Policies to attract and retain health workers in Northern Uganda during and after conflict: findings of key informant interviews

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July 2014

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Executive summary

Introduction

The dynamics of the health workforce in fragmented post-conflict situations is inadequately understood. However, this information is key to restoring a well coordinated and functioning health system. The post conflict period may sometimes provide a window for policy reforms to address long-standing human resources for health (HRH) challenges. This study aims to understand the evolution of government and donor policies supporting health workers during and after the conflict in Northern Uganda, and to derive recommendations on how to improve their effectiveness and sustainability. This report covers one component of a wider ReBUILD research project, which also included in-depth interviews with health workers, document review and stakeholder mapping.

Study methods

In 2012-13, a total of 25 key informant interviews (KIIs) were conducted in four districts of the Acholi sub-region of Northern Uganda (Gulu, Kitgum, Amuru and Pader). The study population at national level comprised of health planners, human resource managers and representatives of professional associations, faith based organisations and development partners who have been engaged in various HR activities in the country for ten or more years. The study population at district level included district health officials and public and private not for profit facility in-charges.

Findings

The findings of this report present evidence on HRH challenges during and after the conflict, and the policy responses to the HRH situation. Key informants' perceptions of the effects of these policies are provided in the 'policy responses' section. Following this is a section that discusses actors involved in policy development and their positioning, as well as factors influencing policy change. The report ends with a discussion of the findings, recommendations from key informants, and a summary of lessons learnt and conclusions.

The HRH challenges affecting recruitment, retention, distribution and performance were perceived not to have changed significantly from 2000 to 2012. However, some changes

were highlighted in relation to magnitude and cause. For instance, during the conflict these challenges were exacerbated by the security situation. Recruitment and retention of health workers, particularly doctors and other skilled cadres, posed the greatest challenge. Lower cadres, such as nursing assistants, who may have been recruited without any training and acquired skills on job tended to stay and work in the region for longer periods than the other cadres, whose training takes over two years.

Policy responses consisted of official policy changes, implementation initiatives and programmes. During the conflict, incentive environments in Northern Uganda were dominated by international non-governmental organisations (INGOs). They focused on improving working conditions, which had been worsened by conflict, boosting staff numbers, and paying salaries as well as allowances. After the conflict, the incentive environment was characterised by a switch from short term measures to long term measures, although there was reduced support from INGOs compared to before. The key issues in HR policy were: i) improvement of working conditions; ii) improvement of recruitment and distribution of health workers in the region; and iii) addressing the training needs of staff.

It was not clear which of the incentive policies were more effective. The findings indicated that very limited attention has been given to evaluating HR policies, other than those implemented by donors.

While a number of policies have been drafted to benefit health workers (including those related to incentives), the majority of the policies were national in scope, rather than having a specific focus on the Acholi sub-region. Nevertheless, there was general acknowledgement that the region needed particular attention.

Policy actors included INGOs and national and local government bodies. Other actors that were influential included district councils, health workers, health workers' unions, professional bodies, members of parliament, health training institutions and academic institutions. The study was unable to ascertain how the roles of policy actors changed over time.

The factors that influenced the health worker incentive policies during and after the conflict were: security changes, economic changes and availability of funding, evidence feedback, changes in technology, changes in capacity building needs, advocacy and politics. These factors also influenced the composition and positioning of actors at national and district levels.

Recommendations from key informants

- A more coordinated recruitment process needs to be introduced in the sub region. This would help reduce wastage of resources in relation to the process.
- Health worker salaries need to be increased to match promotion, the cost of living and inflation.
- Recruitment needs to take the gender balance into consideration so that there are more equal numbers of men and women.
- There is need for more research on quality of care, competence and performance of mid level cadres in the region. This is because the majority of cadres - for instance, the nursing assistants who may have been recruited without any training and acquired skills on the job - tend to stay and work in the region for longer periods than the other cadres.
- The selection criteria for in-service training needs to be aligned with official policy to ensure that the 'most disadvantaged' benefit.
- There is need to evaluate the hard to reach allowance and also clearly explain the eligibility criteria to all intended beneficiaries to avoid misunderstandings. Care must be taken to consider the contextual differences when defining concepts such as urban or rural.

Lessons and conclusions

- In relation to the overall ReBUILD research question about whether the post-conflict period offers a window for reforms, the story seems to be one of continuity, perhaps because only part of the country was affected and so underlying systems continued. This makes Uganda a nice counterpoise to the other countries where conflict was more nationwide.

- Policies to attract and retain health workers should not be piecemeal but rather comprehensive as many of the factors for attraction, retention, distribution and performance are interrelated.
- Some policies are based on evidence, but in general there is a lack of systematic focus on documenting policy effects. There is a tendency for donors to evaluate their policies whereas the governments may not evaluate policies unless they are donor funded and hence evaluation is part of the terms and conditions.
- While policies may be put in place with good intentions, they may also have unintended effects. An ongoing risk assessment should be implemented alongside all policy initiatives.
- Although INGOs boosted staffing levels in some cases, in others their increased salaries resulted in them poaching staff from public facilities.
- The end of conflict may bring deterioration when the intensive support of INGOs and other actors is withdrawn. For all policies and implementation programmes, there should be an accompanying sustainability plan. In most cases the departure of INGOs meant close of business for the projects they were implementing, resulting in restructuring, loss of jobs by some health workers and drug shortages.

Acronyms

AIDS	Acquired Immune –Deficiency syndrome
AMREF	African Medical and Research Foundation
ARVs	Anti Retroviral drugs
AVSI	Association for Volunteer Services International
CAO	Chief Administrative Officer
DANIDA	Danish Agency for International Development
DHO	District Health Officer
DLG	District Local Government
DNO	Nursing Officer
EU	European Union
HC	Health centre
HIV	Human Immune Virus
HRD	Human Resource Development (Unit)
HRH	Human Resources for Health
HRM	Human Resource Development (Unit)
HTI	Health Training institutions
HW	Health Workers
INGO	International Non Governmental Organisation
KII	Key Informant Interview
KI	Key informant
LRA	Lord's Resistance Army
MoES	Ministry of Education and Sports
MoFPED	Ministry of Finance, Planning and Economic Development
MoH	Ministry of Health
MoPS	Ministry Of Public Service
NGOs	Non-governmental organizations
NUMAT	Northern Uganda Malaria, AIDS and Tuberculosis program
PEAP	Poverty Eradication Action plan
PNFP	Private, not-for-profit
PRDP	Peace, Recovery and Development Plan
PSRP	Public Service Reform programme

ReBUILD	Research for Building Pro-poor Health systems during Recovery from conflict
Swap	Sector-Wide Approach
UCMB	Ugandan Catholic Medical Bureau
UDHS	Uganda Demographic health survey
UK	United Kingdom
UNFPA	United Nations Population Fund
UNMC	Uganda nurses and Midwives' Council
UPMB	Ugandan Protestant Medical Bureau
USAID	United States Agency for International Development

Acknowledgements

This work was supported by UK Department for International Development (DFID) through the ReBUILD Consortium. The authors are deeply grateful for the financial support to carry out this work.

This work draws on the perspectives and experiences of key informants (KIs) at national (Kampala district) and regional level (from Gulu, Amuru, Kitgum and Pader districts). Categories of these KIs have been mentioned in the methods section of this report. We are deeply grateful for all the patience, time, cooperation, insights and experiences shared during the research process and without which this work would not have been possible.

We appreciate the technical input of Prof. Freddie Ssengooba particularly towards development of the study tools and training of research assistants. We also appreciate the contribution of research assistants particularly; Mrs Sarah Auma Ssempebwa, Mr. Deo Tumusange, Mr. Tenywa Ronald, Ms. Resty Nakayima and Ms Eunice Kyomugisha for their hard work and contribution to the data collection and transcription of the interviews.

Introduction

The dynamics of the health workforce in a fragmented post-conflict situation is inadequately understood. However, this information is key to restoring a well coordinated and functioning health system. Incentives to attract and retain health workers need to be identified and an appropriate package tailored for the post conflict setting in Uganda.

This report forms part of a ReBUILD research programme looking at these issues across four post-conflict settings – Northern Uganda, Cambodia, Sierra Leone and Zimbabwe. The overall aim of the research is to understand the evolution of incentives for health workers post-conflict, and to derive recommendations on incentive environments, which will support health workers to provide access to rational and equitable health services.

The research programme involves a range of methods; however this report focuses on key informant interviews (KIIs) with actors who have been involved in the implementation of incentive related policies at both national and regional level in Uganda. The objective of the interviews was to understand key informants' perceptions of health worker incentive policies, their evolution in the post conflict period, their implementation and their effects. This report will complement the findings of ReBUILD's wider research in Uganda which include stakeholder mapping, document review and health worker life histories (Namakula et al. 2013). The study will also feed into comparative cross-country analysis.

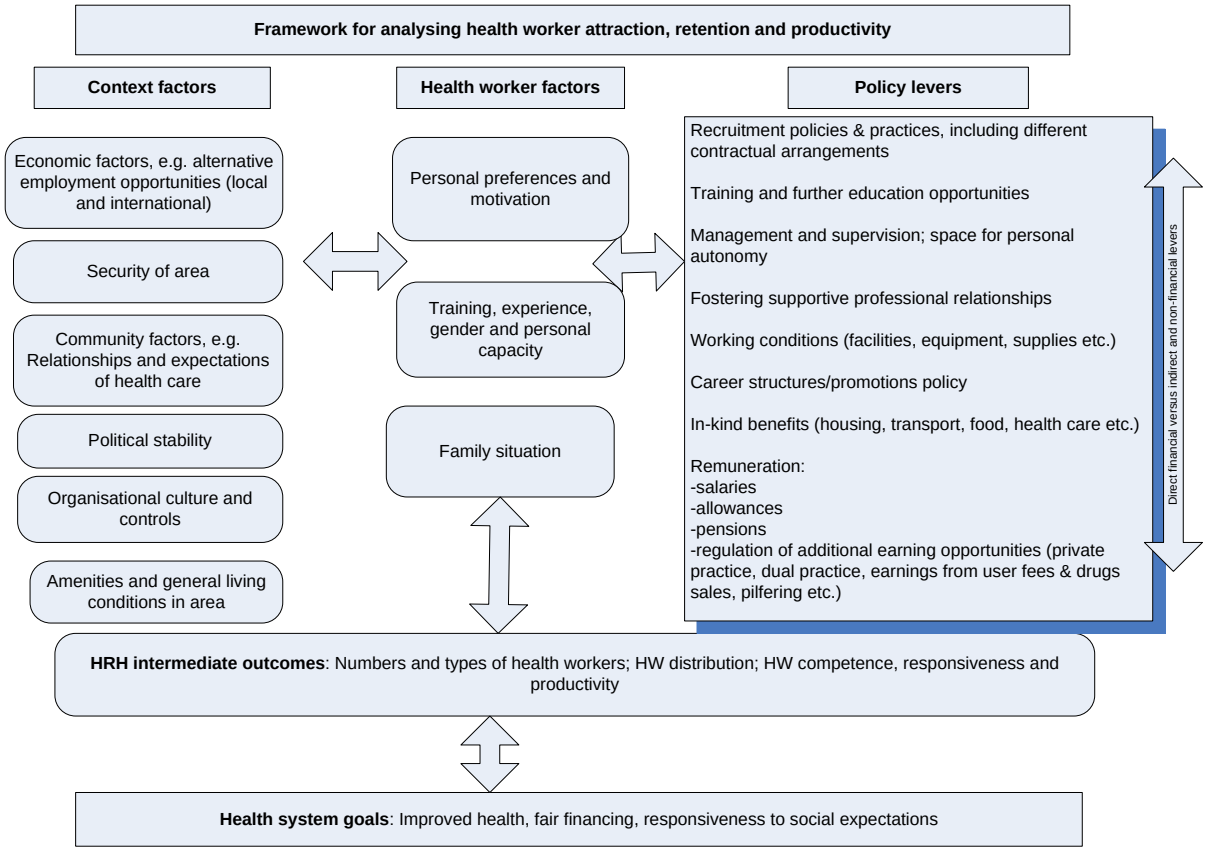
This report begins with a brief overview of our research objectives and methodology. This is then followed by a discussion of our findings section which includes evidence on HRH challenges during and after the conflict and the policy responses during this period. A discussion on KIs' perceptions of the effects of these policies is provided in the section on policy responses. The next section presents findings on actors involved in policy development and their positioning (whether it changed or not), as well as factors influencing policy change. The final sections contain the discussion, recommendations and conclusions.

Research methods

The research programme developed a conceptual framework, which outlines the linkages between contextual features, personal attributes and policies, and how those may influence HRH and health system outcomes (see Figure 1).

Figure 1The key informant interview method was chosen because it would enable the research team to complement other methods of data collection that were used (stakeholder mapping, document review and life history interviews). KIIs were used to solicit complementary information from knowledgeable individuals on HRH incentive policies over time, covering information which was less likely to be contained in official documents, such as drivers of policy and positioning of actors.

Figure 1 Conceptual framework, HW incentive research



Source: Witter et al 2011

Study design

This was a qualitative study, using a semi-structured interview guide to solicit the views of purposively selected informants to give retrospective as well as current insights.

Study setting

Five districts were purposively selected for the study. Kampala district was selected to represent national level, given that most of agencies and actors involved in HRH policy development at national level are located in Kampala. The four districts selected at regional level were Pader, Gulu, Amuru and Kitgum because these formed part of the overall study area for ReBUILD Uganda, were among those most affected by the LRA conflict, and also contained more than 90% of the displaced people[1]. A pre-test was done in Pader and final data collection was conducted in Gulu, Amuru and Kitgum.[2] We aimed to interview in-charges in both public and PNFP sectors who had worked for more ten or more years in HRH in the Acholi region. The rationale for this choice was to help the research team understand the policy trajectory from 2000-2012. Such information could only be provided by those who had longer experience in working on the development as well as implementation of incentive policies and practices over time.

Tool development

The process of tool development was a participatory one between team members from Uganda and the United Kingdom (UK). A generic topic guide was produced by the UK lead researcher and was then pre-tested and adapted by the local team based on insights generated during the training of the research assistants and pretesting. The topic guides were organized into five main sections: context and challenges; policy responses; drivers of change; implementation of policies; and policy effects. This structure aimed to allow possibility of future integration of KIs' perceptions with evidence from document review, which used a similar structure. Tools were tailored to pick up more perception of policy

[1] Source: Department of Disaster preparedness Refugees, also quoted in Namakula, Ssengooba et al, 2011: Research for Building Pro-poor health systems during recovery from conflict: A situation analysis of Northern Uganda, Makerere University, and ReBUILD Consortium. Note that by 2003, Amuru district was still part of the greater Gulu.

[2] Data from the pre-test district (Pader) as well as the 'actual' study districts were all analysed and included in this report. This decision was made to ensure use of rich pretest data and to enable diversity of views from more districts across Acholi sub-region.

design and rationale at national level and of implementation issues on the ground at district level. Final versions of the key informant topic guides are annexed at the end of this report.

Selection of participants

A total of 25 KIIs (13 at national level, and 9 at district level) were conducted. A summary of their characteristics is given in Table 1 below. The key informants were selected using insights from the stakeholder mapping exercise that was conducted in July 2012 (Namakula & Kiwanuka, 2012), followed by further snow-balling. Selection criteria included sector of employment (public and PNFP sectors) and the length of time the participant had been working on HRH issues at national level and in the Acholi sub-region. Those selected were supposed to have worked for ten or more years on HRH issues. This criterion was mainly for those at national and district levels. However, at the facility level, facility in- charges were selected purposively based on ownership of the facility (public or private not for profit/PNFP), level of the facility (HC II, III, IV and Hospital), level of seniority, time spent working in the facility and knowledge of administration and human resource issues.

The study population at national level comprised of health planners and HRH managers and representatives of health professional associations, faith based organisations and development partners who have been engaged in various HR activities in the country for ten or more years. The study population at district level was divided into district health officials and facility in-charges in both public and PNFP sectors.

Table 1: Summary of interviews

District	Number of interviews	Gender
Pader	3	3 female
Gulu	4	2 female, 2 male
Kitgum	4	3 female, 1male

Amuru	1	1 male
National	13	4 female, 9 male
Total	25	12 female; 13 male

Field work

The pre-test was conducted in Pader district in August 2012. Interviews with both national and regional levels started in October. Whereas field work at district level ended in October, some interviews with national level staff continued into November and December due to the extension of appointments by the participants. The research team comprised of 7 people: 6 Research Assistants and the team lead for project 2 in Uganda.

Analysis

Data analysis was guided by the framework analysis approach of Ritchie and Spencer (1994) and used ATLAS TI version 5.0. The analysis framework involves the following stages: familiarisation, listing to the audio recordings, reading field notes, coding and identification of key themes, merging themes, searching for key findings under each theme, comparing and finding associations, and the provision of explanations/meaning (Ritchie & Lewis, 2003 pg. 212).

The audio tapes were listened to and compared with notes taken during interviews to fill in the information gaps that could have been left out or miss-recorded during note taking. Audio recordings were transcribed verbatim so that the original meanings were not lost. Interviews were then filed using identifiers such as district, ownership type of facility, cadre/position held and gender.

Transcripts were read several times to get an overall picture and then recurring themes were identified. A coding frame was generated and agreed upon between team members in Uganda and in the UK. The transcribed interviews were then entered in ATLAS TI Software and coding nodes were attached to the various themes. ATLAS query reports were then

generated and printed out for each and every theme. The query reports were further scrutinised for any other some subthemes that emerged and quotations that epitomised the central themes were identified. Findings were then synthesised across the main themes, noting patterns and differences across the main sub-groups.

Findings

1. The context and HRH challenges during and after the conflict in Northern Uganda

Introduction

This section seeks to explain the various HRH challenges faced during and after the conflict. These included recruitment, distribution and retention challenges, and factors which affect performance. This will be followed by a discussion of the KI's perceptions of these challenges during the two conflict-related phases.

Recruitment challenges

During the conflict, it was difficult to recruit and retain health workers in the Acholi sub-region. These recruitment challenges were catalysed by insecurity in the region. Insecurity resulted in death, fear of death and abduction, which continued even after the conflict ended. This context made it difficult to attract health workers to the region. However, although the security situation improved during the post-conflict period, other recruitment related challenges were reported to have emerged, such as: reduced output from health training institutions, unfavourable nationwide recruitment policies (e.g. recruitment ban and poorly focused recruitment[3]) and competitive labour markets in the region.

In relation to the output of health institutions, it was reported that it was very difficult to recruit nurses in Pader district. This was attributed to the fact that the only training school within the district; Kalongo School of Midwifery, mainly produced midwives. Hence, there was an overflow of midwives and scarcity of nurses in Pader district.

[3] Referring to recruitment of staff that are not necessarily hands-on medical personnel but categories of support staff such as compound cleaners (shamber boys) and askaris (security personnel) responsible for protecting the health facilities

"We had gaps [...] our main challenge was that we did not have nurses. You know Kalongo School of midwifery produces midwives. So the district gets the opportunity to recruit midwives but there were no nurses, there are very few nurses in Pader." (KI, Pader)

In some cases, nationwide policies such as the recruitment ban were identified by key informants as a contextual constraint. Despite acknowledging existing staffing challenges, the recruitment ban was cited as a major frustration in health worker recruitment. There was some uncertainty among some of the key informants regarding when the ban would be lifted.

"[...] for now, I do not know whether they have lifted the ban on recruitment of health workers because there was some discussion in Parliament about that issue." (KI, Amuru)

'' *Recently, the DHO gave the list of staff required to the district service commission. They advertised but before we could do the recruitment, the recruitment ban came.'' (KI, Amuru)*

Lack of payment and delay of funds were also mentioned as challenges to recruitment in the post conflict period. It was noted that funds to facilitate stages of the recruitment process, such as advertisement and short listing, were lacking. Poorly focused recruitment i.e. recruitment which is not related to the prevailing staffing needs, was also another challenge. In some cases, it was noted that whereas the need for qualified staff is known, there is a tendency for the District Service Commissions[4] to keep recruiting low cadres of staff and non-health staff such as guards (locally known as Askaris) and compound cleaners.

"[...] this business of recruiting nursing assistants, you know the level of nursing assistants, they need to recruit the nurses, the midwives clinicians and even doctors, it is possible [...] for nursing assistants we have enough." (KI, Pader)

[4] District Service Commissions are formulated under the Article 198 of the Constitution of Republic of Uganda (1995). They are regulated by the Public service commission which is mandated for human resource needs such as recruitment, appointment, posting, remuneration of civil/public servants for all the Ministries in the whole country. However, under the decentralization act (1997) and under article 198 of the constitution, the District Service Commission is approved and appointed by the Public Service Commission to conduct the above mentioned duties on its behalf at the district level. According to Article 198(2) of the constitution, the District Service Commission comprises: a chairperson and other members as determined by the district council. Urban authorities are also represented.(Government of Uganda,1995)

Additionally, key informants noted that recruitment of health workers in Acholi is done at different times within the region. This inadvertently opens up markets for mobility of labour across districts and creates competition for such labour between districts. Job offers are presented to health workers from different districts and they are free to select a job in their district of preference. Unfortunately, some districts end up losing twice, with resources invested in the recruitment process yielding little or no result and the existing workforce being lost to other more attractive districts.

"Our biggest problem is that usually when the advertisement for health workers is done, you know it is done concurrently; Gulu advertises, Kitgum advertises and Pader, Lamwo and Nwoya districts do the same. So, usually, when adverts come at the same time, the health workers also tend to apply to all these places and also go and sit for interviews in all these places. So now, you find that for instance Kitgum can recruit say 10 midwives who have been successful in the interview but the same midwives have passed interviews in Gulu. In most cases, we stand to lose.'' (KI, Kitgum)

''You could find that the same people who have applied to our district have also applied elsewhere. So they go and do interviews there as well. But if they are admitted elsewhere, they prefer to go and work because those are easy to reach areas than here.'' (KI, Kitgum)

"[...] there is another problem of coordination. In the past, districts were advertising differently. It is still a problem. So people go to do interviews in different places and you give them positions but then they select the best district of their choice. So you would have appointed somebody and they have eaten your money in terms of that recruitment process and then you have to do it again." (KI, Kampala)

Distribution challenges

Distribution challenges were related to low numbers of staff and a poor mix of cadres and gender. Conflict played a major role in these HRH issues as many people died or were living in fear of death, abduction and ambush. The distribution challenge was further worsened by

health workers escaping to safer places in the Acholi sub-region, e.g. camp settlements, or to other regions in the country, leaving low cadres to manage the health facilities.

"Some (health workers) were being killed every day like animals. I remember a colleague who was a nursing officer, he was a male nurse, and [...] they found him at his home just after coming back from the hospital and killed him. [...]a young man (rebel soldier) shot him but before he was shot, he tried to explain to them that he was a health worker but gave him a deaf ear and never spared him.'' (KI, Kampala)

"And in our life situation the war stressed most of the staff, most people fled, some died, it really stressed the staffing numbers.'' (KI, Pader)

''The health workers were their target. They were looking for health workers like needles. [...] Of course they also needed our services in the bush so when they got you as a medical worker, they would want you to help them[...] every time you would be working at risk, any time you would be abducted[...].'' (KI, Pader)

''At that period of time, human resource was inadequate because most of our health centres were at camp setting situation, then only few qualified staffs were at those health centres, most of facilities were being run by Nursing Assistants and they were residents of those areas, they could persevere the hardships of the situation.'' (KI, Gulu)

After the conflict, there was relative peace, which should have meant that health workers would return to their original areas. However, the study highlighted that health workers did not return at the same pace as the general population due to factors including fear of possible recurrence of war. The already small numbers of health staff and poor staffing mix have been further affected by the attrition of health workers to neighbouring South Sudan, which offers better working conditions and pay. Consequently, the health facilities in the study districts still lack adequate staffing and an appropriate skills mix. While the situation is poor amongst all the districts visited, Pader and Amuru seemed to be worse off than Kitgum and Gulu. This could be because these districts are more rural and younger respectively. Key informants highlighted the staffing needs at district and health facility level. Some of the

higher level cadres were also reported to have assumed administrative roles at district level, therefore diverting their time away from patients.

"We have not yet met the number of staff needed (at the health centre III where the respondent works). We only have one clinical officer who is also the overall in charge who can be called anytime anywhere for a meeting. We have nursing assistants, majority are nursing assistants and only one nursing officer. We do not have an enrolled nurse but at least we have midwives. They were supposed to be three here but at least we have two."(KI, Pader)

***"**At the moment, the staffing norm for a health centre IV like ours should be 48 staff members. But here at our HC IV you find that only 50% of the posts are filled. We have only 22 staff members and that is only half of the norm. Then we go to HC IIIs where the staffing norm is 19 staff but when you go there the facilities practically have ten staff members. And then now the staffing norm for HC IIs is supposed to be nine but on average, those facilities have only five or even below.'' (KI Kitgum)*

"But when you go right on the ground, you find that the qualified staffs are not there. When I talk of qualified staff, of course, Health centre II, has to be run by a clinician, at least two, one senior clinical and then the junior but at the moment, not even one." (KI, Pader)

''We [now] have one doctor who is the DHO and of course he is an administrator. Our health centre IV is supposed to have a doctor. Other cadres like nursing officers, midwives are still lacking. Actually, we have filled around 46% of the staff and we do not have most of the cadres. Such is the dilemma we are in.'' (KI, Amuru)

Additionally, the unbalanced gender composition of health staff was pointed out as a major challenge in the post conflict period. Some positions, such as those related to maternal health are dominated by women, who also have the responsibility of running their homes and looking after their families. These are perceived as contributing to absenteeism of female health workers, leaving a heavier workload for the few male workers. Nothing was

mentioned by the key informants in relation to the gender composition of health staff during the conflict period.

"[...] but midwives are few [...] because in practice, all health centre IIIs and IVs should have a midwife. However, you find that we have only one midwife in each of those levels and if she is on [maternity] leave, there is a big gap because there will be no one to remain. And then the HCIIs, with the new construction system, they have a maternity attached but you find that there is no midwife in those facilities. Those are the only challenging part on human resource." (KI, Gulu)

Retention challenges

During the conflict, the retention of health workers was also a challenge. The key informants mentioned a number of factors including health workers leaving their posts for safer placers as a result of war or epidemics such as Ebola. Efforts to recruit health workers during the war were also frustrated by fear of insecurity etc.

''Before the conflict, we were okay with staffing but during the conflict, particularly during the Ebola times, most of the health workers, especially those who did not belong to this end left and the staff numbers began dwindling.'' (KI, Amuru)

''During the war, majority of the health workers ran away. It was very difficult to retain them. Some of them would be advised by their relatives 'although you promised to die for the people eeh eeh!! But you cannot die when you are just seeing death coming'.'' (KI, Pader)

"Then there were some partners who were supporting recruitment in the district. So in 2000, district council and district service commissioner recruited some health workers but they were not able to be retained where they were posted. [...] and with this war people were not able to stay there.'' **(***KI, Gulu)*

There was a general perception among key informants that there was no major change in HRH retention challenges between the conflict and post-conflict period. These retention

challenges were perceived to have remained in the post conflict period, although less pronounced than during conflict.

'' When I compare with the previous years, the percentage of those leaving was high but it has reduced [...]."(KI, Kitgum)

''Right now if we are to list the names of those who have disappeared, they are really many and I find they are wasting money to recruit and staff disappear like that.'' (KI, Kitgum)

Key informants thought that the main factors contributing to retention challenges were: the departure of NGOs from Northern Uganda and the inability to sustain staff formerly employed by NGOs, the inability to retain staff who did not originate from the region, brain drain to nearby south Sudan in light of attractive salaries, fear that conflict will recur, as well as lack of social amenities for health workers and their families in their current districts or places of work.

''Some feel like coming back but they fear because they do not know whether the region shall be stable again. Some health workers have gone to South Sudan. [South]Sudan is considered a greener pasture because they pay them a lot whereas the payment here is very little. Therefore they do not feel like coming back.'' (KI, Pader)

''Majority of our staff are going to South Sudan because these days there are few NGOs but in Sudan, they are better paid than in Uganda.'' (KI, Kitgum)

"Now we are losing a good number of them [clinical officers] to Sudan. We have also lost some nurses. I remember two months ago we lost the in charge of XX Health centre III. He went to Sudan where he is getting better pay. We also lost the clinical officer of another XXX health centre III. We have lost a good number to Sudan." (KI, Kitgum)

"*[…]apart from remuneration we know that there are other things; in places like Northern Uganda the health workers have problems with just basic amenities: water, electricity, schools*

for their children, staff housing those are motivating factors that are not there not available and so they force them to move out." (KI, Kampala)

It was also highlighted that a number of NGOs that came into Northern Uganda during the conflict seconded health workers to both public and private not-for-profit health facilities. These seconded health workers were paid by the NGOs. After the conflict, many of the NGOs pulled out of Northern Uganda and there was no existing local capacity to retain the health workers who had been seconded

'' When the war ended, the NGOs also withdrew, their projects also ended and so the challenges came. [...] we also stopped using their workers because we could not maintain them, we could not pay their salary so we had to lay them off together with the project'' (KI, Kitgum)

Working conditions challenges during and after the conflict

Workload and working hours

During the conflict, the key informants noted that health workers were faced with increased workloads and long working hours. This was a result of increased casualties of war and the flight of health workers from the region to more peaceful areas of the country. This was mostly the case for those who stayed working in the camp settlements, as well as those who worked in the PNFP facilities that remained open during the war. Such health workers not only experienced fatigue and burn out but also showed commitment to their work:

"[...] you could find many gunshot victims in the wards and you would work from the time of arrival up to 5 PM and even if there was a shift coming to relieve you, there was still a lot of work on these patients. [...] for us we were working 24 hours from 8am to 5pm and then from 5pm to 8pm and then 8pm to morning.'' (KI, Kitgum)

"[...] whenever we woke up, we could find the whole place full of faeces. So, before we went on duty, we had to clean the place first [...] the situation of health workers was not really

very good I should say. There were a lot of challenges for health workers. As the war went on, the people were in concentrated camps and the numbers of health workers were few compared to the number of patients. So, in a way, they were overwhelmed with work especially in our hospital here.'' (KI, Kitgum)

'' [...] the worst challenge was insecurity. Two people could do the work which was supposed to be done by 5 people, we would do it slowly, get tired but you finish.'' (KI, Pader)

"[...] within a short time, you could hear that an ambush has taken place along the way. The rebels would do a lot of harm and run away, leaving those casualties there, stuck on the road. You could then receive a report to go and pick casualties. Therefore during those times, we were receiving so many patients." (KI, Pader)

In relation to workload in the post-conflict period, there were mixed perceptions amongst the key informants. Some argued that workload had reduced due to relative peace and reduced war casualties, as well as the revitalisation of primary facilities:

''In relation to workload, I would say workload reduced a bit, not much. This is because health centres are now functioning and people are decongested. Most of the people have gone back to villages. Therefore, sometimes, instead of coming up to this hospital if they had a minor sickness, they prefer to go to the health centres.'' (KI, Kitgum)

''We are not receiving patients as we used to. Those days, we could receive many of them especially due to accidents, rape cases and those things that the rebels could do on purpose like cutting off ears These days we are not seeing those ones.'' (KI, Pader)

Other participants perceived workload to have remained high, with shift a shift from war casualties to other diagnostic illnesses and the existence of few equipped health facilities.

The return of relative peace brought with it a change in service delivery from camp-based to facility-based, yet health workers did not return home at the same pace as the populations. Although overwhelmed facilities in former camp settlements became decongested, the

returned populations were also pushed further away from the health services. The rehabilitation of many health facilities during the post conflict period could act as a workload relief to the previously few but over burdened facilities, many staff still have to brave long distances to their places of work, and have large catchment populations to serve. This may result in demotivation and absenteeism, and increased work load. The key informants below explain the effect of change from camp-based to facility- based service provision on workload:

"We used to have some health facilities in the camps where everybody would conveniently come for treatment but now everybody has gone back to their villages some distance away and so health workers have to commute to those places, which is really challenging." (KI, Kitgum)

"But the patients we serve even right now are more than the catchment area for the health centre." (KI, Pader)

Salary related challenges/remuneration challenges

In relation to remuneration challenges, it was noted that although there has been an increase in salary over time, the increment is still perceived as low, particularly in relation to the cost of living and the inflation rate. In some cases, salary which was not commensurate with promotion was highlighted as a factor affecting the motivation of health workers. Many of them noted that they had not had their salary increased even after they had upgraded or been promoted. Poor salaries still affect the attraction, distribution, retention and performance of staff across public and PNFP sectors in the post conflict period.

''The pay is still low but it has improved in a way. The increment in salary has been taking place gradually. Although we increased the salary for our staff, there is still inflation. The money you used some five to six years ago has changed value. All the same, health workers are not yet satisfied." (KI, Kitgum)

"[...] salary is very little. [she speaks emphatically] [...] you find that as an enrolled nurse for now 10-12 years I am still getting 380 something shillings! As a Ugandan with various needs such as clothing, hospital bills and other necessities for life can you depend on that money per month?" (KI, Pader)

"You find that somebody goes for registration in nursing and registration in midwifery but still gets the same salary as on enrolment. Some people have even taken six years in the field and are on the same scale." (KI, Pader)

From huts to permanent houses: changes in accommodation situation

There was an improvement in health worker accommodation in the post-conflict period compared to during the conflict. Key informants noted that during the conflict, the majority of health workers could not be housed within the health facility given that there were too many staff to accommodate. This exposed many health workers to security risks as they commuted between their homes and the health facilities. Those that had accommodation had semi-permanent houses which were small and uncomfortable.

"The staff quarters were not there. When we first came, we were sleeping in grass thatched houses. They were not comfortable."(KI, Pader)

"[...] there was almost a total breakdown in terms of services. As regards staff, there was no accommodation. They had to put up temporary infrastructures in form of Uniports[5]. Up to now these Uniports are still in existence in the quarters here. They made life very difficult. A uniport that was supposed to house two people was accommodating ten people [...]." (KI, Gulu)

[5] Uniports are pre-assembled mini houses built in a circular shape, just like huts. However, the difference is that they are manufactured from highly galvanized and color steel. They are fireproof, rot proof and need no maintenance. In Uganda, They are ideal for use at army, police, prisons barracks or outposts. They can also be used as farm houses, security cabins, site offices, stores and servants quarters.

However, in the post-conflict period, efforts to improve health worker accommodation emerged under programmes such as the Peace Recovery and Development Plan and other donor-funded initiatives e.g. by the Grauw Foundation (PRDP, 2007). Although there is general recognition that the housing situation has improved, , many are still dissatisfied that the number of houses available is still not enough to accommodate all staff in each facility. Additionally, the size of the houses is perceived as small compared to the family size available to the majority of health workers.

Working in fear versus working in peace

During the conflict, health workers worked in fear of abduction and fear of death of themselves, colleagues and family members. Although this caused trauma and affected their ability to plan for the future, it also created the need for innovative coping mechanisms to ensure their safety. Coping mechanisms included sleeping in the bush, sleeping in wards with the patients, changing sleeping location, seeking protection from the army or running away to safer places within in the country. These mechanisms have also been discussed in detail in the life history report (Namakula et al. 2013). However, the effect on their ability to plan was not identified in that report and it is worth noting here.

"[...] the health workers were working under fear because you could be on duty and within a short time you hear that the rebels are passing or have passed. You would work when your mind is not really settled. You couldn't have a peace of mind. [...] as I told you, fear was the number one problem [...] there was no proper planning. Even for us as health workers, we could not plan. Our minds were preoccupied by the war. During that time, we were seeing a lot of bad things such as people dying. You could see 10 or 30 people dead at once and that would make your mind not think properly. You could also think of death and say, next time it might be me. So we were not planning any thing.'' (KI, Pader)

"I was working in a health centre near the barracks and when the gunshots found you on duty, you would have to sleep with the patients until the soldiers come and rescue you.'' (KI, Pader)

After the conflict, key informants noted that health workers felt relieved that security had returned to the region. In turn, the constant presence of soldiers was also reduced. With the sense of security came an emerging ability to plan for the future which had not existed during the conflict.

''Anyway, we are now a bit relieved that the war ended. As for security, it is a bit okay as of now; you can even spend a whole month without seeing a soldier around and yet those days we used to live together with them.'' (KI, Kitgum)

"[...] now we can even plan. We are working with peaceful minds.'' (KI, Pader)

2. Policy responses

The study sought to identify policies affecting HRH incentives that were introduced during and after the conflict.

Policy responses during the conflict

Interventions during the conflict mainly focused on the improvement of working conditions, boosting staffing numbers and allowances. In relation to working conditions, they were driven mainly by the NGOs and other donor funded programmes. NGOs contributed greatly to the motivation of health workers by providing infrastructure support, drugs and equipment.

''Then we had UPSI, which helped health centre directly […] by putting up some structures like toilets which were missing in the facility. Then the IRC were helping us in terms of drugs, they fenced the health centre, constructed the incinerator where we are burning our instruments and the waste until now and also made for us the placenta pit which we are still using even up to now.'' (KI, Pader)

"During the conflict, there were very few drugs at the health centre at that time and so NGOs like Medicine San Frontiers, AVSI, IMCI started supporting the health centre with drugs [...].'' (KI, Pader)

INGOs were reported to second and recruit their own staff as well as boost staffing numbers in facilities where they had operational projects. In addition to paying the salaries of some health workers, INGOs provided training opportunities and allowances, thereby improving health worker motivation.

''Yes, there was a difference. NGOs were giving assistance to the hospital. [...]I don't know whether to call it seconding the staff but in a way they were paying something to the staff. For example; AVSI was bringing for us some staff. They would bring some few staff and pay their salary.'' (KI, Kitgum)

"Medicins San Frontieres really worked with us […] they integrated their services with ours. When they were with us and the service really improved because they had enough staff, they had two clinicians and then there were nurses, plus the nursing assistants." (KI, Pader)

The end of conflict saw a substantial reduction in the number of NGOs on the ground in Northern Uganda and a subsequent withdrawal of their benefits. The study revealed nostalgia about the times of the NGOs presence. In most cases the departure of INGOs meant their projects closing, as most lacked a sustainability plan. This led to restructuring, health workers losing their jobs and drug shortages. The KIs indicate that end of conflict may bring deterioration, when intensive support is withdrawn.

''[...]When the NGOs left, they also left a gap. So the community knowing that there is a lot of drugs, and when these NGO's withdraw the community think you have stolen their drugs, so it brings confusion in the health centre not knowing that the NGO supplies and the government also supplies and when they leave there is a gap, so the burden is on you who is leading the health center.'' (KI, Pader)

''[...]there are changes because most of the NGOs have now dropped out. For instance, we used to have UPSI but these days, most of their activities ended.'' (KI, Pader)

"It is even becoming worse because those days [...] we had assistance from Medicine san Frontiers. There were enough staff. Now that the war ended, all these NGOs have gone.'' (KI, Pader)

Policy responses during post conflict period

There are two categories of policy response that have been introduced over time: 1) formal policies and 2) implementation initiatives or programmes. In this report 'policy' has been used to refer to both policy documents and implementation initiatives. Clearly there is a bi-directional relationship between written policies and implementation initiatives; for instance, policy documents inform implementation initiatives, which in turn provide evidence for policy development or policy review. The in-service training strategy provides a good example of this relationship:

"We drew of course from the frameworks of the HRH policy and the strategic plan itself because if you read both documents, you will see that the government is aware of the fact that there are certain districts- certain areas in the country - that they call hard to reach and basically those districts find it difficult to attract and motivate staff and even retain them. So based on those frameworks, the HRH policy and HRH strategic plan we, together with the Ministry of Health and DANIDA, came up with a bursary fund initiative [...]." (KI, Kampala)

The study had sought to understand whether there were any HRH policies that were targeted towards the conflict-affected northern regions specifically. The majority of the policies were perceived to have a national scope rather than a specific focus on northern Uganda. However, the implementation initiatives have been found to target the whole country, specific regions or specific cadres.

'' None, because the policies we use apply across the board [...].'' (KI, Kampala)

'' One key area which I was involved in was the development of the National Health policy II which started 2010-1011. But prior to that, we had the national human resources for health policy which was part of the national health policy I, but focusing on Human resources. The

health workers in Acholi sub-region were also bound by the interventions that were stipulated in that document. That is what I can say [...].'' (KI, Kampala)

"No, we do not only look at northern Uganda but we contextualise. We do not really have any specific for Northern Uganda." (KI, Kampala)

"No, the policies cover the entire country. I don't think there is any specific policy that covers the Acholi sub region." (KI, Kampala)

A number of key informants acknowledged that Northern Uganda has gone through difficult period, which has affected the development of the health system.

"[...] but as soon as the war subsided, there was always an affirmative action for the north [...]." (KI, Kampala)

Policy documents were developed during the conflict period e.g. the Human Resources for Health Policy (1999), Human resources for Health strategic plans -HSSP I& II (2000/1-2004/5; 2005/06-2009/10) and the Employment Act(2006), and the post conflict period e.g. Health Strategic Plan-HSSP III (2010/11-2014/15), Peace and Recovery Development Plan (PRDP 2007), Human Resources for Health (HRH) guidelines (undated), and the In-service Training Strategy (2009). Although the key informants could not recall the actual dates of the policies mentioned, the research team included the years to help enhance the readers' understanding of which policies were developed during or after the conflict. Little was said about how these policies were linked or built upon each other.

The key informants also highlighted that of all the policy documents mentioned above, only the PRDP 2007 focused on Northern Uganda alone. Table 2 summarises the policies mentioned by key informants, the objective, scope of coverage, total cost and source of funds. It shows that the majority of the policies targeted the attraction and retention of doctors, implying that doctors are the most challenging cadres to attract, recruit and retain. However, a few of the initiatives also targeted cadres such as nurses, midwives and laboratory assistants.

Policy responses in relation to improving working conditions

During the post conflict period, some INGOs and donor funded programmes continued to offer support to health workers in terms of drugs supplies as well as recruitment and training. The most striking change has been a change of implementation strategy; whereas during the conflict the majority directly implemented services, in the post-conflict phase this was replaced with them providing support to the health facilities to implement services. NUMAT[6] program is one such that was identified;

"NUMAT helped a lot. When they were here with us, they renovated this building and the laboratory. They put for us solar, helped us initiate the ART clinic here. They were also helping us to order for drugs from the national medical stores. During their stay, they could see to it that ARVs were there." (KI, Pader)

The Peace, Recovery and Development plan (PRDP) 2007

The Peace, Recovery and Development Plan for Northern Uganda (PRDP 2007) particularly targeted improving housing conditions for health workers.

Among the interventions implemented under the PRDP included the installation of solar panels on health facilities and the construction of staff houses.

''At least now they are building for the staff, at least they (through PRDP) have put permanent structures there.'' (KI, Pader)

''in relation to accommodation, I can now see PRDP trying to put up some structures […]." (KI, Amuru)

'' With PRDP, we have managed to construct quite a good number of staff houses."(KI, Gulu)

[6] NUMAT in full stands for Northern Uganda Malaria HIV/AIDS and Tuberculosis Programme which was funded by the United States Agency for International Development (USAID). The programme was implemented from 2005-early 2011. Among benefits from the programme were anti retrovirals (ARVs), building laboratories, provision of lab equipment such as microscopes as well as training health workers, particularly those closely linked to testing and treatment of HIV.

Photo by Justine Namakula

Figure 2: New staff housing at one of the health facilities constructed under PRDP in Pader district

The key informants pointed out that even after the PRDP intervention, the accommodation situation has not yet improved to a desired level. There are too few housing facilities for the numbers of health workers and the houses are small in relation to the health workers' family sizes. Unlike the PNFP sector, in the public sector there were no efforts to financially support the staff who were unable to be accommodated. Hence, accommodation is still a problem that could result in staff arriving late to work, absenteeism as well as affecting service delivery in the long run. In these circumstances questions arise about the criteria used to select those for staff accommodation. This causes demotivation and friction among health workers.

''When PRDP came, at least there is room for a health worker. However, it is not enough because you find that a health centre III is supposed to have 19 staff and only one block has been built to accommodate only two staff. So the situation is not yet as it is supposed to be.'' (KI, Amuru)

''The biggest challenge is accommodation; you know a facility is just like a school- the moment you do not keep time to begin work then you will not work up to your expectation.

For instance, if you are a clinical officer or a nurse and you decide to turn up at ten or midday, you will find patients have gathered and even others have left.'' (KI, Amuru)

It was not reported that PNFP facilities benefited from accommodation funded from the PRDP. However, health workers in the PNFP facilities benefited from accommodation funded by some INGOs. Other efforts to ensure accommodation was available were reported by participants in the interviews:

'' The hospital is trying to work with a Spanish based organisation called Grauw Foundation. It is paying for the construction of houses. Those are the last staff houses which have been constructed.'' (KI Kitgum)

Policy responses in relation to remuneration

A number of policy initiatives/interventions were put in place in relation to remuneration of health workers. This discussion will be limited to those that were mentioned by the KIs. References are included here to provide context and enhance understanding of these initiatives which included: hard to reach allowances, salary top-ups and salary increments.

Hard to reach allowance policy (2010)

The hard to reach allowance policy was one of the policy responses mentioned by key informants in relation to remuneration challenges[7]. Although there was a general acknowledgement that the allowance is a motivator for health workers, the discussions revealed that no evaluation had been conducted into the efficacy of the policy. The participants expressed uncertainty about whether the hard to reach allowance still exists and if it does, highlighted the insignificance of the allowance where it was 'merely a drop in the ocean' given the ever-escalating cost of living. Additionally, concerns were raised about it not being given to those in urban areas. In certain circumstances, those in the former

[7] This policy is officially known as Hardship allowance (MOPS, 2010: Hardship allowance circular). The was introduced in 2010 as a result of the Public Service Reform Programme (PSRP), whose main objective was to enable government to attract and retain adequate numbers of skilled and capable personnel in the public service, particularly teachers and health workers (MOPS, 2010 pg 1).

camp areas reported their allowance was 'stopped' on grounds that their health centres were now considered 'urban' because they were in areas that had developed into towns.

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

[...] How many people who are in hard to reach areas actually get this allowance? You see the policy states that if you are in the urban area, you do not qualify. What is the difference between someone in town and somebody in the rural area as far as the cost of living is concerned? '' (*KI, Kampala)*

Salary top –up

There were two categories of salary top- up: salary top-up by donors and salary top-up by districts. These are differentiated by source of funding and by timing. Donors who were implementing programmes in the region decided to pool resources and contribute to a financial incentive programme to motivate health workers in the Acholi sub region. The second salary top-up was funded by district local governments, using district revenue as the main source. Whereas the financial incentive by donors was implemented in the immediate post conflict period, the district incentive is a relatively new initiative which is still ongoing. Nevertheless, both initiatives raise issues of sustainability.

''[...] but there were some donors who were interested in assisting the north and they had been privately giving the top up allowances to people in that region, in addition to the hard to reach allowance provided by government.'' (KI, Kampala)

''Also some of these districts have gone ahead to put aside money to top up health workers' salaries but from what we are told, this is a district initiative other than from the centre.''(KI Kampala)

In the district here, we are giving 400,000 bonus to retain a doctor a month on top of the government salary and hard to reach allowance.'' (KI, Gulu)

Salary increment was cited by the key informants as a national response to the challenges of attraction, motivation and retention of health workers, particularly doctors. At the time of fieldwork, it was highlighted that this initiative was being planned by the Ministry of Health was and there was optimism among the participants that it would improve the retention of doctors. Additionally, the key informants hoped that the salary increment would be extended to all cadres rather than just one category.

Policy initiatives in relation to recruitment

Policy initiatives in relation to recruitment and distribution challenges in the post conflict period included seconding doctors, recruiting expatriate doctors, and using personal contacts for recruitment and training. These are discussed in detail below.

Seconding doctors[8] was another initiative mentioned by the key informants as a response to low staffing numbers, particularly in the PNFP facilities.[9] The participants noted that under this initiative, the medical bureaus lobby governments to send health workers to certain facilities. This initiative yielded some results in post-conflict Northern Uganda. No individualised examples were mentioned in Acholi sub-region but there were some examples cited in Karamoja region. One of the major challenges for the implementation of this initiative was related to the dilemma of competing HR needs for both the public and PNFP sectors. Whereas the bureaus lobbied the government to send doctors and the government had the 'will' to do so, the secondment was heavily depended on whether the vacant and urgently needed positions of cadres in the public sector facilities were filled, hence the PNFP sector coming second.

[8] Seconding doctors is a policy of management of health workers where government recruits through the district service commissions, deploys and pays salaries for health workers but they work under the management of PNFP health units. This policy started way back in 1970s but is currently also emulated as part of the Public-private Partnership policy (Barugahara, Maniple et al, 2008). Therefore, when government recruits HWs in the public facilities, that is called 'recruitment' but when these HWs are deployed in PNFP, then it is called 'seconding health workers'.

[9] Seconding health workers was also an initiative carried out by the INGOs during the conflict and this phased out with the closure of INGOs at the end of the conflict. This has already been discussed in earlier sections of this report under policy responses during the conflict.

''On the whole, I think doctors are very difficult to recruit and that is why we continued to lobby government not to stop sending them, because the government was seconding doctors to our (UPMB) facilities. At the same time, the government had its own problems getting doctors so sometimes they had to prioritise their own public facilities'' (KI, Kampala)

Recruiting expatriate doctors was another initiative mentioned in relation to boosting low numbers of health workers. This was said to be common among PNFPs: dioceses, which are the actors with the strongest influence within the PNFP networks, lobby other churches to mobilise doctors to come and work in Northern Uganda. While the results of such efforts were visible during observations made by the research team at the time of field work, the impact on the quality of health care was still not evident; the sustainability of such initiatives has also not been studied.

"Even now, it is increasingly becoming difficult to convince doctors to just come and work in those hospitals within Acholi sub region to the extent that in some cases, Ugandan doctors who left were replaced by expatriates. This is because those dioceses have relationships with the external churches and such churches would now try and mobilise for an expatriate doctor to come and work. I mean, the expatriates are more willing to come and work than Ugandan doctors.'' (*KI, Kampala)*

The use of personal contacts for recruitment of health workers was also reported as one of the initiatives to respond to the low numbers of health workers in the region. This was mainly a district led initiative. Outsourcing was done using social networks of health workers known by the district officials or via the lobbing of young prospective health workers who were yet to complete their studies at university and paying them a small incentive. This initiative faced taxation challenges which reduced the power of the incentive.

''[...] now the only thing is to try to lobby the sons and daughters of Kitgum who are still at the university.[...] to talk to them and of course give them some kind of incentive of 500,000/=. But at the same time, much as they accept to come and work, they still complain that the 500,000/= that they are given is also taxed again for pay as you earn and that is the reason there is still a bit of problem.'' (KI, Kitgum)

"[...] previously we had wanted also 20 midwives and we got only 2 staff (through the normal process). Last year I had to go to out-source personally. Through linking, I got one midwife and I said can you go and call your colleagues who are midwives? [...]Yes, they were all working at Kalongo hospital (a PNFP in Agago district) she went calling her friends and they all came and we interviewed them. It is not a matter if just appointing [...] Yes, the policy allows us. [...] we wanted 20 but at least we were able to get 16.'' (KI, Gulu)

In-service training opportunities (IST)

The in-service training scheme (2009-June 2013) feeds into recruitment but also contributes to motivation and enhances the skills and performance of staff. The in-service training scheme, also known as the bursary fund, is a DANIDA-funded initiative which is implemented through the MOH and the religious medical bureaus (the Uganda Protestant Medical Board and the Uganda Catholic Medical Board). The strategy targets training of mid-level cadres, particularly nurses, midwives and laboratory assistants, in hard to reach areas which would otherwise have missed out on training opportunities given their location. The trained cadres are then bonded which increases the numbers of staff in the hard to reach areas. The key informants indicated that the initiative is linked to the HRH policy and the strategic plan.

"We *had a project funded by DANIDA which provided for free training for all health workers where those in Karamoja benefited more but not for Acholi sub-region. We had a policy called hard to reach districts training and whenever we were training, we would give them an extra quarter and I think Acholi area, because of the war, they benefited. There were other areas like Bundibugyo, Kalangala and Kotido.'' (KI Kampala)*

"Together with the MOH and DANIDA, we came up with a bursary fund initiative. It started in 2009 and was targeting training and bonding nurses, midwives and laboratory assistants for hard to reach districts, including the districts of Northern Uganda.'' (KI, Kampala)

At the time of interview, the in- service training scheme had not been evaluated. Key informants had mixed perceptions about the implementation challenges as well as effects of

the scheme. Some complained about anomalies in the selection criteria. Such anomalies were exploited by those who originated from disadvantaged districts but stay in Kampala to benefit from the scholarships, instead of those who originated from disadvantaged areas and were still living and working there by the time the scholarships were advertised (making bonding difficult). On the positive note, one of the participants felt that the scheme had enhanced the capacity of health workers to match the changing times and needs, as well as increasing the number of health workers deployed in hard to reach areas.

"I think as the first batch of bonded students was graduating and to the best of my knowledge there was an effort by the government to take those health workers to districts like Pader, Kitgum, so they were actually deployed at the time I was leaving and in that sense you know that is a success story.'' (KI, Kampala)

Table 2: Some of the HRH policies and programmes in Northern Uganda, 2002-12

	Name of Initiative								
Details	**Capacity building programme ***	**PRDP**	**In-service training/ bursary scheme**	**Hard ship allowance/hard to reach allowance**	**Salary top-up of 400,00/=**	**Salary increment**	**Seconding Health workers**	**Recruitment of expatriates**	**Out-sourcing**
Objective	Train and bond HW/ increase motivation	Motivation of HWs through construction of staff houses	Train and bond HW/motivation	To enable government to attract and retain adequate numbers of skilled and capable personnel in the Public Service, particularly teachers and health workers	Attract, motivate and retain HWs	Attract , motivate and retain at lower health facilities	Boost numbers of health workers in health facilities	Fill the gap left by Ugandan doctors	To attract health workers
Scope of coverage	Nationwide (all UPMB)	Post conflict Northern Uganda, including Acholi	Nationwide (with focus on hard to reach districts)	24 districts characterised as hard to reach, including 7 from Acholi sub-region	Gulu district	Nationwide	Northern Uganda(during conflict) and Nation-wide (mainly	Northern Uganda	Northern Uganda(Gulu and Kitgum districts)

							after the conflict)		
Total cost	Not available	$606.5 million	Not available	Not available	Not available	Not available	Not available	Not available	Not available
Source of funds	Churches in Germany	EU	DANIDA	Government of Uganda	District revenue	Government of Uganda	INGOs (during the conflict) and Government of Uganda(post conflict)	Medical Bureaus	District officials (DHT) and District local governments
Period of intervention	2000-present	2007- 2015	2009-June 2013	FY 2010/11-(unclear)	Not known	Not known	INGO led initiative ended, government initiative continues to date	Not available	Not available
Cadres targeted	All cadres	All cadres	Nurses, midwives and lab assistants	Teachers and health workers (no cadre specified)	Doctors	Doctors	All cadres	Doctors	All cadres but mainly midwives

Implementer	UPMB, Health Training Institutions(HTIs), universities, health facilities	Office of the prime minister	MOH, Religious medical bureaus (UPMB, UCMB) and HTIs	Ministry of Public Service and District local governments	Gulu district local government	MOH and DLG	INGOs and Government of Uganda plus all PNFP facilities	Medical Bureaus and PNFP facilities	District officials and health workers within the district.

3. Drivers of change

Who were the actors driving the change?

A number of actors are involved in health policy development and implementation at national and district levels. These are listed in Table 3.

Table 3: Summary of actors and their roles (as mentioned by KIs)

Actor/Category	Roles mentioned by participants
National level	
Government ministries (MOH, MoES, MoFPED, Public service, HRM and HRD divisions and Directorate of planning and development –MOH)	Provide guidelines, mobilising resources, guiding implementation, problem identification, negotiation with various donors, make decisions about expenditure
Parliament (and individual members of Parliament, parliamentary committees)	Advocacy and whistle blowing
Health development partners (EU, DANIDA, UNFPA, UNICEF etc.)	Provide funds for policy development and implementation of programmes
International non- governmental organisations (AVSI, UPSI, MSF,AMREF, World Vision)	Provide funds, implement programmes based on national guidelines, coordinate facilities in their networks
Medical Bureau (UCMB, UPMB and church leaders)	Implement programmes based on national guidelines, coordinate facilities in their networks
Professional Bodies (UNMC)	Advocacy for better working conditions, research etc
Workers' Unions	Advocacy for better working conditions e.g. salary
Universities and health training institutions	Provide training for upgrading and in-service skills
District Level	
CAO	Not provided by KIIs

District Health Office	Coordination of partners at district level
District council	Approve decisions made by the district.
INGOs	Implementation of programmes, problem identification
Health Workers	Identification of problems, networking for recruitment
Media	Whistle blowers
Academic institutions (universities and health training institutions)	Training health workers

The table above complements the results of the stakeholder mapping exercise, which was conducted by the research team in July 2012 (Namakula & Kiwanuka, 2012). The additions from the interviews include: district councils, health workers, health workers' unions, professional bodies and members of parliament. More NGOs were also added to the list as well as academic institutions and health training institutions.

Positioning of actors

The participants indicated that the positioning of the actors depends whether they operate at district or national level, as well as their role. At national level, there was no major change in positioning of actors over time. The Ministry of Health was perceived to have more influence by providing guidelines which are used as a bench mark for implementation. However, the Ministry of Finance was in some cases perceived to have greater influence compared to other ministries given its control over financial resources. Development partners were also perceived as influential given that they provide funds, without which programmes and policies for human resources could not exist. Other actors who may not necessarily have power but have influence include media, parliament, parliamentary committees, members of parliament, professional bodies and civil society. These influence policy through advocacy and whistle blowing.

At the district level, the positioning of the actors did not vary significantly during and after the conflict period. Although the government remained the lead provider of health services in

Northern Uganda, during the conflict period NGOs and PNFPs took an increased role. After the conflict, many of the NGOs closed the projects or scaled down their operations in Northern Uganda, leaving the government to assume the same roles as before the onset of the conflict. The district health team and the local government administration acting on behalf of central government are seen as having more influence, with the district council acting as the body with most influence.

Case1: Positioning of actors at district level - salary top-up

''For us in the district, we go through the council. You cannot give money like 400,000 without the council passing it. Here, district council is the parliament for the district, just like the parliament at central level. If policy is to change, it has to pass through council. Council has to approve it. So this one of 400,000/= was proposed by the district health team to the top management who took it to the council, it was accepted by council and adopted. You cannot just start giving people money without proper channels, they will query you and you go to prison for nothing.'' (KI, Gulu)

Case 2: Influencing decisions, the case of in-service training scheme /bursary fund

" For the bursary fund it was the Ministry of Health having the money and sending it straight to the training institutions to train the health workers and then the training institutions would report to the medical bureaus and the medical bureaus would report to MOH for the utilization of the funds.'' (KI, Kampala)

Factors influencing policy change

The factors that influenced policies included: security changes, economic changes and availability of funding, evidence feedback, changes in technology, changes in capacity building needs, advocacy and politics.

Security changes

Changes in the security situation influenced policy development. With the end of the conflict in Northern Uganda, the situation changed from an emergency response to a more systematic

way of operating. Here, the government took the lead coordination role and the other actors, particularly NGOs, followed.

''I think there is more order now that the conflict has ended, I think the government is going to become much more influential and I think already planned initiatives are going to be implemented according to plan, rather than people just coming in to address an emergency in which case they could justify any thing. They could justify their presence in so many ways because people are dying, children are sick and everyone is running around looking for a solution. So I think post conflict there is much more systematic way of implementing things.'' (KI, Kampala)

"I think because there is stability [in the region], politically, instead of focusing on budgeting for wars, there is need to develop the human resources.'' (KI, Kitgum)

Economic changes and availability of funding

Global economic changes also influenced policies. The recession led to a remarkable reduction in donor funding, particularly for the PNFP sector which relied on this for e.g. the payment of staff salaries. Observations during fieldwork in the PNFP-managed hospitals in the greater Pader district (now Agago) and Kitgum revealed that many lower cadres, mainly nursing assistants, had lost their jobs as a result of down-sizing, which was an effect of reduced funding. Informal discussions with some hospital managers revealed that by reducing the number of staff, the hospital administration would be able to able to accumulate salaries for fewer but more skilled staff over time.

"The hospital has really faced a lot of challenges because of the economic changes which are happening. So in a way, last year, so many donors withdrew and the hospital budget was greatly affected. It was so difficult for the hospital to maintain the number of staff which led to reduction in their number. There was restructuring." (KI, Kitgum)

The availability of funding emerged as a major driver of policy changes. Sources of funding included the central government, development partners and district revenues. Actors that

hold /control finances were reported to have more influence on what gets implemented immediately, and what gets postponed, as echoed by two of the participants in the following quotes:

"[...] I remember one time Dr. X was there in planning department in the ministry when we were still in Entebbe and I think they wanted a training policy and human resources were the first policies, so he asked me, do you have this policies and it was not there, so I think that is when they started thinking we need to develop one and with the grace of European Union, they came and supported the process to come up with that policy and the strategic plan and then they funded it." (KI, Kampala)

"[...] you can approve but if there is no money' then you can't do anything. They can say 'okay the policy is good but we can't implement it this year because there is no money to include in the budget'; then there is nothing you can do." (KI, Kampala)

"[...] what I know is that the government has got some funding for training the Health workers. So because the funds are there, they also need to increase the number of health workers.'' (KI, Kitgum)

"[...] the health sub district policy attracted some doctors because they said the HSDs would have their own funding and eventually manage their own affairs. However, with limited district funding and failure by government to fund the health sub districts, some doctors gave up and started leaving.'' (KI, Amuru)

Incentive initiatives generated at district level may not get implemented at all if the funds are unavailable. In most cases, initiatives are funded by local revenue collected within the district. However, the relatively 'younger' districts may not be in position to come up with funded initiatives as their financial resources may be meagre, with many competing needs. Complete dependence on central level is therefore inevitable. This thwarts innovation in younger districts, leads to delays and it may also encourage health workers to move from 'younger' to older districts, therefore increasing inequality in staffing levels.

"With such arrangements [like salary top-up] to be put in place, you should have known the source of funding in the budget. You can't just mention let us pay this amount-where are you going to get that money? So the source of the money alone will put you down with such thinking. First of all in Amuru, the local revenue is almost not there. Maybe we are just anticipating that probably if we open the border market at Elego towards Sudan, the local revenue would probably help the district such that that kind of incentive pay may be put in place. Otherwise, to date our revenue is very meagre and yet health, production, education, works departments are all requiring funding so when you say you want to budget so as to retain these health workers, it is not possible.''(KI, Amuru)

Evidence feedback

Policy change was influenced by research evidence or experiences within the public and non-profit sectors. Sometimes, failed attempts to get the right staffing mix and unsuccessful recruitment efforts gave rise to important lessons, which then informed district initiatives. Research studies commissioned by NGOs into key human resource indicators shed light on the extent of the problem. Such research findings informed the planning and implementation of policy initiatives:

"[...] The doctors were not just there. You advertise and nobody comes. So, non response to advertisement is a factor to influence changes. What is the problem? Those are the questions to ask and then you come to the solution - why we advertise and the doctors are not coming. They just come for one year and then go away. They say for us who remain here we shall die poor like this. The absence of doctors at lower health sub districts is the one that prompted the district management to work on policy and intervention, particularly that of the salary top up of 400,000 for doctors. Therefore, policy does not change just for the sake of changing." (KI, Gulu)

''We looked at data provided by capacity programme from their study on attrition trends in general. There was a very high turnover with in PNFP facilities and we were worried. Another comparison study on motivation between public and PNFP health workers also conducted by Capacity programme revealed that UPMB was the lowest when it came to motivation. There

was a very high turn-over in the PNFPs so we thought that was a problem and we said there were other things we can do to motivate staff other than giving them salary. So, if we do not have money, what else can we do and all those in combination actually informed our other policies like in-service training which is rolling out." (KI, Kampala)

Change in technology and changes in capacity building needs

The study highlighted that changes in medical technologies over time, such as the introduction of new drugs and the computerisation of systems, are also key factors influencing policy, particularly training policy. The ever-changing environment in which health workers operate creates an urgent need for updating skills and equipping them with new knowledge. Emerging illnesses may require new diagnostic, prevention and treatment methods, and new innovations may have been created for existing diseases. Policy makers started the bursary scheme to enable health workers to acquire skills while on the job.

"[...]the same time the environment in which they are working changes all the time, so they always have new capacity needs and I think a very good example is HIV - how health workers are faced with managing conditions in their patients in that knowledge about it is constantly changing and it is very important to keep updating their skills and their knowledge." (KI, Kampala)

"[...] it could also be changes in technologies because if you look at it now, the equipment and technologies that workers in the past were using was different from today's." (KI, kitgum)

Advocacy

Advocacy carried out by groups and institutions (e.g. workers unions, parliamentary committees, NGOs) working in the health sector emerged as a major driver of change in health policy. The policy on hard to reach allowances for health workers working in remote districts is one such policy that workers unions have become campaigning for.

''What we have been having is that the parliament has lately been involved in these issues[...] The parliament is more defined in terms of research, budget and more technical people and the members are more concerned. This led to strong support to health-related agenda but also the other point is we have been having dynamic workers association which is Uganda nurses' association. Uganda workers union and other associations and union have become more organized and serious and then we also have the civil society organizations that have been very active." (KI, Kampala)

Politics

Political factors clearly play a role in HRH policy development. The importance of government leadership was recognised by key informants. However, key informants were reluctant to comment on these issues in detail, seeing them as inappropriate for technical staff.

"I would say political factors or different ideologies because you find that some people come with new ideas and at the end it also influences the policy.'' (*KI*, Kitgum)

4. Discussion

Study limitations and strengths

This report is based on findings from interviews with 25 purposefully selected key informants at both national and regional level in 5 districts of Northern Uganda (Kampala, Gulu, Kitgum, Amuru and Pader). Although the informants at district level did not cover the whole region[10], the findings from the study can help provide insights relating to perceptions of the evolution of incentive policies during and after the conflict. Many of the key informants at national level were not knowledgeable about the situation in the Acholi sub region or about policies during the conflict period. They were more informed about general national policies, which applied to our study region as well.

[10] Although Acholi sub-region comprises 7 districts, only the 4 mentioned above were selected due to limited availability of resources.

The trajectory of incentive policies was not elucidated as the key informants mainly mentioned those policies that they were aware of or could remember without necessarily discussing their development. However, the team was able to get an in-depth insight into a few policy initiatives both during and after the conflict. The document review complements the key informant report in filling this information gap.

Some questions did not get much traction. These included questions in relation to the total cost of the policies, the period of intervention and the link from some policies to others. The study also found very little evidence about effectiveness of the policies as many of them had not yet been evaluated. However, the study provides perceptions about the effects of many of the policies and these can provide insights and evidence for better incentive policies in the future.

Reflections on the conceptual framework

The study was guided by the framework (figure 1) for analyzing health worker attraction, retention and productivity (Witter et al. 2011). According to the framework, all factors are interconnected in a dynamic relationship and all have the potential to impact on attraction, retention, distribution and performance. The policy levers on the right represent a range of ways in which the incentive environment can be actively engineered in some way. Study findings support this interconnectedness of the domains in the framework. For instance, security situation in Northern Uganda had a major impact on attraction and retention. Security also negatively impacted on health worker performance, given the resultant workload and long working hours during the conflict. The security situation also created a vacuum which NGOs filled, which boosted performance in some of the facilities. It also created a need for government, NGO, donor and district-driven initiatives to boost salaries with an aim of improving attraction, retention, motivation and productivity. Another contextual factor was the labour market that was provided by South Sudan, which led to poor retention, and also frustrated attraction and recruitment policies in Acholi sub-region. The family situation of the health workers (particularly family size) impacted on the participants' perceptions of the effectiveness of the programmes providing non-financial benefits such as housing.

Of the policy levers mentioned in the conceptual framework, the key informants mainly focused on four: those relating to recruitment policies, remuneration, training, and working conditions (mainly housing). Measures relating to supervision and management, fostering supportive relationships, career structures, and professional regulation are surprisingly absent, as is a sense of how these policies feed through into some of the HR outcomes, such as performance. This absence may be attributed to limited knowledge about such polices or the tendency to mention those policies that were seen as most relevant to the key informants.

Summary of research findings

Context and challenges of HRH during and after the conflict

The HRH challenges experienced during and after the conflict in Northern Uganda were many. These are mostly related to attraction and distribution, recruitment, retention and challenges related to working conditions These difficulties are not unique to Northern Uganda but spread across the whole country, although the security of the Acholi sub-region exacerbates the HRH situation here (MOH 2006; Matsiko 2009; MOH 2010a; MOH et al 2012). Some of the coping strategies noted by key informants were similar to those identified by the health workers in the life history report (Namakula et al 2013). Coping mechanisms included sleeping in the bush, frequently changing sleeping place, sleeping in wards with the patients, seeking protection from the army or running away to safer places within the country (Namakula et al 2013 pp 31-41). Key informants noted that the improved security situation during the early post conflict period has not yet resulted in challenges being fully addressed.

The recruitment ban, uncoordinated recruitment procedures, poor targeting of the recruitment process and lack of gender-balanced recruitment emerged as major recruitment challenges. Citing financial constraints, the government instituted a moratorium (also referred to as a recruitment ban) against the recruitment of civil servants, including health workers, in the financial year 2012/2013. This implied that only those who left service would be replaced (Walubiri, 2012). This hampered policy commitments to improve health worker density in hard-to-reach areas from 25% to 60% by 2014/15 as

indicated in the third Health Sector Strategic and Investment Plan (HSSP III 2010-2015). Additionally the ban, impacts other policies such as decentralization/district splitting, which led to the creation of new districts without appropriate staffing levels. The recruitment ban results in staff shortages at health facility level and had wider subsequent effects such as burnout, absenteeism, abscondment, stress, depression, lack of morale and poorer quality service provision (Parliament of Uganda, 2012: p8).

The study highlighted that recruitment and retention of health workers, particularly doctors and other skilled cadres, posed the greatest challenge. This finding is not isolated to this study but has also been well documented in various HRH national policies and related health sector performance reports. (MOH 2007; Matsiko 2009; MOH 2010a; MOH 2010b; MOH et al. 2012). This challenge has been worsened by practices that encourage many of the skilled cadres to get additional administrative duties at health facilities, top managerial jobs at the district quarters or positions in prominent donor-funded programs in the region. Although they stay in the region, they are taken further away from patient interaction (MOH et al. 2012).

Key informants noted that low cadre health workers such as the nursing assistants, who may have been recruited without any training and acquired skills on job, tended to stay and work in the region for longer periods than the other cadres whose training takes over two years. Secondly, the higher cadres are more marketable both within the region and nationally. It is worth noting that the limited skills among the lower cadres could affect competence and the provision of quality of care. Therefore, there is need for more research on quality of care, competence and performance of mid level cadres in the region.

Evolution of incentive environments during and after the conflict

The study focused on the incentive environments during and after the conflict. The conflict in Northern Uganda weakened the state's ability to support the health system. As a result, various INGOs and other non state actors filled the vacuum in health service provision (Newbrander, 2006). During the conflict, incentive environments in Northern Uganda were mainly dominated by the INGOS. They were focused on improving working conditions which had been worsened by conflict, boosting staffing numbers, and paying salaries as well as

allowances. Such policy responses were of a 'fire –fighting' nature and concentrated around camp settlements. The effect on health staff of changing from camp-based services to facility-based services has also been documented by other studies (Namakula, Ssengooba et al. 2011).

The post conflict period was characterised by policies focusing on: i) improvement of working conditions, ii) improvement of recruitment and distribution of health workers in the region, iii) addressing training needs of staff and iv) switching towards government control. Improving working conditions involved the provision of drug support, rehabilitation and reconstruction of infrastructure (e.g. incinerators, placenta pits, toilets, and laboratories), installation of solar panels and the construction of staff housing. Financial incentives were also provided in the form of hard to reach allowances, salary top-up and salary increment. Policies to address recruitment and distribution challenges in the post conflict period included the secondment of doctors, although this role was carried out by government instead of NGOs as was the case during the conflict. Expatriate doctors were also recruited and personal contacts were used. Staffing needs were addressed by implementation of the in-service training strategy.

Policy in this report refers to both policy documents and implementation initiatives. It was not clear which of the incentive policies, those at national level or those initiated by district local government, were more effective. District initiatives were in their infancy and needed more time for evaluation. The majority of those at national level had not been evaluated, with the exception of the few that were implemented by donors.

What influenced the trajectory?

Actors in policy response after the conflict included INGOs (the few that still remained), government and local governments in the region. Other actors that were influential but not directly involved in policy response included: district councils, health workers, health workers' unions, professional bodies, members of parliament, health training institutions and academic institutions. This list of actors adds to that that was already provided during the stakeholder mapping exercise which was conducted by the research team in July 2012 (Namakula & Kiwanuka, 2012).

The positioning of actors at national and district level varied across the phases of conflict. Whereas there was no major change over time at national level, some changes were identified at district level.

The factors that influenced the trajectory of the HW incentive policy environment during and after the conflict were: security changes, economic changes and availability of funding, evidence feedback, changes in technology, changes in capacity building needs, advocacy and politics. These factors may also influence the composition and positioning of actors at either national or district level at any given time.

The study also sought to understand whether there were any policies that were targeted towards the Acholi sub-region specifically during or after the conflict. While a number of policies have been drafted to improve health workers' situation, the majority of policies had a national scope rather than a specific focus on the Acholi sub-region. This has been the case for most national policies that were mentioned by key informants. Only three policies attempted to look at the region in depth: the PRDP (2007), the hard to reach allowance policy (2010) and the in- service training scheme (2009). The PRDP attempted to improve the working conditions of the health workers by providing accommodation, solar systems and contributing to primary health care. However, complaints arose in relation to size of houses constructed and the ratio of the number of houses constructed vs. the total number of health workers in a given facility. Concerns were also raised about the criteria used to select those to access housing and those to rent. This caused friction among health workers and led to some demotivation.

The hard to reach policy focused on allowances during the conflict but has been reported to have been terminated a long time ago. The in-service training focused on those in hard to reach areas but had issues regarding the criteria. The key informants acknowledged that the region needs affirmative action to catch up with the rest of the country.

The KIs at national level were more knowledgeable about the policy documents and their content but tended to have little or no knowledge about how these policies had been

implemented. As would be expected, the district level KIs were more in touch with implementation issues than overall policies.

5. Recommendations from key informants

- A more coordinated recruitment process needs to be introduced in the sub region. For instance, it would be good to have a uniform date for doing interviews. This would help reduce wastage of resources in relation to the process.
- HW salaries need to be increased to match promotion, the cost of living and inflation.
- Recruitment needs to take gender balance into consideration.
- The selection criteria for in service training needs to be aligned with what is documented in related policy documents to ensure that the most disadvantaged benefit.
- There is a need to evaluate the hard to reach allowance and also clearly explain the eligibility criteria to all intended beneficiaries to avoid unnecessary misunderstandings. Care must be taken to consider the contextual differences when defining concepts such as urban or rural. This mainly applies for interventions such as the hard to reach allowance where location is a significant inclusion criterion.

6. Lessons and conclusions

- In relation to the overall ReBUILD hypothesis that the post conflict period offers a window for reforms, the story here seems more to be one of continuity, perhaps because only part of the country was affected and so underlying systems continued. This makes Uganda a nice counterpoise to the other countries where crisis or conflict affected the whole nation.
- Policies to attract and retain health workers should not be piecemeal but rather comprehensive as many of the factors for attraction, retention, distribution and performance are interrelated.
- Some policies are based on evidence. This underscored the importance of research evidence on policy development in the early post conflict period. However, apart from the PRDP, the rest of the policies mentioned by the key informants were not evaluated. There is a tendency for donors to evaluate their policies whereas the governments may

not evaluate policies unless they are donor funded and hence evaluation is part of the terms and conditions.

- While policies may be put in place with good intentions, they may also have unintended effects. Ongoing risk assessments should be implemented alongside all policy initiatives.
- Although the INGOs boosted staffing numbers in some cases, in others they poached staff from public facilities as they offered better pay.
- For all policies and implementation programs, there is need for a sustainability plan. The lack of such a plan by INGOs meant that when they departed many projects closed, resulting in restructure, loss of jobs by and drug shortages.
- There is the need for more research on quality of care, competence and performance of mid level cadres in the region. This is because the majority of low cadres e.g. nursing assistants who may have been recruited without any training and acquired skills on job, tended to stay and work in the region for longer periods than the other cadres.

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8. Annexes

Key Informant Interview Guide: National level

Health Worker Incentives in Post Conflict Uganda
Key Informant Interview Guide: National level

Introduction to interview

Thank you for agreeing to participate in this study. The objective of this interview is to understand the evolution of the incentive environment and its effect on health workers in Uganda as well as the area that was affected by the LRA war, particularly Acholi sub-region (which includes districts such as Gulu, Kitgum, Pader, Amuru, Agago, Nwoya and Lamwo). This will enable us to draw lessons and propose policy and practice options for decision makers nationally and in post conflict Northern Uganda. The period we are referring to is 2001-date.

A. Details of participants (Interviewee Identification): Interviewer should probe for details on
   - Title /position, name of organisation
   - Sex
   - Date of interview
   - Number of years spent engaging in Human resources for health(HRH) activities at national(or district level)
   - In what capacity have you served?
   - How capacity has evolved over time
   - Area of interest in the field of Human resources for health e.t.c.

Theme one: Context and challenges
Evolution of policy from 2001-date (five years before 2006 and from 2006-2012)

1. Please tell me about any government policies/interventions you know of that have been instrumental for human resources for health in Uganda.
   - Recruitment policies(e.g. freeze, retrenchment)
   - Management of staff(decentralisation e.g. DSC Vs MOH/HSC)
   - Workload and working hours (Task shifting e.g. HIV era, TBAs
   - Remuneration (of all kinds, including rules about private practice, for example) e.g. wage increases, negotiations for salary increase, top up, consolidation of salaries, lunch allowance, hard to rick allowance, housing, solar, risk allowance
   - Working conditions of staff and other non-financial benefits
   - Systems of promotion and career progression(promotions)
   - Training opportunities(scholarships)
   - Job security (permanent/contractual employment) etc.

Probe for any policies that were put in place specifically for health workers in Acholi sub-region over time

2. a) In your opinion, what are the successes arising from each of the policies for the work force in Uganda**(mentioned in question 1)** have been since 2001-date?
Probe for successes relating to:

i. Ability to recruit enough staff
ii. Ability to post enough staff to rural areas
iii. Ability to retain them in those areas
iv. Ability to motivate them to work effectively there

b) How similar are the above successes **mentioned in 2a) above** been in Acholi sub- region?
c) How different are the above successes **mentioned in 2a) above** been in Acholi sub- region

3 a) What have been the main challenges arising from these government policies **(mentioned in 1)** in relation to the health workforce in Uganda since 2001-date?

Probe for challenges relating to:

v. Ability to recruit enough staff
vi. Ability to post enough staff to rural areas
vii. Ability to retain them in those areas
viii. Ability to motivate them to work effectively there

b. Which of these challenges was greatest? Why?
c. Which staff were most challenging?**(probe for bullets i-iv in 3a) above)**
d. How have these challenges changed across the period (2001 to date)

3b) In what way have the challenges **(mentioned in 3a)** above been

i) Similar
ii) Different for Acholi sub- region?

Theme two: Policy response

4. Given the challenges you have **mentioned in question 3**, how has policy/practice evolved since 2001-date to address these challenges?

Probe for changes relating to:

- Recruitment policies
- Management of staff
- Workload and working hours
- Remuneration (of all kinds, including rules about private practice, for example)
- Working conditions of staff and other non-financial benefits
- Systems of promotion and career progression
- Training opportunities
- Job security etc.

(Focus on period of which the KI has direct experience)

b) In what way are these responses (mentioned in 4a) similar or different for Acholi sub-region?

5. What were the objectives of the new policies **mentioned in 4**?

Theme 3: Drivers of changes

6. What were the other factors which influenced the development of the new health workforce policies/practices/interventions **(mentioned in 4)? (Discuss for each main policy change described)**
Probe for influence from the following:
a) Specific people?
b) Specific organisations?
c) Funding?
d) Political factors?
e) Evidence?
f) Other factors?

7. Have these factors changed over the period?
a) If so, describe how, and why?

8. Who were the other main actors involved in the process of developing health workforce related policies (**mentioned in 4)** since 2001-date?

9. for each of the new health workforce related policies **(mentioned in 4)**, describe how the main players were positioned (supportive/opposed). **Specifically probe for the following;**

a. How did the actors (government, experts, donors, researchers etc.) relate to one another during the conflict (2001-2006)?
b. How did the actors (government, experts, donors, researchers etc.) relate to one another after the conflict (2006-date)?
c. What is their focus of work and interest?
d. How much influence do they have?
e. How has this been used?
f. Describe how this has changed or not over the post-conflict period

Theme four: Implementation of initiatives

10. a) What are the major health workforce related activities/ interventions that you have been associated with (participated in)?

b) Taking each of the major reform initiative/intervention (**mentioned in 10a**), can you describe how they were implemented? **Probe for:**

a. Name of initiative/intervention(if applicable)
b. Position held by respondent
c. Scope of coverage(districts, national level etc)
d. Total cost of initiative/Intervention
e. Source of funds
f. Period of intervention(Years from start to end)
g. What were the mechanisms?
h. Focussed on which health workers (cadres)?

i. Implemented by whom?

Theme five: Effectiveness of initiatives/interventions mentioned in 11 above

11. In your opinion, what effect did the initiative/intervention/programme have on the health workforce **(probe for both positive and negative consequences on the health work force for a to d below on areas of coverage)**

a) **Health worker recruitment**. (**Probe** for number of health workers being recruited to work in the region/district) for whether and how the programme succeeded in attracting people to work in Acholi sub region). What were the implementation challenges and how were they overcome?

b) **Health worker retention** (**Probe** on effect of the intervention on the number of people staying in the district, did it succeed in reducing attrition (people leaving the public service? What were the implementation challenges and how were they over come?)

c) Motivation of health workers (**Probe** for effect of the intervention on the way health workers provide care to patients, effect on health workers' motivation, remuneration and working practices) What were the implementation challenges and how were they over come?

d) **Improved access to services (Probe:** How has the intervention enabled people, especially the poor in the at national/district level to access at reasonable cost and quality?) What were the implementation challenges and how were they over come?

11b) To what extent were these effects similar or different for the Acholi sub- region

Theme six: Sustainability
12a) Is the initiative **(check question 10 for all initiatives mentioned)** still on-going?

b) If the initiative ended **(Check question 10),** what were the factors that led to the end of the initiative
c) If the initiative ended **(check question 10)** briefly explain what has happened to the health workers who were formerly benefiting from the initiative?

Theme seven: Recommendations

13. In your opinion, what lessons can be learnt from the implementation of the above initiative/intervention (**mentioned in 10)** in relation to recruitment, retention, motivation and performance of health workers in Acholi sub- region?

14. Based on your experiences (those of the organisation/agency you have worked with/are working with), what do you think should be done to improve the situation and work of health workers in Acholi sub- region?

Probe: For strategies to address the current challenges in relation to retention, recruitment and motivation and performance for health workers in Acholi Sub-region

Key informant interview guide: District level

Key Informant Interview Guide: Facility in-charges and District Officials and Development partners at district level

Introduction to interview

Thank you for agreeing to participate in this research study. The objective of this interview is to understand the evolution of the incentive environment and its effect on health workers in post conflict Northern Uganda so as to draw lessons and propose policy and practice options for decision makers nationally and in post conflict Northern Uganda.

B. Details of participants (Interviewee Identification): Interviewer should probe for details on date of interview,
   - Title /position, name of organisation
   - sex
   - District,
   - Number of years spent in district /region etc

Theme one: Context and challenges
Evolution of policy from 2001-date (five years before 2006 and from 2006-2012

2. I am going to ask you some questions about the situation of health workers during and after the conflict.
   a) First, can you please tell me about the situation of health workers in Northern Uganda during the conflict (2001-2006)?
   b) Then, please tell me about the situation of health workers in northern Uganda after the conflict (from 2006-2012)

3. What were some of the most important context(environment) changes over the period which affected health workers in Northern Uganda/the district
   a. Probe:
      i. Economic changes
      ii. Security changes
      iii. Political changes
      iv. Organisational changes
      v. International context
      vi. Other

4. What were the main challenges for government/government policy in relation to the health workforce since 2001-date?

   a. Particularly focus on challenges relating to:
      i. Ability to recruit enough staff
      ii. Ability to post enough staff to rural areas
      iii. Ability to retain them in those areas
      iv. Ability to manage them and motivate them to work effectively there

b. **Also Probe:** Which of these challenges was greatest in the post conflict area? Why?
c. Which staff were most challenging?**(probe for bullets i-iv in 3a) above)**
d. How have these challenges changed across the period (2001 to date)

Theme two: Policy response

5. How did the government/district react to the above challenges related to health workers?

Probe for initiatives undertaken at district or national level in relation to health workforce over time, with specific reference to:

(NB: Focus on period of which the KI has direct experience)

- Recruitment policies
- Management of staff
- Workload and working hours
- Remuneration (of all kinds, including rules about private practice, for example)
- Working conditions of staff and other non-financial benefits
- Systems of promotion and career progression
- Training opportunities
- Job security etc.

NOTE: If the respondent doesn't don't have any answers to question 4 or says they do not know, ask questions in theme 3 but SKIP themes 4,5,6 and then go to last question of theme 7. However, the interviewer needs to probe to the extent possible.

6. How have these public policies changed over time since 2001-date?

Probe for changes relating to:

- Recruitment policies
- Management of staff
- Workload and working hours
- Remuneration (of all kinds, including rules about private practice, for example)
- Working conditions of staff and other non-financial benefits
- Systems of promotion and career progression
- Training opportunities
- Job security etc.
  (Focus on period of which the KI has direct experience)
-

7. What were the objectives of the new policies?

Theme 3: Drivers of changes

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

9. Which factors do you think are most influential in policy change? Please explain how and why
    a. Specific people?
    b. Specific organisations?
    c. Funding?
    d. Political factors?
    e. Evidence?
    f. Other factors?

10. Have these factors changed over the period?
    a. If so, describe how, and why?

11. Who were the main actors involved in the process of developing policies on HRH at district and national level since 2001-date?

12. Describe how the main players are positioned
    a. How did the actors (government, experts, donors, researchers etc.) relate to one another during the conflict (2001-2006)?
    b. How did the actors (government, experts, donors, researchers etc.) relate to one another after the conflict (2006-date)?

    c. What is their focus of work and interest?
    d. How much influence do they have?
    e. How has this been used?
    f. Describe how this has changed or not over the post-conflict period

Theme four: Implementation of initiatives

13. Taking each of the major reform initiative/intervention (mentioned) in turn, can you describe how they were implemented? **NB: Only ask question 12 if respondent answered question 4 in theme 2.**
Probe for:

    a. Name of initiative/intervention(if applicable)
    b. Scope of coverage
    c. Total cost of initiative/Intervention
    d. Source of funds
    e. Period of intervention(Years from start to end)
    f. What were the mechanisms?
    g. Focussed on which health workers (cadres)?
    h. Implemented by whom?

14. Did the initiatives/interventions build/improve on what went before or not?
    a) If no, please explain briefly
    b) If yes above, how do the different initiatives relate to one another?

Theme five: Effectiveness of initiatives/interventions

15. What was the effect of initiative/intervention/programme on the health workforce **(probe for both positive and negative consequences on the health work force for a to d below)**

e) **Health worker recruitment**. (**Probe** for number of health workers being recruited to work in the region/district) for whether and how the programme succeeded in attracting people to work in the region/district). What were the implementation challenges and how were they overcome?

f) **Health worker retention** (**Probe** on effect of the intervention on the number of people staying in the district, did it succeed in reducing attrition (people leaving the public service? What were the implementation challenges and how were they over come?)

g) Motivation of health workers (**Probe** for effect of the intervention on the way health workers provide care to patients, effect on health workers' motivation, remuneration and working practices) What were the implementation challenges and how were they over come?

h) **Improved access to services (Probe:** How has the intervention enabled people, especially the poor in the region/district to access at reasonable cost and quality?) What were the implementation challenges and how were they over come?

Theme six: Sustainability

16. a) Is the initiative (check question 4 for all initiatives mentioned) still on-going?
b) If the initiative/intervention ended (check question 4) **(Probe: If no, briefly explain what has happened to the health workers?**

c) If the initiative ended (Check question 4, what were the factors that led to the end of the initiative

Theme seven: Recommendations

17. What lessons can be learnt from the implementation of the above initiative/intervention in relation to recruitment, retention, motivation and performance of health workers in Northern Uganda?

18. Based on your experiences (those of the organisation/agency), what do you think should be done to improve the situation and work of health workers in Northern Uganda?

Probe: for strategies to address the current challenges in relation to retention, recruitment and motivation and performance for health workers in Northern Uganda