another. Some will have unintended consequences, as highlighted by **Ken Sagoe** from Ghana Health Services, where an attempt to improve staff retention by providing a financial incentive reportedly angered and distanced nurses.

### Recruitment and retention

Pay in some countries is insufficient to provide health workers with a living wage. Some workers have to resort to informal and unregulated work in public and private health sectors (dual practice), theft, or bribes from patients. Donor financial support, such as the UK Department for International Development funding to raise health workers' pay in Malawi, is an example of more direct donor action of the type that **Gilles Dussault** describes.

### Movement of health workers

Some health workers have sector-specific skills, but migrate from health sector employment in one country to a similar post in another country; while others move from the health sector to employment in other sectors. Health worker migration is a symptom of deeper issues linked to poor career opportunities where resources are limited, and inadequate planning and underinvestment in countries that are better resourced.

**James Johnson** argues that developed countries need to become self sufficient in meeting their own health workforce requirements, but the biggest English speaking health care labour market – the USA – will have to be involved in any initiative if



Community health volunteers in Nepal test materials developed for the distance education Radio Health Programme.

(© 2005 Buddhiman Shrestha/CCP, Courtesy of Photoshare)

► self-sufficiency is to work.

A more positive aspect of health worker migration, discussed by **Eldred Parry**, represents an opportunity for health workers from developed countries to make a contribution to developing countries. If well planned in cooperation with the destination country this can often provide additional specialised expertise and the individuals involved can experience personal and professional development.

Large scale 'volunteerism', however, with the temporary mobilisation of thousands of health workers from developed countries, is not necessarily the best use of resources, even in a crisis situation where immediate action is required. Resources may be better invested in training community health workers already in the country.

### The right skills in the right place

The HR crisis requires a creative response that sets aside old constraints and regulations. As **Dela Dovlo** discusses, using substitute health workers (SHWs) to take on the priority roles of health professionals, may be a time and cost-effective option. The use of SHWs, as in Tanzania and Mozambique, is most effective when they are matched to the best mix of skills and staff to deliver care using available resources for a population.

However, the primary purpose of using SHWs must not be to create workers

who cannot migrate because they have different or lower skills than required by international standards. The chances are some will migrate in any case: well qualified nurses from developing countries are working as unqualified care assistants in care homes in developed countries where their qualifications are not recognised. SHWs must be used where they make economic sense and have the right skills to make a quick and positive difference to health care delivery.

Even if they have the right skills, health workers are not always in the right place to make the most effective contribution. As noted by **Kasper Wyss**, the poor distribution of health workers aggravates the impact of staff shortages. This problem often reflects a situation where the best opportunity for a living wage is in urban areas and where any attempts at controlling staff location are compromised by poor management.

New approaches to motivating staff to move to or remain in rural areas can make a difference. To be successful however, any changes have to be linked to improved management practice, and the integration of paid employees who are either absent without leave or located elsewhere within the health system.

### Moving forward

Health HR policy making must open its eyes to good practice in other sectors. There is

strong evidence from research in some health systems, such as the USA, and other sectors such as manufacturing and finance, that coordinated human resource policy and practice can improve productivity and performance.

- There is a need to ensure that HR interventions fit the characteristics, context and priorities of the organisation in which they are to be applied.
- Coordinated interventions are more likely to achieve sustained improvements in HR practice than single or uncoordinated interventions. In the often politicised health sector this is an important message.
- A rapid and substantial injection of resources required to increase health workforces is critical to achieving the health MDGs. Yet it is not just about getting and keeping an adequate number of health workers to meet a target or comply with a plan: it is about supporting and motivating health workers to make the best use of their skills. The ultimate goal is not more health workers, it is better care ■

**James Buchan**

Queen Margaret University College, Clerwood  
Terrace, Edinburgh EH12 8TS, UK  
T +44 (0) 131 317 3600 F +44 (0) 131 317 3605  
jbuchan@qmc.ac.uk

## Stopping the migration of Ghana's health workers

**G**hana's health sector has lost many health care workers, including those migrating to other countries. Strategies aimed at keeping personnel have had varied results.

Health workers have left Ghana's health sector because of:

- limited opportunities for professional training and career development
- poor health care infrastructure
- low salaries
- family pressures and a desire for better living standards
- poor staff management.

The opportunity to work in a developed country's health sector has attracted many Ghanaian health workers because of:

- large numbers of health care vacancies
- higher salaries
- better training and career opportunities
- superior health infrastructure and resources
- proactive recruitment by health services
- poor human resource planning, including regulation loop holes, in the destination countries.

To address the loss of health workers from Ghana a number of strategies were developed and implemented with mixed results.

US\$ 2 million from the World Bank' has been invested in expanding health training. In the past six years, the numbers of newly trained health workers has increased significantly from 550 to 1,500 in 2004.

The retention of academic certificates and transcripts by government training schools has reduced migration. However, attempts to introduce this at universities met with opposition. Since the beginning of 2005 internships for doctors have increased from one to two years to retain newly qualified doctors. Junior doctors are unhappy and have threatened industrial unrest.

The introduction of the additional daily hours allowance for all health workers in 1999 followed industrial action in 1998 by doctors demanding salary increases. Whereas the allowance has motivated a small number of doctors to stay in Ghana, many nurses, who feel doctors have been unfairly favoured, have migrated.

A deprived area incentive allowance was introduced in 2004 without adequate consultation to encourage health workers to stay in deprived areas. The allowance is worth an additional 30 percent of a health worker's salary, but many feel it is too low.

A bilateral exchange arrangement with Jamaica's Ministry of Health and the UK's National Health Service (NHS) resulted in the loss of all exchange candidates to Jamaica and the UK. Since 1992, Ghana has had to temporarily recruit Cuban health workers. There are currently 222 Cubans on two year placements in Ghana and in the upper east region there are three times as many Cuban

as there are Ghanaian doctors.

Some policies may have inadvertently aggravated the migration problem, such as the additional duty hours allowance and the subsequent emigration of nurses. Policy responses must be coordinated to deal with this complex problem.

Policy lessons include:

- Political commitment and leadership are crucial for successful policies. Investment in training would not have happened without the leadership of recent Ministers of Health.
- The decentralisation of health service functions, the empowerment of local staff and the recognition of local issues are critical if retention strategies are to be successfully implemented and supported by health workers.
- All human resources policy decisions must be informed by clear evidence and broad consultation with all key stakeholders, including professional associations. The deprived area incentive scheme and the additional duty hours allowance are well intended policies that have not been supported by professional groups.
- International bilateral agreements for managing migration are unlikely to be effective unless they are backed by internationally enforceable conventions instead of limited ethical codes of practice ■

**Ken Sagoe**

Human Resources Development Division, Ghana Health Service, P.M.B. Ministries, Accra, Ghana  
kensagoe@yahoo.co.uk

# Committing donors to building health workforces

**A major report from the Joint Learning Initiative suggests that donors can support the growth and better performance of health workforces in developing countries by providing technical support and mobilising adequate financial resources.**

Donors committed to the health Millennium Development Goals (MDGs) are responsible for helping to build the health workforces needed to meet the needs of developing countries. This means not only adding to and better distributing available staff, but also:

- improving the quality of initial education and lifelong training
- creating a motivating work environment
- putting in place a policy framework that sustains a stable and performing workforce.

Donors must first recognise the problems, as most have done recently, and commit to helping countries to address the multiple and interconnected workforce problems facing the health sector.

There is a danger that donors' actions will harm health workforces further, for example, through the promotion of programmes that:

- drain staff from health services or add to already heavy workloads

## Human resources for health Overcoming the crisis

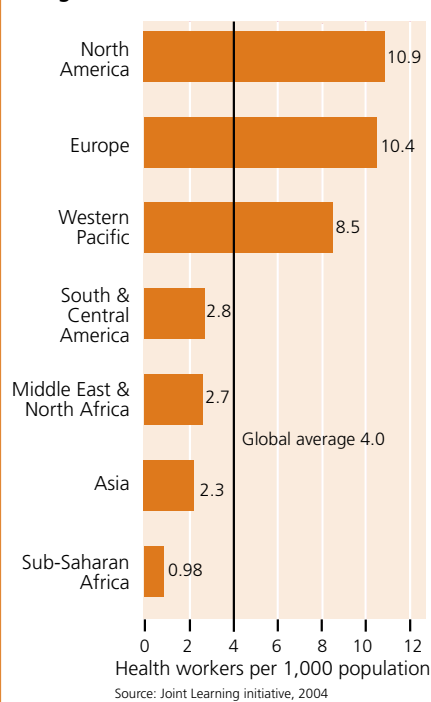
Health system weaknesses mean that death rates are rising and life expectancy is falling in the poorest countries, despite the global health advances of recent years. Health workers hold the key to tackling these challenges. But urgent action is needed to improve the supply, capacity and distribution of the global health workforce.

A report by the Joint Learning Initiative, an enterprise involving over 100 global health leaders, estimates that there are 100 million people working in health care worldwide. This includes 24 million doctors, nurses and midwives, plus many more informal, traditional, community and allied workers. However, there is still a global shortage of at least four million workers. Health workers are overburdened as a result and face additional challenges from three major sources:

- HIV increases their workloads, exposes them to infection and lowers their morale.
- Labour migration is accelerating from countries that can least afford the brain drain.
- Two decades of health sector reform has led to chronic underinvestment in human resources.

Countries can accelerate health gains by investing in and managing their health workforce. This includes recruiting, training

The global distribution of health workers



- recruit, or poach, scarce national staff from general services
- resist contributing to recurring funding needs, such as salary increases.

Also, donor countries should not try to solve their own recruitment problems by importing developing countries' best staff.

Instead donors should coordinate their interventions, such as training and

and retaining health professionals to produce a labour force that meets their populations' needs and redistributing health workers to rural and marginal communities. Improving work environments through better resource management and incentive systems would also boost health worker morale and performance.

The researchers conclude that effective workforce strategies can boost health service delivery, even under difficult circumstances. Recommendations for policymakers include:

- promoting community engagement in recruiting and retaining health workers and monitoring their performance
- managing transnational flows of health workers to harness the potential for workforce development
- delivering international assistance appropriately in the poorest countries
- tailoring national workforce plans to local needs
- delegating core health functions to well-trained community-based auxiliary workers in crisis situations
- building a culture of evidence-based knowledge.

### Piya Hanvoravongchai

Global Equity Initiative, Harvard University, 1033 Massachusetts Ave., Cambridge, MA 02138, USA  
T +1 617 998 0167 F +1 617 998 0173  
phanvora@hsph.harvard.edu

### See also

*Human resources for health: overcoming the crisis*, report of Joint Learning Initiative, 2004  
[www.globalhealthtrust.org/](http://www.globalhealthtrust.org/)

production of technical guidelines, as well as reporting and accounting procedures, as they have committed to in adopting the Rome Declaration on Harmonisation of Aid in February 2003. A recent OECD report suggests that progress is slow but that coordination improves as donors move from a project to programme approach, like sector-wide approaches (SWAP) increasingly preferred in the health sector. Further to this they should:

- Help create capacity, at individual, organisational, and institutional levels, and enhance a country's autonomy in meeting its health workforce needs.
- Give access to technical support to assist the production of national strategies to strengthen the health workforce and health system. This includes making sure that good data and analytical work is available to inform these strategies on costs of scaling-up, fiscal impact, labour market dynamics, and effective practices in planning, training, and performance management.
- Support, politically and technically, the insertion of health workforce policies in Poverty Reduction Strategies and other national policy documents.
- Guarantee the continuity, flexibility, and transparency of their financial support. Health workforce expansion will take time, and developing countries are more likely to succeed if they can rely on long term support.
- Substantially boost their financial contribution to meet the costs of providing populations with equitable access to well trained, motivated, and performing health workers.

Neglecting health workforce problems has prevented people in developing countries from accessing health services. Donors can change that, and now is the time to start ■

### Gilles Dussault

World Bank Institute, 1818 H Street, NW, Washington, D.C. 20433, USA  
T +1 202 473 8709 F +1 202 614 1137  
gdussault@worldbank.org

### See also

*Human resources in health: overcoming the crisis*, report of the Joint Learning Initiative, 2004  
[www.globalhealthtrust.org](http://www.globalhealthtrust.org)  
*Incentives for harmonisation in aid agencies*, report by ODI for OECD, 2005  
[www.oecd.org/dataoecd/61/32/34609836.pdf](http://www.oecd.org/dataoecd/61/32/34609836.pdf)

## The scale of the health workforce crisis

- The World Health Organisation estimates that one million more health workers are needed in sub-Saharan Africa to deliver the health MDGs.
- In Bangladesh 40 percent of doctors are absent from large clinics, whilst the rate rises to 74 percent at smaller health centres with a single doctor.
- In 2001, Chad had only 205 doctors to treat a population of over 8 million.
- In Mali there were only 1,785 nurses and midwives in 2001 for more than 12 million people.



## Tackling international health worker recruitment

Billions of dollars have been invested in efforts to prevent the spread of HIV and other diseases in the world's poorest countries. Yet at the same time, qualified health workers are leaving the same areas to work in the world's richest countries.

Despite having the resources to do so, the English speaking developed countries have historically failed to produce enough medical and nursing staff to meet their health care demands. In the USA there is a projected deficit by 2020 of 200,000 doctors and 800,000 nurses. Instead of growing their own staff, developed countries have actively acquired them from already depleted developing country health workforces.

The USA employs over 50 percent of all English speaking doctors in the world, whilst Mozambique, with a population of 20 million, has only 500 doctors. In 2004, over 12,000

health workers were recruited from overseas to work in the NHS.

The UK Government has led the way in establishing a code of ethical recruitment and the National Health Service (NHS) no longer actively poaches staff from developing countries. However, remaining loop holes mean that the code does not currently include non-public sector providers, and still allows the free movement of internationally sourced staff from privately run UK facilities into the NHS.

Putting an end to the direct recruitment of staff from developing countries is only a short term solution and does not tackle the underlying root causes in developed countries. This will require the implementation of clear and explicit commitments to meet health care needs for the next 20 years and should include:

- All countries must strive to achieve self-sufficiency in their health care

workforce without generating adverse consequences for other countries.

- Developed countries must assist developing countries to expand their ability to train and retain physicians and nurses, to enable them to become self-sufficient.
- All countries must ensure that their health care workers are educated, funded and supported to meet the health care needs of their populations.
- Action to combat the skills drain in this area must balance the right of populations to good health with other individual human rights.

### James Johnson

British Medical Association, BMA House, Tavistock Square, London WC1H 9JP, UK  
T +44 (0) 20 7387 4499 F +44 (0) 20 7383 6400

### See also

International activities at the BMA  
[www.bma.org.uk/ap.nsf/Content/Hubbmainternationalactivities](http://www.bma.org.uk/ap.nsf/Content/Hubbmainternationalactivities)

## Filling the gaps Introducing substitute health workers in Africa

**Massive shortages in trained health care professionals in sub-Saharan Africa have led to an examination of substitute health workers as an immediate response to the workforce crisis.**

For many countries these substitute health workers (SHWs) are not new. They already play various minor roles in health services, especially in rural and deprived areas.

In Tanzania, Malawi and Mozambique, assistant medical officers are used as substitutes for doctors. They perform surgery and a variety of other tasks. Ghana uses community health officers to improve access to health care and Ethiopia is planning large numbers of health extension workers.

Resistance from the health professions, such as doctors and midwives, to retain their status limits the numbers of SHWs trained and the roles that they are

assigned. In the 1980s and 1990s many countries in sub-Saharan Africa, led by the professions, banned the training of enrolled nurses which restricted the numbers available.

Given the shortage of personnel available to respond to priorities such as antiretroviral treatment, the World Health Organisation estimates that sub-Saharan Africa urgently needs up to one million more health workers to be able to meet the health Millennium Development Goals. This urgency suggests that substitutes have a critical role to play.

SHWs are trained for specific roles, may not be internationally tradable and are more easily retained within the country. Other possible advantages of SHWs are:

- Training of SHWs can be easier and faster than for specialist staff. Training for assistant medical officers in Mozambique and Malawi takes half the time of that for doctors. All training is local and practical, whilst academic entry requirements are lower. Training also costs less. In Ghana it costs US\$12,000 to train a SHW compared to US\$ 60,000 for a doctor.

- Many SHWs accept postings and are likely to remain in rural and deprived areas. They may relate better with communities by being less elitist and more integrated. In Tanzania 75 percent of SHWs work in rural areas.
- Pay and incentives for SHWs are lower than for the staff they are replacing.

**Two Kenyan health workers in the video 'Haki Yako' ('It's Your Right'), the story of a couple who seek family planning after the birth of their second child.**

However, there may be disadvantages to SHWs:

- Quality of care may suffer with poor clinical decision-making or limited supervision of SHWs. Increasing the numbers of SHWs may mean a similar expansion in the numbers of professional supervisors.
- SHWs may neglect ethical issues whilst practice regulation can be absent. In Tanzania a medical board regulates training but not practice.
- The potential lower costs may be offset by poor treatment. In Ghana medical assistants often give the wrong doses of drugs to treat malaria.
- Eventually SHWs demand pay and incentives similar to the staff they replace. Conflict between professions and demotivation may occur.

The use of SHWs needs to be investigated so further evidence can be obtained. For SHWs to be a sustainable solution:

- The skepticism and resistance of the traditional professions must be tackled.
- SHWs must receive support and supervision. In-service training is needed to reinforce correct practice and to develop a culture of ethics and leadership.
- Significant new investment in SHWs training facilities is required.

Given the rising emigration of health workers, the use of SHWs should be sustained and planned to fit a country's health workforce needs. SHWs should be allowed to progress, acquire more advanced skills, be entrusted with more complicated tasks, and eventually even qualify as health care professionals ■

### Delanyo Dovlo

PO Box CT5203, Cantonments, Accra, Ghana  
[dovlod@yahoo.com](mailto:dovlod@yahoo.com)

### See also

*Using mid-level cadres as substitutes for internationally mobile health professionals in Africa. A desk review,* Human Resources for Health 2(7), by D. Dovlo, 2004  
[www.human-resources-health.com/content/2/1/7](http://www.human-resources-health.com/content/2/1/7)



© 1994 John Ribber, Courtesy of Photoshare)

# Finding the answers to Chad's health workforce crisis

**With a population of more than 8 million, Chad has around 3,600 health workers: 50 percent of these are unskilled, and 35 percent are nurses and midwives. Chad also faces geographical imbalances in the distribution of health professionals, with approximately half working in the capital N'Djamena.**

Massive shortages of qualified health workers are recognised by the Chad authorities to be a primary 'bottleneck' for the development of the health sector. Policies have been implemented which prioritise human resource development. However, more coherent policies are needed, particularly to improve motivation and retention.

The easiest option in the short-term for increasing the health workforce is to integrate currently unemployed personnel. In Chad the size of the unemployed health workforce is unknown but it is estimated that in recent years nearly all newly trained health personnel have been integrated into the health service, so there may not be a significant pool of unemployed personnel.

Hiring health personnel with specific skills from other countries with an excess supply is another option. Neighbouring countries such as Niger report similar shortages and job vacancies. Chad has temporarily hired around 100 Cuban health workers, most of whom are physicians. However, this strategy requires good financial and other incentives to attract them to Chad, and is likely to only partially lessen health workforce shortages. Moreover there are

only a limited number of countries with a surplus and most countries in sub-Saharan Africa encounter similar problems as Chad.

Investing in training institutions is likely to be the most sustainable approach in the mid-term. However, this would involve collaboration across different ministries and strategic agreement on priority areas for training. It would also take several years for trainees to become qualified.

Improving performance would help

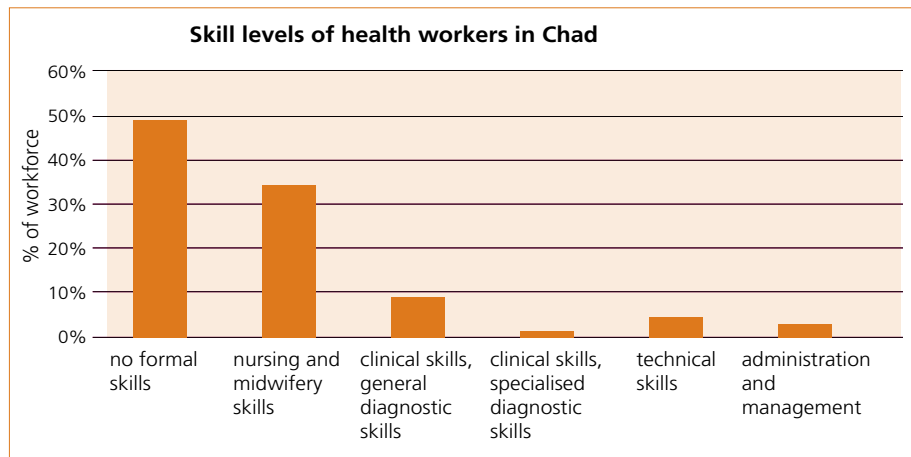
tackle the need for additional health workers. In Chad, at least 30 percent of staff time is spent on unproductive activities such as waiting for patients or simply being absent from the service without explanation. A productivity increase would reduce the need for more staff. Introducing performance assessment and offering decent working conditions would be effective approaches. At present there are no policy initiatives in this direction. Policies to improve motivation and retention should be prioritised ■

**Kaspar Wyss**

Swiss Centre for International Health, Swiss Tropical Institute, Socinstrasse 57, CH-4002 Basel, Switzerland  
kaspar.wyss@unibas.ch

**See also**

*An approach for classifying human resources constraints for achieving health-related Millennium Development Goals, Human Resources for Health 2(11), by K. Wyss, 2004*



Source: Ministry of Health Chad and Swiss Tropical Institute, 2003

## Decentralising health workforce management in China and South Africa

Decentralising health workforce management may help local services to coordinate and plan their human resources more effectively to meet health care needs.

Health sector decentralisation in China and South Africa is complex, with different forms being implemented within varying timescales and for different purposes. In China decentralisation has taken place alongside the transition to a market economy, whilst post-apartheid South Africa is attempting to establish a new district health system.

In the Xinlou and Liancheng counties of China's Fujian Province human resource planning, recruitment and selection, staff performance management and training are all decentralised, though in some cases control has been regained by higher levels of governance. Human resource planning is influenced by the need for health institutions to generate income, and in some cases this may be detrimental to wider health service objectives.

In the Alfred Nzo District of South Africa's Eastern Province, the performance management and training functions are partially decentralised. However, local decision-making regarding human resource planning has been overtaken by higher level staffing initiatives.

In both countries decentralisation allows managers to manage their workforce better, though in some cases – particularly in China – this is to meet organisational objectives as opposed to broader health service objectives. In some cases managers are frustrated as authority is either not fully decentralised or sometimes withdrawn.

The complexity of several forms of decentralisation happening simultaneously means managers, particularly in China, are not prepared or supported in their new roles. There is a need for better planning, capacity development, and monitoring of the process of decentralising human resource management and the impact of decisions made by newly empowered managers. Recommendations include:

- Putting human resources management clearly on the agenda of decentralisation reforms at an early stage.
- Developing clear strategies for decentralising human resources management, including deciding what, how and when functions should be decentralised.
- Developing a system to monitor both processes of decentralisation – to ensure that adequate preparation and support is provided – as well as the impact on both human resources and the achievement of wider health system objectives.

**Tim Martineau**  
Liverpool School of Tropical Medicine, Pembroke Place,  
Liverpool L3 5QA, UK  
T +44 (0) 151 705 3194 F +44 (0) 151 705 3364  
T.Martineau@liv.ac.uk

## The health Millennium Development Goals

The Millennium Development Goals (MDGs) adopted by the international community in 2000 include three directly related to health: a two-thirds reduction in infant and under five deaths; a three-quarters reduction in maternal deaths; and the halt and reverse of the HIV/AIDS, tuberculosis, and malaria epidemics.

### Subscribe to id21 insights

To subscribe to id21 insights health for free please send us your full postal address to:

id21  
Institute of Development Studies  
University of Sussex  
Brighton BN1 9RE, UK  
email id21@ids.ac.uk

## Volunteers can contribute to health care

**D**eveloping countries have lost thousands of skilled health care workers to developed countries. One way to redress this imbalance is to develop innovative methods for training and developing the skills of health care staff in developing countries. Volunteers from developed countries can help to train and motivate health care workers who remain. They are also important in emergencies and in filling vacant posts.

Increased aid for health care in Africa will not be effective unless weak infrastructure is strengthened and unless health care workers feel valued and can progress professionally. Shortages are alarming; one famous medical school has two thirds of teaching posts unfilled. The poorest and voiceless rural people suffer most, because rural posts are lost first as staff leave for other areas.

Volunteers can contribute to health care in:

- Emergencies and disasters. A major agency, for example Médecins Sans Frontières, will recruit workers to respond immediately. The benefit to the country is incalculable; without the volunteers' skills the disaster escalates.
- Specific named posts. An agreement is made between a volunteer agency, for example VSO, and a government or institution; the volunteer posts depend on the current policy of the agency. An inappropriate request by a southern partner or an inadequate volunteer mean that benefits, though very often substantial and sustained, particularly when a post is filled repeatedly, are inconsistent.
- Long term partnerships or links between developed country training schools or hospitals and their counterparts in developing countries. There are now many links between hospitals in different countries that are growing in authority and value, such as those successfully sustained through The Tropical Health and Education Trust.

Partnerships and links are potentially highly cost-effective because they enable the southern partner to:

- make long term plans for staff development and continuing education
- improve care and its audit in hospitals or communities
- run new courses or strengthen weak ones.

Hospital and institutional links should be designed, monitored, planned and advised by committees at each end, and receive long term financial support by the northern partner. Costs are low because the link does not depend on much bureaucracy for recruitment, but on voluntary help within the source hospital. Links are thus cost-effective. Volunteers are selected, briefed, supported by and accountable to their source hospital or school.

All volunteers' activities are driven by the needs and requests of the southern partner and based on an open agreement. Wherever volunteers go, they work to carefully defined objectives within a disciplined framework for a variable length of time, establish their credibility, get to know the country and, ideally, return year after year. They derive great professional and personal benefit and potentially witness genuine health service improvements, planned to the needs of the southern partner.

In order for developing country health services to make the most of volunteers, developed country governments must:

- recognise the contribution volunteers can make
- promote institutional links
- encourage volunteers through appropriate leave and other arrangements
- recognise that volunteers develop professionally, and such work is also an investment in the source health service ■

### Eldryd Parry

The Tropical Health and Education Trust, 210 Euston Road, London NW1 2BE, UK  
T +44 (0) 20 767 98129 F +44 (0) 20 767 98190  
eldryd@thet.org  
www.thet.org

## Useful web links

Eldis dossier: human resources for health  
[www.eldis.org/healthsystems/dossiers/hr/index.htm](http://www.eldis.org/healthsystems/dossiers/hr/index.htm)

Equinet Africa  
Sub-Saharan Africa network doing work on equity in health worker distribution.  
[www.equinet africa.org/workhuman.php](http://www.equinet africa.org/workhuman.php)

Global Health Trust: Joint Learning Initiative  
Enterprise working to improve the global health workforce.  
[www.globalhealthtrust.org](http://www.globalhealthtrust.org)

Human Resources Development Journal  
[www.moph.go.th/ops/hrdj](http://www.moph.go.th/ops/hrdj)

Human Resources for Health: online journal  
[www.human-resources-health.com](http://www.human-resources-health.com)

International Council of Nurses Global Nursing Workforce  
Project aiming to clarify the extent of the global nursing shortage.  
[www.icn.ch/global](http://www.icn.ch/global)

Latin American and Caribbean Observatory of Human Resources in Health  
[www.lachs.org/observatorio/eng/index.html](http://www.lachs.org/observatorio/eng/index.html)

MEDACT  
UK charity focused on the impact of development, environment and conflict on health systems. Their website contains a section on the brain drain.  
[medact.org/hpd\\_brain\\_drain.php](http://medact.org/hpd_brain_drain.php)

World Bank: personnel management  
[www1.worldbank.org/publicsector/civilservice/personnel.htm](http://www1.worldbank.org/publicsector/civilservice/personnel.htm)

World Health Organisation: global atlas of the health workforce  
[www.who.int/globalatlas/default.asp](http://www.who.int/globalatlas/default.asp)

World Health Organisation: human resources for health  
The forthcoming World Health Report 2006 will focus on the health workforce.  
[www.who.int/hrh/en](http://www.who.int/hrh/en)

### Alvaro Alonso-Garbayo

Health Policy Unit, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT, UK  
T +1 (0) 20 7927 2284 [Alvaro.Alonso@lshtm.ac.uk](mailto:Alvaro.Alonso@lshtm.ac.uk)



id21 insights health is published twice a year and is online at [www.id21.org/insights](http://www.id21.org/insights). The id21 site also offers free access to hundreds of short easy-to-read highlights on current international development topics such as health, natural resources, education and social policy issues. To subscribe to our email newsletter email us at [ids21@ids.ac.uk](mailto:ids21@ids.ac.uk) with the words 'subscribe id21health news'. For further information or to subscribe to id21 insights health see [www.id21.org](http://www.id21.org) or contact us at the address below.

id21  
Institute of Development Studies  
University of Sussex  
Brighton BN1 9RE, UK  
T +44 (0)1273 678787  
F +44 (0)1273 877335  
Email [ids21@ids.ac.uk](mailto:ids21@ids.ac.uk)



id21 is hosted by IDS and supported by the UK Department for International Development. Views expressed in id21 insights do not necessarily reflect those of DFID, IDS or any other contributing institution. Unless rights are reserved in specific cases any article may be copied or quoted without restriction, providing the source (id21 insights) and author are properly acknowledged and informed.  
© Institute of Development Studies 2005;  
ISSN 1478-6982 IDS is a Charitable Company no.877338 limited by guarantee and registered in England

Editor: Tom Barker  
Senior Editor: Louise Daniel  
Editorial & technical support: id21 team  
Academic adviser: Barbara McPake  
Design: Robert Wheeler  
Printed by: Colorscope Printers Ltd  
Printed on paper produced from sustainable forests

**Keywords:** health workforce, human resources management, health worker migration, Millennium Development Goals, donors, decentralisation, volunteers, substitute health workers