



Research for stronger health systems post conflict

Research Brief

April 2016

Maintaining an effective health workforce during and after conflict: Evidence from ReBUILD's research in northern Uganda

BACKGROUND: What is the ReBUILD RPC?

The ReBUILD Consortium is a 6-year research partnership funded by the UK Department for International Development (2011-17). We are working with partners in Cambodia, Sierra Leone, Uganda and Zimbabwe to explore ways to strengthen policy and practice on health financing and human resources. Additional affiliate research projects broaden the range of contexts. ReBUILD's purpose is to generate robust, good quality evidence that responds to the challenges faced by policy makers.

ReBUILD in Uganda

In Uganda, the research is being led by the School of Public Health, College of Health Sciences, Makerere University. The ReBUILD projects in Uganda covers: (i) health financing and its effect on poor households, (ii) health worker incentives and retention, (iii) rural posting and deployment of health workers, and iv) aid effectiveness post-conflict. Gender and equity are mainstreamed through all ReBUILD's work.

Why is ReBUILD focusing on post-conflict contexts?

In countries affected by socio-economic crisis or conflict, health systems break down and external emergency assistance is often the main source of care. As recovery begins, so should the process of rebuilding health systems. But health systems research has neglected post-conflict contexts and not enough is known on the effectiveness of different approaches. ReBUILD has been created to address this challenge.

ReBUILD's research on health worker incentives in Uganda

Research objectives:

- a. To describe health worker livelihoods and coping strategies during and after the conflict
- b. To describe the evolution of government and donor HRH incentive policies and initiatives as well as their effectiveness in relation to supporting health workers in affected areas before, during and after the conflict.
- c. To learn lessons from this on supporting an effective and well distributed health workforce in conflict-affected areas

Research questions: *How has HRH policy evolved during and post-crisis? What influenced the trajectory? How did the incentive environment change for health workers? How did conflict affect health workers and how did they cope? What were the effects of the incentive policies and what are the recommendations for the future?*

Study area and methodology

The ReBUILD research team for the health worker incentives study in Uganda used four tools and these were applied across four districts in Acholi sub-region, Northern Uganda. The study districts were; Gulu, Kitgum, Amuru and Pader.

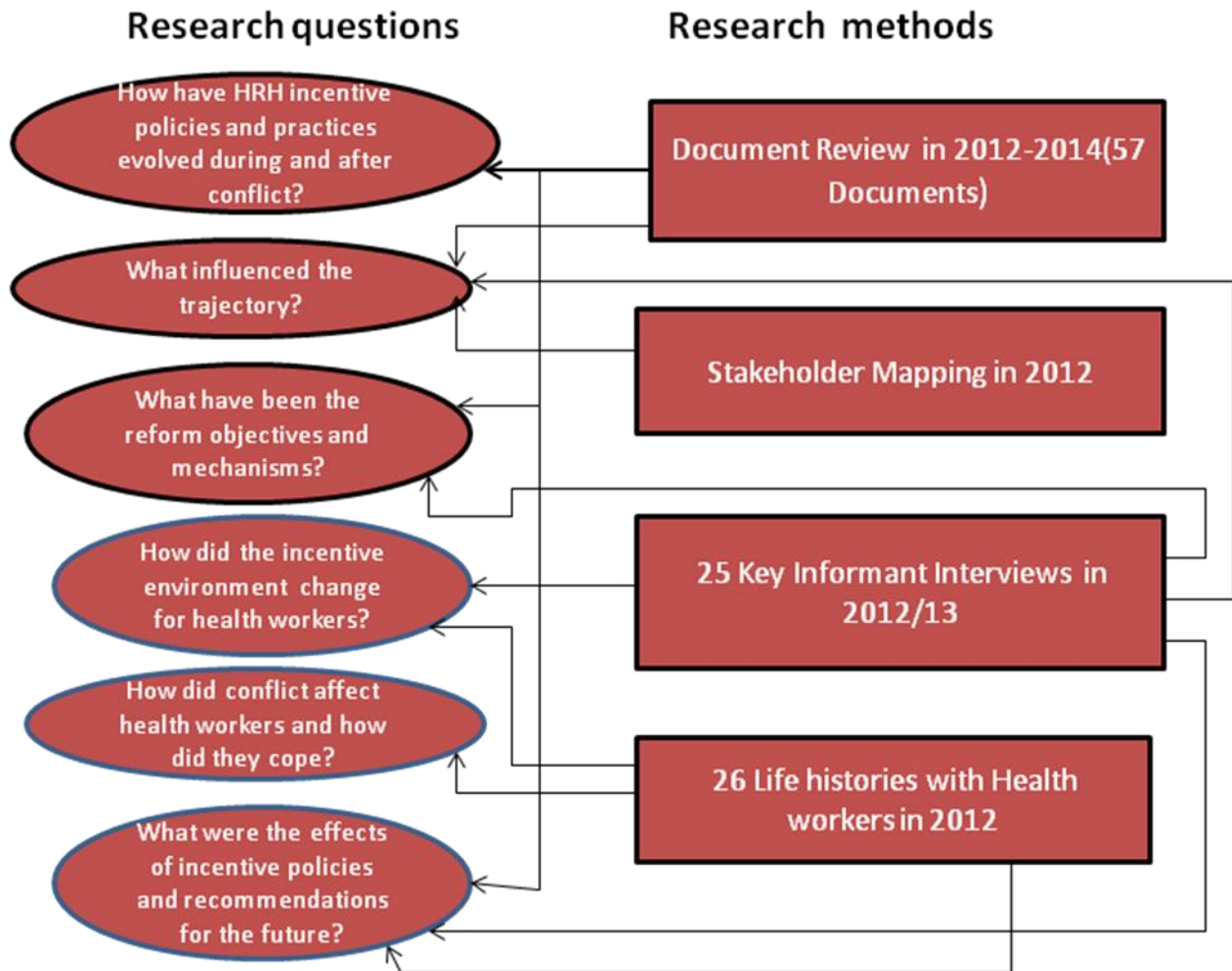


Figure 1: Summary of research tools for Health worker incentives research, ReBUILD Uganda

Key findings and messages

1. Vulnerability of health workers during conflict

The study findings indicated vulnerability of health workers during conflict. Conflict affected health workers' health and security as well as their working conditions. Whereas many run away to safer places, a few of those remained, persevered and stayed committed to 'work for their people' and innovated, even where supplies were lacking. Many of such staff are still working in the region and comprised part of the study participants in 2012.

"[...] Most of the health workers abandoned the hospital including the matron [...]." (Female Senior Nursing Officer, Public facility, Kitgum)

"If we were to run away, now who would help them? So we persisted and the fear slowly disappeared." (Female Nursing Officer, private-not-for-profit (PNFP) facility, Amuru)

Message: Whereas there is a lot of protection for international expertise that work in international non-governmental agencies during conflicts, not much effort is put in trying to protect the local health staff from risk, as well as stabilise them through providing for their psychosocial needs. Local health workers need to be protected during conflict and psychosocial support for them needs to be availed after conflict.

Health workers who stayed and worked during and after conflict need to be openly recognised for their action, in order that other health workers may be encouraged to stay behind and work in the region, with confidence that their contribution will be recognised.

2. Piecemeal incentive policies and practices

There have been various incentive policies and practices to enhance health worker motivation. However, these have mainly been piecemeal, with the majority focusing on financial incentives. Examples of these include; 30% top-up funded by donors(2007), allowances paid by non-governmental organizations (NGOs), 'hard to reach' allowance (2010), salary top-up initiatives by districts (2011-2012) and increment of salaries for doctors(2013). In spite of these, there was reported dissatisfaction amongst health workers. The study revealed that pay (financial incentive) is not the main motivator, although it matters. Other non-financial incentives also

matter, such as good working relationships, skills up-grade, promotion, availability of supplies and proper accommodation, as well as being recognised and appreciated for their role.

Message: For incentive packages to be successful in motivating health workers to stay in underserved areas, they should be holistic: that is, include financial and non-financial incentives.

3. Changing incentive needs across careers and life stages

The study revealed differential incentive needs for health workers at different ages and stages in their career. For example, during their training, younger health workers were okay with a small allowance and some non-cash incentives such as soap, salt and sugar. As they matured and acquired family and marital responsibilities, health workers needed to stay closer to their families, with access to good schools for their children, have more flexible working hours and leave, and a higher salary. However, as they grew older, health workers thought of retirement and would be more interested in working within sectors where retirement packages in age and acquired.

Message: Need to package incentives according to different needs and responsibilities as people mature in their career, life and family responsibilities. This will not only help motivate them to work in underserved areas but also contribute to stabilization of health workforce across districts and also PNFP and public sectors.

4. Motivating factors to join health profession

At the beginning of their careers, health workers were motivated to join the health profession by various factors, including positive experiences such as seeing health workers care for their relatives, and smartness of health workers who were seen passing by the villages in health

facilities. In recent times however, motivation to join may be negatively affected by “toxic branding” in the media, including portrayal of health workers as ‘drug thieves’ⁱ and ‘negligent servants’ without giving the health worker’s ‘side of the story’ⁱⁱ.

Message: There is need to develop career guidance programs that can enhance positive messages of the health profession so that people are encouraged to join.

5. Stabilisation of health workforce across sectors and districts in underserved areas

Competing labour market activities: The study revealed that there were (and still are) competing mechanisms of recruiting health workers across districts in Acholi sub-region and across sectors (PNFP and public). For example, districts are allowed to recruit individually, hence they keep advertising and recruiting on different dates. The effect of this is wastage of resources because some districts keep advertising, conducting interviews but lose staff to other more ‘attractive’ districts within the region. Additionally, whenever the public sector conducts a recruitment drive, it ends up picking health workers from the PNFP sector.

“[...] usually, adverts (from all districts) come out at the same time. Health workers also tend to apply to all these places and also go and sit for interviews in all districts. So [...] Kitgum [can] recruit 10 midwives [...] but the same midwives have also passed interviews in Gulu [and accepted positions]. In most cases we stand to lose.” Key Informant, Kitgum

Message: There is need to recentralize deployment within the public sector so that health workers are sent to the underserved areas. The PNFP sector also needs to adopt some of the features which render the public sector attractive to staff, such as public pension system. This will stabilize health workers in this sector and enable continued delivery of services by PNFP sector to deprived communities in Northern Uganda.

6. Monitoring and evaluation of incentive policies and practices

The study revealed that many of the incentive policies and practices had not been evaluated. For example, some study participants reported that they had suddenly stopped receiving the 'hard to reach' allowance without explanation. Others reported that the reason for stoppage was that they were incorrectly considered to be in urban areas. Efforts need to be undertaken to clearly explain the eligibility criteria to all intended beneficiaries to avoid unnecessary misunderstandings.

Message: More generally, there is need for a bottom-up evaluation of all other incentive policies and practices through the eyes of the health workers themselves. Better evidence on this will improve the outcomes of such policies.

For more information, see the following resources

Namakula J., Witter, S and Ssenooba, F. (in press) Health worker experiences of and movement between public and private not-for-profit sectors- findings from post conflict Northern Uganda. *Journal for Human Resources and Health*.

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 Planning and Management*. 29(Suppl 2): ii6-ii14. doi: 10.1093/heapol/czu022.
http://heapol.oxfordjournals.org/content/29/suppl_2/ii6.full

Namakula, J., Witter, S. and Ssenooba, F. (2014) Health worker incentives policies during and after the conflict in northern Uganda: a document review. Report for ReBUILD. <http://www.rebuildconsortium.com/media/1013/health-worker-incentives-during-and-after-the-conflict-in-northern-uganda.pdf>

Namakula, J. and Witter, S. (2014) Policies to attract and retain health workers in Northern Uganda during and after conflict: findings of key informant interviews. Report for ReBUILD. <http://www.rebuildconsortium.com/media/1017/policies-to-attract-and-retain-health-workers-in-northern-uganda-during-and-after-conflict.pdf>

Namakula, J., Witter, S., Ssenooba 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/media/1021/health-workers-career-paths-livelihoods-and-coping-strategies-in-conflict-and-post-conflict-uganda.pdf>

UCMB (2010) Uganda Catholic Medical Bureau. Annual report Jan-Dec 2010.
<http://www.ucmb.co.ug/files/UCMBdocs/Reports/ARTICLES/UCMB%20Annual%20Report%202010%20-%20FINAL.pdf>

VSO (2012) our side of the Story. Uganda Health workers Speak up. Volunteers services oversees and Coalition for Health Promotion and Social Development (HEPS). Pp. 20-22

Find out more on ReBUILD's work in northern Uganda and beyond

Visit the ReBUILD website: www.rebuildconsortium.com. Or contact:

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ⁱ <http://www.monitor.co.ug/News/National/Two-medics-arrested-over-government-drugs-bribes/-/688334/3048604/-/cmjk3q/-/index.html>

ⁱⁱ See VSO (2012) our side of the Story: Ugandan Health workers speak up. Pp. 20-22