

1. The challenges to health workforce development in the post-conflict context

The key question in developing human resources for health continues to be how to produce, deploy and retain an appropriately trained health workforce of the appropriate skill mix who can deliver the appropriate, affordable and equitable packages of health services designed by ministries of health as the basis of their health service delivery. The problems related to this are common to all countries. In post-conflict situations, the loss or displacement of experienced personnel, the destruction or degradation of training systems, and the complexity of the context within which reconstruction takes place exacerbates the problems (Macrae, 1995; Smith, 2001, 2002). At the same time, such situations offer the opportunity to start afresh. In order to make a new start it is crucial to identify the key issues and to be addressed within the specific context of the country concerned.

The type and nature of conflict are individual to each country, particularly where there are prolonged periods of conflict, say for 20 years or more. There may be a combination of many types and elements of conflict, including local and foreign military bombardment, bloody civil strife, occupation by foreign forces, international political and economic isolation, and many years of “half peace and half war” that can include both guerrilla and frontline military activity. All these elements, regardless of their duration, result in massive population displacement (Curtis, 1994).

In the immediate post-conflict period, it is necessary to examine both the quantitative and qualitative impact of the conflict on the workforce. This is a difficult task in an unstable political environment, where large population movements have taken place, communications are poor or non-existent and records may have been destroyed.

There is also a political aspect to managing human resources. This may create difficulties in terms of reintegrating health workers from different political factions, tribes or sects, both within the country and among refugees returning from neighbouring countries. This situation may result in difficulty in obtaining information, in addition to the problem of recognition of qualifications and establishing a system of professional equivalences. The entire process is invariably overshadowed by the high priority given to patterns of disease burden and the vertical disease control efforts that distort efforts and render almost impossible the attainment of strategic short-term goals. A major challenge for national and international policy-makers is to strike a balance between fragmented emergency approaches to human resources and the necessary short-term strategic approaches.

As countries emerge from prolonged periods of conflict and isolation and start post-conflict reconstruction efforts to rebuild governments and replace lost health professionals, it is crucial that the new health managers understand the wider context within which they are rebuilding their health services. While there is an opportunity to recreate and redevelop new health systems with related policies and plans, the severity of the human resources issues affecting the context within which health sector reform takes place is greater than that of stable countries. Examples from three post-conflict countries illustrate some of the issues (Box 1).

Box 1. Impact of conflict on the health workforce

In **Timor-Leste** prior to 1999, the health workforce numbered approximately 3500, of whom 2632 were people of Timor-Leste. The majority of the senior health management, medical specialty and medical practitioner posts were held by Indonesians who left the country. There were only 31 qualified Timor-Leste doctors, including one specialist. Of the reported 85 Timor-Leste medical students, 23 were reported to be still studying in Indonesia and 23 wished to return to continue their studies. There was, however, an oversupply of other cadres (Smith, 2001).

In **Cambodia**, of the 487 doctors reported in 1975, only 43 remained in 1979. Emergency efforts to replace this loss resulted in a reported 986 doctors and 1810 medical assistants, with a further 1731 students coming through the medical faculty in 1993, the majority of whom had been trained over a 13-year period in extremely poor conditions with no teaching resources and virtually no clinical practice. Many of those trained as doctors and medical assistants were nurses and midwives who had graduated prior to 1975. This strategy, while enabling already trained health professionals to upgrade in less time than it would have taken to train health professionals from scratch, effectively deprived the nursing and midwifery professions of their senior managers and jeopardized the future development of a management structure for those professions (Ministry of Health, Cambodia, 1993; Sileap & Smith, 1996).

In **Afghanistan** the majority of the experienced senior health managers and teachers had either left the country or were employed by donor agencies. Initial available data on the in-country workforce through a limited health information system were unreliable, with wide variations in the numbers (Smith, 2002). A survey of health facilities undertaken in the second half of 2002 revealed a total of 12 565 workers, of whom only 25% were female. This did not include health workers outside these facilities. There were only 199 midwives and 3181 nurses (of whom 29% were female). In a country with one of the highest maternal mortality rates in the world and an estimated 15% female literacy, the Ministry of Health is facing major challenges in redressing balances and, particularly, producing female health providers who can work outside the cities and reach the women in rural areas. The medical workforce is of major concern; there are approximately 3000 doctors who are mainly urban-based and a further 11 000 currently being trained in a variety of schools lacking equipment, resources and qualified teachers. This situation of massive future oversupply will have serious consequences and requires urgent attention (King, 2003).

The lack of experienced senior health professionals, at every level of the health services, results in health workers' having to undertake posts or professional tasks for which they have not been trained, at a time when they are suffering from the effects of conflict, as well as being preoccupied with the security and survival of their families during the period of relative instability that occurs immediately post-conflict. It is within this scenario that many of these health workers, having no knowledge of international trends in health sector reform, must start redevelopment of the health services, together with the related policies and plans. At the same time, they must deal with an influx of multilateral and bilateral donors, as well as international organizations and nongovernmental organizations, all of which are eager to provide input.

These individuals are also under pressure to develop policy quickly so that it can be used as guidance for donor input in the immediate post-conflict period – a few years during which they are assured of substantial donor input and funding. The development of policy within this context is difficult. As a result, human resources policies are very general and include broad statements about ensuring the right skill mix at every level. They are not, however, sufficiently specific to give clear guidance in an area such as human resources development, where historically donors provide ad hoc and uncoordinated input. While efforts are made to develop coordination mechanisms, in the early days these mechanisms frequently act as information and advocacy forums. The real challenge is to find a way to move these forums towards constructively contributing to early policy development.

This urgency to start the policy development process frequently occurs during the transition period, before elections, when a temporary or transition authority is in charge. It is also a period when efforts are being made to involve senior health professionals from previously opposing factions in working together to reconstruct the health services.

The context of post-conflict redevelopment clearly demonstrates the urgent need for rapid capacity building in key areas such as planning and management, clinical skills and education. There is, however, a danger of continuing a “prescriptive” emergency approach to capacity building within what is essentially a development process (Lanjouw, Macrae & Zwi, 1999). This occurs because of the short opportunity period when a large amount of funding is available. It fosters the myth that health

workers emerging from long periods of trauma can be trained to function at the same level as health workers in stable countries, but in less time. Perpetuating an emergency approach is a guarantee of poor results and waste of limited funding.

The first step in addressing the major challenges of post-conflict development of a health workforce is to ensure that a focal unit for human resources development is established. As far as possible, this unit should be structurally integrated into the de facto health authority to ensure that the development of human resources is embedded within the broader aspects of health services redevelopment, in particular through close linkages with policy development, planning, production, both personnel and performance management, and financing (see Figure 1).

2. Re-establishing the de facto health authority structure

The first task usually undertaken in the post-conflict period is to re-establish the de facto health authority structure within the overall reconstruction of the government system. This is a complex process. For those who, having survived the years of conflict, undertake this task, there is a certain safety in recreating the system that existed before the conflict. In the case of Afghanistan and Cambodia, which had experienced more than 20 years of conflict, the memory was of a pre-Alma Ata style, hospital-based curative service with public health and curative services functioning separately, the role of human resources development limited to a training and personnel approach.

In beginning the process of reconstruction, senior health professionals experience difficulty in contemplating a departure from familiar traditional roles. First drafts of the de facto health authority structures tend to be fitted to the former roles of the survivors, rather than health service needs.² Seeing the opportunities for change, donors who support post-conflict redevelopment press for new and integrated approaches. In order to adopt these new approaches, it is important for senior de facto health authority officials to understand the evolution of health service delivery approaches from which they had been isolated.

During the process of developing de facto health authority structures, it is crucial that central and provincial/district structures are firmly and clearly linked. Because of the isolation of the de facto health authority from service delivery, which frequently occurs during prolonged periods of conflict, it may be necessary in some instances to re-centralize, through strengthening the de facto health authority and redefining its role in designing and managing the newly defined health system, in order subsequently to decentralize. This can be a sensitive area when dealing with major political or factional figures or warlords who control large areas of a country.

2.1 Placing health workforce development in the structure

The process of developing new ministry of health structures provides an opportunity for ensuring that human resources development is more realistically and comprehensively addressed. In order to do this there must be a clear understanding of the essential elements of human resources development, their components and their complexity.

Because of the human factor, human resources development is the most difficult area to manage within a health service, and it is this factor that influences the success or failure of service delivery (Dussault & Dubois, 2003). It is comparatively straightforward to identify the basic services to be delivered at each level of health services, the number of required health facilities and accompanying equipment, supplies and staffing levels. The difficulty occurs in implementation. Investment in infrastructure must be matched with comparative investment in human capacity development based on clearly defined human resources policies and strategies that incorporate all the elements of human resources development. Only a balanced approach will guarantee an improvement in health sector

² This was the experience at the first workshop on redevelopment of the Ministry of Health structure in Afghanistan, held in Kabul in February 2002.