

# Establishing a responsive & equitable health workforce post-conflict & post-crisis: lessons from ReBUILD research

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Human resources for health (HRH) is the most expensive, complex and critical health system pillar, and one with more political ramifications – it is crucial to learn lessons about how to rebuild it effectively post-conflict. This brief highlights some of the main findings and recommendations from a wide-ranging series of studies conducted by ReBUILD since 2011. It is an updated version of a brief first published in December 2016.

## Background

Health worker attraction, retention, distribution and performance are arguably the most critical factors affecting the performance of a health system. In post-conflict settings, where health systems and health worker livelihoods have been disrupted, the challenges facing the establishment of the right posting and incentive environment are particularly important, and the contextual dynamics around them especially important to understand and incorporate sensitively into policy measures.

## Research approach

Two initial research areas were pursued – **incentive environments for health workers**,<sup>1</sup> and **deployment systems**.<sup>2</sup> Both used a range of research methods combining quantitative and qualitative analysis, including **life histories**<sup>3</sup> (see Table 1). A **sub-study on health worker remuneration** was supported in Sierra Leone, as well as a **number of gender case studies** with health staff through the **RINGS consortium** and a study of resilience in health systems in three contexts. Further research was subsequently conducted on the **effects of the Ebola outbreak on health workers in Sierra Leone**; **health worker recruitment and deployment in Timor Leste** and **community health workers in fragile and conflict affected settings**.

## Key points:

Health labour markets are more complex in fragile and post-conflict settings.

1. Policies must ensure they avoid distorting the health labour markets and draining staff from hard-to-serve areas.
2. International support should focus on reinforcing and rewarding resilience, and providing decision spaces and flexibility for good staff to thrive and drive forward better health care services for all.
3. Investments in the immediate post-conflict period have a duty to consider longer term implications for HRH.
4. Incentive packages for staff in hard-to-serve areas should focus on more than short-term financial measures, and include
  - a. recognition of their role and achievements in challenging circumstances
  - b. practical measures to improve their security
  - c. provision of decent housing, working conditions, training and pay
  - d. measures to re-establish trust, better communication and teamwork.
5. Remuneration policies need to take into account the different facets of pay which matter to health staff.
6. Improved gender equity in the health workforce requires integrating gender considerations into policy and action at all levels.

Table 1: Research tools used in ReBUILD's health worker incentives research

Research tools	Cambodia	Sierra Leone	Uganda	Zimbabwe
1. Stakeholder mapping		√	√	
2. Document review	√	√	√	√
3. Key informant interviews	√	√	√	√
4. Life histories with health workers	√	√	√	√
5. Quantitative analysis of routine human resource data	√	√		√
6. Survey of health workers		√		√
7. Personnel record review			√	√

All the briefing papers in this series can be accessed at <http://Rebuild-briefs>

This briefing paper series has been developed by the **ReBUILD Research Programme Consortium** to inform a number of key issues around health systems in crisis-affected settings, and draws both on ReBUILD's own work and wider sources. The issues were identified in a **research agenda-setting study** carried out by the **Health Systems in Fragile and Conflict Affected States Thematic Working Group** of Health Systems Global.

## Findings

### Immediate effects of conflict and crisis: impact on existing staff

Our findings highlight some of the immediate effects of conflict and crisis, including a collapse in human resources (HR) and HR information systems. Staff have often been **targeted during the conflict**<sup>4</sup>, leaving areas lacking staff, some carrying out roles above their station, and traumatised. Some positive aspects can be built on – **staff developed coping strategies which allowed them to survive**<sup>5</sup>, both personal and community-based. These should be recognised and rewarded. Where staff have been targets during conflict and crises, **psychosocial support**<sup>6</sup> is also needed.

### Production & training

Post-conflict, **distortion of health worker supply and salaries** is a risk. Foreign staff can fill gaps in the local workforce, usually at senior level. But complaints about skills, appropriateness and capacity of expatriate staff are commonplace, as is resentment against their higher salaries, powerful positions and decision-making freedom<sup>7</sup>. Training is important but can be mishandled – for example, by over-production of poorly trained staff with risks for the future of the sector, or by in-service training which brings in resources but does not improve performance. The introduction

“... so we were always on our guard during that time because there used to be attacks all over the places so it was actually somehow challenging ...”

**Male health worker, Sierra Leone**



of new HRH policies as a response to staffing challenges may generate problems in the long-run<sup>8</sup>. The nature of the longer term political settlement will determine the extent of confidence in the government and willingness to engage in public sector employment.

### Recruitment and deployment

Our research on **health worker recruitment** in Timor Leste highlighted a **fragmented institutional landscape** in the post-conflict period, with diverging agendas and lack of inter-sectoral coordination, to the detriment of the long-term strategic development of the health workforce and the health sector<sup>9</sup>. And our research on **deployment in Zimbabwe and Uganda** suggests that no special changes were made to deployment-related policies following conflict and crisis. However, local managers interpreted the rules flexibly to fill vacant posts and to avoid staff resigning or absconding. Sub-national managers have greater decision-space for deployment during crises e.g. using secondment to staff rural areas, but would benefit from better human resource management skills. Flexibility in implementing deployment policies may contribute to increased retention in hard-to-reach areas: workers' preferences must be taken into account. Bonding has worked effectively in the past, but is not viable in times of crisis<sup>10</sup>.

### Incentive packages

In post-conflict settings, there is commonly a **fragmentation of remuneration**<sup>11</sup> and incentive packages, linked in part to the multiple actors. Incentive policies tend to be **piecemeal, poorly funded and implemented**<sup>12, 13</sup>, with poor feedback loops from staff to decision-makers and funders. Policies are often crafted with external inputs but limited traction. Management reforms are particularly hard to address.

In these contexts, it is especially challenging but important to provide a balanced package over time, prioritising those in hard-to-reach areas but also ensuring equity across conflict lines.

Fragmentation may be adaptive immediately post-conflict, but will distort if it persists too long. Consultation of staff and better communication are key in developing these policies. Aspects requiring organisational change can receive less priority than financial incentives, which donors find easier to finance. Reinforcing supervision and improving working conditions are key areas for staff. Post-crisis moments (e.g. after the Ebola epidemic in Sierra Leone) can be important moments to learn from the past, capitalise on interest and innovate.

### Managing health worker markets

Conflict/post-conflict dynamics affect the balance of attraction and retention across sub-sectors within health, distorting provision of care. In northern Uganda, for example, during the conflict, the private not-for-profit (PNFP, largely mission) sector remained more functional. The public sector was boosted in the post-conflict phase due to development investments, consolidation of allowances and introduction of hard to reach allowances. Salaries became more regular while pension continued to be provided. **Our findings**<sup>14</sup> suggest that retention within the PNFP sector has relied on more personal factors, such as loyalty and family ties, while many still working in the PNFP sector express the intention to leave, if circumstances permit.

In **Zimbabwe**<sup>15</sup>, the public sector has been unable to offer the same terms and conditions for staff as municipalities, which have independent income source and so employ more senior staff to do less demanding roles in urban clinics, adding to shortages in other areas.

### Rural retention

Rural health workers **face particular challenges**<sup>16, 17</sup>. These include:

- Poor working conditions, emotional and financial costs of separation from families, limited access to training, longer working hours (due to staff shortages) and the inability to earn from other sources.
- Rules on rotation are often not respected
- Incentives for rural areas receive limited political focus and are especially ineffectual
- Insecurity

Local staff and mid-level cadres are more likely to work in remote areas, both because of local attachments and more limited mobility in the labour markets.

By contrast, poor management had more resonance in urban areas, with reports of poor delegation, favouritism, a lack of autonomy for staff, and tensions over unclear roles and absenteeism.

During economic crises, rural areas can have advantages, for example, in Zimbabwe<sup>18, 19</sup>, health staff reported lower costs and greater ability to subsist on low salaries in rural areas.

*“If we were to run away who would now help them? So we persisted and slowly the fear disappeared”*



**Female health worker, Uganda**

## The gendered health workforce

There is **lack of gender balance across all settings studied**<sup>20</sup>: women predominate in nursing and midwifery cadres, are clustered in lower paid positions, and under-represented in management. Gender roles, shaped by caring household responsibilities, affect attitudes to rural deployment and women in all contexts faced particular challenges in accessing training. Conflict and coping strategies within conflict emerged as a key theme, with gendered strategies and experiences also shaped by poverty and household structure.

## Thinking longer-term - windows of opportunity & path dependency

While HRH challenges were widely shared across the four countries in the post-conflict period, the policy trajectories were different – driven by the nature of the conflicts and the wider contexts. **Windows of opportunity for change**<sup>21</sup> and reform can occur but are not guaranteed, depending on a constellation of leadership, financing and capacity. Post-conflict environments face particularly severe challenges to evidence-based policy making and policy implementation, constraining the use of windows when presented<sup>19</sup>.

Depending on the degree of destruction and loss of staff, reconstruction of HRH can take decades. In Cambodia<sup>19, 22</sup> the need to focus on increasing numbers took a considerable time, followed by a decade of management reforms and only now is the Ministry of Health regaining control from NGOs and external bodies over policy and incentive schemes. This may have been the result of key decisions in the post-conflict period – the contracting out services to NGOs, for example.

*“I was motivated by the community [...] They were in total support of my well being and able to provide food for me. Another [...] was the district which was able to provide means of transport.”*



**Male health worker, Uganda**

## Human resources for health and state-building

An investigation of the possible **contribution of HRH for state-building**<sup>23</sup> found that the concept of state-building itself is highly contested, with a rich vein of scepticism about the wisdom or feasibility of this as an external project. Empirical evidence for most of the linkages is not strong, which is not surprising, given the complexity of (and measurement difficulties of) the relationships. Nevertheless, some of the posited relationships are plausible, especially: between development of health cadres and a strengthened public administration, which in the long run underlies a number of state-building features. The reintegration of factional health staff post-conflict is also plausibly linked to reconciliation and peace-building in some contexts.

## Conclusions & recommendations

1. Health markets are complex in all settings but even more so in fragile and post-conflict settings when communities and health care providers have often had to fend for themselves without effective state regulation. Reforms to HRH incentive packages need to ensure a fair balance across sectors to avoid distorting the health labour markets and draining staff from hard-to-serve areas.
2. Staff and managers in fragile settings can show remarkable resilience – surviving during dangerous conditions and keeping services functioning through local adaptations. National and international support should focus on reinforcing and rewarding resilience, and providing decision spaces and flexibility for good staff to thrive and drive forward better health care services for all.
3. Investments in the immediate post-conflict period have a duty to consider longer term implications – for example, by not introducing cadres which will be inappropriate and hard to sustain longer term.

*“You know motivation is not physical things only and [...] could motivate through thanking you when you have done some work. And [...] lobby for workshops and courses”*



**Female health worker, Uganda**

4. Balanced incentive packages, which focus on more than short-term financial measures, are key to retaining staff in hard-to-serve areas. These should include recognition of their role and achievements in challenging circumstances; practical measures to improve their security; provision of decent housing, working conditions, training and pay; and re-establishment of trust, communication and teamwork.

- Remuneration policies need to take into account the role of multiple actors and also the **different facets**<sup>24</sup> of pay which matter to health staff (not just amounts, but ease of access, reliability, transparency etc.).
- Key priority areas for addressing gender equity in the health workforce in fragile and post-conflict settings include (1) ensuring gender is integrated into policy and (2) fostering dialogue and action to support change for gender equity within institutions and households.

All quotations are from health workers interviewed as part of ReBUILD's HRH research. This briefing paper is an updated version of a similar ReBUILD brief originally published in 2016<sup>25</sup>.

## Resources on HRH

All reports and articles from ReBUILD's research on human resources for health can be accessed at

<http://bit.ly/Rebuild-HW>

## References

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