

Issues Paper II

The Challenge of Human Resource Management in Conflict–Prone Situations

**The University of New South Wales
Health and Conflict Project**

School of Public Health and Community Medicine,
School of Psychiatry, School of Sociology and Anthropology
and the Centre for Culture and Health,
The University of New South Wales

December 2004

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.

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 previous 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 been 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 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 which 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

Political violence has both human rights and health implications. Addressing the health needs of populations is an important first step to minimising the effects of violence and promoting peace. But the wider peace benefits of health initiatives must eventually be linked to broader questions of justice.

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/>

The views expressed in this publication are those of the authors and do not necessarily reflect those of the Commonwealth of Australia. The Commonwealth of Australia accepts no responsibility for any loss, damage or injury resulting from reliance on any of the information or views contained in this publication.

© Commonwealth of Australia 2004

This work is copyright. Apart from any use as permitted under the Copyright Act 1968, no part may be reproduced by any process without prior written permission from the Commonwealth available from the Department of Communications, Information Technology and the Arts. Requests and inquiries concerning reproduction and rights should be addressed to the Commonwealth Copyright Administration, Intellectual Property Branch, Department of Communications, Information Technology and the Arts, GPO Box 2154, Canberra ACT 2601 or posted at <http://www.dcifa.gov.au>

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.

In conflict-prone settings, health services can be a barometer for tensions in the area. Where conflict is present public health services tend to disintegrate and health professionals leave as conflict escalates, resulting in the closure of hospitals, clinics and aid posts. This paper discusses the role health workers may play in unstable settings and responds to five key questions related to the management and development of human resources in a conflict prone environment:

- What are the issues to consider in restructuring the health workforce?
- How does one respond to ‘Brain Drain’ as a result of insecurity?
- How can one get health services up and running without undermining local capacity?
- What is the emerging better practice in coordinating NGO and donor inputs in the human resource arena?
- What are the issues in financing and funding human resources in health?

Note: This issues paper is derived from a more comprehensive background paper. Within the text, the following symbol, ➔, accompanied by a reference page number indicates where more information can be found in the background paper.

Health workers in conflict-prone settings

Health workers may be among the first to detect increasing cases of violence or abuse against particular groups. Less directly they may also see declining use of services or weakened access to health care. These warning signs may signal vulnerability and grievances which in turn may heighten perceptions of inequalities and injustice.

- A situation that could signal a forerunner to conflict is the deterioration of the economy,

governance and public services such that public health staff are irregularly paid and supported. For most skilled staff, this forces them to consider their options in how and where they work [➔ 5].

Pre-conflict training during times of relative peace may be useful

Sri Lanka has been actively involved in the WHO Health as a Bridge to Peace (HBP) initiative since 1999. HBP training aims to provide health personnel with the skills and knowledge to seek out opportunities for peace building and provides frameworks for delivering health services in conflict-prone situations.
<http://www.who.int/disasters/bridge.cfm>

- Where salaries are irregular, health workers cope by undertaking private work, requesting or demanding something from community members who use their services, and drawing on their public position and access to further their private practice. High rates of absenteeism are common as staff attend to personal matters and pursue other economic opportunities. Coping behaviours, such as directing patients into the private sector, misappropriating drugs and other strategies undermine the public health system. Early appreciation and response to these emerging practices is important.
- 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;
 - Facilitating alternative payment systems 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.

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.

What are the issues to consider in reconstructing the health workforce?

Skill mix, job design and training

The health system requires a wide range of health personnel for efficient functioning. In post-conflict situations, often past expectations cannot be sustained and more innovative and lower cost mechanisms of providing services are required. This typically involves review of roles, up-skilling lower cadre of staff and involving communities in prevention and care. The rebuilding phase is likely to result in 'reform' of the health sector generally; these changes need to be incorporated into a systematic Health Workforce, Education and Training Plan [↗ 3].

East Timor: 100 students are to graduate per year from a new Public Health Worker course offered through a private university in Dili. There is currently no agreement with the Ministry of Health as to how such staff might be utilised.

Sri Lanka: Population Services Lanka (affiliated with Marie Stopes) has provided 'on the job' training up to the level of midwife, for more than 300 female volunteers from local communities. These volunteers have no educational qualifications and can not be integrated into current government services.

Key considerations include:

- **Recognition of existing capacity** - Learning needs of the staff should direct the theme and content of training rather than the assumptions of donors or the requirements of particular vertical programs.
- **Documentation and accreditation systems** are required to recognise and regulate training undertaken. During periods of conflict, opportunities for training by different agencies or in different countries, with different value systems and approaches, may occur. Subsequent integration of these personnel is challenging.
- **Coordination of training requirements** - Ad-hoc training by multiple donors and NGOs contributes to the fragmentation of the workforce. Agreement on the categories of staff, level of skill required, and reimbursement levels demands consultation and central planning.
- **Capacity building and enhancement** are important concepts in development. Many NGO-employed staff operating in post-conflict areas reported that while they were told they were there to develop local capacity, the reality was they ended up being service providers. 'The

needs were so great, that service provision became an end in itself. In the end we questioned how much good we have done there.'

Human Resources and East Timor

- The early stages of rebuilding in East Timor saw a large proportion of senior staff sponsored to train overseas at the time, severely reducing the capacity within the Ministry of Health.
- Currently in East Timor, 65 nurses with certificates or diplomas in nursing have been appointed as Community Health Centre Managers, a role requiring a complex set of skills. Training for their new tasks and responsibilities is required

- **Selection for training** must be done sensitively and in line with priority needs to avoid fuelling perceptions of bias or nepotism that may exist. Training (through associated per diems) represents a significant income source for staff [↗ Case study 2, 10].
- **Availability of staff** - Staff undertaking training are absent from 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). Developing innovative, 'on the job' and distance based training programs helps overcome this.
- **Management training** is a crucial early step, especially where clinical medical and nursing staff have been given responsibility for health service planning and management.
- **Monitor impact of training** - Training inputs must be linked to sustainable change in skill level and practice. Evaluation of training in the post-conflict period is often neglected.
- **Long-term commitment** - Investment in training and building capacity requires a long-term view.

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

How to respond to ‘Brain Drain’ as a result of insecurity?

The loss of skilled staff from the health workforce is one of the major human resource consequences of conflict [➔ 5-7].

External Migration The migration of trained health personnel often begins at the early stages of instability; health professionals are more mobile and are often among the first to flee the country when conflict breaks out. This exodus during conflict generally exacerbates an already substantial problem with loss of skilled personnel to developed countries. 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 that could return for brief periods of in-country service during rebuilding phase;
- creative contracting with national health services of receiving countries, including twinning agreements and joint training arrangements and;
- harnessing the support of the Diaspora in structured ways [➔ Case study 4, 12].

Fiji: ‘I left Fiji because I was concerned for my safety and my family’s. The children needed to go to school where they would not be taunted or threatened. I have not had my medical qualifications recognised yet in Australia, but I work in the health system as a Multicultural Health Worker where my public health training and skills are being utilised...I am not sure I would ever return to Fiji, but maybe in time...’

Internal displacement Staff often move toward secure areas in the lead up to violent conflict, resulting in overstaffing in some areas (such as urban hospital facilities) while health services in other areas are abandoned. Supporting staff to remain in post in rural or remote areas requires:

- maintenance of basic communication lines;
- some system of debriefing and support to assist workers who are taking on additional roles and making difficult decisions about who is treated;
- maintenance of access to basic supplies required for service delivery;
- building local support networks for personnel outside the urban centres and;
- providing a safer working and living environment through collaboration with local communities.

Migration out of the public health sector 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 may be temporary or permanent. NGOs are often accused of ‘poaching’ the most competent and committed staff from public health sector positions to work on their own projects and programs. Awareness of these problems and a coordinated response from donors and other relevant stakeholders is essential as trust and confidence in the public health services is being rebuilt.

People in Aid provides resources which may be useful in bolstering support for health personnel and addressing ‘Brain Drain’ concerns.
<http://www.peopleinaid.org.uk/>

How can one get health services up and running without undermining local capacity?

In post-conflict settings, several cultures and value systems may be operating. Alongside available national staff, an influx of foreign staff and resources associated with humanitarian relief is common. The challenge facing donors is to establish functional health services while limiting interference with the regular workforce. The following principles may assist donors and other stakeholders to provide external inputs in a manner that strengthens local capacity in the longer term [➔ 7-9].

- Invest early in developing the health sector’s human resources.
- Support the central health authority with expertise to formulate policy, develop medium to long term plans and direct service activities.
- Work with partners to develop a workforce and training plan within the framework of National Health Service planning.
- Address the organisational culture of the health system. The post-conflict period is likely to see a mix of staff (local and international) operating in the field under different guidance, policy assumptions and frameworks. Clinicians and staff who come from external agencies may not be sufficiently sensitive to the issues of working in complex teams where role delineations are unclear.
- Support the integration of traditional health systems. Conflict may rekindle traditional or

‘alternative’ systems of health care which continue to be used in the post-conflict period.

- Understanding health seeking behaviours and adopting flexible approaches to supporting the health of communities is crucial.
- Consider how to accommodate and or regulate the private health sector. Private provision often accelerates where governance and public services are poor. Policy and planning must be informed by understanding of who provides services, to whom and how, at what cost and with what quality.

A range of providers deliver health services and contribute to producing health outcomes for the community. Historically, donors have tended to support human resource development only within the public sector. It has been assumed that this will lead to improved quality and greater demand. Often however, users prefer traditional or other private practitioners and use public sector clinics and hospitals as a last resort. Donors and other stakeholders must recognise that interventions to enhance the quality of traditional and private sector care may also be of value.

What is the emerging better practice in coordinating NGOs and donor inputs in the human resource arena?

The responsibility of coordination often falls to a newly established human resource department whose staff may have limited capacity to take on this role. Pressure from individual donors seeking to implement their own pre-determined projects and or programs can be especially difficult for the Ministry of Health (MoH) staff. The establishment of a policy setting body within the MoH in the form of a coordinating committee (such as CoCom in Cambodia) has many benefits. Such a committee may adopt a variety of roles: identifying the categories of staff and agreed skill level for health workers and minimum training required for each category; acting as a mechanism for monitoring and evaluating international aid agencies; advising the MoH regarding planning coordination and implementation of services; overseeing training activities and ensuring that development and distribution of skilled personnel is consistent with national health service plans; and promoting coordination of local payment scales between international agencies [↗ Case study 3, 11].

What are the issues in financing and funding human resources in health?

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.

- 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 and multilateral bodies 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 to continue service provision is often limited. Planning for the recurrent costs of delivering care must be undertaken when new initiatives are being planned.
- There is a clear need to build information systems to manage, deploy and develop the human 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.

Protecting and developing the human resource base in conflict-prone and post-conflict settings is a challenge. Although human resources appear to be simply ‘technical’ they need to be examined in relation to broader peace-building needs and related policy and planning. Early and sustained attention is a necessary element for effective response.

Investing early in long-term HR development is a key component of building more effective and sustainable health systems which can address the legacy of conflict.

