

# Facing the Challenges in Human Resources for Humanitarian Health

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#### Abbreviations:

HCW = healthcare worker  
HRH = Human Resources for Health  
IMCI=Integrated Management of Childhood Illness  
MDG = Millennium Development Goals  
NGO = non-governmental organization

#### Abstract

The human resources crisis in humanitarian health care parallels that seen in the broader area of health care. This crisis is exacerbated by the lack of resources in areas in which humanitarian action is needed—difficult environments that often are remote and insecure—and the requirement of specific skill sets is not routinely gained during traditional medical training. While there is ample data to suggest that health outcomes improve when worker density is increased, this remains an area of critical under-investment in humanitarian health care. In addition to under-investment, other factors limit the availability of human resources for health (HRH) in humanitarian work including: (1) over-reliance on degrees as surrogates for specific competencies; (2) under-development and under-utilization of national staff and beneficiaries as humanitarian health workers; (3) lack of standardized training modules to ensure adequate preparation for work in complex emergencies; (4) and the draining of limited available HRH from countries with low prevalence and high need to wealthier, developed nations also facing HRH shortages.

A working group of humanitarian health experts from implementing agencies, United Nations agencies, private and governmental financiers, and members of academia gathered at Hanover, New Hampshire for a conference to discuss elements of the HRH problem in humanitarian health care and how to solve them. Several key elements of successful solutions were highlighted, including: (1) the need to develop a set of standards of what would constitute “adequate training” for humanitarian health work; (2) increasing the utilization and professional development of national staff; (3) “training with a purpose” specific to humanitarian health work (not simply relying on professional degrees as surrogates); (4) and developing specific health task-based competencies thereby increasing the pool of potential workers.

Such steps would accomplish several key goals, such as: (1) more confidently ensuring that individuals hired for a given post would have the capacity to function at a commonly understood level of training; (2) greatly increasing the potential number and types of workers available for humanitarian work; (3) increasing the efficiency of human resources utilization in humanitarian projects; and (4) recognition that humanitarian work is a multi-disciplinary endeavor: these goals will contribute to ensuring that humanitarian health workers have a minimum training in broader humanitarian action, making them more effective team members in the field.

Efforts were made to highlight some promising pilot programs for human resource development in humanitarian work, to identify a future vision for humanitarian health as a profession, and to develop a human resources strategy for achieving that vision.

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*No improvement in financing or medical products can make a lasting difference to people's lives until the crisis in the health workforce is solved.*

Anders Nordström, Acting Director-General, World Health Organization  
XVI International AIDS Conference,  
Toronto, 18 August 2006<sup>1</sup>

## Background

There is a growing human resources crisis in humanitarian health. The critical shortage of skilled, trained providers available to serve in humanitarian projects highlights an under-appreciated obstacle to humanitarian health projects. In many ways, this human resources crisis parallels the general misallocation of human resources in health services in much of the developing world and, most crucially, in those countries facing complex emergencies.<sup>2-4</sup> This complicated problem involves a lack of: (1) resources in the areas most in need; (2) recognition by funding agencies of the importance of human resources to achieving project goals; (3) investment in human resources by governments and non-governmental entities even when funds are available; and (4) coordination of training to meet actual needs of beneficiaries.

All of this, set within the context of a global crisis in human resources for health (HRH), pulls workers away from the poorest localities toward more affluent nations that also are attempting to fill the gaps in their own healthcare workforces.

## *Increasing Need, Increasing Scope*

While there is a growing recognition of the crisis in HRH, the development of sustainable solutions to this challenge has been limited. Humanitarian health projects face many of the same challenges and, by their very nature, occur in the most resource-poor environments. In an attempt to meet the health needs of beneficiaries in these impoverished settings, humanitarian health agencies are forced to create parallel systems in areas in which the health systems are broken, or create entire health systems where there is no present functioning health system—all with the goal of improving the capacity of local populations to meet their healthcare needs.

Over the last several decades, humanitarian health agencies have been transitioned from implementing *ad hoc* charitable giving to being more disciplined and sophisticated implementers of domestic and international health programs. Concerns over respecting a country's sovereignty, maintaining neutrality between groups in a conflict, and incurring the acceptance of beneficiary populations increasingly have made humanitarian health agencies (both international and non-governmental) critical providers of larger health programs for greater numbers of beneficiaries than ever before. Along with this transition and the accompanying increase in the size and scope of humanitarian health programs, comes the challenge to increase the efficiency and capacity for their practice.

## *Problem*

Despite being critical to meeting the Millennium Development Goals (MDG) necessitating the urgent development of workforce strategies to develop sustainable capacity in the poorest countries, HRH still are in a state of

crisis.<sup>2</sup> Increasing healthcare worker (HCW) density leads to improved health outcomes (Figure 1). Africa, which has been estimated to harbor 25% of all of the world's diseases, has only 1.3% of the world's health staff.<sup>5</sup> Six hundred thousand HCWs provide care for >600 million people. In order to achieve the MDGs, >1 million additional HCWs will be needed.<sup>6</sup>

This shortfall is not unique to Africa. There is a global shortfall in the numbers of HCWs needed to meet the global demand.<sup>3,4,6-8</sup> While HRH data are limited, data from professional registries demonstrate a similar shortfall in the developed world.<sup>3</sup> A fundamental element of this gap is the training of insufficient numbers of HCWs to meet the global demand. There is a link between the gap that exists in HRH in developed, host countries and that in under-developed, source countries. In an effort to meet the growing demand for HRH, host countries employ strategies to recruit HCWs from source countries that cannot afford to lose them. This results in an exacerbation of the unmet need for HRH in developing countries, despite evidence that increased HRH density leads to improved outcomes.<sup>2</sup> The downstream effect for humanitarian agencies from these "fatal flows" is an even greater reduction of the pool of available HCWs in disaster-affected countries in which there is little in the way of professional support, personal security, and financial compensation.

Chen divides countries into clusters based on their socio-economic conditions and HCW density. He describes several groups (Figure 2): (1) poorer, worker-deficit, high mortality (e.g., Africa); (2) richer and more worker-dense, low mortality (e.g., Organisation for Economic Cooperation and Development (OECD) nations); (3) transitional (e.g., Philippines, Southeast Asia); and (4) other countries (e.g., Middle East, Latin America).<sup>2</sup> Countries in the first group typically have the "triple threat" of a large burden of disease, insufficient numbers of HCWs, and insufficient resources for training additional workers, as well as a level of poverty that results in many of the most talented citizens seeking opportunities abroad, resulting in further shortages. Countries in the second group have lower burdens of disease, greater economic resources, but still do not train to meet their demand for HRH. Therefore, these nations recruit from other countries to supplement their workforce capacity. These countries also are the largest donors of humanitarian assistance and traditionally have been the headquarters of the largest international assistance organizations and United Nations agencies. Countries in the third group are developing rapidly, and have made a significant commitment to HCW training. While economic opportunities remain somewhat limited, these countries have become net exporters of HRH, while not significantly depleting the capacity of their own workforce. Countries in the last group represent the remaining nations; some have resources and have not yet made the commitment to meeting their own domestic HRH needs, while others lack resources but do not have significant gaps in their domestic HRH capacity. Understanding the differences between these groups can help to predict directions of healthcare labor flows and identify potential sources for increased healthcare capacity during times of need.

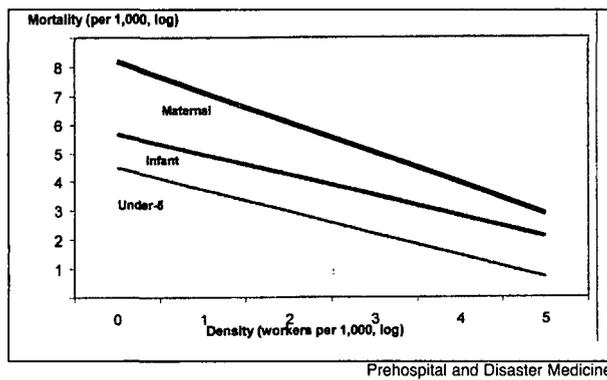


Figure 1—Worker density and health outcomes<sup>18</sup>

Countries also vary by the skill mix of their HCW workforce, the density of HCWs and their distribution, and the overall burden of disease in their populations.<sup>2</sup> These characteristics also have a strong correlation. For example, countries or regions within countries that lack adequate HCWs with sufficient training often also have a correspondingly high burden of disease. Unfortunately, it is these areas, with their lack of economic and human resources, burdens of disease, and resultant social turmoil, that are the most vulnerable to becoming full-blown humanitarian crises—whether by the result of a disaster caused by natural hazards or through man-made emergencies such as armed conflict or displacement. It is in these places that humanitarian health agencies will continue to be faced with the challenge of how to confront such a dearth of developed capacity for health care while trying to accomplish their mission of alleviating the suffering of the affected population.

#### Current Context

Finding a comprehensive solution to the problem of HCW emigration is beyond the scope of this paper. However, understanding the context in which shortfalls of human resources for humanitarian health exist is the key to developing novel solutions to train and retain workers for humanitarian health programs.

Worldwide, there is under-investment in HRH. Government health ministries and humanitarian health agencies operate on lean budgets and, under pressure to demonstrate fiscal responsibility, have tried to do more with less. This lack of investment parallels that seen in developing countries and much of the rest of the world. It is estimated that 60–80% of countries spend <1% of their Gross Domestic Product (GDP) on HRH.<sup>2</sup> Budgets for HRH development in humanitarian agencies are constrained similarly. In wealthier countries, a larger percentage is spent directly on recurring human resources costs of training and salaries. In Europe, these range from 17% (Czech Republic) to 71% (Cyprus).<sup>9</sup> This often represents an expenditure on critically needed human resources than in the poorer locations requiring humanitarian action. While an ideal percentage spent on human resources for health has yet to be established, the widespread lack of coverage for worldwide populations continues to indicate that current expenditures may be too low.

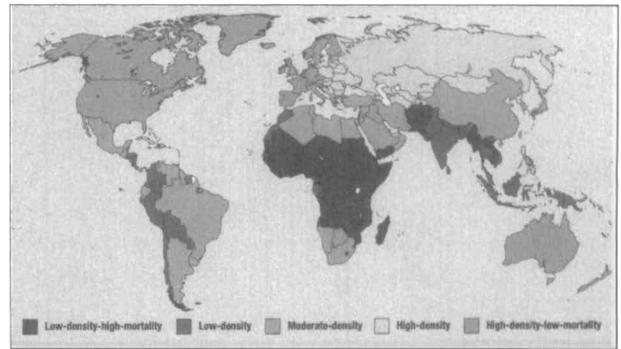
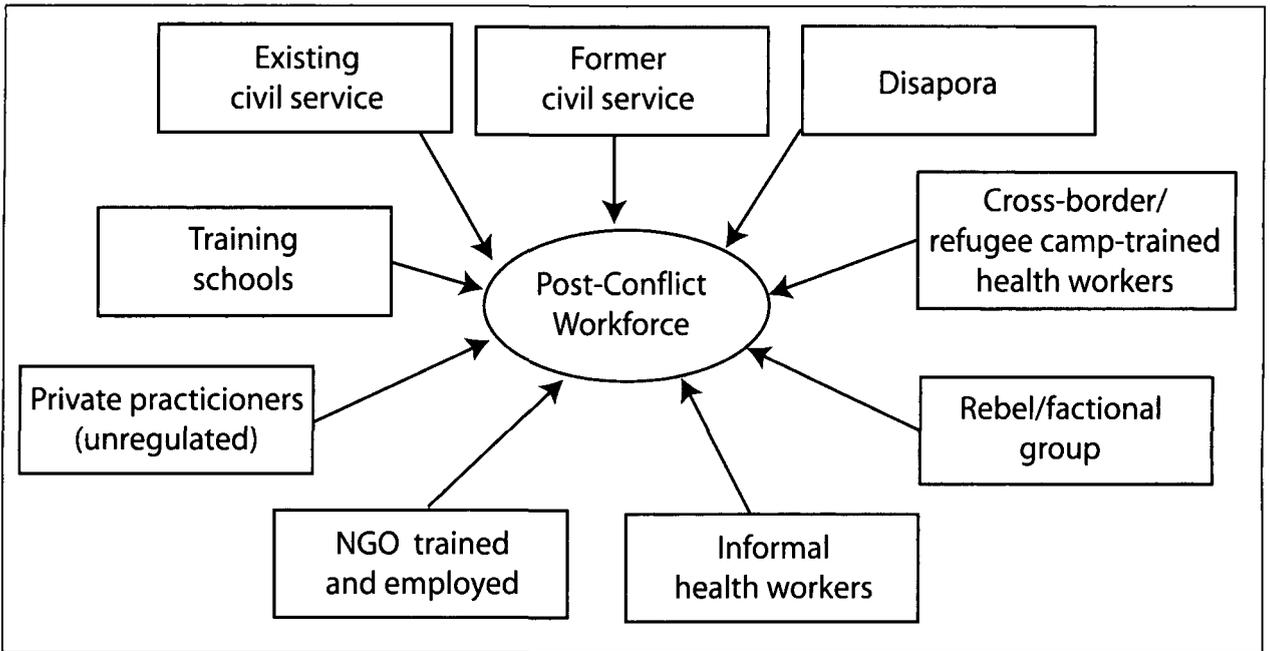


Figure 2—Country clusters by HCW density and mortality<sup>19</sup>

There also is a lack of directed training for health care in much of the world, including humanitarian action. There is heavy emphasis on *professional degrees* as surrogates for *competencies* or *skills*, even when the two are not highly correlated. Often, such a dependency on limited numbers of degree holders results in an even greater deficit of HRH capacity. Few countries have national examinations to test for competency.<sup>10</sup> The same is true for non-governmental agencies (NGOs) and other humanitarian actors. The result is the potential to err in both directions, with a lack of available workers with professional degrees, while some degree holders cannot meet the minimum competencies needed for their positions. Traditionally, degrees and measures of competency were established to ensure the safe and competent disbursement of services to beneficiaries. However, by focusing on degrees and not competencies, the end result often is a lack of standardized skills in the field and an over-reliance on physicians and nurses to fill basic healthcare roles. There is an urgent need for better targeting of skills so that highly skilled providers only are utilized in situations requiring their degree of training.

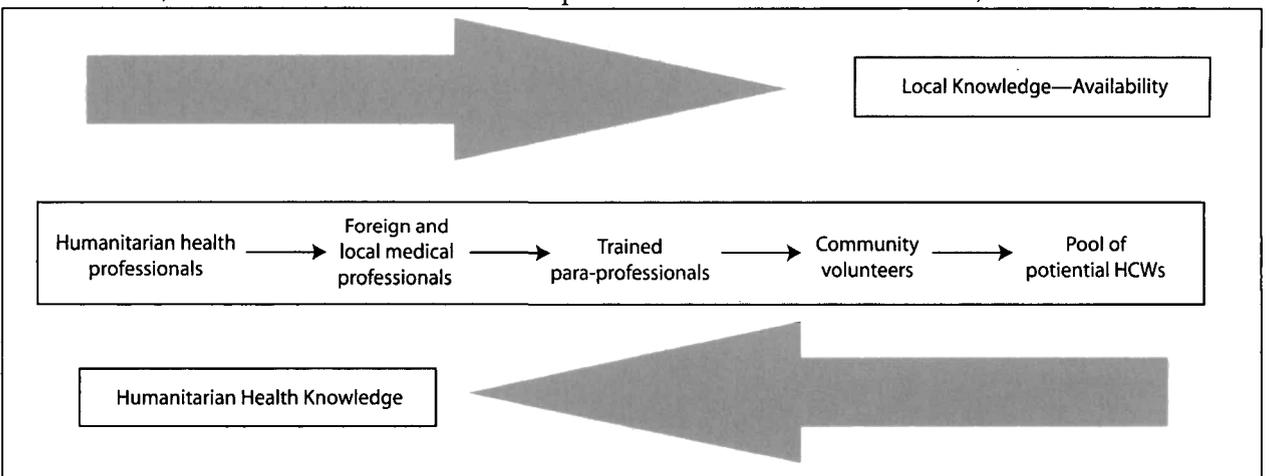
Furthermore, training HCWs to meet the challenges of the developing world, especially the needs of communities experiencing complex emergencies, is not the same as training for practice in the developed countries of the “Global North”.<sup>3,10</sup> Many developing nations explicitly or indirectly train HCWs to meet global standards that are not applicable to the experience of patients in their countries. As such, the training is geared more to passing licensing examinations in host countries than to addressing the problems endemic in their home countries.<sup>3,10</sup> This distortion of training results in a mismatch between providers in these countries and the skills needed to treat local patients. It also leaves providers dissatisfied, as they are unable to practice much of what they have learned, and thus, increases their desire to seek out professional opportunities elsewhere.

The same can be said of HCWs in the humanitarian aid setting. Too often, positions are advertised as requiring an MD, RN, MPH, or other high degree designation for positions that might be covered adequately by lesser-trained individuals. Indeed, Cash raises several ethical questions regarding the use of such a high standard for training in HRH in resource-poor settings.<sup>10</sup> Is it ethical to apply such a standard even when it limits access to care? How do



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Figure 3—Potential sources of healthcare workers in a post-conflict (NGO = non-governmental organization)  
 Source: WHO, Guide to Health Workforce Development in Post-Conflict Environments, 2005



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Figure 4—Balance of professional training vs. local expertise<sup>3</sup> (HCW = healthcare worker)

humanitarian agencies rectify trying to deliver the best possible care in a given setting when that doesn't meet the standards they would apply elsewhere? How can humanitarian actors balance the desire for improving the lot of beneficiaries with a commitment to increasing the standard of care they provide to their communities?<sup>10</sup>

By training other paraprofessionals, who are more abundant, in the specific skills necessary to meet health needs in the settings of complex emergencies, coverage can be expanded to the greatest number of beneficiaries.<sup>4,8,10</sup> The World Health Organization's *Guide to Workforce Development in Post-Conflict Environments* demonstrates potential pools of new workers for the healthcare workforce (Figures 3 and 4). When drawn from the local population, the training of such individuals not only increases local capacity, but also increases the likelihood that the community will retain that human resource. Retention remains one of the major challenges of HRH for humanitarian agencies for specific individual projects and for the organization in general.

*Complications*

The issue of *brain drain*, when the best and brightest members of developing societies emigrate to other countries in search of improved living and working conditions, greater professional opportunities, and higher remuneration, is one of the major human resource challenges facing the health sector in the developing world. International humanitarian health projects rely heavily on local professional talent as the prime movers of programs, and suffer heavily from these transnational flows of human capital.<sup>2-4,7,8,10</sup>

In addition to the so-called "push" factors of poor working conditions and low pay in developing countries, the demand for trained human capital in host countries is a key determinant of these labor shifts. It is estimated that by 2020, there will be a shortfall of health professionals in the United States to the tune of 200,000 physicians and 800,000 nurses.<sup>6</sup> Similar patterns of health workforce shortages can be seen in data from most OECD countries. Low birth rates in developed countries necessitate the need

for immigrants to fill the open healthcare positions in the countries with strong economies and rapidly aging populations that, because of their demographic and ability to pay, will continue to create an increasing demand for health providers in the foreseeable future. Stemming the tide of trained HCWs flowing from the poorest nations to labor-hungry, wealthy nations will require addressing both “push” and “pull” factors. Furthermore, since humanitarian HCWs are drawn largely from the national staff in affected countries or from their regional neighbors, developing and maintaining viable HCW bases in developing nations will be a key determinant for increasing human resource capacity for humanitarian health agencies as well.

#### *Ethical Implications of Human Resource Recruitment*

Some analysts argue that promoting and encouraging this transnational flow of trained labor constitutes a “theft” by rich countries from the developing world, amounting to roughly US \$500 million annually for emigration of skilled labor from Africa alone.<sup>6</sup> Developing nations not only lose a critical resource, but also are denied a return on their large investment in training—most of which is funded sacrificially through the public sector. Potential solutions have ranged from compensating these countries directly to initiating bilateral agreements that would control rates of immigration, to establishing public campaigns to improve conditions in home countries. All of these are fraught with practical, economic, and ethical concerns.

There is an often neglected ethical dimension to the training of HCWs in resource-poor settings. How should the need for additional human resources be balanced with the ethical concern for ensuring technical competence of those taking the lives of others into their hands? The allocation of scarce human resources also has ethical implications. When does the laudable goal of striving for equity result in unacceptable inefficiency? Is it ethical to send highly trained workers to areas where they cannot make use of their training due to a lack of support materially, professionally, or otherwise?<sup>10</sup> Humanitarian assistance has an additional complexity of operating in areas of geophysical, political, and military instability. When should humanitarian health professionals not be there? Are their skills too valuable to risk in austere settings where they are likely limited in their scope of practice?

A further dilemma is whether health care constitutes a special case in the global flow of human resources.<sup>8</sup> As with workers in other sectors, physicians and nurses increasingly are sourced globally. However, unlike information technology professionals, with the exception of purely diagnostic radiology and a few other sub-specialties, the greatest need for healthcare providers, and indeed, most healthcare services, are those provided *in-situ*. Such services require that the professionals relocate to their places of service. The long lead time of training a HCW from start to completion makes them difficult to replace. The loss of this critical resource is expensive and difficult to anticipate in unstable environments, making it almost impossible for countries experiencing complex emergencies to maintain a local surge capacity to respond to sudden increases in healthcare

needs in times of crisis. Filling this gap in the acute phase and then decreasing vulnerability to such crises in the future is ultimately the mission of most humanitarian health agencies.

#### *Parts of a Solution*

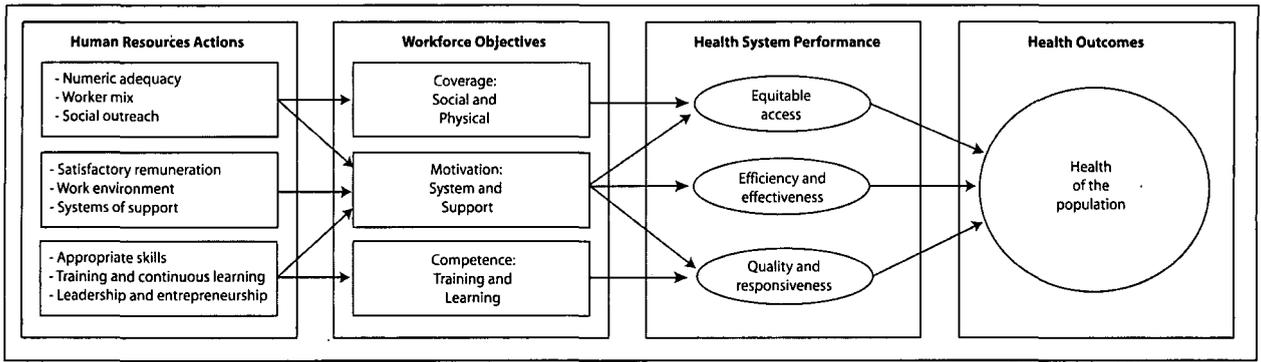
The Working Group for Human Resources in Humanitarian Health included a wide range of participants, including field workers and managerial staff from governmental and non-governmental institutions, US-based and international actors, academics, and important UN agencies with a healthcare mandate. While there were different approaches to the problem of scarcity of qualified HCWs in humanitarian work, there was broad agreement that the solutions to this problem lie within three broad themes: (1) better definition of a career path for humanitarian health professionals; (2) increased recruitment, training, and retention of qualified workers with emphasis on national staff; and (3) greater investment in human resources for humanitarian health on the part of actors and financiers.

#### *Competencies for Humanitarian Health*

While the idea of training paramedical staff to perform medical functions that do not require a nurse or physician is not a novel approach, humanitarian health projects remain plagued by the inefficient use of their most highly trained staff. In the absence of workflow analyses and precise definitions for needed skills, humanitarian health projects resort to the use of professional degrees as surrogates for specific competencies. The result is a heterogeneous workforce, even within the same specialty, and frequent mismatches of skill-sets with skills needed. As has been demonstrated with the Directly Observed Therapy Short course for tuberculosis treatment, paraprofessional staff can be trained to perform what otherwise would be considered healthcare tasks using standardized diagnostic and therapeutic protocols that provide a consistent approach and measurable outcomes.<sup>11-13</sup> Furthermore, innovative programs like the Aravind Eye Institute have demonstrated that careful workflow analysis and tasking of individuals based purely on competencies can result in tremendous health outputs and measurable impacts at a low cost to the system and often at no cost to the beneficiary.<sup>14</sup>

An over-reliance on degrees rather than competencies also perpetuates a lack of training in the problems of the developing world—as medical training focuses primarily on maladies present in wealthy nations.<sup>10</sup> The training of paraprofessionals from the beneficiary community to fill key roles in healthcare delivery results in: (1) more precise targeting of skills to face the actual needs of beneficiary populations; (2) greater cost-effectiveness; and (3) a workforce less likely to emigrate and with a cultural awareness that would take outside practitioners months if not years to obtain (Figure 4).

Effective staff development will revolve around the issue of developing and measuring new competencies for humanitarian health tasks and this investment must be directed at analyzing the workflows of key humanitarian health positions. From that analysis, competencies that reflect the actual skill set needed to fulfill the requirements of those positions must be developed. This alone will increase the numbers of potential HCWs available for humanitarian projects greatly.



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Figure 5—Human resources plan to health outcomes<sup>19</sup> Source: Lancet

<p><b>Hard</b></p> <ul style="list-style-type: none"> <li>- Pay/Financial benefits</li> <li>- Title/Position</li> <li>- Improve working conditions</li> </ul>	<p><b>Difficult</b></p> <ul style="list-style-type: none"> <li>- Opportunities for planned rotation between more and less “desirable” posts</li> <li>- Self-advancement or additional experiences without leaving an organization</li> <li>- Opportunities to enhance collegueship—e.g., professional conferences</li> <li>- Provision of higher level of professional/technical support</li> </ul>
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Table 1—Types of incentives

Training can focus on yielding the necessary number of HCWs, and may allow that training to be *in situ* and to draw from the local beneficiary population, thus increasing cultural awareness and beneficiary acceptance of services. This type of training with purpose can yield human resources in increased numbers and reduce the dissatisfaction resulting from professional over-qualification. Concordant with having measures of minimum competencies is developing tools to assess those competencies on an ongoing basis in the field. Such measures will be critical to maintain the quality of the care delivered and the confidence of the beneficiaries of that care.

*Increasing Recruitment of National Staff for Humanitarian Health Projects*

Recruitment and retention of national staff for humanitarian health is a multi-faceted problem (Figure 5). As has been demonstrated in studies of health care in the developing world, the wage differentials between host and source countries are so large that this problem cannot be addressed by focusing on remuneration alone.<sup>15</sup> Efforts must be made to improve working conditions, increase opportunities for professional advancement, and provide a higher level of professional support. However, it must be recognized that recruiting national staff is a process that is fraught with potential problems.

Understandably, while humanitarian agencies attempt to attract the best and most qualified personnel to join their team, they must realize the perils of doing so with excessive financial inducements. Higher pay and improved working conditions in these organizations can result in distortions to the local healthcare system (Table 1). This “mini brain-drain” from local health facilities to those run by international humanitarian agencies deplete the local facilities of their primary resource and breed resentment in the HCWs

that remain behind. Without a concomitant investment in increasing the capacity of community health resources generally, humanitarian health agencies run the risk of being discredited in the eyes of beneficiaries, the very resource they must rely on once the humanitarian actors have left.

*From Professional Development and Support to Increased Retention and Satisfaction*

Humanitarian health agencies can do much to support their national and field staff and increase retention of that staff for future projects. Some agencies like the International Rescue Committee, the largest US NGO that provides healthcare services during humanitarian crises, have developed technical support units.<sup>16</sup> These specialized units provide training and ongoing technical support to field units in order to increase their capacity to provide service and their capacity to collect critical data to build the case for future additional resources. Such units can reduce the stress on field staff who constantly are asked to do more with less, while assisting them to provide higher quality services to their beneficiaries.

It has been suggested that international placements are sought by national staff and may be seen as more prestigious posts. With this in mind, it is suggested that policies for regional promotion be established to help retain country- and region-specific expertise close to where it is most effective. Emergency response workers, field epidemiologists, water and sanitation experts, and other specialists rely significantly on the accumulated local knowledge of what has worked in the past. Familiarity with local languages, customs, and religious traditions are invaluable resources that are difficult to replace. Maintaining such experts for regional deployment is a wise strategy that decreases the time from emergency response to the effective rebuilding of health systems during times of crisis.

For expatriate workers who have devoted themselves to careers in humanitarian health, there is wisdom in retaining country- and region-specific expertise. Understandably, the most difficult posts are the ones with the highest turnover rates. The austere nature of many of these settings and their constraints—such as unsuitability for accompanied families, lack of communication, and lack of professional stimulation—result in posts filled by a continuous rotation of national and expatriate staff. One approach may involve planned rotations where professionals in such posts are rotated in, then out to a more desirable post, and back in again at known intervals. Thus, institutional memory can be developed and sustained at the field level, and greater efficiency can be built into the system of providing and improving health care in such settings while at the same time, maintaining HCW morale.

The involvement of national staff in professional conferences can increase retention and skill acquisition. The isolation of difficult field placements often is cited as a factor in the decision of national and expatriate health workers to leave their field posts. The opportunity to share experiences and learn from other professionals in the field may reduce this sense of isolation and provide for more rapid dissemination of the best practices to the field.

#### *Keys to Success*

Developing new strategies for human resources development will require several key elements to success, including mentorship, development of critical measures of competency, broader education in elements of humanitarian assistance, and a focus on developing the capacity of beneficiary communities to participate in humanitarian health work.

#### *Training with Purpose*

As in all professions, technical expertise and professional acumen in humanitarian health programs require mentorship of talented junior staff in an explicit and directed fashion to yield a new crop of humanitarian leaders. One innovative program for humanitarian health training includes an innovative program by the United Nations Children's Fund (UNICEF), where promising staff are deployed as additional personnel in a complex emergency, along with experienced field managers. This "extra set of hands" approach allows for rapid, consistent, on-the-job training of emergency staff.

The main argument against such an approach stems from the limited resources available for training. Traditionally, it has been considered easier to recruit talented professionals with relevant degrees and put them right to work. This "sink or swim" approach is counter-productive and relies on "false economies". The apparent cost-savings of a less robust training program quickly become dwarfed by costly mistakes, worker dissatisfaction, and lower retention rates, necessitating new training costs and loss of institutional memory. Work conditions in humanitarian settings are unique and require skills that not always are intuitive or provided as part of routine professional health training. By deciding to send additional, supervised personnel into complex emergencies, the program explicitly builds in professional time for junior health leaders to

learn, both "by doing" as well as by observing more experienced colleagues in action, without having the primary responsibility of decision-making. The support of senior staff allows for the rapid transmission of information, techniques, and style in situations that are difficult to simulate.

Limitations of human and financial resources result in "on-the-job training" of humanitarian health professionals during times of crisis. While acquiring skills in this setting may build character, it also can result in the inappropriate allocation of already scarce resources, causing costly mistakes. It is incumbent on humanitarian actors to push for new programs that provide for structured mentorship and professional development for HHWs, for it is only when such programs are given support and data are collected to demonstrate their effectiveness, will they become more widely accepted.

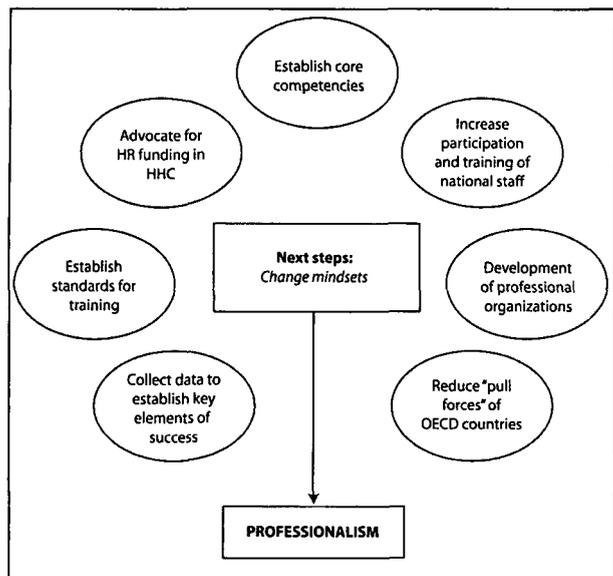
#### *From Competencies to Competence*

Important advances have been established in the area of competency development for healthcare in resource-poor settings. The Integrated Management of Childhood Illness (IMCI) is one example. The IMCI breaks down key elements of childhood health and survival into discrete tasks that can be performed by families, local practitioners, and paraprofessional health staff. By determining and emphasizing key measurable tasks rather than advocating advanced training in pediatrics, the IMCI greatly increases the number of potential HCWs and enhances the capacity of a community to help itself. Similar measures must be developed for a wider range of health problems common to humanitarian health practice. Using such guidelines can further define the key elements of improving and preserving health in vulnerable populations. This definition also can help determine the minimum effective level of human resources needed to reach these desired outcomes.

Using competencies as the basis for selection of HCWs rather than surrogate degrees rapidly can increase the pool of talented workers available for humanitarian health work. The development of such competencies is paramount to creating new strategies for human resources training. Such competencies can be used to develop measures for monitoring and evaluating humanitarian health programs.

Efforts in this regard already have begun in the US with a focus on developing competencies for practitioners of medicine within the traditional healthcare system—the Physician Accountability for Physician Competence Initiative. This project, generated within the "house of medicine", has a goal of establishing a uniform system to develop and measure competencies for physicians over the course of their careers. This initiative is a large, multi-stakeholder effort designed to incorporate all the various aspects of a physician's practice and to envision not just the current needs, but also what the practice of medicine will become in the future, as well as to develop standard training and assessment strategies to meet those needs.

Similarly, efforts to bring together the various stakeholders of humanitarian health work should be made to set similar goals and standards of practice. As humanitarian health work becomes increasingly complex and interrelated, commonly agreed-upon standards are needed to facili-



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Figure 6—Agenda items moving forward

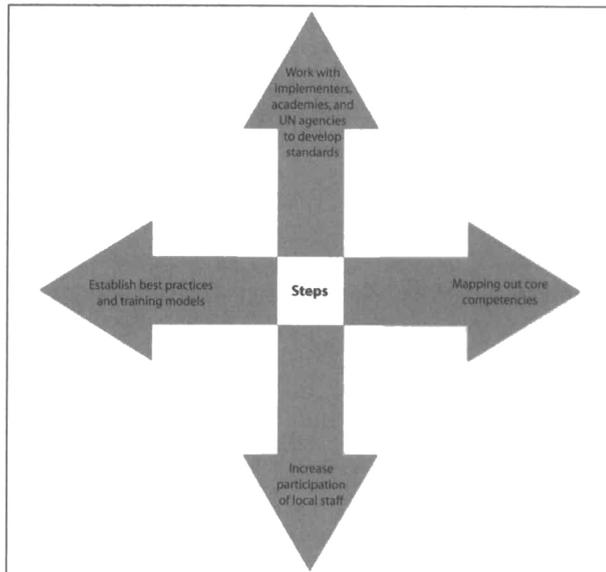
tate the education and recruitment of competent HCWs. Furthermore, such an effort should be initiated and driven by the key stakeholders in humanitarian health—the agencies that deliver such assistance, the beneficiaries, and the donors that support their work—who understand best the needs, limitations, and potential scope of such work.

*“Humanitarian”-ism*

Humanitarian work is a multi-disciplinary endeavor. Increasingly, it is recognized that humanitarian HCWs must be grounded in the other aspects of humanitarian work. One promising direction is the partnerships of academic institutions in the developed and developing world to address the problem of human resources in humanitarian health. Such programs focus on the key health problems facing populations in complex emergencies, and provide a minimum training that more broadly incorporates other inter-related aspects of humanitarian action, including water and sanitation, shelter, food and human security, human rights, and international laws and norms. Many programs exist to provide such training in the US and Europe including: (1) the Inter-University Humanitarian Studies Initiative at Harvard, Tufts, and MIT; (2) the courses in refugee health taught at Johns Hopkins University; (3) the courses on Forced Migration and Health at Columbia University; (4) the World Health Organization-sponsored Health Emergencies in Large Populations Course offered worldwide; and (5) other public and private courses.

*Helping Communities Help Themselves*

Even with an expanded scale, such programs cannot directly put a dent in the vast deficit in human resources that exists in global humanitarian health. They can be most effective through partnerships for training in beneficiary countries. This training-the-trainers approach is the mainstay of another innovative program at the Foundation for the Advancement of International Medical Education and



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Figure 7—Next steps

Research Institute (FAIMER). The Foundation is a two-year fellowship program that provides training and mentorship for international health professionals with the explicit goal of educating graduates to train future fellows in their home countries at FAIMER Regional Institutes. Currently, there are six regional centers in South Asia, South America, and Sub-Saharan Africa that provide a context for training and outreach to local educational centers to meet the healthcare needs of those communities. While these institutes are focused on general healthcare, such educational vehicles can be replicated for regional training to meet the specific needs of humanitarian health.

Ultimately, programs that engage beneficiaries in the delivery of health care to their communities hold the most promise for success. One such model is that of the Backpack Health Worker Teams on the Thai-Burma border, known informally as the “Backpack Medics.”<sup>17</sup> The program engages motivated young people from the ethnic Karen community in the refugee camps that line the border between Thailand and Burma. The medics receive training in basic healthcare diagnostic and treatment techniques from local and expatriate health professionals. They travel back and forth across the border to provide care and community health education to >140,000 internally displaced people with the goal of equipping “people with the skills to manage and address their own health problems while working towards long-term sustainable development.”<sup>21</sup> The program has increased steadily in both scale and the extent of services provided. The medic’s knowledge of the local language, customs, and environment, as well as their investment due to their status as displaced persons, have created a successful, community-supported program.

**Humanitarian 2025**

Many of the elements that have been identified as components of success in improving human resources for humanitarian health can be gathered under a single heading—“Professionalism”. This idea encompasses all of the ideas of

agreed-upon standards for training, minimum competencies for humanitarian work, and, more broadly, minimum training in an agreed upon body of knowledge related to wider humanitarian action.

The natural progression of all new fields is toward a higher level of professionalism. During the last 30 years, new professions have been on the rise. Similar to wireless telecommunications, information technology, critical care medicine, and biotechnology, humanitarian work steadily has increased in scope and practice. Technologies and fields of work that did not exist a few years ago have developed bodies of knowledge, fields of practice, professional associations, and training programs.

Humanitarian health work should, and inevitably will, follow a similar progression. Humanitarian health work will be a competitive and widely recognized field associated with a known body of knowledge, clearly identifiable core competencies, widely accepted standards, opportunities for training, and an explicit and rewarding career path with opportunities for mentorship and professional advancement (Figure 6).

Improving human resources for humanitarian health will require renewed vigor to advocate for funding, resulting in a need to change mindsets. Too often, human resource spending is considered wasteful “overhead” in the thin margins of most humanitarian agency budgets. Unfortunately, this funding bias also has infiltrated the senior management of many agencies. A bottom-up push must occur in order for support of pilot programs to identify and implement best practices and to increase the yield of human resources for humanitarian work.

Part of advocating for humanitarian health HR investments is advocating for developed country health HR self-sufficiency. There must be a campaign to reduce the “pull

forces” of OECD countries by encouraging them to train a sufficient number of personnel to meet their needs and decrease the depletion of HR resources from the poorest nations. Furthermore, part of changing mindsets is changing the actual minds present at the table. Just as there is a need to increase the participation of local staff in humanitarian health programs, there also is a need to increase the representation of beneficiary populations in the senior management of humanitarian agencies.

Globally, there is a lack of adequate data on human resources for health. This knowledge deficit especially is acute in the developing world,<sup>3,8</sup> and almost non-existent during humanitarian emergencies. Such data will be crucial to planning and securing funding for human resources training in the future. Pilots to identify the key elements of success in humanitarian health training must be developed. Specifically, there is a need for data on whether the current training is meeting the health needs of the beneficiaries, and what strategies, if any, have been effective in improving the quantity, quality, and retention of humanitarian health workers. Such data can be used to develop better practices and to advocate for funding for their broad-based implementation.

The Working Group felt that the next step toward achieving the vision of Humanitarian 2025 should be to develop the core competencies that will define the body of knowledge upon which the field will be based (Figure 7). Once such competencies have been established and widely accepted, standardized measures of assessment can be developed with a view towards ultimately creating systems for standardization and accreditation. Such development of competencies likely will serve as the basis for future conferences on advancing human resources for humanitarian health.

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