

THE UGANDA COUNTRY CASE STUDY: Positive Practice Environments



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Uganda Case Study: Enhancing health worker and health system performance



Positive Practice Environments in Uganda:

Enhancing health worker and health system performance

Developed by

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For the Positive Practice Environments Campaign

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ACRONYMS

ACR	annual confidential report
AHPC	Allied Health Professional Council
CPD	continuing professional development
DSC	District Service Commission
DHO	District Health Officer
FY	financial year
GHWA	Global Health Workforce Alliance
GoU	Government of Uganda
HC II-IV	Health Centres II to IV
HMIS	Health Management Information System
HRH	human resources for health
HSC	Health Service Commission
HSD	Health Sub–District
LDAs	Local District Administrations
MDG	Millennium Development Goals
MoH	Ministry of Health
MoLG	Ministry of Local Government
MoPS	Ministry of Public Service
NGO	non governmental organisation
NHA	National Health Accounts
NHE	National Health Expenditure
PEAP	Poverty Eradication Action Programme (Plan)
PNFP	private-not-for-profit
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey
UMDPC	Uganda Medical and Dental Practitioners Council
UNMC	Uganda Nurses and Midwives Council
UPMC	Uganda Pharmacy and Medicines Council

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Charles W. Matsiko

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EXECUTIVE SUMMARY

The mission of the health sector of the Government of Uganda is to attain a good standard of health for all people in Uganda (MoH 1999 p.6). However, sadly, geographical access to health care has been limited to about 49% of the population (MoH 1999 p.3).ⁱ This is in large part due to the crisis in health human resources. Human resources for health (HRH) include all those persons employed by government, non-governmental organisations and the private sector in the protection and improvement of health.

The inability of the public health sector to attract and retain skilled health workers is due to a number of factors including lack of sufficient incentives and poor work environments, leading to sector out-migration and brain drain. The situation is compounded by the proliferation of other opportunities within the for-profit commercial sector and with NGOs that provide better compensation, benefits and working conditions (Matsiko 2005; MoH 2009; MoH 2009b). Difficulty in attracting and retaining service providers is particularly critical in the remote, rural and insecure difficult-to-reach and difficult-to-stay districts. There is a heavy urban/rural imbalance, with an extremely heavy bias towards the central region.

The Human Resource Policy (MoH 2006 p.2) reveals that highly trained cadres including medical doctors, nurses and midwives, dentists, pharmacists as well as diagnostic personnel are extremely unequally distributed throughout the country. Attrition from the districts is high among medical doctors, dentists and pharmacists (MoH 2006 p.3).

The findings of a study carried out by the MoH with Capacity Project support (MoH 2009b), revealed that working conditions of health workers are often very difficult, characterized by poor infrastructure, lack of staff accommodation, inadequate equipment and supplies, work overload and inadequate remuneration. The poor working conditions are aggravated by weak HRH management; with HR managers ill equipped to effectively and efficiently manage the health workforce. Performance management, regulatory and disciplinary mechanisms are ineffective.

These poor working conditions do not attract staff nor motivate them to stay. As a result, the staff turnover is high. Data shows that the proportion of approved posts filled by health workers in the country stands at 52%, leaving a national vacancy rate of 48%. The mapping study carried out in Uganda (MoH 2008a p.1) indicated that vacancies are available for additional staff but are not promptly filled despite the fact that funds are budgeted for the vacant positions every year. Only about 70% of approved posts are filled each year.

The morale of health workers is low, which often results in poor attitude towards clients, absenteeism and low productivity. The public image of health staff has been eroded

ⁱ Geographical access is defined by the number of people within a 5 km distance from a health facility

(MoH 2009b), the quality of care provided is perceived as poor and the utilization of health services is low, particularly in the public sector. Health seeking behaviour studies indicate that many people will first go to a private clinic (largely unregulated) or pharmacist as their first option when ill (Konde-Lule et al 2006 p.3; MoH 2009b). The Human Resource Policy further indicates that the greater majority of Ugandans rely on associate health professionals for clinical, nursing, midwifery, diagnostic, therapeutic and rehabilitative health services (MoH 2006 p.2).

Health indicators in Uganda reveal a high burden of disease. The under-5 mortality rate is 137 per 1000 live births. The infant mortality rate (IMR) stands at 76 per 1,000 live births while maternal mortality rate (MMR) is 435 per 100,000 births (MoH 2007). The life expectancy at birth for both sexes is estimated at 52 years (MoH 2009c, Musoke & Candia 2009 p.2). Despite the high disease burden, there has been a gradual improvement in the health status of the people of Uganda following the health policy implementation through two successive Health Sector Strategic Plans (HSSP) of five years each.

Since the launch of the Health Sector Strategic Plan II in 2000, the MoH together with its cooperating partners have directed their efforts towards increasing the staffing levels in various facilities, building the training capacity of health training institutions to improve the quality and quantity of output, as well as providing tools and an enabling environment for improved work performance. These efforts were further enhanced by the Global Health Workforce Alliance Kampala declaration of March 2008 that emphasized the need for collective and sustainable political, structural, systemic and economic interventions to address the global health workforce crisis.

In response to this crisis, the Government of Uganda (GoU) has instituted many reforms and initiatives that will be described in this paper including motivation and retention strategies, new incentive programmes, and improved performance management systems.

In the early 1990s, the GoU started implementing decentralisation policies as part of the wider public sector reforms. Public institutions were restructured and strengthened as part of the wider “Structural Adjustment Programmes”. These reforms made considerable changes in the management and delivery of health services. The country adopted a “devolution” type of decentralisation where the district has absolute powers for management of district resources including HRH.

The aim of further decentralisation of health services was to take services closer to the people and improve geographical access, particularly to the rural poor. Devolution of the health sector and its integration into the national decentralisation policy was generally thought to be advantageous. This was to lead to improved options for target group oriented health service delivery, and more transparency and accountability through closer responsibilities.

The district local governments took on the role of translating policies into plans of action, planning for management of district health services; provision of disease prevention, health promotion, curative and rehabilitative services with emphasis on the Uganda Minimum Health Care Package. The approach of initiating health sub-districts (HSD) is one reform that the government of Uganda undertook to enhance performance of health workers and health systems.

A health sub-district is a division of a health district and is equivalent to a political constituency in Uganda. A district may have more than one HSD (MoH 2000). There are 214 such HSDs in the country. Functions of HSDs include service delivery, handling obstetric emergencies and supervision of lower level health facilities. Personnel decentralisation was also initiated and will be discussed. The HSD was designed to fit within the referral system and thereby strengthen the health system structure at the district level. Creation of Health Centre Level IV at the level of the HSD was intended to improve recruitment and retention of health workers through promotions and sub-autonomy that would bring professional staff nearer to the people who may require hospital services.

Subsequent to the creation of the HSDs, the GoU initiated various approaches to improve their functionality. These approaches include among others:

- improved work environment;
- health sub-district management training;
- continuing professional development;
- the “Area Team” strategy;
- improved occupational health and safety and
- Government of Uganda and faith-based private-not-for-profit (PNFP) collaboration.

They were initiated to improve sector performance by focusing on health workers and improving their work environment.

Decentralization of services and human resources is a challenge in itself, whereby low-resourced and unskilled districts are given the responsibility to plan and deliver health services with a constrained human resource structure and budget. Evolution of this system is still in its early stages, as it is undecided which responsibilities will lie with the districts, and which will remain at the centre.

This paper recommends quick action in enhancing health worker performance at the district and health sub-district levels in order to tackle many emerging health issues. Health worker imbalance may be reduced by paying health workers a living wage and additional set of incentives for those health staff serving in “hard-to-reach” areas such as Islands of Lake Victoria, and Karamoja region.

There is need for coordinated HRH planning between GoU and PNFPs to reduce staff movement among the sectors and improve harmonization of staff recruitment and deployment in the country.

INTRODUCTION

An efficient and effective health-care delivery system largely depends on having “carefully planned, effectively trained, equitably distributed and optimally utilised” health workers (MoH 2006). This, in practical terms means the achievement of an optimal balance in employee numbers, skill-mix, staff distribution, deployment and career progression to enhance staff motivation, retention, performance and maximum productivity. To reach prime performance, all actors in HRH management must recognize and value the need to establish the availability and adequacy of the required skills for effective delivery of the National Minimum Health Care Package (MoH 2009c) – a package of health services required at all levels of health care delivery in Uganda.

According to Palmer (2006 p.27), in Sub-Saharan Africa, health systems are fragile and staffing is grossly inadequate to meet rising health needs. Despite growing international attention, health development partners “have been reluctant to undertake the significant investments required to address the human resource problem comprehensively, given social and political sensitivities, and concerns regarding sustainability of interventions and risks of rising donor dependency”.

This paper aims to explore the current key issues facing Uganda’s health human resource climate with particular attention to practice environments including recruitment, retention and productivity of its health workforce, to identify the HR solutions that are being or have been employed to address these main challenges. The paper will also help in identifying knowledge gaps for future in-depth research and recommendations for future strategies.

This information will serve as background information for the implementation of the Positive Practice Environments Campaign on the national level. The Case Study of Uganda will also contribute to the knowledge base being amassed by the World Health Organization (WHO) related to “Increasing access to the health workforce in remote and rural areas through improved retention” of health workers.

CHAPTER 1: COUNTRY OVERVIEW

1.1 Geography

Uganda is a landlocked country located in East Africa, just north of Lake Victoria, astride the equator. The country has a total area of 241,039 square kilometres of which 43,943 square kilometres are swamps and 197,096 square kilometres island (UBOS 2007 p.1).

The country is divided into 80 districts which are decentralized. Broadly these districts are divided into rural and urban districts. More districts are being created by the approval of the national parliament. See Figure 1.1, p.14.

1.2 Languages and ethnic groups

English remains the official language of Uganda although about 40 languages are spoken in the country (Ladefoged et al. 1972; Lewis 2009). These languages include 19 Bantu languages spoken in central and southern Uganda, the bulk of them belong to the Banyoro -Baganda sub-family. The Baganda are the largest in terms of number of speakers, at over three million. Kinyarwanda is spoken by about 500,000 Ugandans, mainly in Kisoro district, near to Rwanda. There are a number of Nilo-Saharan languages spoken in the north, and also several smaller languages such as Amba, Gungu, Ruli and Talinga-Bwisi (all less than 70,000 speakers).

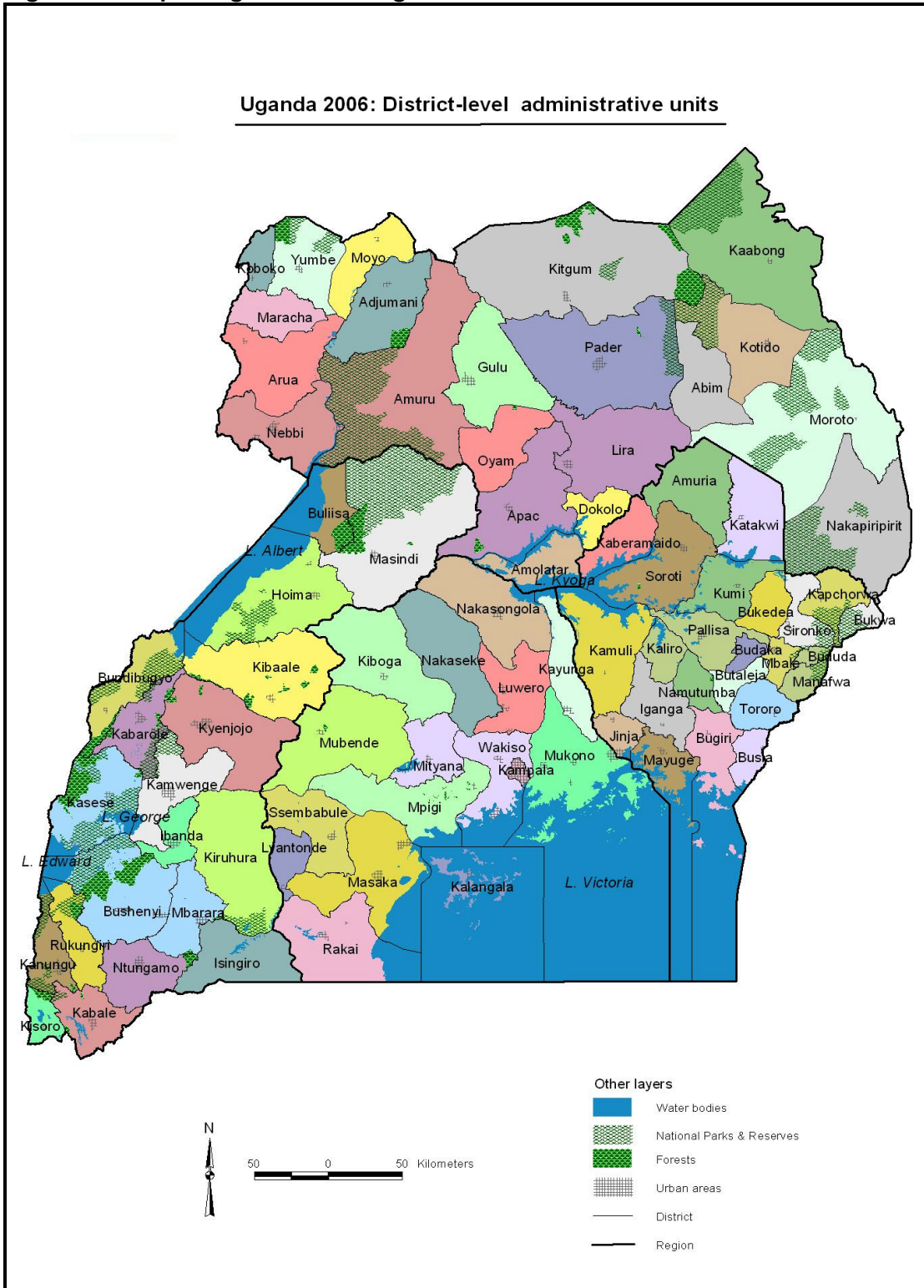
1.3 Socio-political characteristics

Uganda enjoyed considerable economic, political and social development between 1962 and 1971. After the army take-over in 1971, the country suffered from numerous difficulties which eroded what had been achieved previously. Consequently, the period 1972-86 has been termed "The Lost Time" because of the civil strife, mismanagement and political instability into which the country was plunged.

When the National Resistance Movement (NRM) government took over power in 1986, it promised a fundamental change to the people of Uganda. Through its 10-point programme, the Government committed itself, among other things, to build and consolidate democracy, to build an independent, integrated and self-sustaining economy and to fight corruption. Since that time, the Ugandan government has carried out a number of comprehensive reforms which have included comprehensive public service reform, democratization initiatives, and measures to increase community participation through the Local Council System. Efforts culminated in the promulgation of a new Constitution in 1995, in addition to changes to promote economic liberalization (Nsibambi 2000)

Several studies to determine the efficiency and effectiveness of service delivery by the Government of Uganda indicate significant progress in streamlining policies, structures and operations of the various sector ministries (MoH 2007)

Figure 1.1 Map of Uganda showing districts



1.4 Demography

From the National Census Report of 2006 (UBOS 2006), Uganda has a population of 29.8 million people, and a fertility rate of 6.9%. Uganda has experienced a fast increase in population since the year 1980. At 3.4% population growth, the population is expected to double in about 22 years from the year 2006.

1.4.1 Population composition

The government of Uganda together with UNFPA have analysed the situation of three census periods. Results of this analysis are presented in Table 1 below.

Table 1.1: Percent Population Distribution by Age Group 1969-2002

Age Group	1969	1991	2002
0-14 years	46.2	47.3	49.3
15-64 years	50.0	49.4	47.7
65+ years	3.8	3.3	3.0
Total	100.0	100.0	100.0

Source: UBOS (2002).

The Table shows that over the past two decades, the youth have formed the broad base of the population and have increased proportionally over time. On the other hand, the share of the productive and reproductive age group, 15-64, decreased from 50% in 1969 to 47.7% in 2002, implying that the dependency ratio is on the increase.

It is estimated that 12% of the total population is urban while 88% is rural (MoH 2009a)

1.5 Economic context

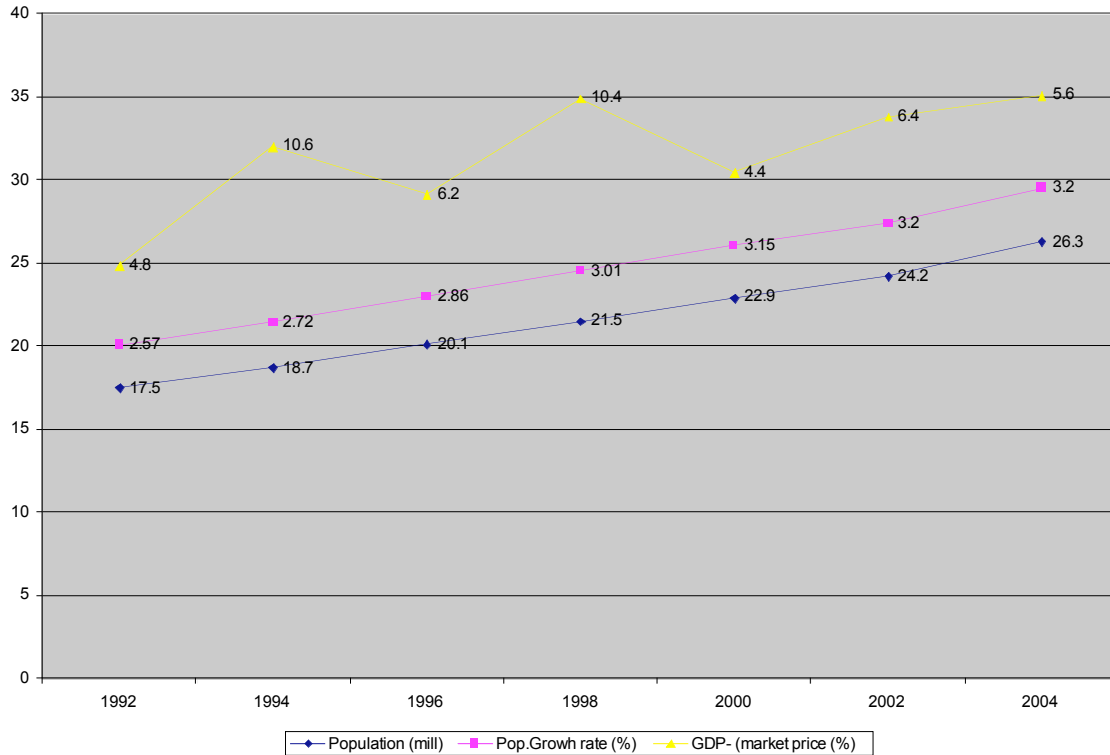
Since 1986, the GoU has been implementing various reforms including economic and health reforms. The World Bank (2002 p.1) reported that Uganda's reforms have placed it among the top economic performers in growth and inflation control in Africa. The country has relocated its expenditures to the social sectors including education and health.

The number of people living below the poverty line now stands at 37% (UBOS 2009 pp.1-5). Poverty is overwhelmingly rural, mainly concentrated among food crop farmers and women, and more marked in northern and eastern parts of Uganda. More efforts towards poverty alleviation are needed to reach the 2015 target of 28% (Musoke & Candia 2009)

One policy that was adopted that has contributed to economic growth is the Poverty Eradication Action Plan (PEAP). This was started to encourage growth-promoting macro-economic policies, and sufficient broad-based growth to benefit the poor and especially those working in agriculture. Other reasons were "to provide social infrastructure, create the capacity for a quick response to economic shocks, build a just,

secure and tolerant social order, and promote balanced regional development” (Nsibambi 2000)

Figure 1.2: Population and Per Capita Gross Domestic Product of Uganda 1992-2004



Source: Republic of Uganda (2006).

In terms of per Capita Gross Domestic Product (GDP) at market price, Uganda registered an average growth of 4.7% between 1992 and 2004 (UBOS 2006). It is argued in *the Population Report* that if this growth rate continues, per capita GDP (at market price) will double after 15 years. In practice this implies a very slow improvement in standards of living of the people for more than a decade at least. The real GDP per capita has tripled in the last 20 years, according to UN Human Development Report, from US \$515 in 1987 to US \$1,454 in 2005 (Musoke & Candia 2009).

1.6 Major health indicators

The under-5 mortality rate is 137 per 1000 live births. The infant mortality rate (IMR) stands at 76 per 1,000 live births while maternal mortality rate (MMR) is 435 per 100,000 live births (MoH 2007). The life expectancy at birth for both sexes is estimated at 52 years (MoH 2009b; Musoke & Candia 2009).

CHAPTER 2: HEALTH SYSTEMS OVERVIEW

2.1 Priority health problems as identified by the national health policy

According to the burden of disease study (cited in MoH 1999 p.3), over 75% of the life years lost due to premature death were due to preventable diseases. Perinatal and maternal conditions (20.4%), malaria (15.4%), acute lower respiratory tract infections (10.5%), AIDS (9.1%) and diarrhoea (8.4%) together account for over 60% of the total national disease burden. Malaria is still responsible for more illness and death than any other single disease and is more prevalent during the rainy seasons of March to June and August to November (UBOS 2009 p.34).

Others at the top of the national disease burden list include tuberculosis, malnutrition (with 38% of under-5s stunted, 25% underweight for age and 5% wasted), trauma/accidents and measles. Geographical access to health care has been limited to about 49% of the population (MoH 1999 p.3).ⁱⁱ

The Health Policy further indicates that together with the heavy burden of infectious diseases, Uganda is simultaneously experiencing a marked upsurge in the occurrence of non-communicable diseases such as hypertension, cancer, diabetes, mental illness and chronic heart disease. Uganda has therefore already entered into the phase of epidemiological transition. While infectious diseases have been given priority, selective attention has been given to all the key determinants of ill health in Uganda, including unhealthy lifestyles and the rising toll of accidents.

Despite the high disease burden, there has been a gradual improvement in the health status of the people of Uganda following the health policy implementation through two successive Health Sector Strategic Plans (HSSP) of five years each. According to the Uganda Demographic and Health Survey (UDHS) carried out in 2006, child mortality declined from 89 deaths per 1,000 in 1995 to 76 per 1,000 in 2006, while under-five mortality fell from 158 per 1,000 to 137 per 1,000 during the same period (UBOS 2009 p.2). Child nutrition has also improved. Stunting (chronic malnutrition) has reduced from 38 percent in 1995 to 32.2 percent in 2006. There was an increase in vitamin A supplementation from 37 percent to 70 percent, and 100 percent sustained household consumption of iodized salt. The 2006 prevalence of exclusive breastfeeding among children under 6 months of age was 60 percent (MoH 2009c p.xiv)

Evidence available at the MoH (2008c) indicates that the maternal mortality ratio has declined from 527 to 435 maternal deaths per 100,000 live births between 1995 and

ⁱⁱ Geographical access is measured by the number of people who are within 5 km walking distance to reach a health facility.

2006. The contraceptive prevalence rate has improved, from 14.8 percent in 1995 to 23.7 percent in 2006.

2.2 Major drivers of the national health policy

The national health policy is driven by the national development plan which provides thematic areas of development including health, education, water and sanitation, agricultural production and human resources development and management. The national development plan incorporates the poverty eradication action programme (PEAP) elements of government. Health is seen as a component contributing to overall national development through the provision of quality and accessible health care contained in the Uganda minimum health care package.

In addition, the national health policy is driven by the political agenda. The National Resistance Movement (NRM) government came to power in 1986 with a 10-point programme that constitutes a political agenda. This agenda is being followed through implementation of different programmes throughout the country. A policy of decentralization gives power to the local governments. At the district level, there is a fully fledged local government. One of the departments at the local government level is health. The political wing of the district also has a secretary in charge of health and education to address micro policy issues at this level.

The national health policy is further driven by the realities facing the population of Uganda. Information on these realities such as the burden of disease, health financing and human resources for health, is elicited through research and periodic reports. There is periodic monitoring of health sector performance through periodic reviews and commissioned studies to assess health policy implementation. Quarterly, bi-annual, and annual performance reviews are held and reports are written to inform policy.

Finally, the national health policy is driven by external forces such as the health development partners, international policies and plans, such as the Millennium Development Goals (MDGs) and other international conventions that Uganda has signed.

2.3 Financing model for the health system

Uganda finances its health budget from GoU funding, health development partners and individual out of pocket health expenditure.

A recent study (MoH 2009d p.24) indicates that private sources (including household) continue to be the main source of health financing in Uganda contributing 50% of the national health expenditure (NHE).

The share of NHE by the central government has declined from 18.2 percent in FY 2000/01 to 14.4 percent in FY 2006/07.

The latest figures of the national health accounts (NHA) for the financial year 2006/07 (MoH 2009d p.24) indicate that the national health expenditure was UG Shs 1,610 trillion equivalent to (US \$904 million), accounting for 8.0 percent of Uganda’s GDP, with a per capita expenditure of UG Shs 57,245 (US \$32). Table 3.1 provides the details of financing source contributions FY 2000/01 and 2006/07.

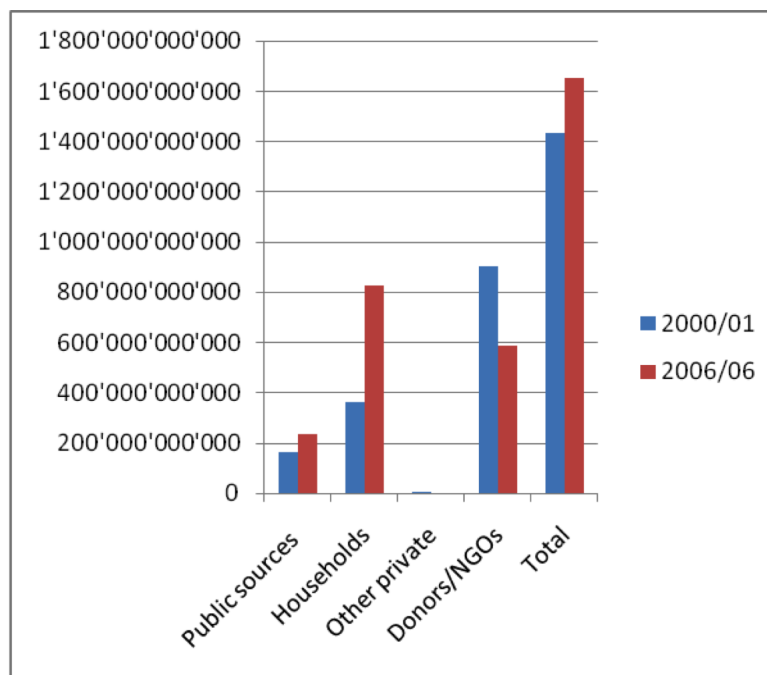
Table 2.1: Absolute Value of Financing Source Contributions FY 2000/01 and 2006/07

Financing Source	2000/01	2006/07	Percent change
Public sources	164,356,901,350	238,467,351,114	45.1%
Households	364,634,291,593	826,236,015,958	126.6%
Other private	2,822,234,971	n/a	n/a
Donor/NGOs	369,323,524,104	586,751,284,214	58.9%
Total	901,136,952,018	1,651,454,651,286	83.3%

Source: Adapted from Planning department, MoH, NHA 2006/07

Table 2.1 above and Figure 2.1 below show that there have been changes between FY 2000/01 and FY 2006/07 regarding financial contributions by various financing sources. Household expenditure remains the main mode of financing health care in Uganda.

Figure 2.1: Financing Service Contributions FY2000/01 and 2006/07



2.4 Decentralization policy

In the early 1990s the GoU started implementing decentralization policies as part of the wider public sector reforms. Public institutions were restructured and strengthened as part of the wider “Structural Adjustment Programmes”.

These reforms made considerable changes in the management and delivery of health services. The country adopted a “devolution” type of decentralisation where the district has absolute powers for management of district resources including human resources for health.

The mandate of the central government remains policy formulation, standard setting and quality assurance, capacity development, technical support; provision of nationally coordinated services such as epidemic control, monitoring and evaluation of overall sector performance, and resource mobilization.

The district local governments took on the role of translating policies into plans of action, planning for management of district health services; provision of disease prevention, health promotion, curative and rehabilitative services with emphasis on the Uganda Minimum Health Care Package. Others functions include vector control, health education, ensuring provision of safe water and environmental sanitation, health data collection, management, interpretation, dissemination and utilization, technical support to the lower level health facilities, and mobilization of additional resources.

The “Minimum Service Standards” provided depend on the level of the health facility. The district hospital carries out all the functions performed at the level of health centres but at an advanced level. It also acts as a referral centre for all health interventions in the district (Nsibambi 2000; Matsiko 2005)

Political and administrative institutional relationships in the decentralisation process are dictated by the legal framework, as is the nature of interaction between various actors including donors, central government, local authorities, NGOs and the citizenry (Sabiti 2000). Local Councils were conceived as institutions of the people to ensure security, settle local disputes, enhance development and check the abuse of power by corrupt officials and chiefs (Sabiti 2000).

2.5 Policy on public-private health care

Although the policy on public-private partnership is still in the draft form in 2009, the operating mechanisms are documented. Institutional mechanisms were set up to enable the participation of the facility based private-not-for-profit (PNFP) institutions as appropriate. The districts are the main public partners in health service delivery and are the principle actors in the dialogue with the faith-based PNFP representatives in the process of improving health care.

At the central Ministry of Health, the Joint Review Mission, the Health Policy Advisory Committee and the Public Partnership in Health working groups are very prominent as part of sector wide approach processes (SWAp) because they provide fora for partnership dialogue.

The role of Joint Review Mission is to review financial, technical and institutional progress in the sector on a bi-annual basis and agree on the outputs and resource allocation for the year by both the GoU and its development partners (Nsibambi 2000; Matsiko 2005).

CHAPTER 3: HUMAN RESOURCES OVERVIEW

Human resources for health include all those persons employed by government, non-governmental organisations (NGOs) and the private sector in protection and improvement of health. Since the launch of the Health Sector Strategic Plan II in 2000, the Ministry of Health together with its cooperating partners have directed their efforts towards increasing the staffing levels in various facilities, building the training capacity of health training institutions to improve the quality and quantity of output, as well as providing tools and an enabling environment for improved work performance. In addition to international organisations, civil society organisations and local agencies, the cooperating partners include the private sector with three sub-sectors namely private-not-for profit (PNFP), private health practitioners and traditional and complementary medical practitioners. The contribution of each sub-sector varies widely (MoH, 2009c p.25). The PNFP sub-sector is well organised with a functional collaborative framework with the MoH. Efforts of these actors were further enhanced by the GHWA Kampala declaration (March 2008) that emphasized the need for collective and sustainable political, structural, systemic and economic interventions to address the global health workforce crisis.

3.1 National HRH strategic plan/policy

Uganda developed its HRH policy in 2003 and published it in 2006. The country further developed a human resource strategic plan to implement the policy with a time frame of 2005 – 2020. The two documents are currently in use.

3.1.1 Uganda Human Resources for Health Policy 2006

The purpose of the HRH policy is to communicate the GoU position on HRH (MoH 2006). It provides a basis for decision-making regarding planning, training and deployment of HRH; and creates a sound basis for developing guidelines, strategies and plans as well as providing transparency and accountability.

The policy provides a shared vision among the key stakeholders in the area of HRH, seeking better coordination, generating commitment to a common cause and harmonizing HRH practices with global developments and other sectoral policies.

The HRH policy covers planning for the number and composition of the health workforce; distribution characteristics; staff dynamics and attrition; financing; education and training; management issues; standards and rights of health professionals and clients; information and research on HRH; partnerships; and institutional framework.

3.1.2 Uganda Human Resource Strategic Plan 2005 – 2020

The purpose of the Uganda HRH strategic plan is to provide a framework for policy implementation and to guide operational planning, development and management of the workforce in the health sector in Uganda. It relates human resources with the current and future health service needs, with emphasis on improved effectiveness and efficiency in the use of the health workforce for good quality health care and optimal productivity.

Its major focus is on health development priorities in the National Health policy, the HSSP II, global health goals, as well as key HRH issues, identified through studies and broad consultations that require urgent attention to promote good performance productivity and cost-effective practices.

The HRH Strategy is based on the sector-wide approach policy and integrates public, PNFP and the private-for-profit sub-sectors to promote unified standards in health workforce development, deployment and utilization, and complementarity for universal access to good quality health services in all parts of Uganda.

3.1.3 Development Process

A task force together with a drafting team were identified and subsequently appointed by the permanent secretary of the MoH to develop and work on the HRH strategic plan for the health sector. The existing HR working group of the Health Policy Advisory Committee acted as Steering Committee to ensure that progress was made.

3.2 Situation analysis

The human resource inventory (MoH 2004) indicated a total health workforce of 27,487 covering both GoU and PNFP health workers. The GoU had a total of 18,333 health workers while the PNFP had 9,154 as indicated in Table 3.1

More recent tables show that there has been tremendous improvement in health worker staffing levels in Uganda since 2004 due to the annual recruitments that followed. The total doctors in the health facilities were 953 in 2004 as compared to the current 3,917. The nurses were 2,074 in 2004 compared to the current 5,702 which can be attributed to the heavy recruitment drive conducted in local governments over the years.

Comparative data recently analyzed to reflect the staffing situation at all levels of health care (including the MoH, Mulago hospital, Butabika hospital, regional referral hospitals, general hospitals and health centres level II – IV) are presented in Table 3.2.

Table 3.2 shows that the proportion of approved posts filled by health workers in the country stands at 52% leaving a national vacancy rate of 48%. The mapping study carried out in Uganda (MoH 2008a p.1) indicated that vacancies are available for additional staff but are not promptly filled despite the fact that funds are budgeted for the vacant positions every year. Only about 70% of approved posts are filled each year.

Table 3.1: The Number and Density of Health Personnel as at August 2004.

Cadre of Staff	Districts	DHO	Total districts	*Regional Ref. Hosp	Mulago Hosp	Butabika Hospital	Total GoU	PNFP	Total
Doctors	308	50	358	164	111	15	648	305	953
Clinical Officers	1,319	53	1,372	168	91	7	1,638	436	2,074
Midwives	1,635	18	1,653	312	147	35	2,147	914	3,061
Nurses	2,542	34	2,576	758	1,114	86	4,534	1,915	6,449
Total Medical & Clinical	5,804	155	5,959	1,402	1,463	143	8,967	3,570	12,537
Nursing Assistants	4,165	21	4,186	175	123	-	4,484	2,005	6,489
Diagnostic	356	4	360	79	75	3	517	358	875
Pharmacy	76	22	98	29	25	6	158	43	201
Other Medical related	988	161	1,149	63	144	5	1,361	126	1,487
Other Staff	1,627	245	1,872	462	433	79	2,846	3,052	5,898
Total	13,016	608	13,624	2,210	2,263	236	18,333	9,154	27,487

Source: MoH 2004

Regional Ref. Hospitals: these are regional referral hospitals (a total of 11 hospitals in all)*Table 3.2: Uganda Current Health Workforce in Public Health Facilities as at Dec 2009**

No	Cost Centre	No. of units	Total Norms	Filled	Vacant	% Filled	% Vacant
1	MoH Headquarters	1	810	592	218	73%	27%
2	Mulago Hospital	1	2,178	1,956	222	90%	10%
3	Butabika Hospital	1	432	367	65	85%	15%
4	Regional Referral Hosp	11	3,595	2,513	1082	70%	30%
	Sub-total (MoH)	14	7,015	5,428	1587	77%	23%
5	General Hospitals	39	7,300	4,550	2,750	62%	38%
6	DHOs Offices	80	880	462	418	53%	48%
7	HC IV	161	7,500	4,104	3,396	55%	45%
8	HC III	803	14,872	6,821	8,051	46%	54%
9	HC II	1321	11,296	4,051	7,245	36%	64%
10	Municipal Councils	10	80	37	43	46%	54%
11	Town Councils	32	180	53	127	29%	71%
	Sub-total District	2,446	42,108	20,078	22,030	48%	52%
	Total National Level	2,460	49,123	25,506	23,617	52%	48%

Source: Uganda Capacity programme database 2009

3.3 Major human resource problems

In the Ugandan context, the HRH problems result from mal-distribution and poor utilization of the people available in the service, inadequate motivation as evidenced by a series of complaints over low salaries and health worker allowances, and general dissatisfaction of health workforce (Matsiko 2005).

The inability of health systems to recruit and retain sufficient numbers of health professionals – especially skilled workers – is one of the biggest challenges for the health sector (MoH 2009a). On the other hand, the lack or inadequacy of service providers is due to slow and lengthy recruitment processes, delays encountered in accessing the pay-roll, and high absenteeism. The high absenteeism may be due to lack of accommodation on site but also low morale because of poor remuneration and poor HR management.

Difficulty in attracting and retaining service providers is particularly critical in the remote, rural and insecure difficult-to-reach and difficult-to-stay districts. Many of these districts do not have personnel officers to declare the vacant posts for recruitment in addition to maintaining the personnel records of the health workforce in the districts. In fact, many of these remote districts have no functional District Service Commission (DSC) (which are tasked with recruiting health personnel for the districts) coupled with inadequate resources to recruit skilled personnel (MoH 2009b p.12).

The human resource policy (MoH 2006 p.2) reveals that medical doctors, dentists, pharmacists as well as diagnostic personnel are extremely unequally distributed throughout the country, serving only a fraction of the population. The policy further indicates that the greater majority of Ugandans rely on associate health professionals for clinical, nursing, midwifery, diagnostic, therapeutic and rehabilitative health services. This creates a lot of work pressure on the associate health professionals.

The policy further reveals that there is a heavy urban/rural imbalance, with an extremely heavy bias towards the central region.

Attrition from the districts is high among medical doctors, dentists and pharmacists although staffing levels for several other cadres have been rising in the public sector (MoH 2006 p.3)

In the December 2003 Financing Service Contributions FY2000/01 and 2006/07 Uganda Catholic Medical Bureau Bulletin, it is argued that a lot of cross movements have taken place among the professionals in the Health Sector, following the lifting of the ban on recruitment by the GoU in 1997, thus leaving the PNFP sector with insufficient staff. The PNFP sector often services the remote, rural, hard-to-reach areas.

CHAPTER 4: PRACTICE ENVIRONMENTS

Information on practice environments was derived from the analysis of the current human resource situation in Uganda, the health management information system (HMIS), recent in-country studies and other government reports.

4.1 Motivation and Retention of HRH

The inability of the public sector to attract skilled health workers is due to a number of factors including lack of incentives, brain drain and sector out-migration. It is compounded by the proliferation of other opportunities within the for-profit commercial sector and with NGOs that provide better compensation, benefits and working conditions (Matsiko 2005 p.30-36; MoH 2009a pp.40-41, MoH 2009b p.58).

The findings of the retention study carried out by the MoH with Capacity Project support (MoH 2009b) revealed that working conditions of health workers are often difficult and characterized by poor infrastructure, lack of staff accommodation, inadequate equipment and supplies, work overload and inadequate remuneration. The poor working conditions are aggravated by weak HRH management; with HR managers ill equipped to effectively and efficiently manage the health workforce. Performance management, regulatory and disciplinary mechanisms are ineffective.

These poor working conditions do not attract staff nor motivate them to stay. As a result, staff turnover is high, particularly in remote rural districts generally regarded as difficult-to-reach and difficult to stay in areas. The morale of health workers is low, which often results in poor attitudes towards clients, absenteeism and low productivity. The public image of health staff has been eroded (MoH 2009b), the quality of care provided is perceived as poor and the utilization of health services is low, particularly in the public sector. Health seeking behaviour studies indicate that, when ill, many people will first choose to go to a private clinic (largely unregulated) or pharmacist (Konde-Lule et al. 2006 p.3, MoH 2009b pp.3-5).

In response to the above, Uganda has developed a Motivation and Retention Strategy (MoH 2008c) to improve the existing practice environment of professional health workers.

The Motivation and Retention Strategy (MoH 2008c p.3) indicates that the underlying causes of HRH problems in Uganda range from HRH management systems, leadership, policy, finance, education, partnership and other health systems. The strategy is anchored on improving four areas highlighted below.

4.1.1 Salaries and benefits

The strategy advocates for improved salaries and other personnel costs. It recognises that health professionals are required to work irregular hours, in conditions of mental and physical stress, and in an environment that is risky and hazardous. It has been documented that paying inadequate salaries and benefits to health workers tempts them to charge illegal fees, which is not in the interest of patients (MoH 2008b p.7).

4.1.2 Leadership and management

It is documented in the motivation and retention strategy (MoH2008c p.8) that poor management at all levels is one of the most frequently cited weaknesses mentioned as a cause of inadequate health workforce performance. The government wants to address good supervision and management - including adequate technical support and feed back, recognition of achievements, good communication, clear roles and responsibilities, and norms and codes of conduct.

4.1.3 Conducive and safe working environment

The strategy notes that in the decentralised health care system, the district health officer (DHO) occupies a senior level management position in the district. The DHO is supported by two deputy DHOs, each responsible for management and supervision of a sub-district. In turn the hospital superintendents and health facility managers carry out the day to day management and supervision of their respective health facilities. A number of strategies have been outlined to make the working environment conducive to retain and improve productivity of health workers (MoH 2008c pp.13-16). These include among others: 1) institutionalize and maintain sustainable schemes for salaries and benefits to attract and retain health workers; 2) strengthen leadership and management capacities to manage the health workers in a manner that will attract, retain and motivate them to be productive - this includes establishing effective management at district and health facilities; and allowing community participation in health unit management; 3) provide institutional accommodation of health staff at health facilities and basic medical equipment and supplies.

4.1.4 Professional values and ethical practices

The strategy notes that the professional values and ethical practices have been eroded. The plan is to make the regulatory and disciplinary capacities and mechanisms stronger to improve staff attitudes, ethical behaviours and time management. Absenteeism, lack of confidentiality, corruption and abuse of patients are to be addressed under this plan by enabling managers to cause disciplinary action as and when necessary.

4.1.5 Health Worker Incentives

There is a widespread and strong feeling among health workers in Uganda that the salary paid to all health staff is inadequate to meet their basic needs. In the MoH study (MoH 2007), the majority of health workers interviewed indicated that their salary package was inadequate and unfair, thus being one of the major factors resulting in health worker dissatisfaction.

The process of salary review and enhancement is currently ad hoc, reactive to pressures from the health staff, and not based on any rational analysis (MoH 2008c p.10). The salary structure is provided by the Ministry of Public Service. Health workers currently receive consolidated housing and lunch allowances as part of their salary. In addition, each district under decentralisation provides district specific monetary and non-monetary incentives. Some districts provide additional top-up allowances; others provide short term in-service training or accommodation, depending on the financial possibilities of the individual districts.

In Northern Uganda, the Ministry of Health, together with its health development partners, provided financial incentives of up to 30% salary top-ups, to attract and retain professional health workers and to address the HR crisis in this part of the country after 20 years of armed insurgency. A number of health workers, including doctors and nursing staff, received this allowance as a salary top-up for a period of six months. Following this payment, more health workers moved to northern Uganda and were recruited (MoH 2007 p.3). Anecdotal evidence seems to suggest that since this was a one-off activity, the 30% top-up was not able to retain health staff permanently. In fact, health workers moved away to other regions when allowances stopped coming.

Evidence from the Karamoja region in the northeast corner of Uganda indicates that the 30% salary top-up together with housing, free transport and automatic scholarships for master degree programmes, retained doctors for at least four years at the health sub-district level (Matsiko 2005). In the Karamoja region, health workers were given a little more money than their counterparts in other regions as it is considered to be a remote, hard-to-stay and hard-to-staff area. In addition to housing and lunch allowances as part of the basic pay, doctors in Karamoja were given Uganda shillings (UGX) 300,000 (about US\$ 200) on top of their salaries and automatic scholarship after serving for a period of two years. All health sub-districts retained doctors while they waited for their turn to go for further studies (Matsiko 2005). Comparatively, Mpigi district which is about 32km from Kampala has a very severe shortage of medical doctors because they did not have similar conditions of service. In the recent countrywide staff audit exercise (MoH 2009a), the vacancy rate of all health workers at Health Centre IV was 33.3% in Mpigi while that of Kotido (in Karamoja) was 25%. However, there were a lot of variations in staffing at Health Centre IV within the districts.

Findings of other studies (Matsiko 2005 p.102) indicated that 36% of health workers considered UGX 1,000,000 (US\$ 555) per month adequate for an enrolled nurse/midwife. In another interview 33% of the doctors put the adequate pay per month at UGX 3,000,000 (US \$1,666).

For comparative purposes, in the FY 2009/2010 the starting salary for a senior medical officer stood at UGX.840,749 (US\$420.37) per month. Other senior officers in the graduate class such as degree nurse, radiographer and laboratory scientist were earning UGX 769,517 (US\$384.76) per month. The entry point for a medical officer in FY 2009/2010 was UGX.657,490 (US\$328.75) and it may take this doctor a period of three to five years to become a senior medical officer in service. The entry salary for technical

cadres such as a registered nurse in FY 2009/2010 was at UGX.353,887 (US\$176.93). These salaries are quite low compared to the market value of goods and services in the country. This situation creates one of the biggest bottlenecks in attraction and retention of health professionals in service.

To access the poverty incidence in Uganda, the 2005/06 Uganda national household survey collected information on consumption expenditure on food, beverages and non consumption expenditure on households among others (UBOS 2006b). Findings indicated that household monthly expenditure rose from UGX 136,468 (US\$68.23) in 2002/03 to UGX 152,068 (US\$76.03) in 2005/06 (UBOS 2009). This means that a health worker who resides in the city will not have enough money to spend on food, housing, clothing and transport. In essence then, some other ways of topping up the monthly income has to be devised by all the health workers irrespective of the cadre of staff.

4.1.6 Performance Management

The Ministries of Health and Local Government, the districts, the recruitment authorities, and the four professional councils are responsible for the performance of the health workforce. However, the current health workforce is performing below standard because the systems to enforce performance and professional ethics of the health workers are deficient or non-existent.

Available information (MoH 2009a pp.36-42; MoH 2009b pp.58-76) reveals that there is inadequate HR planning and management capacity at national and district levels, including follow up support, mentoring, coaching, appraisals, rewarding for good and bad performance, and enforcement or adherence to public service standing orders.

The redesign of the performance management system for the civil service addresses the short comings of the old system of using a closed performance appraisal system, using an “annual confidential report” (ACR) format.

Currently the Capacity Project, together with Ministries of Health and Public Service are pilot-testing a new performance management system (PMS) in three districts of Uganda namely Kabarole, Oyam and Amolatar aimed at further improving performance in the health sector. Lessons from the pilot-test, including adjustments on the tools, will assist the health sector to later implement the system throughout the country.

Among other things, the PMS includes recognition of health workers who perform well and sanctions to those who do not perform to the expected standards set by the line Ministries. Ministries such as health, education, local government and agriculture are called line ministries because they have equivalent departments at the district level. Introduction of PMS has encouraged improved rural practice, particularly with those health workers deployed to work in their own districts of birth in Uganda. This is because under normal circumstances, these health workers hardly receive recognition from their own people.

Under this system, all public servants are asked to sign performance agreements of one year with their supervisors. The appraisee and supervisor are required to meet formally on a quarterly basis throughout the year, to discuss performance. However, all health care workers are encouraged to meet their supervisors more frequently, for the purpose of monitoring performance more regularly.

4.1.7 Continuing Professional Development

Continuing professional development (CPD) is a compulsory requirement for renewal of practice or operating licenses for all professional health workers. Professional councils require mandatory attendance of continuing education courses for a specified number of hours within a one year period to enhance health worker performance. The pharmacy council is still deliberating on the number of hours required by its members for licensing.

Each health worker records the CPD activities undertaken, i.e. personal study, clinical or professional meetings, workshops, conferences, conventions, examining/supervising learners, etc. in a CPD personal diary. Since CPD is a compulsory requirement for licensing and registration, it is critical that In-Service Training (IST) opportunities be available to all health professionals regardless of the care or location. However, capacity resource and systems constraints are still impacting on the councils' ability to ensure equitable opportunities and to comprehensively monitor the full range of CPD activities undertaken and to effectively evaluate the impact on performance (MoH 2008a).

4.1.8 Conclusion of findings

The number of trained workers is insufficient to meet the needs of the populations they are intended to serve. The education sector, under which all the pre-service training schools fall, has also undergone reforms that have decreased the number of lecturers and tutors in these schools. As a result, there are cadres of staff like anaesthetists, Ear Nose and Throat (ENT) and midwives that are always in short supply. In-Service Training in the country thus requires strengthening, expansion and support to address the current and future human resource demands.

4.2 HR Management Structure and Decentralization

Uganda has a complex management structure for human resources in the health sector, which contributes to the HR crisis. There are six central ministries: four Professional and Regulatory Councils, and two recruitment Authorities with overlapping mandates to manage HRH.

The MoH manages the human resources at the MoH headquarters and at national and regional referral hospitals as well as planning and management of in-service training in the country. The Ministry of Education & Sports is responsible for pre-service education and the certification process. The Ministry of Public Service (MoPS) provides policy guidance and manages the pension and the salary pay roll. The Ministry of Finance, Planning and Economic Development finances the payroll while the Local District

Administrations (LDAs) that fall under the Ministry of Local Government (MoLG) manage the human resources at the district and lower levels.

The four health Professional Councils of Doctors and Dental Surgeons, Pharmacists, Allied Professionals, and Nurses and Midwives regulate the training and practice, and oversee Continuing Professional Development (CPD).

Of the two recruitment Authorities, the Health Service Commission that falls under the MoH recruits health workers for the MOH headquarters and all hospitals; and the District Service Commissions (DSCs) that are under the MoLG recruit health workers for the districts. However, not all the 80 districts in Uganda have a functional DSC and many lack the capacity to effectively perform their duties. This complex management structure of HRH contributes, to a great extent, to the HR crisis, especially in the remote and insecure districts.

The decentralization process of governance was instituted in the years 1991-1997. Personnel decentralisation was initiated in response to the recommendations of the public service review and reorganisation commission of 1989/1990, which had been set up to study the problems of public service and make recommendations (MoPS 2005).

Decentralization of services and human resources is a challenge in itself, whereby low-resourced and unskilled districts are given the responsibility to plan and deliver health services with a constrained HR structure and budget. The roles and functions that have been devolved to local governments not only demand a clear understanding of the reform process but also requisite skills and behaviours that facilitate the functioning of local governments (Nsibambi 2000). Evolution of this system is still in its early stages, as is it is undecided which responsibilities will lie with the districts, and which will remain at the central level.

Prior to the implementation of the personnel decentralisation policy, each district and urban authority had its own service committee (Nsibambi 2000) which were appointed by the president, and not by the local governments as it is now. This meant that the president had direct appointing powers at all levels including appointing lower level committees. With the personnel decentralisation, these powers were devolved to the district local government. At the district level the chairperson has the power to hire and fire staff through the various committees described above.

The objective of personnel decentralisation was to make all staff executing functions accountable to local governments and those in recently decentralised departments (employees of the district or urban councils) to be fully accountable to the local councils through the Chief Administrative Officer (CAO) or town clerk as the case may be (Nsibambi 2000). In each district, a DSC empowered to appoint persons to hold or act in any office in the service of a local government council, including the power to confirm appointments and to exercise disciplinary control, was set up. This change in policy gave power to the district governments to make and implement decisions. However, the districts in general have weak managerial capacity to make rational decisions affecting

human resources for health. This has largely been due to inadequate numbers and quality of managers at the district level.

The Sector Wide Approach (SWAp) works through the governance structures such as the Human Resource Technical Working Group (HRTWG). The HRTWG involves HRH stakeholders to make decisions and recommendations to the higher levels of the MoH. However, advocacy across the various ministries and bodies responsible for HRH is not as apparent (MoH 2009b).

4.3 Health System Structure under new decentralized system: Health Sub-Districts

As part of the overall health sector reforms, the health care delivery system has undergone several changes to improve its efficiency and effectiveness in meeting the national targets and aspirations. Some of these changes have taken place at the national level, but other critical changes have also taken place at the district and sub-district levels. *The approach of initiating health sub-districts (HSD) is one reform that the government of Uganda undertook to enhance performance of health workers and health systems.*

Bataringaya in the *Uganda Health Bulletin* (2002 p.295) gives a comprehensive explanation on the infrastructure and levels of service delivery. The different levels of health care delivery are the village health committee (HC I), HCs II, III, IV, general hospital, regional referral hospital and national referral hospitals. At the district level, the functional operational zone in terms of service delivery is a HSD whose function is to plan, implement, monitor and supervise all basic health services. The leadership of a HSD is based at the existing hospital (government, PNFP, or private) or upgraded HC IV.

A health sub-district (HSD) is a division of a health district. It is an equivalent to a political constituency in Uganda. This is a structure below the district level headed by a medical officer who works in a team with other health professionals. A district may have more than one HSD (MoH 2000). There are 214 such HSDs in the country, whose functions include service delivery, handling obstetric emergencies and supervision of lower level health facilities.

The HSD was designed to fit within the referral system and thereby strengthen the health system structure at the district level. Creation of HC level IV at the level of the HSD was intended to improve recruitment and retention of health workers through promotions and sub-autonomy that would bring professional staff nearer to the people who may require hospital services.

The HSD strategy also created a position of medical officer who would handle obstetric emergencies at the constituency level thereby reducing maternal deaths significantly.

In order to improve efficiency and effectiveness and to strengthen the functionality of the HSD, the Government of Uganda, through the MoH, undertook to implement feasible approaches. These approaches include among others: a) improved work environment, b) HSD management training, c) continuing professional development, d) the “Area Team” strategy, e) GoU and faith-based PNFP collaboration; and f) occupational health and safety. These approaches were initiated to improve sector performance by focusing on health workers and improving their work environment. Various approaches that focused on improving functionality of the HSD are described below.

4.4 Initiatives to improve functionality of Health Sub-Districts

4.4.1 Improved work environment

It is widely acknowledged that the work environment has an impact on the productivity of staff (MoPS 2005 p.50). The strategy for enhancing the work environment in the public service of Uganda was three pronged.

Firstly, it aimed to spearhead the development of policies on cross-cutting issues that affect the public service work environment. Secondly, it sought to support ministries, departments and agencies to identify and implement measures to improve their work environment. The public service reform programme (PSRP) established a fund that facilitated improvements in the work environment through a demand driven approach. Thirdly, the strategy aimed to enhance record management.

The MoPS (2005 p.51) specified how the demand driven improvements to work environment should function. The need for improvements to the work environment in various ministries, departments, agencies, and local governments can generally be identified. In the health sector it was easier to use a HSD as an implementation level to identify the need for quality improvement in all the health facilities.

Record management in the health sector was enhanced through establishment of a user friendly health management information system (HMIS) in all health centres and hospitals. The HSDs were encouraged to collect, analyze and use the information collected on a daily, monthly, quarterly and annual basis. Training manuals and guidelines were developed by the MoH to guide implementation of the system.

4.4.2 Health sub-district management training strategy

From 2003 to 2006, a total of 102 HSD teams spread out in 33 districts of Uganda mainly in the Northern and Eastern regions of the country. Most of these regions had been included in a management training programme of the MoH to prepare them for the newly decentralised responsibilities.

In 2007, before committing more funds and other resources for extending the programme to the rest of 80 districts, the government of Uganda found it necessary to evaluate the training programme (Mshana & Hitimana 2007 pp.6-16).

The MoH commissioned a consultancy through the support of the European Union (EU) funded *Developing Human Resources for Health Project* to evaluate the training programme.

The purpose of the assessment was to review and consolidate the HSD management course and training materials and to document the impact, best practices and lesson learned in the HSD management training.

HSD Management Training Evaluation

The evaluation team carried out a desk review of key documents to establish the nature, concepts and methodology of the training function. The team further interviewed key informants at the health sub-district, district and ministry of health headquarters including the health development partners. This was followed by training of research teams and data collectors on the instruments and the data collection process.

Generation of data from the national, district and health sub-district levels was guided by the data collection instruments, which were developed and pretested in two districts Mukono and Tororo, during the first of phase of evaluation. The data collection process employed the blending of methods, with emphasis on qualitative techniques. It employed structured and semi-structured interviews, as well as focus group discussions.

Data analysis applied a participatory approach whereby the study team and some key players were involved through a continuous consultation process to ensure that there was consensus on the results.

The evaluators presented a report to the stakeholders and incorporated the participants' comments and thereafter finalized the report. Upon approval by the MOH, the report was disseminated and distributed to relevant stakeholders.

Evaluation Results

Findings of this evaluation revealed that from 2004 to December 2006 the training covered 88 health sub-districts in 28 districts mainly in the North and Eastern parts of Uganda. The training was financially supported by the government of Uganda, DANIDA and ADB (Mshana & Hitimana 2007 p.10)

1. Presence of management teams

It was found that the majority of HSDs has a management team comprised of 3-4 officers, mostly medical officers, nursing officers, environmental health officers and health educators. Opinions concerning the HSD team composition were mixed, with more than 50% of the respondents not finding it appropriate due to the apparent gaps in the skill mix. Pharmaceutical supplies skills were lacking, while medical officers were considered too young and mobile to act as heads of

HSDs. The local authorities preferred experienced clinical officers, possibly those with further advanced training.

Results further indicated that 21 out of 25 trained members (84%) were still serving while four (16%) had left the service to pursue various professional careers. A total of three out of four had gone for further studies and five of the trainees had been transferred to other stations.

2. Course content

Results indicated that the course was easy to follow (67% responded in this fashion). Most of the health sub-district teams interviewed agreed that the health sub-district training intervention was appropriate.

Respondents indicated that the training curriculum should be reviewed periodically to address the emerging health problems such as nutritional related diseases, and other non-communicable diseases that are new to the country. This is in agreement with other research findings (MoH 1999 p.3, Matsiko 2005 p.132) that revealed rapid changes in the needs of Uganda health care system.

The study recommended that the future management capacity building strategies continue with the same approach – that is through a “cascading” training of facilitators approach. In this strategy, the central Ministry of Health experts train the district officials and in turn, the district officials train the HSD staff. The same approach is followed during support supervision. It is therefore expected that the district health officials shall endeavour to keep a closer look at the HSD planners and managers.

3. Performance Improvement

On a whole, it was revealed that the team had adequate knowledge in planning and this had influenced the way they had been planning. Another area that was greatly improved according to the results was teamwork, organisational skills and management of resources.

Qualitative information provided by the health professionals indicated that some HSDs performed much better than others even though they had received the same training. Ways in which some teams were seen to perform better included activities such as regular voluntary counselling and testing (VCT), community mobilization, submission of reports, planning and quality of health plans, absence of financial impropriety, self motivation and good team spirit.

Respondents indicated that factors which made superior teams perform better included commitment and interest, training, good team spirit, maturity, availability of equipment and other resources, and supportive supervision (Mshana and Hitimana 2007 p.11).

In one region, the evaluation results indicated that out of 11 trained HSD teams, 10 teams had experienced improvement in communication, six reported improved mutual support while others mentioned improved participation in Local Council activities including meetings, dealing with health unit management committees and advocating for health care improvement among their various communities. However, there were indications that some communities had no trust in the HSD teams due to non-availability of drugs, outright hostility and insecurity in some areas, political interference with the work of the health facilities, negative publicity and lack of transport facilities for undertaking outreach activities (Mshana and Hitimana 2007 p.12).

4. Management Needs

Interviews with the untrained HSD teams revealed that the management needs of their HSDs included data management, human resource management and HMIS. They further revealed the need to be trained in leadership and management of the health care system (Mshana and Hitimana 2007 p.12)

Conclusions of findings

Implementation of HSD management training ushered in positive changes, particularly by empowering the HSD teams to manage and plan for their health services with support from both the district headquarters and the central Ministry of Health.

It was reported that the training intervention should be maintained to build capacity for health sub-districts to plan, manage and gain control over the health programmes which are implemented at this level. It was recommended that the newly created districts should undergo the same training to enhance their performance. The HSDs which were not covered under the previous arrangement should also be incorporated under the new training programme.

It was noted, however, that though the course had been beneficial to those who were exposed, the training progress had been too slow and not enough districts had been trained.

Additionally, it was concluded that the training strategy by the MoH departmental heads and programme managers was not sufficiently effective. The course was more of information giving than hands-on training experience to build sustained capacity for planning and management. Training alone was not considered sufficient unless accompanied by other capacity building efforts.

The respondents reported that the training was not linked or harmonized with past or ongoing initiatives, that the programme was too vertical and not encouraging connections between the district health management teams and HSDs and that it was not based on the training needs assessment. It is

recommended that every training should be preceded by a training needs assessment.

The evaluation report indicated that in some instances there was lack of sufficient efforts by the central MoH and the district supervisors to follow up the trained HSD teams to maintain high level of performance. It is recommended that deliberate action be taken by the district health teams to support all the HSD teams to improve their planning and management capacity. In addition more courses are necessary for the HSD teams that focus on strengthening communication and coordination of HSD activities.

4.4.3 The Area Team Approach for performance improvement

The MoH used the “Area Team Approach” to strengthen supervision and improve performance at the district and health sub-district levels. There are about 11 to 13 teams formed at the MoH, whose members supervise the country’s regions periodically. Each team is composed of multi-skilled health workers, including a chairperson who is a member of senior management, selected by the planning department of the MoH, a team secretary and other professionals from the technical programmes and departments. A team may have 10 to 12 people who include senior medical and paramedical staff, at least one planner, one accountant, nursing staff, environmental health staff and nutrition staff. The composition is based on the availability of staff but also the areas to be supervised during the quarterly district visits. The planning department guides the teams on the areas of focus during supervision. The areas of focus may include malaria control, infection control, environment health issues but in addition, the teams must look at financial flows, utilization of primary health care funds, HMIS, and HRH. The idea is to bridge the gap between the central MoH and the local governments in the provision of care. The secretary for the team acts as the team administrator who organizes funding for the activities, logistics and travels; and also manages the overall functionality of the team.

Each area team periodically writes a report and submits it to the planning department for incorporation into the overall sectoral reports prepared for the Joint Review Missions of April and October each year. These reports are also used by the MoH as evidence for decision making. In this way information is shared between the GoU and the cooperating development partners in the health sector development.

Previous reports from the key stakeholders indicate that the area team strategy is good but districts get little feed-back from the MoH at times. This demoralises the health workers serving in the local governments. Other key informants have indicated that HRH management at the district level has not yielded its intended results. In some instances, health workers reported political interference, false accusations and poor handling of staff as factors contributing to their poor morale at the decentralized level. In the recent district planning meetings, professional health workers indicated strongly that they needed centralisation of recruitment and management of staff.

4.4.4 Occupational Health and Safety (OHS)

The Ministry of Health and that of Gender, Labour and Social Development (MGSD) are mandated by the constitution of Uganda to develop relevant Occupational Health and Safety (OHS) policies, set minimum safety standards, improve the safety and working environment for health workers, and insure equity in accessing OHS services (MoH 2008b). The government of Uganda has prioritised OHS services for the health sector as one of the key elements for protecting all cadres of health workers from occupational hazards and risks resulting from their occupations.

The government developed a policy for mainstreaming OHS in the health service sector (MoH 2008b). The policy intends to improve safety and health for all health workers through adequate protection of health workers against occupational hazards. During the three week training of the HSD teams, this component was handled by the department of clinical services to ensure consistency in implementation of clinical standard guidelines and other standards on patient care.

4.4.5 Government of Uganda and Faith-Based Private-Not-For-Profit (PNFP) collaboration

Bataringaya et al. (2002 p.295) quoting the Frazer Commission (1956) wrote, “In the colonial time, government recognised the contribution of the voluntary health sector to health care provision, and as such established a commission to study the sector”. The report of this commission recommended a form of collaboration that involved government giving subsidies to the voluntary health organisations (Grant-in-Aid). The “Grant-in-Aid” later became an official policy and was implemented in 1957 (Bataringaya et al 2002)

Bataringaya et al. (2002 p.295) further reveal that the subsidy, which was allocated in FY 1997/98 and given to 24 hospitals, was based on strategic considerations that the hospitals faced significant difficulties. The mechanism of allocation was through service agreements signed by the hospital Chief Executive and the Chief Administrative Officer of the district. The disbursement of funds went through the district administration to the beneficiary units. The district administration was then required to follow and receive financial reports for the expenditures incurred. The mode of reporting was on specific items of expenditure including medicines and sundries, equipment and hospital functionality through provision of monthly expenditure returns (Bataringaya et al. 2002 p.297).

However, the net funds released that year, according to the paper, fell short of the approved funding. “This amounted to about 76 percent of the sum total”. From that time onwards, the MoH in consultation with the health development partners, modified mechanism and guidelines to improve the utilization, management, disbursement and accountability of the subsidy.

Implementation of the HSD concept allowed effective integration of the PNFP in the district health system. This is evidenced by the participation in the functional components of the HSD including planning for health services, service coordination, monitoring and supervision of health activities and management of referral system within the HSD (Bataringaya et al. 2002 p.298).

In one publication (UCMB Bulletin; December 2003), it is argued that a lot of cross movements have taken place among the professionals in the health sector, following the lifting of the ban on recruitment by government of Uganda in 1997, thus leaving the PNFP sector with insufficient staff.

4.4.6 Evaluation of HSD Implementation Strategy

The aim of further decentralisation of health services, as discussed above, was to take services closer to the people and improve geographical access, particularly to the rural poor. Devolution of the health sector and its integration into the national decentralisation policy was generally thought to be advantageous. This was to lead to improved options for target group oriented health service delivery, and more transparency and accountability through closer responsibilities.

However, during evaluation, the HSD was considered by most respondents as “hanging” both politically and administratively. There is neither direct political authority nor executive authority to oversee the performance of the health workers at the HSD level (Bataringaya et al 2002 p.298). This is perhaps because of the way the HSDs were created. These are equivalent to political constituencies, with each constituency allocated enough money to construct an operating theatre and a medical officer’s house. Services of a doctor were put at constituency level to handle obstetric emergencies in a bid to reduce maternal mortality rates. In addition, the HSDs were supposed to improve the referral system. However, to date, patients still move from the primary level of care to the tertiary level of care without necessarily being referred properly by the qualified health workers (MoH 2009b). The main reason for this has been largely due to inadequate staffing and sometimes absence of medicines and equipment at the primary level of care (Matsiko 2005, MoH 2009b)

Information from the key informants at the central MoH indicated that some difficulties faced by many of the HSDs are due to the “disconnect” between the district health office (DHO) and the sub-districts themselves. In some instances, the regional hospitals were described as “hanging” within the structure of the district health system since there is no planning authority for their activities at the local level. Furthermore, there is a “disconnect” between the general hospitals and Health Centre IVs that head HSDs. This disconnect creates a working conflict between the clinical staff in the hospitals and health workers at HC IVs and those at the district health office. Matsiko (2005 p.132) found a disconnection between the production and recruitment of health workers in the Ugandan health sector.

CONCLUSIONS

The inability of health systems to recruit and retain sufficient numbers of health professionals – especially skilled workers – is one of the biggest challenges for the health sector (MoH 2009a). In the Ugandan context, the HRH problems result from inadequate recruitment as well as maldistribution and poor utilization of the people available in the service, inadequate motivation as evidenced by a series of complaints over low salaries and health worker allowances, and general dissatisfaction of health workforce (Matsiko 2005). Difficulty in attracting and retaining service providers is particularly critical in the remote rural and insecure difficult-to-reach and difficult-to-stay districts.

As part of the overall health sector reforms, the health care delivery system has undergone several changes to improve its efficiency and effectiveness in meeting the national targets and aspirations. Some of these changes have taken place at the national level, but other critical changes have also taken place at the district and sub-district levels. *The approach of initiating health sub-districts is one reform that the government of Uganda undertook to enhance performance of health workers and health systems.*

Further decentralisation of health services and subsequent creation of HSDs transformed the health care system in Uganda. The move, which was aimed at improving efficiency and effectiveness in health care delivery, has improved human resource management and to some extent retention of highly trained health personnel such as doctors and nurses by creating more positions below the district level. Since decentralised policy changed the functions of the central MoH as well as the district, and gave new roles to the HSDs, there was need to build capacity for planning and management in the HSD teams.

This paper recommends quick action in enhancing health worker performance at the district and health sub-district levels. Health worker imbalance may be reduced by paying health workers a living wage and additional set of incentives for those health staff serving in difficult areas such as Islands of Lake Victoria, and Karamoja region. These areas are considered “hard-to-reach” for health workers.

There is need for coordinated HRH planning between GoU and PNFPs to reduce staff movement among the sectors and improve harmonization of staff recruitment and deployment in the country.

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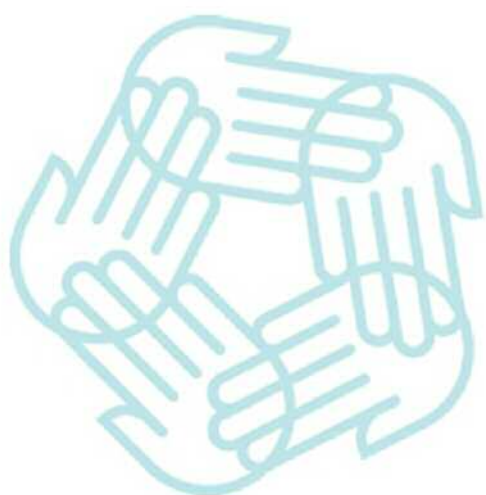
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