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# Health worker incentive environments during and post-conflict: early findings from health worker life histories in Uganda

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# Session content

**Health worker  
incentive  
environments post-  
conflict: early findings  
from ReBUILD**

- Introduction to ReBUILD
- Research aims and questions
- Framework and methods
- Key issues in case study countries
- Preliminary results from life histories of health workers, northern Uganda

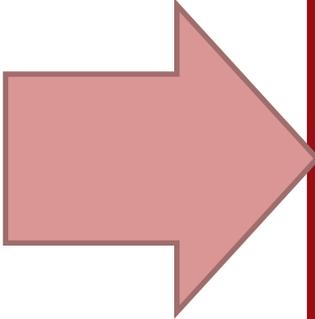
# Key starting points of ReBUILD programme

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



# Aims and questions for HW incentive research

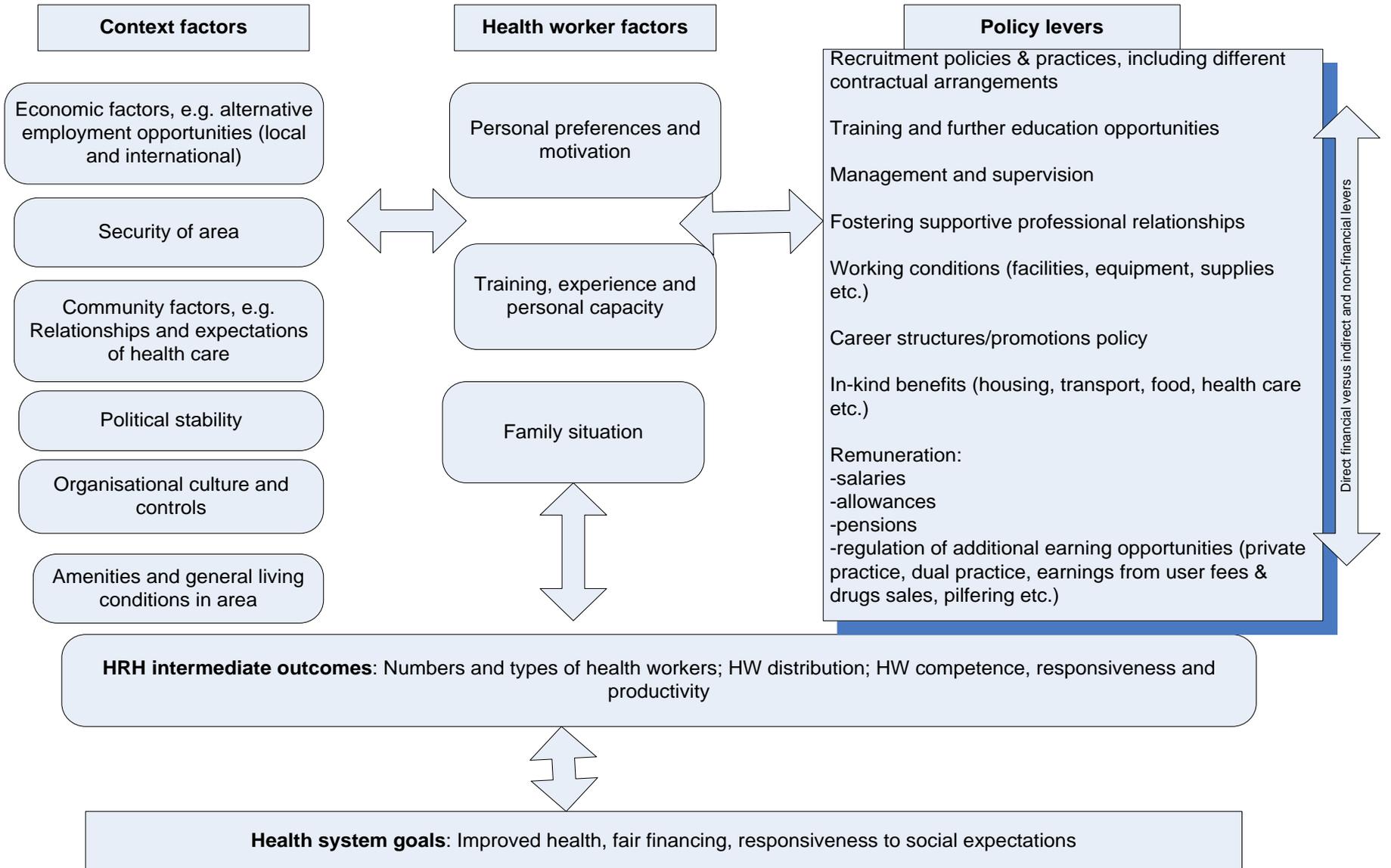
To understand the evolution of incentives for health workers post-conflict and their effects on HRH and the health sector



## Research questions:

1. How have HR policies and practices evolved in the shift away from conflict in each country?
2. What influenced the trajectory?
3. What have been the reform objectives and mechanisms?
4. What are their effects (intended and unintended)?
5. What lessons can be learned (on design, implementation, and suitability to context), especially for post-conflict areas?

**Framework for analysing health worker attraction, retention and productivity**



# Research methods

## *Quantitative and qualitative data collection methods*

Research tools	Cambodia	Sierra Leone	Uganda	Zimbabwe
1. Stakeholder mapping		√	√	
2. Document review	√	√	√	√
3. Key informant interviews	√	√	√	√
4. Life histories of health workers	√	√	√	√
5. Quantitative analysis of routine data	√	√		√
6. Survey of health workers		√		√

# Key issues in case study countries



## Cambodia

- Continuing shortages of staff in rural areas and for specific cadres (e.g. midwives)
- Need to understand effects of multiple schemes
- How to integrate and streamline them?

# Sierra Leone

- Post-conflict legacy of shortages of workers and also low and uncontrolled remuneration
- Addressed to some extent recently through pay uplift (2010) and through performance-based pay innovations (2011), but understanding their impact and sustainability is still required.



# Northern Uganda



- New investments affecting health workers are proliferating – need to understand their effects
- How can they best be managed to avoid fragmentation and distortion?



- Ongoing high outward and internal migration
- Limited understanding of the different factors affecting staff in the public, municipal, mission and private-for-profit sectors

## Some preliminary findings

From 'Health worker's career paths, livelihoods and coping strategies in conflict and post-conflict Northern Uganda', Namakula, Witter and Ssenooba, 2013

# Respondents' profile

*Selection criterion:* those who had worked for ten years or more in the region

	Characteristic	Description	
		Average	Range
1	AGE	42 years	30-60 years
2	TIME SPENT WORKING IN REGION	17 years	7-38 years
3	SEX	23% M: 77% F	
4	CADRES	Clinical officers (16%); Nurses (58%); Nursing assistants (8%) Midwives (12%); Others (12%)	
5	DISTRICT	27% Pader; 27% Kitgum; 19% Amuru; 31% Gulu	
6	SECTOR	65% Public; 35% PNFP	
7	LEVEL OF FACILITY	Hospitals (31%); HC IV (15%); HC III and II (46%); others (8%)	
8	HIGHEST LEVEL OF EDUCATION(formal)	69% O Level; 12% A level; 15% Diploma; 4% Degree	

*Participative method* – life line drawing and discussion of key events and choices over working life; 26 participants

# Limitations

- Qualitative tool focussing on HW experience – needs to be cross-checked with other tools
- Sample concentrated in mid-level cadres and women – they form the bulk of the staff working in these areas
- Positive deviance – those who stayed – not representative of whole cohort

## Why did they join profession?

- Personal calling
- Influence of parents and teachers
- Attraction of uniform and social status
- Positive and negative experiences of health workers
- Wanting to pay back to the community
- No other means to get an education – could train gradually on the job
- Proximity to health facilities

Most trained locally

Most worked with the institution/sector which sponsored them through training, at least initially



# Experience of conflict for health workers

General disruption but health workers and facilities were targeted in particular. Direct experience of trauma by all interviewed

- Injury and death of colleagues and family members
- Abduction and fear of abduction
- Ambush
- Displacement
- Increased workload and working hours
- Worsened working conditions (e.g. loss of facilities' supplies through raiding)
- Disconnection from professional support systems (including pay stoppages, difficulties with supplies etc.)
- Isolation – dangerous roads, lack of transport, insecurity

# How did they cope?

## Practical safety measures:

- sleeping in the bush
- frequent change of sleeping places
- sleeping in wards with the patients
- hiding themselves amongst the community
- running away to safer places within the district, region or to other districts

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

*“ You work and leave the workplace at around 3pm and then prepare food quickly in order to go in the bush early, we were sleeping in the bush somewhere there.[...] could come back from the bush around 8:30 9:00, clean ourselves and come to office”*

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

**Emotional:**

- Counselling and support from managers, elders and community
- Religious faith & sense of service to the community
- Fatalism
- Taking pride in resilience – e.g. ability to take on roles for which not strictly qualified; inventiveness when key equipment lacking

**External and financial:**

- Protection by the army, though only partially effective
- Support of NGOs and external donors, including missionaries
- Supporting themselves though local income generation, or relying on the community

*“If we were to run away, who would now help them? So we persisted and slowly the fear disappeared”*

# Motivators

- **Appreciation** by supervisors and the community
- **Community support** and practical assistance of various sorts, provided by the district, external agencies and small gifts from patients
- **Effective working conditions** – equipment, referral transport etc.
- Being able to **learn and develop one's skills** and roles were important motivators for many (or dissatisfiers, if absent), even those in relatively lowly posts. They were eager for further training and certificates to demonstrate their advancing skills
- **Formal promotion** – recognition of your contribution
- **Employment benefits**, such as food, accommodation, transport, free health care, uniforms, and other occasional additions, such as sponsorships for their children
- **Good leadership and communication** in the workplace (staff encouraged to express themselves)
- **Regular and adequate pay**, especially after the end of the war and as staff reached the expensive time of life (children at secondary school)
- **Flexible working** – able to augment salaries and build up some assets
  - The public sector tended to offer higher pay for many cadres (though not all), fewer restrictions on outside earning opportunities, and greater access to training opportunities and pension rights

# Some preliminary policy conclusions (based on life histories alone)

In general, the findings suggest the importance of **selecting and favouring those with higher intrinsic motivation**, especially in difficult times, when formal structures of promotion and recognition cannot function well, when pay is low and erratic and when working conditions are hard.

- For those who have strong internal motivation – ‘I work for God and my country’ as one respondent put it – lower satisfaction may not cause lower effort or retention.
1. **Recruiting from local areas** is likely to be productive – these respondents tended to stay in their districts, and ties of family and land were part of their ‘stick’ factors.
  2. They were also **loyal to the sector** (and often facility) which first sponsored their training, suggesting that is also effective at retaining them.
  3. Offering **training routes which favour those with lower levels of education** also appears to be important, allowing incremental steps which may include volunteering, on the job training and access to in-service training so that those who have less access to education can nevertheless enter and progress. These people are more likely to be motivated to stay in hardship areas.

5. **Gender** also appears to have been an important feature: the staffing of the facilities is predominantly female, which may reflect a number of factors, including the ties of family commitments in the area, greater resilience, and higher female attraction to the mid-level cadre roles
  - Noting some of the greater barriers which women face in accessing training and gaining promotion, greater support for carers and flexibility about training policies is important.
6. It is also a recommendation that **training be focussed on those serving in under-served areas** (the opposite of the current MoH approach, which increases opportunities for those in well-staffed facilities).
7. Human resource management policies should focus on **maintaining the intrinsic motivation** which many HWs bring when they join the profession through practices which foster good communication, support professional pride, and develop the links with the community – all of which are motivators, especially in remote and difficult situations.
8. Need to **recognise and reward higher responsibility** which has been taken on de facto by some workers during conflict – link to training, promotion and pay policy
9. During conflict, need **code of protection for health workers**, who can be particularly vulnerable

## Summary and next steps

- Very little research has been done on how HWs are affected by conflict, how they cope and what that implies for the post-conflict period – this study contributes to filling this gap
- Life history method found to be effective at eliciting experiences
- Need to compare findings across tools and across countries
- No recognition post-conflict of contribution of those who continued to serve in conflict areas – HRH policies uniform
- Policies on pay and incentives should select for and reinforce intrinsic motivation and professionalism, particularly for remote and insecure areas – build on resilience

# Thanks to ReBUILD partners



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# Thank you

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