



## Improving the global health workforce crisis: an evaluation of Global Health Corps

The health workforce crisis has contributed to many countries' inability to achieve the Millennium Development Goals, and is likely to affect the ability to achieve the Sustainable Development Goals and universal health coverage.<sup>1,2</sup>

Solutions to the workforce crisis have mainly targeted service providers (physicians, nurses, etc) by either improving the local and global supply of these workers or reducing the workload burden through task-shifting.<sup>3,4</sup> However, focusing on service providers will not overcome crucial barriers in the implementation and scale-up of health services such as stockout of health commodities, ill-constructed facilities, and outdated information systems.

Global Health Corps (GHC) was launched with two goals: to immediately increase the supply of leaders and managers with diverse skills, and to build a leadership pipeline to ensure health equity. GHC recruits fellows and places them in selected global health service delivery organisations in sub-Saharan Africa and the USA. It identifies partner organisations that are interested in hosting a team of two fellows. Partner organisations identify a capacity gap in their organisation and apply for a pair of fellows to fill it. Fellows are selected on the basis of the relevant skills set needed by partners for that fellowship year and on their demonstration of GHC's key leadership practices: commitment to social justice, ability to inspire and mobilise others, interest in collaborative work, willingness to adapt and innovate, self-awareness and commitment to learning, and demonstration of achieving results. A team of fellows is created by selecting at least one fellow from the partner organisation's country and at least one fellow from other countries.

GHC fellows work for 1 year and are co-funded with the partner organisation, depending on the financing capacity of the partner organisation. Throughout the fellowship, GHC invests heavily in learning and leadership development via a pre-fellowship training session, quarterly retreats, mentorship with global health leaders, and post-fellowship retreats and networking events.

From 2009 to 2015, GHC has placed seven fellowship classes totalling 584 fellows (from more than 5000 applicants) with 95 partner organisations across seven countries: Burundi, Malawi, Rwanda, Uganda, USA, Tanzania, and Zambia. The 2014–15 class represents 22 countries of citizenship, an average age of 25.7 years, a 2:1 female-to-male ratio, and more than 45 disciplines including architecture, agriculture, communications, computer science, economics, engineering, finance, supply chain optimisation, management consulting, and technology development.

Of the 2013–14 partners (n=47), 87% reported that having a fellow was "critical" or "contributed positively" to the success of the organisation, 89% reported that their fellows met or exceeded established work goals during the fellowship year, 85% reported that the GHC co-fellow model and quarterly retreats increased fellows' effectiveness at their placement sites, and 75% would want GHC fellows again.

Models such as GHC could offer the opportunity to help to address the supply and skill-mix imbalance in the global health workforce<sup>5</sup> by aligning the specific problems plaguing health systems with systems thinkers who possess the needed skills and leadership traits to address those problems. As health systems have advanced to encompass a range of disciplines, the approach to human resources for health should include more effort to include a greater diversity of talented young leaders.

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\*Rajesh Gupta, Barbara P Bush, Jonny Dorsey, Emily Moore, Cassia van der Hoof Holstein, Paul E Farmer  
rgupta1@stanford.edu

Stanford University, Freeman Spogli Institute for International Studies and Center for Innovation in Global Health, Stanford, CA, USA (RG); Global Health Corps, New York, NY, USA (BPB, EM); The Aspen Institute, Impact Careers Initiative, Aspen, CO, USA (JD); Partners In Health, Cambridge, MA, USA (CvdhH, PEF); Harvard Medical School, Global Health Delivery Partnership, Boston, MA, USA (CvdhH); Brigham and Women's Hospital, Division of Global Health Equity, Boston, MA, USA (PEF); and Harvard Medical School, Department of Global Health and Social Medicine, Boston, MA, USA (PEF)

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