Re-energizing the HRH Agenda for a Post-2015 World – Responding to the needs of fragile states

TEHCNICAL WORKING GROUP (TWG) #6

This paper serves as a background report to inform the Global Strategy for Human Resources for Health. The development of this paper has been coordinated through a thematic working group (TWG), comprising of 2 co-chairs and a group of experts drawn from various Global Health Workforce Alliance (GHWA) constituencies, operating under the oversight of the GHWA Board working group. The views expressed in the paper, do not necessarily reflect the official position of GHWA. All reasonable precautions have been taken by the co-chairs to verify the information presented in the papers.
## Table of Contents

- **INTRODUCTION** .......................................................... 1
- **RESEARCH QUESTIONS** .................................................... 2
- **HEALTH SYSTEMS AND THE HEALTH WORKFORCE: THE EFFECTS OF MAJOR EVENTS AND CHRONIC FRAGILITY** ...... 3
- **REBUILDING THE HEALTH WORKFORCE: WHAT ARE THE CHALLENGES?** ......................................................... 5
- **RECOMMENDATIONS FOR ACTION** ........................................ 6
- **CONCLUSION** .................................................................. 8
- **REFERENCES** ..................................................................... 9


**BIBLIOGRAPHY** .................................................................. 10

---

### ACKNOWLEDGEMENTS

This paper was written mainly by Barbara Stilwell, who takes responsibility for any errors. Working Group 6 members have contributed ideas, text, literature search (Kris Horvath) and papers.


We gratefully thank all who contributed comments on the first drafts of this paper.

---

### INTRODUCTION

Page | 1
The World Development Report, in 2011 (The World Bank 2011), addressed issues of global conflict, security and development and pointed out that no low-income, fragile or conflict affected country has yet achieved a Millennium Development Goal. Although inter-state wars have declined throughout the 20th century, 1.5 billion people globally currently live in places that are violent, conflict-affected and fragile. Health indicators for these people are extremely poor: for example, they are more than twice as likely to be undernourished as people in developing countries, twice as likely to see their children die before the age of five, and more than a third of all maternal deaths worldwide occur in a fragile state (The World Bank 2011; Newbrander 2007). Responding effectively to the needs of fragile states is an ongoing challenge for the international community of donors and implementers, requiring a high level of coordination, setting priorities that meet short and long term needs, and, especially relevant for health care, promoting resilience in complex interlinking systems.

This paper explores the evidence of success in overcoming the challenges of health workforce development in fragile states. In doing so we acknowledge that there are many definitions of ‘fragile states’ and we opt for a broad concept that reflects a discernable common thread in the literature. Our conceptualization is that fragile states lack the ability to develop mutually constructive relations with society and have weak capacity to carry out basic governance functions, which results in an absence of essential services to the population (François and Sud, 2006, Kruk et al 2009, OECD 2012). Not all fragile states have the same level of fragility. Newbrander suggests states may be deteriorating, collapsed, recovering from conflict or in early recovery. This links with a discussion elsewhere of ‘difficult environments’ (DfID 2005) where there is a recognition that conflict or disaster are not necessarily pre-requisites for a fragile state. In some states, governments are unwilling to take on responsibility to provide equitable health and social services, even though the government may have the ability; in others, governments may be willing to do so but lack the capacity. In some states, there is a post-conflict opportunity for rebuilding with the possibility of unplanned transition from donor driven humanitarian support to the development of sustainable systems and attendant risk of “collapse back into conflict” (Collier & Hoeffler 2004). Understanding the root causes of the failure of a state, and the stage it is at, are the first steps in planning successful interventions.

**Research Questions**

Research questions were developed to inform the literature review. They are:

1. Is there a common definition and understanding of the meaning of fragile states among researchers and the development community?
2. What research exists about the effects on health systems and specifically on the health workforce, of major events that lead to fragile states (such as conflict, disasters, structural readjustment)?
3. Is there information from one or more fragile states to map current condition of HRH and outstanding needs?
4. What are the global, national and regional influences on health workforce scale-up and retention including: adequate financing; health workforce training and continuing education; push and pull factors on retention; performance incentives or disincentives; appropriate health workforce distribution; needed infrastructure and resources; governance and policy.
5. What is known about successful and failed interventions in scaling up HRH in fragile states?

In addition to the literature found by searching, key informants were asked to recommend papers known to them, including any reports available from non-published sources.

**Health systems and the health workforce: the effects of major events and chronic fragility**

The resilience of health systems is inevitably tested by a major disruptive event, no matter what the cause. For natural disasters, such as earthquakes and tsunamis, the health system has to be able to respond rapidly and sustain a response as the system is rebuilt. Health workers may be killed in the disaster and made homeless with their families, resulting in less availability of skilled help from the health system. Where the health system is already weak complete rebuilding may be needed. One such example is Haiti, devastated by an earthquake in 2010, but even before that a country with a struggling health system and poor health indicators. Interestingly, the assistance to the health sector that Haiti received after the earthquake (and subsequent cholera outbreak and typhoon damage) has resulted in health indicators that have improved over the 2006 pre-earthquake measurements – for example, improved child nutrition and increased attendance at ante-natal clinics (USAID 2014). This could suggest an ongoing transition from donor assisted emergency relief to more sustainable health system strengthening initiatives, with a population impact beyond meeting immediate survival needs.

Other states exhibit chronic fragility, usually in the presence of a longstanding complex emergency situation, which is characterized by a long term failure of the state to govern, the presence of violence, and shelter and food insecurity. South Sudan is one example of a state that experiences chronic fragility, which is now complicated by the effects of a return to war after a period of peace and state building. By the time the civil war ended in 2003, most health professionals had left the country or had been absorbed into the military. The lack of qualified health workers was the greatest limitation to the expansion of health services. As the country began to rebuild its systems, it was estimated that there was less than one health worker per thousand people and in rural areas, hardly any qualified staff.

Health workers who had remained in South Sudan during the conflict had no opportunity for continuing education and were not up to date or safe in their practice, while faculty had also fled the country, so re-
establishing pre-service and in-service education was at first impossible (World Bank 2007; Pavignani 2009). And in addition to these practical challenges to rebuilding the health sector, the government was new, and lacked expertise in implementing policies and strategies throughout the decentralized system. Communication was poor also, with no internet connection and few phones. All of these factors presented multi-faceted challenges to rebuilding the health systems, and highlights well the need for donor coordination and for a mixture of short and long term approaches that will build governance capacity in the longer term, while emergency measures are being implemented.

As Haiti and South Sudan well illustrate, to rebuild health systems there has to be a shift over time from crisis intervention to more sustainable development. Much of the initial donor funding will aim to resolve the humanitarian crisis and Collier and Hoeffler (2002) suggest that there will be a drop in resources after the initial early enthusiastic donor support.

Countries in conflict tend to see spending on health diminish substantially. As a result, the average developing country experiencing armed conflict has less than one health worker per thousand (WHO 2008). One large study concluded that for every one person killed in armed conflict, as many as fifteen people die of diseases or malnutrition that would have been prevented if not for the loss of health workers created by the conflict (Geneva Declaration Secretariat 2008). Long term conflict can cause a state to move from a sudden descent into fragility to a chronic state of fragility that seems in itself to be so entrenched as to be the norm, requiring further decades to change. The occupied Palestinian territory is one such case.

Pavignani and Riccardo (2012) describe Palestine as a ‘severely disrupted’ environment, a condition which results from decades of intermittent violence, weak governance, occupation and aid dependency. The Palestinian health sector is fragmented, and depends on expensive referrals outside the country to deal with more complex medical cases. But the greatest challenge is that of implementing strong control by the government to regulate and coordinate the sector. Many developments are donor led, with little direction from the government to direct the investments. The result is health services that are of inexplicably poor quality, despite the investment of resources in their production. Changing this situation will require multi-faceted interventions over a long term, that include building leadership, governance and management systems, a legislative framework for health professionals and service delivery, as well as developing and implementing policies to support a high quality accountable health sector (Stilwell 2014).

Health workers in fragile states face many challenges, and those working in rural and remote areas are particularly vulnerable to the problems caused by shortages, the retreat of the state, and general violence typically associated with fragility. In sudden emergencies as well as chronic fragility of the state,
there are likely to be severe shortages of trained health workers, and also of teaching faculty, supervisors and managers. The scenario may be further complicated by well-meaning but ad hoc training of health workers to meet immediate needs, by a variety of nongovernmental organizations and donors. This can result in a plethora of categories of health workers with no recognized qualifications and a number of competencies that are not regulated (WHO 2007).

Even if there is a political will to undertake strategic health workforce planning the likely dearth of reliable information, or functioning information systems, will make it difficult to assess the present situation or predict the future needs. As Box 3 shows, even knowing the number of women in the workforce might be critical.

**Rebuilding the Health Workforce: What Are the Challenges?**

Of all health system elements, the health workforce is most likely to be critically weakened by failing state ability to govern (WHO 2005). Health workers are vulnerable to the threats that all people experience in situations of conflict and disasters, and may be injured or killed or have their homes destroyed. They may flee sectarian violence, fearing attack because of their political or tribal allegiances. A weak government that fails to pay its health workers faces migration of the workforce out of the country, and continued poor working conditions may have the same effect. Indeed, the stress of staying to work in difficult conditions can itself result in ‘burn out’ and absence from post (WHO 2008). And once the health workforce is depleted it takes years to rebuild it, particularly if universities and colleges are destroyed and faculty gone. Even with training facilities in place, educating competent health workers takes years of investment.

Our vision of a health system is one that provides universal health coverage and reflects the values of availability, accessibility, acceptability and quality of services. Rebuilding sustainable health systems and supporting the goal of universal coverage will inevitably take time, collaboration and smart on-the-ground programs supported by a policy and legislative framework that might also have to be rebuilt. In particular, the special vulnerabilities of health workers in fragile states result in challenges in ensuring that they are on-the-job, prepared to practice, connected to the health system and their communities, and safe from harm.

---

**Box 4: Risks of being a health worker**

“No one is immune from this conflict. I am as affected as everyone else. “It makes our jobs very difficult, especially at night when, because of too few staff, we are forced to work alone. “I was helping a woman in labour. We have no electricity here so it was dark, candles only. Two men arrived, both armed. They raided the clinic and stole everything I had. They tortured me for a while with a knife and then left. By the time I returned to the mother, her baby had suffocated and died. “I tried to remain calm but I was totally emotional – scared, anxious and of course angry. We are trying to save lives and they are trying to kill us. “Three health workers left last year to work in less insecure areas. It is hard to keep staff when things are so dangerous. Also in less remote places, health workers are more likely to be paid. Here you can be forgotten for a long time. “I was last paid maybe three months ago – the first time in a long time. I got 3000 Congolese francs (about $3) for 2 months work.

Donald, nurse in the Democratic Republic of Congo, March 2010 (Merlin 2010)
The gap is likely to be wide between what exists in a fragile state – wherever it may be on the continuum of fragility – and the vision of a health system that provides universal access to high quality health care. The goal is to create a resilient health system that can be self-sustaining, and as Newbrander et al (2012) point out, building capacity in a fragile state is usually aimed at ‘building back better’ rather than replacing the old. Witter (2012) also points out that as ‘health systems in fragile and post-conflict states are often forced to innovate, they can generate useful lessons for other settings’.

In an early stage of recovery the health sector has multiple objectives, as it has to continue to provide care but also build new systems to meet longer term goals (Vergeer, Canavan and Rothman 2009). For donors – and even for those providing technical assistance – it may be difficult to focus on objectives that are have different time frames, goals and players, and yet to move past emergency relief to rebuilding requires re-framing the problems and working within a degree of uncertainty and risk.

The point here is that capacity development in this setting becomes (or perhaps should become) a process of change rather than simply training and providing missing care. Equally important is to develop health institutions – more difficult and time consuming, but more likely to result in resilience. Capacity development must also be led from within the country (Vergeer, Canavan and Rothman 2009), with a country led plan for long term assistance that leads to strong institutions that are politically acceptable. Rebuilding the health workforce, to be truly sustainable, has to focus not only on technical or clinical skills, but also on educating managers, so that planning, problem analysis and solution development and securing resources are skills available within the health system. Beyond the accepted skills of management are those of managing power relations and politics which often have undue influence in fragile states. Economies of scarcity and conflict create opportunities for those in civil administration to siphon funding for personal gain or engage in petty extortion, and health systems, including workforce development, can be undermined if such issues are ignored (McKay and Aryeetey, 2004).

**Recommendations for action**

These recommendations are targeted at the international communities and at Ministries of Health who consider that they are part of governance of a fragile state.

1. **Understand the type of fragile state and the implications of this on interventions.** Each fragile state is unique, solutions have to be developed accordingly, and the typologies of fragile state can guide strategies and actions. This review of literature suggests that rather than apply a one dimensional definition of fragility, it is useful to consider states as occupying points along a continuum for each element of fragility. States may be chronically fragile in the sense that they do not exhibit resilience, or, in keeping with the idea of a continuum, they may move in and out of fragility. It is important to remember that once states appear to be performing satisfactorily, they may still be in a tenuous position from which they may slip back into fragility (Newbrander 2007). In addition, a region of a state may be considered fragile, even though the state as a whole exhibits less characteristics of fragility.
The debate about definitions of fragility is more than an academic preoccupation; it is relevant to the sequencing of interventions and thus to the design of donor proposals. When a state lacks the capacity to control and implement programs, sustained development will be difficult to achieve. This is especially true for health workforce development, which requires institutions and policies that ensure a regulatory framework, as well as management and supervision of service delivery. Without a strong central system of governance, health workforce changes – indeed health systems changes – may be more effective targeted at a decentralized level, where results can be seen more quickly, and lessons learned for scaling up.

2. **Use the window of opportunity:** - this is the stage when there has been a major event that has precipitated the slide into a fragile state, and is linked to 1 above. The immediate response is to meet emergency needs, and this is a legitimate concern, but at the same time this constitutes a rapidly receding opportunity for the health sector to benefit from donor interest by moving beyond the emergency phase to a more sustained response. Consider the breadth of interventions planned, and an innovative multi-faceted response that addresses not only the health workforce but the other elements of the health system, and also addresses how progress will be achieved – how change will be planned, implemented and measured. The window of opportunity is often perceived as a stage of stabilization, but greater progress might be made if it is visualized also as a way of making rapid progress towards stronger institutions.

3. **Address governance issues from a health systems framework:** under the New Deal\(^1\) there are five Peacebuilding and State building Goals (PSGs) – legitimate politics; security; justice; economic foundations and revenues and services. These are ‘an important foundation’ for effective governance. The New Deal also recommends a shift to country-led fragility assessments, support for capacity development, greater transparency in more predictable aid.

Governance is critical to recovering fragile states, especially when aid pours in and interventions are in danger of being donor driven. In terms of health systems, WHO (2007) has proposed the definition of governance as “ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design and accountability” to manage all the building blocks of a health system. An example of a practical application of a governance perspective in the context of fragile health systems would be the ability of the state to manage a diverse donor portfolio in such a way that the investment resulted in sustainable health workforce strengthening. In this example there will be many stakeholders, political interest, economic implications, security influences and issues about equity and quality of services. Ignoring governance implications for the health system can result in uneven development that cannot be sustained and may not achieve its goals.

---

The literature, as well as our informants, was unanimous in recommending that there needs to be a mechanism for achieving a common understanding of context and interventions that brings all the stakeholders together, with the state in a coordinating role. This is likely to be especially true for health workforce development, when there is potential for strategies that may provide immediate answers to shortages but in the long term can lead to workforce outcomes that take time to rectify. One common example is the rapid growth of different cadres through ad hoc training usually donor funded – in Cambodia, for example, there were eventually 59 cadres – and a mammoth task to align them.

4. **Use health workforce development tools but use with caution!** The health workforce is one of the health systems building blocks in the WHO Framework for Action (WHO 2007) and while always critical, the articulation of the health workforce with the other components takes on an even great importance in situations where governance is fragile. This is because the health workforce is vulnerable to the catastrophes that affect the population as a whole – displacement, illness, political prejudice and persecution. Financing of the sector and of the health workers will not, alone, tackle this complex situation: to be really effective health workforce development requires good governance across all the elements of the health sector. Health workforce development is unlikely to be linear in a fragile or post-conflict state – in other words, return on investment may not be seen immediately which can make donors and implementing partners anxious. Mikkelson-Lopez et al (2011) suggest re-conceptualizing the health systems elements in a non-linear perspective that reflects the need for governance, in which they include participation and consensus, strategic vision and system design, addressing corruption, being transparent and accountable. Progress in health workforce development, if it adheres to the principles of governance, will involve all stakeholders, seek consensus on a strategic vision for change, and hold government accountable for its actions. In this scenario, the Ministry of Finance would be accountable for non-payment of salaries for health workers (common in post-conflict environments), while health workers themselves would be participants in developing new strategies (participation and consensus).

Finding new ways to measure progress – maybe using a rapid results approach where targets are short to medium term and measured regularly – may be more encouraging than a 5-10 year vision that never materializes.

**CONCLUSION**

Responding to the needs of fragile states for health systems and especially health workforce development requires new thinking on strategic investment and likely results. A stronger commitment

---

to state led governance assessments is seen in the G7+ New Deal and giving the state the lead can ensure a collaborative, consensus-building approach and attention to governance.

REFERENCES

World Bank 2007. Aide Memoir (Government of South Sudan – Multi-Donor Trust Fund) South Sudan Umbrella Program for Health Systems Development.


BIBLIOGRAPHY


General background sources:


Paul E et. al. (2013.) Aid for health in times of political unrest in Mali: Does donors’ way of intervening allow protecting people’s health? Health Policy Planning 2013.


