Understanding deployment policies and systems for staffing rural areas in Northern Uganda during and after the conflict: Synthesis Report

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The ReBUILD Research Programme Consortium is an international research partnership funded by the UK Department for International Development.

ReBUILD is working for improved access to effective health care for the poor and for reduced health costs burdens in post-conflict and post-crisis countries. We are doing this through the production of high quality, policy-relevant research evidence on health systems financing and human resources for health, and working to promote the use of this evidence in policy and practice.

ReBUILD is implemented by a partnership of research organisations from the UK, Cambodia, Uganda, Sierra Leone and Zimbabwe;

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- Institute for Global Health & Development, Queen Margaret University, Edinburgh, UK;
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Executive summary

Introduction: The maldistribution of health workers and the associated difficulty of filling health worker posts in rural areas has long been recognised as a serious challenge to the equitable provision of health care and the achievement of the health-related sustainable development goals. Whilst this is a relatively well-researched area, there has been little focus on addressing the problem in post-conflict contexts, where it is particularly important to re-establish equitable health services.

Improving deployment policies and their implementation is an important approach to addressing staff maldistribution, but there is little information in the literature from low and middle income counties about deployment policies and systems, and even less that relates to the post-conflict context. This is an important gap in the evidence for building an effective health workforce after conflict.

Between 1986 and 2006 the Northern Uganda, particularly the Acholi sub-region, was characterised by a protracted armed conflict due to rebel activities, leading to population displacement that forced large numbers of people into Internally Displaced People's Camps (IDPs). The entire health care system was disrupted and health centres at the health sub-districts were closed. Health care professionals were displaced into larger trading centres and to safer, more stable neighbouring districts, many having fled the conflict-stricken rural areas where the effects of the war were intensified.

Since mid-2006, relative peace has returned to the region and the health care system has been reconstituted: displaced populations have been resettled, dilapidated health centres have been reconstructed, and a new generation of health care professionals have been recruited and deployed.

The evolution of the deployment process of health care professionals during and after the conflict in Northern Uganda has not been studied and systematically documented. This study explored deployment systems and policies in a conflict and post-conflict context in order to derive useful information about creating resilient health systems capable of addressing future shocks that may be caused by conflict or crisis. It examined how two significant employers in the health sector - one governmental and one non-governmental - addressed the challenges of staffing services to provide equitable access both during and after the conflict in Northern Uganda.

Setting: This study was conducted within the three districts of Amuru, Gulu and Kitgum in Northern Uganda. These three districts formed the epi-centre of the conflict that lasted from 1986-2006. In Gulu, St Mary's Hospital Lacor (hereafter referred to as 'Lacor Hospital'), a private-not-for-profit (PNFP) employer was included, since it was an important non-state provider of health care in this region.

Objectives:

- **General objective**
  - To identify ways to improve the deployment systems to rural areas used by large employers of health personnel, in conflict and post-conflict contexts.

- **Specific objectives**
  - To describe the current deployment policy and systems and how and why they have changed over time since the emergence from conflict.
  - To assess the impact of the key changes in deployment policy and systems on the staffing of rural areas.
  - To identify useful lessons for policy-makers concerned with contemporary deployment issues throughout Uganda, as well as for an international audience interested in conflict/post-conflict contexts.

Methods: We conducted a retrospective enquiry to identify how the deployment policies and systems in use during both the conflict (1986-early 2006), and post-conflict (mid 2006-2013) periods had changed, and to ascertain the resulting impact on staffing, particularly in rural areas.

National policies and systems in place at different stages were identified from reviews of documents (Method 1). Descriptions and systems maps were developed through key informant interviews at national and district levels (Method 2). The implementation of deployment systems within rural areas both past and present were "audited" using three further methods: personnel record review at district level (Method 3); in-depth interviews with district level managers who operate the systems (Method 4); and in-depth interviews with health workers, which included job histories to identify the impact of the systems on individuals (Method 5).

Results: During the conflict period (1986-early 2006), the growth of a better-paying NGO sector distorted the labour market in a significant way by attracting high level cadres such as medical officers, clinical officers and midwives from both the government district level services and Lacor. However, with the return of peace (from mid-2006 onwards) government jobs became more attractive because of the associated fringe benefits (such as access to paid study leave and job security). Most of the evidence for a distorted labour market in favour of NGO employment in comparison to government and Lacor Hospital were obtained by qualitative means. Quantitative data to back up these claims were scanty and incomplete because of challenges related to information gathering and archiving.

A review of official government deployment-related policies did not reveal any specific response to the changing labour market caused by the emergency provision of services that took place mainly within camps during the conflict. This lack of responsiveness may be explained by the fact that government deployment-related policies as given in the public service standing orders relate to the whole country, whereas the conflict only affected the Acholi region.

The most significant policy change related to deployment in the government health sector was the decentralisation process that started in the 1990s. This took place well into the period of conflict and was implemented on a nationwide scale. Concerns about the impact of decentralisation, which included concerns about political interference in the recruitment process and the loss of career mobility for individuals, were not unexpected. Nevertheless, some benefits were identified, such as the recruitment of local staff who would feel more accountable to their community and who may receive support from their family networks.

Whilst there was no discernible change in deployment-related policies in local government or Lacor, actual implementation did not necessarily follow the policies. In fact, it is clear that managers interpreted the policies in a relaxed manner relevant to the prevailing context. This was in part out of compassion because of the dangers that health workers would inevitably be exposed to if given certain postings. But it was also out of pragmatism, since health managers anticipated that staff might leave the service rather than work in dangerous locations.

Both the local government and Lacor were flexible about posting, not wishing to send staff into areas of danger. Gulu district supported the separate posting of married couples to avoid "putting all the eggs in one basket." Lacor managers used task-shifting to fill staffing gaps, using enrolled comprehensive nurses instead of fully qualified midwives. They also recruited staff in times of shortage through offering bonded training places and retained potentially high-performing employees by recruiting them whilst they were still trainees.

Conclusions: There were no specific changes to deployment policies in either organisation (local government or Lacor Hospital). Managers in both institutions implemented the policies flexibly while adapting to the conflict and post-conflict situations, and to closely meet the demands of their staff with the aim of retaining them in post. The lessons from this study are that managers can act responsively in challenging contexts. However, better preparation for and support during times of crisis would enable them to make better decisions regarding deployment and other areas of human resource management. Where possible, forces driving the labour market which add to the challenges of deployment need to be addressed, but at a higher level.

The following recommendations derived from the study are all relevant to some extent to all three stakeholder groups: managers in Northern Uganda; policy-makers and managers responsible for deployment throughout Uganda; and policy-makers and managers in other countries that are emerging from conflict or crisis.

1. Basic human resource management information systems across all major employers are needed during the conflict and post-conflict periods - and beyond - across all sectors in order to be able to adapt deployment policies and practices to the prevailing labour market conditions. During the conflict, it may be difficult to establish routine data collection, but managers could share their observations of attrition trends to get a better understanding of the labour market dynamics.
2. During conflict, local governments, humanitarian agencies and central governments should establish a harmonised platform of staff recruitment and deployment, in order to avoid unhealthy competition for staff and encourage a stable labour market. The NGO Code of Conduct for Health Systems Strengthening should be introduced and followed.
3. The option of policy change - or suspension - should be considered in times of severe and prolonged conflict or crisis. In particular, this should take place in order to support the staffing of rural areas in conflict-affected regions to respect the safety of health workers, relieve the pressure on local managers and to maintain an equitable distribution of health workers.
4. Managers of health services in conflict-affected areas should be supported to innovatively implement existing human resources policies so that they can contribute to the creation of resilient health systems. This requires not only an understanding of human resource

management, but also the emotional intelligence to select the strategies that will support the staff and not alienate them. In relation to deployment, this means avoiding posting staff to areas where they and their families will be in danger and possibly waiving rules about the length of posting. They may also need to be flexible about other rules such as those on dual working, if the staff members themselves are facing economic difficulties because of the conflict. Managers need to be aware of the options available for improving deployment and of the unintended consequences of certain deployment strategies. They also need to be able to manage the trade-offs of using different strategies.

5. Human resources systems that have collapsed during the conflict – such as formal recruitment and promotion – need to be re-established as soon as possible. In decentralised contexts, the central authorities may need to intervene on a temporary basis to rebuild the workforce – for example, by carrying out limited centralised recruitment.

The post-conflict period also offers an opportunity to re-evaluate existing deployment policies. For example, in Uganda, since the guidance on the length of posting does not appear to be adhered to following decentralisation, its utility could be reconsidered. In addition, the gender-sensitive nature of the policies should be reviewed.

List of abbreviations

AVSI	Association of Volunteers for International Service
CAO	Chief Administrative Officer
CO	Clinical Officer(s)
DANIDA	Danish International Development Agency
DHO	District Health Officer
DHT	District Health Team
DSC	District Service Commission
ECN	Enrolled Comprehensive Nurse
FBO	Faith-Based Organisation
HC	Health Centre(s)
HRH	Human Resources for Health
HSD	Health Sub-district
HW	Health Workers
IDI	In-depth Interviews
IDPs	Internally Displaced Peoples' Camps
KII	Key Informant Interviews
LG	Local Government
LRA	Lord's Resistance Army
MoFPED	Ministry of Finance Planning and Economic Development
MOH	Ministry of Health
MOs	Medical Officers
NGO	Non-Governmental Organisation
NUHITES	Northern Uganda-Health Integration to Enhance Services
NUMAT	Northern Uganda Malaria AIDS and Tuberculosis
PNFP	Private Not-For-Profit
PPO	Principal Personnel Officer
PSSO	Public Service Standing Orders
TASO	The AIDS Support Organisation
UCMB	Uganda Catholic Medical Bureau

UHC	Universal Health Coverage
UNICEF	United Nations Children's Education Fund
UNMHCP	Uganda National Minimum Health Care Package
UPMB	Uganda Protestant Medical Bureau
USAID	United States Aid
VHT	Village Health Team
WHO	World Health Organisation

1.0 Introduction

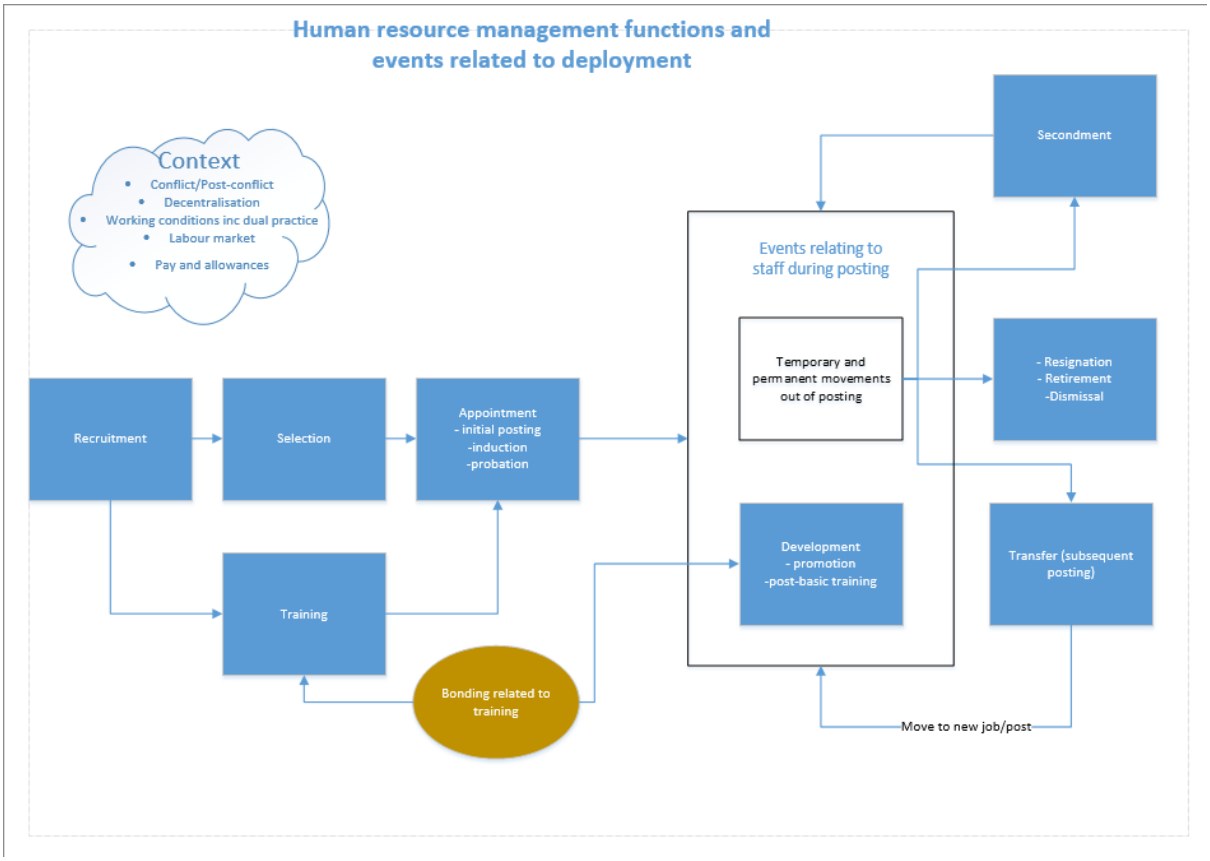
1.1 The contribution of deployment systems to effective staffing of rural areas

In the past decade, the initial emphasis in tackling the so-called "human resources for health crisis" (Joint Learning Initiative 2004) has been on scaling up the health workforce (Crisp, Gawanas et al. 2008). However, the maldistribution of health workers and the associated difficulty of filling health worker posts in rural areas has long been recognised as a serious challenge to the equitable provision of health care and the achievement of the health-related sustainable development goals (Campbell, Buchan et al. 2013). Much research has already been devoted to understanding health worker behaviour in relation to taking up and remaining in posts within different locations (Dussault and Franceschini 2006, Lehmann, Dieleman et al. 2008, Lemiere 2011). The problem of maldistribution is also exacerbated on the management side by ineffective deployment systems (Vujicic, Ohiri et al. 2009, Schaaf and Freedman 2015).

The term 'deployment' is frequently used in relation to the distribution of staff, but rarely defined. One of the few definitions can be found in the Canadian Public Service Employment Act which states that deployment means "the transfer of a person from one position to another" (Government of Canada 2016). An alternative definition given by the HRH Global Resource Centre is "how health workers are assigned to different posts or how the distribution of personnel is determined"[1]. We interpret deployment more widely in this study to include the initial posting of staff and retention of staff in post; and the related human resource management (HRM) functions. These include recruitment, selection (which for those entering public service and being funded by the government often takes place on entry into pre-service training), appointment to the organisation (on a variety of forms of contract), initial posting (often linked to bonding), induction and probation. Once in the post there may be development activities including post-basic training and promotion. Both will have implications for staff movements: post-basic training may lead to promotion or the individual seeking a higher-level role; promotion usually involves a change of post and possibly a change of location if higher level positions are not available locally. Possible movements from the initial posting include: secondment to another post (normally temporary with the person returning to the original posting); transfer to another position (either decided by management or granted at the request of the individual); or exit from the organisation (resignation to take up another job, retirement or dismissal). These functions are represented in Figure 1 below.

[1] http://www.hrhresourcecenter.org/node/2985

Figure 1: Human resource management functions and events related to deployment



Each of these HRM functions will be governed by relevant policies and rules. Posting and transfer policies and rules relate to posting locations, periods and benefits. For example, in order to ensure the mobility of staff, the Ghana Health Service has a rule that "No one person shall be allowed to stay at a (new) post for more than four years continuous" (Human Resource Division 1997). Employees who have served in rural areas may get priority for promotion, as in the Nepalese health system (Nepal Law Commission, 2010). There may be arrangements for getting a joint posting for the spouse of an employee. There might also be specific allowances to compensate for working in less desirable locations (WHO 2010). If the government funds the initial training of employees, there will be rules governing the initial deployment of graduates, which may include a bonding arrangement (Frehywot, Mullan et al. 2010).

The implementation of deployment policies relies on the authority of those who manage the systems. The levels of authority may differ according to the type of staff. For example, in some countries doctors can only be posted by a central authority whilst lower grade cadres such as nurses may be posted at regional level. In decentralised organisational structures or where responsibility for service delivery has been devolved to local government, responsibilities for posting may be at district level.

As with the translation of any policies into action, the effectiveness of the policy will depend on the "implementation fidelity" of the relevant human resource management systems (Patterson, Rick et al. 2010). There is evidence in the public sector in both higher and lower income countries that the HR systems related to deployment can be inefficient (Vujicic and et al 2009, Davidson 2010). There is an increasing use of incentives to support the deployment of staff to rural areas (World Health Organization 2010) that would be administered as part of the deployment system. As with all

administrative systems, there are also sanctions developed to ensure compliance with the regulations. For example in Nepal, grounds for dismissal from service include: "If he or she does not serve for the period as specified [elsewhere in the regulations]" (Paragraph 74) (Nepal Law Commission 2010). The deployment system will include the appropriate management of these incentives and sanctions.

Because it can be very important to individuals to secure jobs in preferred locations (for personal or family reasons), implementation of the deployment policies according to the specified rules may come under pressure through patronage (Lewis and Pettersson 2009, Schaaf and Freedman 2015). This will of course undermine the objectives of the deployment policies and systems, which usually include increasing equitable access to health services.

Little research has been done on the specific HR systems for staff deployment in low and middle-income countries. A study carried out in Pakistan found that deployment systems were not sufficiently robust to withstand the pressures of political patronage (Collins, Omar et al. 2000). In the education sector in Ghana, Hedges found that as well as manipulation of the posting system by those who had influence, many new teachers simply did not report to their postings if they did not like them (Hedges J 2002).

In countries recovering from conflict or crisis, staffing problems normally found in low and middle-income countries may be exacerbated. Geographical imbalance of health workers between urban and rural settings is found in post-conflict settings (Newbrander, Yoder et al. 2007, Varpilah, Safer et al. 2011). An indication of the weakness of the systems after conflict or crisis is demonstrated by the rise in the number of ghost workers (Pavignani 2011). This is partly due to the collapse of information systems, including the lost or weak capacity of those concerned with collecting HR data (Waters H 2007). We found no specific references to deployment policies and systems in the health sector post-conflict/post-crisis literature (Roome, Raven et al. 2014). The recovery phase may also provide opportunities for not only rebuilding systems but also for correcting problems that existed before the conflict or crisis (Alonso and Brugha 2006).

1.2 Rural deployment in the Ugandan context

In Uganda, the decentralised system of governance is meant to 'bring power nearer to the people.' This literally means that communities, usually through their local councils, can moderate deployment mechanisms and develop local sanction systems that could theoretically improve the equitable distribution of health workers (Azfar, Livingston et al. 2006). However, this has proved very difficult in the post-conflict districts of the North, contributing to the significant staffing shortages at district level (e.g. over two-thirds of posts are vacant in Lamwo district (Namakula, Ssengooba et al. 2011).

Under the decentralisation framework in Uganda the healthcare system is typically organised based on a decentralised structure, with the District Health System (DHS) as an autonomous unit, and the Health Sub-district (HSD) being the operational or implementation unit. The District Health System can be viewed as a three-tier model (Ministry of Health 2010d): the District Health Office; the Health Sub-district; and a network of health centres. The DHS is headed by a District Health Officer (DHO) who is assisted by a team of health professionals, who together constitute the District Health Team (DHT).

At the second level, the DHS is made up of a series of Health Sub-districts (HSDs) whose administrative structure resembles that of the DHT (comprised of a medical superintendent, a hospital administrator, a nursing officer, an accountant and a personnel officer). At the third level, the HSD is surrounded by a

satellite of smaller health units usually referred to as health centres (HC). These can be health centre levels IV, III, II or I. The HC I concept is a virtual system with no physical structures but composed of a group of lay people normally referred to as Village Health Teams (VHTs) (Ministry of Health 2010c). The VHT is considered within the Ugandan health system to be the first point of contact. The VHT strategy offers a complementary healthcare delivery model; they have a mandate of advocacy, social mobilisation and communication. Village Health Teams comprise a cadre of workers that are informal in nature and are expected to function at the village level with no possibility of redeployment to another village or to follow any career path. Moreover, there is no defined sanction system for them and they are characterised by a high attrition rate.

Deployment of health workers at the remaining levels of care (IV, III and II) is usually dictated by the National Minimum Health Care Package (UNMHCP), defined in the Health Sector Strategic Plan (Ministry of Health 2010). The DHT and HSD teams are therefore mandated to deploy health workers depending on the level of care. Nevertheless, healthcare managers sometimes make the decision to deploy health workers based on other criteria that may suit a particular, local context. By definition, therefore, the health centre level IV is expected to function as a general hospital performing emergency obstetric surgery and blood transfusion services, thus necessitating the deployment of, amongst others, a medical doctor, registered midwife and laboratory technician. The health centre level III is expected to offer basic obstetric care, laboratory diagnosis and emergency curative services including temporary hospitalisation, which therefore requires the deployment of a midwife, laboratory technician and a senior clinical officer. Meanwhile, the health centre level II is essentially an outpatients' department, with a prominent preventive component and basic curative services requiring the presence of enrolled nurses and nursing assistants.

In practice, however, the situation may be far from the ideal, the dominant cadre of health professionals are likely to be the auxiliary nurses often referred to in the Ugandan context as nursing assistants, and enrolled nurses. Nursing assistants still head many health centres and the staffing levels may vary across the country from nearly 100% in the capital city of Kampala to less than 50% in most rural districts of Uganda (Ministry of Health 2006). The situation could have been worse during the conflict and immediate post-conflict periods in the affected regions of Northern Uganda. General hospitals in Uganda occupy a rather unique position within the District Health System. A regional referral hospital such as Gulu Hospital reports directly to the Ministry of Health, even when it doubles as a district referral hospital, therefore its relationship with the local District Health System and the District Health Office is ill-defined. This implies that health workers in the regional referral system cannot be redeployed anywhere else in the district other than to another regional referral hospital in the country for example to Arua; and this redeployment can only be done by the National Health Commission and the Ministry of Health. On the other hand, health workers in the general hospitals (formerly called district hospitals) all belong to the district local government, and are usually very senior staff with many years' experience, and are therefore available for redeployment. In many districts, however, these health workers tend to resist any transfers from the hospitals (which are usually urban-based) to rural health centres at levels IV, III or II. How this plays out within the post-conflict situation is one interest of this study.

More details of the decentralised structure for providing health services is given in the Results section below. Health service provision in Uganda is pluralistic, with several actors providing health care. The main care providers in Uganda are government, private-not-for-profit (PNFP) including PNFP

organisations, private health providers (PHP) and complementary health care providers (CHP). In Uganda, health services are free at the point of care in all public/government health centres but out-of-pocket expenditure for health contributes up to 50% of total expenditure for health. Maternal mortality is estimated to be 438/100,000 live births, child mortality is 54/1000 and neonatal mortality is 27/1000 live births. In Northern Uganda, frontline health services are provided by the government whilst specialised hospital care is mainly provided by PNFP through Lacor Hospital in Gulu and Amuru, Kalongo Hospital in Agago and St Joseph's Hospital in Kitgum. The backbone of the human resources for health for Uganda is comprised of medical officers, clinical officers, nurses and midwifes. However, there are other critical staff that are always difficult to attract to rural areas and these include medical officers, pharmacists and anaesthetists (Ministry of Health 2010d). The Health Sector Performance Report indicates staffing levels for all cadres at the local government level to be 69% (Ministry of Health 2016 (page 14)). In the same report, when staffing levels were assessed by cadre, nursing officers and nursing assistants were found to be in excess of the staffing norms.

Since 1986 there have been several political and economic reforms. The structural adjustment policy was introduced in 1993 whereby the government of Uganda was forced to reduce public services through retrenchment of public officers. At the same time, there was a ban on the recruitment of public servants. It was around this time that the concept of debt forgiveness for highly indebted poor countries (HIPC) was introduced. Under the HIPC, more finances were made available to the health sector, which saw the increment in finances for medical supplies. Within the framework of HIPC there was a temporary lift of the recruitment ban, leading to an increase in the recruitment of health workers. After the end of HIPC the recruitment ban returned into force, and remains in existence to this day.

1.3 The context of conflict and post-conflict in Northern Uganda

Between 1986-2005, Acholi sub-region was characterised by a protracted armed conflict. Populations were displaced into Internally Displaced People's Camps (IDPs) scattered across the Acholi districts of Amuru, Gulu, Kitgum, Pader and Agago, with the epi-centre of the conflict being in Gulu.
Several adaptations took place in the health service during the conflict period: health centres were closed because of insecurity and some of them relocated to the IDPs and were run by non-governmental organisations (NGOs). Health care professionals were equally displaced into larger trading centres, some fled the rural areas where the effects of the war were more direct, whilst others migrated to more stable, neighbouring districts. In Amuru, the supply of medicines was limited to bigger health centres. Supervision was limited. Lacor Hospital constructed barrier walls around the main hospital and the satellite health centres in order to provide security and to retain health workers at the facilities. When the insecurity intensified, satellite centres of Lacor were also temporarily closed and staff were redeployed to the hospital until the security situation normalised.
Since mid-2006, peace has returned to the region. Resettlement of displaced populations has taken place, the reconstruction of dilapidated health centres began and the recruitment and deployment of new health professionals started. The period of conflict and post-conflict provides the opportunity for understanding how health managers applied available human resource policies under a constrained situation.

1.4 Research questions and objectives of study

Evolution of the deployment process of health care professionals in post-conflict Northern Uganda has not been studied and systematically documented.

ReBUILD is an international research Consortium of academic institutions concerned with research on health system development in post-conflict or post-crisis countries. It aims at developing lessons for governments on how to make or recreate and sustain fair health systems post-crisis. Rural posting and deployment of health workers is part of the wider ReBUILD portfolio undertaken specifically to explore the effectiveness of deployment systems in Uganda, and in a parallel study in Zimbabwe, on getting and keeping staff in post. It is expected that the results of this study can contribute to the attainment of Universal Health Coverage (UHC) in post-conflict or post-crisis contexts. This study complements a second study on the health workforce that ReBUILD is conducting related to government health worker incentives in Zimbabwe, Uganda, Sierra Leone and Cambodia (Witter, Chirwa et al. 2012).

The aim of the study was to identify ways to improve deployment systems to rural areas used by large employers of health personnel in post-conflict and crisis contexts.

The specific objectives in Uganda were:

1) To describe the current deployment policy and systems in Northern Uganda and how and why they have changed over time since the emergence from conflict;
2) To assess the impact of the key changes in deployment policy and systems on the staffing of rural areas;
3) To identify useful lessons for policy-makers concerned with contemporary deployment issues throughout Uganda, as well as for an international audience interested in conflict/post-conflict contexts.

2.0 Methods

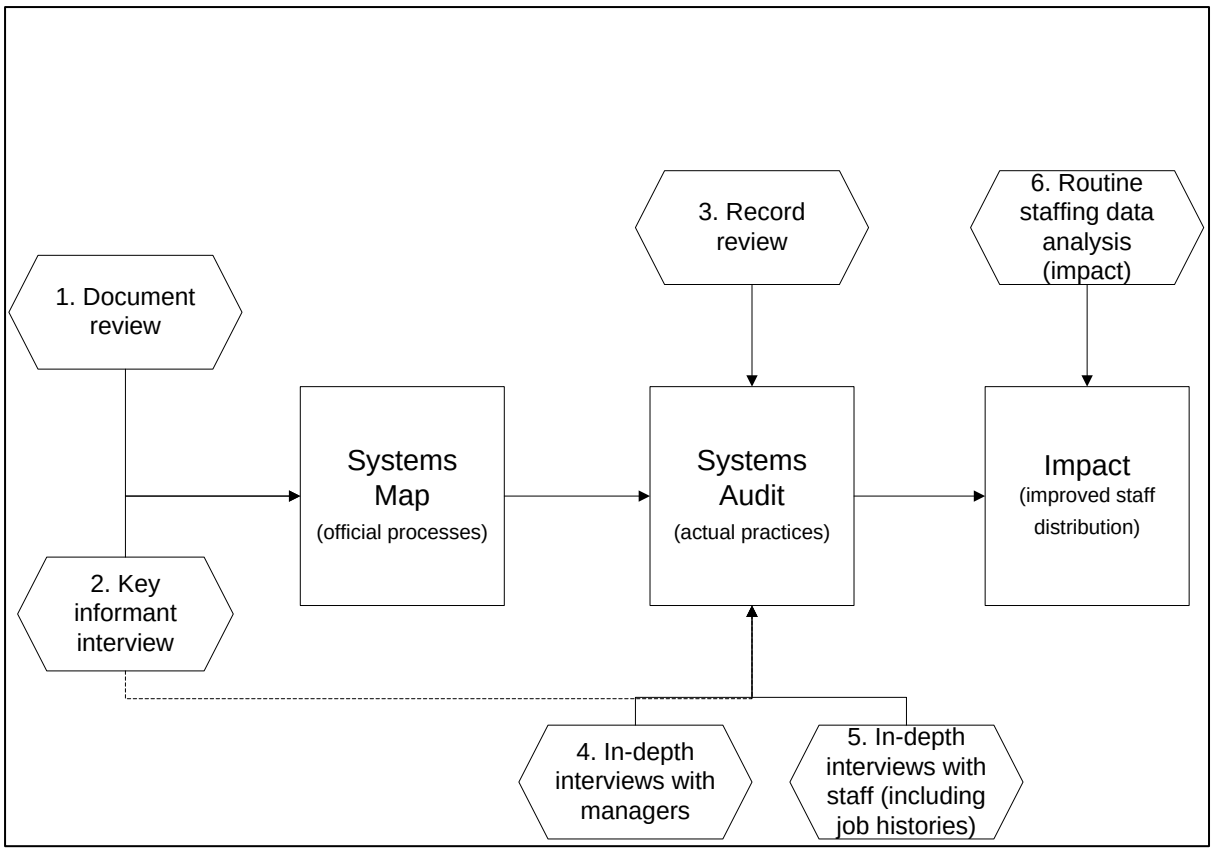
2.1 Study design

The study had a retrospective element to identify the deployment policies and systems in use during the conflict (1986-early 2006) and the post-conflict period (mid 2006-2013).

This research is organised as case studies of the three districts directly affected by the conflict, namely: Amuru, Gulu and Kitgum. Lacor Hospital as a large employer also operating satellite health centres was chosen as a comparator. The deployment policies and systems were examined as case studies for the government employer (the three districts) and the one non-state employer of health personnel (Lacor Hospital). This was undertaken in order to learn lessons from comparisons between how the non-state actor with a relatively large workforce spread across a number of facilities manages the challenge of deployment compared with public-sector health providers. The study used both qualitative and quantitative data collection techniques, allowing for the in-depth investigation of rural postings of health care providers within real-life contexts of the selected districts by looking at rural posting policies and systems over time. National policies and systems at different stages in the period under investigation were first identified from reviews of documents (Method 1), from which initial descriptions and systems maps were developed. National policies and systems were reviewed in key informant interviews (Method 2), to check for accuracy and realism. Contextual factors that may have influenced the development of the policies (e.g. broader public sector reforms) or the implementation of the systems were explored both in the document review and the key informant interviews.

The implementation of the deployment systems in rural areas, both in the past and the present day were "audited" using data collected via three further methods: personnel record review (Method 3), in-depth interviews with district-level managers who operate the systems (Method 4), and in-depth interviews with health workers, which included job histories to identify the impact of the deployment systems on individuals (Method 5). Method 6, a quantitative technique, was a review of routine staffing data meant to identify vacancy and turnover rates at different stages of the period under investigation, and to measure the impact of the deployment policies on the filling of rural vacancies. We planned to analyse routine staffing data (Method 6), in order to interpret this alongside qualitative data from Methods 2, 4 and 5. The structure of the different components of the research is summarised in Figure 2.

Figure 2: Overview of research methods and relationships with deployment systems map and deployment systems audit



2.2 Study setting

The study was based in three purposively chosen districts of the Acholi sub-region (Amuru, Gulu and Kitgum), selected as the most affected areas of the LRA conflict, where more than 90% of the people were displaced. Gulu and Kitgum districts are older districts, whilst Amuru was carved out of Gulu district in 2006. The selected districts have a mixture of both rural and urban characteristics: each has a municipality and rural characteristics, with the remainder wholly rural. The government employers and one non-governmental employer were included in the study. The non-government employer, Lacor Hospital, was selected following a visit to the field site and based on the following criteria: being a large employer of health personnel; having several health facilities and therefore having an internal labour pool; as well as showing willingness to be part of the study. St Mary's Hospital Lacor was founded in 1959, and is the largest private-not-for-profit (PNFP) facility in Uganda. It has a bed capacity of 482. Henceforth, St Mary's Hospital Lacor will be referred to as Lacor Hospital. The hospital operates three satellite health centres, in Opit in Gulu district, in Pabo in Nwoya district and in Amuru district. In addition, it runs a nursing school as well as a laboratory training school, and is also a training site affiliated to Gulu University Medical School.

2.3 Study population

The study population included: policy makers (national and regional), health service managers and health workers based at the district local government facilities and Lacor Hospital.

2.4 Methods of data collection

This section provides an overview of the research methods that were used. The methods of data collection are organised according to the specific objectives. The data collection tools are included in the annexes and the data collected is shown by the location and sex of the respondent where applicable in Table 1 below.

2.4.1 Sources of information/data for specific objective 1

Specific objective 1: To describe the current deployment policy and systems and how they have changed over time, since the emergence from conflict.

To achieve specific objective 1, the research team utilised the methods of document review and key informant interviews. These are explained in detail in the following sections:

2.4.2 Document review

In order to describe the deployment policies and systems, the reasons for their introduction, how they have been implemented and any effects of policy changes over the selected period, a number of current and historical documents (covering the conflict and post-conflict periods) were reviewed by the research team. These were:

- National HRH policies
- National strategic HRH plans
- Mid-term reviews of HRH plans
- Health strategic plans
- Specific deployment policies and operations manuals
- Annual health and HRH reports
- Civil service handbooks (e.g. general orders)
- Academic papers on staffing of rural areas.

Data collection: Desk reviews were carried out by the senior researchers. An initial list of documents was obtained and subsequently added to through a snowballing process of following up references and getting recommendations for further reading from the key informant interviews.

We conducted a document review to describe the deployment policies and systems, the reasons for their introduction, how they have been implemented and any effects of the policy changes on the staffing of rural areas during the conflict (1986 to 2005) and post-conflict (after 2005) periods.

2.4.3 Search strategy

Our search strategy was twofold: an online search of documents was carried out using the key terms “deployment” and “rural posting” for human resources for health from PubMed, Google Scholar, Google search engines/databases, e-health government’s library and grey literature, along with relevant government policy and non-governmental documents on human resources for health. Government documents retrieved were mainly reports (reviews and audits) and policy documents. PubMed and Google Scholar databases were systematically searched with language, publication and date restrictions (1986 to 2006 and after 2006) in October 2012. No restrictions were put on the study design. Using this strategy, thirty documents were retrieved by the research team. Half were grey literature (Ministry of Health , AMREF 2007, Iipinge S, Dambisya Y M et al. 2009, Mitchell-Group-Inc. 2009, WHO 2009, Awases, Nyoni et al. 2010, Cicciò, Makumbi et al. 2010, Kiapi 2010, Matsiko 2010,

Ministry of Health 2010b, Bertasi 2013, Seifman R, Bailey R et al. 2013, Intrahealth-Uganda 2014). Eight of the documents were original research articles (Matsiko and Kiwanuka 2003, Lethbridge 2004, Ssengooba F, Rahman S A et al. 2007, Nguyen L, Ropers S et al. 2008, O'Neil 2008, O'Neil and Paydos 2008, Spero, McQuide et al. 2011). These were mainly cross-sectional in nature with a strong retrospective focus. There were nine national level policy documents (Government of Uganda 2006, Ministry of Health 2006, Ministry of Public Service 2006, Ministry of Health 2008, Government of Uganda 2010, Ministry of Health 2010a, Ministry of Health 2010c, Ministry of Health 2010d, Government of Uganda 2012). All documents were saved and registered in the EndNote software library whilst capturing the following details from each document: document title, authors/institution, commissioning institution, journal title, issue, volume and page number, publisher, URL and access date, date of publication, status, inclusion, the name of the reviewer and the date of review.

2.4.4 Key informant interviews

Key informant interviews were conducted to help clarify the documented information on the deployment policies and systems, to identify contextual factors that may have influenced the development of the policies or the implementation of the systems. The key informant interviews further helped the research team to identify and enable an assessment of the effectiveness of the rural deployment and posting systems of large governmental and non-governmental employers of HRH during post-conflict or post-crisis periods and the time immediately prior to that.

Sample size and sampling methodology: Key informant interviews from national down to local level for both government and non-government employers were purposively selected, according to their knowledge of the focal topics. At national level, these included the HR department for the Ministry of Health, Public Service and Health Service Commission, whilst at district level, key informants included officials from the District Service Commission, Planning Unit, Personnel Unit, directors and managers of Lacor Hospital and officers from NUNITES programme.

Table 1: Data collection by location and sex

Type of interview	KII (female)	IDI manager (female)	IDI health worker (female)	Routine staffing data: # health centres	Personnel record (female)
District					
Kitgum	5 (2)	3 (0)	6 (2)	18	21 (12)
Gulu	4 (0)	2 (0)	7 (3)	33	20 (12)
Amuru	5 (1)	2 (0)	7 (3)	27	19 (10)
Lacor	0	3 (2)	5 (4)	4	21 (14)
Central	9 (3)	0	0	0	0
Totals	**23** (6)	**10** (2)	**25** (12)	**82**	**81** (58)

Data collection: The key informant interviews were conducted using a semi-structured guide and focused on the following topics:

- Clarification of the deployment policies and their implementation during the study period
- Key changes in the policy context (e.g. major reforms)

- Policy iterations (whether any lessons were learnt along the way and acted upon)
- Clarification of the draft deployment systems maps developed on the basis of findings from Method 1
- Synergies or dissonances between interventions
- Implementation experiences, constraints and lessons.

2.4.5 Sources of information/data for specific objective 2

Specific objective 2: To assess the impact of the key changes in deployment policy and systems on the staffing of rural areas.

To achieve specific objective 2, the research team used the methods of routine analysis of staffing data, personnel records review and in-depth interviews for managers and health workers (including job histories for health workers).

Sample size and sampling methodology: The routine staffing data for four cadres (medical officer, nurse, midwife and clinical officer) in government service as well as from the non-governmental employer were collected in each of the study districts.

Data collection: The data was collated by year for the defined period using structured data extraction forms. Four key cadres were selected for inclusion (medical officer, nurse, midwife and clinical officer). These were selected because they form the biggest percentage of the health workforce and are commonly found at facilities whereas other cadres such as radiologists and gynaecologists are rare, and are generally posted at regional referral hospitals. Where possible, data has been disaggregated by sex.

The indicators included:

- Staffing numbers for key cadres and proportion of filled posts (where applicable)
- Length of posting
- Attrition rates (staff lost per year)
- Turnover rates.

2.4.6 Personnel record review

Personnel records were examined with the aim of identifying actual posting practice. A sample of personnel records were reviewed to identify posting histories (dates, locations of postings and further training and promotion) for comparison against stated policy.

Sample size and sampling methodology: For medical officers, nurses, midwives and clinical officers in government and selected non-government service, the personnel records were sampled at district level in each of the study districts. Our aim was to stratify the sample according to the length of service to ensure that the impact of current and previous deployment policies can be observed. The length of service data was grouped as follows: up to two years, three to five years and more than five years. A sample of 10% of records within each grouping was reviewed.

Data collection: The data was collated by length of service group using structured data extraction forms (a sample is given in Annex iii). In addition to data on date and posting location, information on further training (dates and qualification) and promotion (dates and grades/job title) was collected if

relevant to the deployment policies identified in Methods 1 and 2. Data on the sex of the employee and, if relevant to the policy, change in marital status was collected.

2.4.7 In-depth interviews with managers

In-depth interviews were conducted with managers to explore their perceptions and experiences of implementing the deployment policies and systems during the study period and the impact on vacancy rates and turnover in rural areas.

Sample size and sampling methodology: District level managers for government organisations were selected from three selected study districts: Gulu, Kitgum and Amuru. Hospital managers were selected for Lacor. The overall manager and the officer responsible for deployment were selected for interview. Ten in-depth interviews were conducted (Kitgum=3; Gulu=2; Amuru=2; Lacor=3). If either was very new, an older member of the management team was selected to provide a historical perspective.

Data collection and analysis: In-depth interviews were conducted with managers in selected districts using an open-ended topic guide and the systems maps developed as a result of Methods 1 and 2. A topic guide was used to shape the discussions with district managers, covering the following areas:

- Changes in vacancy levels and turnover over time and possible explanations (commenting on routine data if available)
- Changes in deployment policy and systems and the perceived impact on vacancy levels and turnover
- Changes in wider policy context (e.g. general organisational reforms) and possible impact on vacancy levels and turnover; how they enrolled into nursing and medical training institutions to became health workers.

2.4.8 In-depth interviews with health workers

In-depth interviews, which included job histories, were conducted amongst health workers to explore their perceptions and experiences of the deployment policies and systems and their evolution over time.

Sample size and sampling methodology: Four key cadres were selected for inclusion (medical officers, nurses, midwives and medical auxiliaries). The health workers were selected from the same districts as the managers for Method 4, for government and non-government employers at different levels of facilities.

A mixture of staff with longer service (at least five years), and newer recruits to the district were selected to provide a balance between historical information and the effectiveness of the deployment system for bringing new staff into districts. The selection of study participants was meant to ensure a gender balance to find out whether the policies and systems impacted differently on men and women. However, of the staff available for interview nearly all of the medical officers and clinical officers were male, and almost all nurses and midwives were female. Twenty-five in-depth interviews including job histories were conducted. Participants included were male and female of different cadres from government and non-government employers, based at different levels of health facilities and with short or longer lengths of service.

Data collection: In-depth interviews were conducted with selected health workers using an open-ended topic guide. Questions were asked to reflect the conflict and post-conflict period and highlight other differences in the public compared with the private provider. The topic guide covered the following areas:

- Changes in vacancy levels and turnover over time in facilities, where they have worked and possible explanations
- Knowledge of changes in deployment policy and systems and perceived impact on vacancy levels and turnover
- Perceptions of the fairness of deployment policies and systems at different stages of their employment
- Job history – for each job:
    - Job title, location (district and facility type) and start and end dates for each job held
    - Administration, explanations given for change of job (including reference to posting/transfer instructions)
    - Personal efforts to secure a change of job (whether successful or not)
    - Future job plans and perception of whether the current deployment policies and systems will support these plans.

For job histories, health workers were asked to give information about previous postings as far back within the study period as possible, and to provide their perceptions of the factors that led to these job changes.

2.4.9 Training of research assistants

The research tools were piloted in the non-study district of Agago before the actual field work. A team of experienced research assistants were contracted and trained to use the tools and were supervised by the senior researchers.

2.4.10 Data management and analysis

Analysis of data from document reviews (under specific objective 1) was based on simple content and time series analysis. The main output was a narrative of the evolution (featuring timelines and systems maps) including a description of the deployment system at various points in time and an assessment of the rationale for changes if any to the systems of rural deployment and posting over time.

For key informant interviews, in-depth interviews and job histories, participants' responses were coded and grouped by themes related to the research questions. Thematic analysis using *Atlas.ti*[2] was carried out on transcribed texts.

With regard to data analysis of staffing data we planned to analyse this by describing the trends in health worker availability and distribution during the study period and matched to changes in deployment policy. Data would be disaggregated by geographical location (urban/rural) and by sex, cadre and level of facility.

Data analysis for review of personnel records would be analysed to correlate posting history with posting policies and systems in place at the time of each move. Data would be disaggregated by geographical location (urban/rural), type of facility and by the sex of the health worker and level of cadre.

[2] www.atlasti.com

Summaries for topics generated in the thematic analysis were entered into a spreadsheet first by district (district KIIs and in-depth interviews). A summary by topic was then generated across the three districts and with the addition of the national KII summaries. A single step was required for summarising different data sources for Lacor. Finally, the summaries for the government employers (district councils) and Lacor were compiled for comparison[3].

[3] This process was managed using a series of spreadsheets in Excel. Data was only entered once, but automatically copied to subsequent sheets to enable comparisons to be made by district and subsequently by employer.

3.0 Results

The results are presented under themes derived from the analysis in two parts. Section 3.1 describes the context and changes over the study period relevant to the deployment of health workers in the study settings. Section 3.2 describes the changes in the human resource management function related to deployment at policy and implementation levels. It also provides some anecdotal evidence of the changes in staffing in rural areas over time, though it was more difficult to identify or attribute these effects to the key changes in deployment policy and systems.

3.1 Context

This section discusses the context related to deployment policies and practices, beginning with the changes related to the working and living environment of health care staff. This includes the terms and conditions offered by employers affecting the labour market which will be subsequently explained. Finally, the major policy changes in local government and Lacor that affected human resource management in general and deployment in particular, which for local government was the policy of decentralising the provision of government services to district councils, are described.

Central level staff said that during the conflict, there was a breakdown in societal norms, e.g. men and women engaged in multiple relationships, rape was commonplace, villages were disintegrated and people were confined to living in camps. An Amuru leader said that community leaders did not distinguish between centralised and decentralised systems. HWs preferred to work in their home areas so they could support their family members. In the post-conflict period in Gulu, NUHITES had hired an assistant DHO, an environmental health officer and some nurses.

> *"The social break down, some men had to marry other wives and other wives had to get married to other men and then others were raped by the rebels, others were whatever of course you know what it all accumulates to." (**p4 central PPO MOH**)*

3.1.1 Working environment and living conditions

During the conflict, there was a breakdown of nearly all aspects of life as described by one central respondent. This included widespread fear so that critical staff were scared away, the breakdown of infrastructure (such as health centres), and the disintegration of communities, villages and families. People were confined in camps, could not fend for themselves and relied on handouts. A respondent from Amuru suggested that meaningful deployment was not possible and several HCs closed. Another from Gulu said they gave regular encouragement to staff so that they did not leave the HC. In Kitgum, health workers were harassed, accommodation was lacking, accessing pay from town was difficult and it was not possible to conduct night duties. Even in the post-conflict period, staff are still arriving late to work**:**

> *"Ok, well during the insurgency period certainly there were a lot of system break downs and families were disintegrated you find that during that period, people were in confined places in the IDP entirely, displaced camps. So, it was a bit difficult for health workers to even accept to be deployed in areas which are affected by war so because you don't know what's happening; people fear for their lives."* (**p5: central KII MOLG)**

In Gulu, local government construction of staff accommodation began during the conflict period with anticipation of this being used post-conflict.

During the war, Lacor Hospital too was insecure, because the ongoing fear that rebels would come and abduct health workers and steal supplies such as drugs scared staff members away.

> *"They would come through the gate and they would go through the store, they would collect drugs and other items they go to the bush. They would take the sisters to the bush and then they would come later." **(p54: life hist. midwife Lacor Hospital)***

> *"The distance is very far from social places, like you find yourself in a place where you cannot even buy salt, soda there is even no school for your children, so there are not social amenities. The rural areas do not have schools right from nursery to secondary and you find a health worker with children who are supposed to be school going so if you say am now taking you to this place far away in the rural areas, they will definitely have issues." (**p12 district planner Amuru**)*

In the post-conflict period, staff from Lacor reported that the hospital uses seven-hour nursing shifts, however the nurses are complaining that they do not have time for themselves, comparing their situation to that in public facilities where some staff report late to work and leave early without reprimand.

3.1.2 Labour market

Dynamic labour market

Central level respondents say that critical staff such as medical officers, pharmacists, midwives and anaesthetists fled the region during the conflict, and rarely did those posted to affected areas take up their positions. Those that did report for duty soon left. Key informants from Amuru acknowledged the difficulties with attracting MOs especially.

During the conflict the growth of NGOs providing services led to an increasing demand for health workers from a limited labour pool. In Amuru respondents[4] reported that during conflict, staff found jobs with NGOs. Similarly, in Gulu, HWs were attracted to NGOs where they were better paid. Two managers from different districts explained the impact on the labour market:

> *"*[a] *negative effect of having many powerful NGOs in the region is that they compete for the same health workers who should have been rendering services* [in public service]*. These health workers are recruited as advisers, project officers, project managers so that they are taken away from giving clinical service to patients, instead to doing administrative work. And most of the people left the government job for NGOs because of the salary or the wages … you know the government salaries are just meagre ……."* (***p24 DHO Amuru***)

[4] During they conflict they were part of Gulu district

> "*They* [health workers] *were paid better by partners and, as I said. They opted to work with World Health Organisation, IMC which was paying better. These people* [NGOs] *were paying better, may be five times the salary government would offer. They opted to go there." (**p20 ACAO Kitgum**)*

It was most difficult to employ health workers whose skills were in the highest demand such as doctors and clinical officers:

> "*Basically, the clinical officers and doctors were nowhere, we couldn't get the doctors, even the ones that would be sent here would just turn down the offer. If you look at our staffing, you would find the lower cadres like the askaris, compound cleaners, nursing assistants those ones are there but the nurses were countable, we had only two doctors, one was a DHO and one in charge of Attiak HC IV." (**p12 district planner Amuru**)*

At this time, there was an active process of attracting health workers from local government to NGO services. This was explained by one health worker who was based in a rural health centre and was enticed to join the NGO. Sometimes, government officers attempt to make the best of both worlds if their employer cannot enforce regular attendance/avoid absenteeism, by retaining their government post whilst working part-time within an NGO. However, this further speaks to the orientation of 'survival' during the conflict.

> *"They* [TASO] *had activities in my health facility i.e. Bobbi HC III so eventually I started working with them. Because I liked my work, the branch manager picked interest in me and actually offered me a place but I consulted so I got advice from some other friends who tried to highlight to me on the benefits that I would get in working in the government than those in the NGO like TASO. Besides it would develop my administrative talent so it was out of that advice that I decided to continue with the government. I didn't pick up that offer so I told them that I can only part-time with you but I cannot completely leave government." (**p38 life history CO Gulu**)*

Although there was competition for staff between LG and NGOs, in Amuru, NGOs still supported the LG in the areas of water and sanitation as well as the training of staff. In Gulu, district officials said international NGOs complemented health workers employed by local governments by providing incentives such as food, allowances, training and sponsorship for further training during the conflict period. In Kitgum, some NGOs supported hospital staff to make outreaches. Some NGOs were providing direct services in camps, and supplying medicines.

> *"During the period of the war there were a number of NGOs in this district in Gulu most of them were supporting the health sectors in terms of putting up infrastructures, building the staff houses, building the health facilities for example maternity, OPD* [outpatient department] *and the rest so they contributed quite a lot. During that time, we were able to achieve much more in terms of infrastructures. When you move to the different facilities, you find most of them were put by our development partners or the NGOs." (**p18 sect. for health**)*

Stabilisation of the labour market

Towards the end of the conflict and immediately afterwards, the NUMAT organisation seconded their own staff to work in the DHO's office. In the post-conflict period NUHITES also followed suit..

> *"We have NUHITES the USAID program, recently* [post-conflict] *they supported us and we recruited three nurses and they will be in position to pay those nurses. It is on a contract basis … They give the safari* [a trip made out of duty station] *day allowance. The district will be in charge to make sure that they are doing the actual work." (**p17 DSC sec. Gulu**)*

> *"… we used [conflict period] to have; Medicins Sans Frontieres* [MSF], *that was supporting Lalogi H.C IV and Awor. When they left, everything was absorbed into the system, currently we have NUHEALTH that has assisted us in recruiting assistant DHO in charge of environmental. Uuh … and a few staff. Then NUHITES is also bringing in [recruiting more staff], these are staff they have supported. Staff like enrolled nurses and enrolled midwife who are on contract, so these are some of the people who have been seconded* [from NUHITES to local government]*." (**p27 HRH Gulu**)*

Nevertheless, all health workers were benefiting financially from the external funding for interventions, for example for attending workshops, although such workshops could sometimes be disruptive.

> *"I would say that when partners were carrying out a lot of interventions, there was also a lot of money in the hands of people because at least they would pay you allowances you go and do your work and it was creating a big challenge again with the population because you find that a staff may remain in the town for two–four days. He is attending this workshop, tomorrow he is in another workshop, the other day he is in another workshop so that was another challenge but to them it was okay because they were drawing allowance as a result of being in town." (**p20 ACAO Kitgum**)*

In addition, financial benefits accrued in the form of allowances which were paid by NGOs during war time, and this has continued even after the post-conflict period:

> *"what happens is NGOs normally participate actively in training of staff for example currently NUHITES is doing a lot of it, then there are other projects like safe medical circumcision, that is ongoing at the moment and these, I do not say affects deployment but it is like a motivating, uhh … what motivates others because they get this extra pay for this extra service they give." (**p27 HRH Gulu**)*

During the conflict, there was also some migration of local government staff to PNFPs based in towns for reasons of security. At the same time, whilst staff were migrating away from LG to PNFP, others were migrating away from PNFP to NGO employment which still paid a better wage. For example, one officer said that he left Lacor Hospital for an NGO job that was paying about four times the wages in Lacor.

> *"I looked at the kind of money I was getting in Lacor and compared with the work that we were doing. The work in Lacor Hospital was too hectic with too little money. In 2004, a friend called and told me that the International Medical Corps wants a clinical officer who can be deployed at the therapeutic centre in Pajule* [Pajule is located in Kitgum district] *and you will be paid eight hundred thousand shillings (800,000/=). In Opit Health Centre* [operated by Lacor Hospital] *I was earning only two hundred twenty-five thousand shillings (225.000/=)." (**p39 CO life history Gulu**)*

Managers at Lacor said that NGOs came to poach their staff with offers of better and more attractive pay. This practice continued after the conflict, although the NGOs were far fewer in number.

> *"And also, these NGOs have not spared us the international organisations which come in contact with our staff, somehow they poach on our staff and we are not able to compete with their salaries so when they come in contact with our specialist the next time we know the specialist is gone." (**p53 Inst. Dir**)*

However, during the conflict Lacor managed to retain many hardworking and committed medical officers, nurse and midwives, partly because of available accommodation.

During the post-conflict period, respondents reported that more staff have reverted to public service since most of the NGOs were shutting down their offices, and that some organisations, with donor funding, are actually collaborating with LG to recruit and post staff to the latter. For example, bilateral (USAID) and multilaterals (UNICEF) recruited more staff for Gulu on contract terms. Some HWs from LG worked part-time with NGOs. HWs said it was better to work with an NGO than for PNFP because of the latter's heavy workload. During the post-conflict period, NGOs were supporting LGs with fuel to run their cars and conducting outreach programmes; and also provided support in running advertisements for vacancies in the LG.

Nevertheless, as one key informant reported, local governments faced an additional challenge of a national recruitment ban during the post-conflict period (from mid-2006 to date). Even medical officers had to find jobs within the NGO sector before they would eventually get absorbed into the local government.

> *"I completed my internship from 2009-2010 in Gulu Referral Hospital. From there I worked with Marie Stopes Uganda for four months, three months in Gulu branch and one month from Pader i.e. from November 2010 to February 2011. From there I joined Reproductive Health Uganda Gulu branch as a senior medical officer, I worked for eight months. I enjoyed the work at Reproductive Health Uganda, because they were paying me 2.5million per month. The job contract was for nine months."* (***p48 life history MO Kitgum***)

The most difficult posts for both the PNFPs and local government to keep filled were the medical officer roles, both during and after the conflict. In Kitgum, NGOs were blamed for recruiting from among LG employees instead of recruiting from newly qualified staff. Central officers say that it was more challenging to manage a supply of highly qualified staff compared to the less qualified staff. For example, medical officers are said to be very unstable at their jobs compared to lower cadres such as nurses. The former are likely to find other job offers compared to other cadres, suggesting that they are more unpredictable in terms of staffing rural health centres.

> *"Of course staff turnover, there are so many dynamics that were in play here because much as the place has become peaceful, there are other things which have come in, the money has gone away, so now people move with virtue of that. In the hospital where I worked if I am looking at doctors, the time when we had the conflict I would see doctors come, they would work, but now following the post conflict, again there are so many projects which have come up on board, HIV projects and so on, so the project funding has actually also contributed to the destabilisation of staff so you will find that when a staff comes again inevitably there is an offer somewhere and they leave. Right now the government is in a recruit drive and so on, so if you look at all these, it becomes very difficult to attribute staff turnover to the war or the new interventions which are happening now; true I will believe that depending on the level, and the lower levels people become stable but at the higher levels, say doctors, clinical officers and so on, it becomes a bit versatile."* (***p9 central UPMB***)

> *"The turnover is low but save for medical officers. We recruited two medical officers recently and one left immediately after about eight months for this NGO called Marie Stopes. The second one also wanted to leave but he was convinced* [otherwise]. *Before the introduction of this allowance* [hardship allowance] *the district used to pay medical officers what they called consolidated allowance of five hundred thousand shillings top up, but eventually that source of fund became very little so the district stopped it because there was low revenue base at that time* [during conflict] *That is why I am saying that I am worried once the central government stops paying the hardship allowance, something will happen."* (***p19 records Kitgum***)

During the post-conflict period, staff retention has improved with better security. The human resource officer for Gulu district said that staffing levels improved from 40% during conflict to 87% post-conflict.

> *"At the moment* [2013] *we have more people showing interest, we are having more vacancies filled compared during the conflict period*." *(**p10 Amuru ACAO**)*

> *"Now after the conflict civil servants have gone back to government health facilities. I think the biggest challenge we have now is the turnover in PNFP, while they were able to retain health workers during conflict when nobody was willing to stay in the government facilities now people are willing to stay in the government facilities. So, the issue is causing a higher turnover from this side* [PNFP] *to the other side* [government] *people moving away." (**p8 central UCMB**)*

Cadres such as nurses and midwives were considered to be more stable at their jobs compared to clinical officers who were more sought after in the job market.

> *"When you are clinical officer, you can get employment in other health centres. They could just leave and go to other health centres but with midwives and nurses they would ask that where will I go? What will I do? Let me just dare and continue." (**p14 sec for health Amuru**)*

The labour market is not only influenced by pay and allowances formally offered by employers, but by other opportunities of generating income. During the post-conflict period the economic situation has not changed very much. Respondents in Kitgum said that people could not engage in economic activities and depended on handouts and donations, and that the cost of living was very high.

The local government policies seem to be silent about dual practice as a source of additional income for staff in local government service. For example, in Kitgum, one officer is doubling as a privately contracted surgeon to provide services to an NGO. The same officer is trying to set up a private practice.

> *"Right now, I am practicing in Kitgum and at the same time I am creating my clinic. I have done work with Pathfinder* [an NGO] *for one-and-a-half years and every month I dash there and work for three days … providing family planning among HIV-positive clients. I am the contracted surgeon performing vasectomy and permanent tubal ligation* [for Pathfinder]*." (**p48 MO Kitgum**)*

The rules in Lacor do not permit dual practice. This rule has been in force throughout the conflict and post-conflict periods. The administration in Lacor considers that dual practice may lead to a conflict of interest within their staff. From available data, we could not confirm the degree of enforcement of the rule prohibiting dual practice. In Lacor, salaries can only be supplemented through extra assignments offered by the hospital. However, they are considering the formation of a private wing which the doctors can use in order to earn an extra income. These proposals have to be presented to the board of directors of the hospital for consideration before approval, and at the time of publication the outcome of this proposal is not known.

> *"We have a policy; there is a rule in the employment manual that all the employees in the hospital especially the medical workers: you can't run a drug shop or a clinic etc. so some of them think that this is a hindrance in supplementing their income whereas if they were working for a government facility, these rules are not applicable." **p51 personnel officer Lacor**)*

> *"I have a feeling that maybe we could do private practice within the hospital. Our board is looking at this and we have not yet reached a stage where we want to open this. Maybe in the future it is something that could change, so I think those are some of the complexities that I have." (**p53 Inst. Dir Lacor**)*

3.1.3 Decentralisation

The management of health services and health personnel throughout the health system was the responsibility of the Ministry of Health prior to decentralisation. This changed with the passing of the Local Governments Act of 1997, which gave local government the responsibility for medical and health services within the district. Local Government (LG) services are the responsibility of the Chief Administrative Officer (CAO) of the District Council. District Health Officers have to report to both CAO and the MOH. The responsibilities at district level include "recruitment and management of personnel for district health services … [and the] district administrations are responsible for the human resource management functions in the district, through the personnel office. These personnel offices will be strengthened to ensure that capacity for the required personnel functions for the district health

services will be present." (Ministry of Health 2006 p19). The implementation of the human resource management functions is the responsibility of the District Services Commissions for all decentralised government services which "recruit, appoint, promote, retire and discipline staff, including health staff, in the districts. The Commissions also consider and approve study leave for local government public officers and advise the Chief Administrative Officer on matters of training for local government employees" (Ministry of Health 2006 p21).

The specific findings of deployment-related systems and decentralisation will be reported in section 3.2, though some of the perceptions of managers and staff related more generally to decentralisation are reported in this section. The central level managers lament the loss of control over the health workforce since they have been unable to act even when they noticed apparent staffing gaps within local government. Since hiring of staff is the mandate of local governments, central government is unable to deploy to the former, even when they notice a need for recruitment and deployment in a particular area, as was suggested by a central level officer. The health managers and health workers at the district level complain that decentralised systems are open to abuse by the responsible officers, who can recruit relatives and friends or people of the ethnicity of the relevant local government. However, for local politicians and district leaders, decentralisation is considered to be a good policy that gives them the autonomy to solve their own problems.

Some officers are discontented with the decentralised system because they feel that it constrains them to serve in one locality, unlike in the centralised system where a staff member would be posted to serve "anywhere" in the country. Posting to different parts of the country can provide exciting career opportunities, as expressed by one of the district officers.

> *"I am not comfortable with that system of decentralisation. Decentralisation limits someone's development and people will never appreciate your abilities yet it's good also to share your experience with other people from different regions, that's what it means to serve the nation. But here I am stuck; if you were under the Ministry of Health I would be posted to Mubende or elsewhere but now I am narrow-minded." (**p26 DHO Gulu**)*

In a decentralised system, local governments are likely to favour and give preference to staff who hail from the same district in cases of recruitment, postgraduate training or promotions and transfers.

> *"One of the challenges of decentralisation is you know people tend to recruit the local people of that area. Normally local people are given the priority, sometimes favouring those without substantive qualifications for a particular job. Sometimes, when a person from that land does not have the necessary qualification and they don't advertise. Instead, they keep an officer in acting position until the preferred officer has qualified from training…because people think decentralisation means everything has to be local including its employees." (**p22 ADHO Kitgum**)*

However, these concerns about the decentralised system may not be limited to the conflict or post-conflict region only, but could represent similar views held elsewhere in the country. One central government official said:

> *"But another challenge [with decentralisation] is that it has somehow localised things; people have said you know when it comes to recruitment the issues of sons and daughters of soil has been highly pronounced. So, from short listing,… if your name is not matching with the common names in an area then they will say ''where is this one coming from?"* ***(Central MOLG)***

In the case of Lacor Hospital, they contend that operating alongside a decentralised system is a welcome idea, but they suggest that the systems of collaboration between LGs and Lacor should be streamlined. It is not clear to Lacor Hospital whom should be contacted within local government in order to receive their allocation (whether CAO, MOH or MoF). Sometimes this process has been frustrating to managers at Lacor Hospital.

> *"Well for me decentralisation should work well if all the procedures are followed to the dot because us Lacor Hospital we had difficulties in the beginning, we were receiving money from the centre then the finances were transferred to the local government. But, we find it extremely difficult to trace up money at the district. It does not reach us, we don't know who to talk to; you go to the CAO they tell you this is for finance department to handle, you go to finance they tell you we don't know, this is ministry of health to handle, you go to ministry of health they say it's treasury so … nobody has the answer ……. But last year there was a bit of improvement though the money of the first quarter came with the money of the second quarter…. money for third quarter and fourth quarter came together in fourth quarter. So, the disbursement is not timely. Those are some of the difficulties we face with decentralisation." (****p53 Inst Dir Lacor****)*

3.1.4 Human resource management in Lacor

In Lacor there was a shift in human resource policies after establishing the human resources department during the post-conflict period. Recruitment processes and appointments were regulated through interviews and written appointment letters and managed by a human resource officer.

3.2 Changes in the human resource management functions related to deployment at policy and implementation levels

This section describes the changes in the human resource management functions. It is divided into three broad areas and deals with the related deployment functions in each (see Figure 1 above):

1) Getting new staff into their first posting (recruitment – including in some cases training and bonding, selection, appointment, initial posting, induction and probation).
2) Development whilst in post (post-basic training – and bonding and promotion).
3) Subsequent staff movements (temporary or permanent) from the first posting (secondment, transfer and exit, which includes resignation, retirement and dismissal). However, exit from the system is considered to be beyond the scope of this study.

The findings on the changes in policy response are followed by changes in how policy was actually implemented – first for local government employers and then for Lacor. A general finding about the deployment polices for both local government and for Lacor was that they were generally gender-neutral with certain exceptions.

3.2.1 Recruitment

Local government policy
During the pre-decentralised period, invitations to staff for interviews were conducted over the radio and deployment was effected directly from the Ministry of Public Service to the recipient health centre or hospital.

Following decentralisation to local government, the guidance given is that "respective responsible officers shall, upon receipt of clearance from Ministry of Public Service (MoPS), submit requests for filling of the vacant HR post(s) to the respective District Service Commissions using guidelines issued by the MoPS and PSC; ([page 4-5] (Government of Uganda 2012). The term 'responsible officers' at the health service at district level refers to the District Directorate of Health Services (WHO 2009). No change of policy on recruitment was made as a result of the conflict and post-conflict periods.

Local government practice
Although the policy permitted local governments to recruit their own staff, during conflict it was not possible for LG to hire new staff due to security problems. Moreover, fewer resources were sent from central government to the local level. After the conflict, local governments implemented the policies, including the hiring of staff.

> *"Those policies of decentralisation were affected by insecurity, but right now with improvement of security, those policies are now being implemented, the decentralisation is being implemented at all levels, when you come to health workers, there is that liberty now, we recruit health workers locally." (**p11 DSC chair Amuru**)*

> *"Yes, we have a functioning District Service Commission and we are using the decentralisation policy in the implementation. It is not a locally-made rule, but under decentralisation policy, districts are supposed to render services. And in rendering services they should equitably distribute health workers to provide services including rural areas." (**p24 DHO Amuru**)*

Advantages and disadvantages of decentralised recruitment were cited by different groups of respondents. Central officers spoke of the advantage of attracting locals to work in their home areas where staff will feel accountable to their own people and can rely on socio-family networks for support. However, in Amuru, some staff reported a heavy family pressure when working in their home locations which made it difficult for them to focus on their work.

When district councils did start recruiting in the post-conflict period they had difficulty in advertising their vacant posts. Therefore, with the support of development partners, central government made a joint advertisement for the different districts in the post-conflict region to attract candidates and then each District Service Commission carried out the shortlisting and interviews. This was a central government strategy to staff post-conflict areas which were considered to be "hard-to-reach" zones.

> *"Central government and our partners* [NGOs operating within the local government] *decided that we can make the recruitment process move faster if the recruitment is going to be countrywide then they do a central advertisement so that one advert covers*

> *vacancies in the different districts in order to make the recruitment process to move a little bit faster. It happened for the last recruitment. All advertisements for all the districts were done centrally." (**p24 DHO Amuru**)*

The drawback with centralised advertisement is that some staff make multiple applications to more than one LG. Multiple responses to job adverts gives a false impression of an overwhelming response to job vacancies to the local government officials. Staff make multiple applications in order to improve their chances of getting a job, since each local government independently hires staff according to the decentralisation policy. Most of the time those that apply to multiple districts are then short-listed for interview within the different districts and end up with multiple appointment letters, meaning that one health worker could receive job offers from two or more district local governments.

> *"I submitted job applications to Amuru and Kitgum district. I wasn't sure of getting a job so I tried both districts but good enough I succeeded in both districts. Yes. They called me for both and I did the interviews." (**p49 life history nurse Kitgum**)*

The local governments' recruitment of staff is compromised by limited finances, not just for recruitment but for interesting candidates in roles located within less attractive districts. Sometimes NGO interventions (for example NUHITES, World Vision) supported staff recruitment in the districts of Amuru and Kitgum. The staff recruitment conducted by NGOs was done during the post-conflict period, as governmental and non-governmental attention was shifting away from emergency to recovery under the Peace, Recovery and Development Programme (PRDP) for Northern Uganda. Under this arrangement, staff are recruited through the District Service Commission but are offered short contracts until a later date when they can be formally subsumed into the permanent and pensionable scheme of the local government.

> *"We have a few NGOs helping us to pay up the health workers' wage - they recruit using the District Service Commission and then they pay up. This is boosting our human resource." (**ACAO Amuru**)*

During the post-conflict period, recruitment was sometimes conducted by CAO and DHO in the absence of DSC. Direct recruitment by CAO was justified for the post-conflict situation because of the unique circumstances that they were emerging from.

> *"There were no district service committees* [during the post-conflict period] *so instead when I wrote my application, DHO took it to CAO and the CAO wrote to the personnel so the PPO gave me an appointment letter straightaway." (**p31 Kitgum**)*

Lacor policy

The recruitment policy for Lacor states that: "*The recruiting authority is the Hospital Executive Director on proposal from the Medical Director, the Institutional Director or the Administrator. The criteria for selection of a candidate is based both on the academic qualifications and on the level of experience needed to effectively carry out the functions of the post. It is understood that consideration will also be given to written references of past and present employers, previous professional experience, other references and the candidate's behaviour and conduct at the time of the interview.*

Following evaluation and recommendations, the Hospital Executive Director or his or her designee(s) will take a final decision and select a candidate for recruitment. This decision can't be in any way challenged by anybody." (St Mary's Hospital lacor 2012) [page 6]).

Lacor practice

During the conflict, there was a scarcity of midwives in Lacor because the hospital was not training midwives at that time, therefore it was dependent on those trained from Kalongo School of Midwifery. Lacor also relied on enrolled comprehensive nurses (ECN) to perform the work of midwives since they received some midwifery training. At that time, multilateral and bilateral organisations tried to address the problem of rural posting in PNFP hospitals such as Kalongo, Lacor and Matany, by recruiting people from rural areas into training and then bonding staff to remain in their home areas.

During the post-conflict period, Lacor Hospital managers feel that they are training staff who are leaving too soon, although they do hope that some staff will one day return. Sometimes Lacor advertised roles on the radio but still did not attract midwives. Previously, Lacor employed ECNs to carry out midwifery roles. After starting a midwifery school, Lacor Hospital retains some students to continue working after training.

> *"This year* [2013] *in particular has been difficult for us as a hospital. We were highly destabilised especially with the midwives, we lost a very big number as well as nurses but luckily, we have we just started recently training midwives. We had been getting our midwives from Kalongo hospital but luckily the enrolled comprehensive nurses are also trained in midwifery so we had to use them but it wasn't easy. We have just got new nurses and midwives - the ones who completed exams in November - because we even tried to advertise on radio but we weren't able to get*." ***(p51 personnel officer Lacor****)*

In Lacor, bonding was practised more during the conflict and to a lesser degree afterwards. Bonding was considered important during the conflict because of the low numbers of staff and also low enrolment numbers in training school. The bonding agreement spells out Lacor Hospital's obligation to the staff and what is expected of the latter. In the post-conflict period, there is a personnel officer who deals with all aspects of human resources, including bonding.

> *"There again I had to sign a contract* [in 2005-2006] *because I was being sponsored by Uganda Catholic Medical Bureau, you are conditioned that after this sponsorship, you work with UCMB for five years or three years so I was given that condition to work for them for three years so I signed a contract for three years." (**p56 life history Lacor**)*
>
> *"In Kalongo, once the NGO* [referring to DANIDA & AVSI] *pays for you, after your study, you first work in Kalongo for two years. That is more of compensating for what the NGO has done for you, after that you are free to look for other jobs. Some students were being paid for by DANIDA and then others by AVSI. DANIDA paid half of my tuition and my mum paid the other half … others who are being paid for by AVSI are taken to other hospitals*

> *like St Joseph or Lacor or any other private hospital* [private hospital here meant faith-based hospitals or health centres affiliated with AVSI]." ***(p46 life history Kitgum**)*

During the middle of the conflict, when enrolment in nurse training school at Lacor improved, the recruitment process was altered to a degree, from providing a scholarship with bonding conditions to retaining the best performing students.

> *"For the earlier years [pre-conflict and conflict] we were keeping the nurses for at least two years, we would subsidise the school fees and we ask them to work for us for one or two years. The nurses would choose the best by that time according to the number of posts. But, once we started getting many more I think this policy stopped around '93, '94." (**p53 Inst. Director Lacor**)*

3.2.2 Selection

Local government policy

The Public Service Standing Orders (2010) which guide human resource management at the district level has no specific guidance on selecting staff for employment, but entry into the public service is through an examination.

Local government practice

Before decentralisation (1993-1995), job interviews were centrally conducted by the Public Service Commission. Staff that had completed professional training school were invited over the radio to go and attend public service interviews. The same posting instructions as in public service exist within local governments, where a candidate is posted to any health facility within the same district, whilst under the former arrangement posting could have been to any health facility in any district.

> "*No, it was just announcement over the radio* [before 1993]. *Our names were read to go for the interviews. Then we all went; I think all of us who did the course by then. We all went and did the interview, we waited, our names just came out – "For you, you are posted to this hospital" … like that. I went and did the public service interview after completing the course, we were called for interview, we went and did the interview, then we were posted to various hospitals with my colleagues." (**p34 MO Amuru**)*

In Gulu, staff say that some people are hired for a job even if they did not actually qualify when they originated from the same district. The cause of this may be nepotism whereby officers hire people who are friends or family members. A manager in Amuru confirmed this practice and the possible impact on the level of qualifications of new staff.

> *"Decentralisation is good but it is not 100% good ……because they have abused the meaning of decentralisation. You know it has also created nepotism in recruitments whereby when you are not from the district recruiting, it's very difficult for an individual not from the district to benefit from the recruitments because of nepotism and sectarianism they cannot attract the right people to work." (**p25 personnel Amuru**)*

In Amuru district it was stated that they avoided gender bias in the selection (referred to here as the broader function of recruitment) process:

> *"we also maintained fair recruitment of both female and male qualified staff and posted them in those areas."**(p10 key informant Amuru district)***

Nevertheless, it was reported that there was a higher proportion of male staff in the rural areas in Amuru district.

Lacor policy

Section 2.2 of the employment manual for Lacor Hospital states that:

> *"The criteria for selection of a candidate is based both on the academic qualifications and on the level of experience needed to effectively carry out the functions of the post. It is understood that consideration will*

> *also be given to written references of past and present employers, previous professional experience, other references and the candidate's behaviour and conduct at the time of the interview"* [Page 6].

Lacor practice

Lacor's response to the low staffing levels during the conflict changed over time. Initially, they subsidised tuition fees for some students and then retained them for some years after completion. Later, the subsidy for tuition was stopped, and instead they began retaining the best students in training. The candidates enrol as nursing students and then during the training process, certain individuals are identified for retention by the institution. On completion of the training they are requested to continue working at the hospital. When results for the final exams are released these students, who are by now classed as employees, are given formal appointments to work in Lacor Hospital for a period of time.

> "*And for the earlier years we were keeping the nurses for at least two years. We would subsidise the school fees and we ask them to work for us for one or two years [*after which*] we give them the certificates and they go anywhere they wish. But once we started getting many more I think this policy stopped around 1993, 1994, we started producing a lot of people in excess, now we do not subsidise their tuition but the nurses would choose the best by that time according to the number of posts." (**Inst. Director**)*

One health worker confirms how the recruitment processes have evolved from the pre-conflict/conflict era to the post-conflict period whereby, during post-conflict, staff are given both oral and written interviews before the appointment is issued.

> *"during the first training that time* [1993]*, when you are in the school the in-charges of the ward and the administrators will just be observing you and they write a report about you … Then when you are about to sit your exams they write the names and they send them to the training school that we need these students to remain. After your training, you find they have taken you to different wards, … so immediately after sitting you just remain in the school you don't even go … you start working as you wait for the results. So, when the results come they just confirm that now we are absorbing you, you start working as a full staff … immediately they start paying you the same like the qualified people. There is a difference these days because these days* [2013] *there is a procedure whereby you first undergo* [an interview] *before being absorbed in the system." (**life history health worker Lacor Hospital)***

After the conflict the recruitment process for Lacor seems to have been regulated, with written and oral examinations and formal appointments issued.

3.2.3 Appointment

Local government policy

Two types of appointments were identified - pensionable and non-pensionable appointments. Non-pensionable appointments may occur when a public officer is on probation or on a contract. The appointment may be pensionable when such an officer has completed a mandatory probation period or had his/her probation period waived. A **public officer** is defined as "any person holding or acting in an office in the public service". And a **public service** is "Service in a civil capacity of the central government or of a local government" (**PSSO 2010 page 304**) The probation period is stated as follows: "Appointment to a pensionable office shall be preceded by a six month' probationary period which shall count from the date of assumption of duty" (**PSSO 2010 page 10**). An officer may also be considered pensionable if they have had a transfer of service from one local government to another after confirmation in services **(PSSO 2010; page 6; no 1 a-b) (Government of Uganda 2010)**. We did not find any reference to appointments and probation in the Human Resource for Health Policy document of 2006 (Human Resource Policy for Health 2006).

Local government practice

The process of getting appointed appears to be quite rapid in some cases:

> *"[I] applied … in May then I wrote an application so I did the interview and I was given the appointment on the 28th June 2010 as a staff for Amuru."* ***(life history health worker Amuru district)***

Though the experience of others indicated quite a complex and lengthy process, and difficult for those from outside the district:

> *"The procedure is too long, I don't like. If I have already written the acceptance letter that means I have agreed to do the work. Assumption of duty and acceptance letter, there is no big difference between the two. You have accepted you are going to take the job, …. So, we waste a lot of time."* ***(life history health worker Kitgum)***
>
> *"The procedures are quite long because if you consider someone who doesn't stay in the area the person has to keep moving here and there to gather that information, gather that necessary requirements to take to the offices and sometimes you don't catch up with time and the process is delayed but it's important to have those details about the employees."*
>
> ***(Life history health worker Amuru)***

Lacor policy

Lacor Hospital appointment policies are reported to have been quite informal prior to the introduction of its first HR policy document, issued in 2001. The updated policy from 2010, said to be much the same as that of 2001, states that there are five types of appointments named in the policy section 3.1 to 3.5 page 6:

3.1 **Probationary Appointment**

"*It applies to employees who have the qualifications/experience to occupy an established post, but are on their first appointment in Lacor Hospital. The probation period shall be (6) months in the first instance and can be extended for a further period of not more than (6) months with the employees' consent."*

3.2 Permanent Terms Appointment (open term employment)

"It applies to employees who have successfully completed the probationary period and have received a letter of confirmation from the Hospital Executive Director.

Should the Government in the future move from the present system based on permanent employment, to the fixed term system for all health workers, Lacor Hospital shall also adopt a fixed term contract system for all its employees."

3.3 Fixed Term Appointment

"Applicable to employees over the age of 50 years, expatriate staff, staff with managerial responsibilities, senior professional staff and in general all staff with University degree, staff belonging to different administrations released for service in the unit, staff recruited for specific tasks and projects. The Hospital can employ these cadres on permanent terms appointment when deemed appropriate.

The terms and conditions of employment, the duration of the probationary period and the duration of the contract will be specified on the contract."

3.4 Appointment on Vocational Training

"Unskilled or inexperienced personnel can fall under this category. The duration of vocational training shall normally not exceed two years. The recruitment under this arrangement does not entail any obligation of permanent or contractual appointment by the Hospital at the end of the period. At the end of the vocational period, the Hospital might offer probationary appointment"

3.5 Casual Terms

"As and when the need arises, the Hospital shall employ personnel on Casual Terms. Employment on Casual Terms does not create an obligation for the employer to provide work for the employee on a continuous basis. Employment on casual terms entails payment on a daily basis. Due to administrative reasons, payments can be arranged on a weekly, bi-weekly or monthly basis, on the ground of days of actual work. This arrangement does not modify the terms of employment. Employment on Casual Terms does not require a written appointment. If the relation is continuous for more than six months, then it must be written."

Lacor practice
During the conflict, appointments in Lacor were mainly verbal. The staff felt that the verbal appointment was less binding and this made staff feel insecure, as was suggested by one employee:

> *"That word of mouth at that time* [during conflict] *was really not very good because at least for you to get work, you have to be given an appointment letter telling you the condition of your service… because somebody to give you something just verbally without documenting it giving you the condition of your work I feel you can even be terminated at any moment." (**life history nurse Lacor**)*

After the conflict, formal appointment letters were issued at Lacor after selection.

Staff that served in PNFPs commonly received fixed-term contracts from their employers. Contracts were of different durations: some contracts were very short (four months) and sometimes two years, however termination could be done at short notice. In Lacor, some of the staff said the contract terms including rates of monthly wages were not clear to them.

3.2.4 Initial posting

Initial posting and transfer (subsequent posting – dealt with in a separate section) are both used by managers to deploy staff to vacant posts and particular areas of staffing need. The general policies and practices will be reported in the section on transfer, whilst the specifics related to the initial posting of a new recruit are reported here.

Local government policy
Regarding reporting to duty after appointment the policy states that a staff should report immediately to the responsible officer on posting and spells out that an officer is liable to disciplinary action if they fail to report. Government policies on appointment were considered to be unchanged during conflict and the post-conflict period.

Local goverment practice
Some new staff prefer to be posted in urban areas although the posting instructions suggest that one must be ready/willing to work anywhere in the district. During the centralised system staff were centrally recruited and posted to any health facility in any district.

> *"For us the two of us who did the course together, we were posted to Lira Regional Referral Hospital. We did not choose to go there; it was just normal posting from the Public Service Commission." (**p34 MO Amuru**)*

According to the in-depth interview from Gulu, the initial posting policy under decentralisation clearly states that one must be willing to work anywhere in the district and an individual must first accept the terms before taking up the job offer, therefore the preference of working in urban/rural areas should not arise.

> *"Always when you pass the interview, it's the head of department* [in this case the DHO] *to post you in a vacant place where you should go and work. It's not you to choose because you have already written the acceptance letter committing yourself to the job description of that job you have been employed to go and do." (**p31 CO life history Amuru**)*

Lacor policy
"*The successful candidate will be informed, will receive a copy of Lacor Hospital Employment Manual and will be invited to sign an employment contract. This can be a standard contract/letter of appointment or a personalised contract/letter of appointment where necessary." ((St Mary's Hospital lacor 2012) [page 6])*

Lacor practice
This policy document was authored during the post-conflict period (2010). In Lacor, staff are notified of their initial postings made through a general list that is displayed on the general notice board indicating which unit they have been deployed to. It is in the new unit that the staff are given orientation.

> *"Ok they make a list and send it to the training school yeah, then from the training school the principal will tell you that you have been taken you are going to remain and work in this particular ward also they will send the report to the in-charge then the in-charge will welcome you …" (**p58 MW Lacor Hospital**)*

In Lacor, the hospital management was able to recruit additional staff through the Catholic Church. If the medical superintendent identified a nun trained in nursing/midwifery, he could then write to the head of the nuns, known as Superior General, requesting for the deployment of such an individual to the hospital. If the Superior General was in agreement with this request, then she would write to the nun, directing her to report to Lacor Hospital. One nun who experienced this scenario had this to say:

> *"When I was posted to Lacor by my Superior General, she wrote to me a letter stating that I am on transfer posted to Lacor Hospital and ……. So, when I reported to that new community, my superior in that new community together with those letters written took me to the medical director and introduced me to him then there I was given a form to sign a kind of contract then there I begun to work." (**p56 life history Lacor**)*

3.2.5 Induction

Local government policy
The public service training policy (page 6-7) stipulates that "All Government Officials must be inducted into their new jobs in order to orientate them to the culture of the Public Service as well as the challenges of their new jobs/responsibilities" (Ministry of Public Service 2006).

Local government practice

Only in Gulu LG, induction of staff was mentioned and was carried out over five days, detailing some of the relevant responsibilities. Gulu district organises induction courses for new staff before deployment.

> *"Before they go* [to their new posts]*, we have an induction training of about five days, about management positions; how the system of decentralisation is working; about the local government systems; the norms in the health system; background of the situation*."
> (**DHO Gulu**)

In Kitgum, new hospital staff are made to rotate to different wards before final deployment.

Lacor policy
The policy document does not mention induction.

Lacor practice
Managers provide induction once staff have been posted to a new location.

> *"they will send the report to the in-charge then the in-charge will …. do the orientation."*
> *(**p58 MW Lacor Hospital**)*

3.2.6 Post-basic training

Local government policy
The Public Service Standing Orders currently states that "study leave will be granted in public interest, that the course must be relevant to the performance needs of the ministry, local government or career progression of the officer. Such study leave will be granted by the responsible officer in case of short training and by the appointing authority in case of training lasting three months or more".

Regarding the duration of staff development, the Standing Orders suggests "A public officer must undertake staff development activities for a minimum of forty (40) hours in a Financial year to improve his or her competencies" (Government of Uganda 2010). Such study leave will be granted by the responsible officer in case of short training and by the appointing authority in case of training lasting three months or more". Moreover, approval of long-term training has to be sanctioned by the relevant service commissions and regulations. The same clause goes on to state that "any public officer who proceeds for full time studies without authority shall be regarded as having abandoned duty" (Ministry of Public Service 2006).

The public service training policy states that officers who are sponsored by government should be bonded for three years, whilst staff that sponsor themselves but remain on the government payroll should be bonded for the number of years that they have been in school (Ministry of Public Service 2006). The Public Service Standing Orders goes further, in suggesting that an officer shall be bonded

for three years whether or not the officer was sponsored by the government (Government of Uganda 2010).

There is a penalty in public service in cases where an officer does not honour the bonding terms. The Public Service Standing Orders suggests that the government shall recover from the officer the costs of training in cases of a breach of bonding agreement (Government of Uganda 2010). There is no evidence that these policies have changed over the conflict and post-conflict period, neither did we find evidence to suggest the enforcement of the rule in case an officer does not adhere to the bonding agreement in the LG.

Local government practice

Managers confirmed the policy on providing further training for staff, but one manager implied that this was now seen as a right rather than a reward.

> *"Yes, we have that arrangement for health workers to go for further studies but the competition is rigid, those days it was a priority of hardworking people but now it's abused. Those who want to go for further studies every month come to my office, I have to support them; I don't sit on one's chances. But if the staff is going for more than three years that is not accepted …" (**p26 DHO Gulu**)*

The fear expressed by staff over this system under decentralisation is that selection for training is open to abuse by the DSC and is therefore unlikely to be equitable.

> *"There are no criteria, it is personal decision and personal relationship with the administration. I have been denied three times opportunity to go to school when I had my admission letters presented to the administration to discuss it over but they would say No." (**p39 CO life history Gulu**)*

In-depth interviewees in LG did mention the signing of bonding agreements. In Gulu, the key informants felt that the process of recruitment for training was operating well through the DSC; LG can decide to send their staff to school for further training and hire them when they return. However, the duration of the bond was said to be equal to the number of years that the individual would be undertaking the training, in contradiction to the policy statement identified.

In Amuru, the bonding process seems to be working well, as one respondent stated during in-depth interview, saying that officers were returning to work after completion of studies.

> *"You know we have been bonding them, we issue a study leave and we bond you. If you come back and if its noted then you may be followed but in most cases, nobody has still absconded, all these guys have been coming back." (**p13 DSC Amuru**)*

In Gulu and Kitgum districts, the experience is that the bonding agreement is not usually adhered to because staff find new jobs after qualifying. The breach of bonding agreements is explained by one key informant:

"*Mmmh, much as some of the staff who go for further studies aaah when they return, they provide much more quality health services but experience has shown that most of them who go for further studies do not came back, they look for greener pastures and immediately go… by the way some of them have been sponsored by the district local government and … unfortunately the district sometimes could not tie them* [referring to enforcement of the rules] …. *that has always been a challenge, you will find that after completion they go away and some of them join NGO's, some of them go outside the country …….*" ***(KII sec, health Gulu)***

In Kitgum, in-depth interviewees said that junior MOs recruited during the conflict specifically did not return after postgraduate training and study leave.

"*You know in 2000 to 2004 and 2003 there was a bit of security so we were able to attract more doctors …normally you bring these doctors when they are junior and then after working for a few years, they want to go back to school but when they go back to school you don't see them again that is one of the challenges. … you send somebody to school, they don't come back. I don't know whether the weakness is with the district where they don't make strict bonding agreement or they are over-qualified to come back and stay here with us.*" *(**ADHO, Kitgum**)*

*"Training is an exit route. But of course, when somebody starts to specialise, then he becomes over-qualified to work in a district. He needs to go to a referral hospital and that has been a big challenge to us. Some health workers we have in our health facilities want to upgrade to get degrees in nursing, degrees in laboratory, degrees in medical education. Now these positions we don't have norms for them in the districts. So, training at a specialisation level is a challenge."(**p24 DHO Amuru**)*

Staff expressed concerns regarding unclear procedures or guidelines for further studies and the fact that career guidance is not taken seriously, with staff left to make decisions on their own.

"*… first of all, career guidance isn't something taken very seriously here. Most time staff are not very straightforward on how they could advance with their studies, develop their career …….. Secondly you must already have a post for what you are going to qualify, the post must be existing in the district. Those are some of the reasons that in most cases it conflicts with peoples' own initiatives to move up the ladder so you find some other staff going without permission and at the end of the day, you find that their names are being knocked off the payrolls.*" *(**p38 life history CO Gulu**)*

Lacor policy
The training policy for Lacor [page 22] states that:

> *"In case the employee intends to join a training programme, it shall be at the discretion of the Hospital Executive Director to grant an extended leave without pay, if he recognises that the Hospital might in future benefit from the additional qualifications acquired by the employee. In this case the employee shall retain his/her job and can come back to it at the end of the unpaid leave. If the new qualifications are relevant for the Hospital, the Hospital Executive Director shall submit the case to the Promotion Committee for recommendations."*

Lacor practice
Lacor managers say that medical officers generally served for one or two years before going for further studies, although clinical officers seemed to have no opportunity for further studies and so tended to stay put.

> *"The clinical officers do not move so much, the movement is mainly with the doctors, nurses and the midwives. The doctors, if they give you a long period of service, it's three years because they tend to be in a hurry to go and specialise. Usually after one-two years of service, they want to go but this isn't a big problem because we expect it from them. They are interested in becoming specialists in different fields and after getting some experience they want to go to school." (**p51 personnel office Lacor**)*

The hospital is said to encourage staff to go for further studies after they have worked for some years. Lacor provides partial financial support to staff on half-pay until they have completed school, before reinstating them on full salary. This policy has been in force during and after the conflict.

> *"Ok that the hospital was starting to sponsor people but it had not started fully so for me I joined knowing that I was going to pay my school fees with the help of my husband but when I applied and were admitted I think the sponsorship started from us I think from the nursing side, so they told us that they are going to pay some money but not full so they pay for us half and we contribute half of the money*." (***p58 life history nurse Lacor Hospital)***

3.2.7 Promotion

Local government policy
"Promotion after Training" (PSSO 2010; page 154 section J-a): This clause indicates that attainment of higher qualifications does not automatically qualify a public officer for promotion to the next grade. It suggests that such an officer who has attained a higher qualification is eligible to a higher grade when a vacancy exists but the said officer must compete with other eligible candidates.

Local government practice
In Gulu, promotions were automatically effected during the pre-conflict period. It was reported that during the conflict there were no promotions, so that staff remained in the same posting for up to five years and this affected retention of staff.

> *"There were no promotions during the conflict period. People would work for many years without promotion. Instead of being there for two years after which promotion should come, you find the person has stayed for five, three, four years so that one affected retention of people. Then of course the war worsened things." (**p13 DSC Amuru**)*

In Kitgum, post-conflict staff who braved the conflict period were seconded for further training and were given special consideration for promotions, in recognition of their resilience to service during the conflict. However, as mentioned above, some staff did not return post-training because they become over-qualified or were now much stronger candidates for new jobs.

> *"Now after confirmation certainly there are schemes of say advancement, you might find somebody is an enrolled nurse; she can apply for upgrading to become registered. And the beauty with public service is that when you're admitted you go on with your salary because you are released procedurally you must be cleared by District Service Commission and when you are for studies, you remain on a payroll. You come back to join the service." (**Central MOLG**)*

As mentioned in the promotion policy, staff did not necessarily get new jobs that matched their new qualifications, which led to dissatisfaction.

> *"when I am already registered, there is no post that's what they are telling me that there is no post for nursing officer midwifery so I am just serving here as enrolled midwife in Gulu from that time up to now. And I am just getting my salary as 400.000/= four hundred thousand shillings then I am on loan with my condition also. I was just requesting the government if they could promote us to our real cadre to also make us happy because at the moment we are not even happy even the salary is low, even there is nothing we are benefiting." (**p41 midwife life history Gulu**)*

Lacor policy

The policy on training for Lacor (St Mary's Hopital Lacor 2010) states that:

> "For employees on standard contractual terms promotion to a higher level of the salary structure – and title, if applicable - can be obtained either:
>
> Through seniority: …This promotion is not automatic, but shall be granted on recommendation by the Promotion Committee of the Hospital, which shall have the right to withhold or postpone the promotion…. Promotion through seniority is granted only once during the career of an employee in Lacor Hospital."
>
> "Through additional qualification: shall be granted on recommendation by the Promotion Committee of the Hospital as per a). While additional qualification might allow promotion to the corresponding salary level, it does not give any entitlement to higher position or different deployment in the hospital organisation, being just a pre-condition for being considered in case of vacancy. Through outstanding merit: this type of promotion has to be considered exceptional and shall be justified by the Promotion Committee. Through career paths established for specific professional cadres by standing order of the Executive Director." (p22)

Lacor practice
In Lacor, promotions were based on working experiences of two - five years, hard work and capabilities. When a staff member is identified to be hardworking they are seconded for further training after which they can get promoted. Abuse of positions to favour certain individuals was not reported in Lacor.

3.2.8 Secondment

Local government policy
The Public Service Standing Orders make no reference to the term 'secondment'. However, other clauses like attachments, delegation, coaching and mentoring were mentioned in relation to staff training and development in the public service *(PSSO 2010*; page 152-54; section J-a).

Local government practice
As reported above, some staff members were seconded to local governments by NGOs, but there were no reports of secondments between government facilities.

Lacor policy
No policy on secondment was identified for Lacor.

Lacor practice
Lacor Hospital also receives interns to practice in the hospital for a period of one year - although not directly recognised as secondment, this could be classed as a secondment by the central government.

> *"I haven't told you is that we, only doctors, are sent* [to Lacor Hospital] *by the central government …. I am a senior consultant … a promotion of the central government. Still I am a seconded staff here* [Lacor Hospital]. *But there are those who are not seconded to this hospital." (**Inst. Dir. Lacor**)*

3.2.9 Transfer

Local government policy
Under the section A-i (P*SSO 2010*; page 27) *"Movement of personnel within the public service"* provides that an officer will be deployed taking into account the following situation: "such deployment will be in public interest and on recommendation of the responsible officer, not a punitive or disciplinary measure". Second, "a public officer may be transferred after a continuous stay in his/her station for at least **three** years and not exceeding **five** years". This clause states that "…when a transfer in service is approved, effective date of appointment will be the date the officer assumes duty in the new office". Such officer will maintain the same grade, salary scale and level. In cases of non-compliance with reporting the Standing Orders in (-c), page 99 suggests that "A public officer reporting for duty on first appointment shall immediately report to the responsible officer at the station to

which he or she is posted. An officer who does not comply with the posting instructions will be liable to disciplinary action."(Government of Uganda 2010).

The Employment Act 2006 (page 17) states that "A contract of service shall not be transferred from one employer to another without the consent of the employee". Instead, the PSSO 2010 suggests that "Movement between districts is subject to the agreement of the districts. While it is unlikely that the Chief Administrative Officer (CAO) or District Health Officer (DHO) would want to interfere with a worker's opportunity for advancement, nonetheless it is up to them to agree to release a worker". The Act further states that transfer may be used as a disciplinary measure: "…. before deciding on dismissal as the final penalty, the employer will first consider alternative penalties, the loss of privileges, job transfer or suspension without pay." (Government of Uganda 2006)**.**

Special considerations are also given for married couples, further studies and staff illness. For example, the policy for couples in Clause 3 Section F-c (page 99) of the Public Service Standing Orders states that "Under normal circumstances, the government shall not post husband and wife for duty in the same duty station". If they need to be posted to the same duty station, then the clause 4 of section F-c states that "they should not be employed in a relationship of immediate supervisor" (Government of Uganda 2010).

The official policies on transfers did not change during the conflict and post-conflict period but central officers suggest that this official position can always be negotiated if there are genuine conditions expressed by the staff. For example, one central official had this to say:

> "*The posting policies I would say did not change much but what I know is there was a win - win situation, for example if am the DHO and you have family issues that you are unable to work in sub-county A and you want to work in sub-county B, if you give me a convincing reason I think I cannot say since am the DHO I can make you static and I cannot make you move to this to that. No, there is that flexibility by helping workers to ensure that at least a few who were able to work would do work where they want or where their interest is or may be of family ties yeah.*" *(**central MOLG**)*

Another respondent at the centre said:

> *"Posting policies don't change because there is peace or war. They remain the same."* (***p1 central KII)***

Local government practice

Transfers within the districts

During the conflict period, it was difficult to expect staff to move to areas of insecurity. Most health centres were abandoned. The few that survived were staffed by a small number of health workers and therefore it was difficult to move staff around, as expressed by one hospital manager.

> *"It* [transfer of staff] *was really very difficult because health workers were not in those centres even in government setting, in urban centres like this were very few so the*

> *management was very difficult. How do you manage something which is not there?"* ***(MS Kitgum hospital)***
>
> *"Ok, well during the insurgency period certainly there were a lot of system break downs and families were disintegrated, you find that during that period, people were in confined places in the IDP entirely, displaced camps. So, it was a bit difficult for health workers to even accept to be deployed in areas which are affected by war so because you don't know what's happening, people fear for their lives." (**p5 central MOLG**)*

Although there were general concerns about political interference in deployment, one respondent explained that other factors had a greater influence.

> *"At that time, politics didn't influence so much, the most important thing that influenced the retention was the war and economic matters, for example salary."*
> *(**p13 sec DSC Amuru**)*

In Gulu, transfers were minimal and staff were encouraged to work in the same duty station. During posting the DHO applied the guidelines for transfers but also used his ingenuity to post good performers together with those who were performing less well.

> "*Hmm, … we normally use Uganda Public Service Standing Order, that guides us in the process of deployment, transfers, we look when we are doing this we look at the duration in which someone has been in a particular facility, then we look at the performance of the facility, for example there are facilities that are less performing, then we want to strengthen it, you pick a cadre who is good in some other facility you add onto you the existing staff, remove the weak one and take them to be under strict supervision." (**HRH Gulu**)*

Staff experiences of posting were varied - some had regular posting according to the Standing Orders while others reported their transfers were too frequent (some six-monthly). An analysis of transfers recorded in the personnel records of 62 staff (MO, CO, nurses and midwives) across the three districts was made to check compliance with the rule about not being transferred before being in post for three years and not after being in post for more than five years. Seventy-eight different transfers were recorded for a total of 62 staff. There was insufficient data to comment on the transfers that took place either before or during the period of conflict as only seven transfers were made in total. Fourteen (12.8%) transfers took place less than three years after staff were posted (24 (30.76% - if all staff in that category are included even if they had not yet completed three years). Twenty-six (33.33%) transfers are known to comply with the three-five year rule. And 21 (26.9%) postings were longer than five years in the post-conflict period; the majority were in Amuru (11) where the longest posting was 14.24 years.

During the conflict in Kitgum, HWs were concentrated in camps and some were deployed to Kitgum hospital, as staffing levels were low (42%) and they could not attract critical staff. Management functions such as supervision were suspended, and some administrative issues were ignored.

Central officers say that deployment in the regional referral hospital is effected by the Director General of health services, MS deploys at the hospital level and DHO and CAO for the local government. Overall deployment is a mandate of the local government.

District officers say that deployment is effected without coercion and there should be no negotiations - suggesting that once posting has been determined the staff member either accepts or declines the offer. The IDIs do acknowledge that deployment was met with a lot of resistance during the conflict. During the post-conflict period in Amuru, posting is done in a systematic manner targeting areas with gaps and needs. Gaps are identified together with the officer in charge of the health centre and the District Health Officer.

> *"as far as I know, the DHO usually identifies facilities with gaps as in facilities with fewer staff then after he has identified them, he posts the staff that has just been recruited to fill in the gaps so that a particular health centre has the required number of staff."*
>
> *(**p32 CO life history Amuru**)*
>
> *"The guidelines are quite clear and they are set by Ministry of Health and Public Service with the norms for the various categories of health facilities; HCII, HCIII, HCIV and HCV for hospital. It is not a locally-made rule, but under decentralisation policy, districts are supposed to render services. And in rendering services they should equitably distribute health workers to provide services including rural areas. We have a challenge that if the person is not interested in the position where he has been posted; say it is in a far-off rural area, the person turns it down. But the guidelines are set from the Ministry."*
>
> *(**p24 DHO Amuru**)*
>
> *"A health worker who has taken oath to serve the country ready to serve anywhere. We have had cases for those ones who try to resist and disciplinary measures have been taken, including even interdiction apart from the warning letters. At that time, it was insecurity which was discouraging people from going to the rural health centres but now the situation is difficult in terms of economic and social services." (**p12 district planner Amuru**)*
>
> *"But if a person resists going there then we give them a listening ear, what are your reasons for resisting? And if the reasons are genuine then we replace and if a person says that she can conveniently work in another alternative and it's ok then we do. So, it's administratively given time so hearing, you get me right, because human beings are not handled as machines, you must look at and listen to them you must look at their issues may be where you have put me I have a problem with that place and I can work better in another. This is because deployment is done to make sure that we do not lose anybody, we do not want to lose anybody. So, if anybody gets a problem with the environment, we are supposed to come in and solve that problem immediately because we are looking for health workers, they are very scarce so we can't afford to lose any single person."*

*(**p4 central PPO MOH**)*

Within the decentralisation policy, the central government is not mandated to deploy in any district. This restriction is sometimes perceived to be a limitation to the stewardship role of the central government since they are unable to intervene even when they have identified obvious gaps in staffing levels in a particular district.

> *"We* [MOH] *cannot deploy directly even if you knew that in Bundibugyo* [a local government] *there are no health workers, there is service delivery suffering, we need to first of all ask for permission even to deploy those ones. I told you who we were bonding. So, the policy is a memorandum of understanding between us and the district that we deploy people there because we can't dictate to them." (**p4 PPO MOH**)*

Although routine, the transfer of personnel is a policy matter, some staff may not be in favour of the new transfer so they bypass the normal system through the DHO's office and negotiate directly with the CAO so that they can be transferred to another unit of their preference in the district.

Sometimes, staff perceive transfers to be of punitive or corrective measures. Occasionally, it is perceived to deploy a brilliant health worker for his/her talent in a particular aspect of care:

> *"They can decide to post you very far away from where you have been as a disciplinary issue, sometimes they look at you as potential person who can develop health service delivery in another centre. Sometimes it's because of understaffing in certain health facility so it's not a very clear thing to me." (**CO HCIII Gulu**)*

In Gulu, couples were sometimes deliberately not posted together during the conflict. The reason for not posting couples to the same place was to preserve the family unit in case of a rebel attack, as it was hoped that at least one partner would therefore survive the war and be there to take care of the children and family.

> *"Oh yes, we do consult because it is cost-effective to transfer couples in the close units but in most cases, they wanted to separate during the conflict, it was understandable because you cannot put all your eggs in one basket. During that period* [conflict] *they would prefer not to be posted together so that in case one is attacked one can stay to take on the family. But after the conflict we have tried as much as possible to deploy them in respect of the families but still some come and request to be deployed separately." (**DHO Gulu**)*

However, in Gulu during the post-conflict period, couples were allowed to work together.

In Amuru and Kitgum, special considerations were made for illness amongst staff members and they were posted nearer to the hospital for quicker medical attention.

*"Those are some of the considerations when making transfers. There are those individual cases that are considered: issues of spouse, disability etc. if somebody is pursuing a course genuinely and has all the evidences and sometimes the district is even facilitating them, we delay such transfers. Taking the person very far away will frustrate the person and hinder our objective of capacity growth and development." (**p12 planner Amuru**)*

***"**You know when you are posting a person, there are few things that you need to take note of, one there are people who are sickly, you need to post them near health centre." **(p13 DSC sec Amuru**)*

Transfers between districts

Transfers between LGs can occur whenever there are vacancies for which a staff member qualifies and the current employer is willing to release them, and the new employer is willing to take them on [a double coincidence of wants!].

*"If you want to go to another district, you have to request for transfer of service and we will release you if the gap is okay. Even us if we want to get another person from outside, we tell that person to request for transfer of service like recently we got one from Moroto, she is coming to join Amuru." (**p14 sec. finance Amuru)***

Local governments can also negotiate with staff posted to another local government to apply to their district, meaning that district managers can go around head-hunting as expressed by one officer from Amuru. This type of negotiation may in future provide some bargaining powers to certain staff members, who will make a demand for better pay/incentives before they accept a job offer to a particular district, therefore raising the stakes in the external labour market because staff will go to the highest bidder.

Lacor policy

In Lacor, there is a policy of transfers to satellite centres. The policy states that: "In the appointment letter or contract, the Hospital reserves the right to deploy the employee to its peripheral units on prolonged or permanent basis. In the absence of such a clause in the appointment letter or contract, the Hospital can only request an employee to serve in a peripheral unit on a temporary basis for a period not exceeding two weeks" (Lacor Hospital 2010) [page 8]).

Lacor practice

During the conflict in Lacor, hospital managers had to negotiate with health workers that were willing to continue serving at the satellite health centres, in spite of the rules that stated otherwise. The hospital also provided a hardship allowance for staff that were serving in satellite health centres to

cover transport costs to enable them to come to town or to hospital for other business such as salaries:

> *"During the time of war the major issue was security and this affected our health facilities a lot. We could not force people to go to those areas so we were asking them to volunteer. We know our manual says you can be deployed everywhere but because we knew there could be death on the way, there could be ambush on the way, there could be other problems, we ask them to volunteer to go to the health centres. Well we gave them little money* [over and above regular staff pay] *we called it hardship allowance but hardship allowance is just to allow travel maybe once or twice in a week to come and collect their salaries. That time we were still paying within the hospital because the banks were not there*." *(**Inst. Dir Lacor**)*

Some staffs negotiate to remain in the satellite health centres for longer than two years and this is acceptable to the administration.

In Lacor, staff that were married and those with children were given special consideration, for example they were given the freedom to choose their next transfers. As the staff members said, when they were with their families, transfers were unlikely:

> ***"**We definitely consider people who are married. We take into account also the number of children they have and the possible difficulty that they could. It's also an opportunity for you to tell us the appropriate area where you will be happy to work and we put all that into consideration." (**p53 Inst. Dir Lacor**)*

Although the rules suggest that staff will be transferred every two years, those staff that were willing to continue working within the satellite health centres of Lacor Hospital were also welcome to express their interests to stay. These individuals are given the opportunity to continue serving.

> *"Working in the peripheral health centres like ours here, normally the policy of Lacor is that each and every staff that work in the hospital must come and have an experience in the peripheral health centres so it's a kind of rotation, they rotate us every after two years but if you feel like working for more than that, you can also continue. You tell them that you are still interested." (**p56 life history nurse Lacor**)*

> *"I contracted TB then from there I requested the medical superintendent that as I have already contracted TB from the medical ward I want now to go and work in the TB ward as the in-charge so that I will also be educating the patients that even me I am taking TB drugs and TB can be cured so they accepted and they shifted me to be the in-charge of the TB ward." (**p55 nurse life history Lacor**)*

4.0 Discussion

4.1 Limitations of the study

Inability to obtain and analyse routine staffing data

Analysis of routine staffing data was meant to help in analysing changes in health worker availability, distribution and attrition during the study period. In particular, *existing* human resource information system data were collected from district or facility sources. However, these data were later found to be incomplete with several key data items missing making it difficult to analyse. Therefore, in this report we cannot quantitatively indicate how the staffing of rural vacancies evolved during and after the conflict. Since the only formal policy change for government health staff was the introduction of decentralised management, and no formal policies were introduced to cope with deployment problems caused by the living and working conditions and labour market both during and post-conflict, the absence of 'hard' data is less important. The changes in rural staffing were brought about by implementation (or lack of it) or adaptation of policies by managers in a non-uniform way. As such, attribution to quantitative staffing changes would be difficult. Qualitative data from KIIs, managers and staff – particularly through the job histories (Witter, Namakula et al. 2017) – provided more useful information on the impact on rural staffing, thus partially addressing Objective 2.

Gender and length of service considerations during enrolment of respondents

We had planned to deliberately recruit a mix of male and female respondents but this was not practically possible, as most of the available key informants and in-depth interview respondents at the district management level that met the selection criteria were men. On the contrary, the health worker in-depth interviewees were predominantly women, mainly because nursing and midwifery training schools tend to recruit mostly female candidates. Secondly, during the personnel record review, we planned to select a mix of staff that had worked during the conflict and post-conflict, in order to get a trajectory of staff appointment, deployments and transfers during these periods. However, it was not possible to identify adequate numbers of staff that had served during the relevant time, therefore, the majority of selected staff had actually been recruited during the post-conflict period.

4.2 General discussion

This study, as part of ReBUILD's research programme, was focussed on lessons about the policy and practice of deployment in the conflict and post-conflict period in Northern Uganda. However, as the field work also reported on the situation in 2013, some useful lessons have been identified for current deployment policy and practice, about which there is a dearth of literature internationally (Schaaf and Freedman 2015), for other regions of Uganda and for other conflict and post-conflict contexts.

The conflict and post-conflict period inevitably had an impact on the health labour market in Northern Uganda between 1986 and 2013. With the growth of the better-paying NGOs providing health services in safer camp environments, health workers were understandably attracted away from the government jobs and to some extent the PNFP employers. This had a greater impact on more highly skilled personnel such as doctors, which is unsurprising since this section of the workforce is normally

the most mobile (Buchan 2000). With the return to peace and the gradual withdrawal of NGOs, health workers returned to government jobs and the PNFPs. Government jobs became more attractive because of the fringe benefits (including access to training, job security etc.).

The general movement of staff during the conflict was from LG to PNFP, or from LG to NGO. This drive was mainly due to better overall remuneration in these two sectors compared to LG. The financial gains in the NGO sector were compelling, for example, as reported earlier, an NGO was paying 800,000 shillings compared to the 225,000 shillings paid by the PNFP facility (about four-times the pay from Lacor). There was something of a contradiction in the NGO sector: whilst some organisations were attracting staff away from the local government facilities, other NGOs were actually supporting the local government by constructing more health centres and staff accommodation and by helping with recruitment. The role of NGOs in delivering services in the context of emergencies is complex, but the NGO Code of Conduct for Health Systems Strengthening, developed in 2008, calls for NGO practices that "contribute to building public health system and discourage those that are harmful".[5]

The PNFPs were not spared from the negative effects of the labour market. Lacor Hospital specifically complained about the predatory nature of NGOs. It would therefore seem that the work aspiration during the conflict was more of 'survival' and less of career growth. However, when the conflict came to an end, health workers were attracted to the LG sector due to particular incentives including career growth, promotions and job security.

Despite what this study was able to report on the changing labour market, as identified in the limitations of the study, there was little quantitative data available that could be used for management purposes. Although it would be challenging to obtain staffing data across different and changing employing organisations, this is essential for understanding changes in the labour market in real time. Roome, Raven et al. suggest that ways of setting up basic HR data systems that would be helpful in these circumstances need to be developed (Roome, Raven et al. 2014).

When analysing the responses of the employers within the labour market, this study has taken a broad interpretation of the concept of deployment, as expressed by the HRH Global Resource Centre (cited above), with a focus on the equitable distribution of personnel, and its components (see Figure 1 above). It has also acknowledged the fact that meeting one HR objective can have a negative impact on other areas of HR management, namely retention and in the words of one respondent ensuring that "we do not lose anyone". Managers at various levels, especially at district level, need a broad understanding of the need for coherence between HR strategies – referred to as "horizontal integration" in the strategic HR management literature (McCourt and Eldridge 2003) - in order to ensure that they do not use conflicting methods. The study also echoes findings from two studies from India that the deployment policies were largely gender-neutral (Kadam, Nallala et al. 2016, Purohit, Martineau et al. 2016), which may not lead to the best utilisation of the available workforce.

A review of official government deployment-related policies did not reveal any specific response to the changing labour market caused by the emergency provision of services, mainly in camps, during the conflict, and the subsequent gradual withdrawal of these services once peace had been restored and people were able to leave the camps and return to their homes. This lack of responsiveness may be explained by the fact that government deployment-related policies as given in the Public Service

[5] http://ngocodeofconduct.org/home-page-introduction/

Standing Orders (Government of Uganda 2010) relate to the whole country, whereas this particular conflict affected only the Acholi region. Secondly, as corroborated by one respondent at national level, there appears to be a viewpoint that posting policies should not change because of war. There was no further clarity on this issue but one explanation might be that it was not possible to predict when the war would end, and therefore to decide whether the policy should be changed. However, it does suggest that a more flexible approach to procedures in times of conflict would be appropriate and would take the pressure off local managers, who had to improvise in order to make deployment work as well as possible in the circumstances. Nevertheless, the special case for strengthening certain HR strategies in the Acholi region was made as part of the Peace, Recovery and Development Plan of 2007 (Witter, Bertone et al. 2016).

The most significant policy change related to deployment in the government health sector, with the exception of referral hospitals, was the decentralisation process that started in the 1990s – well into the period of conflict – and was implemented on a nationwide scale. Concerns about the impact of decentralisation, which included political interference in the recruitment process and the loss of career mobility for individuals, were not unexpected (Wang, Collins et al. 2002). Nevertheless, some benefits were identified, such as the recruitment of local staff who would feel more accountable to their community and could receive support from their family networks.

It appears that Lacor did not have clear polices on deployment early on in the conflict. This was probably because the organisation started as a small, informally run hospital founded in 1959, at a time when human resource management was not very common in private organisations. As part of wider organisational change, the hospital began formalising its HR policies with the adoption of an employment manual in 2001 and then a revised HR policy in 2010 which complies with the Employment Act, supported by a fully-fledged human resource management department within the organisation. This administrative evolution may not be related to the conflict and post-conflict situation but rather to the evolving global financing architecture that would have preceded the conflict.

Whilst there was no discernible change in deployment-related policies in local government or Lacor, actual implementation did not necessarily follow the policies. In fact, it is clear that managers interpreted the policies in relaxed ways relevant to the prevailing context – both during the conflict and during the post-conflict period. This was probably in part out of compassion because of the danger that certain postings would expose health workers to. However, it also appears to have been out of pragmatism, since health managers anticipated that staff would leave the service rather than serve in dangerous locations. Some strategies were particularly notable. Both the local government and Lacor were flexible about posting, not wishing to send staff to areas of danger. Gulu district supported the separate posting of married couples to avoid “putting all the eggs in one basket”. Lacor managers used task-shifting to fill staffing gaps, using enrolled comprehensive nurses instead of fully qualified midwives. They also recruited staff in times of shortage through offering bonded training places, and retained potentially high-performing employees by recruiting them whilst they were still trainees.

Recruitment was carried out in one district in the post-conflict period by local council officials in the absence of established District Service Committees. In local government, managers appear to have turned a blind eye to dual working – probably as this is a means of retaining employees. Even in Lacor,

during the conflict, managers had to negotiate with staff about being posted to satellite health centres because of the dangers involved. In times of stress such as during conflict periods, managers need not only to be pragmatic in the strategies they use, but they also need "emotional intelligence" (Daire, Gilson et al. 2014) in order to determine which strategies are likely to be most effective with their staff.

The conflict and its aftermath posed significant challenges for both the local government employers of health workers and Lacor Hospital. Neither organisation responded by adjusting their policies related to deployment. However, both showed evidence of adapting implementation processes even though, particularly for the local government employers, the evidence collected in this study was patchy. For any system to survive or remain relevant it needs to be adaptive in the face of shocks. This is easier for small organisations, and at the time Lacor was only just beginning to develop more formalised HR policies. Decentralisation breaks down the monolithically centralised organisations into smaller, more autonomous units. Perhaps decentralisation therefore helped the districts to become more adaptive to the changing circumstances created by conflict. Nevertheless, until the labour market for competing districts is better developed they will probably have to rely on the Centre (Ministry of Health) for some HR support such as centralised recruitment.

This study also presents some more general lessons related to deployment. In the early stages of the deployment process, induction was not reported as being of major importance. It was only mentioned in Kitgum and Gulu districts. The five-day programme seemed quite comprehensive. However, there was no evidence of induction specific to the person's particular job – a failing identified by managers in Kabarole district in Uganda in a recent study (Baine, Kamukama et al. 2015). The use of induction is widely seen as good human resource management practice both for helping staff to work effectively from an early stage in their jobs, but also as a way of making staff feel valued, which in turn aids retention (Armstrong and Taylor 2014).

In the activities related to staff development and advancement it appears that managers need a better understanding of the use of training and promotion and in particular, the importance of managing expectations. Training is seen by managers as a way of rewarding staff, yet without careful selection not all staff will have the ability to succeed on post-basic courses. If they do, they will expect promotion in line with the new qualification and be disappointed when vacancies at this level are unavailable and may look elsewhere for such opportunities. Others may go directly to jobs in other locations, possibly ignoring the bond set by the sponsoring employer. As one district manager said; "training is an exit route," and will often have a negative impact on staff retention. This highlights the importance of ensuring coherence across the different HR strategies used (Martineau, Mirzoev et al. 2015) and managers need to be able to assess the different 'trade-offs' of the strategies.

The management of transfers during the conflict period has already been mentioned. In the post-conflict period, only 33% of transfers were compliant with the rule for local government employees. However, no concerns were raised because of the low compliance to local government transfer rules. The usual explanation for such a transfer rule, which are common in a number for countries – particularly former British colonies – is to ensure that people are in post long enough to have an impact but not long enough to become complacent or engaged in inappropriate business. Yet within a decentralised system the options for transfer within a district are limited – especially for higher-level

posts. It may be time to review the relevance of this rule, which appears not to be monitored. Problems with transfer were not identified in Lacor, probably because of the size of the organisation.

Regarding subsequent staff movements after initial posting, temporary transfers known as secondments (sometimes referred to as deputation) seem to be neither a problem as in some countries (La Forgia, Raha et al. 2015) nor a solution. With the disconnection between districts due to decentralisation, secondment will rarely happen. Lacor is too small an organisation for this to be an issue.

Looking at the levers for change to respond to labour market variations induced by shocks to the health system, modification of the deployment policy may not be the best option. Perhaps more emphasis is needed in helping managers to adapt the implementation of the policies appropriately - particularly where they have more scope for action such as in decentralised environments or small organisations.

To prepare managers to be responsive to shocks, they first need a better understanding of human resource management and the intended and unintended consequences of a range of HR strategies e.g. induction in relation to performance management; post-basic training and the impact on staff retention. Then they need support - possibly just peer support - in testing out HR strategies in their own contexts. In times of stress, such as conflict, managers need help with emotional intelligence to help them to identify the most appropriates strategies to use in the circumstances.

In the post-conflict period, when assistance comes – for example in Uganda in the form of the Peace, Recovery and Development Plan – HR systems that could not be used effectively during the conflict need to be restored and strengthened. Examples from the case of Northern Uganda involve recruitment, including the advertising of vacancies, and the re-establishment of promotion processes. The transition period also provides the opportunity for revisiting some of the HR practices such as bonding, which Lacor dropped after the conflict, the rule regarding the duration of a posting (three-five years) which seemed to be ignored and no longer relevant in a decentralised system, and induction – an important function as organisations invest in new staff (Armstrong and Taylor 2014) - that was not being carried out.

4.3 Recommendations

The following recommendations derived from the study are all relevant to some extent to all three stakeholder groups: managers in Northern Uganda; policy makers and managers responsible for deployment throughout Uganda; and policy makers and managers in other countries emerging from conflict or crisis. Building more responsive deployment and other human resource management systems locally will prepare managers better for future shocks such as epidemics, as studied by ReBUILD in Sierra Leone (Wurie, Witter et al. 2016) or economic, as studied by ReBUILD in Zimbabwe (Chirwa, Chandiwana et al. 2016, Witter, Bertone et al. 2017).

1. Basic human resource management information systems across all major employers are needed during conflict and post-conflict periods - and beyond - across all sectors in order to be

able to adapt deployment policies and practices to the prevailing labour market conditions. During the conflict, it may be difficult to establish routine data collection, but managers could share their observations of attrition trends to get a better understanding of the labour market dynamics.

2. During conflict, local governments, humanitarian agencies and central governments should establish a harmonised platform of staff recruitment and deployment in order to avoid unhealthy competition for staffs and to ensure a stable labour market. The NGO Code of Conduct for Health Systems Strengthening should be introduced and followed.
3. The option of policy change - or suspension - should be considered in times of severe and prolonged conflict or crisis, in particular to support the staffing of rural areas in conflict zones in order to respect the safety of health workers, take the pressure off local managers and to maintain an equitable distribution of health workers.
4. Managers of health services in conflict-affected areas should be supported to innovatively implement existing human resources policies so that they can contribute to the creation of resilient health systems. This requires not only an understanding of human resource management, but they also need the emotional intelligence to select strategies that will support and not alienate staff. In relation to deployment, this means not posting staff to areas where they and their families will be in danger and possibly waiving rules about the length of the posting. They may also need to be flexible about rules, such as those on dual working, if staff are facing economic difficulties because of the conflict. Managers need to be aware of options available for improving deployment and of the unintended consequences of certain deployment strategies, and to be able to manage the trade-offs of different strategies.
5. HR systems that have collapsed during the conflict – such as formal recruitment and promotion – need to be re-established as soon as possible. In decentralised contexts, the central authorities may need to intervene on a temporary basis to rebuild the workforce - for example - by carrying out limited centralised recruitment.
6. The post-conflict period also offers an opportunity to re-evaluate existing deployment policies. For example, in Uganda, since the guidance on the length of posting does not appear to be adhered to following decentralisation, its utility could be reconsidered. In addition, the gender-sensitive nature of the policies should be reviewed.

5.0 **Conclusion**

This study sought to identify ways to improve deployment systems as a means of improving the staffing of rural areas in a post-conflict context, using case studies of two types of organisation that need to move staff around to ensure optimum service coverage. There were no specific changes to deployment policies in response to the conflict in either organisation, yet there were examples of how managers implemented the policies flexibly and sensitively, in order to meet staffing objectives as best they could and retain much-needed staff. In the case of local government, this flexibility was helped by the introduction of decentralisation during the period of conflict.

When implementing deployment policies, it is important to understand that incentives for health workers operate differently during and after conflict. Managers could be helped even more to tailor the implementation of deployment policies to need. A better understanding of the range of HR strategies is needed, and in particular, there is a need to develop coherent packages of HR strategies to avoid unintended consequences e.g. of "training staff for exit". Managers should also be supported to be able to take risks to adapt policies according to local needs - and not just during conflict-affected periods. They will then be better prepared to support a more effective workforce that will contribute to more resilient health systems (Kruk, Myers et al. 2015) in preparation for future conflict or non-conflict related shocks.

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7.0 Annexes:

7.1 Annex 1: Document Review

Method 1: Document review

Objectives: To describe the deployment policies and systems, the reasons for their introduction, how they have been implemented and any effects of the policy changes over the selected period.

Collecting the documents

1. Request initial policy documents from the HR Department (government and non-government organisations)
2. Follow up references in documents to previous policy documents
3. Use key informant interviews to identify new documents and check status of existing documents

7.1.1 Annex 1a) Review guide

1. Register details of the document in the table below
2. Carry out a quick review of the document (see Guidance on structured skim reading – seven steps below)
3. Decide whether to include in review or not and briefly register reason for decision
4. If included, make notes – using pages or paragraph numbers (often used in government documents) – on the following points – but not limited to them – about the policies.

    - Rationale for policy changes
    - Key policy items
    - Guidance on implementation
    - Monitoring and evaluation framework and/or data
    - Reviewers' own thoughts on the document

Details of Document:

1. Document title	
2. Authors/ institution	
3. Commissioning institution	
4. Journal title + issue, volume # and pp	
5. Publisher	
6. URL and access date	
7. Date of publication	
8. Status	

9. For inclusion? Reasons for or not	
10. Name of reviewer	
11. Date of review	

Notes (Page or paragraph number followed by note)

[add notes here]

Annex 2: Topic guide for key informant interviews

Method 2: Key informant interview: topic guide

Objectives:

- To clarify the documented information on the deployment policies and systems
- To identify contextual factors that may have influenced the development of the policies or the implementation of the systems
- To identify and enable an assessment of the effectiveness of the rural deployment and posting systems in large government and non-government employers of HRH during post-crisis period and the periods immediately prior to that.

Introduction: Introduce the project, the scope of the interview

Informed Consent Process: Ensure participant has read the information sheet, ask if she/he has any questions or areas for clarification, explain about confidentiality including recording the interview, complete consent sheet.

Details of participant:

1. Interviewee ID		6. Gender	Male ☐ Female ☐
2. Date of interview		7. Age	
3. Place of work		8. Name of interviewer	
4. Title of interviewee			

Topic guide

1. **Evolution of policy since 2006 year**

Context and challenges

- What were the main challenges for government policy in relation to posting of health workers to rural areas?
    - Particularly focus on challenges relating to:
        i. Ability to post enough staff to rural areas
        ii. Ability to keep them in those areas
        iii. Deputation of staff
    - Which cadre of staff were most challenging?
    - How did the challenges vary across the period (2006 to present day)?

- Tell me about the most important context changes over the period which affected health workers
    - Probe:
        - Economic changes
        - Security changes
        - Political changes
        - Organisational changes /reforms
        - International context
        - Other

Policy response

- How did the government react to these challenges?

- Can you explain to us how the posting policies changed over time since then?
    - Describe each of the policies, including any different policies for the different cadres of staff (check against map or description generated from Method 1)
    - Ask for the titles of relevant documents which articulate the policies (and ask where they might be available from, if you don't already have them)
    - Do you have any schemes of service? Please describe them. Have these changed over time?

- What were the objectives of each policy?

- Did the policies build on what went before or not (any learning from previous policies)? How do the different initiatives relate to one another?

2. Drivers of changes

- What were the main factors which influenced the changes in policy? (Discuss for each main policy change described)

- Who were the main actors involved in the process of developing rural posting policies?
    - How did they bring about the change? What did they do/influence?

- What resistance was there to policy changes? Describe this resistance

3. Implementation challenges

- Taking each of the policy changes in turn, can you describe to me how they were implemented?

    - What were the mechanisms?
    - Over what areas of the country?
    - Focussed on which health workers?
    - Implemented by whom? At what level?

- What were the implementation challenges?
    - Were they overcome? How?

- What were the strengths in relation to implementation?
    - Describe how they were achieved?

- Overall, how effective was the implementation?

4. Effects of the policy change(s)

For each major policy change/intervention described by the KI, ask:

- Was it ever evaluated? How and by whom? What were the results?
- What was its overall impact, in your view?
- How did effects differ across regions? Across cadres? Across ethnic groups? Across genders?
- How do others view the experience? What lessons have they drawn from it?
- Did it have any unintended effects (positive or negative)?

And more specifically:

Staff turnover

- What was the effect of the policy on the turnover of staff? Give examples of this with numbers
- Why do you think the policy had this effect?

Staff vacancies

- What was the effect of the policy on the vacancy rates? Give examples of this with numbers
- Why do you think the policy had this effect?

Improved access to services

- Has the policy enabled people, especially in poorer areas, to access services at reasonable cost and quality (or had the opposite effect)?
- Explain your answer

Systems effects

- Has the policy affected the wider health system?
    - How?
    - Any positive or negative effects (whether intended or not)? Please describe them (example: depletion of health workers in urban areas)

5. Your recommendations

- Based on these experiences, what do you think should be done to improve the posting of health workers to rural areas?

- Which strategies should be adopted in the future to address the current challenges for rural posting?

Annex 3: Personnel record data collection tool

Method 4: Personnel record data collection tool

Note: this tool might be slightly modified following an analysis of the document review and KII data; it will also need to be pre-tested in a non-study district.

[The sampling would be based on a random selection of 10% of the records by cadre]

Data collection information:

1. Name of enumerator:
2. Date of data collection:
3. Location (facility or office name):

Personnel record information:

4. Personnel record number: Provide Study ID number:
5. Sex:
6. Place of birth or 'home':
7. Nationality:

POSTING INFORMATION (START FROM THE EARLIEST POSTING)

JOB 1

8. Job title:
9. Job grade:
10. Contractual status (permanent, probationary/unconfirmed, fixed-term contract)
11. Posting station:
12. Facility:
13. Posting date (date on initial posting letter):
14. Reporting date (date the person first reported for work):
15. Reasons for posting (information provided in posting letter, if any):

JOB 2

16. Job title:
17. Job grade:
18. Contractual status (permanent, probationary/unconfirmed, fixed-term contract):
19. Posting station:
20. Posting date (date on posting letter):
21. Reporting date (date the person first reported for work):
22. Reasons for posting (information provided in posting letter, if any):

JOB 3 etc.

PROMOTION INFORMATION (START WITH THE EARLIEST PROMOTION)

PROMOTION 1

23. Job title (including if unchanged):
24. Job grade:
25. Reason given for promotion:

PROMOTION 2

26. Job title (including if unchanged):
27. Job grade:
28. Reason given for promotion:

PROMOTION 3 cont'd

TRAINING INFORMATION (START WITH THE EARLIEST TRAINING)

INITIAL/BASIC TRAINING

29. Professional qualification:
30. Educational institution:
31. Graduation date:
32. Funding of training:

POST-BASIC TRAINING 1

33. Professional qualification:
34. Educational institution:
35. Entry date:
36. Graduation date:
37. Funding of training:
38. Reason for training (if provided):

POST-BASIC TRAINING 2

1. Professional qualification:
2. Educational institution:
3. Entry date:
4. Graduation date:
5. Funding of training:
6. Reason for training (if provided):

POST-BASIC TRAINING 3 etc.

OTHER INFORMATION RELEVANT TO POSTING

This might include long-term illness; maternity leave; disciplinary case; extended leave of absence; etc. – but need to check ethical implications for this. This would also be checked for usefulness in the pre-testing.

Annex 4: Personnel record data analysis tool

Policy compliance analysis (separate sheet for each cadre)

Policy items/record ID	**001**		**002**						Totals y and n
	y	**n**	**y**	**n**					
Policy 1 (date start)									
Item 1	1	0							
Item 2	0	1							
Item 3	1	0							
Etc.		0							
Policy 2 (date start)		0							
Item 1	1	0							
Item 2	0	1							
Item 3	0	1							
Etc.		0							
Policy 2 (date start)		0							
Item 1 etc.	0	1							
		0							
Total score	3	4							

Y = mostly or fully compliant

N= mostly or fully non-compliant

What to do if more than one item within a single policy date range (e.g. two postings)?

Outputs of analysis (descriptive analysis):

1. Compliance rates by policy
2. Compliance rates by individual policy item
3. Compliance rates by total job history (possibly)

Annex 5: Topic guide for in-depth interviews with managers

Method 5: In-depth interview with managers (overall manager for deployment): topic guide

Objectives: To explore managers' perceptions and experiences of the implementation the deployment policies and systems during the study period and the impact on vacancy rates and turnover in rural areas.

Introduction: Introduce the project, the scope of the interview

Informed Consent Process: Ensure participant has read the information sheet, ask if she/he has any questions or areas for clarification, explain about confidentiality including recording the interview, complete consent sheet.

Details of participant:

1. Interviewee ID		5. Job title and cadre of interviewee	
2. Date of Interview		6. Gender	Male ☐ Female ☐
3. District		7. Age	
4. Facility name		8. Name of interviewer	

Topic guide

I would like to understand about how the system of posting/deployment has changed over time and the impact on your ability to fill vacancies, particularly in remoter posts. First, I would to ask some questions about your role.

1. Experience in managing deployment

a) How long have you been managing deployment in this current post?

b) Were you managing deployment in previous jobs - where and when?

c) What does your job involve in managing the deployment process?

Perhaps you can give us an example of a recent posting that you managed.

2. Changes in ability to fill posts

a) What have you noticed in the time that you have been managing deployment regarding vacancy levels and turnover – particularly in small rural areas in your current job and any previous job in which you were managing deployment?

b) For which cadres have there been the biggest changes?

(Show staffing data identified through Methods x, and talk through any significant changes.)

c) Can you offer any explanation for these changes?

3. Changes in deployment policies

a) What changes in deployment policy are you aware of since you have been managing this function? (Check whether any specific policies are referred to; ask for policy documents or guidelines available to the individual and note down the details of these documents.)

b) How did these changes affect the way you managed deployment? Probe for specific issues identified in the document review and key informant interviews.

c) Do any of the changes in deployment policy explain the changing vacancy levels and turnover discussed earlier? Interviewer to probe based on his/her knowledge of these policies.

d) Are there any specific difficulties in implementing both the current policy and previous policies (as discussed earlier?) Probe for issues related to skills, knowledge of the policy, or adequate HR information. Also, probe for issues of pressure to bypass policy in the deployment of staff, either within the district or from higher levels.

e) Are there any other factors that have influenced the effectiveness of the deployment policies – either positively or negatively? Probe for specific issues identified in the document review and key informant interviews.

4. Suggestions for improving deployment

Based on your experiences what do you think should be done to improve the posting of health workers in rural areas?

5. Closure

Is there anything that you would like to ask me?

The interviewer thanks the interviewee for their time and explains how the information will be analysed and the findings of the study disseminated.

Annex 6: In-depth interview/case history guide

Method 6: In-depth interview (with job history) with health care providers: topic guide

Objectives: To explore health workers' perceptions and experiences of the deployment policies and systems and their evolution over time.

Introduction: Introduce the project, the scope of the interview

Informed Consent Process: Ensure participant has read the information sheet, ask if she / he has any questions or areas for clarification, explain about confidentiality including recording the interview, complete consent sheet.

Details of participant:

1. Interviewee ID		5. Type of health care provider	
2. Date of Interview		6. Gender	Male ☐ Female ☐
3. District		7. Age	
4. Facility name		8. Name of interviewer	

Topic guide

I would like to understand about your career. Can you draw me a line, starting with your birth and leading to the present day? What are the major events that you would put on it? Suggestions to include: marriage, births, training, different jobs. Describe them to me.

Allow respondent to draw the whole life history. Then using that diagram explore their career with probing questions, such as:

- How did you come to work in the health field?
- What basic training (pre-service) did you have? How was this training funded?
- For each job:
  - When was that job? (Start and end times for each job).
  - Tell me about the job – what was the title, where was the job (type of facility), what did you do there?
  - Why did you do take that job? Is this the job you wanted or did you want to go somewhere else? Why?
  - How were you posted to that job?

- Tell us about the administration procedures that you went through to be posted to this job?
- What do you think about these procedures?
- Did you have any help in getting this job? Who helped you and how did they help?
- Did you try to change your job at any time? How did you go about doing this? Was it successful and why? Was it not successful and why?
- What do you understand about the policy of posting at this time?

- What post-basic training have you had during your career (e.g. upgrading from enrolled nurse to registered nurse?) What were the selection criteria for this training? How was this funded?
- What are your future job plans? How do you think the current deployment policies and systems will support these plans?