ReBUILD Consortium

Research for stronger health systems post conflict

Evidence submitted by the ReBUILD Research Programme Consortium to the High-Level Commission on Health Employment and Economic Growth

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The ReBUILD Research Programme Consortium[1] is an international research partnership, funded by the Department for International Development, led by the Liverpool School of Tropical Medicine and Queen Margaret University, Edinburgh, with partners in several post-conflict countries, and working to provide evidence for improved health systems and access by the poor to effective health care in post-conflict settings.

We welcome the opportunity to submit the following evidence to the Commission, addressing:

- **Question 8** on ***fragile settings, complex emergencies and humanitarian crises*** and
- **Question 1** on ***financing health workforce investments***.

1. **Best intelligence** on both supply and demand for human resources, related to services, is needed, in order to be able to plan and monitor, as this changes significantly in fragile and conflict-affected settings (Witter et al, 2012). This is difficult to do in the absence of robust data (Kruk et al., 2009) and with changing HR demand, including a rapid growth of employers in humanitarian responses which continues post-crisis (Roome et al., 2014, Pavignani, 2003, Laleman et al., 2007; Hill et al., 2014). Protecting or rapidly developing personnel information systems will support recruitment and workforce planning processes post-crisis as long as there is a clear focus on how to use and disseminate this information (Smith and Kolehmainen-Aitken, 2006; Hamdan and Defever, 2003).

2. **Workforce planning,** using the best available intelligence, needs to include task-shifting to fill gaps (e.g. following flight of more highly skilled health professionals) and planning for the provision of accelerated training to support task shifting and different kind of work after conflict (Witter et al, 2012; Roome et al., 2014).

3. **A strategic HRH framework** should be developed using local ownership, to cover staff availability and performance in the short and longer term (Fujita et al., 2011); this is because of the time usually needed to develop a detailed strategic HRH plan and the potentially rapidly changing nature of health workforce needs, where a lighter touch framework is more appropriate. The framework should be agreed amongst key stakeholders and used for planning, monitoring and coordination. Where possible, planning should include considerations of **how temporary cadres or existing cadres should be (re)absorbed** into the workforce after the conflict or crisis (Pavignani, 2003). Reforms to the planning and management of HRH may not be possible immediately after crisis or conflict. The appropriate 'Window of opportunity' for change may take place some years later and only remain open for a short time (Bertone et al., 2014)

4. Consideration should be given to the **working environment** which includes safety (from disease or conflict), supplies (with which to work) and management support (for example through supervision – even if remote). When workers feel that they have not been abandoned and their

[1] For more information about the ReBUILD RPC, visit www.rebuildconsortium.org.

needs are being considered, they are more likely to stay and perform better (Wurie et al., 2016; Namakula and Witter, 2014; McPake et al., 2015).

5. Support for health workers' **living environment** is important. This includes safety and may require managers to adapt rules on posting rather than lose staff who refuse to go to dangerous or unattractive areas, and to support accommodation for health workers in these settings or involved in contentious programmes e.g. polio vaccination or Ebola [ReBUILD, unpublished)

6. **Harmonisation of remuneration levels** across the public sector and humanitarian NGOs may be possible (Varpilah et al., 2011) and would help to avoid high turnover due to salary escalation. And it is important to recognise the significant value of relatively small but critical non-salary remuneration benefits in incentivising health workers to stay and perform in fragile contexts. (Bertone and Witter, 2015; Bertone and Lagarde, 2016)

7. Empirical evidence for most of the **linkages between HRH and state-building** is not strong, which is not surprising, given the complexity of (and of measuring) 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. Reintegration of factional health staff post-conflict is also plausibly linked to reconciliation and peace-building
(Witter et al., 2015a)

8. As a stimulus for investment in HRH, the Free Health Care Initiative in Sierra Leone is an example of how a combination of political will, donor support and a wider health system reform can improve HRH and deliver on a promise of basic services for core population groups (Witter et al, 2015b).

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