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Research on health worker policies, incentives and retention in post-conflict countries: an overview of ReBUILD work

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Presentation for CCGH, Montreal, October 2015

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Content

- Objectives and methods of project
- 3 case studies:
  - From Sierra Leone, on post-war reconstruction and lessons for post-Ebola investments
  - From Zimbabwe on attempts to retain HRH post-crisis, particularly focussing on rural areas
  - From Uganda on experiences of conflict by health workers and how they coped
- Some cross-cutting themes
- Outstanding work
- Questions and discussion

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Key starting points

Decisions made early post-conflict can steer the long term development of the health system

Post conflict is a **neglected** area of health system research

Opportunity to set health systems in a pro-poor direction

Focus on **HRH and health financing** but also on health system/state building links

Choice of **focal countries** enable distance and close up view of post conflict

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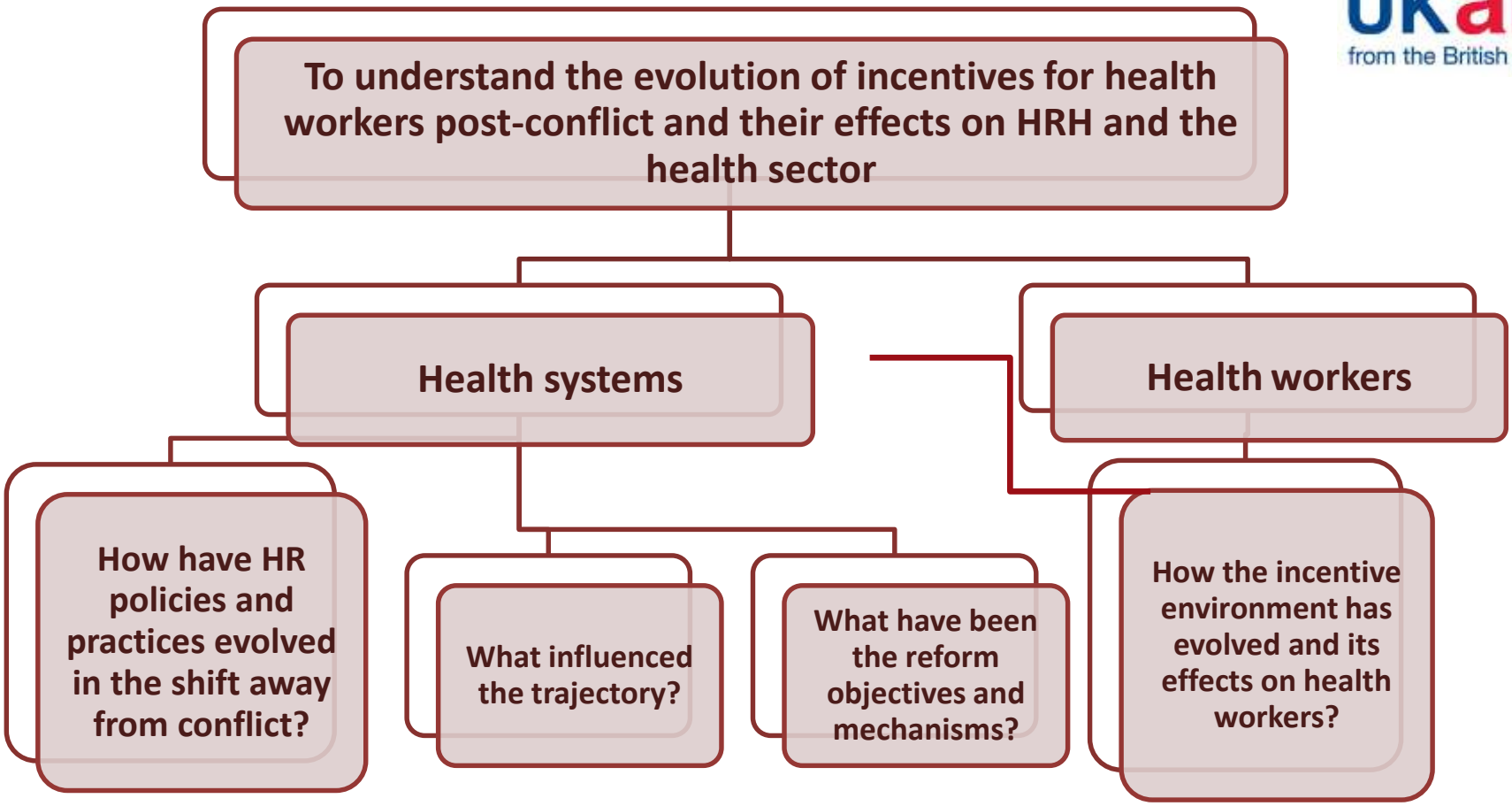
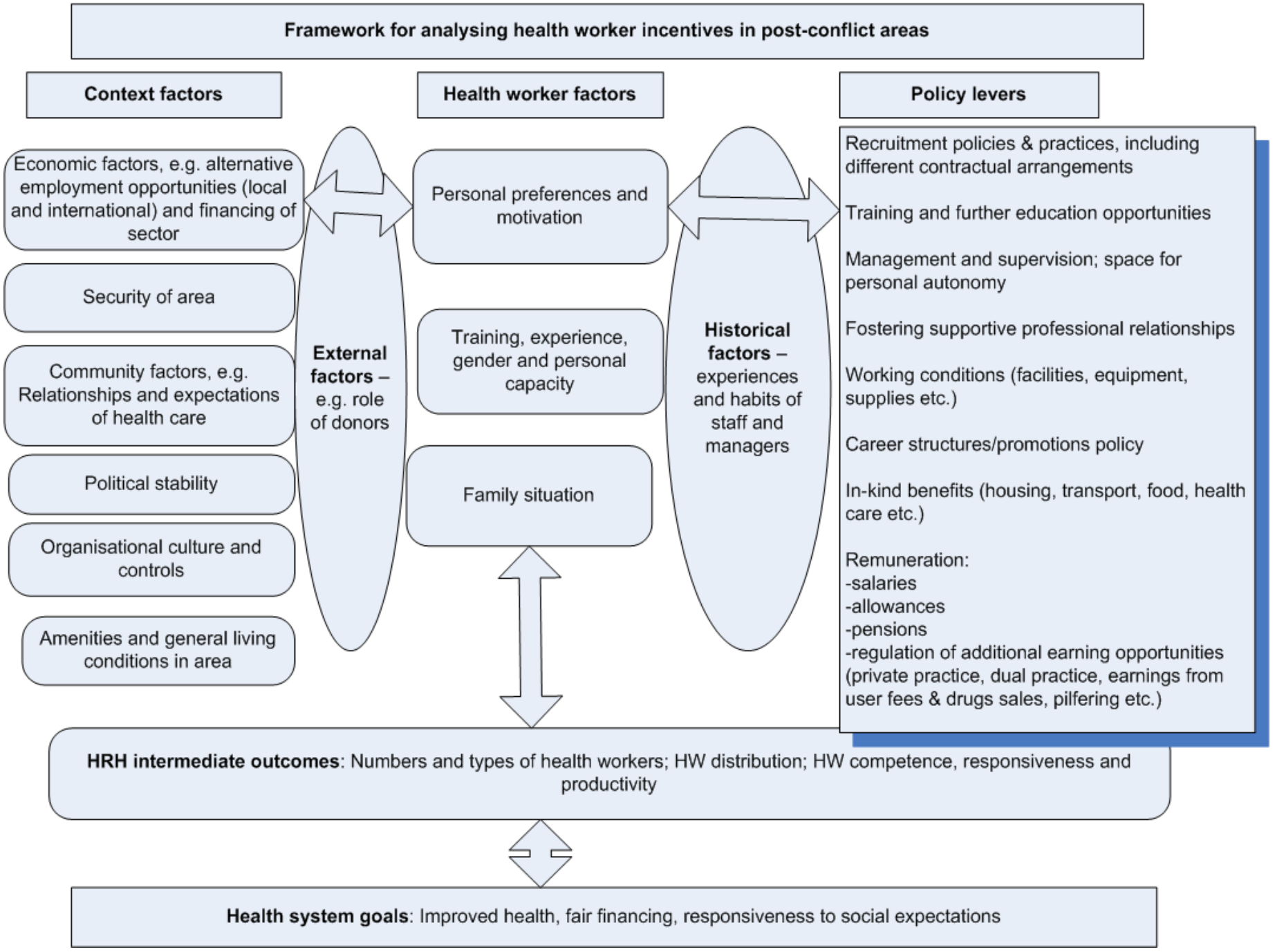
Aims and research questions for HW research



What lessons can be learned (on design, implementation, and suitability to context) of different incentives, especially for post-conflict areas?


Framework for analysing health worker incentives in post-conflict areas
Context factors
Health worker factors
Policy levers
Economic factors, e.g. alternative employment opportunities (local and international) and financing of sector
Security of area
Community factors, e.g. Relationships and expectations of health care
Political stability
Organisational culture and controls
Amenities and general living conditions in area
External factors – e.g. role of donors
Personal preferences and motivation
Training, experience, gender and personal capacity
Family situation
Historical factors – experiences and habits of staff and managers
Recruitment policies & practices, including different contractual arrangements
Training and further education opportunities
Management and supervision; space for personal autonomy
Fostering supportive professional relationships
Working conditions (facilities, equipment, supplies etc.)
Career structures/promotions policy
In-kind benefits (housing, transport, food, health care etc.)
Remuneration:
-salaries
-allowances
-pensions
-regulation of additional earning opportunities (private practice, dual practice, earnings from user fees & drugs sales, pilfering etc.)
HRH intermediate outcomes: Numbers and types of health workers; HW distribution; HW competence, responsiveness and productivity
Health system goals: Improved health, fair financing, responsiveness to social expectations

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Summary of research tools

Research tools	Cambodia	Sierra Leone	Uganda	Zimbabwe
1. Stakeholder mapping		√	√	
2. Document review	√	√	√	√
3. Key informant interviews	√ 33	√ 23	√ 25	√ 14
4. Life histories/ in-depth interviews with HWs	√ 24	√ 23	√ 26	√ 34
5. Quantitative analysis of routine HR data	√	√		√
6. Survey of health workers		√ 310		√ 227

Witter, S., Chirwa, Y., Namakula, J., Samai, M., So, S. (2012) Understanding health worker incentives in post-conflict settings: study protocol. ReBuild consortium.
http://www.rebuildconsortium.com/media/1209/rebuild-research-protocol-summary-health-worker-incentives.pdf

Sierra Leone: rebuilding the health workforce post-crisis

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HRH context and challenges during and post conflict (2002 – 2009)

- Availability, retention, recruitment, deployment, performance and governance challenges in the immediate post conflict and post conflict period

"*It was horrible. The health personnel had migrated outside or were working for NGOs. There were critical shortages*." (8003, line 8 – MoHS).

- Solutions were proposed to address HRH challenges however, they were rarely implemented and where reportedly not based on evidence

"There was no policy and plan, or rather it was outdated and not based on evidence". (8001, line 15 – MoHS).

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HRH context and challenges during and post conflict (2002 – 2009)

- Lack of clear political vision and strategic plan /direction on the future of the health system.
  - It was perceived that the first government was weak in terms of leadership and drive for reform
- Most of the policies were externally-driven, lacking the national ownership that would ensure their effective implementation.
- Lack of coordination between the different actors in the HS

"During and immediately after the war, a lot of NGOs had entered the country and started on a kind of not very coordinated manner, to do all kinds of things everywhere." **(9001, line 31 – NGO).**

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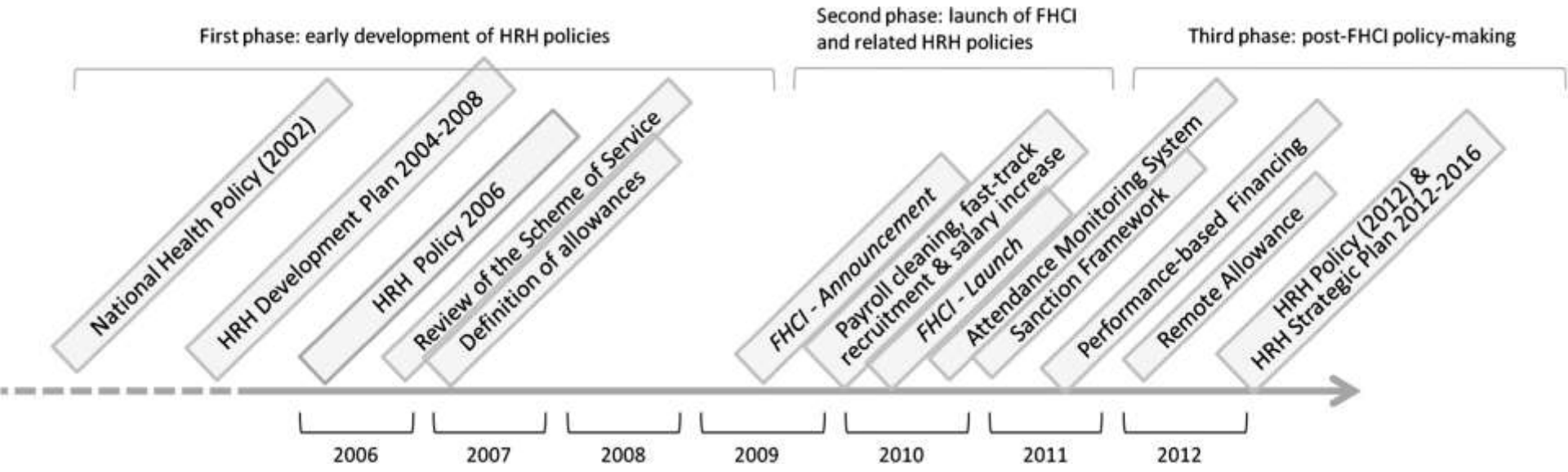
How have HR policies and practices evolved in the shift away from conflict?



Source: From Bertone & Witter (2014)

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Window of opportunity for reform

- ‘Window of opportunity’ for reform did not open in the immediate post-conflict
- FHCI was launched in 2010 and brought about the following HRH reforms
  - Payroll cleaning
  - Fast track recruitment
  - Staff Sanction Framework
- It also changed the incentive environment for health workers with the introduction of
  - Salary uplift
  - PBF
  - Remote area allowance

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What influenced the trajectory?

The key drivers of HRH policy trajectory in Sierra Leone:

- the political situation
- the availability of funding and the stances of agencies providing such funds;
- the sense of need for radical change – which is perhaps the only element related to the post-conflict setting.

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What are the effects? - positive effects – HW perception

Health worker

- Increased motivation
- Improved quality of service given

'The PBF came in as sort of motivation to add more effort because it has some criteria that you have to meet before you get it, […]It has created awareness among the health staff that they have the responsibility to improve the quality of the service they provide for the patient,' ***(Male, Kenema, IDI-5)***

Health system

- Improvements in the health facilities
- Increased service utilisation

'For the health facilities, people are now making use of the facilities even the maternal beds compared to before' ***(Female, Bonthe, IDI-1)***

- Increased institutional deliveries

*'with this free health we have laws, that no women should deliver with TBA. […] now if you deliver any pregnant woman at home you are going to be fined'****(Female, Koinadugu, IDI-10)***

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What are their effects? - negative effects

- Increased workload

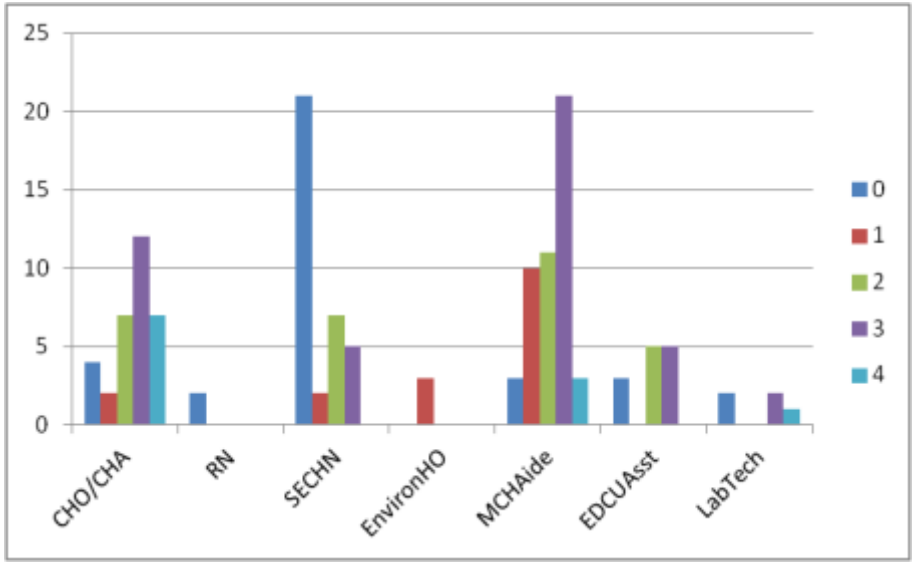
'[…] the work is strenuous, before this time people were not coming because of finance but now after removing users fees people are coming 24hours' ***(Male, Koinadugu, IDI-11)***

- Irregularities in PBF payments

'That was also a good motivation to encourage people to work hard since the harder you work, they more money you get. But again this is not forthcoming..' ***(Male, Bonthe, IDI-2)***

- Irregularities in RAA payments

'That was one policy I was really happy about […] But these monies are not forthcoming and this has started discouraging staff posted in remote areas' ***(Male, Bonthe, IDI-2)***



Source: HWIS, ReBUILD SL, unpublished

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Salary uplift

- The salary uplift was a motivating factor for all the health workers and changed the way they work in a positive way.
- However, there were different perceptions about the salary increase, with an underlying theme of it being a positive step that was long overdue but not commensurate with the role health workers play

'Like I said earlier even with the last salary increment what they are paying us is not enough to take care of our families, care for your children, provide feeding for them; like what I am receiving is just barely enough to take care of my family so thinking about having accommodation, medical bills, transportation, paying fees for my children' ***(Male, Kenema, IDI-5)***

'But now they say nurse salary is increase but you do everything in that salary, you have responsibility, so I think that is not helping much because those day they leave to do extra things so they will be able to provide for themselves […]but for now they restrict them so much, they work so much 24hr, yet they don't have much; it's a problem' ***(Female, Koinadugu, IDI-8)***

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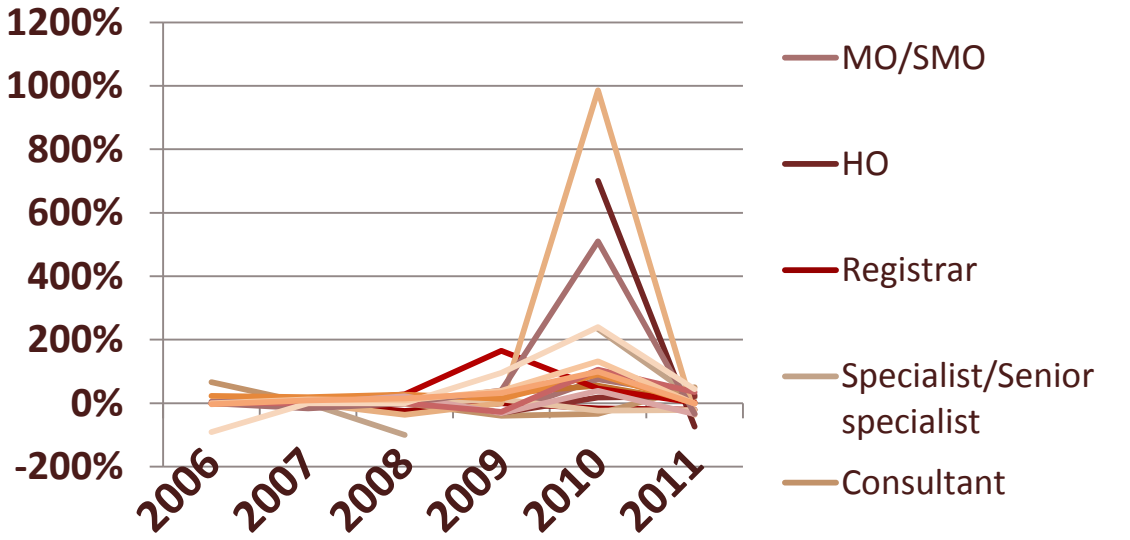
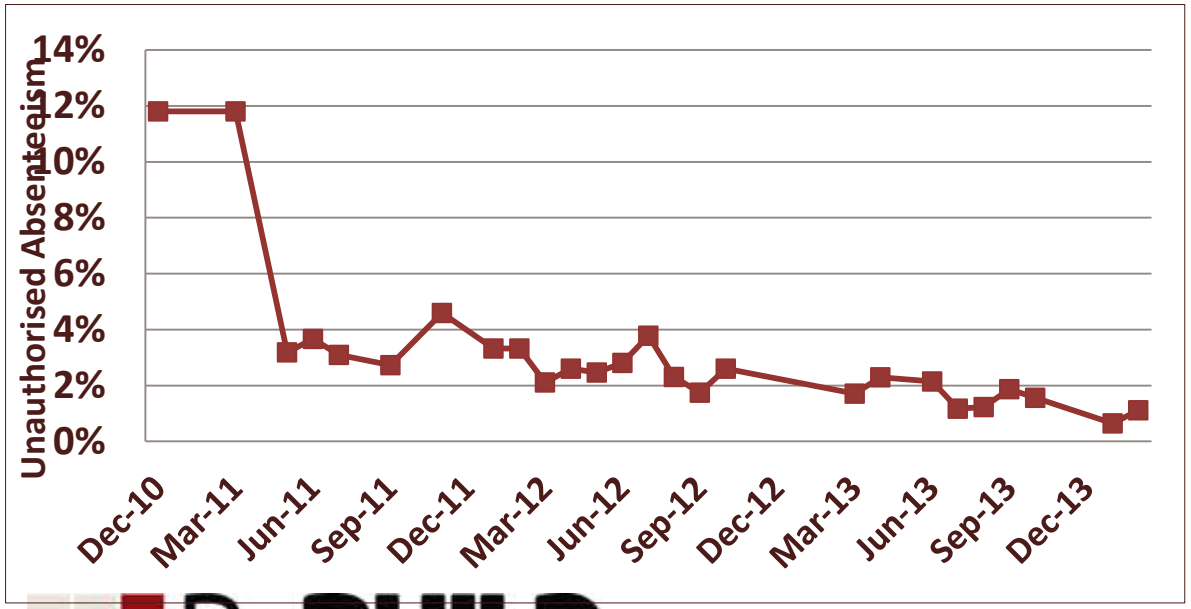


Proportionate increases in staff numbers 2005-11



Staff sanction framework - Rates of reported unauthorised absenteeism, Sierra Leone health workers, 2011-14

Source: Wurie, Samai & Witter, 2014

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Overall perception of career - satisfaction

Motivating factors

- **Being effective in their role**

'Before this time maternal death was on the rampage, but over the past 2 years we've had none, we refer in time and we manage cases that are at our level the one that we cannot manage we refer them appropriately'.(Male, Koinadugu, IDI-11)

- **Community Service**

'…. well what I like most is when I see a patient walking in the hospital and going back with a smile and saying thank you going back home so I really love that and I appreciate that very much' (Female, Koinadugu, IDI-9)

'… what I like about the job is honestly speaking it's I get satisfaction when I save lives […].because I feel my people appreciate what I'm doing' (Male, Koinadugu, IDI-12)

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Overall perception of career - satisfaction

- **Financial incentives**

'I want to have a decent salary that will enable me to plan the lives of my children so that they too can be in the position to be of use to their communities in the future.' (Male, Kenema, IDI-4

'……yes if I'm motivated ,it will improve my livelihood because if salaries and remunerations are being paid on time […] especially my salary […]and is increased ,that means I will satisfy my children even if I am away […] even assist my old man in paying the college fees and school fees for my children' (Female, Koinadugu, IDI-9)

- **Improved working conditions**
- **Training opportunities**
- **Religion**

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Demotivating factors – pre and during EVD outbreak

Demotivating factors
Working conditions
Poor Management
Limited training opportunities and lack of career progression
Limited financial incentives and benefits
Political interference
Relationship with community
Separation from family
Security (job and personal)
Tensions in the workplace
Poor retention of staff
Long working hours
Recruitment of staff
Challenges in rural postings

Pre-existing challenges faced by the health sector that effected the EVD response
Poor working conditions
Lack of IPC measures in place
Health workers ill-equipped to deal with EVD/ health workers not trained
Lack of enablers
Low levels of motivation with health workers
Relationships with the community
Mal distribution of the health workforce
Retention challenges

Recommendations

- In general health workers expressed the following recommendations to retain health workers in rural postings.
  - creating a conducive working environment, with improvements in the health facilities
  - decent staff accommodation or housing allowance,
  - equal training opportunities
  - Career progression pathways and CPD
  - transportation allowance or transportation provided,
  - improved salary scales, with improved conditions of service
  - recruitment of more staff, strengthen career pathways
  - regularisation of allowances pertaining to health workers in rural postings

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Outstanding challenges for HRH

- Recruitment and deployment of staff
- Geographical imbalance in the spread
- HRH management challenges at central level
  - No HRH unit at district level
  - No HRIS system in place
  - Ongoing payroll management issues
  - Issues with sustainability and intuitional memory
- Incentives
  - Financial vs non-financial
  - Continued irregularities in payment of allowances

Post Ebola reconstruction phase: lessons

- Health system should be rebuilt using evidence based findings
- Coordination of efforts between development partners and key stake holders
- National ownership

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Research outputs

Online reports available on the ReBUILD website:

- Stakeholder mapping report
- The development of HRH policy in Sierra Leone, 2002-2012 – a document review
- Serving through and after conflict: in depth interview report
- Health Workers incentive: survey report, Sierra Leone
- The development of HRH policy in Sierra Leone, 2002-2012 – report on key informant interviews FHCI
- Staffing the public health sector in Sierra Leone, 2005-11: findings from routine data analysis'
- The Free Health Care Initiative: how has it affected health workers in Sierra Leone

Peer reviewed publications:

- Bertone, M. and Witter, S. (2015) An exploration of the political economy dynamics shaping health worker incentives in three districts in Sierra Leone. *Social Science and Medicine*, volume 141, pp56-63.
- Witter, S., Wurie, H. And Bertone, M. (2015) The Free Health Care Initiative: how has it affected health workers in Sierra Leone? *Health Policy and Planning* journal, 1-9
- Bertone, M., Samai, M., Edem-Hotah, J. and Witter, S. (2014) A window of opportunity for reform in post-conflict settings? The case of Human Resources for Health policies in Sierra Leone, 2002-2012. *Conflict and Health*, 8:11.

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Policies to attract and retain health workers post crisis in the rural areas and across sectors in Zimbabwe

Yotamu Chirwa, Wilson Mashange, Pamela Chandiwana,
Malvern Munjoma, Mildred Pepukai,
Shungu Munyati & Sophie Witter

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Background

- High/acute vacancy rates for CHWs service wide due to crisis(HSB, 2011,)
- Decline in HRH expenditure to 0.3 percent of the public health budget between 2005-208 (Osika, 2010)
- Deterioration in health indicators (ZDHS 2010-2011).
- Reversal of gains made in primary care provision -access unaffordable for the poor, especially underserved rural areas(NHS 2009-2013)
- Health care provision compromised(quality, equity) when CHWs with the right skills are in short supply where and when they are needed

The vacancy rates for cadres critical for Primary care services like Doctors, Clinical Officers, Environmental Health Technicians and Officers, nurses and midwives were very high especially in rural areas

December 2007	Establishment	In Post	Vacancy Rate
Nurses/ MWs	17338	11822	38%
EHWs	2395	2395	52%
Drs	1761	660	63%
Cos	48	48	56%

Source: HSB Annual Report 2007

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Policy responses (during crisis)

Government responses –

- Creation of a Health Service Board responsible for HRH
- Introduction of new primary care nurse for rural areas and deployed them in rural facilities starting 2005.
- HSB Responses(should have been service wide)
- Duty free vehicle importation schemes (not beneficial for rural HWs)
- Post Basic allowances increased (targeted health workers with such qualifications urban based)
- Rural allowances increased(Inflation quickly rendered all these ineffective)

Policy responses during crisis (municipal)

- HW awarded 20% of their salary as a retention or critical allowance and introduced direct cash payment of salaries due to bank note shortages in 2007/2008, form collected revenues from rate payers

- Beginning in October 2008 part payment of salaries in South African rand introduced

Post crisis policies

- Harmonised Human Resource Retention Policy introduced in 2009 with donor support. (service wide-Public, Mission Municipality) All inclusive at first but Later targeted grades C5 and above (HSB Human Resources Retention Policy 2010

- Health Transition Fund (supporting the wider system dimensions- Health Workers in grades C5 and above, Doctors (up to three per district), Midwifery Tutors, “Practising” Midwives Critical Posts (Mudyara, 2015) supposed to be service wide

Salary differentials

Salary received in the month preceding the study by profession by sector (USD)

Sector	Government			Municipality			Mission			p-value
Cadre	Median	Min	Max	Median	Min	Max	Median	Min	Max	
EHPs	250	210	420	1,100	258	2,700	232	219	550	<0.001
Midwives	250	200	485	1,730	249	2,200	249	200	350	<0.001
Nurses	250	200	434	1,000	200	2,203	240	199	400	<0.001
Doctors	500	500	500	-	-	-	285	285	285	-
Total	250	200	500	1,303	200	2,700	246	199	550	<0.001

Survey Report 2015

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Comments on adequacy of salary

- *I am not happy, am not satisfied because of the salary and the conditions of service. A person in my post must have incentives e.g. car loan, i.e. incentives that make you comfortable (***IDI 011 female matron Public sector District 1)**

- *When I joined the nursing profession twenty six years ago it was satisfying to be a nurse. Remuneration, was good, availability of resources was good. The hospital infrastructure was good and it felt good to be a nurse.* (**IDI 010 female Matron Central Hospital District 1)**

- *Salaries in the public sector were unrealistically low especially during the difficult times…there is some improvement, health workers continue with private work and the question of whether this is sanctioned or not does not arise because the salaries are very low***. (KII 22 female Doctor Public sector)**

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Views of rural area allowance

Universal, Not related to hardship

- *[There are some facilities] located in hard to reach areas, it will be probably in addition to the rural allowance, having a hard to reach area allowance, maybe we can say rural allowance but then have various categories… some rural areas like, say Mahusekwa which categorised as rural; but somebody can drive from Harare to Mahusekwa. we say Goromonzi is rural; but somebody can drive from Marondera or Harare to Goromonzi. Can you compare Siyakobvu and Goromonzi; can you compare Chikombedzi and these peri urban areas* **[KII 031 policy specialist**]

- *I used to know about rural allowance but I do not know if it is still there.* **[IDI 016 female nurse mission hospital District 2]**

Generally view as too low and insignificant

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Types of additional income – urban /rural (midwives; USD)

Sector	Municipality			Mission		
Allowances	Median	Min	Max	Median	Min	Max
On call/locum	-	-	-	35	30	560
Transport	29	20	100	90	10	100
Housing	150	70	424	100	10	116
Retention	49	20	380	46	38	101
Uniform	28	8	46	12	10	15
Professional	160	72	339	-	-	-
Elderly	75	70	75	-	-	-
Water	20	10	30	-	-	-
Locomotion	58	58	58	-	-	-
Total	271	138	802	252	30	307
Percentage of monthly salary	27.7	13.4	120.7	93.5	11.70	132.3

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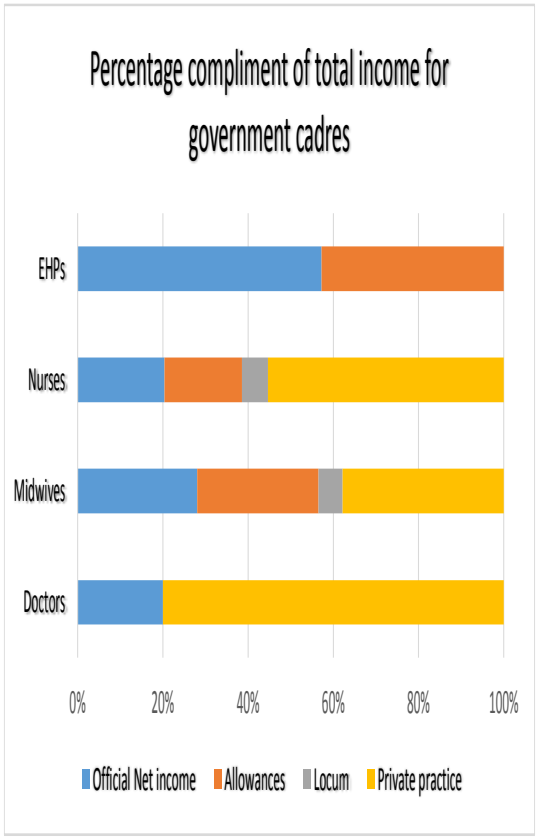
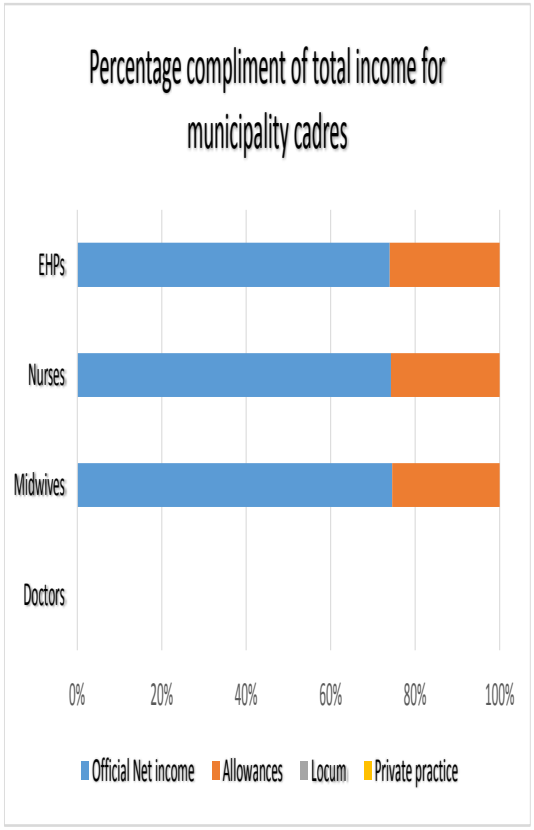
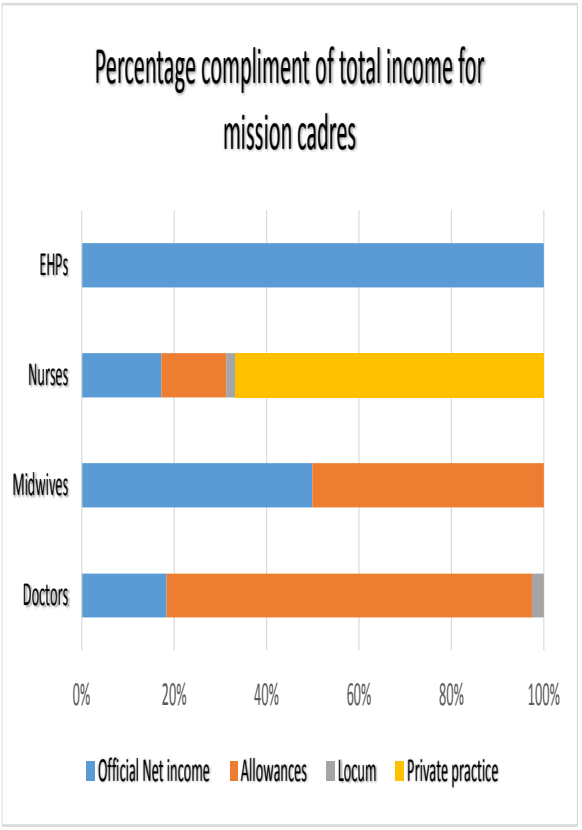
Composition of total income







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Staffing levels for select critical cadres, December 2014

Cadre	Authorized establishment	In-post	Vacant	In-post (%)	Vacant (%)
Junior resident medical officer	250	219	31	88	12
RGN/SCN/Sr/principal	9,870	9,651	219	98	2
Primary care nurse	1,277	1,231	46	96	4
Environmental health technician senior/principal	1,483	986	497	66	34
Pharmacist senior/principal	125	58	67	46	54
Pharmacy technician senior/ principal	186	163	23	88	12

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Zimbabwe – some conclusions

- Attrition rates have reduced due to implementation of incentive schemes but rural areas staffed more by less experienced newly trained PCNs.
- Harmonisation of the incentive scheme(s) service wide is long term solution to internal labour market to sustainably retain HRH in rural areas.
- No specific incentives linked to rural area posting except RAA which is very low.
- Maldistribution an expression of HRH rational choice on posting.
- Sub optimal skills utilisation epitomised by concentration of critical HWs where the money is rather than where the need is greatest.
- Distinction between rural and hard to reach should determine allowances paid.
- Retention systems should not surpass salaries like is the case in government and mission sector (compliment of allowances as percentage of total income is 100%+ compared to 20% in the municipality).

References

- Chirwa. Y, Mashange. W, Chandiwana. P, Munyati. S, Witter S. 2014 Understanding health worker incentives in post-crisis settings: policies to attract and retain health workers in rural areas in Zimbabwe since 1997, a document review Http//www.rebuild consortium.com
- Chirwa. Y, Mashange. W, Chandiwana. P, Munyati. S, Witter S. 2015a Policies to attract and retain health workers in rural areas in Zimbabwe since 1997, IDI report
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Health workers in post conflict Northern Uganda: experiences of conflict, coping strategies and policy responses to health workers' needs post -2006

Justine Namakula

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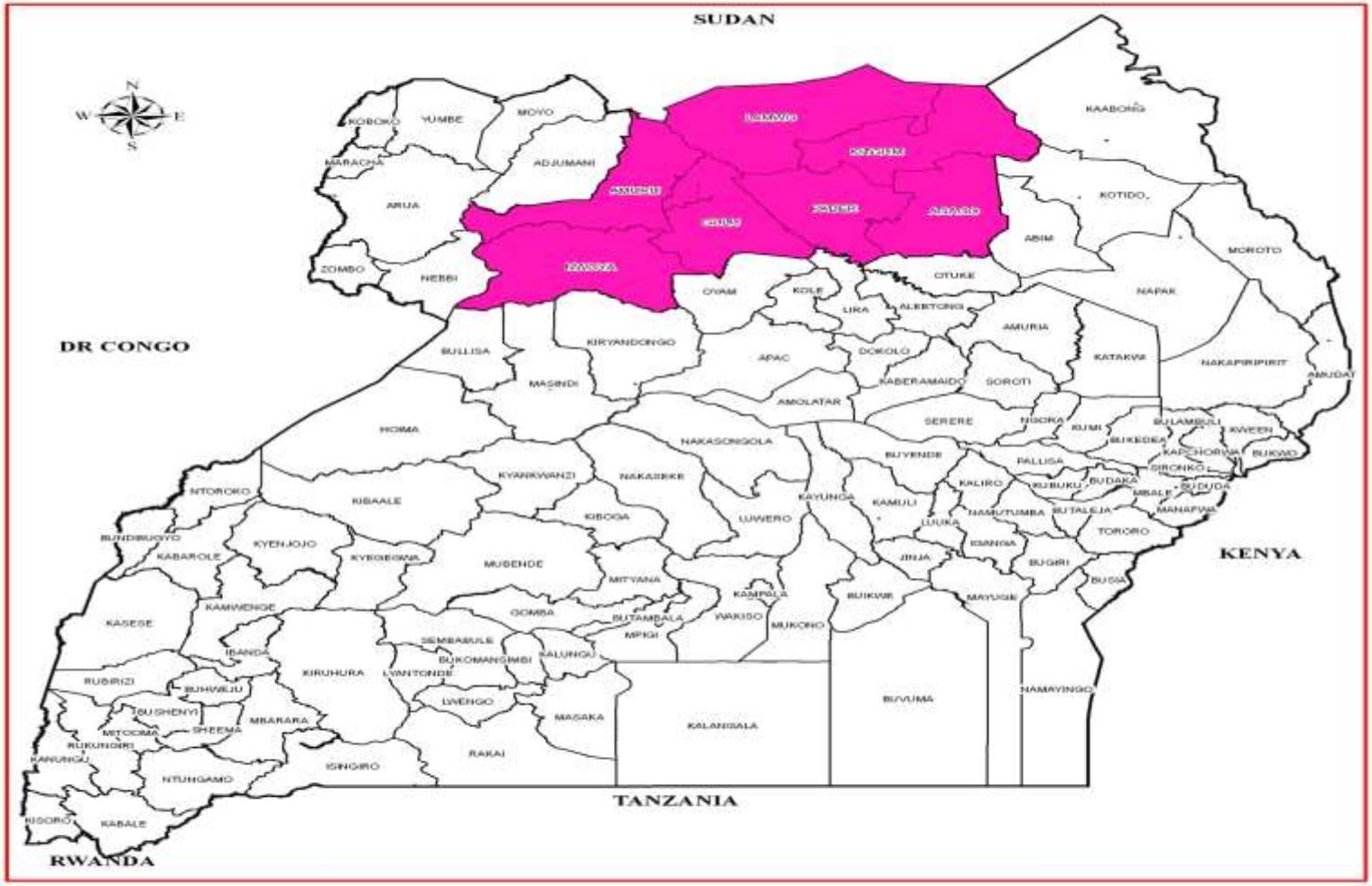
MAP OF UGANDA SHOWING ACHOLI SUB-REGION



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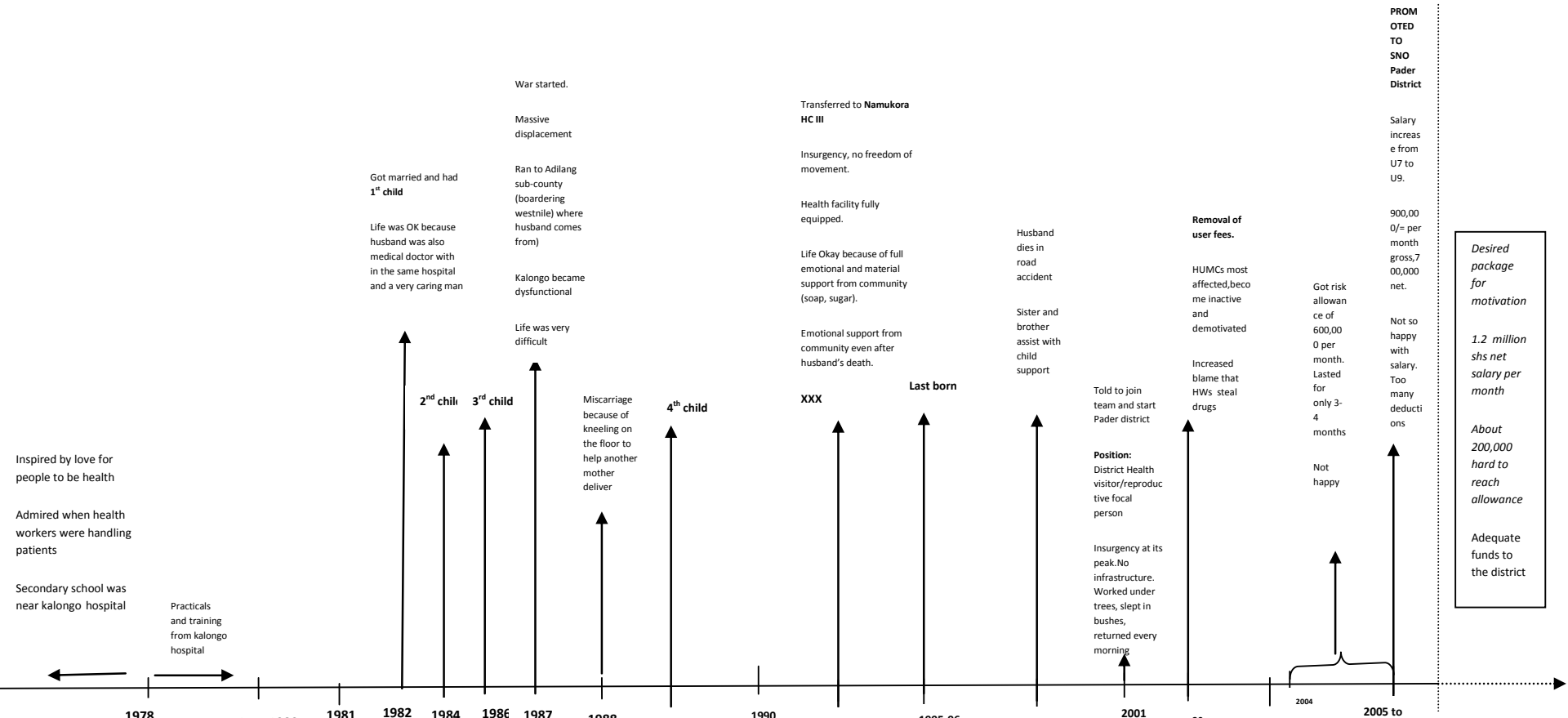
Map users are invited to inform the Executive Director of any Errors or ommissions

Delineation of International and other boundaries on this map is not considered Authoratative

Female Senior Nursing Officer



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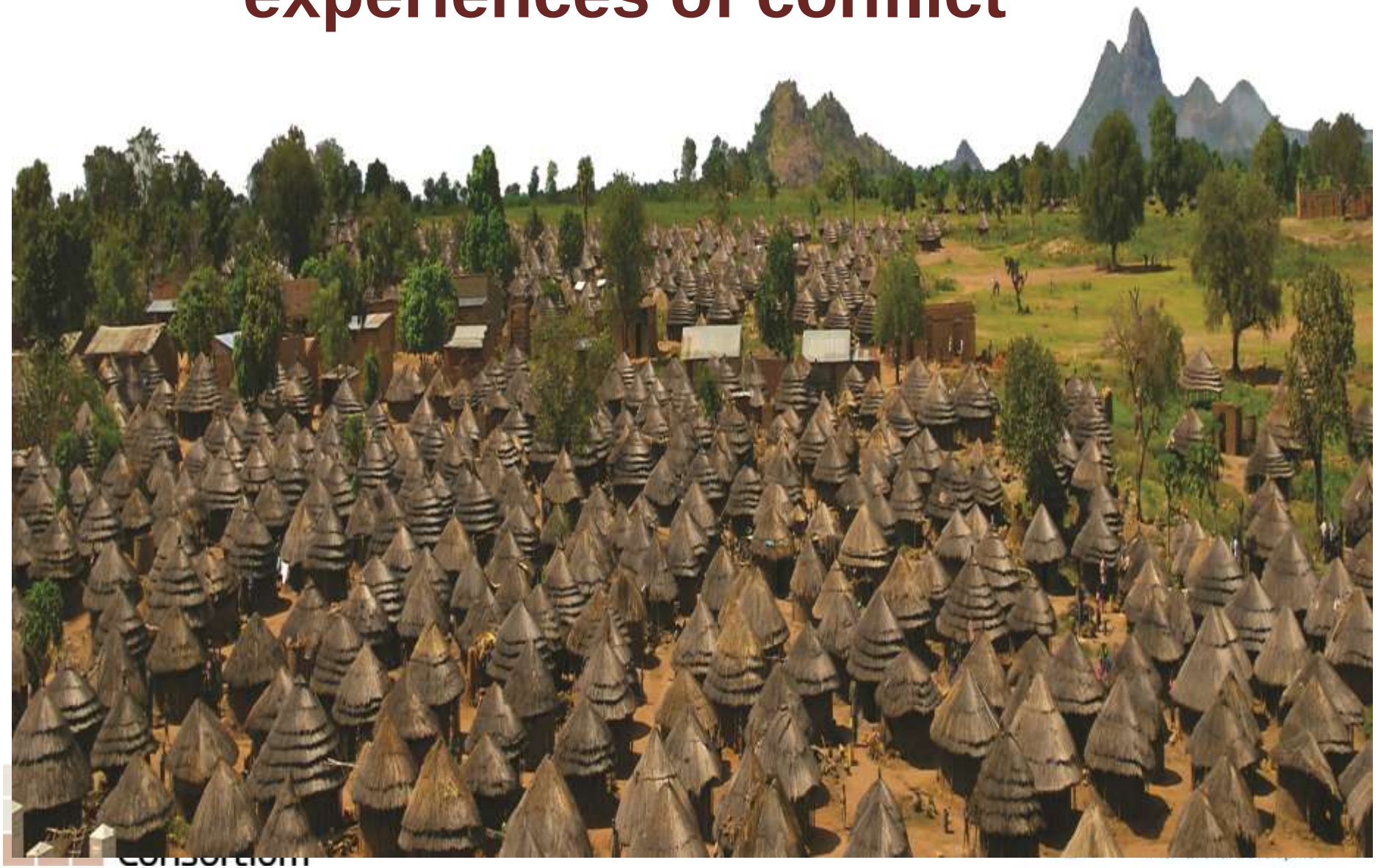
Health workers experiences of conflict



Health worker's experience of conflict

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How did they cope?

'' You[would] 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''

"I used to buy simple clothes for my baby like for the community, even this one for tying on the back - everything was like for the community, so if am mixed with them you can't differentiate me from them"

''They were looking for health workers like needles. So when you sleep *this side today, the next day you have to sleep the other side.[...] Of course, they also needed our services in the bush so when they got you as a medical worker, they would want you to help them. So the only thing you had to do was to change your sleeping place because when the rebels landed on the villagers, they would tell them to go and show them the health workers.[...] then also you would be working at risk, any time you would be abducted[...]''*

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How did they cope?

"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"

"[...] 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 [had to] separate these people. I had to struggle with the knowledge I had-."

"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"

"The security personnel tried very much to secure the situation but they still penetrated "

"[...] 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"

Health workers' needs – post conflict

- Protection
- Counseling and psycho-social support
- Recognition
- Improved working conditions
  - ✓ Salaries(timely, reasonable, accessible, match with level)
  - ✓ Equipment available
  - ✓ Accommodation(available/Improved)
- Training
- Other Incentives to stay

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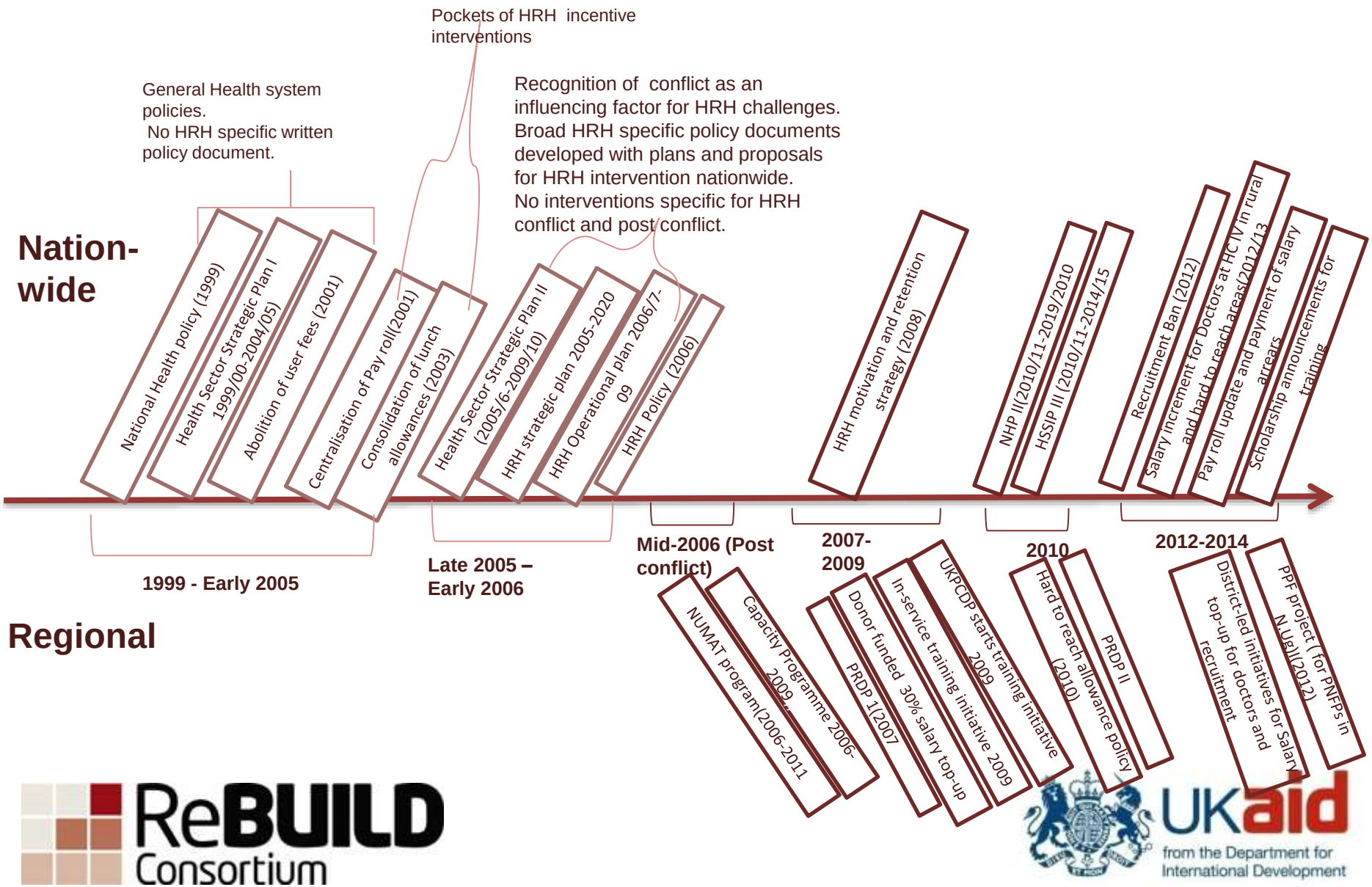
Evolution of HRH policies and practices in Uganda (1999-2014)



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Policy response to health workers' needs – post conflict

- No specific policy on protection of health workers
- Lack of counseling and psycho-social support for health workers
- No recognition yet

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Policy response to health workers' needs – post conflict

Pockets of improvement but major complaints exist

✓Working conditions

e.g. Accommodation

"[…]it is not enough because you find that a health centre III is supposed to have 19 staff and only one block has been built to accommodate only two staff[..]."

✓Training initiatives

✓ Hard to reach allowance

"Hard to reach allowance is just wound dressing [...] for instance if a nurse is getting 200,000/= and you say hard to reach allowance is 30%, that is about 60,000/=, how far will the 60,000/= take the nurse [...] in the present day Uganda?"

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Policy implications

- Health workers are often targeted specifically in war time – need to be better protection measures and training in how to cope
- In times of conflict, alternative mechanisms for paying workers should be developed
- Health services should recognise and celebrate the contribution of those who continued to serve on the front line during conflict-affected times
- Incentive policies need to target mid-level cadres and local staff because they are more likely to stay during turbulent times; importance of developing their career paths
- Human resource management policies should focus on maintaining the intrinsic motivation which many health workers have when they join the profession
- Need for a bottom-up evaluation of human resources for health policies through the eyes of the health workers themselves

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http://www.rebuildconsortium.com/media/1021/health-workers-career-paths-livelihoods-and-coping-strategies-in-conflict-and-post-conflict-uganda.pdf

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Some overall reflections on ReBUILD questions

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Windows of opportunity?

- Sierra Leone case study suggests that post-conflict weakness of institutions may prevent emergence of systemic reforms in immediate post-conflict period
- Changes came later (7 years post-conflict) when more stable political leadership was established and could give focus for donors
- Sense of urgency may have been related to recognition of post-conflict system weaknesses
- Post-Ebola window seems to be thrown wide… linked to sense of global threat?

Bertone, M., Samai, M., Edem-Hotah, J. and Witter, S. (2014) A window of opportunity for reform in post-conflict settings? The case of Human Resources for Health policies in Sierra Leone, 2002-2012. *Conflict and Health*, 8:11. http://www.conflictandhealth.com/content/pdf/1752-1505-8-11.pdf

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Post-conflict trajectory

- Immediate ‘fire-fighting’ stage is common
- Government slowly regains initiative, but timing very varied
- Expectation of weaning off donor dependence may not be met in medium term – e.g. donors still paying key inputs for staff in Zimbabwe, Sierra Leone, and overall support in Uganda and Cambodia

Policy and practice

Even more divorce of policy and practice in post-conflict settings?

- In SL, policies had limited traction; change came through higher level political initiative
- In Uganda, change driven by practical initiatives at district level; policies unfunded
- Gridlock in Zimbabwe
- Evidence of importance of other players at district level in policy implementation

Witter, S., Wurie, H. and Bertone, M. (2015) The Free Health Care Initiative: how has it affected health workers in Sierra Leone? *Health Policy and Planning*

Bertone, M. and Witter, S. (2014) An exploration of the political economy dynamics shaping health worker incentives in three districts in Sierra Leone. Submitted to *Social Science and Medicine*.

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Path dependency

Individual life stories of HWs – e.g. effects of training in one sector (often based on location)

Also at sectoral level – e.g. not choosing contracting out approach in SL post-conflict

Namakula, J., Witter, S., Ssengooba F. and Ssali, S. (2013) Health worker's career paths, livelihoods and coping strategies in conflict and post-conflict Northern Uganda ReBUILD Consortium report.
http://www.rebuildconsortium.com/publications/index.htm

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Impact of conflict on health workers

- Trauma, but also resilience & coping strategies of those who stayed
- Importance of recruiting and maintaining intrinsically motivated people, mainly mid-level cadres
- Making entry routes for students from lower income households
- Need for better protection and recognition

Namakula, J. and Witter, S. (2014) Living through conflict and post-conflict: experiences of health workers in northern Uganda and lessons for people-centred health systems. *Health Policy and Planning* for 2014 special edition on People-Centred Health Systems.

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Complex remuneration of HRH in low income and post-conflict settings

- HWs in post-conflict settings face even greater fragmentation of revenues
- Important to understand overall composition, including
  - Causes of the fragmentation in the income structure and the variability in income levels
  - Consequences of the 'complex remuneration' on health workers' motivation and performance
  - How HWs perceive and manage different income components (whose value depends on more than value – also ease of access, predictability etc.)
  - How to improve information on different revenues streams in order to fine-tune incentive packages

Bertone, M. and Witter, S. (2015) The complex remuneration of Human Resources for Health in low income settings: policy implications and a research agenda for designing effective financial incentives. *Human Resources for Health*, 13; 62. http://www.human-resources-health.com/content/pdf/s12960-015-0058-7.pdf

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When post-crisis is not post-crisis..Zimbabwe

- HR policies – problems are known but not resolved
- Stasis and continuing blockage
- Contributes to fragmentation between sectors in Zimbabwe – different terms and condition; lack of coordination and information sharing (also influencing research strategies)
- Also to informal coping strategies – informal secondments etc

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HRH and state-building

- Empirical evidence for most of the linkages is not strong, which is not surprising, given the complexity of the relationships.
- Nevertheless, some of the posited relationships are plausible, especially:
  - between development of health cadres and a strengthened public administration, which in the long run underlies a number of state-building features
  - reintegration of factional health staff post-conflict is also plausibly linked to reconciliation and peace-building
  - role of medical staff as part of national elites may also be important.
- The concept of state-building itself is highly contested, with a rich vein of scepticism about the wisdom or feasibility of this as an external project

Witter, S., Benoit, J-B, Bertone, M, Alonso-Garbayo, A., Martins, J., Salehi, A., Pavignani, E., Martineau, T. (2015) State-building and human resources for health in fragile and conflict-affected states: exploring the linkages. *Human Resources for Health* special edition.

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Themes for continued exploration (1) – recruitment and retention

1. What motivates health workers to join the profession, and the implication for policy and career progression in post-conflict states?
2. HW motivating and demotivating factors and their implications for effective retention packages in rural areas
3. Lessons on retention of health workers post-conflict
4. Movement between and within sectors and perceptions of HWs of employment in different sectors post-conflict

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Themes for exploration (2) – policy and practice, and effects of conflict

1. Evolution of HRH policy and practice (and their drivers) post-conflict
2. The changing health system pre, during and post-conflict: views of health workers
3. Effects of the crisis/conflict on HWs and their coping strategies (how can we reinforce these?)

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Themes for exploration (3) – other

1. Experiences using life histories with health workers: methodological reflections
2. Understanding effect of Ebola on HWs in Sierra Leone: lessons for rebuilding
3. Building post conflict health systems: gender analysis of health workforce

Thank you

On behalf of ReBUILD consortium and Partners

- Institute for International Health and Development (IIHD), Queen Margaret University, UK
- Liverpool school of Tropical Medicine (UK)
- College of Medicine and Allied Health Sciences (CoMAHS), Sierra Leone
- Biomedical Training and Research Institute (BRTI), Zimbabwe
- Makerere University School of Public Health (MaKSPH), Uganda
- Cambodia Development Research Institute (CDRI)

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