

Which role for Medicus Mundi Internationalis in Human Resources Development?

Current critical issues in Human Resources for Health in developing countries

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Abbreviations & acronyms

AIDSCAP	Aids Control and Prevention Project
CB	Capacity building
CD	Capacity development
CDC	Centers for Disease Control and Prevention, Atlanta
CHA	Church hospital/health association
CME	Continued Medical Education
CPD	Continued Professional Development
Cuamm	Cuamm Medici con l'Africa
ECDPM	European Centre for Development Policy Management
FHI	Family Health International
GAVI	Global Alliance for Vaccines and Immunisation
GDLN	Global Development Learning Network
HAART	Highly Active Anti-Retroviral Therapy
HIV	Human Immunodeficiency Virus
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immuno Deficiency Syndrome
HR	human resources
HRD	Human resources development
HRH	Human Resources for Health
HRM	Human resources management
ICT	Information and Communication Technology
INCLN	International Clinical Epidemiology Network
INTRAH	Innovative Technologies for Health Care Delivery
ITM-A	Institute of Tropical Medicine, Antwerp
MM	Medicus Mundi
MMI	Medicus Mundi Internationalis
MNH	Maternal and Neonatal Health
NGO	Non governmental organisation
OECD	Organisation for Economic Cooperation and Development
UCMB	Uganda Catholic Medical Bureau
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WB	World Bank
WHO	World Health Organisation
ZACH	Zimbabwean Association of Church-related Hospitals

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Preface

Medicus Mundi Internationalis (MMI) commissioned this report in September 2002 in the framework of a study on current human resources development issues in the health sector. Specific subjects of interest to MMI were the brain drain, the concept of stewardship and capacity development. The aim of this report is to contribute to developing the background for an action plan that could guide policy action of MMI and that could inform MM branches on human resources development policies.

Most Medicus Mundi partner organisations, both church-related and non-related NGOs, are operating at district level. It is at this level that human resource management issues are really biting. MMI sees the coordination role of its partner organisations as critical and as a consequence would like its human resources development activities to focus particularly on the strategic management function at organisational level of private not-for-profit organisations. MMI's experience with contracting only stresses the importance of adequate local capacity.

In a first phase, a review of the literature, specifically regarding health work force distribution, stewardship and capacity development was carried out. This included a review of the human resource development strategies used by international agencies. A first draft was presented to MMI in November 2002. The current document represents the final version and includes the synthesis of the results of a mail survey, which was done in an effort to document the experiences of MMI organisations in this field.

1 Introduction

Human resources management is widely considered as a strategic element in healthcare management (WHO 2002). In financial terms, its importance is beyond discussion: in general, 65 to 80% of the recurrent expenditure in health care concerns staff salaries (Martineau 1997). These costs are strongly linked to how and how efficiently human resources are used (Mercer *et al.* 2002).

There is also a growing consensus that above and beyond budgetary implications, human resources are a key determinant of performance of healthcare organisations and systems, for example in health sector reform (Martineau & Buchan 2000). In 1995, the World Health Assembly urged WHO to make better use of resources, and more specifically of human resources (WHO 1995). The World Health Report 2000 stated that human resources are the most important of the health system's inputs (WHO 2000). The establishment by WHO of the Global Health Workforce Strategy Group in 2000, bringing together stakeholders to support WHO's work in improving health services through increasing health workforce performance, is another sign of the increasing recognition of the role of HR (WHO 2001b).

Human resources have been identified as constraints to achieve the Millennium Development Goals (Mercer *et al.* 2002). Many decision-makers readily point to human resources as the chief bottleneck in attempts to scale up health systems' interventions on the major health problems, such as HIV/aids, maternal health and malaria (Mercer *et al.* 2002, Van Lerberghe *et al.* 2002). Insufficient implementation capacity is equally seen as a hindrance to the international initiatives as the Global Alliance for Vaccines and Immunisation (GAVI) or the Global Fund to Fight AIDS, Tuberculosis and Malaria (Brugha *et al.* 2002, Kvale 2002).

Today's emphasis is no longer uniquely on optimising quantities, skills and distribution of manpower. During the last decade, the implications of the public/private debate, decentralization and civil service reform and performance management for human resource management became central concerns (Van Lerberghe & Ferrinho 2002). Nowadays, the impact of HIV/aids on the health workforce and the effects of globalisation on staff retention and global professional migration are the emerging themes. Although migration of skilled medical professionals is nothing new, brain drain is emerging on the agenda of international development (Amore 2000, Bundred & Levitt 2000, Anonymous 2000, Buchan 2002, Frommel 2002, Heller & Mills 2002, Smaglik 2002, Van Lerberghe *et al.* 2002, Zurn *et al.* 2002).

However, the brain drain is perhaps merely one more visible aspect of other human resource issues affecting performance of health services of developing countries.

We will use the term *Human resources management (HRM)* describing the process of creating an appropriate organisational environment and ensuring that the personnel performs adequately using strategies to identify and achieve the optimal number, mix and distribution of personnel in a cost-effective manner (Martinez & Martineau 1998). We use the definition of *human resources development (HRD)* as it has been defined broadly by Martinez and Martineau (1998) as including planning, managing and supporting the professional development of the health workforce within a health system, both at the strategic and policy levels and not involving merely training and management. As such, it is one element of HRM.

In the first part of this report, we will present a broad framework that describes human resources performance from a health system perspective. In this part, we will introduce three themes. First, chapter 2 takes the brain drain issue as an entry point of a discussion on Health workforce (im)balances and its impact on performance of health systems. Chapter 3 discusses the second theme, stewardship, an emerging paradigm in WHO's thinking on health system performance. Capacity building is the third theme, presented in chapter 4.

In a second part, we will discuss some strategies regarding these three themes. This review is based on the literature and on MMI's and its partners' experience. First, chapter 5 presents the findings of a mail survey among MM branches and partner organisations. Second, strategies addressing health work force distribution, general strategic options for capacity development and an overview of some capacity building methods are presented in chapter 6, 7 and 8 respectively. Finally, chapter 9 explores some issues, which could constitute possible future action domains for MMI.

2 From 'brain drain' to a systemic view on performance of health care services

2.1 The brain drain in health care

Globalisation and deregulation of trade made international migration far easier, resulting in huge transfers of human resources (Bundred & Levitt 2000). Nowadays, a medical qualification proves to be a quite valuable portable possession (Anonymous 2000). In Africa, 23.000 professionals leave their country annually, contributing to already poor human resources conditions (Pang *et al.* 2002). Of the around 2000 doctors trained, only 400 doctors are still practising in Zambia. Only 239 doctors remain of the 836 who graduated from the University of Zambia between 1992 and 1887 (Blas and Limbambala 2001). An estimated 18,000 Zimbabwean nurses work abroad, while South African medical schools see one third to half of their graduates leave for abroad (Pang *et al.* 2002).

But not only Africa is affected by migration of skilled health professionals. More than 150.000 Filipino nurses work outside the Philippines (Pang *et al.* 2002). India and China are other major suppliers. Jamaica saw its number of nurses reduce from 3.000 to 1.000 forcing it to look for nurses in Cuba (Wickramasekara 2002). Half of Tongan doctors are working outside Tonga, mainly in New Zealand and Australia (Kerse & Ron 2002).

It should equally be noted that the issue of brain drain affects not only the health sector. In the information and communication technology (ICT) sector, India has been losing annually an estimated 15.000 to 20.000 ICT professionals (UNDP 2001). On the other hand, scientists from all over the world have since long been attracted to North America, Japan and Europe.

The migration of professionals can be orderly, encouraged and even organised by receiving countries. In other cases, it is irregular, unwanted or unauthorised. In any case, the brain drain is different from migration at large in that it involves a net loss of skilled workers. Regarding health personnel, historically nurses have been always involved, as well as doctors, be it to a lesser degree. More recently, other medical personnel, such as physiotherapists and pharmacists, are joining the exodus.

The brain drain follows many channels. Globally, it goes from south to north, but for certain professional groups, such as scientists also from Europe to the USA, and for health personnel from central and eastern Africa for example to southern Africa. At country level, the flow is traditionally from rural areas to towns and cities, from clinical to managerial positions, and from the government service to the private sector. Finally, donor programmes tend to cream off the best elements of the other

sectors. In many countries, gaps created by departing professionals are filled by attracting medical personnel from other countries, leading to cascades flowing from the most deprived regions to middle-income countries and from there to high-income countries.

In addition to the long-term migration, there may be also a relatively high level of shorter-term migration, but since this is much harder to measure, accurate data are not available (Martineau *et al.* 2002). Overall migration from Europe to the USA is in fact more temporary than permanent, resulting in 'brain circulation' rather than 'brain drain' (OECD 2002).

On the whole, the USA and to a lesser extent Canada are the net gainers, able to attract health professionals from all over the world (OECD 2002).

Consequences are grave. First, equity is at stake. At national level, internal migration first increases imbalances in availability and quality of services between rural zones and cities (Anonymous 2000, WHO 2001b, Wickramasekara 2002¹). Furthermore, deregulation of the healthcare market, worsening working conditions in the public sector and privatisation policies contribute to the move of health professionals to the private sector. This may contribute to less accessible services for the poor. Brain drain from universities affects the quality of medical education and research capacity (Teferra 2000, Martinez *et al.* 2002). At trans-national level, the brain drain affects levels of health system performance and quality of care across country and regional borders.

Second, cost implications are clear. The United Nations Commission for Trade and Development estimated that each professional leaving Africa costs \$184.000 to the continent, while it spends \$4 billion yearly on the salaries of 100.000 foreign experts (Pang *et al.* 2002). Six hundred South African medical graduates are currently registered in New Zealand, leading to a financial cost to South Africa estimated at \$37m. Third, in the north, brain waste contributes to inefficiency in the sense that a number of the expatriate professionals, initially sent for specialisation, but also staying in these high income countries, are now being employed for functions below their qualification (Bundred & Kerse 2000).

¹ Wickramasekara P. 2002. The brain drain: Some reflections on migration of highly skilled persons from developing countries. Presentation to the plenary session of the symposium "Brain drain, brain gain or brain transfer?" 24 May, 2002, Brussels, organized by the Centre for Equal Opportunities and Opposition to Racism, the Higher Institute of Labour Studies of the Catholic University of Leuven and the Flemish Inter-university Council (VLIR).

On the positive side, remittances and foreign exchange sent back to the home country are often mentioned. According to the World Bank (2000), these remittances amount to about US\$ 75 billion each year and account for 50% more than total official development assistance. Quite substantial, these improve primarily household income and indirectly enhance local trade. However, these funds are usually not injected directly in the public health systems (Kerse & Ron 2002, Wickramasekara 2002). Although long-term professional networks and improved training can be considered as positive consequences of the brain drain, it is commonly agreed that these do not outweigh the negative effects (Pang *et al.* 2002). Finally, some claim that migration acts as a safety valve to alleviate internal labour market surpluses (Teferra 2000, World Bank 2000). Indeed, the Philippines, for example, sends out over half a million temporary migrants annually, providing an outlet for its workforce plagued by high unemployment rates (Albuero and Abella, 2002). However, it is hard to see how this argument would apply to the health sector in most countries.

The mechanisms underlying the brain drain are diverse and are commonly analysed in terms of push and pull factors, and of sending and receiving countries.

In the sending countries, the attraction of the pull factors, like career perspectives, remuneration, flexibility of work hours, workload, opportunities of continuing educational opportunities, and working environment, is generally weak (Bundred & Levitt 2000, Kerse & Ron 2002²). Push factors such as political instability, civil strife, insecurity and oppression, economic and social deterioration and demographic factors all affect motivation to stay or to leave. Lack of commitment to improve the necessary incentives and environment on the part of most African governments has been considered as a major bottleneck to the full use of existing capacity (Economic and Social Council 2001). All these factors reduce job satisfaction. On top of that come the psychological factors determining the perception of comparative financial and career opportunities (Economic and Social Council 2001, Pang *et al.* 2002).

In the receiving countries, the domestic workforce balance needs to be assessed in terms of pull and push effect on 'national' professionals. This attraction of the medical professions in turn determines to a substantial degree if and how measures are taken to increase the pull on non-national professionals.

² Kerse L, Ron A. 2002. Migration of skilled health professionals in the Pacific. Presentation for the symposium "Brain drain, brain gain or brain transfer?" 24 May, 2002, Brussels, *ibid.*

In most importing countries, the current mechanisms to provide and maintain the required workforce are unable to meet the increasing demand for health care for several reasons. First, in many of the higher income countries, intake for medical education has been reducing. In Canada, ill-informed cost control decisions in the 1980s predicted a future oversupply and recommended a 10% reduction in posts for medical residents. Combined with a reduction of the intake of foreign medical professionals, this contributed to current deficits of doctors (Bundrett and Levitt 2000). Also for nursing, the inflow to the profession is problematic. For the USA, increasing alternative career options for women (who still represent 94% of the nursing workforce in the USA) and the reduced attraction of the job reduce inflow to the profession (Berliner and Ginzberg 2003). Second, in the UK as in many other European countries, not only the inflow in the profession, but also the retention of professionals is becoming problematic, especially for nurses and midwives. Both inflow in the profession and retention of nurses and midwives are influenced by pay levels and the cost of living, the changing nature of the job, perceptions of being 'valued' and other employment opportunities (Finlayson *et al.* 2002). Third, outflow out of the profession is determined by the increasing shortening of the average length of careers.

The underlying reasons for leaving the profession mentioned by nurses in the UK are strikingly similar to those mentioned by health professionals in the south when asked why they leave their country. A core issue seems to be the perception by professionals, the patients, government and society at large of the medical professions. Although the phenomenon is still poorly understood, the esteem of medical professionals seems under pressure, which could be an important factor in the reduction of the attraction of the medical professions.

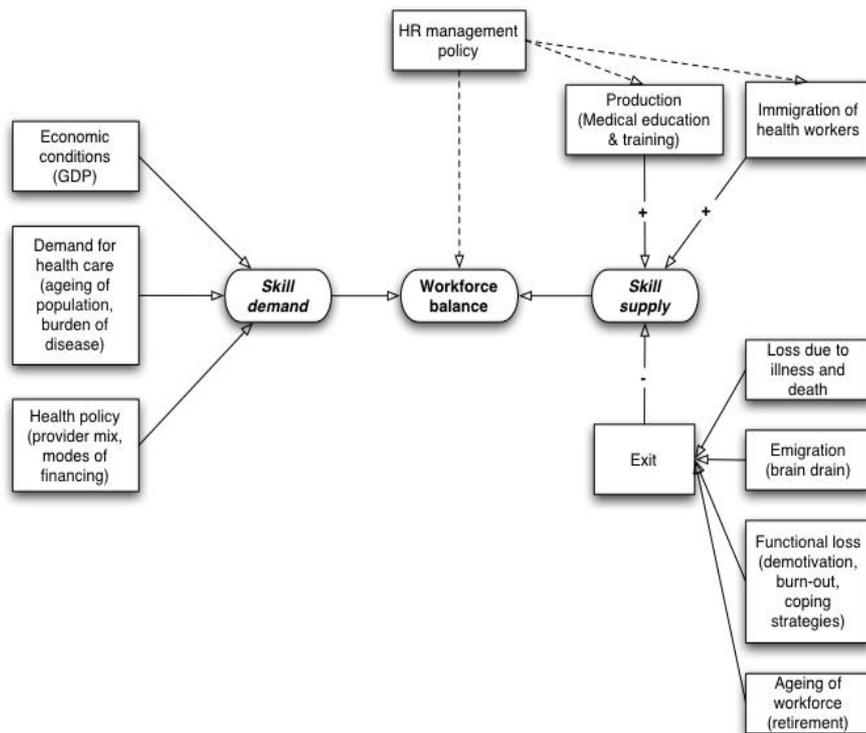
2.2 Imbalances in the health workforce

Given the stakes and the complexity of underlying causes, the brain drain should not be considered in isolation. Instead, a wider perspective needs to be adopted. The brain drain can be considered as representing a loss to the resources pool of the health system of the sending county and a gain for the receiving country. Zurn *et al.* (2002) present a model of skill imbalance in health workforce defining workforce imbalance as a mismatch between the quantity of skills that is supplied by the workforce and the quantity that the health system demands. The framework is assuming that population health needs constitute a demand to be met by the health system, which is reflected in a specific health workforce demand. Imbalances in health workforce then would mean there is a gap between

the available workforce supply and the labour force required to satisfy the population's needs.

Skill demand is influenced by environmental factors (Figure 1), such as general economic conditions: GDP has been shown to affect demand for health care staff. But also sociodemographic factors (ageing population), health policy context (provider mix, degree of use of medical technology, modes of financing), demand for and utilisation of health care (burden of disease patterns, modes of health insurance) all affect demand for skilled personnel (Zurn *et al.* 2002).

Figure 1 - Health workforce imbalances (adapted from Zurn *et al.* 2002)



Skill supply is equally determined by numerous factors. First, 'production' of personnel (education and training) and immigration of professionals influence skilled human resources supply. Exit out of the profession is caused by factors such as degree of emigration (brain drain), ageing of the workforce (retirements), functional loss (coping strategies, burn out) and

loss due to illness (HIV/aids, etc.) (Zurn *et al.* 2002). In some countries, losses of 20% of the nursing workforce due to HIV/aids have been quoted (Mercer *et al.* 2002). HR management can affect degree of demotivation and burnout leading to functional loss.

Depending on the structure of the health care system, national level *HR management policy* can affect balances directly through distribution and posting policies and its influence on retention capacity, and indirectly through its influence on medical education and training.

2.3 The HR performance equation

The analysis of health workforce balances can be pushed up one level, as in its own right, it can be considered as one of the determinants of the performance of human resources (Figure 2). Competence and motivation are the two other factors, whereby performance will not be merely the accumulation of the inputs of each of these components. Rather, each of the three elements needs to reach a minimal critical level to obtain performance in a multiplication-like formula (Kegels 1999). Although this is evidently a simplification of reality, in that motivation, competence and workforce balance influence each other, it offers a useful framework on the determinants of overall work force performance. In our assessment, currently the elements 'workforce balance' and 'motivation' are posing major problems, more than the 'competence' of the workforce.

Figure 2 - Elements of the HR performance equation (Kegels 1999)

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Motivation can be described as the motivation to be available, to remain competent, to work properly / to do the right thing right (striving at excellence) and is influenced by internal and external factors (Kegels 1999).

Competence has been described in various ways. Epstein & Hundert (2002) define *competence* in professional medical practice as the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individual and community being served. Competence is more than just factual knowledge and problem solving capacity, it should allow professionals to deal with uncertainty in complex situations, allow them to manage ambiguous problems, tolerate uncertainty and make decisions

with limited information. Competence is very context-specific issue, reflecting the links between an ability of a person, a task and the system one is working in; it is a balance, which has to be sought always again. Assessing competence can be done at four levels: the *knows*, *knows how*, *shows how* and *does*. Practically assessment occurs through assessment by supervising clinicians, multiple-choice examinations, standardised patient assessment of physical examination and technical and communication skills (Leach 2002). Fraser & Greenhalgh (2001) define *capability* as the extent to which individuals can adapt to change, generate new knowledge and continue to improve their performance, while they define *competence* as what individuals know or are able to do in terms of knowledge, skills and attitude.

Obviously, human resource management and policy influence these three determinants of human resource performance.

2.4 From performance of human resources to health system performance: a conceptual model

Finally, we would like to present a model allowing analysis of the performance of human resources from a systems perspective. Our conceptual model (Figure 3) builds on the model of human resources performance of Kegels (1999) on one hand, and on a framework developed by Dubois & Dussault (2002) that explores the links between the performance of the health workforce on one hand and health services performance on the other hand. We combine and expand these models to indicate how human resources performance (defined by competence, motivation and workforce balance), organisational performance and system performance are interrelated.

The health system being a complex open system, both the external environment (policy context, socio-economic conditions, legislation and community) and the organisational environment (organisational culture and structure, availability and distribution of resources) are important determinants at all levels.

Figure 3 - Linking individuals to performance of HR, organisations and the system

QuickTime™ and a TIFF (Uncompressed) decompressor are needed to see this picture.

2.5 Overview of strategies addressing health workforce distribution

The brain drain issue is complex, both in scope and in causes. We will categorise a number of strategies that have been discussed in the literature according to Wickramasekara's framework (2002). Economic growth, political stability, democracy, good governance, respect for human rights are all assumed to contribute to a general conducive environment, but these are long-term goals and less vulnerable to health care organisations. Here, we will mainly discuss interventions that influence the pull side in developed countries.

2.5.1 Interventions aimed at improving staff retention

An overall conducive environment that offers opportunities and favourable working conditions is considered important. Improved fringe benefits (like paying schooling for their children), clear-cut career structures, better supplies especially for rural facilities and hardship allowances are other documented measures. In Peru, the government designed the Focal Health Spending Programme to attract health personnel to remote rural areas, under which medical staff are awarded higher salaries and higher

allowances for schooling and housing (Martinez *et al.* 1999). Similar programmes exist in several other countries.

Other authors argue that the curricula of the medical schools should be better focused on local conditions so as to equip graduates with skills and knowledge relevant for their real life working conditions. This would reduce professional frustration (Frommel 2002). Intake for medical education could identify more mature settled persons, who would consider less easily to leave their family and country.

Heller & Mills (2002) go further, suggesting that developing countries may need to restructure staffing of health services. They call for training of medical cadres that are less marketable and to whom some duties could be delegated. Medical auxiliaries and maternal/child health workers. would replace doctors to a large extent and would manage patients suffering from the diseases of poverty. While the countries themselves would organise the training of the auxiliary cadres, Heller and Mills suggest that developed countries could finance the training of personnel to an international standard, graduates of which would be allowed to go abroad after working for a fixed period in their own country first. In our opinion, however, creating new cadres of lesser-qualified staff specifically to fill gaps left by departing professionals could perhaps be effective on the short term, but it raises serious questions regarding equity between exporting and importing countries. Also the consequences of an accelerated training of lesser-qualified health workers on their performance and especially on the degree of professionalism could be problematic.

Better systems are required not only for bonding trainees sent abroad (Kerse & Ron 2002), but also to impose barriers to migration. South Africa (among other countries) increased the time needed for full registration and imposed compulsory community service (Bundred & Levitt 2000). Pang *et al.* (2002) also mention demanding compensation from departing professionals.

2.5.2 Return of migrants to their source country

Return can be induced or non-induced, permanent or temporary. Assisted return programmes have been set up in Africa by the International Organisation for Migration (IOM). Its strategy is based on stimulating the selective return migration of qualified nationals. The Return and reintegration of Qualified African Nationals (RQAN) ran between 1983 and 1995, through which 2.565 of the most urgently needed professionals of all kinds returned to Africa. IOM was inspired by stimulated return migration programmes operated by India, Korea and China, which focused on professionals working in research and development and involved the

private sector. But their successes may not be easily reproduced, as these programmes were initiated well before the current wave of globalisation (Wickramasekara 2002). Secondly, even the International Organization for Migration (IOM) concedes that unit costs of the current interventions are too high (International Organisation for Migration 2001).

Currently, the most fashionable paradigm is to tap into the skills and resources of the diaspora. Several speakers at the Regional Conference on Brain Drain and Capacity Building in Addis Ababa 2000 called for the international development community to hire indigenous expatriates for short-term assignments and development activities in their home countries. Diaspora networks were called for in order to reduce brain decay and under utilization of expertise (Economic and Social Council 2001). The IOM initiated the 'Migration for Development in Africa (MIDA)' programme (International Organization for Migration 2001). It aims at stimulating governments, private sector, civil society and donors to draw on the diaspora for their capacity development programmes. UNDP runs the Transfer Of Knowledge Through Expatriate Nationals (TOKTEN), a similar scheme. Several grass roots networks of African professionals in the diaspora emerged during the last years. The South African Network of Skills Abroad (SANSA 2003) and the Ethiopian North American Health Professionals Association (ENAHPA 2003) are two often-cited examples. However, these seem rather engaged in supporting dispersed small scale efforts.

The most important argument for this approach lies in the fact that the interests of neither the sending country nor the receiving country are undermined (Meyer 2001). However, it is too early to assess the impact of this strategy. Regarding health professionals, evidence is missing and it seems highly unlikely that the concept of brain mobility could be applied to alleviate shortages of personnel in hospitals and health centres.

2.5.3 Reparation for loss of human capital

The concept of taxing the brain drain originated in the 1960s. UNDP (2001b) raised the issue again in its Human Development Report 2001. Modalities include student loan recovery mechanisms, exit fees for departing nationals, a flat tax for overseas workers and basing the tax system on nationality rather than on residence (e.g. the US tax system). Bundred & Levitt (2000) believe WHO should administer a system whereby gaining countries compensate the less-developed countries for the loss they incurred. However, transaction costs are high and practical problems abound in determining the level, paying procedures, enforcement and

redistribution. Most important, it does not tackle the root causes (Wickramasekara 2002).

2.5.4 Restriction of international mobility & international rules

The Durban declaration of the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (Wonca) in 1997 called for governments to examine their recruitment policies. The UK Department of Health instituted a code of practice regarding international recruitment and the Commonwealth is working on a similar code, aiming at ensuring that recruitment is based on fair principles. However, Kerse & Ron (2002) argue that not fair, but *less* recruiting is needed. Indeed, northern countries engaging in mass recruitment incur no cost at all.

2.5.5 Measures in receiving countries

Besides increasing wages and benefits, recruitment of expatriate health staff has long been a standard solution to meet acute demands for health professionals in the higher income countries. Given the relative inefficacy of these measures, structural and long-term solutions need to be pursued. Similar to the situation in sending countries, measures to enhance the pull of the profession on nationals need to be taken. Upgrading the social position of the medical professions may well prove the most important, but also the most complex solution.

2.6 Conclusion

Both the scope and the underlying causes of brain drain and health workforce in general are complex. While there is little documented evidence regarding effective strategies, a few issues seem to emerge. First, not the brain drain in isolation should be the focus, but the wider perspective of health workforce imbalances needs to be adopted. Second, imbalances in the low-income countries are inevitably linked to imbalances in the higher income countries, requiring action in both. Indeed, for many health professionals, emigration or leaving the profession is now an effective socio-economic coping strategy

Any strategy aiming at effectively retaining professionals will have to acknowledge the high aspirations of skilled professionals, both in developing as in developed countries. Indeed, the medical professions are under pressure, reducing both the attraction and the retention capacity.

3 How useful is the concept of stewardship in health care?

3.1 Introduction to the concept of stewardship³

WHO (2000) defines stewardship as *the careful and responsible management of the well-being of the population*. For Travis *et al.* (2002), the scope of stewardship includes ensuring oversight, regulation and accountability of all actors involved in any of the four health system functions (stewardship, financing, service provision and resource generation).

In our opinion, HRM (and HRD specifically) should be a direct focus of any health policy in the sense of planning, managing and supporting the professional development of the health workforce within a health system, both at the strategic and policy levels.

The concept of stewardship was introduced in the health system performance debate by the World Health Report 2000 (WHO 2000). It starts in the framework developed for the assessment of the *health system* performance (Figure 4), which aims at exploring why health systems vary widely in performance: indeed, countries with similar levels of income, education and health expenditure are seen to differ in their ability to attain key health goals.

The health system and its goals

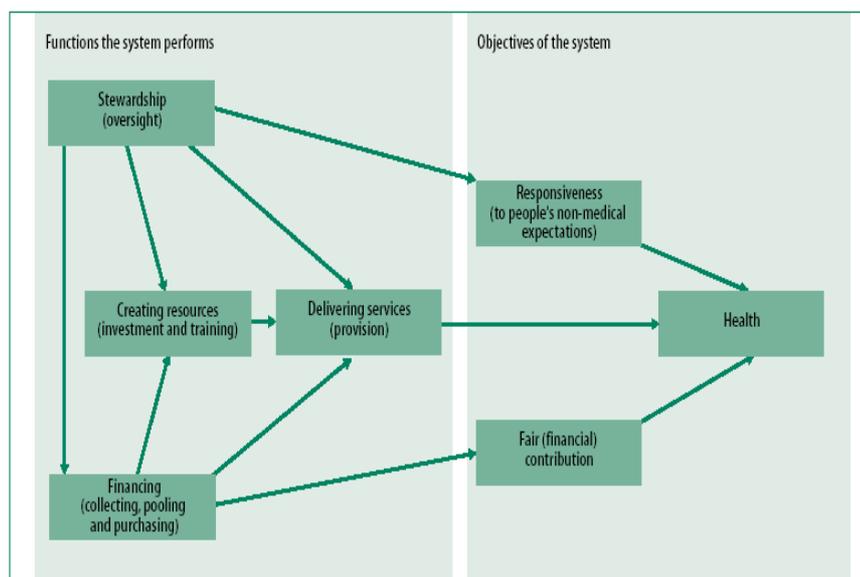
For WHO, the boundaries of the health system are based on the concept of health action: any set of activities whose primary intent is to improve or maintain health. Within these boundaries, the concept of performance is centred around three fundamental goals: improving health, enhancing responsiveness to the expectations of the population and assuring fairness of financial contribution.

Improving health means both increasing the average health status and reducing health inequalities. Responsiveness includes two major components: first, respect for persons (including dignity, confidentiality and autonomy of individuals and families to decide about their own health) and second, client orientation (including prompt attention, access to social support networks during care, quality of basic amenities and choice of

³ Based on Boffin (2002) Stewardship of health systems. Department of Public Health, Institute of Tropical Medicine, Antwerp.

provider). Fairness of financial contribution means that every household pays a fair share of the total health bill for a country (which may mean that very poor households pay nothing at all). This implies that everyone is protected from financial risks due to ill health or health care (WHO 2000).

Figure 4 - Functions and objectives of health systems (Reproduced from WHO 2000)



Health system performance: the importance of four key functions

For WHO, the measurement of performance relates goal attainment to the used resources. Variation in performance is a function of the way in which the health system organises four key functions: 1. stewardship; 2. financing (including revenue collection, fund pooling and purchasing); 3. service provision (for personal and non-personal health services) and 4. resource generation (including personnel, facilities and knowledge).

3.2 Two schools regarding the underlying principles

Despite ideological disputes on the role of the state, there is now a considerable consensus on the importance of good governance and the need to (re)configure and apply state authority in the health sector in the interest of attaining health sector objectives.

Good governance implies policymaking serving the public interest. In his paper on stewardship and public service in Canada, the central argument of Armstrong (1997) is that public service reforms of the last two decades were necessary and had positive results. He notes, however, that the underlying market theory is not robust enough to embrace the full range of public sector activities such as governance and guarding public interest. Market driven reforms have touched mainly on the delivery of public services, focusing on technique and strategy, paying inadequate attention to the consequences for the public interest.

For Saltman & Ferroussier-Davis (2000) *stewardship can infuse normative, content-oriented values into what remains a set of largely technical, process-oriented institutions*. They argue that stewardship pursues both ethical and efficient policymaking. As such, it could serve as the basis of a new configuration of state involvement, transcending the traditional Weberian bureaucratic model as well as the public choice model of state organisation, which is based on the assumption that every actor basically pursues his/her personal interest (*homo economicus*). *Stewardship at its best could provide an organising principle for power in a society transcending economics to base itself on the common interest,(...) reinvigorating the sense of social purpose among public sector administrators* (Saltman & Ferroussier-Davis 2000). This view goes beyond a mere technical approach to stewardship, to include the public interest as the specific main focus.

The World Health Organisation defines stewardship as *the careful and responsible management of the well being of the population* (WHO 2000). It is the responsibility of the government, usually through the Ministry of Health, but certain stewardship tasks may be delegated to other actors. Responsibilities for different aspects of stewardship may be divided between central and sub-national health authorities, local government, other Ministries, civil service commissions, parliamentarians, professional associations, etc. However, through its Ministry of Health, a country's government remains the "steward of stewards" for the health system (Travis *et al.* 2002). The six domains of stewardship proposed by Travis *et al.* (2002) seem to confirm the rather technical-managerial approach the WHO currently seems inclined to follow.

Most authors agree that in both cases, the introduction of stewardship requires a strong commitment by all actors involved and a simultaneous introduction at all levels of the structure. Furthermore, some basic capacities need to be present as a condition to adopt the stewardship principle. For Saltman & Ferroussier-Davis *certain political, economical, social and/or religious patterns may help or hinder the implementation of*

the stewardship approach. More fundamental is the condition to have a relatively strong and well functioning (state) structure to begin with.

Despite the fact that the Scandinavian welfare states show some positive elements of stewardship, experience of adopting the stewardship model at *state* level is unfortunately inexistent at this moment (Saltman & Ferroussier-Davis 2000). However, the concept has been applied to management & business and in the environmental protection debate.

3.3 Linking stewardship to health workforce, organisational and system performance

Despite the little documented experience, the principles underlying the concept of stewardship could be applied in health care at organisational level. Stewardship acts directly on the organisational and system level and indirectly through its influence on the organisational and external environment (Figure 5).

Figure 5 – Relationship between stewardship and individual, organisational and system performance

QuickTime™ and a TIFF (Uncompressed) decompressor are needed to see this picture.

4 Capacity development and technical assistance in health care

4.1 Introduction

Emerging in the 1980s, capacity development became a central paradigm in the field of development in the 1990s (Lusthaus *et al.* 1999), closely related to the rise of sustainability as the new buzzword (LaFond *et al.* 2002).

Traditional models of development assistance in health care focused almost exclusively on organisational and institutional capacity development by strengthening service delivery, expanding service provision, marketing services and raising quality of care (LaFond *et al.* 2002). From the sixties onwards, technical assistance by expatriate staff virtually always accompanied investment and financial support (Brown *et al.* 2001). However, critical issues of design, implementation and management were largely ignored (UNDP 1997), as the focus remained on individual training and restructuring of organisations (Milèn 2001).

Under pressure of increasing awareness of limited effectiveness and sustainability, a critical rethinking of capacity development strategies emerged in the late 1980s (Grindle 1997, Milèn 2001). More efficient strategies were sought as donors found themselves increasingly under budgetary pressure. A new enthusiasm for capacity development was born (Milèn 2001), despite the fact that a consensus on underlying concepts is only now emerging. International agencies such as OECD and UNDP started developing frameworks on *effective* development. Since then, about all international development organisations or research institutions introduced a capacity development component in their programmes. Despite the lack of evidence regarding effectiveness of the strategies and the relationship with increased performance, capacity development is now considered by many as the only way forward under current conditions to maintain the investments made through international aid, development and research programmes.

From a historical perspective, capacity development is the current stage in a series of dominating paradigms. It is complementary to concepts as institution building (1950s-60s), institutional development and strengthening (1960s-70s), development management/administration (1970s), HR development (1970s-80s) and new institutionalism (1980s-90s) (Lusthaus *et al.* 1999). Capacity development integrates aspects of the above paradigms, but also includes ideas from the fields of organisational development, community development, integrated rural

development and sustainable development. Short, capacity development is a broad term, an umbrella under which lots of concepts are integrated, contributing to its difficult definition.

The question remains whether this amalgam of perspectives and concepts of unsuccessful previous models will be effective now. Few publications bring evidence on the effectiveness of CD strategies or impact on sustainability. All too often, development interventions remain decided and designed in a top-down and donor-driven fashion, interfering in national priority setting. The asymmetric power distribution that comes with the money continues to skew relations between the partners, despite fashionable words like partnership, local ownership and empowerment.

4.2 Why engage in capacity development?

The instrumental view on capacity development considers sustainability of the benefits resulting from an intervention or a programme as the ultimate goal of capacity building (AIDSCAP/FHI 1997, Land 2000, LaFond *et al.* 2002). Capacity building should develop the capacity of the national level of the health system to design and implement health policies in an effective and efficient manner, with a minimum of external input (AIDSCAP/FHI 1997, LaFond *et al.* 2002).

However, to be fully effective, capacity development should be more holistic or comprehensive in approach and not merely be seen as instrumental (Qualman & Bolger 1996). For an organisation to be effectively strengthened, the capacity itself and the process to improve it is at least as important. The ultimate objective is to create effective and productive organisations, perhaps the scarcest of all development resources (Morgan 1998). Capacity development then touches on changes of societal politics, social capital and development of healthy communities. In short, capacity development is in this view almost synonymous with development (Fowler 1997, Morgan 1997).

If the ultimate goal of capacity building can be defined as development itself (see UNDP 1997 & 2001), as a consequence, capacity development should aim at ensuring the sustainability of national development efforts, going beyond simply the project or programme level. This requires a uniform, shared national vision of development, and related definitions and standards (Lusthaus *et al.* 1999). Mission statements of organisations such as the Swedish International Development Cooperation Agency (SIDA 2000) reflect this more holistic approach.

4.3 Definitions and concepts

Capacity

The UNDP definition is most commonly cited. It defines capacity as the ability of individuals and organisations or organisational units to perform functions effectively, efficiently and sustainably (Milèn 2001, UNDP 1998). For LaFond *et al.* (2002), capacity is the possibility to carry out stated objectives.

These definitions assume a link between capacity and performance and use extensively strategic management-derived terminology. In developed countries, the less comprehensive terms of strategic management, human resource management, institutional development and change management are used rather than capacity development (Milèn 2001).

Capacity building / development

LaFond *et al.* (2002) define capacity building (CB) as a process or activity that improves the ability of a person or entity to '*carry out stated objectives*'. For the health sector, the ultimate objective is a sustainable (local) health system. The OECD Development Assistance Committee definition describes the capacity development similarly as *a process by which individuals, groups, organisations, institutions and societies increase their abilities to 1) perform core functions, solve problems, define and achieve objectives; 2) understand and deal with their development needs in a broad context and in a sustainable manner* (UNDP 1998).

Operational definitions reflect the shift to a more comprehensive view. SIDA (2000) defines capacity development as the combined efforts to support the development of knowledge, competence and well functioning organisations and institutions. UNDP (1998) uses explicitly the term capacity development, defining it broader than merely organisational development to include an emphasis on the overall system, environment or context. Grindle (1997) discusses capacity building as intending to encompass a variety of strategies that aim at increasing efficiency, effectiveness and responsiveness of government performance. Dimensions include human resource development, organisational strengthening and institutional reform.

Capacity building, capacity strengthening and capacity development are considered by most as synonyms (Grindle 1997, Milèn 2001). In this paper, we will use them interchangeably.

Characteristics of capacity building

A number of properties of capacity development interventions emerge from the literature on best practices in capacity strengthening.

CB is *in se* an internal process, but can be stimulated by external actors. The term *capacity building* is used to describe the external assistance to an organisation, usually through specific, well-defined and planned interventions, while *internal capacity building* is mostly used to describe the organisational learning process. CB should ideally be demand driven. External partners' role should be catalytic and supplementary, strongly focused on building upon existing capacities and providing methodological support (OECD 2001).

Implementation should be incremental and modular, (UNDP 1998), building on and enhancing existing capacities (UNDP 1998, Lusthaus *et al.* 1999, Milèn 2001). Lacking basic capacities should be reinforced before embarking on the main intervention (Mills *et al.* 2001).

Since capacity exists at various levels, CB is essentially multidimensional: it can be described in terms of components, levels, strategies, interventions (UNDP 1998, Milèn 2001). Comprehensive and integrated capacity development interventions taking into account the interconnectedness of the various levels will have a greater impact because of the synergistic nature of strengthened interrelated levels of capacity (Kotellos 1998, Morgan 1998, UNDP 1998). However, implementation strategies must be horizontally and vertically integrated to reduce overlaps and gaps (UNDP 1998).

Capacity development is a process that is dynamic, continuous (UNDP 1998, Milèn 2001) and involving the long term (Lusthaus *et al.* 1999).

Capacity development issues are complex phenomena of personal, organisational and institutional change (Morgan 1999, UNDP 1997). Capacity development commonly introduces changes in organisational culture and in underlying values, willingly or not. Consequently, skills to manage the change process are required. Development of a clear policy framework, good communication with staff members and ensuring commitment should be priorities. Particularly the organisational culture needs to be taken into account (Mills *et al.* 2001).

To conclude, universal blueprints do not exist (UNDP 1998, Lusthaus *et al.* 1999, Milèn 2001). There is no single answer to how to develop capacity (Land 2000). Instead, interventions need to be based on specific capacity needs assessments.

4.4 Influence of capacity development on health system performance

Figure 6 takes the systems framework we discussed above to indicate where the entry points of capacity development interventions are located. Capacity development intervenes at two stages. First, at the individual level, (medical) education and training shape competence. This could be called individual capacity development, in that it is an inherent function of any health educational system. Secondly, capacity development interventions can be directed at the individual, organisational and system level. This is what the development literature usually calls capacity development. In the development literature, the user/community level is recognised as an important domain, strengthening of which should increase the civil society's capacities.

Figure 6 - Entry points of capacity development

QuickTime™ and a TIFF (Uncompressed) decompressor are needed to see this picture.

4.5 Level-specific capacities

For each level of the system, specific capacities can be specified, which will highly depend of the responsibilities or the functions to be carried out. We will discuss below the various levels in more detail and present some

examples of particular capacities that can be the object of capacity strengthening interventions.

Capacity at individual human resources level

This level involves all individual staff working in the health system. Required capacities are highly dependent on the function an individual occupies and the related professional competence demanded. For physicians for example, this could include competencies such as patient care, medical knowledge, practice-based learning, interpersonal and communication skills, professionalism and systems-based practice (Leach 2002).

It should be noted that technical skills and competence alone will not lead to excellence/performance. In safe motherhood for example, resource availability (human resource distribution, infrastructure, drugs and equipment) has been rightly identified as the 'enabling environment'. However, in many health systems, the single most challenging determinant may be staff motivation.

Capacity at organisational level

The organisational dimension includes any organisational entity: a hospital, a health centre, or a health district. Required capacities again depend of the responsibilities of the organisation, but include the human, physical and knowledge resources of any health care organisation. Required capacities can cover functions such as strategic planning, financial management, information management, logistics systems management, communication networks and human resources development (LaFond *et al.* 2002). UNDP (1998) adds mission and strategy, culture/structure and quality management.

Capacity at health system level

The health system encompasses broadly all actors, organisations and resources concerning and directly dealing with health and health care (WHO 2000). LaFond and colleagues (2002) discern the following capacities at health system level: designing the overall structure of the health sector, drafting and implementing health policies, coordination of all actors involved, allocation and management of resources and finally regulation. UNDP (1998) adds management/accountability and process dimensions. The latter includes the interdependencies, interactions and inter-relationships (flow of resources and information, networks of people, communication infrastructures) amongst the organisations or components of the system.

The capacity to responsibly manage the whole system is defined by WHO as the *stewardship* function (WHO 2000). For stewardship considered as a set of management functions, Travis and colleagues (2002) describe the following domains 1) generation of intelligence, 2) formulating strategic policy direction, 3) ensuring tools for implementation, 4) building coalitions & partnerships, 5) ensuring fit between policy objectives and organisational structure and culture and 6) ensuring accountability.

In theory, these domains offer a useful framework to identify relevant capacity building intervention needs concerning stewardship. In WHO's vision, the skills and strategies through which public bureaucracies are traditionally controlled are inadequate for stewardship of contemporary health systems. Entrepreneurial, analytical and negotiating skills are needed to steward such systems. Better stewardship requires an emphasis on coordination, consultation and communication processes. A full picture of what is happening is needed to be able to base decisions on evidence. All stakeholders in health should be known to the MOH and regular lines of communication established. The MOH also needs a strong communication capacity and strategies to ensure that the media are aware of the health system's goals and progress or obstacles.

Consultation is often a widely neglected part of the policy process, both in policy formulation and in implementation. A massive investment in management information systems will not, of itself, bring about better stewardship. Advocacy strategies are needed to influence other branches of government and non-government health system players. The scope of regulation has to be broader, bringing in and giving voice to consumers, private providers, professional associations, and external assistance agencies (Travis *et al.* 2002).

Capacity at user & community level

The individuals who benefit from and contribute to the shaping of the health system constitute the fourth dimension. Required capacities are defined by the roles individuals play. Through their (health seeking) behaviour, individuals influence health outcomes and the need for health care. Community members can be involved in health care matters through participating in health committees, through pressure groups and the media (LaFond *et al.* 2002).

Community participation, involvement and empowerment refer to the process of enabling individuals or communities to participate in the definition of their needs and possible solutions, in partnership with health professionals. The literature suggests that participation enhances community ownership, which in turn reinforces capacity and promotes programme maintenance Shediac-Rizkallah & Bone 1998). Community

capacity building can be considered as the nurturing of and building upon the strengths, resources and problem-solving abilities already present in individuals and communities.

At the provider-patient level, *enablement* can be achieved through proper patient-centred techniques (Howie *et al.* 1998, Howie *et al.* 2000). Frameworks of competencies for informed shared decision making have been developed (Towle & Godolphin 1999, Greenhalgh 1999), which are essential to ensure that offering information does not become manipulation.

4.6 Linking required capacities to health system objectives

Determining required essential capacities starts in the first place from the specific objectives and goals one is supposed to pursue. We summarise the conceptual elements in Annex 1, showing how the required capacities depend on the general and specific objectives for each of the four levels. It should be noted that the entries are merely an example and do not pretend to be exhaustive.

4.7 General strategic options for capacity development

Initially, capacity building strategies of the international development agencies focused primarily on providing funds and equipment to local organisations and institutions in developing countries, on stimulating financial accountability and assisting in improving specific technical skills. It became clear that these were not sufficient to allow these organisations to obtain all skills for good strategic management, which would enable them to define their vision, analyse the problems, design strategies, implement, monitor and evaluate their activities (UNDP 1997). Furthermore, initial efforts focused mostly on the individual and/or organisational level, not taking into account the external environment or the system. Usually, interventions were directed only at human resources and processes, pertaining to organisational structure (UNDP 1998).

The Canadian International Development Agency (CIDA 1996) approaches capacity building as a necessarily holistic exercise, which needs to take into account not only the internal organisational aspects, but also the environment and the specific context. UNDP (1998) places capacity building squarely in the strategic management framework, which *integrates and addresses all dimensions of capacity at the systems, entity's (organisational) and individual level.*

Key issue is the definition of the objectives, the vision that is being pursued, as this ultimately defines the required capacities, which in turn

allows the identification of the existing gaps and the capacities to be developed and the appropriate strategies to be used.

Morgan's overview (1998) of general strategic options for development is quite useful in that it allows classification of all major historical trends and types of development interventions.

Supplying additional financial and physical resources

In this view, the main cause of low capacity is the lack of resources, assuming a *want, can't do* attitude. This paradigm, in vogue in the international development circles in the 1950-60ties, focuses on supplementing equipment, building and infrastructure, trained staff, operating costs and salaries. For donors, it is a relatively easy approach, but the assumptions may mask deeper underlying organisational failures, which may lead to misappropriation and capture of resources by certain people or groups. This approach may work for well-managed organisations, requiring rapid expansion of activities.

Improving organisational and technical capabilities

In this view, technical capacities, more than other resources, are lacking. This is still the most widespread strategy, including delivering technical assistance, training, system improvements and improving working conditions in general. Problem is that many organisations are rather in a *could but don't want to* category, because of constraints such as politicisation, poor salaries, irrelevant functions and tasks, etc. It should be noted that lack of skills is nowadays far less a constraint than it was in the 1960-70ties. Now, proper utilisation, retention, deployment and sustaining capacities are the issues.

Defining a strategic direction

In this approach, the lack of a properly developed vision, or strategic direction for the organisation is missing, either due to internal organisational weaknesses (incompetent, lacklustre, de-motivated management, fragmented and incoherent activities), inappropriate objectives, and political pressures. Help can induce a general policy direction, exemplified by policy dialogue. This view assumes that a properly defined strategic vision will pull up performance of the organisation.

Creating islands of innovation

The lack of a conducive, protective environment reduces chances and opportunities for organisations to develop slowly and by experimenting. This view acknowledges the existing local capacity and defines the role of donors as nurturing and catalysing. This means protecting innovation,

offering opportunities for experimentation and learning, adapting support to local needs without imposing ready-made solutions and assisting the organisation with key supplies if necessary.

A lot of importance is attached to individual and group attitudes regarding improving organisational performance. Activities focus on promotion of social capital (collaboration, trust, solidarity, etc.). Results emerge from a joint analysis of the problems and search for solutions.

Strengthening the system level

Here, capacity is considered as a systemic problem, due to lack of specific organisations and institutions or of technical capacities at national level. Assumptions here are that relationships with the environment shape organisational effectiveness and that important, complex problems cannot be solved by single organisations.

Since interventions can be directed at many aspects, donor support risks to be fragmented. Also, this approach is rather complex and hard for small donors to implement.

Shaping an enabling environment

This view defines improper general environments and contexts as the major constraint to capacity development. Donors should therefore focus their attention on supporting changes in the institutional context and in social and political conditions. Currently, many activities developed under the good governance umbrella encapsulate this approach.

Creating performance incentives and pressures

Economic analysis identifies lack of appropriate structural incentives as a major cause of low performance: irregular or low wages, capture of organisations by pressure groups or local elites, etc. Services end up being abandoned by users, who lost trust. Major organisational redesign aims at bringing in different incentive patterns (e.g. decentralisation, breaking up state monopolies).

4.8 An example of a framework of strategic options for implementation of capacity development

A useful example of a strategy choice framework was developed and described by AIDS Control And Prevention/Family Health International AIDSCAP/FHI (1997) and Kotellos (1998). This framework involves seven capacity building strategies regarding HIV prevention, which are based on theories of organisational development and institutional development and

influenced by practices of empowerment, community mobilisation and participation.

1. Technical skill building: the improvement in skills necessary to carry out specific technical aspects of programmes or initiatives
2. Management skill building: improvement in the skills necessary to effectively manage programmes and efficiently utilise organisational resources
3. Management systems development: improvement of internal systems, operational procedures or tools that facilitate more effective management
4. Resource diversification: diversification of sources of financial and physical resources
5. Network building: improvement of organisational ties to constituents, peers and policy makers to increase support for project activities
6. Organisational cross-fertilisation: improvement in the exchange of information and experience between programme managers involved in HIV/AIDS programmes
7. Multi-sectoral collaboration: expansion of programme activities and ties to other public and private sectors not actively engaged in addressing the pandemic

These strategies fit the open-system model as follows (Table 1).

Table 1 - Relating capacity development strategies for the four levels (Adapted from AIDSCAP/FHI 1997)

	<i>Individual staff level</i>	<i>Organisational level</i>	<i>System level</i>	<i>User & community level</i>
<i>Strategy</i>	Technical skill building Management skill building	Organisational development	Organisational cross-fertilisation Multi-sectoral collaboration	Skill building Participatory decision-making Social capital development

First at *individual level*, human resource development is pursued through technical skill building and management skill building.

At *organisational level*, organisational development includes systems and structure strengthening, leadership and governance, resource diversification and networking.

At *system level*, organisational cross-fertilisation and multi-sectoral collaboration is stimulated (AIDSCAP/FHI 1997).

For the *user/community level*, strategies such as skill building, participatory decision-making and social capital development could be used. Interactions between the levels can lead to synergistic or reducing effects.

4.9 Capacity building methods at the individual level

4.9.1 Medical education: intake, selection & curriculum development

The literature usually does not include medical undergraduate education in capacity development (Milèn 2001). However, as mentioned earlier, a point could be made that this is an essential part of internal capacity development in so far that it is simply one of the basic elements of a proper human resources development policy. However, for various reasons, many academic institutions in developing countries depend not from the Ministry of Health and enjoy often a semi-autonomous status. This contributes to the fact that some are not optimally involved in the reality of both the peripheral and the policy-making level nor opening up easily to change.

4.9.2 Post-graduate training & retraining

On the job training, external training (in-country, abroad) and continuing professional education have been widely used in development, focused mainly on skill development for managers at the organisational level and often executed by expatriate technical experts.

On the job training

In the increasingly widespread systems perspective on capacity development, isolated training activities are insufficient (Milèn 2001). A comprehensive approach requires developing and sustaining strong organisational cultures, management practices and communication networks (Grindle 1997). Secondly, they need to be embedded in the existing local capacity, whereby external experts should assume a facilitating role rather than implementing isolated projects. Experience in Kasongo (Zaire) shows that it is possible to implement an effective hands-on training for district medical officers that complements existing capacities

and is geared towards felt needs (Kasongo Project Team 1976, De Brouwere & Van Balen 1996). The capacity building component of Maternal & Neonatal Health Program Framework for Social Mobilisation (Maternal and Neonatal Health 2002) uses a 'learning by doing' approach combining some conventional methods and is similar to personal development plans that were also used in Kasongo (De Brouwere & Van Balen 1996). In Zambia, the Philippines and Colombia, mobile capacity building teams allowed district level managers to be trained in specific skills required by health sector reforms. However, sustainability of these travelling training teams may be low due to the opportunity cost of drawing the staff from their usual working place (Martinez & Martineau 1998).

Postgraduate training (MPH/PhD)

MPH courses have been set up in many developing countries aiming at educating public health professionals. Furthermore, many development programmes include scholarships for training at institutes in Europe or North America (De Brouwere 1994). Documented evidence on impact on local capacity is rare and anecdotic in nature.

Continuing medical education

Continuing medical education (CME) is the continuous updating of the knowledge of medical professionals, a key component of most strategies to ensure good professional behaviour. The underlying assumption is that gains in knowledge will lead practitioners to better practice and improve patient outcomes. A shift toward *Continuing Professional Development* (CPD) adds the skills and attitudes doctors increasingly need: management, education and training skills, communication and teambuilding skills (du Boulay 2000). CPD should allow medical professionals to be able to meet the needs of patients, of the health system and of their own professional development (Peck *et al.* 2000). The latest development is knowledge translation, which aims at changing health outcomes by starting from the practice of health care. This approach surmises and builds on CME and CPD (Davis *et al.* 2003).

Distance learning has been another approach in CME, including non-interactive and interactive courses and virtual learning environments. Computer-assisted learning (CAL) packages are provided by universities (e.g. *Studying Populations* by University of Dundee) and development agencies (e.g. JHPIEGO 2002a). JHPIEGO (2002b) sets up Technology-Assisted Learning Centres (TALC) in developing countries, offering computers, Internet service, CD Rom based learning packages and workshops.

Davis *et al.* (1999) studied the effectiveness of formal CME activities such as ward rounds, educational meetings, conferences, refresher courses, seminars, lectures, workshops and symposia that involve methods ranging from passive, didactic methods to interactive, small group approaches. If performance change is the goal of CME, exclusively didactic approaches were found to have no effect: knowledge is essential, but in itself insufficient to induce change in practitioner behaviour. In contrast, providing active learning opportunities (case discussions, hands-on practice sessions, interactive workshops), using longitudinal, sequential programming (learn-work-learn) combined with provision of enabling methods to facilitate implementation in practice (patient education material, flow charts, clinical guidelines) do have an effect. Validity of basic principles of adult education such as learner-centeredness, being engaging and reinforcing was confirmed. Assessment of learning needs and demands, interaction between physician-learners with possibilities to practice the learned skills and sequenced multifaceted educational activities are essential elements of effective CME (Mazmanian & Davis 2002).

Review of the literature shows that very few studies exist regarding effectiveness of distance-learning. Learners may appreciate the flexibility offered by CAL. JHPIEGO (2002a) argues that CAL is cheaper, less time-consuming and motivating in that it allows individual pacing.

A review of cost effectiveness of CPD by Brown *et al.* (2002) concluded that economic evaluations of CPD activities are rare and not consistent in approach to costing and analysis, making interpretations of results impossible.

Conclusion would be that there is no good evidence to suggest that traditional CME is significantly effective. Some evidence exists to say that active learning opportunities, longitudinal, sequential programming and provision of enabling methods are essential elements of successful CME. Evidence on effectiveness of CAL in developing countries is missing. Evidence for cost-effectiveness of CME is currently non-existing.

Involving patients in medical education & training

In Europe and North America, patients are increasingly being involved in both undergraduate programmes and postgraduate programmes and continued professional education. Patients' roles include giving presentations, demonstrations and personal tuition, facilitating seminars and assisting in performance assessment. Doctors participating in these studies mentioned gaining more respect for patients and a better understanding of patients' experiences. One of the studies reviewed by Wykurz & Kelly (2002) concluded that *using patients as teachers improved*

local delivery of health care, changed professional behaviour and was cost effective. Regarding developing countries, there is no documentation. However, this practice seems useful in bringing together providers and users to improve service delivery and prompts further innovative research.

4.9.3 Mentoring

The underlying idea is an experienced mentor to guide and nurture individual staff members or little groups. In essence, mentors assist their protégés in finding their way in the organisation, clarifying its mission and vision, stimulating the socialisation process regarding the organisational culture and showing how things are done. A mentor takes an active interest in educational needs of his protégés and can assist in setting up a personal network of relations. They may *teach, sponsor, advise, coach, counsel, guide, motivate or critique* (Umiker 1998, p 293-4).

In *reciprocal mentorship*, peers exchange expertise by sharing their own experience, knowledge and skills. *Team mentorship* involves senior team members assisting their junior colleagues. Finally, in *group mentorship*, one mentor takes care of a whole group.

Unfortunately, mentoring is not widely discussed in the medical human resources literature, leading to lack of information concerning effectiveness.

4.9.4 Coaching

Coaching can be considered as a management style whereby dedicated leaders encourage people to attain their full capability, focusing on achieving good performance of individual staff members (Umiker 1998, p 120). It takes cues from the *Management by wandering around* concept: meeting people in their working place, listening more than talking, asking employees if they have a problem, but also asking them for suggestions and advice on how to solve it. Ensuring self-sufficiency of staff members is the primary aim.

Expert coaching is a method of empowering and providing continuous inputs through outreach visits, aiming at production of context-specific strategic knowledge. In contrast to supportive supervision, where the experts-supervisors belong the local health system (e.g. Kasongo experience), expert coaching is implemented by outsiders (Van Heusden 1999). The PALINAS project at the National Institute for Health Administration (Institut Nationale d'Administration Sanitaire, Rabat, Morocco) shows that demand based scientific guidance based on expert coaching principles is filling a niche (Zayyoun & De Brouwere 2001).

4.10 Capacity building techniques at organisational level

4.10.1 Twinning

Twinning involves institutional cooperation between government agencies, private companies and NGOs with the same task and focus (SIDA 2000) both in north-south and south-south direction. It fits squarely within the partnership approach to development. Because of the high opportunity costs for the southern partners, issues such as consideration of self-interests, expected benefits and incentives need to be addressed. Experience shows that funding and power relations, leadership, responsibilities, transparency, defining objectives, results and measurement require a lot of attention. Current experience may be promising, but evidence is still inadequate (Milèn 2001). Reeder (2000) mentions successful twinning in case of the Papua New Guinea Institute of Medical Research, where the partnerships developed beyond merely twinning arrangements into a coalition that provides collective support to sustain the institute's infrastructure.

4.10.2 Networking organisations

Networks of organisations are being set up with the aim of connecting peers, exchange information and experience and reduce intellectual isolation (Peterson 1997). The International Clinical Epidemiology Network (INCLEN 2002) for example supports an international communication network between researchers and their teams, not only to stimulate north-south exchange, but also to reinforce south-south interactions.

4.11 Capacity building strategies at system level

4.11.1 Networks

Also at system level, networks are becoming increasingly important often with the aim to change institutional conditions on national, regional and international level. SIDA (2001), for example, uses this method in policy definition matters to stimulate interaction between government and civil society.

4.11.2 Sector-wide approach & Poverty Reduction Strategies

Sector-wide approach (SWAp) aims at ensuring attainment of sectoral goals rather than individual donors or project objectives through optimal

interaction between government and donors. They superseded the project approach and offer, at least theoretically, opportunities for capacity development at policy level. A SWAp is intended to strengthen decision-making, national leadership, and institutional capacity building (Peters & Chao 1998). However, most SWAps did not give sufficient attention to capacity development issues (Milèn 2001) and did not eliminate but rather increase the need for technical assistance and support to implementation issues (Soucat 2001). On the other hand, SWAps theoretically offer a better heard voice for NGOs in the participatory decision making process and possibly some avenues through which national level decision-making capacity could be fostered.

Poverty Reduction Strategy Papers (PRSP) have been introduced as the next step, describing a country's poverty reduction strategy, integrating and superseding SWAps in the process. PRSPs are developed by the country itself with participatory consultation of civil society. They outline expenditure plans for government budgets and should address public sector issues. They aim at offering new opportunities to address health outcomes rather than health services, in the light of equity rather than efficiency solely (Soucat 2001). PRSP is the current WB/IMF preferred approach to poverty reduction, which made them a condition for debt relief after the failure of the Structural Adjustment Programme approach. Remains the question if anything changed in the World Bank's analysis, as *most PRSP ignore the complex relations between poverty and policies on trade liberalisation, tax reform, privatisation of public utilities and cost recovery* (Verheul & Rowson 2001).

5 Results of the Medicus Mundi Internationalis mail survey

5.1 Introduction

In an effort to document the experience of national Medicus Mundi branches and partners in the south, a limited mail survey was organised at the end of 2002. The specific objective of this survey was to gather information on the problems encountered and the interventions and initiatives developed by MM branches and/or by their partners regarding human resource development or capacity building in health care in developing countries.

The mail survey consisted of a short, open questions questionnaire that was sent by mail, fax or email to 10 MM branches in Europe and 30 mostly church-related partner organisations all over Africa. Operational definitions were briefly explained and clarified with some examples (See example in annex 3).

A word of caution is due: the response rates were quite low. Indeed, five European MM branches responded, while from the south, only four responses were obtained at the moment of final editing. The rather limited time frame, the slow surface mail communication and the difficult email access are probably to blame. Although obtaining an exhaustive inventory was not the aim, these low response rates obviously preclude firm (scientific) conclusions. However, as we will discuss below, the scope and range of problems and interventions mentioned is quite broad, leading to some interesting insights.

5.2 Overview of the human resource problems encountered by MM organisations

The analysis and synthesis of the responses was based on the systemic framework already discussed above (see Figure 6). Table 1 categorises the issues cited by the respondents according to the level of the system where they are situated: individual, organisational/system, user/community and external environment-level. Given the complexity and the interrelationships between the different components and determinants of performance, it should be noted that it is not always easy to disentangle the issues listed by the respondents.

Table 2 - HR issues cited by MM branches and partner organisations

<p>The individual level</p> <p>Health workforce balance: Inadequate manpower</p> <ul style="list-style-type: none"> ▪ Loss of manpower due to HIV/aids (Zimbabwean Association of Church-related Hospitals (ZACH), Cordaid) ▪ Loss of manpower due to internal and external brain drain (ZACH, Cordaid) ▪ Rapid staff turnover (Hospitals and lower-level units belonging to the Uganda Catholic Medical Bureau (UCMB), Family Life Association of Swaziland, Cordaid) ▪ Inappropriate planning and deployment (Cordaid) <p>Motivation</p> <ul style="list-style-type: none"> ▪ Low motivation & burn-out (ZACH, MM Alavia.) <p>Competence and Professionalism</p> <ul style="list-style-type: none"> ▪ Inadequately trained manpower (Cordaid) ▪ Professional and ethical standards not maintained. Professional associations unable to keep up standards (Cordaid) ▪ Health workers' commitment towards the population is sometimes quite low (MM Navarra, Cordaid)
<p>Organisational/system level</p> <ul style="list-style-type: none"> ▪ Insufficient local general management capacity (Calcutta Project Basel) ▪ Inadequate leadership, including prevailing high degree of individualism and inadequate long-term vision (MM Navarra) ▪ Inadequate coordination of health sector actors (MM Alavia) ▪ Difficult working conditions with lack of resources (ZACH, MM Navarra, Family Life Association of Swaziland, Cordaid)
<p>Community level</p> <ul style="list-style-type: none"> ▪ Low counter-power capacity of the population in the face of disrespectful and unprofessional behaviour of health providers (MM Navarra)
<p>External environment</p> <ul style="list-style-type: none"> ▪ General difficult economic conditions resulting in inadequate resources (ZACH, UCMB members, MM Alavia)

5.3 Summary of the HRD interventions set up by MM organisations

In this section, we present the interventions developed by MM organisations in the field of human resource development and where possible also their (perceived) effectiveness.

5.3.1 Initiatives aimed at the individual level

Supporting local medical and paramedical training institutions

MM Alavia supports a local nursing school through provision of scholarships and improving infrastructure. CUAMM supports both the diploma course and the Master in Health Services Management at the Uganda Martyrs University, Nkozi (Uganda). Graduates took up positions at district director level, at hospital director level and at NGOs. For this academic year 2002-2003, the Advanced Diploma in Nurse Education course and the Diploma in Health Education course were added.

Provision of scholarships for formal training

In Uganda, a programme of scholarships for formal training is in its second year, considered by UCMB as very successful in terms of perceived usefulness. However, at this initial stage, effectiveness is difficult to assess at this moment. MM Alavia, Cordaid and Family Life Association of Swaziland have a similar programme. Cordaid mentions bonding contracts attached to scholarships. Cordaid supported programmes allowed training of relatively high numbers of students. Most of their graduates took up positions at the sponsoring organisation. Some problems occurred concerning the selection procedure of candidates for training, while in some instances students dropped out during the training, leading to loss of investment.

Continued medical education

MM Castellón supports a programme of continued medical education for auxiliary medical personnel in Nayita (Colombia), which contributed to a better functioning health centre and improved health education. Also Cordaid supports CME programmes in a number of places.

Cuamm currently explores the possibilities offered by ICT for continuing education, lifelong learning and telemedicine.

Training of and delegation of responsibilities to lower cadres

MM Alavia supported capacity development initiatives for traditional birth attendants (TBA), which included providing them with supplies. As a result, TBAs worked in better conditions and were more appreciated by the population.

Cordaid assisted in several countries to the set-up of training courses for new cadres, usually less-specialised assistants to whom duties of higher trained staff are delegated (for example pharmaceutical technologists instead of pharmacists). Despite strong resistance of some professional associations, similar initiatives were carried out in Lesotho, Ghana, Malawi, Zambia, Indonesia and Papua New Guinea.

Supporting international courses

Cuamm supports various international courses, including a health services management course for experienced health providers from low-income countries at the University of Padova that took off in January 2002.

5.3.2 Reducing workforce imbalances

Tackling low motivation

Retaining staff through financial incentives

MM Alavia initiated a system of financial incentives for health workers that aimed at improving staff performance, which resulted merely in contributing to retaining staff. Family Life Association of Swaziland is currently working on a similar review.

Cordaid offers topping up of salaries for essential local staff in a limited number of cases, which at least on the short term is quite effective in retaining staff. But in Cordaid's view, the resulting distortion of local remuneration policies and the low degree of sustainability limits this approach to acute crisis situations. In other cases, Cordaid subsidises partner organisations for their recurrent expenditure to allow them to ensure salary payments. This seems to be a far more coherent approach that contributed to stabilisation of thousands of local employees.

Retaining staff through non-financial incentives

MM Navarra set up a broad system of non-financial incentives that aimed at the improvement of working conditions, including improved housing and rationalisation of off-duty schedules.

Cordaid has similar arrangements ranging from staff house construction to supplying means of transport for local staff and improving working conditions by supplying standard essential equipment and supplies to raise operational effectiveness and professional job satisfaction. This approach was very effective in that it even allowed to attract professionals in shrinking markets and to replace expatriate staff by local personnel.

In order to respond to the understaffing and rapid turn over of personnel, some of the hospitals of the Uganda Catholic Medical Bureau modified the general terms and conditions of service (contracts, pay levels). Take up by other local organisations is slow.

In other cases, Cordaid is assisting in setting up a system of retirement benefits (for example in a land buying scheme for future pensioners). Although it is not easy to protect pension funds against inflation, the prospect of social security at retirement has a quite strong influence on recruiting and retaining staff in economically unstable and uncertain situations, as proven by Cordaid in Ghana and Malawi.

Supporting staff morale

MM Navarra works on improving motivation through improved self-recognition (*reconocimiento personal*).

Reducing loss of personnel through occupational HIV infection

The Zimbabwean Association of Church-related Hospitals (ZACH) drew up guidelines on prevention and management of needle prick accidents.

Cordaid trains local staff on aids prevention and lobbies to give employed (para)medical staff priority in HAART programmes.

Addressing workforce distribution issues

Employing more local personnel

Since a few years, Cuamm employs increasingly local personnel. Cross-fertilisation between expatriate and local staff is appreciated by all parties.

Topping up of staffing levels with expatriates

Cordaid and MM Alavia send out expatriate personnel to supplement the local staff. For Cordaid, it is clear that supplementing is a mere drop in the ocean, except in the case of deploying staff at teaching institutions.

Cuamm improved its selection process to ensure employment of qualified and competent expatriate personnel. Selected professionals are offered appropriate training and are supervised closely. Staff appraisals are carried out for all staff. A refresher course of health policy, planning and

management for expatriate personnel has been organised for the first time in 2002.

5.3.3 Interventions at the organisational level

Institutional support to training institutions in the south

Cordaid supports training institutions (including a school for business administration, medical faculties, paramedical training centres) financially and by deploying (expatriate) teaching staff. Good results are seen in that supported institutions meet higher standards of quality.

Increasing local managerial capacity

Many examples were given of interventions aimed at strengthening the capacities of managers and leaders. Calcutta Project Basel aims at increasing the local management capacity through capacity building in order to allow for delegation of more responsibilities to local staff. Training, coaching and mentoring are used to transfer strategic management and administrative skills, including ICT.

MM Navarra supports similar activities, both formally and informally (coaching and mentoring through supervision). However, attrition rates of trained personnel are high reducing the effectiveness for the local organisation.

MM Navarra also focuses on developing leadership skills: promising individuals are given a training and basic resources to develop a personal professional project. Results are good in that commitment of these 'leaders' increases. However, the results are short-lived because of the high attrition rates resulting in a high turnover of 'graduates' of these trainings.

A course in management for experienced health workers was set up by UCMB. Demand for this course is currently not (yet) strong, but steadily growing. Evaluation was not yet done. MM Alavia facilitates participation to similar courses, but results were not (yet?) noticed.

Cordaid focuses on management capacity in various ways. Relevant literature on health care facility management and health economics is distributed. HR management is included in hospital and health administration training.

Re-organisation and teambuilding

MM Navarra introduced reorganisation of health providers into teams, which are focused on common goals and through which exchange of experience is stimulated.

5.3.4 System-level initiatives

Decentralisation and contracting

Cordaid promotes decentralisation and the contractual approach in an effort to increase management capacity of peripheral centres and hospitals to manage their own personnel, including the right to hire-and-fire. Where decentralisation of HR authority is introduced, it seems that awareness of the importance of proper HR management rises. Furthermore, job fulfilment, discipline, supervision and team working are more easily attained, especially if effective community participation channels users pressure on providers.

5.4 Discussion

Although due to the low response rate, the previous sub-chapters present the responses of only a particular sample of MM organisations, practically all fields and avenues for action represented in the analytical model are somehow mentioned.

External environmental factors are virtually invulnerable to the efforts of small NGOs. Few interfaces with the central level and limited effective influence on the determinants of the performance of the system explains why few interventions are aimed at the system-level.

Interesting issues include the difficulties mentioned by MM Navarro of the usually low capacity of the community to exert a countervailing power to inappropriately behaving providers. Also striking are the comments of several respondents regarding the lack of commitment and of professional behaviour of some providers.

Some interesting approaches have been mentioned. Particularly the field of motivation remains challenging and innovations regarding non-financial incentives merit thorough analysis and documentation. Finally, MM Navarra's and Cordaid's experience seems to be quite illustrative of the fact that measures taken in isolation are not or far less effective than a more holistic approach. Here again, MM related organisations can play a role in ensuring good documentation of approaches that analyse the root problems, the resulting interventions and the outcomes.

6 Possible action domains for MMI

Given the complexity of the issues and the fact that MMI is active both on the international scene and through its national branches indirectly on the field, several possible domains of action can be discerned. The main challenge remains how to tackle the problems discussed above in a comprehensive, yet sustainable way. MMI's main actions will logically be on the international scene, while it could facilitate, stimulate and coordinate actions by the national members and partner organisations.

6.1 At operational level

The national MM branches are supporting a number of NGOs and other partners that are active mainly at provider level: first line health services, district and mission hospitals. A second type of supported organisations are the church hospital/health associations or national coordination bodies. MMI's role could be to assist the national MM branches by developing common frameworks and best practice guidelines.

Another issue is the creation of discussion forums to maximise opportunities for interaction and exchange of experiences. The lack of well-documented and evaluated innovative interventions in the literature makes systematic documentation of new approaches a priority. NGOs occupy a niche in that they often have a certain margin of freedom to try out new things.

6.1.1 Developing capacity

Capacity development actions preferably focus not only on individuals, but also take the context into account, and more specifically the organisation as an entity (although in some cases even the system level should be targeted).

Regarding *individual human resources*, undergraduate medical education is usually not included in capacity building and requires a long term perspective, but it is a fundamental determinant of HR capacity and performance. MM members' experience indicates that some are already supporting both national and international initiatives. Although Continuing Medical Education is a common strategy to maintain professional competence, the literature suggests that in many instances current practices may benefit from a critical analysis of the used methodology.

At *organisational* level, the notion of stewardship seems promising to some extent, but lack of documented experience highlights the need for creativity. Church hospital/health associations (CHA) could in some cases

offer interesting channels of action, depending on their organisational performance, the degree to which they offer services to their member institutions and to which they have an agreement with government (Green *et al.* 2002). Strengthening their general management capacities and capacity for advocacy and policymaking could be objectives. CHA could also constitute test sites to examine in how far the stewardship concepts are valid and how exactly stewardship capacity can be developed.

At *community* level, capacity development initiatives could be developed directed at creating skills and an organisational basis to allow more effective expression of the 'voice' of the community. Challenges abound once it gets practical: what is the community, how to obtain representative bodies that effectively represent the poor? Again, local experience merits to be documented to allow analysis and dissemination.

6.1.2 Stabilising the workforce

Strategies aiming at retention of health professionals and paramedical staff need a holistic approach, as shown by Cordaid's and MM Navarra's experience. Financial and non-financial incentive schemes need to be integrated. Innovative social security-mimicking initiatives seem a logical pathway, as demonstrated by Cordaid's retirement benefit schemes, but present also fundamental questions regarding sustainability.

The creating of new cadres of lesser-qualified staff to fill gaps left by departing professionals is in our opinion a strategy that should not be attempted without careful analysis of possible consequences.

6.2 At national level

Also at national level, MMI could exert an indirect influence through its national branches. This would regard developing common cooperation strategies and policy directions.

6.2.1 Strengthening local coordinating bodies

In many countries, Church Hospital/health Associations are active. Their specific role could in some cases be reconsidered to reach beyond being a collective drug-purchasing agency. CHAs could be more active regarding their members and vis-à-vis the national health system level. As mentioned above, they could constitute a forum for discussion, a channel for dissemination of information and best practices and for support of their members. The interface with the ministry of health may provide opportunities to present alternatives for health policy and service

organisation. This reorientation would in some cases probably require an in-depth review of the mission and a redefinition of the organisational vision of the CHA.

6.2.2 Participating in SWAps, PRSP debates and other forums for policy making

There may be opportunities for NGOs to voice their concern at policy 'influencing' forums, such as participatory meetings preparing PRSPs and at Ministry of Health level through associations of NGOs for example. As already discussed briefly, well-organised and representative CHAs could play a role here.

6.3 At international level

The international level is MMI's working terrain *par excellence*. First, MMI has a potential role in international health policy agenda setting. MMI could bring up important issues at international agencies and forums through lobbying and through media campaigns. Issues could include the northern side of the brain drain issue that needs to be brought under closer public attention. Particularly the professional malaise that currently sweeps through health services in European and other developed countries and that may be an important drive of the brain drain needs to be put on the agenda.

Second, MMI has a privileged access to its own member organisations, amongst which it could initiate a broad human resources debate. An alliance with other organisations would be a logical next step, similar to MSF's actions regarding drugs and neglected diseases. Another domain already touched upon is the supporting role MMI could play for its MM branches. The preliminary results of the MMI mail survey show that MMI could play a role in documenting and analysing the experiences and initiatives developed by its members and organisations it supports.

Dissemination of 'best practice' by MM branches and national coordinating bodies could speed up innovation in difficult domains such as improving motivation and retaining health staff. Special attention could go to stewardship issues, although perhaps rather from a research perspective, as up to now, little research has been done in this field. The resulting lack of descriptive and analytical frameworks impedes straightforward description and inventarisation of stewardship-related actions.

7 Conclusion

In this report, we discussed the issues of the brain drain, stewardship and capacity development and explored how they are related and relevant to human resources development in health care in developing countries.

Health workforce imbalances, stewardship and capacity development are entwined to a certain extent and all share two essential elements: their complexity and their interrelations with other broad issues rooted in the international scene. As a consequence, there are no blueprints: in all situations, the specific context and the stakeholders will need to be taken into account and isolated actions preferably avoided. In our opinion, MMI's particular position at the interface between the realities of the field and the international health policy scene offers opportunities to influence the agenda in the direction of real world concerns.

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Annex 1 - Relevant consulted websites

Capacity building

- www.acdi-cida.gc.ca/cida_ind.nsf/ - Capacity development site of CIDA
- www.capacity.org - is an initiative of the European Centre for Development Policy Management with the aim to look at policy and practice of capacity building within international development cooperation. It focuses on both the "why" of capacity building - fostering debate on policy questions - and the "how" of capacity building - learning from practical experiences in the field.
- www.capacity.undp.org/resources - UNDP Capacity Database
- www.cgiar.org/isnar/ecd/keyreferences.htm - The Consultative Group on International Agricultural Research (CGIAR) hosts this International Service for National Agricultural Research (ISNAR) site that promotes the use of evaluation as a tool to advance the development of organizational capacity and performance. Its main purpose is to support a group of managers and evaluators who are evaluating capacity development efforts in their own organizations, in Africa, Asia and Latin America. This group makes up a global project on "Evaluating Capacity Development Project (The ECD Project)".
- www.ecdpm.org/ - European Centre for Development Policy Management
- www.euforic.org/by_theme/120.htm - European Forum on International Cooperation
- www.gdln.org - Global Development Learning Network
- www.universalia.com/english/capdev.main.htm

Stewardship

- www.fiocruz.br/cict/dis/ - WHR 2000: discussion group
- www.healthsystemsrc.org/ WHR 2000 summary & comments

International organisations

- www.acdi-cida.gc.ca - Canadian International Development Agency
- www.who.org - World Health Organisation
- www.worldbank.org/oed/ - World Bank, Operations Evaluation Department
- http://europa.eu.int/comm/development/sector/social/health_en.htm - European Commission

Research capacity building

- www.cohred.ch - Council on Health Research for Development
- www.globalforumhealth.org - The Global Forum on Health Research
- www.inclen.org - International Clinical Epidemiology Network - INCLEN
- www.wellcometrust.ac.uk - The Wellcome Trust
- www.who.int/reproductive-health/hrp/ - Capacity strengthening, UNDP/UNFPA/ WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction
- www.who.int/tdr/about/strategy - UNDP-World Bank-WHO Special Programme for Research and Training in Tropical Diseases, WHO

Annex 2 - Linking required capacities to general and specific objectives for the four levels

	<i>Individual level</i>	<i>Organisational level</i>	<i>System level</i>	<i>User & community level</i>
<i>General objectives</i>	<ul style="list-style-type: none"> ▪ Achieving excellence / optimal performance in the defined area 	<ul style="list-style-type: none"> ▪ Achieving optimal provision of health care through optimal utilisation of available resources, information and knowledge 	<ul style="list-style-type: none"> ▪ Improve health of the population ▪ Respond to people's expectations ▪ Provide financial protection against costs of ill-health (WHO 2000) 	<ul style="list-style-type: none"> ▪ Obtain optimal health care: affordable, high quality, accessible, equitable ▪ Participate in the shaping of the service supply ▪ Define the values of 'the good life'
<i>Specific objectives</i>	<ul style="list-style-type: none"> ▪ To provide good quality curative, preventive and promotive care 	<ul style="list-style-type: none"> ▪ To organise and set up conditions for best practice ▪ To ensure optimal conditions for the human resources 	<ul style="list-style-type: none"> ▪ To reduce suffering: mortality and morbidity 	<ul style="list-style-type: none"> ▪ Exert pressure on providers to offer optimal health care ▪ To get correct information allowing informed choice at individual and community level
<i>Required Capacities</i>	<ul style="list-style-type: none"> ▪ Skills specific for the function ▪ Skills to ensure accountability ▪ Enablement capacity⁴ 	<ul style="list-style-type: none"> ▪ Strategic planning, including mission definition ▪ Financial management ▪ Information management ▪ Logistics/infrastructure systems management ▪ Communication ▪ HR development ▪ Skills to ensure a culture of accountability (both upwards and downwards) 	<ul style="list-style-type: none"> ▪ Design of appropriate structures in the health sector ▪ Design and implementation of policies, including training ▪ Coordination of actors ▪ Allocation and management of resources ▪ Ensure accountability ▪ Regulation 	<ul style="list-style-type: none"> ▪ Assess/ analyse own (individual/community) needs ▪ Assess/ analyse health providers' offer (quality, coverage...) ▪ Voice: expressing needs and demand; represent and defend rights

⁴ See Howie *et al.* 1998

