Health workers' career paths, livelihoods and coping strategies in conflict and post-conflict Uganda

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Acknowledgement

Contents

Executive summary

Introduction

Understanding the dynamics of the health workforce is key to developing a well-coordinated and functioning health system. This is even more pronounced when a country is recovering from a prolonged period of conflict. To improve health worker retention in rural areas we must examine the experiences and perceptions of frontline health workers. This can enable us to establish an effective policy environment for quality service delivery.

Study aim and Methods

The study aimed to understand the livelihoods of health workers along with their coping strategies for dealing with conflict. We also examined public incentive policies both during and after the conflict in northern Uganda.

Using a life history approach, 26 case studies were conducted with serving health workers in four districts of the Acholi sub-region in northern Uganda; Gulu, Kitgum, Amuru and Pader. To our knowledge, this is the first time that a life history approach has been used to investigate the lives of health workers in low and middle-income settings.

Findings

Our research was structured around the various stages of health workers' career paths. We discussed their motivation to join the health work force, their experiences at initial and subsequent trainings, job selection, and any specific motivators and challenges that they experienced. We also sought their experience of any incentive policies they had encountered during their careers.

The research highlights the desire for professional status, particularly the want to wear a uniform, in attracting staff to join the medical profession. Other factors contributing to their decision included their innate caring personality, influences from role models within the participants' social network, their previous encounters with health workers and the need to 'pay back' to society. Feasibility was also an issue with the proximity to hospitals and convents being cited a decision-making factor. The study also revealed loyalty within a sector if a person had undertaken volunteering, training and had received their first job in this sector.

The report highlights conflict as a major contextual factor which affected both the lives and career choices of health workers. Participants recalled traumatic situations and innovative coping strategies during conflict, as well as stressing the commitment and resilience of some health workers throughout this period. Strategies for coping with the conflict included task shifting, disguising themselves, hiding amongst the community and finding innovative ways to work with limited supplies.   They also deployed psychological strategies such as fatalism and relying on their faith.

During the conflict, health workers also had to manage without absent or delayed salary. Many devised alternative means of generating income such as alcohol brewing and selling food stuffs.   Respondents highlighted how many others relied on hand-outs from the community as well as allowances from NGOs.

In general, the findings suggest the importance of selecting and favouring health workers with a higher level of intrinsic motivation.   In difficult times, when working conditions are tough, salary is erratic and formal structures of promotion and recognition cannot function well, motivation is key. Strong leadership, supportive professional relationships, good links to the community and small in-kind rewards appear to have incentivised these staff to stay in turbulent times.

The study highlighted the existence of a crowded policy environment within which health workers operate. Efforts are needed to evaluate such policies from the perspective of the health workers.

Recommendations

1. The interviews raise questions on how best to protect health workers during conflicts. In some cases, health workers may be protected under an agreed policy of not disrupting services; however, in this context health workers were specifically targeted as being of use to the rebel forces. In conflict-affected areas where this may occur, training in how to react to these situations (and agreed procedures with the local community) might be advisable.

2. In times of conflict, alternative mechanisms for paying workers should be developed. Insecurity means that opportunities to move or access services such as banks are very limited.

3. The trauma that health workers who stayed through conflict go through is rarely recognised. Health services should recognise and celebrate the contribution of those who continued to serve on the front line during conflict-affected times.

4. Incentive policies need to target mid-level cadres because they are more likely to commit to long-term employment.

5. Gender was important in many factors ranging from motivation to join the profession, upgrading, coping strategies and roles at work. Gender-responsive policies are needed e.g. to support the training and promotion of women without compromising their wider roles in the household.

6. While local employment can aid retention, this may also cause discrimination against people born out of the area. This should be controlled through sensitisation of the local leaders and communities.

7. Providing opportunities for those willing to learn and work for the community despite having limited education is important. These people can progress to mid-level cadres of employment, which provide a large proportion of staffing in remote areas.

8. Increased seniority and pay for mid-level cadres within their home area will help to retain staff and develop their loyalty. This career progression should be formalised as documentation of their promotion has considerably more value for staff.

9. Human resource management policies should focus on maintaining the intrinsic motivation which many health workers have when they join the profession. This can be implemented through practices which foster good communication, support professional pride, and develop the links with the community.

10. Some of the features which render the public service attractive could be adopted by the PNFP sector e.g. linking staff to the public pension system. Given health workers' reluctance to change sector, it is important that long-term PNFP staff are not left unprotected in their older years. Having transparent pay and promotion processes also emerges as an issue for some PNFP providers.

11. There is need for a bottom-up evaluation of human resources for health policies through the eyes of the health workers themselves. This provides better evidence for improvement of the intended effects of such policies.

Introduction

Understanding the dynamics of the health workforce is key to developing a well-coordinated and functioning health system. This is even more pronounced when a country is recovering from a prolonged period of conflict.

The Acholi sub-region in northern Uganda has seen many different conflicts including, from 1986 until 2006, that between the government and the Lord's Resistance Army (LRA). This conflict claimed many lives, displaced people from their homes and devastated the social services and physical infrastructure in the region (Kindi, 2010; Rowley, Elizabeth, Robin, & Huff, 2006; WorldVision, 2009; WorldVision., 2009). Research into the effects of conflict over time has focused more on the general community rather than specific types of workers e.g. health workers.

Incentives packages that are tailored to attract and retain health workers need to be identified to effectively rebuild the health system in post-conflict Uganda. This report forms part of a ReBUILD research programme looking at this issue in four post-conflict countries; northern Uganda, Cambodia, Sierra Leone and Zimbabwe.

The goal of this research is to understand how incentives for health workers have evolved in post-conflict settings and what effects they have had. We aim to derive recommendations for incentive environments in varying contexts, which will further support health workers in their mission of providing accessible and equitable health services.

This report uses a case history approach to understand the careers of health workers in northern Uganda. This served as a way for health workers to describe their livelihoods to date and for the researchers to explore their coping strategies for dealing with conflict. We also examined public incentive policies during and after the conflict.

The findings of this research will be integrated with those of Rebuild's complementary research activities in Uganda to give an overall report complete with recommendations. These activities include key informant interviews, document review and stakeholder mapping. The study will also feed into comparative cross-country analysis.

This report outlines our research methodology, analysis of our findings, recommendations and conclusions.

Research methods

Introduction

The research programme developed a conceptual framework for this study, which can be seen in figure 1. This shows the linkages between contextual factors, personal attributes and the policy environment in influencing human resources for health (HRH) outcomes in the post-conflict period.

The case history methodology was chosen because it allows for a dynamic exploration of the personal experiences of health workers over time.
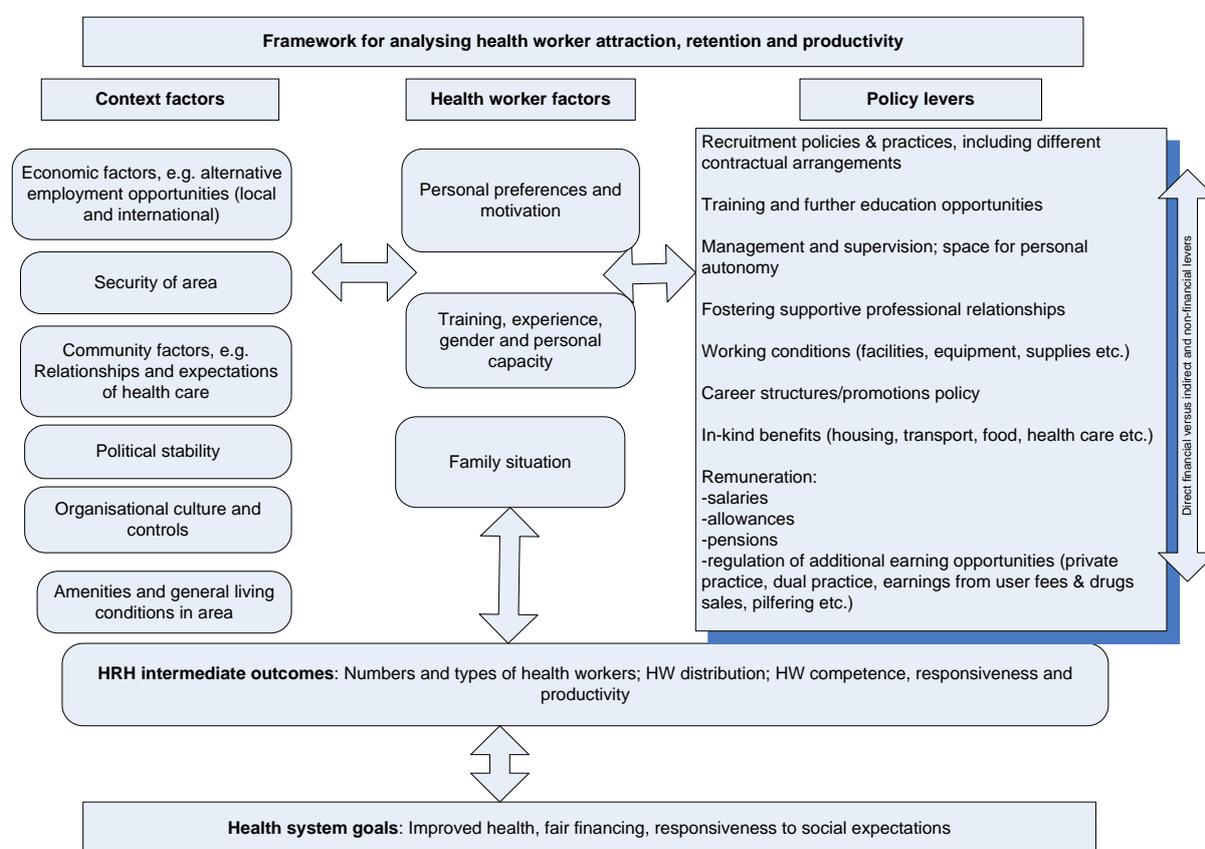
Figure 1: Conceptual framework: health worker incentive research

Study design

This was a qualitative study, combining case histories and in-depth interviews with health workers, with observational research.

Study setting and population

Four districts of the Acholi sub-region that were the most affected by the LRA conflict were selected for the study; Pader, Gulu, Amuru and Kitgum. These districts also contained more than 90% of the displaced population.

We aimed to interview health workers who had worked for ten or more years in both the public and private-not-for-profit (PNFP) sectors. We required health workers with more experience as we wanted to understand how their lives have changed since the war.

Health workers from health centre II to hospital level were included in the study. At district level, our participants were district health officials (DHOs).

Tool development

We developed our study tools using a collaborative approach between team members from Uganda and the UK. A generic topic guide was produced by the Lead Researcher (UK) and was then adapted by the local team during training and pre-testing.

The topic guide (as shown in Annex 1) covered the following areas:

- How they became health workers
- Their career paths since becoming health workers and any influencing factors either during or after the conflict
- What motivates/discourages them to work in public/PNFP facilities
- The challenges they have faced throughout their careers and how they have coped both during and after the conflict
- Their career aspirations
- Their knowledge and perceptions of incentive policies during and after the conflict
- Their personal experience and the role of gender, age and family responsibilities in making decisions during and after the conflict

Using a case history approach, participants were asked to draw their career life lines while the interviewer probed for information about key events. However, the pre-test in Pader, plus subsequent data collection in other districts, revealed that participants were unwilling to draw their life lines, citing a lack of time and confidence as their reason. A decision was made for the interviewer to draw the lifeline on behalf of the participant.[1]

Participant observation was not anticipated to form part of our research methodology. However, some observations by the research team are included in our findings as they form a useful addition to the perceptions of the health workers themselves.

Selection of participants

A total of 26 case histories (7 in the pre-test and 19 from the data collection) were conducted. Table 1 summarises the characteristics of the respondents. Participants were selected from a list of health facilities obtained from the DHO in each district.

Telephone calls were made to each of the facilities to identify respondents that met the inclusion criteria for the study. One exception was made where a male working in a PNFP with only 7 years' service in the region was included to improve the gender balance of respondents.

Appointments were made with each of the prospective participants and interviews were conducted.

We found that the majority of health centre IIs[2] were relatively new, under renovation or not yet operational and that they hired staff with less experience (2-3 years) of working in the region. Most health workers who had worked in the region for over 10 years were found at health centre III facilities. No interviews were conducted at health centre is given that

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[1] The methodology was not uncomfortable for participants; in fact many found it interesting to see the major events of their life displayed in this way. The researchers will send copies of the life lines to the participants that requested them.

[2] A health centre II/2(HC II) is the second level of health facility of the Ugandan Health system found at the parish level. The health system is organised in a tier form (from lowest to highest), each incremental level having incremental services not offered at the level lower but also based on the administrative units. The roles of the HC II are to provide preventive, promotive and curative services (mainly outpatient). Antenatal services may also be available. The organisation of the health system was based on an assumption that when people fall sick, they will first go to a health centre II to and if they illness persists; they are referred to a higher health facility. These higher facilities in ascending order are: HC III/3, HC IV/4, general hospital, regional referral hospital and national referral hospital. The lowest and first health facility level which is below the HC II is the HC 1/one, located at the village level and responsible for first aid and mobilisation.

the workforce at this level is made up of community members who lie outside of the formal health system.

7 interviews were conducted in Pader, Gulu and Kitgum and 5 were conducted in Amuru. 19 of the participants were female and 7 were male, with 17 being employed in the public sector and 10 in PNFP. These distributions reflect staffing patterns at facility level in this region.

District	Number of interviews
Gulu	7
Kitgum	7
Amuru	5
Total	26

Table 1: Number of Life histories, per district

Fieldwork

The pre-test was conducted in Pader in August 2012 and the fieldwork was undertaken in October 2012. The research team comprised of 7 people: six research assistants and the Research Officer who coordinates this ReBUILD project in Uganda.

Ethical approval

Ethical approval was granted by Makerere University School of Public Health Higher Degrees Research and Ethics Committee, the Uganda National Council for Science and Technology and the University of Liverpool in 2012.

Analysis

Data was analysed using a framework approach (Ritchie and Spencer, 1994) and this was assisted by ATLAS TI version 5.0.

Framework analysis adopts an iterative approach and involves the following stages: familiarisation, listening to audio recordings, reading field notes, coding and identifying key themes, merging themes, searching for key findings, finding associations, and providing explanations for the results (Ritchie et al, 2003 pg. 212).

Audio recordings were transcribed verbatim so that original quotes were not lost. The audio recordings were compared with notes taken during interviews to fill in any gaps in information that could have been left out or miss-recorded during the interview. The

interviews were then filed using identifiers such as district, type of facility, cadre and gender.

Transcripts were read several times during familiarisation and recurring themes were identified. A coding framework was developed between team members in Uganda and in the UK. The transcribed interviews were entered in ATLAS TI software and coding nodes were attached to the various themes. ATLAS query reports were generated and printed out for each theme. The query reports were further scrutinised for emerging sub-themes and quotations that epitomised the central themes were identified. Findings were then synthesised across the main themes, noting patterns and differences across the sub-groups.

Study limitation and strengths

It is important to note that the study was one of 'positive deviance'. The research explored the underlying reasons as to why health workers stayed in Acholi during conflict, but we are unable to comment on what caused others to leave. Another important limitation is that the report reflects the views of the health workers themselves but it does not account for how they are viewed by others or how they perform in their roles. We also did not investigate how the experiences of health workers who have worked in conflict transfer onto younger staff members who are new to the workforce. This should be a point for further research.

Despite this, very little research has been focussed on the experiences of health workers during and after conflict. This qualitative research gives rich insights into their lives and how they coped.

The life history methodology has been effective in eliciting personal information from the respondents. Participants were comfortable with the approach and found it to be a useful tool for reflecting on their experiences. Although it was completed by the researcher, the visual lifeline gave structure to the conversation (see annex 2 for examples).

Findings

Description of participants

Participants' characteristics are outlined in Table 2.

The average age of respondent was 42 (range: 30-60) and the average time spent working in the region was 17 years. The study group was predominantly female (77%), which reflects the staffing pattern in the region. 65% of participants were employed in the public sector

and 35% in the PNFP sector and the cadres of staff that were interviewed were: clinical officers (16%), nurses (58%), nursing assistants (8%), midwives (12%) and others (8%). No doctors were interviewed.

The majority of the participants were from Health centre IIIs, district hospitals and PNFP hospitals, with only one participant that worked in a health centre II. This was because apart from one facility in Gulu district, the team were unable to recruit a long-serving staff member at health centre II level into the study. This may also reflect an uneven distribution of experienced staff at the health service frontline.

Many took up their medical training after completing their O'level in Senior 4 (69%), whilst some had completed their A levels in Senior 6, acquired diplomas or attempted a degree. These relaxed entry requirements are indicative of policies in place to expand the numbers of people entering into training institutions.

Characteristic	Average	Range
Age	42 years	30-60 years
Time spent working in the region	17 years	7-38 years
Sex	23% M: 77% F	
Cadres	Clinical officers (15.38%); Nurses (57.68%); Nursing assistants (7.69%) Midwives (11.53%); Others (7.68)	
District	27% Pader; 27% Kitgum; 19% Amuru; 31% Gulu	
Sector	65% Public; 35% PNFP	
Type of health facility	Hospitals (31%); HC IV (15%); HC III and II (46%); others (8%)	
Highest level of formal education	69% O Level; 12% A level; 15% Diploma; 4% Degree	

Table 2: Characteristics of respondents

Stages in health workers' careers

1. Decision to join the medical profession

Guided by the career lifeline of the health worker, the study team aimed to understand what motivated health workers to join the medical profession. This decision was determined by many factors: self-inspiration; influential people in their lives (parents, siblings, religious leaders); the attitudes of health workers they had encountered; incentives offered at the time; dress code and personal circumstances.

Personal desire/calling

Some respondents felt that becoming a health worker was a calling to serve, care for and save people's lives. In some cases, joining the medical profession was a result of the innate caring character of the individual.

"…. it was a calling and feeling of wanting to serve people, so I thought that if I am trained I can also come and save the life of my people." (Male HE, PNFP HF, Kitgum)

"I picked interest (of joining medical profession) because right from my childhood, I had that love for caring for the mothers, especially pregnant mothers." (Female, SNO, PNFP HF, Kitgum)

'' [...] since child hood, I had so much sympathy for sick people and I could care for any one even before I was trained. [...]I have had that heart since I was born'' (Female EN Public HF, Gulu)

"[...] I just liked becoming a nurse [...]" (Female SNO, PNFP HF, Pader)

Advice of family and relatives

The influence of social networks in the decision to become a health worker cannot be under-estimated. These people can include parents, relatives or religious leaders. Fulfilling the wishes of family members and a desire to make their parents happy were found to be deciding factors in choosing a medical profession.

"[...] before my father died in 1972, he used to tell me, 'you are so calm, you are fit to be a nurse and he could tell people that this one can be a very good nurse [...]'. So, after my

completion of 0-level in 1978, I applied to Lacor Nursing school for my enrolment and there I was called for the interview''. (Female SNO, Public HF, Amuru)

"My father told me he had wanted to become a doctor but instead ended up as an agricultural officer by mistake because he missed some points. , So he said my son you can be a doctor, so I took off right from primary I wanted to become a doctor." (Male CO, Public HF, Pader)

Influence of role models

Emulation of practice is also an important factor as some participants were influenced by religious people (nuns) who were also working as health workers. They were mentored into becoming both a nun and a health worker and for these participants these two roles were not distinct from one another. Family members who were employed in the health sector were also considered role models.

"[...] Not only that. My mother used to work as a mid-wife in Padibe HC IV, so I started picking the interest of becoming a nurse. After my senior 4, I went to St Joseph's Hospital as a nursing aide for 3 years". (Female EN, Public HF, Kitgum).

"[...] when I was growing up, I would escape and watch my grandmother conducting deliveries because she was a traditional birth attendant. That is how I picked the interest in joining nursing" (Female SNO, PNFP Facility, Kitgum)

'' *[...] so the nuns advised me to go and join nursing, [they said I] have the heart of nursing"* (Female EN, Public HF, Gulu)

Many respondents had encountered health workers caring for their family members as a result of the conflict and wanted to emulate that service. Both the positive and negative attitudes of these health workers influenced the participants' desire to join the health workforce. The health workers with a good attitude had a lasting impression on the participants during their childhood and later translated into a need to emulate this good work and provide a high standard of care. Conversely, respondents who had experienced poor attitudes from health workers felt compelled to join the health sector to change this poor quality of care.

"I remember when I was 6 years old, I fell sick and then my mother brought me to Lacor hospital [...] and they were talking to me in a good way as if they knew me before. My

mother is a poor woman, she is not educated and we stayed in the village, but the way they were talking to us yet they were very smart and talking to us despite our dirtiness or what, then I admired them and chose to become a nurse" (Female EN, Public HF, Gulu)

"[...]when my mother became very sick in 1992,We took her to the hospital and we experienced a lot of things [...]from there I liked the way the nurses were dressing and the service they were giving to my mother[...] so I felt they were doing important things that could make my mother alright. My mother became ok and so when they discharged us and we went back home, I started feeling that I want to be like them." (Female NA, PNFP HF, Amuru)

"[...]there was a day, when I went to the hospital with a wound to be dressed and I spent the whole day in the hospital without any person attending to me so from that time I started feeling that with time I want to become a nurse" (Female EN, Public HF, Kitgum)

"What drove me to become a health worker is personality of elders who were working in our hospital of Kitgum and they were coming in the sub-county where I came from and I got to like the way they used to handle the patients and it motivated me to become like them in future." (Male District Official, Pader)

Health worker's dress code

Many of the respondents were motivated to join the medical profession by the professional dress code, in particular the uniform of nurses. This could explain why many of the respondents undertook nurses training.

"[...] I used to see my Aunt very smart; she was a nurse in Kiryandongo hospital. I liked that cap, looking at the nurses, so that is how I joined nursing on 22nd November 1997" (Female EN, Public HF, Gulu)

"[...] so when I was in primary school, at break time, I had to go to the health centre and look at the white coats, I picked interest. I would say when I study well; I want to join medical services. So when I finished senior four I went to Kalongo hospital and trained on the job." (Male NA, Public HF, Kitgum)

"[...] I could see the nurses fully dressed and very smart. So that is one thing that inspired me mostly. I therefore decided that I should be a nurse and be smart like them.'' (Female EN, Public HF, Kitgum)

"[...] those gentlemen could put on smartly[...] and that was the reason I went for health training''(Male District Official, Pader)

"[...] they were very smart[...] then I admired them and chose to become a nurse.''(Female EN, Public HF, Gulu)

'' [...] so I just loved seeing the nurses [...] they could be so smart in their uniforms. Then I said I wish I could [...]'' (Female SNO, Public HF, Amuru)

'' I admired the way the nurses were dressing. I liked the way they dressed and I told myself that I should become a nurse'' (Female NA, Public HF, Amuru)

Respect for health workers

Participants also cited their desire to join the profession as a way of 'paying back' to society. They were also influenced by the level of respect the community had for health workers at the time.

"I had already chosen to be a health worker, because I had seen people who were helping others, that was in 1980. I was a cholera victim and I survived but I lost most of my brothers, so I found that health facility could be the only place to be to pay back the service I was offered[...]So, I went for nursing instead of a course in agriculture." (Male SNO, Public HF, Kitgum)

"[...] those gentlemen (read health workers) from my home area were highly respected [...] that was the reason why I went for health training" (Male district Official, Pader)

Health profession as a way of continuing education

For some respondents, the medical profession provided an opportunity to continue their education despite dropping out of school due to insecurity (at the peak of the conflict) and/or poverty.

"[...] I completed senior 4 because of the war and during that time (1987) the war of Kony was very serious here that I could not continue with studies [...] that was also another reason why I decided to join." (Female SNO, Public HF, Gulu)

''Before I completed Senior.6, the war became serious. My father told me to come home and wait until the situation was calm. However, the soldiers came and shot my father was shot when me and my mother were seeing, so that was the end of the story. So from there, my brother was a mere teacher and he told me 'now you cannot proceed, you join a nursing school', so that is the time when I joined a nursing school'' (Female SNO, Public HF, Gulu)

''You know, by that time my father was not there, so those people wanted me to stop in Primary 7 and become a grade II teacher but my paternal Uncle said that I should go and complete my senior 4. So I went, studied and passed my senior four very well. After that, I had two choices; education or health but I decided to pick on Health [...] that was the reason I went for Health training'' (Male district Official, Pader)

''[...] in our family, we led a fair life. Although our parents were poor, they struggled to pay for all of us at school. The elder siblings were already working [...] When I was almost sitting for my O level, I also wrote an application to Lacor, they called me and I went for interviews. [...] so I decided to just join nursing and left the issue of convent even though my parents were not happy'' (Female EN, Public HF, Kitgum)

Proximity to health facilities and convents

The proximity of convents, health facilities, schools and medical training institutions also played a major role for many of the respondents in their decision to join the health workforce.

Living in convents near to health facilities gave some participants the early chance to become nursing aides. This voluntary role could then lead to on-the-job training or undertaking this work inspired participants to enrol in medical-related training.

Incentives provided to health workers

Only one respondent reported that they were motivated by the incentives provided to the health workers at the time. These included accommodation and transport.

"[...] The health workers were accommodated well, they had means of transport, I thought it was good work and that was the reason why I went for health training" (Male district official, Pader)

2. Initial training

Health workers entered into employment at a young age, with the average being 16 years old. The majority had basic knowledge of sciences but required additional knowledge about the medical profession. This section presents findings on their training.

During the conflict, initial training was largely done at nursing schools within missionary hospitals as well as at government owned institutions. Table 3 shows a summary of these training institutions and their location.

Name of initial training institution attended	% of respondents trained there	Ownership	District & Region of location
Lacor school of Nursing	38%	PNFP	Gulu, Acholi sub region
Kalongo school of midwifery	19%*	PNFP	The greater Pader, Acholi sub region
Lira School of Enrolled comprehensive Nursing	12%	Government(Public)	Lira, Lango sub region
Gulu School of Clinical Officers	8%	Government(Public)	Gulu, Acholi sub region
Arua school of Nursing and midwifery	8%	Government(Public)	Arua,West Nile
Matany School of Nursing and midwifery	4%	PNFP	Moroto, Karamoja Region
Mbale medical training school	4%	Government(public)	Mbale, Eastern region
Butabika school of Psychiatric nursing	4%	Government(public)	Kampala, Central region
Gulu Regional referral hospital	4%*	Government(public)	Gulu,Acholi sub region

Table 3: Training schools attended for initial training

*This percentage includes 2% of respondents (mainly nursing assistants) who were trained on the job but they considered this as their initial training.

The majority of the participants chose training institutions that were close to their secondary schools, implying that proximity could have been one of the main reasons for their choice. Health workers who attended training institutions outside of Acholi did so with

because they were seeking specialist training that was not available in the region or as a result of displacement during the war.

The major sponsors for initial training included missionary hospitals, the Ministry of Health, family members and self sponsorship (listed in order of frequency with which they were mentioned). In some cases, respondents split scholarship costs between self payment, Ministry of Health and the district local government.

The length of this initial training ranged from 3 months to 3 years. Enrolled nurses and clinical training took the longest time, while public health education and orientation of nursing aides took the shortest time.

Experience of the initial training

Participants' experiences of their initial training were mostly positive. Some emphasised the importance of the ethical messages learned as well as the practical skills gained at this stage. They highly appreciated the food which was provided during the training.

Respondents who undertook their training at PNFPs said it was stricter than for those who trained in public sector institutions. In the past, many of the PNFP trainers were expatriates who demanded high standards but were also viewed as inspirational.

''In fact life was so fine because from there, we were being fed as students'' (Female NA, PNFP HF, Amuru)

"Lacor is a very good training wing and one can gain experience and you come out a real health worker if you are a serious person [...] There are even certain procedures which we can do which a clinical officer cannot do" (Female EN, Public HF, Kitgum)

"In fact you know, by that time I was still new and everything was difficult. Learning something which you have not seen before was not easy. But I managed because sometimes when you feel you want to know, you can have some interest in it" (Female NA, PNFP HF, Amuru)

"The founders [...] were very strict about patient care as the mission states that we are here for the poor and the needy and the misfortune. So they would like all the good care to be rendered to these patients and if you don't do the way it is needed, they call you and ask you why and if you are not performing well, they say try, and if you cannot manage they say, go

and deal with other things because we are dealing with life so we need the best and the next time it can be you who will be sick and you will expect good medical care. So, we were modelled in a good way and they were taking us with love, so we felt we belonged to the institution because the way they were taking the students as part of the staff. They were so motherly and when one is not performing well, there is a mentor always to direct you" (Female SNO, PNFP HF, Gulu)

3. Entering employment

The study revealed a pattern of progression from volunteering, undergoing training and finding first employment within a sector. Two of the nursing assistants that participated, reported that they worked first as volunteers before finding work at a PNFP. Other factors that influenced participants' first employment were sponsorship, training location, training policies and related conditionalities.

The study revealed that most of the respondents who were sponsored by a missionary hospital went back during practice and also had their first jobs here. This was due to bonding, retention for good performance during training or their certificates being withheld. Returning to work in missionary hospitals was perceived as a way of 'paying back' their sponsors. It also provided job security after training.

"[...]I was recommended because during our time there, the school could post people according to your competence, how you have been performing during your training[...] I was performing very well, so they retained me there[...]" (Female SNO, Public HF, Gulu)

"When we completed our training in Lacor, They used to have a criterion of selection: there were other girls who used to be stubborn naturally. So they would post you to other health units which are missionary. So it depended on how we behaved. Some of us were chosen to remain and work while we were waiting for our results." (Female EN, Public HF, Kitgum)

''They are the ones who sponsored me and so they said I should come and serve with them" (Male SHE, PNFP HF, Kitgum)

Respondents who were sponsored by the Ministry of Health also had little choice regarding their first job. In some cases, politicians/district administrators decided where health workers were posted after the training, with many being posted outside of Acholi. This was

followed by further postings to other public health facilities in their subsequent jobs.   Many were also posted to camps as other health facilities were abandoned during the conflict.

"[...] I completed my enrolment from Lira school of nursing in May 2000. I was sponsored by Ministry of Health[...] So they said that after my studies, I should go back to Kilak because the sponsorship I had was for Kilak county [then in Gulu but now part of Amuru][...] then I also followed what they told me after completing my studies inspite of insecurity. People were in the camp. So I went to the DHO's office then he directed me to go to Pabbo Health centre III." (Female EN, Public HF, Gulu)

Training created a sense of loyalty among health workers. Those who had been sponsored by both missionary hospitals and government tended to stay longer within their respective sectors.

"[...] everything was paid by Ministry of Health and I was very grateful. That is why I am very happy and serving here in the village because without that sponsorship from MOH, I had no money. My mother is a very poor woman, I have no father and there was no one to pay my school fees [...] that is why I have continued and I will never withdraw from the district because it was a nice foundation." (Female EN, Public HF, Gulu)

"[...] I was sponsored by Lacor Hospital [...] for 20 years I was working there; I was never transferred and they never wanted me to transfer. We still have a good relationship." (Female SNO, Public HF, Gulu)

4. Subsequent postings

This stage in a health worker's career spanned early adulthood, middle age, and late adulthood. During the active workforce stage of their career, health workers changed jobs, received promotions or engaged in various in-service trainings.

As health workers matured in their careers, the majority of them did not stay in the same post. Some moved to facilities within Acholi, to neighbouring regions but some did not move at all.

Movement within the Acholi sub region was within districts, sectors and across sectors. Factors that contributed to this were: transfers (both requested and compulsory), insecurity and a desire be with spouses/family. The number of transfers per respondent ranged from

0-9, with an average of 4 times in their career to date. This implies that on average participants moved once every four years.

Relative peace in the Acholi region contributed to the return of some health workers who had received their initial or subsequent training in other regions of Uganda. Respondents also returned to satisfy their scholarship bonding conditions and to adhere to official transfers.

Some health workers stayed within the same region and the same sector. Health workers who received their initial training in PNFP owned institutions tended to have their subsequent postings within PNFP facilities. This was similar for those who had been trained in government facilities.

"I have worked in this region since I qualified. I did my training from Lacor School of nursing and after that I applied to the government and I was taken straight away to Gulu regional referral hospital. That was in 1996". (Female SNO, Public HF, Gulu)

Some of the respondents changed sectors during their subsequent postings. Those who changed from PNFP to public sector reported their desire to do community outreach work, receive a better salary and pension and, in some cases, to work in facilities that had less managerial influence from religious figures. None of our participants shifted from private sector to public sector.

"What made me come to Local Government from PNFP was that although as a public health worker in Lacor my job description there was fine, I was not practicing it so much [...] You know Lacor is full of curative [...] You know as a public health nurse you have to cure in contact with the community, there it was not very easy to go outside." (Female SNO, Public HF, Gulu)

"[...] the way they (referring to a PNFP in central region) were paying people the scale was not really the same. You find a nursing assistant getting more salary than an in charge of a department. For them they were giving their salary according to how I think they know you and how they what, because I remember that time I was getting 140,000/= and that 147,000/= included everything there was 15,000/= for in-charge ship allowances that they were giving and yet other Nursing Assistants were getting 200,000/= per month so the scale was not the same, it was may be according to how you knew the people , those nuns or how you are related to them that one I cannot tell." (Female Public HF, Amuru)

Subsequent training

Health workers were found to value the training opportunities that they received. Subsequent trainings were undertaken at nursing schools within missionary hospitals and government owned institutions in the region. A number of the respondents went for subsequent training outside the Acholi sub-region and either returned immediately or after undertaking a period of work.

Sponsorship for subsequent training

The conflict in Northern Uganda attracted a number of partners who sought to address the various health problems in the region. These actors included international non-governmental organisations (e.g. AVSI, Marie Stopes). In the post conflict period, donor-funded programmes such as NUMAT, SUSTAIN and Baylor arrived. These partners had different focus and funding structure, which influenced the time, location and duration of subsequent trainings. Unlike the initial training, health workers had little or no choice about the focus or the location of subsequent trainings if they had not sponsored themselves.

Subsequent trainings were stand-alone short courses (ranging from 1 week to 2 months) aimed at providing skills in the management of specific illnesses/health conditions in line with the donors' funding objective. Table 4 shows a summary of the categories of subsequent training undertaken.

Short courses	Up-grading
A)Reproductive Health	Nursing assistants course
Reproductive Health	Enrolled Midwifery
Youth friendly services	Midwifery, Diploma in community Health
B)Trauma related/Management	
Management of epilepsy, Bipolar Affective disorder(BAD) management	Diploma in Public Health Nursing
Post traumatic Disorder Management,	Registration in Nursing
C)HIV/TB/Leprosy	Degree in Nursing
PMTCT course	
Aids counselling of Special groups	
HIV prevention	
TB/HIV management	
TB/Leprosy management	
TB management	
Sensitisation of communities about Safe male circumcision	
D) Paediatrics	
Training in paediatrics	
Paediatric counselling	
Integrated management of Child hood illnesses (IMCI)	
E) Cancer	
Cancer management	
F) Epilepsy	
G) Training in emergency,	
H) Sexual gender based violence prevention	
i) Management	
Customer care management	
Management of medical equipment	

Table 4: Further training reported by respondents

As health workers matured in their career, the need for promotion and to enhance their skills beyond their initial training became more prominent.

Hindrances to further training/upgrading

As training often required time away from home it was sometimes difficult for health workers, particularly women, to attend. The effects of the conflict, plus a duty to care for family members made it hard for health workers to upgrade their skills.

"I got distinction in all my papers, but unfortunately up to today I have not gone for registration because I have a lot of responsibilities, we have many orphans who were lost by the rebels, so with the little money I'm trying to push them ahead to study" (Female EN, Public HF, Gulu)

"[...] Just to upgrade- you know. So the liberation war interrupted because at that time I had done the interviews and was supposed to come to school and was expecting my first born so I couldn't go for that upgrading. Then after having children, I thought of looking after them because if I was to go for upgrading, nobody would take care of them so I decided to remain." (Female EM, PNFP HF, Greater Pader)

5. Later stages in careers

As health workers progressed in their career, their expectations changed. Staff were more likely to notice and respond to differences in pay and restrictions on earnings across institutions and sectors. Respondents coped by carefully managing of their resources; some went into agriculture or opened up side enterprises such as drug shops, secretarial bureaus and kiosks, whereas others would have to undergo family separation to work in different jobs.

"Yeah during that time (2006) [...] for me I worked for six months without payment[...] but my husband was assisting me[...] During that time he was in Sudan he was working with the NGOs. When i finally got salary, it was only 227,000. I had to use it just for feeding the family. With the school fees and the rest my husband used to do it because my money was too little" (Female EN, Public HF, Kitgum)

"[...] I already have six children [...] what the government is giving cannot sustain me and my children. So outside government work [...] i have already opened a drug shop selling some small items within the trading centre in Pader town. But there are lots of restrictions, the district comes with their policies and the government with their own also that we should not be having these drug shops or clinics. And if they are hardening on health workers not having other businesses out, then it means I am unable to continue with the district. I have to look for another job because the government job cannot sustain me." **(**Male CO, Public HF, Pader)

Additionally, the restoration of peace in South Sudan led to increased external investment and an opening up of labour markets. This caused the attrition of high level cadres from Uganda in search of better pay in South Sudan. It would be interesting to understand what made health workers stay after the conflict even after receiving information about better job alternatives across the border.

"Generally all health workers should have good pay. That is why in [...]Kitgum here, we have lost very many to South Sudan...Their pay is better than Ugandan Pay[...] Others are triple, there is a Clinical Officer who last from Orom, I think the guy is getting a basic pay of 5.2 million [...] He was even getting 780,000 while in Uganda [...] a midwife get up to 1.2m to 1.6m, others to 3 million in Sudan, so people have left, and doctors are many also who have gone there" (Male SNO, Public HF, Kitgum)

Health workers' lifelines in the later stages of their career were characterised by a number of plans and aspirations which included: further study (for degrees, masters or other diplomas); retirement;   supplementing income through other business ventures; undertaking home improvement works, and travelling overseas for business. Retirement plans were common amongst the older health workers, whereas those below 40 years tended to focus on educational plans.

"Now I do not intend to move anywhere; the next step I am going to take is to retire and go home to rest!" (Female ENMidwife, PNFP HF, Greater Pader)

"You do not expect to push yourself until the earth stops" (Male NA, Public HF, Kitgum)

"I want to continue with health service delivery but I must first go to school because now we are going away from 'P.O Box' to 'dot com' era very soon. I want to do a Bachelor I Nursing, probably next year. If I get in touch with Mbarara I should go" (Male SNO, Public HF, Kitgum)

For the relatively young health workers, aspirations included a changing sector, mainly from PNFP to public. The reasons for the desired change ranged from a desire for less work, higher pay, fully paid study leave, increased training opportunities, and an increased chance of scholarship and getting funds from user fees. User fees exist in PNFPs but they are charged as low cost flat rates for particular services.

"I want to be in a government hospital or health centre [...] their payment is very good. They are getting around 600 something shillings [...]Also less work[...] They (read HWs in public

facilities) do not work because when they are only having a headache, they come to our hospital. So it means where they are serving where they are working is not compared to this hospital[...] even other people come from Kampala for operation because they told us the price of the operation in Kampala is very expensive[...] (Male, RN, PNFP HF,Greater Pader)

Conflict as a contextual factor

Conflict provided a canvas against which many of the health workers' career lifelines were drawn. The effects of the conflict with the LRA affected both the health workers' health and also their working conditions. Effects on health workers' security and included but are not limited to: abduction, ambush and death.

Conflict-related challenges in the workplace included being disconnected from professional and social support systems, working with limited supplies and equipment, increased workload, long working days, and absent or delayed salaries.

In some cases epidemics also brought challenges similar to those brought about by conflict. These included fear of infection, death and trauma, as well as increased workload and long working hours. The effects of both conflict and epidemics are discussed together. Despite these challenges, health workers were not docile; they actively created coping strategies. This section presents the effects of conflict on the lives and careers of health workers, as well as their coping strategies to deal with the context.

Effects of the conflict on health workers' security and health, and how they coped

Abduction

During the conflict, some health workers were abducted by rebels whilst others feared abduction. Participants noted that as health workers, they were a particular target as the rebels needed medical attention and advice from them.

Almost all respondents witnessed traumatic events, wither being abducted themselves or witnessing the abduction or near abduction of colleagues. Before abductions, rebels would either send warning or arrive unannounced. Many of the participants who were abducted were lucky to have been set free after a period of time. This ranged from a matter of hours to many months.

"We were living in fear of abduction because the rebels would call us and say that they are going to abduct us. So we had it rough [...]'' (Female NO, PNFP HF, Amuru)

''The insurgency started when I was still working in Lacor. I missed being abducted several times. And I call it God's Luck! [...]'' (Female RN, Public HF, Kitgum)

''In 1986, I was abducted by rebels for 2 days because they expected me to help them. They said,'' this is the right man to help us in the bush' [...] but a rebel who was born in Mucwini, where I also come from saved me and released me and then I found my way back home in Mucwini.'' (Male NA, Public HF, Kitgum)

''[...] and so the rebels went with the clinical officer to go and tell them which drug works for which infection[...] but he came back after some months[...]'' (Female EN, Public HF, Gulu)

The health workers devised a number of coping mechanisms against being abducted. If at the health centre, they would mingle with patients, sleep in the bush, frequently change their sleeping place or sometimes they would stay stationary.

The findings show that health workers needed to build trusting relationships with the community as they sometimes they acted as protectors by hiding health workers from the rebels. During these times, nurse uniforms changed from being a symbol of professionalism to a symbol of vulnerability. The voices below illustrate each of the five coping mechanisms listed above:

"I ran among the community members [...] I would not treat my hair like yours [referring to the interviewer]- so like you they would follow you because you look different from other people. I looked exactly like the community that's why they (rebels) did not focus on me particularly because I was exactly like the community. And I used to buy simple clothes for my baby like for the community, even this one[3] for tying on the back everything was like for the community so if am mixed with them you can't differentiate me from them." (Female EN, Public HF, Gulu)

"Other staff who feared staying in the nurses' quarters again could run and sleep with the patients in the hospital because when you are abducted as a nurse you will not escape! So at least when the rebels find you among the patients they will leave you thinking you are also a

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[3] Referring to a handmade piece of cloth specially designed to carry babies on the back. This is still used by many women of lower socio-economic class

patient and at night we could not put on uniform so that you are not detected" (Female EN, Public HF, Kitgum)

''We could work are there you work and leave the workplace at around 3pm and then prepare food quickly in order to go in the bush early, we were sleeping in the bush somewhere there.[...] could come back from the bush around 8:30 9:00, clean ourselves and come to office'' (Female SNO, Pader)

''So when you sleep this side today, the next day you have to sleep the other side [...] So the only thing you have to do, you have to change your sleeping place because when they land on the hands of one of the villagers, they will say, go and show us where the health workers are so when you sleep in one place, automatically even the village people would know, so and so is sleeping here in this area and so they come and get you and you are taken and some people are even killed" (Female EN, Public HF, Pader)

''[...] I remained at the facility but the other staff from Eastern region who tried to leave were killed.'' (Female SNO, Public HF, Kitgum)

Ambush

Many health workers recall being ambushed by rebels. Ambushes were common along the roads connecting districts or at particular road junctions. Many of them survived death or got lasting physical injuries. The main coping mechanism against ambushes was staying stationary in one place.

"In 1999 after I qualified, I went to Kitgum to do an interview. We were five clinical officers from Pader. On our way back, we were ambushed, one of our colleagues was shot in the chest but he survived narrowly. The rest of us survived as well but our documents were burnt including my driving permit.[...]You could not move 2 kilo meters from the centre, any slight mistake you make to move, it means you will get problems, so I stayed there" (Male CO, Public HF, Pader)

"[...] I survived a total of three ambushes [...] One of the ambushes was in 2003. We were about eleven of us coming from an outreach. We met an ambush and the rebels fired at us at Pela; it is a trading centre in Omiya Anyima. I lost a tooth. Then another instance was when I was coming from a workshop in Gulu. We entered one in Angagura but I also survived with other colleagues. Then the worst of them was when we were travelling in an Otada bus.

I can't remember the year but that was the time I nearly got finished. The rebels fired at us [...]'' (Male SNO, Public HF, Kitgum)

'' *In 1998 I escaped an ambush at corner Kilak when I was on my way to visit my brother in Lira [...] in 1999 I survived another ambush and lost a tooth. [...] in 2000 I narrowly escaped another ambush at a burial''* (Female SNO, Public HF, Kitgum)

Death and fear of death

During the conflict many health workers lost their lives or witnessed the death of their friends and colleagues. Death was not only a result of security related issues but also epidemics such as Ebola. Those who survived death remained traumatised and in constant fear for their lives from either war or epidemic. The death of health workers in the region further affected the human resources for health problems in the region.

"[...] but the nursing aid was killed there and then at the health centre'' (Female EN, Public HF, Gulu)

''*I lost so many friends; we lost even some of our staff during the ambushes on our way to Gulu.''* (Female EN, Public HF, Kitgum)

"The first person, our colleague with whom we had gone to train, died of Ebola [...] So, we suffered. Many students and even many health workers died from there in 2000" (Male RN, Public HF, Pader)

"There was that fear because one of the health workers died in Pabbo" (Female EN, Public HF, Amuru)

''*We were also working at the same time fearing. We had students who also at that time had Ebola. At times I was discouraged because I thought I was going to die."* (Female NO, PNFP HF, Amuru)

"Then you could hear gunshots, someone shooting just very near at times you feel like you are going to be short at that time, that fear was there''(Male SCO, Public HF, Amuru)

Turning to God, fatalism and developing self-defence skills were found be other coping mechanisms during the conflict.

"You wouldn't bother so much but tell God 'I am here and if the worst comes to the worst it is you who knows'. So some of us have persevered up to now" (Female EN, Public HF, Kitgum)

"As a human being you have to persevere with the pain because there was nothing I could do because these people could come any time they want. We would just leave all those problems to God. Nothing as a human being you do apart from praying to God" (Male SHE, PNFP HF, Kitgum)

"The good thing is I started a good relationship with some detachment around and we were trained and I got a gun. The detachment was very close to the health centre, so in case of any order from the detachment, you just take off and go to your andaki (fighting hall). We all had our andaki (a fighting hall) so that was the life" (Male CO, Public HF, Pader)

Effects on health workers' working conditions, and how they coped

Disconnection from professional support

Unfortunately, staying stationary had a short term effect as it led to infrequent travel for fear of ambush or standing on landmines that lined the paths connecting districts. This also disconnected health workers from professional support, medical supplies and regular salaries, which were often in the other districts. In some cases, security was provided through convoys to escort vehicles with supplies and patients however most health facilities in remote areas remained disconnected from this. Health workers in remote areas had to endure long periods of shortage and were forced to be innovative or lobby for buffer supplies from non-governmental organisations. In areas where there was no security from the army, travelling to another district to access salaries became a necessary evil which put health workers' lives in danger.

"Yeah I walked from there up to the health centre where I had been posted because the vehicle that was taking me was stopped by the army men not to continue ahead because of the insecurity, land mines had been planted on the way " (Female EN, Public HF, Gulu)

"[...] we would work until our gloves where over, because of too many injuries and at times we would use kavera [polythene bags], because you cannot leave a person to die, so we used 'kavera', fortunately the Red Cross and the UNCHR came in and they started supplying us with gloves and other equipments" (Male CO, Public HF, Pader)

"In Patongo I would rate it (read satisfaction) at 3 because we had logistics but the only problem we had was lack of ambulance. You could refer a patient and there is no way that patient could move to the facility where you have referred them and the place was in same that it needed people to move to the facility where you have referred them and the place was in same that it needed people to move in a convoy" (Female SNO, Public HF, Pader)

"And then also our movement, once we didn't have any bank here in Pader and you had to risk if you didn't have money, to go up to Kitgum. That is where we always get our salary in the bank." (Female, EN,Public HF, Pader)

Displacement

As a result of conflict many health workers fled to safer areas within the same districts, or to other areas within or outside Acholi sub-region. In most cases, they abandoned their duty stations and moved to facilities elsewhere or even abandoned health work as a profession.

''In 1987, I had just gone back to work in kalongo hospital because my husband was working there. Then war broke out and there was massive displacement. We were displaced to Adilang sub-county and life was very difficult.'' (Female SNO, Public HF, Pader)

'' [...] people were running away. People were leaving work. They were running to Kampala, to other districts. Some were shifting to other hospitals especially Lacor because it is in town or other clinics.'' (Female EN, Public HF, Gulu)

Limited supplies/equipment

During the conflict, there were limited supplies of medical equipment. Facilities were raided by rebels and new stock was unable to be delivered from other districts as a result of insecurity.

'' Yes they even went with some vaccines, they went with drugs they went with very many things'' (Female EN, Public HF, Gulu)

"[...] Some medical equipments were taken by the rebels [...]'' (Male CO, Public HF, Pader)

In addition, the overwhelming number of casualties during this time further limited supplies available. Maternal Health and casualty departments were reported to be affected most. Insecurity and limited supplies worsened the working conditions of health workers.

"It was a health centre IV but we were demoralized and frustrated because we were in a HCIV but o.k. the HC was there but the equipment was not there. You find in a labor ward the equipment like the forceps; all those things were not there [...] .Sometimes IV fluids are not there for these women who come with abortions, bleeding after or before delivery like that. One may come to you but you have nothing to do and yet you know what to do but those things may not be there, the IV fluids may not be there." (Female SNO, Public HF, Amuru)

"In Adilang, [...]I remember struggling to help a woman kneeling with no bed but just on the floor so that was the worst experience I had. I was also pregnant and I got a miscarriage" (Female SNO Pader)

Health workers were forced to improvise with unsafe tools to continue providing their services. In some cases they had international NGOs offering buffer stocks or providing means of transport for collection of supplies.

"[...] At times we would use kavera [polythene bags], because we didn't want to leave people to die, so we used 'kavera', fortunately the Red Cross and the UNCHR came in and they started supplying us with gloves and other equipments [...]when I was transferred to this place at least we were a bit free because UNCHR gave us an ambulance and at least we could ferry drugs from Pader'' (Male CO, Public HF, Pader)

Increased workload and long working days

The conflict also resulted in long working days and a greatly increased work load from those who remained in functional health facilities during the war. These were mainly the PNFP facilities and those located in camp settlements. Increased workload was a result of war casualties, child related illnesses and epidemics such as cholera (2000-2001) and Ebola (2005-6) and which hit the region during the same period. As a result, health workers were emotionally and physically affected.

"Yeah, during those days, during the war times [...] around June-august 2002[...] when i came here, the experience we had here was not very easy because there was a period we would work all night, we were having casualties, two lorries [...] we started working during those days from 6.00 p.m. to around 4.00 a.m. then the whole week then the following day from 11.00am to midnight because we could not finish the casualties. [...]" (Male RN, PNFP HF, Pader)

"The main problem was the number of patients was overwhelming, because all these five refugee camps where being served by 2 health centres; I think they about 13,000 people being served by this two health centres.[...] we would work until our gloves were over, because of too many injuries" (Male CO, Public HF, Pader)

"When I joined St. Joseph's in 2001, it was hot because we were few also. I was posted to the children's ward but the work there was hectic and during that period, there was real war in Kitgum here. We also had many children who used to fall sick and therefore the ward was always full. The number of clients over whelmed us because we could get about 700 to 800 cases. You could be on night duty but are required to report at 7.30 every morning. During that one year I lost weight and became very thin because the work was too hectic."(Female EN, Public HF, Kitgum)

"You would find many victims of gunshots and you would be there working from the time you arrived in the morning up to 5 pm almost and even if there was a shift coming to relieve you, there was still a lot of work on these patients.'' (Female SNO, Public HF, Kitgum)

"During those days, during Ebola outbreak, it was not easy because we had many patients" (Female NO, PNFP HF, Amuru)

Health workers resorted to task shifting to cope with the increased numbers of patients. They would often work in shifts and, particularly in PNFP, were encouraged by expatriate doctors. Under task shifting, health workers had to manage conditions that, under normal and legal circumstances, required those of a higher cadre than theirs. Working in shifts enabled the health workers to have some rest. They were motivated by the fact they were saving lives.

"[...] this is not my role, it was a role of a doctor, and you know it very well but we don't want to bury the feutus in the dead mother's womb - so i separate these people. I had to struggle with the knowledge I had." (Female SNO, Pader)

"So it was very tricky while at St. Joseph's because it was during the insurgency and we were doing the work of a doctor and ours especially at night. During the day we didn't have much because the doctor would come to do a ward round and discharge.'' (Female EN, Public HF, Kitgum)

"There was a time when there was an outbreak of meningitis and the nurses were helping a lot, because when somebody comes you just do a lumbar puncture. Which we are not supposed to do, but you know there are settings when there are no doctors." (Female SNO, Public HF, Amuru)

"So we used to go home at 6pm while the evening group could go home at almost 10pm! It is good most of the staff were around here though we had those who used to come from outside. Those from outside were usually assigned only day duty because with us we were working 24 hours from 8 am to 5pm then from 5pm to 8pm and then from 8pm to morning; so for those colleges who were coming from far, we used to relieve them and for them they used not to even stay far- they used to be around the town here and at night they could not move." (Female SNO, Public HF, Kitgum)

Abandoning their jobs, perseverance and counselling were other coping strategies for this increased workload. Counselling and support from managers and elders played an important role in reducing panic and attrition. Some health workers strengthened their resolve to serve their people, even in periods of nationwide industrial action for health workers.

"In 2002, the insurgency was at its peak and the patients were too many, I took off and went to Gulu. We could not help them." (Male CO, Public HF, Pader)

"[...]Most of the health workers abandoned the hospital including the matron[...]" (Female SNO, Public HF, Kitgum)

"If we were to run away who would now help them? So we persisted and slowly the fear disappeared." (Female NO, PNFP HF, Amuru)

"[...]Aah!, It was too much for us but only that[...]professor [an italian expatriate]told us that 'supposing you were the one who is, you put yourself as if you were the person? So that taught people to work [...]" (Male RN, PNFP HF, Pader)

"We had our teachers who were counsellors and so the fear disappeared itself [...]" (Female NO, PNFP HF, Amuru

"We just continued surviving like that. One good thing that I saw was health workers became committed and I remember there was a strike during that time also, where the health workers were striking and did not want to work, but for us we continued working.

Prior to the strike day, we sat down and said 'our people have suffered enough and we cannot go back, we cannot join them or the rest of the country in the strike'. Let's remain and continue to work" (Male SNO, Public HF, Kitgum)

Salary related challenges

During the conflict, health workers had to cope with absent or delayed salaries. Many devised alternative means of generating income such as alcohol brewing and selling food stuffs. However, others relied on hand-outs from the community as well as allowances from NGOs.

"In the first place I was motivated by community of Lira Kato, the present Apono sub-county. They were in total support of my well being, they were able to provide food for me." (Male CO, Public HF, Pader)

"[...] When I was in Adilang, I wasn't getting anything. We were in the village and we could get food stuffs and we would sell food to get some money" (Female SNO, Pader)

"[...] around 1986-87, there was no salary so I brewed alcohol to survive [...]"(Female SNO, Public HF, Kitgum)

"The work was okay, but the problem was no money, because we could not get money because at that time I was not on salary they were giving us some motivation when we go for outreaches, and the NGOs who were on the ground would motivate us plus those risk allowance during the period of Ebola" (Female Reg M/W, Public HF, Gulu).

Localised conflicts

Localised conflict such as cattle rusting from Karimojong warriors also created insecurity for one of the respondents. He responded by befriending soldiers, undergoing military training, acquiring a gun and becoming a fighter, in addition to health work.

"It was a time when the Karamojong are moving back with their cows, and when they are going back they raid people's cows. You could not move 2 kilo meters from the centre, any slight mistake you make to move, it means you will get problems, so I stayed there. The good thing is I start a good relationship with some detachment around and we were trained and I got a gun. The detachment was very close to the health centre, so in case of any order from the detachment, you just take off and go to your andaki (fight hall). We all had our andaki (a fighting hall) so that was the life" (Male CO, Public HF, Pader)

"Yeah, security was there, in fact there was a very big detachment in Anaka hospital ...even during the night within the hospital they used to put there soldiers to guard.'' (Male CO, Public HC, Amuru)

Motivators for the health workers

Community support and practical assistance from the district and external agencies created satisfaction among health workers during and after the conflict. Community support enhanced the health workers' wellbeing, whilst agencies provided transport to strengthen referral systems and improve working conditions.

"In the first place I was motivated by community of Lira Kato, the present Apono sub-county. They were in total support of my well being, they were able to provide food for me. Another motivation was the district which was able to provide for me means of transport. In my second job, UNCHR gave us an ambulance and we were to refer patients and it enabled us to go for workshops and there was insecurity and they would even mobilise for us security to move [...] we used to use radio calls to communicate to the district and to our families [...] they also renovated an old house where we lived and that was one of the motivation we got, and they also used to give us things from the refuge council. They gave us food and also good things like blankets and mattress because we had children" (Male CO, Public HF, Pader)

Employment benefits such as food, accommodation, free health care, uniforms, sponsorship for their children and small gifts from patients, were important in motivating and retaining staff.

Some also enjoyed taking on more serious responsibilities beyond that of their job description.

"I liked my job because of the experience I got while in the children's ward because we were doing LP (lumbar puncture) which was supposed to be the work of a doctor[...]But in the absence of a doctor I did it. So working in the children's ward helped me gain a lot of experience and I knew a lot of things beyond my training" (Female EN, Public HF, Kitgum)

Appreciation by the supervisors and training opportunities were also seen as motivators. This emphasises the importance of non financial incentives as sources of motivation.

"You know motivation is not physical things only and that particular in-charge could motivate even through thanking you when you have done some work. And of course once in

a while, more often, not like these days, he could lobby for out workshops also and refresher courses" (Female EN, Public HF, Amuru)

Self-actualisation was an important motivator for many, including those in relatively low-level posts. Health workers were eager for further training and certification to demonstrate their improving skill set.

"Because you are there and sometimes you may not be allowed to do some things [...] for example, when a person comes like this, you are not allowed to do certain thing because from there they would put you as a nursing aide. So you don't have time to learn [...] In fact I was not happy. The little knowledge I had, if I did not use it, it would disappear" (Male NA, PNFP HF, Amuru)

Some also reported achieving a state of mental equilibrium through their work:

"One, was the occupation of becoming a sister, I liked it so much. Then the same time, the desire to become medical personnel, which was realized. Then also learning to be free, simple to every person and not to go round gloomy that one made my life easy" (Female NO, PNFP HF, Amuru)

Timely promotion and improvements in salary motivated health workers both during and after the conflict. Health workers attached more value to formal written offers promotion than those offered verbally.

"Ok of course you know once do basic training you need to again have skills and you need to move to another level so that you improve your career." (Female SNO, Pader)

"When I came back here, I got a promotion as in-charge theatre. My salary also increased [...] They used to pay us 208,000/= but these days they give us 450,000/=" (Male RN, PNFP HF, Pader)

De-motivating factors for health workers

Delayed promotion and promotion without a matching salary was a source of dissatisfaction which in turn lowered performance levels. Some of the health workers reported not having been promoted even before the conflict ended.

"Up to now I have not been promoted I must tell you. I am earning a salary of an enrolled nurse! I qualified in 1998 and up to now no promotion. So I feel that burden and it has discouraged me from doing the best of my capacity" (Female EN, Public HF, Kitgum)

Lack of adherence to written policies, such as the workers' rights to paid leave and the right to air their views, was a source of dissatisfaction. This demotivated health workers and was a reason for people moving from the PNFP to the public sector.

"When you go for study leave they give us 40,000/= as pocket money but in the government they give full salary. So if you have a family like mine you cannot do anything with that 40,000/=[...]If you're in government, you have a very big chance of going for workshop[...]there are very many scholarships[...]you know if you go higher you are going to do less work and you will be getting more money." (Male RN, PNFP HF, Pader)

"We were never given freedom of speech and whenever you talked something they would say you are not respectful; they never wanted anyone to talk the truth about them" (Female EN, Public HF, Kitgum)

Poor relationships with supervisors were also a cause of dissatisfaction. Some of the respondents reported leaving sectors as a result of this. Some also reported absenteeism from managers and supervisors. Observations by the research team also revealed that many of the health facilities, usually in more remote areas, were being managed by lower cadres such as nursing assistants and registered nurses, while the in-charges were in urban areas working on their side businesses. Such respondents reported being dissatisfied due to lack of recognition.

Health workers' experiences and perceptions about different incentive policies during and after the conflict

During and after the conflict, health workers worked in a crowded policy environment. The implementation of these policies had an effect on health workers' lives throughout their careers. Respondents had experienced policies on recruitment and deployment, in service training, remuneration and motivation, dual practice, district splitting/ decentralisation, leave entitlement, promotion and career progression, primary health care (PHC) grants and cost sharing.

Recruitment and deployment policies

At the start of their careers, and during the conflict, health workers in both public and PNFP facilities were subject to recruitment and deployment policies. In order to get a job at a public facility, health workers had to apply, go for an interview, undergo training and then be posted to any government facility within the region after completion. For PNFP facilities, after training, health workers stayed in same facility or were posted elsewhere. The Ministry of Health and DHOs were responsible for posting decisions in the public sector, it is not clear who was responsible for this in PNFP. Analysis shows that posting in PNFPs could have been done as a result of networks within the PNFP sector. In both sectors, the study revealed that bonding was a recruitment policy of which respondents were unaware.

In-service training policies

 In-service training was done whenever the need arose and selection was made by the districts on the basis of good performance. In most cases, there was a limit on how many staff could go for training and usually it was only allowed if there were 'enough' staff in a given facility, as perceived by the Ministry of Health or hospital administration (in case of PNFPs). Institutionalized inequality can arise from this policy on in-service training as underserved areas are often omitted from training because they always have a shortage of staff.

Systems of promotion and career progression

 Attending training gave qualifications that sometimes led to promotion. However, this was not the same for administrative-related promotions. Health workers reported having only been promoted to in-charge when the incumbent died, left for further study or was transferred to another place. A good performance record was also basis for promotion.

District splitting and decentralisation

For some respondents, district splitting, which was linked to decentralisation, increased their opportunities to join the local government and work in their home areas. However, some reported being forced/ requested to go and 'kick-start' the young districts that were being created at the time. Others reported that decentralisation has increased corruption, with people being employed or promoted more on personal connections than qualifications.

"Health workers are under fear and influence of politician" (Nurse, Public HF Kitgum)

District splitting was also perceived to create urban and rural districts within the region. This led to a 'spiral' effect of remote districts becoming even more rural, therefore creating fewer training opportunities or scope for other motivators. However, decentralisation seemed to creating an enabling environment for health workers to shop between sectors and districts by responding to different job advertisements.

 The practice of splitting districts along ethnic lines created poor relationships within the community. The feeling that the community did not respect the health facility and staff was a source of unhappiness. A few of the respondents were born in Teso and Lango, both neighbouring sub regions. Such respondents reported that they were viewed as outsiders, making it more difficult to work outside of their own area.

"Some even tell you that 'why are you bothering us when even you are not a born of this place? So go away' and yet they don't have any of their children who has studied a medical course to may be replace you!" (Female EN, Public HF, Kitgum)

Primary health care (PHC) grants

 The Primary health Care (PHC) grant[4] was appreciated as a source of flexible money at the facility level, but has diminished over time. In some cases, the minimum balance on the bank account was reported to reduce further. Unexplained delays, problems of

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[4] The PHC grant is a conditional grant which was introduced by the Government of Uganda in FY 2004-2005. It aimed to improve health for all (see Alma-Ata conference 1978) through the support of curative and health promotional activities at all levels of the health system. Detailed funding, distribution, expenditure, accountability and punishment modalities are laid out in the Health sector Conditional grant document published by the ministry of Health (MOH, 2004)

mismanagement, embezzlement and local leaders' interference with PHC funds were also reported.

"The primary health grant in the past was actually better, yeah it was better as compared to this time, these days, because they use to give some money that could run the health centre very well and run all other activities very well, for example the drugs were available. The purchase of drugs by then was centrally, we were receiving it by the management at lower level. So, that was then and it would cover for so much at the health facility but not anymore, the amount is even small now" (Male CO, Public HF, Pader)

Cost sharing/user fees

Cost sharing was experienced by health workers in public facilities until early 2001, when it was abolished. The abolition of cost sharing was not received positively. The removal of user fees in 2001 affected the working conditions of health workers as it resulted in a lack of motivation and reluctance from health management committees (HMCs) to monitor the delivery of drugs. As a result, the HMCs increasingly blamed health workers for stealing drugs.

The abolition of user fees was perceived to supplement the wealth workers' salaries instead of being spent on necessary utilities such as compound clearing and minor repairs.

"I would say that the abolition of user fees somehow it has affected health service delivery because if you see now the health facilities are bushy and the community has nothing to contribute, they are just at the recipient side [...] I don't think the user fee was really bad, the user fees would maintain the place it would do repairs and so on, and there was something given to the health workers also." (Male District Official, Pader)

Almost all respondents were aware of what cost sharing was, although not all had experienced it. Only one respondent did not understand what cost sharing was as he misunderstood it to mean replacement. This implicit "break and buy" policy exposed workers to unfair deduction of their salaries and created uncertainties in their pay and clinical practices.

"I have heard of cost sharing in our facility this year where if you break anything, you pay for it" (Male NA, PNFP HF, Amuru)

Researchers observed that although users are not charged for services or drugs in public facilities, the lack of recurrent funds has affected stationery, so users need to bring in their own record books. This creates a financial barrier for some users.

Leave entitlement

 Leave entitlement was another policy which affected health workers during the conflict. Leave days, which ranged from one week to one month, were appreciated to enable abduction survivors to 'rest their minds' and try to overcome these traumatic experiences before resuming work.

In some cases, some participants were granted leave whenever they went for further study. There were differences between study-related leave in PNFP and public sectors. Health workers in the public sector reported getting ''full paid study leave'' where as those in the PNFP sector were granted ''non paid study leave'' or paid a certain percentage of their salary.

"[...] I reported to the DHO's Office. I did not say a thing. [...] they said, it is good you have escaped. Let's pray that your in-charge comes back. But you should first go and stay home for a week without coming to office so that your mind rests and settles." (Female EN, Public HF, Gulu)

"[...] So they had to give me a one month holiday to rest my mind'' (Female SNO,PNFP HF, Kitgum)

Provision of non-financial benefits

PNFP facilities were characterised by a policy of predominately in-kind rather than financial benefits. These ranged from free/subsidised housing, free/subsidised medical care, scholarship, training opportunities and entitlement to National Social Security Fund benefits among others. Welfare benefits packages differ between PNFP facilities, although all fall under the umbrella of the Uganda Catholic Medical bureau. Particular variations were identified in relation to housing and access to medical care as echoed by some of the participants below:

"The sleeping quarters[...]they are not for free, you have to pay.[from 2001-2006] the enrolled nurses were paying two thousand per month but registered nurses they are many

compared to the number of the rooms available for them, so they pay 5000 per month" (Male Nurse PNFP, Pader- Agago)

"Yes, in comparison with Lacor, the staff get free medical treatment but here, we are given a bonus card of 80,000/= which we can use for treatment [...] Like my daughter here, who is sick, I have to bring the bonus card of 80,000.If you use up all the money, then you have to top up with your own money." (Male Nurse PNFP, Greater Pader)

"We have been given accommodation, there is light (power), there is water and if you are not well treatment is free plus your children, husband and parents. We are provided with that free medical service." (Female Nurse PNFP Gulu)

"[...] here they are accommodating me (laughter) I was forgetting that. They also provide free medical care for me and my family'' (Female Nurse PNFP Kitgum)

Allowances (hard to reach allowance and consolidated allowances)

Only those in public facilities had experienced and were aware of allowances such as hard to reach allowances[5] and consolidated allowances.[6]. Consolidation of allowances was perceived to further reduce the already meagre salary through higher taxation. Health workers were also uncertain as to the criteria for receiving hard to reach allowances, particularly in relation to district administrative borders.

"[...]before that they were saying that there was some was it around 2001-2002 there they used to give us lunch allowance in our hands 66,000/= but it lasted only for one year then they told us it has already been consolidated in the salary and now when it is consolidated it is taxed and there are so many different taxes. We have to pay the local service tax, pay as

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[5] Hard to reach allowance policy was set up through a Ministry of Public Service circular (MOPS, 2010). It was aimed at providing an enabling environment to attract and retain adequate numbers of skilled and capable personnel in the Public Service, particularly teachers and health workers to areas classified as 'hard to reach' and 'hard to work in' (MOPS, 2010 pg 1).

[6] A system whereby all allowances –for housing, lunch etc are merged into a single pay package (collapsed into the Salary). This was as a result of the Circular standing instruction (CSI no.2). The CSI no.2 was a correspondence which was passed in 2003 by the permanent secretary of Ministry of Public Service, Uganda. It was aimed at communicating policy change related to salary payments for al civil servants including medical workers. The CSI outlined the new salary for all but had been, to a larger extent, been informed by a job evaluation exercise which had been conducted in 1996.(Kanyesigye, 2003)

you earn, there are so many, so all that money is taxed completely and you remain with very little"(Female SNO, Public HF, Gulu)

"[...] right from the first, second and all the jobs that I was being transferred to, I still received the hard to reach allowance. It's of recent because of decentralization that they have chopped it off and taking it back yet this place is the district headquarter and it is even still a hard to reach place[..]. There two things to be considered, hard to reach area and hard to work in." (Male CO, Public HF, Pader)

Respondents from PNFP facilities had not experienced either of these allowances. Observations by the research team found that some health workers received a 'Safari Day' allowance, for those who went to work in satellite PNFP facilities. This was particular to those in Gulu. This was specific to level of cadre whereby the higher the rank, the more the safari day allowance and vice versa. Nevertheless, a number of participants who were working in the PNFP sector expressed envy of their colleagues in the public sector who were benefiting from theses allowances and related the absence of such to a possible cause of movement between sectors.

"That is why the rate of retention of staff in NGOs is less because we work minus those consolidated lunch allowances [...] We are depending on donors so we cannot really complete with the government scale" (Female SNO, PNFP HF, Gulu)

Policies on dual practice

The study revealed that both PNFPs and public health institutions had restrictions on dual practice. However, PNFP institutions tended to have zero tolerance on dual practice among health workers, with some being forced to close their drug shops. Health workers were allowed to have small businesses that were not related to drugs at all - for instance, selling second-hand clothes.   Their counterparts in public facilities continued to run drug shops or other small businesses.

"There are some people are running small business but it is allowed if it is not interfering with their work like these second hand clothes which can be sold after work. But what they don't want is selling drugs because you know you will be tempted so your work should not be in line with the hospital one" (Female SNO, PNFP HF, Gulu)

Staff recommendations for an effective retention package

Respondents highlighted the need to consult workers about what motivates them.

"The need depends on individuals so it should be a bottom up approach. The health workers can tell you exactly what they feel, especially these survivors. You may give somebody money but he says give me a bicycle so that I can ride to outreach so it depends. You should talk to the health workers and get their views. It should not be this push method, they should call them, have open discussion" (Female SNO, PNFP HF, Gulu)

Good equipment, accommodation, transport, and community relationships help retain staff. However, many are still working in places with limited accommodation, no running water and limited numbers of staff. Good leadership, the creation of strong referral systems and allowing staff to supplement their salary with external income, are all mentioned as factors that would improve retention.

"I want to go to a place where the leader, the manager is good, a very conducive environment, within the working area and accommodation has to be there" (Female SNO, Public HF, Amuru).

"One thing that I would like to see in place is having a facility with good settings with all the equipments, which is number one. I would want to have OPD fully equipped. That would make me happy. Another thing is get me accommodation and settle me down there. Then whenever am moving to the headquarters, I need a motorcycle to help me move. Then the last one which important but last is that I should have good coordination between the members of the community and the health centre. This will motivate me but if there is poor relationship then it's not good" (Male CO, Public HF, Pader)

Staff recognition is also of importance for motivation and retention. Promoting long-serving members of staff and ensuring that they are paid regularly would encourage staff, particularly those working at mid-level, to stay.

"[…] also top up their salaries and also be able to recognize – because actually the nurses are never recognized in spite of the work that they do" (Female SNO, PNFP HF, Kitgum)

"First, they should give people good pay, secondly they should give enough supply of material resources to be used by nurses, they should promote people, they should motivate us, they should give us chance also to be exposed to seminars, they should also try to get some people from NGOs and sponsor them if possible, we also need good roads.. And water supply in those areas, they should do something" (Female SNO, PNFP HF, Gulu)

"In Amuru here, the staffs are fewer on the part of the government. [...]They should also look for the lower cadres and give them sponsorship. [Asked whether they won't also disappear after training] No. For them they will not because they have been working there for so many years" (Female NA, PNFP HF, Amuru).

"I think the ministry should try to help the people especially the lower cadres because they are the ones who stay in the village to help people there" (Female SNO, PNFP HF, Gulu)

Discussion and conclusions

Reflections on the conceptual framework

In this section we revisit our conceptual framework to examine what lessons we have learned from our interviews with these health workers. In general, the findings show that the three domains of the framework (context, the individual and the policy environment) are all important and inter-related. They influenced both the decision to take up employment and to stay in these rural and conflict-affected areas.

The factors that motivated respondents' to join the profession, their largely positive training experiences and their family role models, formed the 'stick factors' which retained them.

Gender also appears to have been an important feature as some of the female health workers were influenced by their female relatives, who acted as role models. The staff of the facilities are predominantly female, which could be due to family commitments in the area, greater resilience, and a greater attraction to the mid-level cadre roles. Being female was also cited as a hindrance to upgrading or receiving additional training.

The long period of conflict and its aftermath was hugely significant for the respondents. Hardship, fear and injury to themselves or family members were reported by all respondents who had nevertheless stayed in the area. Health workers' coping strategies were impressive. Personal faith, community commitment and sheer fatalism were amongst their psychological defences.

Not all effects on their working conditions during conflict were negative. While short-staffing increased their workload, it also boosted their professional interest in taking on tasks beyond their official duties. Many took pride in their inventiveness in managing with few supplies. Side enterprises allowed them to feed their families when salaries were interrupted.

In this context, some policy levers emerge as significant in boosting recruitment and retention. Recruiting from local areas is likely to be productive as these respondents tended to stay in their districts, as the ties of family and land were part of their 'stick' factors. They were also loyal to the sector (and often facility) which first sponsored their training, suggesting that is also effective at retaining them. Offering training routes which favour those with lower levels of education also appears to be important, allowing career progression via incremental steps which may include volunteering, on the job training and access to in-service training. These people are more likely to be motivated to stay in remote/difficult areas. The decline in government training sponsorships since 2005 is likely to mean that the government is now missing an opportunity for binding relationships with health workers, as well as reducing the entry chances for people from poorer backgrounds.

Discussion of key findings

The majority of those interviewed were mid level cadres with an average time of 17 years spent working in the region. Although this reflects the existing staffing mix, which is dominated by mid level cadres, it is also indicative of the difficulties in attracting and retaining more qualified cadres such as clinical officers, doctors, and medical officers in hard to reach or conflict-affected areas (Matsiko, 2010; MOH, 2006).

In general, the findings suggest the importance of selecting and favouring those with a higher level of intrinsic motivation. This is especially pronounced in difficult times, when pay is erratic, working conditions are difficult and formal structures of promotion and recognition do not function well. During the conflict in northern Uganda, health workers displayed values like empathy, professionalism and selflessness. This is something to be celebrated, rewarded and reinforced after the conflict.

Our findings are consistent with those of a study in Ethiopia which showed that intrinsic motivation to work may be developed right at the entry of the health profession and is propagated throughout one's career. Such motivation is common among those who started their career in not for profit facilities. Those with intrinsic motivation were found to be satisfied even when they were getting lower salary than their colleagues (Danila Serra, Pieter Serneels, & Barr, 2010).

Supportive professional and community relationships, good leadership, and small in-kind material rewards appear to have motivated participants in our study to stay through turbulent times.

Volunteering was shown to be a pathway to employment in the health sector. This entry path should be taken advantage of since volunteers tend to show more commitment and motivation to their roles as health workers, even in the absence of salary. Such persons need to be tapped into as they provide a ready pool for recruitment of health workers during the conflict.

The research highlights the importance of professional status in attracting and motivating staff. The role of uniforms and the attraction of 'looking smart' should not be neglected. It creates a sense of identification and confidence in one self which in turn translates into a motivation to perform.

Pay is not the main motivator for many health workers but it matters, as does the flexibility to be able to earn money outside of their day job. Other 'in kind' benefits are also highly valued reflect the recognition to which health workers aspire. As conflict wanes and as they advance in their career, they face the most expensive phase of family life e.g. having children at secondary school. Mid-level workers therefore require pay, training and opportunities for promotion, which recognise their contribution. Irregular salaries, unfair pay policies and poor working practices (e.g. an environment where they cannot speak openly about problems) are all demotivating factors.

In his classic 'motivation to work' Hertzberg argues that money is a 'hygiene' factor – one whose absence causes demotivation but which does not in itself boost long-term motivation (Herzberg, 1959). A good motivation package should have a mixture of both motivating factors and adequate hygiene factors. However, there is also a breadth of literature also showing strong links between salary, motivation and retention of health workers (Ssengooba & Rutebemberwa et al, 2005).

Some of the extrinsic rewards appear to be better in the public sector than the PNFP sector in northern Uganda. This may explain why movement was generally towards the public sector. Annual reports indicate deliberate policies to develop 'comprehensive packages' for attraction and retention in some mission hospitals. Nevertheless, attrition of staff to the NGO and public sector from the mission based facilities is also acknowledged (Punto, 2006; St Mary's Lacor, 2004, 2007, 2008, 2009; St Mary's Lacor, 2005, 2006, 2010, 2011).

A trend analysis of the attrition rate within the Uganda Catholic Medical Bureau network indicated a persistent high staff turnover of about 25-30% in 2007-11, particularly among clinical officers and medical officers (Luwedde & Orach, 2013). These trends are somewhat puzzling given the amount of resources dedicated to retention within the sector. Our study

revealed that higher pay for many cadres (though not all), fewer restrictions on outside earning opportunities, greater access to training opportunities and pension rights were all features which encouraged people to seek out and stay in public sector employment. Nevertheless, the public sector is also struggling with high attrition rates, in part to the private sector (Matsiko, 2010; MOH, 2006).

Our respondents were asked about their job satisfaction at different points in their career and while satisfaction varied according to work, personal and contextual factors, low satisfaction had not led to a career change or even necessarily less willingness to work. For those who have strong internal motivation e.g. 'I work for God and my country' as one respondent explained, lower satisfaction may not cause lower effort or achievement. Some studies have found that satisfaction was a result of their ability to handle health problems, acknowledgement from the community, being able to 'make a change' (VSO, 2011). In some literature it is argued that that there is no significant link between intrinsic and extrinsic satisfaction and retention, rather that satisfaction is generated as a result of career commitments and organisational commitment, which could also have a link to leadership strategies (Land, 2003; Peace, 2011).This was raised specifically for the not-for-profit sector.

Our research findings highlighted the existence of a crowded policy environment within which health workers operate. Health workers have differing experiences of these policies, hence efforts are needed to re-evaluate them from a health workers perspective.

Our study adds to the existing literature on health workers in conflict by focussing on the experiences and motivation of a group of health workers who stayed during and after conflict. It provides details on their coping strategies and compares experiences across public and PNFP sectors.

Recommendations

Some of the recommendations build on existing literature on good practices for attraction and retention in remote areas (Matsiko, 2010). The additional factor in this study is the exposure to the trauma of the conflict and the strength of those who worked through it.

1. The interviews raise questions on how best to protect health workers during conflicts. In some cases, health workers may be protected under an agreed policy of not disrupting services; however, in this context health workers were specifically targeted as being of use to the rebel forces. In conflict-affected areas where this may occur,

training in how to react to these situations (and agreed procedures with the local community) might be advisable.

2. In times of conflict, alternative mechanisms for paying workers should be developed. Insecurity means that opportunities to move or access services such as banks are very limited.

3. The trauma that health workers who stayed through conflict go through is rarely recognised. Health services should recognise and celebrate the contribution of those who continued to serve on the front line during conflict-affected times.

4. Incentive policies need to target mid-level cadres because they are more likely to commit to long-term employment.

5. Gender was important in many factors ranging from motivation to join the profession, upgrading, coping strategies and roles at work. Gender-responsive policies are needed e.g. to support the training and promotion of women without compromising their wider roles in the household.

6. While local employment can aid retention, this may also cause discrimination against people born out of the area. This should be controlled through sensitisation of the local leaders and communities.

7. Providing opportunities for those willing to learn and work for the community despite having limited education is important. These people can progress to mid-level cadres of employment, which provide a large proportion of staffing in remote areas.

8. Increased seniority and pay for mid-level cadres within their home area will help to retain staff and develop their loyalty. This career progression should be formalised as documentation of their promotion has considerably more value for staff.

9. Human resource management policies should focus on maintaining the intrinsic motivation which many health workers have when they join the profession. This can be implemented through practices which foster good communication, support professional pride, and develop the links with the community.

10. Some of the features which render the public service attractive could be adopted by the PNFP sector e.g. linking staff to the public pension system. Given health workers' reluctance to change sector, it is important that long-term PNFP staff are not left unprotected in their older years. Having transparent pay and promotion processes also emerges as an issue for some PNFP providers.

11. There is need for a bottom-up evaluation of human resources for health policies through the eyes of the health workers themselves. This provides better evidence for improvement of the intended effects of such policies.

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Annexe 1 Case history/Life history guide for Health workers

Introduction

Thank you for agreeing to participate in this study. The purpose of this research is to explore changing working conditions in the conflict and post conflict period for health workers. The experiences you share with us will help us document challenges and coping mechanisms of health workers under changing conditions in the post conflict period in order to propose strategies to improve health worker livelihoods.

Participant background information

Interviewee ID	
Date of Interview	
Name of organisation/facility	
District	
Title/position of interviewee	
Gender	Male ☐ Female ☐
Age	
Marital status	
# of children	
Education level	
When did you start working in this district?	

Participant life history

I would like to understand about your life as a health worker working. In this part of the interview I would like you to draw me a line of your life as a health worker.

Draw line with the participant to mark the land marks/milestones. For example, along the line, mark the years and indicate the following milestones

- When they enrolled for health worker related training
- Completion of training
- Searching/shopping for jobs
- First job
- Second job
- To the current job (leave space for the future)

Note: The interviewer should allow the participant to tell the story naturally and the probed should only be applied if the information was not mentioned

Probe for the following:

Decision Making

Note: This comes just before the training. The interviewer should probe looking at the period before the participant enrolled for the training. Let the participant tell you about the decision to become a health worker. You can use the probes below if information is not mentioned:

- What made you choose to become a health worker?
  Was it a personal choice?
- If influenced by any one or any situation, who was it or what was it?

Training

Let the participant talk about the training they had before they became health workers. Take note of over-laps. For example some might have had graduate training after their first jobs, endeavour to indicate this on the life line.   The interviewer can use some of the probes below if information has not been mentioned by the participant:

- Where was the training?
- Who paid for the training?
- How long was it?
- What was your experience in the training school?
- How was life then?
- What happened after the training?

Job-related probes

 Look at the line and probe about the participants' first job and probe for each of the subsequent jobs mentioned and indicated on the time line. The interviewer can use some of the following probes in case the participants has not mentioned.

- How did you get this job?(was it through application, recommendation, what factors favoured this process
- If it is a new job(was it a fresh application, transfer)
- What was your position?
- Where did you work?

- How much did you earn?
- How did the money you earned compare to your expenditure at the time?
- What assets were you able to acquire: probe for assets like bicycle, cattle, car, house, land, Wife being able to pay fees etc.
- Any promotions while there? How did the participants feel about them?
- What did you like about your this job?
- What did you dislike about your job?
- Were you happy/satisfied with your first job? (Here the interviewer asks the participant to rank their satisfaction on a scale of 1-5 where: 5 = very satisfied, 4 = satisfied, 3= neutral (in between), 2=dissatisfied and 1= very dissatisfied. NB: Use stars that indicate the number attached to each perception e.g. 5 stars stand for very satisfied.
- Apart from salary, what other benefits did you get from the job? (Interviewer should probe for financial, non-financial incentives, community based initiatives, availability of equipment a work or lack of it, schools for children, housing, training etc)
- What was the source of those benefits/incentives (where were they from?)
- Were there any major shocks at work during that time?   E.g. conflict, loss of loved one, floods, having a sick person to look after etc.
- How did the shocks mentioned affect you as a health worker?
- How did you manage?
- Do you have any other jobs apart from this one, tell me about them?
- How long did you work /remain in that job?
- If they moved to another job, why did they leave?

Map Drop outs from jobs on the time line: Before the subsequent jobs the interviewer needs to take note of drop outs. If the person dropped out of job temporarily before getting another what were they doing? How did they cope or survive?

Social events

If not mentioned, the interviewer needs to ask the participant about their social events such as birth of a child, marriage, camp movement and how these affected their life as a health worker.

Policies related to health worker incentives over time

Note: The interviewer needs to probe for policies that were experienced by the participant over time from training to the current job and map each of the policies (and their years) on the lifeline.

Probe for what the experiences about the policies were

How the policies affected their work and motivation as health workers

 Possible policies include:

- District splitting (Linked to decentralisation)

- Consolidated allowance (lunch allowance) for those in the public health facilities
- Cost sharing
- PHC grant (mainly from government to those in PNFPs)
- Credit lines
- Hard to reach allowance
- Results based financing schemes

Coping Issues

Coping issues are cross cutting at all points of the lifeline. The interviewer needs to probe for how the participant was able to survive at all points on the lifeline.

Way forward/recommendations

- What plans do you have for your future career? What package incentives /benefits would convince you to move elsewhere and perform better as a health worker?

- In your opinion, what can the government do to get health workers to motivate them to go work and remain working in rural areas?

Notes for the interviewer

As respondent starts to draw, follow the story along the line drawn with probing questions, such as:

- What happened here?
- When was that?
- Why did this happen? Why did you do that?
- What was your experience about it?
- How did you manage in that situation?
- What happened next?

Appendix 2: Examples of lifelines

Registered Nurse, PNFP

Ebola time. Many (fellow students and Hws died e.g Dr. Matthew Lukwiya

Time of war

2 lorries of casualities daily

Sometimes worked the whole night (6pm-4pm) and started 11am midnight next day

War started

Picked interest since employed as nursing Aid at Kalongo(salary rose from 18,000 to 22,000

Sponsorship offer by Kalongo Administration

2004: Married

1999-2001 | 2001-2002 | 2002 | 2002-2006 Dec | 2007 Jan-2009 | 2009 to date | 2012 (August)

1999-2001

Training as enrolled nurse, Lacor Hospital

Likes: Free treatment for all HWs, Lots of hands on experience, Good equipment (ICU), Many other HWs thus not a lot of work

Dislikes: Very busy hospital, too strict, must stay within hospital gate unless permitted

2001-2002

Called back immediately to Kalongo, to work while waiting for results

Salary: rose from 22,000shs to 27,000shs

2002

2002-2006 Dec

Exam results returned

Promoted to work in theatre as anaesthetist (one of the 7 qualified out of total 21 with in theatre)

Salary: 166,000shs

Paid 2000 monthly for staff housing

Other motivation: Motivated by italian professor(supervisor) who worked so hard yet a foreigner

Professor told us to be empathetic

2007 Jan-2009

Went for upgrading, Diploma in Nursing (Registered nurse training), Lacor Hospital

2009 to date

Promoted to become Theatre in-charge

Paid 5000 monthly for staff housing (bigger house, fee paid by all registered nurses in the facility

Salary: 240,000 at promotion time

Current salary: 450,000shs net per month (gross=544,000shs

2012 (August)

Time of Interview

Not satisfied because;

Salary low compared to Lacor which is 550,000

Facility gives us Bonus of only 80,000shs which, if used up must be topped up unlike in Lacor

Few health workers, nursing aids discontinued. Must do their work as well e.g cleaning wards

Not chosen to go for workshops yet have stayed in facility for long

Clinical Officer, Public

Timeline (left to right):

Above the timeline:

- Further told him that he should be a doctor
- Had done science subjects in secondary school
- Meets rebel ambush (loses all documents)
- Rains, Karimojong raids
- No freedom of movement
- Friendship with barracks and gets gun for protection
- Some nursing assistants boost security
- **Decentraliation**: Pader is curved out of kitgum (but respondent he remains in kitgum)
- Insurgency worsens, intensive rebel attacks
- Massive rebel attacks, difficult to move around freely
- Overwhelming number of patients (13,000 people: 2 health centres . 1 HC III and 1 HC II
- Rebel attack on night of arrival
- All supplies raided, depend on reserve supplies
- Overwhelming number of casualities
- Runs away to Gulu to stay with mother shortly and returns to Kitgum
- Insurgency rages on
- Overwhelming number of casualties
- Health facility moves to former town council hall
- MSF starts to construct structures for Health facility
- Rebels attack facility health
- MSF hands over new structure for health facility
- Starts work in new structure
- Rebel attacks
- Security strengthened
- Relative Peace with pockets of rebel activities
- Transferred on request to Patong HC III due to conflict with new in-charge
- Opens up private clinic in Pader town

Timeline markers:

1999 | late 1999 | 2001 | June 2002 | Aug 2002 | Dec 2002 | 2003 | 2005 | 2006 | 2008 | 2010 | Early 2012 | August 2012

Below the timeline:

1999
- Enrolls and completes training medical/clinical school in Kitgum
- Job searching
- Does Job interview in Kitgum

late 1999
- Lucky to be recruited and posted by kitgum district to Lira Kato HC III as second clinical officer
- No supplies, using polythene bags as glooves
- **Motivation:**
- **Salary:** 166,000shs (net) U7
- District gives him a motorbike which eases transport
- Gets free accommodation in pool house

June 2002
- Transferred to Acol Pii HC III in IDP camp (kitgum) as In-charge as reward for good performance
- A UNHCR supported facility
- Life better. Ambulance donated by UNHCR eases transport for supplies
- Buys a music system
- Goes back to kitgum

Aug 2002
- UNHCR decides to locate services in more central areas for security purposes
- Transferred by UNHCR to Agago HC II

Dec 2002
- Receives warning letter ordering him to report to Pader HC III immediately
- Reports to duty in Pader HC III
- No structure for facility. Facility housed in shop
- Life is hard. Use polythene bags as gloves

2005
- Applies for Study leave Enrolls for surgical and clinical medicine training in Jinja
- Becomes surgical clinical Officer

2006
- Returns and posted to Pajule HC IV as In-charge based on previous performance
- NB: Doubled as in-charge Aruu HC II for one year. Work load!!
- Low motivation from district and implementing partners.
- Motocycle provided has no fuel

2010
- **Decentralisation:** Pader district split further, to create Agago district.
- Decides Remains in mother district (Pader)
- Returns to Pader HC III as ordinary clinical officer because he had ART skills which were badly needed
- **Automatically Promoted** to position of In-charge when incumbent dies
- Buys land in Pader ton

August 2012
- **Time of interview**
- Transferred to Atanga HC III to manage nodding disease
- Not happy. Thinks they are only taking him to rough places to ruin his career

Senior Nursing   Officer

Inspired by love for people to be health

Admired when health workers were handling patients

Secondary school was near kalongo hospital

Practicals and training from kalongo hospital

Got married and had **1st child**

Life was OK because husband was also medical doctor with in the same hospital and a very caring man

War started.

Massive displacement

Ran to Adilang sub-county (boardering westnile) where husband comes from)

Kalongo became dysfunctional

Life was very difficult

2nd child

3rd child

Miscarriage because of kneeling on the floor to help another mother deliver

4th child

Transferred to **Namukora HC III**

Insurgency, no freedom of movement.

Health facility fully equipped.

Life Okay because of full emotional and material support from community (soap, sugar).

Emotional support from community even after husband's death.

XXX

Last born

Husband dies in road accident

Sister and brother assist with child support

Told to join team and start Pader district

Position: District Health visitor/reproductive focal person

Insurgency at its peak.No infrastructure. Worked under trees, slept in bushes, returned every morning

Removal of user fees.

HUMCs most affected,become inactive and demotivated

Increased blame that HWs steal drugs

Got risk allowance of 600,000 per month. Lasted for only 3-4 months

Not happy

PROMOTED TO SNO Pader District

Salary increase from U7 to U9.

900,000/= per month gross,700,000 net.

Not so happy with salary. Too many deductions

Desired package for motivation

1.2 million shs net salary per month

About 200,000 hard to reach allowance

Adequate funds to the district

1978

Late 1980

1981

1982

1984

1986

1987

1988

1989

1990

1992

1995-96

1998

2001

2000 Dec

2003

2004

2005 to date

August 2012

Started training as enrolled mid wife at **kalongo hospital**

Sponsored by Parents, Life was okay because respondent was still a young girl, without many needs.

Incentives: 1bar of soap, 1kg sugar and 12,000 for all students monthly. Little money but enough.

Completed training for enrolled midwifery

Remained at **Kalongo**

Worked at St **Josephs kitgum** for 2 months and went back to kalongo because husband was also there

XX Joined local government (went to DHO and applied for temporal appointment)

Started Health facility in Adilang sub-county (doubled as midwife and doctor)

Nasty experience, time of displacement!!

No equipment (could help mothers to deliver on the floor, operated on mothers who had still birth) Used experience acquired in kalongo.

Motivation: No salary. Felt it was important to save lives. Felt good when mothers survived

XXX: Nurse at Patong HC III

Enough equipment but difficult to render services at night for fear of rebels

Referral difficult because had to wait for convoy to escort

Rebels attack, raid home looking for drugs

Rebels take all belongings and husband (husband returns in a short while)

Registered Midwifery training at Kalongo (practice at Namukora)

Funder: Kitgum local gov't

Life difficult. Missed Children back home

Applied and joined DHO's office in Kitgum as Reproductive health focal person **XXXX**

Applied for promotion same year but not granted. Very frustrating

Personnel officer dies before promotion is granted

Enrolled for diploma in community health funded by DANIDA

Life hard. Missed children alot

Time of interview