ReBUILD Consortium

Key Messages From ReBuILD Research Program

1. Household Health Care Access and Costs

1. GovernmentHealth Facilities Largest Providers of Health Care

Public health facilities were the most preferred health care providers over the three time periods. Preference was highest before and after the war, despite the reported frequent drug stock-outs and the few health care workers. Two factors explained this: 1) most health care facilities found in the community being government owned and, 2) the high cost of accessing health care after the war. Before and during the war, there was hardly any private health care provider. After the war, the number of public (government-owned) facilities has increased. Moreover, many people had such impoverished livelihoods that they could not afford health care from fee-paying facilities that had been established in Gulu after the war.
Public facilities were followed by faith-based facilities as largest providers of health care, especially Lacor hospital.

2. Clinics and Drug Shops on the Rise

Clinics and drug shops, often located in urban areas were the next resort due to the predominant practice of self-medication and the persistent drug stock outs. Self-medication is often undertaken for illnesses people perceived to be less severe, such as colds/flus, headaches, cough and fevers.
It was also preferred for chronic illnesses, because the sufferers felt they had mastered their illnesses and their cures. The increase in choosing these facilities after the war and their limited existence before the war was because before the war health care was largely free and perceived to be of good quality, compared to after the war where health care seeking is accompanied with costs households considered very high, in a context of frequent illnesses, drug stock outs and absentee health workers.

3. Cost is the Main Reason for Choice of Health Care Facility

Cost was a major factor in determining the choice of health provider. This choice was either direct (actual cost of care) or indirect (in form of transport, perceived quality of care or illness severity). These three were all related to cost because illnesses perceived to be less severe were taken to the public health centres and drug shops, while more severe conditions were taken straight to fee-paying facilities where the health care was perceived to be of better quality. Within these, distance and the ensuing transport costs were crucial, as facilities perceived to have better quality were fee paying and further off in town. This was because by the time they sought care, they did not consider free health care as an option.

4. Declining Reliance on Alternative Health care

The reliance of households on alternative health care or non-facility-based health care is clearly on the decline post conflict. It was higher before the war because many

people then believed in them. And with long distances to health facilities, many preferred to, for instance, deliver from home. But the free provision of health services closer to the people in the camps during the war exposed many to modern professional health care which they appreciated even after the conflict. As such, many preferred professional health care from health facilities and only resorted to non-formal medicine when they had no other options.

5. Post conflict Advent of Specialised Health Care

The presence of organizations such as The AIDS Support Organization (TASO) were also a recent phenomenon, owing to HIV and AIDS being a new health challenge in the region. But their presence also signifies the trend in the verticalisation of health care programming which started in the late 1980s in Uganda. As such, TASO was only used by those who had HIV, for specialized health care.

2. Health Workforce Developments

1. Special Targeting of health workers by rebels during conflict

The study findings indicated unique vulnerability of health workers during conflict. During conflict, many health workers were targeted by the rebels either for medical supplies, or abducted to go and provide services to wounded rebels or to stop them from providing services to injured civilians. Whereas many run away to safer places, a few chose to stay and continued to serve the local population, innovating where supplies were lacking. Many of such staff are still working in the region and comprised part of the study participants in 2012.
Study findings also indicate that the health workers who stayed to serve amidst the risks feel unappreciated without any form of recognition. This potentially kills the morale of others, in the event of another conflict. Additionally, there is a lot of protection for international experts that work in international non-governmental agencies during conflicts. While in Northern Uganda, efforts were made by the military to protect health workers and civilians, sometimes providing convoy protection to civilian and health service vehicles, in some instances the protection was not adequate, exposing the local health staff to risks.

2. Piece-meal incentive policies and practices

There have been various incentive policies and practices to enhance health worker motivation. However, these have mainly been piece-meal, with majority focusing on financial incentives. Examples of these include; 30% top-up funded by donors (2007), allowances paid by Non-governmental organizations, hard-to--reach allowance (2010), salary top-up initiatives by districts (2011-2012) and salary increments for doctors (2013). In spite of these, there was reported dissatisfaction amongst health workers. The study revealed that pay (financial incentives) is not the main motivator, although it matters. Other non- financial incentives such as good working relationships, skills up-grade, promotion, availability of supplies and proper/ decent accommodation as well as being recognised and appreciated for their role, also matter.
What this finding implies is the need for designing holistic incentive packages to include appropriate financial and non-financial incentives for conflict-affected areas.

3. Stagnant incentives for Changing 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 acquired family and marital responsibilities, health workers needed to stay closer to their families, needed nice schools for their children, flexible working hours and leave and higher salaries to be able to clear the bills at home. However, as they advanced further in age, health workers reported that they would prefer working in sectors which provided for favourable retirement packages. Incentives packages should therefore be evolving to meet needs as health workers grow in career and age. In addition, special incentive packages need to be designed for health workers in conflict and post conflict areas.

4. Childhood images of health workers are a key motivation to join the profession

At the beginning of their careers, health workers were motivated to join the health profession by various factors. Among such factors were positive experiences such as seeing health workers treat and care for their

relatives; and smartness of health workers who were seen passing by the villages or walking around in the wards. In recent times, the media is full of "toxic branding" through publication of negative images about of health workers such as 'drug thieves'[1] and 'negligent servants' without necessarily portraying the Health worker's 'side of the story'[2]. Such images may negatively affect motivation to join.

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

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 at different times. 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 where the same people have applied. Additionally, whenever the public sector (government) conducts a recruitment drive, most of the health workers who apply are from the PNFP sector.

Therefore, deployment of health workers with in the public sector should be recentralized 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.

3. Workforce Deployments

1. Change in Recruitment Practices during conflict

It was observed that while deployment policies for the public sector did not change during the conflict and post conflict, however practices changed, sometimes in interesting ways. During conflict, the formal processes were still in place, but alongside them were informal practices of HR management.

For government, recruitment as well as transfers during the conflict were rare; the few that were done were negotiated.

At the PNFP facility (Lacor hospital), there were innovations used instead of following the standard recruitment procedures. Some of these included retention of well-performing students/interns, using both coercive and non-coercive means. Deployment was also done by word of mouth, with undocumented contract terms. Scholarships were also given out to new entrants and this was accompanied by a bonding agreement.

2. Changing Labour Market Dynamics across the three periods

There was movement of health workers from the public sector to Private- Not-for-Profit (PNFP) sector, during the conflict. This is largely attributed to the better remuneration and other benefits by the PNFP. Additionally, the PNFP also provided better physical security to the health workers and community members, it was the most functionally viable facility and people identified with it. Naturally, it became attractive to workers.

In the post conflict period, the reverse happens; there was movement from PNFP to public service, the motivation being job security, career post-graduate development. Additionally, NGOs were closing so jobs in that sector were reducing. This however, was mainly for the lower cadres (nurses, midwives, clinical officers). Medical doctors remained unstable during and after conflict, mainly because of their marketability.

3. Impact of conflict on documentation/ records

During conflict, health system concerns become less important (HMIS, HRH). So documentation and record in these was affected and makes retrospective research complicated. A case in point is routine staffing data which was either not available or incomplete which made achieving one of the objectives of this study, unattainable. In order to obtain data under such circumstances, life histories may be more useful.

4. Aid effectiveness and Health System Developments

1. Sub-national service delivery systems in post conflict Northern Uganda are characterized by high dependence on non-state organizations with short-term commitments.

This situation generates both positive and negative implications on health system development. In the short-term, non-state organizations assist in expanding service provision especially services linked to high international funding such as HIV. The downside is the frequent shocks and loss of capacity to the health systems that arise from frequent flight and transitioning of organizations away from these health systems.

2. The distribution of the non-state organizations and the support roles they bring to service delivery is less guided by the state.

The result is uneven distribution of non-state organizations among districts. Some districts have highly congested non-state actors while others have scanty presence of such actors. Highly congested districts are likely to have more resources to the health system although this may bring about a duplication of services.

3. State capacity for fair distribution of non-state organisations and resources-

Rebuilding of state capacity should, among other objectives, enhance the allocation of non-state organizations and their contributions in a fair manner across the many sub-national administrative units/districts affected by the conflict.

4. The contributions to health systems are biased towards measurable service outputs and less on systems strengthening.

In our study, the support for workforce functioning – a proxy for system strengthening was much lower than the direct support provided for the inputs for HIV treatment and maternal care services. For HR, there were incentives mainly linked to outputs and little support provided for recruitment, wages and pre-service training.

5. There is high satisfaction of health systems actors about the aid relationships for service delivery in the post conflict districts in northern Uganda.

The satisfaction with aid relationship is mostly influenced by financial contributions, performance-feedback, and timeliness of resource contributions. Although important to aid effectiveness, issues such as negotiation, addressing main priorities, non-existence of Memoranda of understanding did not contribute to satisfaction of aid relationships.

6. The analysis and display of results using social network analysis generated interest from decision makers.

Increased use of visual data display for organizational relationships in post conflict settings and health systems have high utility in communication of complex inter-organizational relationships.