

Background Paper II

The Challenge of Human Resource Management in Conflict–Prone Situations

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Health and Conflict Project**

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Prologue

In September 2003, AusAID funded the Australia-Canada Consortium on Health and Conflict to draw on the experience of academics and practitioners from Australia and Canada at the interface between health systems and conflict prevention and peace-building, conflict management and reduction, and support for post-conflict recovery. The study aims to contribute to the knowledge of, and evidence around, the interface between health and conflict by documenting experience and identifying good practice.

The initial year of the project was largely devoted to exploring the vast area of health and conflict, types of conflict situations, and specific country situations. The countries forming part of this study are East Timor, Sri Lanka, Solomon Islands, Bougainville/PNG, and Cambodia. A two-phase approach has been adopted to drive the project forward. The first phase predominantly involved secondary research and concentrated largely on framing the research questions. The two initial papers cover what the team deems essential to introduce the area of health, conflict and peace-building:

I. Health and Peace-building: Securing the Future

II. The Challenge of Human Resource Management in Conflict-Prone Situations

Issues Paper I: *Health and Peace-building: Securing the Future* sets the scene for contemplating the relationship between health and peace-building in humanitarian crises and development, specifically focusing on the long-term health and social impact of violence.

Issues Paper II: *The Challenge of Human Resource Management in Conflict-Prone Situations* explores the characteristics of post-conflict and transition periods, and challenges they present to the health workforce.

Comments on these materials would be appreciated: please submit these to the Project Coordinator, Anne Bunde-Birouste (ab.birouste@unsw.edu.au) or to the Project Leader, Anthony Zwi (a.zwi@unsw.edu.au). For information on related projects, please check the project website at <http://healthandconflict.sphcm.med.unsw.edu.au/>.

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Preamble

The growing number of states in crisis internationally has created the need for new approaches to global governance to address the effects of political violence, to prevent conflict, and to build more peaceful societies. The international consensus is that earlier strategies of national development have not realised their goals and that growing levels of poverty are a major cause of political violence and social insecurity. Moreover it is now realised that any response to humanitarian emergencies must go beyond relief to address the longer term well-being of populations in distress. Humanitarian responses have become integrated with development strategies in order to improve human security by addressing the root causes of conflict.

The complexity of current conflicts makes a simple analysis of them hazardous. Too often conflicts are approached as if they were between clearly identifiable protagonists when in fact they are dynamic and reflect shifting and competing interests both within and between groups.

Conflict is not just about social breakdown but it is also about social transformation. The requirement that humanitarian assistance and development projects need to be conflict-sensitive is recognition of this reality. The ‘do no harm’ imperative warns us that current conflicts become symbiotically connected to the social and economic resources introduced into conflict areas. On both sides there are state and non-state actors as well as legal and illegal business interests that can overlap producing patterns of ‘cooperative conflict’.

The reality that any intervention becomes part of the dynamic of a conflict means we should be modest in evaluating the conflict prevention and peace building potential of any particular initiative. Projects will usually have local and wider potential benefits. At a minimum we should ensure that there is a local benefit which will endure for the individuals and communities directly affected. Wider peace building gains may be more difficult to measure especially in situations where the overall conflict persists.

Abstract

Human resource (HR) management and development are major challenges in any health system. The unique characteristics of conflict-prone settings place added strain on planning and implementing effective human resource policies. HR needs fluctuate during different phases of crisis and recovery yet continued support to local health personnel is essential at all stages if a health system is to be maintained and its collapse prevented. HR issues are always sensitive, especially in societies riven by ethnic, class and other cleavages, where unemployment is high, and the resource base limited.

This paper outlines some of the key challenges and possible responses to managing and developing human resources in a conflict-prone environment.

Section 1: outlines some of the characteristics of conflict-prone environments and examines how HR management and development are affected by conflict.

Section 2: presents case studies from several countries and applies a conflict and health lens to a range of HR interventions that may be considered pre-, during, and post-conflict to support the health workforce.

Section 3: considers Australia's particular contribution and whether this country has a comparative advantage in HR management and development in conflict-affected situations.

This paper is intended as a supplement and not a replacement for in-depth texts on HR management and development. It aims to take the reader beyond a general appreciation of HR issues to considering the specificities of work in conflict-prone environments.

Introduction

Human resources are cited as the most costly component of health budgets; in many countries salaries represent 65% to 80% of health system expenditures. The *World Health Report 2000* defines human resources for health as ‘the stock of all individuals engaged in the promotion, protection or improvement of population health.’ Without skilled human resources, health services could not be provided to diagnose, cure, treat and prevent illness and promote health. Human resource issues are always sensitive, especially in societies riven by ethnic, class and other cleavages, when unemployment is high and the resource base is limited.

1. Human Resources and Conflict-Prone Settings

Investment and support of human resources is critical to enable both the delivery of essential health services and to enhance the longer term capacity of the public health system. Careful analysis is required to ensure that interventions are effective and produce positive and sustainable outcomes; application of a ‘health and conflict lens’ to intervention plans (see *Issues Paper I: Health and Peace-building*) is recommended.

1.1 Types of conflict

The type of conflict affects the scope, scale and complexity of health services management and HR issues. The many different types of conflict each have different implications for HR management and development during and after major periods of conflict. Whether the conflict is a civil war affecting one or more regions of the country (e.g. Sri Lanka) or a UN-sanctioned armed intervention will have consequences for governance and the ‘handover’ of authority. In many circumstances a regime change occurs and this poses particular challenges to human resource management and development. In East Timor, an agreed timetable from the United Nations Transitional Authority in East Timor to an independent state allowed a focus for developing systems and enhancing local capacities.

1.2 Characteristics of conflict-prone situations

In conflict-prone environments we commonly find:

- Levels of instability fluctuate in place and time; often in the ‘post-conflict’ phase, there are regions where violent conflict persists;
- Uncertainty as to regime legitimacy and legal status;
- Uncertain ability to govern;
- Weak, factionalised political and social institutions;
- Dispersed communities – including flight of professional workforce;
- Fragmented civil society – for example, non-governmental organisations, professional organisations and the media, may not be functioning well;
- Economic disruption and;
- Damaged or destroyed infrastructure and disrupted services.

In post-conflict settings there may be a feeling of optimism and expectations of change. There may be heightened international interest and an influx of human and material resources, offering opportunities despite the ongoing socio-political instability. Consideration of all these factors is crucial in the planning, development and management of the health workforce.

1.3 Health workers in conflict-prone settings

- Health workers may be among the first to detect increasing cases of violence or abuse against particular groups or sub-groups. Less directly they may also observe declining use of services or weakened access to health care. These warning signs can signal vulnerability, grievances or distrust, and may heighten perceptions of inequity and injustice.

- Awareness raising for health workers operating in contested and conflicted environments may be valuable. This could include the use of Conflict Vulnerability Assessments and guidance for documentation of human rights abuses. Not all health workers will feel comfortable participating in these processes; in highly contested environments the collection of information reflecting violence and abuse must be dealt with sensitively. Furthermore, it cannot be assumed that health workers are neutral players in highly contested environments; they too are part of the community and local political processes. It is important that they receive adequate training to protect themselves against accusations of misconduct – health personnel like others will be held accountable for their responses during the conflict.

- A situation that could signal a forerunner to conflict is the deterioration of the economy, governance and public services such that public sector staff are irregularly paid and supported. For most skilled staff, this forces them to consider their options in how and where they work (see ‘Brain Drain’, p5).

- Where salaries are irregular, health workers cope by undertaking private work, requesting or demanding ‘payment’ from community members that use their services, and drawing on their public position to enhance their private practice. High rates of absenteeism may be common as staff attend to personal matters and pursue other economic opportunities. Coping behaviours, such as directing patients into the private sector or

The under-explored issue of HIV/AIDS and Human Resources

HIV/ AIDS is often exacerbated in periods of conflict. Health workers are prone to HIV infection as are other community members. Rising levels of HIV reduce staff morale and result in increased workloads and pressure for remaining health workers. Training and education of health workers must address both issues affecting their own risk as well as the role they may play in preventing HIV transmission in the community. Ongoing attention to spiralling rates of HIV in some conflict-affected areas in the Asia-Pacific region is warranted.

misappropriating drugs, and other strategies undermine the public health system. Early appreciation and response is indicated.

- The provision of a safe working environment and personal and professional support for staff who remain in less secure areas demands innovative responses. These include:

- Decentralising supplies,
- communications and logistic support;
- Strengthening linkages between the health workers and the communities they serve;
- Developing networks between health workers in similar circumstances and adjacent areas;
- Facilitating alternative payment mechanisms (e.g. payment in kind rather than with cash) for services received and;
- Boosting morale by recognising the difficult circumstances in which health workers operate and assisting them to see the important role they have in their community.

- Retention of staff may enable services to operate for longer, may help prevent breakdown of civil services and could play a role in preventing the escalation of violence.

1.4 Effects of conflict on human resources for health

Crisis and conflict have the potential to impact on the health workforce in multiple ways. The pre-conflict state of the health sector as well as the nature and outcome of the conflict will determine many of HR changes. Key challenges include:

- How to restructure the workforce (considering skill mix, job design and training)?
- How to respond to ‘Brain Drain’ as a result of insecurity?
- How to get health services up and running without undermining local capacity?
- How to coordinate NGO and donor inputs in the human resource arena and?
- How to finance and fund human resources in health?

These issues are addressed in this section and in the four cases studies that follow.

Restructuring the workforce: skill mix, job design and training

The health system requires a wide range of health personnel for efficient functioning. In conflicted settings the availability of appropriately trained health staff is often very limited. The health workforce may be greatly reduced in size as a result of:

- deaths;
- abandonment of health jobs
- external migration
- internal displacement
- migration of staff from public to private sector (see ‘Brain Drain’, p5).

Restructuring the workforce will be one of the most politically controversial HR measures. It is vital to achieve political support for major changes. Pavagnani (2003) suggests a ‘convergence of powerful players within government and among donors offers the best chance of success.’

Paradoxically, conflict may also produce a proliferation of health personnel as a result of deregulation and fragmentation of training¹.

Warring parties often establish their own parallel health services – as occurred in Kosovo, Eritrea, Tigray, and Sudan, while NGOs may provide health training courses in refugee camps. This can lead to overstaffing of lower level health workers, while significant gaps in higher level skills, management and public health persist.

As demobilisation occurs, ex-combatants may join the ranks of job-seekers at a time when the labour market has a low capacity to absorb them. Re-integrating staff into the national health service may be technically and politically difficult; this should nevertheless be an important focus and may contribute to breaking the cycle of conflict and violence. Balladelli *et al.* (2003), suggest that ‘conspicuous investment in integrating military and rebel health personnel is largely justified.’

Agreeing on quantity, levels of personnel, training required, types of services to be provided, and how and at what level remuneration will take place are supposedly simple but are in fact very complex decisions. They are strongly influenced by:

- current availability of health service personnel from internal and external sources;
- future roles of the government and non-government sectors within the health care system;
- pattern of health service delivery;
- availability of personnel training resources;
- allocation of health personnel training responsibilities and;
- financial resources.

¹ Beesley M and Scuccato R. 2003. First steps towards healing a workforce: in-service training in Angola. *World Health Organisation Health in Emergencies*. 18; 11. Available at: <http://www.who.int/hac/about/en/12010.pdf>

Existing personnel often have disparate job descriptions, no documentation of qualifications or experience and have received fragmented training. It is unlikely that the public health sector can absorb and pay all health-related staff following a conflict, especially if recurrent funding support has been reduced.

Recognition of prior staffing

In addressing deficits in staffing it is important to take into account the staffing situation prior to conflict – sometimes imported ‘advisors’ have difficulty in accepting staffing levels and patterns which are typical of countries other than their own. Such advisors may also place an emphasis on medical practitioners, failing to consider nurses or indeed the full range of health service personnel that are required.

Health Human Resources in North Eastern Province, Sri Lanka 2000
(Source – Tudor Kalinga Silva, 2004)

Category	Cadre	Vacancies	% Vacant
MO-specialist	51	40	78
MO	402	86	21
Pharmacist	133	59	44
PHI	383	139	36
Nurses	1191	511	43
Midwife	1231	679	55
MLT	59	22	37
Microscopist	40	14	35

Planning for appropriate skill mix

In the post-conflict phase, it is often clear that past expectations in terms of the size and skill level of the health workforce can not be sustained and more innovative and lower cost avenues for providing services are required. This typically involves a review of roles, up-skilling lower cadre staff and involving patients, families and the community in the delivery of health services. Furthermore, in the rebuilding stage, the opportunity to ‘reform’ the entire health sector is often seized. This may change the workforce requirements significantly; a Health Workforce, Education and Training Plan should reflect these changes.

Where roles have been re-defined and responsibilities expanded, new expectations must be clearly communicated to personnel.

Cambodia In 1994 the health workforce of 22,000 staff was characterised by 59 different classifications of health workers with various competencies and no regular career structure (World Bank, 1994). The Health Coverage Plan collapsed health roles into 23 core categories of staff and focused on developing job descriptions; providing a clear assignment of roles and responsibilities within the public health system. Staff had undergone a variety of training to re-orientate them to this ‘new public health.’

Education and training

Education systems are typically severely disrupted in war-torn states and investment in training capacity will need to be a priority over the long-term to ensure a sustainable health workforce. There are several important considerations in training health personnel in conflict-affected areas:

- Existing capacity must be recognised prior to establishing education and training modules. The learning needs of the staff should direct the theme and content of training rather than assumptions of donors and NGOs or the requirements of their particular vertical programs.

Periods of relative stability offer opportunities to train staff in peace and conflict prevention skills. The WHO ‘Health as a Bridge to Peace’ (HBP) initiative improves health workers’ skills to deliver services in conflict-prone environments and to identify opportunities for peace-building in their practice. The following website provides links to the HBP curriculum and early reflections on the training initiatives in Sri Lanka, Indonesia and Russia: <http://www.who.int/disasters/bridge.cfm>

- A major frustration in the immediate post-conflict phase is often the lack of planning and coordination of training activities. Many emergency relief and development agencies will have some commitment to training and capacity building. In Sri Lanka, up to 3,000 different NGOs have operated. Early agreement of the categories of staff, level of skill required and reimbursement levels should be a priority.

Systems to accredit and regulate training deserve early consideration. Ad-hoc training by multiple agencies produces a fragmented workforce and creates difficulties in integrating health workers into the public sector.

- Training (through associated per diems) represents a significant income source. Selection of staff for training must broaden opportunities to participate and be undertaken in line with priority needs rather than based on patronage or seniority.
- Staff undergoing training are absent from their regular duties. Training needs must be balanced against availability of staff to maintain health services (especially where re-establishment of community trust in the public health sector is a concern). Agencies should plan and coordinate both locally-based training courses and invitations for senior staff to train abroad in a way that minimises impact on service delivery. Distance based learning, ‘on-the-job’ training, short courses, and problem-based learning applied to recognisable scenarios and other innovative models for training delivery offer promising solutions.
- Training and capacity building at management level is a crucial first step in re-establishing health services and ensuring effective deployment of available staff. The post-conflict period often sees clinically-orientated staff tasked with high level management and administrative responsibilities. Such staff must be supported and trained for their new roles.
- Monitoring and evaluation activities should be built into training plans. Much of the training activity undertaken in post-conflict environments is not evaluated. Greater efforts are required to understand what types of training are effective in producing changes in skill level and practice.

In supporting workforce restructuring, Australia should avoid:

- the employment of inexperienced or inappropriately oriented Australian personnel
- supporting large numbers of small, localised NGOs who are not integrating their activities into the national workforce plan.

Activities to be promoted include:

- formalising links with lead agencies in education and training
- identifying niche areas where Australia might lead in training and service development

‘Brain Drain’ as a result of insecurity

The loss of skilled staff from the health workforce is one of the major challenges facing HR management and development in conflict-prone settings. Insecurity and instability are significant causes for skilled personnel to migrate – to the cities, across borders, and out of the public sector.

- **During periods of unrest, one of the HR issues facing the health sector is: How to boost morale and provide incentives for workers to remain in post in rural and remote areas?**

In conflict-prone environments a displacement of health personnel towards the most secure regions of the country is common and may result in overstaffing in some areas while less secure (often rural) areas experience a collapse of health services. Following conflict, reluctance to return to unstable, poorly supported or remote areas often persists. Urban areas may provide opportunities for private practice, consulting for NGO projects and non-health related economic activities that are not available in rural and remote regions. Retaining staff in rural health posts is difficult and requires monetary and other career incentives that may be hard to provide.

Health workers face significant challenges. These include fatigue and burnout, lack of supervision or support, and demands to take

on a host of new roles without adequate training and/or support. Health workers may be exposed to difficult and challenging environments, some of which will result from intensive exposures to prior trauma – their own or that experienced by members of their community. Health workers are challenged to make difficult decisions – such as whether a patient should be charged for services rendered or whether the community or service should subsidise such costs.

Among the responses to these difficulties are the following possibilities:

- maintaining communication channels and systems;
- facilitating debriefing and guidance for health workers exposed to a range of experiences of abuse;
- working with health staff to envisage and plan for a better future and;
- developing health worker skills to interface with and collaborate with traditional practitioners.

Workers in the Mozambican Ministry of Health set about the task of planning the post-conflict health system...this kept them going through a long period of ongoing conflict and violence.

- **In resource-poor environments the exodus of even a few experienced doctors and nurses may represent a significant loss to the public health sector. One of the challenges in the post-conflict phase is how to encourage and support the return of nationals to assist with reestablishment of services.**

External migration of health personnel in response to insecurity has occurred time and again from Kosovo to the Solomon Islands, from Afghanistan to Cambodia. ‘Brain drain’ is, to some degree unavoidable. Professional staff are often among the first to flee the country when violent conflict breaks out. Health personnel as part of the country’s educated elite may be targeted for attack. They are also more likely than others to have the means to escape and the opportunity to be accepted as skilled migrants in other countries.

Developing countries the world over are facing the serious financial and service delivery implications of out migration of health professionals². The exodus of doctors and nurses during conflict generally exacerbates an already substantial problem. The rebuilding phase should look to address both the immediate concerns of repatriation of staff and the broader issues of health personnel migration. Options which may be considered include:

- Establishing a register of health personnel who could return for brief periods of in-country service during rebuilding phase. The International Organisation for Migration (IOM) used this system in the Return of Qualified Afghans (RQA) Programme³. South Africa has also established a database of skilled professionals now based overseas, who can be called upon for short-term assistance should they be required.
- Creative contracts: at the point of migration, the receiving country could contract health staff to a hospital position which requires a mix of service in the host country and country of origin (a five year contract would involve 3 years of hospital service and 2 years of in-country service, to be negotiated in relation to the security situation)⁴.
- Harnessing the support of the Diaspora: those overseas may wish to contribute to the reconstruction of the health system following the cessation of conflict. Such highly skilled professionals are able to work in the local language and can provide valuable technical input. While

² World Health Organisation. 2003. *International Migration, Health and Human Rights*. Health and Human rights publication series. Issue 4, December 2003.

³ See <http://www.iom-rqa.org/>

⁴ World Health Organisation. 2003. *International Migration, Health and Human Rights*. Health and Human rights publication series. Issue 4, December 2003.

their inputs are typically short-term, nevertheless a coordinated approach is required to maximise this resource and ensure that efforts are compatible with MoH planning. In particular, it is important that they do not contribute to existing health inequities. An ad hoc approach to donation of drugs, equipment and building health clinics in one's home village runs the risk of reinforcing inequities and ill-feeling between groups.

- **Both during and following conflict, migration of staff from the public health system to the private health sector and to other job opportunities can further weaken capacity to deliver services.**

Migration out of the public health sector may be complete and permanent or may occur on a continuum where skilled staff are lost temporarily and partially (i.e. they retain a role in the public sector while pursuing other opportunities). In the post-conflict period, major changes take place in the health sector and a blurring of employment arrangements may occur.

Where these problems are severe, including a 'Human Resource Impact Assessment' as a condition of approval for donor or NGO health projects should be considered.

- A frequent complaint is that donor agencies and NGOs 'poach' the most competent and committed staff from the public sector to work on their own projects and programs.
- Educated health workers often have foreign language skills and may be employed by external agencies to act as interpreters and translators, taking them away from their health duties.

In periods of insecurity, the morale of staff and the stability of the health workers within the public system are particularly affected when salary payments are irregular and inadequate). This often leads health personnel to adopt a range of coping strategies that may not be in the interest of normal health system functioning, including:

- moonlighting in private practice;
- charging under the table fees, directing public patients into the private sector, and misappropriation drugs and;
- regular absenteeism as staff prioritise other income-earning activities over attendance at work.

Understanding and responding to these practices is essential as they can undermine the entire public health sector at time when rebuilding community trust and confidence in civil services is a priority⁵.

To counter the effects of 'Brain Drain' Australia can consider:

- offering to fund attachments and secondments of Australians to international organisations operating in post-conflict countries - this will also enhance Australia's capacity to better respond in conflict-prone settings;
- establishing a register of relevant Australian personnel willing to commit time and energy to supporting HR management and development, and more broadly, post-conflict health development, in the Asia-Pacific region;
- harnessing the support of the Diaspora through establishment of databases of skilled staff willing to support post-conflict recovery, both in-country and by distance (for example translating text books etc);
- formalising links with educational facilities in some countries for long-term responses to staffing problems and;
- engaging in government to government agreements concerning ethical recruitment policies for skilled personnel.

⁵ See Ferrinho P, Van Lerberghe W. 2002. *Managing Health Professionals in the context of limited resources: a fine line between corruption and the need for moonlighting*. Available from: <http://econ.worldbank.org/wdr/wdr2004/library/> for analysis of coping strategies and possible responses.

Delivering health services without undermining local capacity

Acute phase

During conflict and in the immediate post-conflict phase, the top priority in human resources is to mobilise and support staff to cope with an urgent 'humanitarian emergency'. Public health problems are often significant. Alongside available national staff, an influx of foreign staff and resources associated with international humanitarian relief organisations is common. Coordination of international agencies and local staff is essential to limit the interference with regular health workforce and ensure that external inputs strengthen local capacity.

Perceptions of outside intervention

The military intervention and high foreign presence in the Solomon Islands is perceived by some as another form of occupation or return to colonial rule. Donor interventions must avoid fuelling these perceptions by carefully considering the composition of monitoring teams (local and/or foreign personnel), recruitment methods, systems for delivery of financial support, salaries for local and expatriate staff, and the proportion of donor assistance that is finding its way back to donor countries (UNDP, 2004).

HR-related tasks calling for early attention include:

- Arranging short-term staffing and developing a longer-term workforce and training plan within the framework of national health service planning
- Staffing the *de facto* central health authority with personnel with experience and expertise to contribute to formulating policy, developing plans and directing service activities.
- Addressing the organisational culture of the health system. In post-conflict settings, several cultures and value systems may be working alongside one another. A mix of staff (local and international) may be

operating in the field under different guidance, policy assumptions and frameworks.

- Clinicians and other health staff who come from external agencies may not be sufficiently sensitive to issues of working in complex teams where role delineations are unclear. Major challenges in terms of team building and developing shared goals and values are present. Assigning responsibility for managing the 'organisational culture' may ensure this important issue is not neglected.

Rebuilding phase

This period of new peace or stability sees increased demand on the public health sector at a time when its resources are depleted and management capacity may be lacking. Contributing HR expertise to the development of the HR-related elements of situation analysis and overall health service policy development and planning becomes a priority. This will include:

- Establishing a unit within the central health authority responsible for the administration of HR-related matters. This unit may have overall responsibility for health service employment or may operate with some other government agency, such as a Public Service Commission.
- Installing and operationalising a health workforce information system.
- Ensuring health workforce policy and planning recognises the relationship of the central health authority to other government agencies such as the Treasury, the Public Service Commission and the Education Ministry.
- Ensuring that investments in building infrastructure are compatible with the human resource available to staff facilities.

Making use of other available capacity

Aside from the public health sector there are often traditional health care systems and a range of private providers both traditional and conventional; from nurses and midwives, to pharmacists and private doctors providing health care.

Conflict often rekindles traditional or 'alternative' systems of health care. These typically work in parallel with, or replace, Western health systems, especially where the latter have disintegrated or become dysfunctional. 'Alternative' practitioners form part of the complex private health care sector. In the post-conflict phase they may remain the preferred providers of certain forms of health care for the community. Understanding health seeking behaviours is a crucial element in planning the delivery of health services.

- Historically, donors have focussed support on the public health services and supported human resource development and training in the hope that this will lead to improved quality and increased demand. Often these assumptions are flawed and consumers continue to prefer traditional or other private practitioners and use government health clinics and hospitals as a last resort. Donors should seek a balance in supporting human resources within the public health sector and those outside of it.

Private provision often accelerates where governance and public services are poor. Policy makers must consider how best to accommodate and/or regulate this sector. This

Cambodia's Health Coverage Plan encouraged health centre staff to develop links with the complex traditional healing networks in their community which included *kru khmer* (traditional healers), spiritual healers attached to the Pagoda, traditional birth attendants, herbalists and others. One of the aims was to forge collaborative relationships to ensure that community's physical, mental and spiritual needs were being met. However, many health centre staff understood their role to be one of promoting their own services and training to bring traditional practices into line with the bio-medical focus of the health centre. Integration of health systems must occur at all levels and health staff requires support and training if they are to contribute to this process.

may be contested by pharmacists, doctors, nurses and other providers involved (many of whom may also have roles in the public health sector). An understanding of who provides services, to whom and how, at what cost and with what quality, must inform policy and planning.

Financing and funding of human resources

Staff salaries, wages, allowances and other benefits are generally the largest single item of recurrent expenditure in national health budgets. Immediate steps to ensure staff continue to receive salaries during and after conflict, may assist in retaining health personnel in public services and their local area and prevent the collapse of health care delivery. However reliable mechanisms for delivering this support are not always available.

- Understanding different funding streams and sources of finance are essential for planning human resource budgets. The transition from immediate humanitarian relief, where generous resources are often available for direct service provision, to more long term development, which requires a focus on sustainability, has implications for who will fund what activities and how finances will be managed. Despite high levels of need, donors are often reluctant to contribute to recurrent salary budgets. They may seek to intervene directly by establishing vertical programs which they can monitor or may top-up salaries in selected areas. This has the potential to contribute to inequalities and tensions.
- NGOs often provide critical services in the immediate relief period. When they withdraw, the base for continuing service provision is often limited. Planning for the recurrent costs of delivering care must be undertaken when new initiatives are being planned.
- Donors often find it attractive to fund physical infrastructure but fail to plan for

the training and remuneration to operate and staff these facilities.

- There is a clear need to build information systems to manage, deploy and develop the HR resource base. Attention needs to be devoted to updating and maintaining data on staff at appropriate levels in the system.

Personnel files may become outdated, central authorities may lose contact with remote staff and ghosting, where salaries are being drawn for staff who are no longer serving in the public sector, may occur.

2. Response to Human Resource Issues: Applying a health and conflict lens

2.1 Case study: Cultural competence

Roberts and And (1990) define cultural competence as a *program's ability to honour and respect those beliefs, interpersonal styles, attitudes and behaviours both of families who are clients and the multicultural staff who are providing services.*

The management of human resources in conflict-prone settings demands consideration of the cultural and social context in which the health workforce operates.

- *East Timor*: the exodus of senior and specialist ethnic Indonesian health professionals - there were few Timorese in senior positions – created a situation where there was a vacuum in well trained, more senior personnel and a preponderance of health service personnel at lower levels.
- *Kosovo*: ethnic Albanians were discriminated against when Kosovo was controlled by Yugoslavia and the local Serb community. After the international military intervention, the Albanian Kosovars assumed local control and ethnic Serbs were typically shut out of employment opportunities. Although understandable, in turning the tables,

bridging social capital was shattered and opportunities to build trust through progressive employment policies may have been missed.

- *Mozambique*: after the post-colonial period, almost all the Portuguese doctors, the backbone of the medical workforce, returned home or migrated to Angola and South Africa. Only a handful stayed behind and assisted in any way the transition to a post-colonial state.

These country-specific examples illustrate how conflict can precipitate and expose uneven access to medical workforce training and education. One of the roles of HR development in the post-conflict period is to explore ways of reducing inequity by equalising opportunities for training and employment.

Adopting a framework of cultural competence requires interventions at the individual, service delivery, program administration, infrastructure and policy levels. These interventions should include a focus on:

- valuing diversity and similarities among all peoples;
- understanding and responding to cultural differences;
- promoting cultural self-assessment and;
- institutionalising cultural knowledge⁶.

2.2 Case study: Education and Training, East Timor

Context The Ministry of Health has established its own institute of health sciences for training health workers but has so far

⁶ Denboba, 1993 Maternal and Child Health Bureau Guidance for Competitive Applications, Maternal and Child Health Improvement projects for Children with Special Health Care Needs; Goode, 1995 Definitions of 'cultural competence', available from <http://cshenleaders.ichp.edu>; Maternal and Child Health Bureau (MCHB), 1999 Guidance for SPRANS Grant, Health Resources and Services Administration. US Department of Health and Human Services.

focussed exclusively on midwifery training. The Ministry of Health (MoH) also has a mid-term human resource development plan but some senior personnel within the ministry consider this inadequate at the present time. An MoH official described, ‘scattered courses’ being held but says the Ministry does not trust them and is not sure of their practical value. The European Union plans to fund the development of a Human Resource Development Plan, to more clearly set out strategic investments for the future.

Response In 2003 a private university in Dili established a four-year training program for public health workers. Drawing on a senior member of the health ministry working privately for this university, a training program was rapidly established. By 2004, there were 170 students studying part-time in the 1st and 2nd year classes. There are 24 lecturers involved in delivering the training, 11 of whom hold Master degrees; senior personnel in the MoH and others are involved in teaching. A substantial proportion of students are employed within the MoH or have jobs elsewhere in the health sector. Students are reported to be very serious and committed. There are no clear frameworks from either the ministries of education or health regarding this and related programs. To date there has been no formal endorsement of the program by the Ministry of Health nor have roles been identified for the graduates, the first group of which will be completing in 2006.

Applying a health and conflict lens The public health worker course represents a locally-driven, entrepreneurial response to an apparent need in the health system; it identified broad based public health needs which are often neglected in the post-conflict period and set out to boost the skills of a wide range of health personnel. Applying a conflict and health lens though highlights the following issues:

- The desire to respond rapidly has led to short-term thinking.
- Privatisation of training of health workers creates the potential for training opportunities to be limited to those who are able to pay for them.

- There may be significant opportunity costs brought about by highly skilled Timorese health personnel applying their time, effort and skills which may or may not be recognised.
- Risk of entrenching inequalities in access to training for workers based in urban or rural areas with the possibility of this reinforcing inequality in the quality of health care provided in these two settings.
- The potential for those who have invested in their own education wishing to recoup their investment: in most places this would involve moving into the private health sector.
- The large number of people being trained, many of whom are employed by the Ministry of Health, poses an additional risk of the MoH’s hand being forced to recognise them and certain practices that have not been agreed in advance.
- Given that the course operates outside of the purview of the MoH there is no formal mechanism for monitoring and assessing quality of training or graduates.

Where such initiatives develop, they run the risk of privileging some groups over others and reinforcing grievances.

2.3 Case Study: Coordination of NGO inputs, Cambodia

One of the challenges that emerge in the post-conflict setting is how best to coordinate the human resource inputs from a multitude of NGOs. The responsibility for coordination often falls to a newly established human resources department whose staff may have little or no training to enable them to take on this role. The pressure from individual donors and NGOs who seek to implement predetermined programs can be especially difficult for MoH staff. The Cambodian response to this was to develop a Coordinating Committee for Health (CoCom) whose mandate included:

- monitoring and evaluating all health activities by international aid agencies working in the health sector;
- providing advice and recommendations to the MoH and;
- supporting the planning coordination and implementation of health services.

CoCom activities included coordination of human resources in the health sector, both in terms of financial inputs, training and education of staff and strengthening management capacity. The CoCom model began in 1991 with a national level committee, (led initially by WHO) which was expanded to include provincial coordination committees (ProComs) and technical subcommittees concerned with specific health services; 1996 saw the establishment of a human resources subcommittee. While there have been various constraints on what the CoCom model could achieve, it has been argued that its existence has contributed significantly to the MoH's capacity to coordinate human resource and other NGO inputs in the health sector. It has provided information, established reporting mechanisms and enabled staff to gain experience in important methods for overseeing coordination such as NGO mapping⁷. By adopting a coordinated approach

The process of policy development varies greatly in post-conflict situations

The policy framework and process itself may not be clear-cut. Much of the policy development is situation-specific. For example, in Kosovo, the World Health Organisation (WHO) supported the development and publication of a draft health policy. In East Timor, the UNTAET coordinator and his East Timorese counterpart collaborated with a group of East Timorese health professionals to develop the health policy framework for the country ('one table, two chairs').

Source: Tulloch et al. 2003. Initial Steps in Rebuilding the Health Sector in East Timor. The National Academies Press: Washington, D.C. and Shuey et al. 2003. Planning for Health Sector reform in post-conflict situations: Kosovo 1999-2000. Health Policy, 63, (3).

⁷ Lanjouw S, Macrae J and Zwi A. 1999. Rehabilitating health services in Cambodia: the challenge of coordination in chronic political emergencies. *Health Policy and Planning*. 14 (3): 229-42.

to NGO inputs early in the rebuilding phase Cambodia was in a better position to link NGO activities to national policy once the MoH had sufficient capacity to take on management and policy development for the health sector.

Widening inequalities

Key concerns in post-conflict situations are differentials between payments to national and expatriate personnel, between national staff employed by government and those employed by international agencies or NGOs, and between government employees and health personnel in the private sector – both in-country and elsewhere. 'People in Aid' provide some useful mechanisms for coordinating and assessing payment scales for local and expatriate staff. <http://www.peopleinaid.org.uk>

2.4 Case study: Contracting health in East Timor

Scenario Immediately after the violence which followed the referendum in East Timor, the United Nations Transitional Authority for East Timor and the Ministry of Health recognised they did not have the capacity to deliver comprehensive health services across the country. A decision was taken to contract out the rehabilitation of health services in districts and to engage NGOs in providing these services and developing links between the district and the centre. It was envisaged that NGOs would assume responsibility for delivering services *and* developing district health capacity and complementarity with national health planning processes. Anecdotally, many of these emergency relief NGOs were effective and able to rebuild and deliver services but were much less able to ensure that local capacity was developed or that linkages between district and MoH were deepened. One year after the initiation of the contracts, most NGOs left without their contracts being renewed – the MoH felt that they had failed to build the capacity and sustainability required for effective management and planning and at the district level.

3. Post-conflict HR issues: Australian involvement

What are some of the avenues for Australian contribution to HR management and development?

- supporting multilateral activities
- direct government to government support
- subcontracting other players such as NGOs to support HR development in these settings

What should not be done?__Australia should not invest in and support interventions that:

- fail to consider meeting recurrent costs
- are not financially sustainable over the long-term
- do not attempt to link in with emerging Ministry of Health programs

Education and training Health service and educational institutions in Australia could play a more strategic role in training health care personnel in the Asia-Pacific and in countries emerging from major periods of conflict. Training of teams from conflict-affected countries could be undertaken by groups with established expertise and interest in this specialised area. Training for managers, and for managing major public health problems, would be important. Key areas may be skilling people up to run a ministry of health, an information system, public health programs, key services at provincial or state level, and to coordinate the activities of multiple providers and donors. A recent contribution to the debate on AusAID's role in health-related support stressed the contributions that Australia could make to enhancing governance (including within the health sector), or promoting stability and security through better delivery of services, and emphasised human resources development as an area of Australian comparative advantage over other countries involved with development cooperation in this region.⁸

Is there scope for a Whole of Government approach?

AusAID has a major role to play in unstable environments. In the presence of peace keeping forces, Defence may also have role, for example in providing immediate capacity to manage major public health, safety and health care problems. In times of relative peace the Department of Health and Ageing may facilitate strengthening HR capacity in key areas, such as surveillance and control of infectious diseases.

AusAID is likely to be a key player in health human resources. The agency may offer development advice and support to emerging Ministry of Health. In key periods AusAID may be subcontracting NGOs to provide services. In periods of development cooperation there may be other forms of long-term support to promote good governance and basic services delivery.

Whether, and to what extent, AusAID should become involved in providing or assisting in the provision, management and development of health service personnel in post-conflict situations will be determined principally on political, economic and security grounds. Whatever those grounds may be in a particular post-conflict situation, it is apparent that Australian support has, in recent years, been available to the HR-functions in a number of countries. Numerous mid-level and senior managers from Cambodia have been trained in Australia and now continue to maintain links. The UN health representative in East Timor during the transitional period leading up to independence was an Australian. AusAID has provided support to developing mental health activities, service provision and HR development in East Timor. Numbers of other Australian agencies, and some individuals, have been engaged in health workforce-related activities in post-conflict situations. Among sources of finance have been government money, public subscription and self-funding on the part of some individuals.

⁸ New South Global Pty Ltd. 2004. *Health and Development Issues Paper*.

Does Australia have any comparative advantages in human resource development in conflict-affected settings?

Australian contributions are apparent through:

- a track record of involvement in the region in resource poor settings and in conflict-prone and post-conflict environments;
- the considerable experience and capacity for training in Australia and off-shore and;
- professional and tertiary institutions that see training and education as a major contribution they can make and one which can also bring economic and political benefits to Australia;

Through AusAID and a large number of other agencies – most of them operating as non-profit organizations - Australia has a considerable record of involvement in development assistance activities. The record of participation in post-conflict situations is growing: Cambodia, East Timor, Bougainville, the Solomon Islands, Sri Lanka, and contributions to Afghanistan and Iraq, though not necessarily within the health sector.

Evidence of systematic evaluation of the impact of these activities has not been available for examination. While the past performance of Australia's development assistance activities in this field has probably been on par with those of other affluent countries, it would be particularly valuable to examine this experience and reflect on lessons learned in more detail.

If Australia's role is to be more comprehensive, strategic and to build on comparative advantage in human resource support, then more information is needed.

- AusAID could undertake rigorous evaluation of the HR development initiatives it has supported in the region;

- Documentation and reflections of experiences and lessons learned in unstable, fragile and resource-poor settings should be promoted by participants, training organisations, and educational institutions;
- Arising from distilling these lessons should be a commitment to working with and training other providers in basic approaches to HR capacity building and development in resource scarce and unstable settings. This would enable a more visible Australian identity in relation to HR management and development.
- More insight into perceptions and attitudes of national governments and their health ministries and professional organisations in relation to how Australia has performed and can best contribute to HR development;
- Ensure that Australia does not worsen existing inequity and maldistribution of skilled person power in the region – this will require domestic policy that supports the ethical recruitment of health personnel to fill existing gaps in the Australian health service;
- Compilation, publication and distribution of relevant HR management and development material and tools either independently or in association with a lead agency or network;
- Financing of 'HR field reporters' to obtain relevant material from field studies for inclusion in a developing post-conflict databank which would benefit from AusAID support.

Attempts to locate systematic evaluations of the costs and benefits of major human resource investments by Australia have to date, not been successful. Maximising our learning from earlier experiences in conflict and post-conflict settings, positive or negative, would be extremely valuable.

Interesting reading:

Smith, J. 2004 *Human Resources for Health: Exploring experience and opportunities for change in a post-conflict environment.*

<http://www.unsudanig.org/JAM/clusters/social/background-docs/HumanResourcesForHealth.pdf>

Joyce Smith has a long nursing and management experience in refugee camps in south-east Asia and as a WHO human resource specialist in post-conflict Cambodia, East Timor and Afghanistan.

Her book, available free electronically introduces the reader to the importance and concerns of human resource development (HRM/HRD) in post-conflict settings and provides a how-to-do-it guide to post-conflict health workforce. This book is unique in the post-conflict literature in its emphasis on human resource management and development, rather than on broader policy or management issues, or specific areas of health service delivery such as personal health care or disease control. It is currently in draft format with plans to introduce a website/chat line facility for the sharing of experiences and resources.

WHO. 2003. Human resources development in crises – issues. *Health in Emergencies* 18, December 2003.

Topics include:

- National health workers in crises: a neglected asset
- Timor-Leste: planning for human resources in a newborn country
- Mozambique and Angola: re-integrating health workers of rebel groups
- HIV: coping strategies of health workers in South Africa

For more general issues of human resources in development, the following literature is useful:

UNFPA. 2004. Culture matters – working with communities and faith-based organisations. Case Studies from Country Programmes. Available http://www.unfpa.org/upload/lib_pub_file/267_filename_CultureMatters_2004.pdf

WHO. World Health Reports.

- In *World Health Report 2000: Health systems; improving performance* see Chapter 3 'Health services: well chosen, well organised?' and Chapter 4 'What resources are needed'.
- In *World Health Report 2004: Changing History* see Chapter 4 'Health systems; finding new strength'.

Chen et al. 2004. *Human Resources for Health: Overcoming the crisis. The Lancet*; 364: 1984-1990.

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