Mapping the Human Resources Management Processes in Uganda

Uganda Ministry of Health and The Capacity Project

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The views expressed in this document do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

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Executive Summary

The purpose of this study was to identify and recommend strategies for tackling the underlying issues in the human resources for health (HRH) management process in Uganda with an eye towards addressing the HRH crisis.

This study was carried out through document review and interviews. Interviews were conducted at both central and regional levels. Interviewees included key staff in the ministries of health, public service, education and finance.

Among the findings:

- There is an absence of agreed staffing standards and staffing structures that are partially funded and cumbersome to update
- Insufficient collaborative decision-making related to planning and development of health worker training leads to a mismatch between numbers of staff required in a given cadre and the number being trained
- Decentralized responsibility for certain aspects of human resources management in the health sector makes it difficult to assure adequate human resources for health across the country
- Complexities in the recruitment process create a variety of delays in filling of vacant posts
- A number of issues hinder the planning, budgeting and expenditure of funds in the most effective manner
- Unclear and/or unenforced standards for health worker performance erode the quality of care and service provided
- Limited capacity for management and leadership of the health system makes it difficult for managers and supervisors to make best use of the limited resources they have.

While none of the study findings was unexpected, what is powerful about them is that they are context-specific, drawn from the reality of the processes mapped in Uganda. From the findings, eight recommendations were advanced to improve HRH planning and budgeting as well as the management of human resources in the health services.

1. **Expand effort to strengthen workforce planning, staffing and structure**
    - Review staffing structure more frequently in more dynamic situations
    - Strengthen data-based decision-making as it relates to staffing
    - Continue efforts to clean the payroll and/or take such other initiatives as are necessary to get a clear picture of numbers of staff by cadre and location.
2. **Improve collaboration and decision-making related to pre-service education and in-service training**
    - Renew efforts at collaborative planning and decision making among the key parties (Ministry of Health; Ministry of Public Service; Health Services Commission; Bureau of Business, Technical, Vocational Education and Training) to assure that identified needs for various health cadres are addressed by timely and appropriate training.

3. **Explore selected recentralization of authority for human resources management in the health care system**

   - Explore "recentralization" of certain aspects of human resources management in the health sector. Two potential approaches, presented for purposes of illustration:
     - Recentralize the employment functions for health workers—at its most comprehensive, this would entail centralized recruitment, hiring, assignment, compensation and transfer
     - Form a council, at the national level, that coordinates recruitment, hiring and assignment of staff while leaving the authority for hiring at the district level.

4. **Streamline recruitment and hiring**

   - Reduce the number of steps in the recruitment and hiring process and minimize amount of time taken at each step
   - Use different strategies at different times, depending on the urgency of the situation
   - Use a variety of means of advertising vacant positions
   - Introduce intermediate screening processes to increase efficiency, reduce time spent on recruitment activities.

5. **Improve planning and budgeting for effective expenditure of limited funds**

   - Review work processes and eliminate redundancies; align budgets with stated priorities and otherwise assure that available resources are used in the most effective manner
   - Assure that annual budget requests are comprehensive with respect to HRH needs—and that the requests are aligned with the anticipated timing of needs
   - District officers should assure that the bases for budget requests are both defensible and well documented
   - Explore "premium" payments as a means of compensating for extra shifts, supervision and other duties in excess of standard
   - Advocate for more funds in both operating and capital budgets to cater for housing allowances and social amenities in remote sites
   - Convene a group of health workers, district officers, community members and others to look at the problems of poor housing and absence of social amenities together and to explore what might be done to improve the situation.

6. **Establish and use standards for health worker performance**

   - Re-establish, communicate and enforce performance standards
   - Provide mentoring and supportive supervision
   - Recognize and reward health workers for good performance.

7. **Build capacity for management and leadership in the health system**

   - Develop and conduct a supervision, management and leadership training program for district directors, deputy directors and the in-charges of all health facilities.

8. Increase capacity for planning and budgeting for health system expenditures

- Develop and conduct a course on planning and budgeting for district directors, deputy directors and health facility in-charges which introduces basic concepts and assists participants to learn to employ these concepts in the context of the Government of Uganda annual planning and budgeting cycle.

Background

Uganda, like many developing countries, is experiencing a human resource for health (HRH) crisis. Uganda is ranked (World Health Report 2006) among the 57 countries worldwide with a "critical shortage" of health service providers (defined as doctors, nurses and midwives). The health workforce numbers and population/patient health worker ratios are low. The total numbers of the main categories of health workers and the population/health worker ratios for the nation, based on the 2002 household and population census, are shown in the table.

Table 1: Population/Health Worker Ratio

Cadres	Number	Population per Health Worker
Medical Doctors	2,919	8,373
Allied Health Clinical	3,785	6,458
Nurses and Midwifes	20,165	1,212

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.

The shortage of the health workforce is aggravated by the extreme degree of maldistribution of the already scarce human resources. Some 70% of medical doctors and dentists, 80% of pharmacists and 40% of nurses and midwives are encountered in urban setting, serving only 12% of the population.

Retention, especially of highly trained cadres including medical doctors and registered nurses, is perceived to be problematic although there are currently no reliable data on attrition rates. In particular, retention of health workers in remote or hard-to-reach rural areas is a serious issue. It is also likely that the productivity of the existing health workforce can be greatly improved if its composition is better distributed and its management improved.

The structure for the management of human resources is complex, requiring adequate guidance and coordination. In a system that is intended to be decentralized, the management of human resources (HR) at the central headquarters, national and regional referral hospitals is the responsibility of the Ministry of Health (MOH), while the HR at the district and lower-level health facilities are managed by the district administrations. The Ministry of Public Service provides overall guidance and support to the sectoral ministries and districts. The HR training function is the responsibility of the Ministry of Education. Poor management at all levels is the one most frequently cited weakness as a cause of inadequate health workforce performance. Recruitment, equitable distribution and adequate retention of staff need improvement, particularly in hardship areas. Motivation and empowerment of the health workers need to be addressed. Poor supervision, particularly in lower-level institutions, is a major management shortcoming, while staff appraisal fails to distinguish between good and poor performers.

Purpose and Objectives of the Assignment

The purpose of the study was to identify and recommend strategies for tackling the underlying issues in the HRH management process in Uganda towards addressing the HRH crisis.

The objectives of the study were to:

1. Map out the key HRH management functions (recruitment, hiring, posting, processing payment, etc.) and describe the responsibilities of and linkages among the various players in the decentralized health care system in Uganda
2. Identify the bottlenecks and underlying issues in the HR management processes for the various functions
3. Identify options to address the bottlenecks and underlying issues in the HRH management processes.

Approach

This study was carried out through document review and interviews. Interviews were conducted at both central and regional levels. Interviewees included key staff in the ministries of health, public service, education and finance. Annex A provides a list of documents reviewed and individuals interviewed.

Observations and Findings

The observations made and bottlenecks identified in this report are not necessarily new discoveries. Numerous earlier studies and reports (*Tracking Human Resource and Wage Bill Management in the Health Sector,* September 2004; *World Health Day Symposium*, April 2006; *Uganda Health Workforce Study: Satisfaction and Intent to Stay Among Current Health Workers*, March 2007) document the issues well. The challenge faced by the Government of Uganda is not just to identify the issues, but rather to break them down into sufficient detail as to be able to understand their causes and address them effectively. The recommendations presented in this report are intended to facilitate that process.

Structure and Staffing

- The Public Service Commission establishes a job structure that defines the number and kind of positions authorized at each facility. The structure limits the number and cadres of staff that can be hired.
- The structures are reviewed and updated by sector, with an entire ministry being reviewed at once. This presents some difficulty for the MOH, in which some components are more dynamic than others. The needs of referral hospitals, for example, and perhaps the higher-level clinics, change more rapidly than those of the central ministry. This ministry-wide approach to structure review works against the needs of those facilities whose needs are changing rapidly.
- To be effective, the structure must be closely tied to the numbers and kinds of positions (cadres) that are needed and there must be funds to support it. Otherwise, newly emerging and needed specialties aren't reflected in the structure and so cannot be filled. As an example, if there is need for a radiologist and the structure is outdated and doesn't provide for one, then the radiologist cannot be hired. Further, if an individual has been sent for training in radiology and returns to the system, but there is no position in the structure, he/she cannot practice in that specialty and be paid for it. This creates difficulties for the facility that needs a radiologist and considerable disincentives for the newly trained radiologist.
- For budgetary reasons, the staffing structure is not fully funded. Thus, even in instances when there are positions authorized, they cannot always be filled. This creates staff

shortages, heavy workload and poorer quality of patient care.

- The converse is also true: often the funds for wages are made available but recruitment of all authorized, funded positions is not complete, so funds are returned to the treasury at the end of the financial year. This is due to a number of factors, including inadequate facilitation of the Service Commissions, cumbersome recruitment processes (see Recruitment, below) and weak HR management capacity in general.
- This situation is compounded by absence of agreed patient/health worker staffing standards (how many patients should a medical officer be able to see per day, what is the proper patient/nurse ratio, etc). Without those standards, it is merely a matter of opinion as to how many are needed and whether the structure, if fully funded, would provide adequate numbers of staff.
- Despite efforts to clean the payroll and update rosters, it seems there are still problems in determining exactly how many staff of each cadre are on the payroll and where they are assigned. This makes it difficult to frame a cogent argument for review or modification of the structure.

Collaboration and Decision-Making Related to Health Worker Training

Training of health workers was not a focus of this study. Nonetheless, in the course of interviews, respondents raised the issue of a disconnect among the MOH, Ministry of Public Service and the Health Services Commission concerning numbers and cadres of staff to be trained. As a result too many of one cadre are trained, and not enough of another. In addition, there also seems to be a disagreement among the same bodies with respect to competencies required for each level of post.

Authority for Human Resources Management of the Health Care System

With decentralization, authority and responsibility for recruiting and retaining health workers devolved to the districts. This has created a situation in which the health care system, at least from an employment perspective, is seen as a district system and health workers are viewed as district resources. This has implications for both the health worker and for the optimal delivery of health care services across the country.

For the worker, transfer and movement in the system is impeded by decentralization. Movement between districts is subject to the agreement of the districts. While it is unlikely that the chief administrative officer (CAO) or district health officer (DHO) would want to interfere with a worker's opportunity for advancement, nonetheless it is up to them to agree to release a worker—and that does impact mobility. For example, if there is only one enrolled nurse in an area, it will be difficult to release her for further training or a transfer to another place. Thus those workers in most remote districts are in some senses stuck in those districts.

To the extent that the health system is defined on a district basis, it becomes more difficult to assure that national health care delivery needs are met. Because authority rests at the district level, it is difficult, if not impossible, to assign and reassign staff across district lines to address needs across the country.

As a consequence, in some places there are more workers of a given cadre than there are authorized positions, while in other locations as little as 25% of the staff complement is filled. In the former case, trained workers leave the health care system to seek other kinds of employment. (An example was cited of nurses opening drug shops or private [illegal] clinics). In the latter case, high staff vacancy rates result in unacceptably high worker/patient ratios and overwork, which impacts on quality of care, staff morale and turnover, worsening the situation.

Recruitment

The steps involved in the recruitment process are as follows:

- Health facility in a given district experiences the loss of a staff member
- Facility contacts District Directorate of Health Services (DDHS)
- DDHS advises the CAO
- CAO declares the post vacant
- District Services Commission (DSC) meets to review the declared positions and decide whether, when, how to advertise
- DSC advertises posts
- Applications are received and short-listed
- DSC convenes an interview panel
- All short listed candidates are interviewed
- DSC declares post for selection
- Candidates are notified
- Candidates present at DDHS office, sign letter of appointment and are advised of their postings
- Candidates report to duty station to take up posts.

Different districts have different experiences with this process. Among the bottlenecks reported:

- Cost-related delays
    - The DSC has a role at several stages of the recruitment process. Because the commissioners must be convened and paid transport and seating allowances, the chair of the commission is likely to wait to convene the commission until there are a number of positions to be processed. Some commissions meet twice per year, some less frequently.
    - Advertising is also costly. Where funds are limited, the chair of the commission is likely to wait to advertise until there are a number of positions to advertise.

    The Central Ministry has attempted to relieve some of the costs by running block advertisements addressing the needs of all districts. This has created additional time challenges because the advertisements are not placed until all districts submit their information. In addition, because some candidates apply for posts in more than one district, a situation is created where the districts compete with one another for the best candidates.

- Delays related to bureaucracy
    - As noted, the recruitment entails a number of steps and each step carries both signatory and record-keeping requirements. Delays occur in the hand-off from one authority to another and in terms of the time each authority takes to act.
    - Further, in the event that a form or document is not fully completed or is completed incorrectly, it must be returned to the initiator for completion or correction. In addition, few of the processes are automated which adds to the delays.

- Because the process can take a number of months it is sometimes difficult to locate the candidates once the selection decision has been made. In other cases, in the interval between applying and being offered the post, the candidate has found other employment

- Delays related to process design
  - Once applications have been short-listed, all short-listed candidates (those who meet minimum qualifications) are interviewed. In cases where there are many candidates, the interview process is quite time-consuming.

- Delays in accessing payroll for newly hired staff
  - For a number of reasons, including cumbersome processes and inaccuracies in paperwork that accompanies the hiring of a new employee, staff often begin work several months before the paperwork has been completed, allowing them to be paid.

- Delays in confirming new staff
  - Newly hired staff are placed in probationary status for a period of time during which, theoretically, their performance is monitored and decisions are made about their suitability for confirmation into a permanent position. The tool for carrying out the assessment is the performance appraisal form. However, the form is both generic and lengthy. As a consequence, supervisors often delay in completing the appraisals. Delay in filing the appraisals leads to delay in the staff being confirmed as permanent employees.

- Delays in separation from service and access to terminal benefits, including pension
  - The process for separating staff from service, like the process for hiring them in the first place, is cumbersome and fraught with delays. As a result, staff report experiencing a delay of weeks or months between the time they leave service and the time they are officially retired and able to access their benefits. In the meantime, as long as the position is "occupied" recruitment for a replacement cannot take place.

Salaries

Salaries are reported to be insufficient to meet the daily needs of the health worker. As a consequence, medical officers, for example take additional positions—sometimes holding more than three positions at one time—in order to assure adequate income for their households. The result is that they are not available at their ministry posts when and as needed to carry out their duties. Members of other cadres also seek additional sources of income and so are often overworked and exhausted in addition to being unavailable on site when and as needed.

Allowances, Social Amenities and Other Issues

Housing allowances (which are folded into base salaries) are considered inadequate to cover the cost of housing. In places where there is no available housing, a housing allowance does no good.

Absence of housing near the health facility (which is common in Kampala) means a medical officer or other staff member must live some distance away from the hospital or health center. In case of emergency he/she may not be able to arrive at the facility in time to carry out the needed actions.

Absence of housing in more remote places also means workers seek housing farther and farther from the work site. This may result in coming in late or absenteeism because commuting is difficult or because the health worker has concerns for his/her family. It may also lead to the health worker

subsisting in inadequate quarters (as is the case for two nurses in Gulu District who share what was formerly a kitchen as housing quarters).

In the remote areas, the health worker may have difficulties finding schools for his/her children. Similarly, the health centre may be some distance from a town making it difficult to shop for food and other household necessities. These situations make it difficult for the health worker, may impact on quality of care and definitely impact on recruitment and retention of staff.

Standards for Health Worker Performance

Many of the people interviewed at facility, district and central levels described instances of what they referred to as "bad attitude" or "lack of discipline." Examples of the bad attitude included staff coming late and leaving early, staff absenteeism, staff shouting at patients and even pilferage. Taken individually, the examples are troublesome enough. Taken together, they suggest an erosion of the bonds between the health worker, his/her patients and the health care system—a situation where the health worker is more concerned about his or her own well-being than about the patients in his or her care, or the health system of which he/she is a member. Again, those interviewed suggested that the situation, manifested differently at different levels, nonetheless exists at all levels of the sector.

While it is tempting to blame the health worker, it is more useful to think about what conditions would lead to the kind of behavior described. Presumably people enter the health field with a wish to be of service, to heal and to care for the sick and disabled. So what happened? Several issues come to mind fairly readily:

- The first is that the combination of low salaries, high workload, difficult living situations and increasing disease burden, taken together, has a corrosive effect on the dedication and commitment of the worker. The combination of feeling exhausted, being overworked and working without adequate facilities or equipment over time diminish—and eventually can destroy—the wish to serve and the ability to care.
- The second issue has to do with establishment, communication and enforcement of clear standards for health worker performance and conduct. It would appear that over time, and given the situation, standards have to some extent been forgotten or otherwise overlooked. How else to explain the reluctant acceptance of a medical officer who comes late and leaves early? Or a midwife who shouts at a patient? Or another worker who takes medicine or supplies home with him?
- The third issue is the absence of adequate supervision. Even if standards are in place, excessive workload, absence of funds and other factors limit the extent and quality of supervision received. Whereas effective supervision is supportive in nature, the situation on the ground works in favor of less frequent and more perfunctory visits. This is a problem in terms of identifying and correcting performance problems, but it can also exacerbate the sense of isolation a health worker experiences, leaving the worker feeling like he/she is "in it alone" with no one watching or caring what happens.

Capacity for Management and Leadership in the Health System

In traveling to various districts and meeting with the directors of health services it becomes clear that there is great variation in the knowledge, skill and confidence with which they plan and budget for and manage their human resources. Some have a good working knowledge of HR management issues and how to address them. These individuals are likely to be able to conceive innovative approaches to meeting their needs when more traditional approaches are insufficient. Others, however, have more difficulty. They are less likely to be able to analyze a problem such as

recruitment and to understand its root causes. As a consequence they are limited when it comes to addressing the problem area.

Similarly, some are very knowledgeable about the planning and budgeting systems while others are not. Those who know how to "work" the system are able to maximize their access to available resources. Those who are less knowledgeable are less likely to budget for all costs, with the result that the district misses out on funding to which it would be entitled. Or, they fail to link the timing of the request to the time frame in which the need will be experienced. This can result in the district's inability to absorb and use the funds in a timely manner.

A third example has to do with what is actually requested in a budget. Some districts are able to think about the costs and needs in their districts in innovative ways—if funding isn't available from one "envelope," they identify other ways to allocate the costs and to request funds for them. Other districts struggle more.

In Uganda's decentralized health care system, the district director of health services (DDHS) occupies the senior-level management position in the district. The DDHS is to be supported by deputy directors of health services, each responsible for management and supervision of a subdistrict. In turn the hospital superintendents and health facility in-charges carry out the day-to-day management and supervision of their respective facilities. The model is well conceived and seems likely to facilitate the effective management of a complex set of issues and challenges related to delivery of quality health care services across the country.

One of the obstacles to successful implementation of decentralized management as described is the lack of management and supervisory skills among the incumbents of those key positions. Management is not a skill that has been taught (or taught effectively) in health/medical training programs. Further, because of shortage of staff, it is often the case that a young medical officer, clinical officer or member of an even less-skilled cadre, will be given responsibility for management of a health facility. In addition to limited technical skill and experience, he/she will often have no background on management of the people reporting to him/her at the health facility.

This is a key issue because, absent management skill, the in-charges will have a difficult time making the most appropriate use of the resources they do have. Those who participated in this study are very clear about this. While most of them were very clear about what the health indicators are and about the importance of tracking progress towards meeting them, they were also very clear that they lack management skills. In their view, an investment in management training would pay great dividends in terms of their ability to cope with a difficult situation.

Recommendations

The recommendations presented below are of two kinds—those that address changes to systems and processes, and those that strengthen health workers' capacity to work effectively within the health system to deliver quality health care. Changes in any of the recommendation areas have the potential to improve management of HRH; changes in all are necessary for optimum benefit to the health sector and its beneficiaries.

As was noted repeatedly during the study, the problems Uganda faces are inherently complex and difficult to resolve. Many of the system improvements require cross-sectoral discussion and collaboration; some require changes in the law. Thus, time—as well as willingness—is needed.

However, the complexity of the situation and range of recommendations should not be allowed to serve as a barrier to taking any action at all. Indeed, we would recommend beginning immediately on a course of action to improve planning, budgeting, supervision and management through training and follow-up coaching and support. Done properly, actions here would enable district health officers and others to take maximum advantage of the resources currently available to them.

A list of the specific recommendations is provided below. This section is followed by a more detailed description of each.

1. **Expand effort to strengthen workforce planning, staffing and structure**
    - Review staffing structure more frequently in more dynamic situations
    - Strengthen data-based decision-making as it relates to staffing
    - Continue efforts to clean the payroll and/or take such other initiatives as are necessary to get a clear picture of numbers of staff by cadre and location.
2. **Improve collaboration and decision-making related to pre-service education and in-service training**
    - Renew efforts at collaborative planning and decision making among the key parties (Ministry of Health; Ministry of Public Service; Health Services Commission; Bureau of Business, Technical, Vocational Education and Training) to assure that identified needs for various health cadres are addressed by timely and appropriate training.
3. **Explore selected recentralization of authority for human resources management in the health care system**
    - Explore "recentralization" of certain aspects of human resources management in the health sector. Two potential approaches, presented for purposes of illustration:
        - Recentralize the employment functions for health workers—at its most comprehensive, this would entail centralized recruitment, hiring, assignment, compensation and transfer
        - Form a council, at the national level, that coordinates recruitment, hiring and assignment of staff while leaving the authority for hiring at the district level.
4. **Streamline recruitment and hiring**
    - Reduce the number of steps in the recruitment and hiring process and minimize amount of time taken at each step
    - Use different strategies at different times, depending on the urgency of the situation
    - Use a variety of means of advertising vacant positions
    - Introduce intermediate screening processes to increase efficiency, reduce time spent on recruitment activities.
5. **Improve planning and budgeting for effective expenditure of limited funds**
    - Review work processes and eliminate redundancies; align budgets with stated priorities and otherwise assure that available resources are used in the most effective manner

- Assure that annual budget requests are comprehensive with respect to HRH needs—and that the requests are aligned with the anticipated timing of needs
- District officers should assure that the bases for budget requests are both defensible and well documented
- Explore "premium" payments as a means of compensating for extra shifts, supervision and other duties in excess of standard
- Advocate for more funds in both operating and capital budgets to cater for housing allowances and social amenities in remote sites
- Convene a group of health workers, district officers, community members and others to look at the problems of poor housing and absence of social amenities together and to explore what might be done to improve the situation.

6. Establish and use standards for health worker performance

- Re-establish, communicate and enforce performance standards
- Provide mentoring and supportive supervision
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7. Build capacity for management and leadership in the health system

- Develop and conduct a supervision, management and leadership training program for district directors, deputy directors and the in-charges of all health facilities.

8. Increase capacity for planning and budgeting for health system expenditures

- Develop and conduct a course on planning and budgeting for district directors, deputy directors and health facility in-charges which introduces basic concepts and assists participants to learn to employ these concepts in the context of the Government of Uganda annual planning and budgeting cycle.

Detailed Recommendations

1. Expand effort to strengthen workforce planning, staffing and structures

- *Review staffing structures more frequently in more dynamic situations.* Identify those facilities or locations where the situation is more dynamic and review the structure in those areas more frequently in order to be able to respond to the changes.
- *Strengthen data-based decision-making as it relates to the staffing.* A key first step is to establish some sort of work-load or patient/health worker ratios. Preliminary work has been done in this area and can be found in *Health Service Staffing in Uganda: Developing a New Workload-based Methodology from Studies of Mukono and Mbale District Health Systems* (February 2007). Once established, the standards must be used rigorously to assess the need for staffing changes, and all requests for staffing should be presented in terms of staffing standards.
- *Continue efforts to clean the payroll and/or take such other initiatives as are necessary to get a clear picture of numbers of staff by cadre and location.*

2. **Improve collaboration and decision-making related to pre-service education and in-service training**

   - Decisions related to the training of staff of various cadres to meet the needs of various levels of facilities in various locations cannot be taken by a single division, department or ministry. Collaborative efforts are essential. Such collaboration must be rooted in a mutual respect among the parties for the perspective, knowledge and authority that each brings to the table. Efforts have been made in the past to foster such collaboration, with the Division of Business, Technical Vocational Education and Training taking the lead.
   - It would be worthwhile to understand better what initiatives were undertaken, and where the problems arose that led to a discontinuation. With that information in hand, a new approach or an approach modified to rectify the problems could be undertaken with higher likelihood of success.

3. **Explore selected recentralization of authority for human resources management in the health system**

   - Government functions were decentralized in the interest of improving the management of those functions. Arguably, decision-making is best done by those closest to the issues about which decisions are being made. One of the trade-offs has been the creation of district systems and the loss of a national perspective—a significant issue when it comes to assuring equitable access to health care and services across the country.
   - With this in mind, it would be worthwhile to explore "recentralization" of certain aspects of human resources management in the health sector. One approach would be to recentralize the employment functions for health workers. At its most comprehensive, this would entail centralized recruitment, hiring, assignment, compensation and transfer.
   - Another approach would be to form some sort of council, at the national level, that coordinates recruitment, hiring and assignment of staff while leaving the authority at the district level. Further study would be necessary to develop a detailed approach. What seems clear, however, is that the purely district-based approach results in maldistribution of staff, and a very uneven provision of health care services to the citizens of Uganda.

4. **Streamline recruitment and hiring**

   - *Reduce number of steps in the process.* The number of steps in the process almost certainly adds to the time it takes to recruit staff. It would be worthwhile to explore whether any steps can be eliminated or consolidated to speed up the process.
   - *Minimize amount of time taken at each step.* In addition to trying to reduce the number of steps, it would also be important for individuals and offices at each step in the process to examine their involvement in the process in order to determine whether there are ways of moving the paper more quickly. Similarly, ongoing efforts should be made to assure that paperwork is completed (and completed accurately) before it is passed along to reduce the likelihood of being returned for correction.
   - *Use different strategies at different times, depending on urgency of the situation*. It seems clear that cost is one of the issues that influences the way in which the recruitment process is carried out. It is the objective of containing costs that leads to "bulk processing" of recruitment activities, thereby minimizing the number of times the DHSC must meet, thereby minimizing the number of advertisements that must be placed and so forth. The efforts to contain costs work against the efforts to recruit and place new staff as quickly as

possible. There is no easy answer here, but if it is not already being done, it would be important to make situational choices about when cost containment should be the driver and when expeditious hiring of staff should take precedence over cost considerations.

- *Introduce intermediate screening processes to increase efficiency, reduce time spent on recruitment activities.* In those districts where there is often a surplus of candidates for vacant positions, one way of reducing cost and speeding up the process would be to introduce an intermediate screening process between short-listing and interviews. Where short-listing identifies all those who meet minimum qualifications, the intermediate screen would involve ranking or prioritizing the minimally qualified candidates according to the strength of their candidacy. Then a select number of the best qualified candidates could be invited for interview, rather than inviting all who meet the minimum requirements.
- *Use a variety of means of advertising vacant positions*. When interviewees spoke of "recruitment," they referred almost exclusively to the practice of advertising in the English-language newspapers based in Kampala. In those districts where it is difficult to attract sufficient candidates for positions, alternative modes of advertising should be explored. While this study didn't go into sufficient detail to permit the making specific recommendations, alternatives might include arranging for public service radio advertisements or placing fliers in various sites both in the district in question and in others. Further examination of the issue would doubtless suggest other avenues that might bear fruit.

5. Improve planning and budgeting for most effective expenditure of limited resources

- *Assure that available resources are used in the most effective manner.* Clearly, availability of additional funds would resolve some of these issues. In the meantime, several actions should be taken to assure that available resources are spent in the most effective manner. Specific suggestions include the following:
    - Parties at all levels of the sector should examine their operations to determine whether and how operations can be made more efficient, thereby freeing up additional resources. This might involve looking at work processes to eliminate redundancies and duplications of effort. It could involve streamlining or harmonizing processes to remove hurdles or bottlenecks. It might involve looking at budgets and resource allocation priorities and making adjustments.
    - DDHSs, working with the district CAOs and others, should assure that annual budget requests are comprehensive with respect to HRH needs—and that the requests are aligned with the anticipated timing of needs. This means, for example, that all recruitment costs are requested and that funds are requested for disbursement during the quarter in which they will be needed.
    - District officers should assure that the bases for their requests are both defensible and well documented.

  Explore "premium" payments. While funds for base salary increases are in short supply, it would be worth exploring whether and under what circumstances "premium pay" could be offered in recognition of certain kinds of responsibilities. Such payments could be "top-ups" as opposed to base salary increases and could be awarded when the situation warranted. So, for example, a "premium payment" might be offered in recognition of supervisory visits to health facilities. Another example would be payment for hours worked in excess of a certain number in a day or a week. While the concept seems to make sense on its face, further exploration would be necessary in order to understand administrative requirements and, in turn, what is feasible and sustainable. To the extent that such payments are considered, it is

important to think about them not as "incentives"—paid to encourage the worker to undertake certain tasks—but rather as payments in recognition of the demands of certain activities which the worker is obligated to undertake whether or not there is premium payment available.

- *Advocate for more funds in both operating and capital budgets.* These are difficult issues without obvious solutions. While it is tempting to say that higher salaries will address the problems, higher salaries won't make housing more accessible if the housing doesn't exist. On the other hand, higher salaries might permit staff members to make choices not available to them at present (they might be able to send their children to school in another town, for example). Similarly, availability of capital funds would make it more likely that additional and suitable housing could be organized for health workers. With these thoughts in mind, persistent advocacy, using clear and convincing arguments backed by documentation of the needs is certainly worth doing, as part of a package of interventions.
- *Convene a group of health workers, district officers, community members and others together to work together and to look for some answers, even if they are only temporary solutions.* Absence of housing and social amenities is a complex issue, one that is broader than the health sector and one that impacts different individuals in different ways. For these reasons, it might be useful to bring together a group of individuals to look at the problem together and explore what might be done. There may be a series of small interventions that, taken together, can improve the situation, even if only temporarily. This approach has the advantage of bringing many different perspectives to bear on the issue. It also allows health workers to comment on what would make a difference to them—and for community members to talk about what is and is not possible in that community. Done well, it can also foster relationships among the disparate groups and perhaps strengthen their interest in working together to find a solution.

6. Re-establish and use standards for health worker performance

- There was a fair amount of agreement among those interviewed that this "pattern of poor behavior" is pernicious and eroding both quality of care and service for patients and morale for staff. The question is about how to bring about a change.
- Since the problems are reported at virtually all levels of the sector in one manifestation or another, it would make sense to tackle them in the same way:
    - Leaders in the sector could begin by exploring with one another what the issues are and what acceptable standards might be
    - Having determined what the standards should be, sector leaders then must both hold themselves accountable for meeting the standards and communicate the standards to those below them in the sector hierarchy
    - Through a combination of mentoring, supervision and recognition, health workers would begin to recognize that the standards are important, that their leaders are willing to support them in trying to meet the standards, and to recognize their good performance and invoke discipline for unacceptable behavior.

  As noted in the findings, there are two issues at play here—the first being the provision of technical assistance to the health worker—assisting him or her to understand the standards, and guidance on how to meet them. The second has to do with re-establishing the bonds between the health worker and the system within which he or she works—re-enforcing the notion that supervisors are watching, and that they care both about the quality of the work being done and about the person doing the work. The mechanisms need not be elaborate to

be effective. Supervisors and health workers interviewed attested to the importance of supervisory visits that are frequent enough and lengthy enough to permit real discussion of issues and problems, and of the value of an annual recognition and rewards dinner.

7. Build capacity for management and leadership in the health system

- Absence of skill in a variety of management functions precludes the health manager's ability to take full advantage of the resources that are available to him or her. While it is true that there are insufficient numbers of health workers, and a maldistribution of those in the system, improved supervision and management would allow the health system to improve the productivity of the workers that are available—whether through better planning and budgeting, better supervision or improving cooperation and collaboration among members of the health care team. The managers interviewed in the course of this study are keenly aware of this and struggling to improve their skills. They are able to describe their management and supervisory goals. They are also hungry for management and supervision training that will help them know the best ways of achieving those goals. With this in mind, we recommend development and conduct of a supervision, management and leadership training program for district directors, deputy directors and the in-charges of all health facilities. Important characteristics of such a course include the following:
    - Content should include job design, setting performance expectations for staff, monitoring and evaluating staff performance including carrying out effective conversations about both good and problem performance, principles and practices of supportive supervision, developing plans to improve performance
    - As much as possible, examples, cases and exercises should be taken from real-life situations where theory and practice can come together in the context of the challenges they face every day
    - The training should be a combination of interactive lecture, demonstration and real-life problem solving
    - To increase its likely impact, it should include both classroom training and coaching/mentoring
    - In the course of the training, participants should be encouraged to establish an informal support network among themselves
    - Program design should be tailored to the different management challenges present at each level in the system; this would mean designing a program appropriate to DDHSs, one for deputy DDHS and a third for facility in-charges and hospital in-charges
    - The program should be designed to "cascade" down through the system, and more senior, more effective district personnel should be developed to serve as co-trainers for the facility-level training.

8. Increase capacity for planning and budgeting in the health system

- In the interest of leveling the playing field—and reducing the variation in skill and ability in the various districts—and in the interest of assuring that available resources are used as efficiently as possible, the relevant ministries should offer a training program for district staff. For optimal effectiveness, the course should incorporate the following features:
    - Course content should include planning, budgeting and creative financing of district needs
    - The training should be participatory and include activities and problems to solve as well as interactive lectures
    - The training should include both classroom experience and some sort of follow up—

whether that be coaching/mentoring or creation of a support network among the districts

- To further enhance the transfer of learning from classroom to district offices, a team that comprises district personnel as well as central staff should deliver the training.

Annex A: Documents Reviewed

AMREF. Tracking human resource and wage bill management in the health sector: A study to identify bottlenecks and constraints in the production, recruitment and management of health workers and funds for the wage bill in the public health services. Nairobi, Kenya: AMREF, 2004.

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Namanganda G, Ozcan S, Hornby P, Oketcho V. Health service staffing in Uganda: Developing a new workload based methodology for studies of Mukono and Mbale district health systems. Developing Human Resources for Health Project, Keele Consortium, 2007.

Ministry of Health Ministerial Policy Statement 2007/2008.

Presentation by Professor George Kirya to the Central Region Sensitization Workshop on the Code of Conduct and Ethics for Health Workers, July 2007.

Proceedings of the World Health Day Symposium: Addressing the Human Resources for Health Crisis in Uganda, April 2006.

Uganda Human Resources for Health Strategic Plan 2005-2020, July 2007.

Annex B: Persons Interviewed

Kyobutungi, Naomi	Assistant Commissioner, HRD, MOH
Matte, Rita Florence	Nursing Registrar, Uganda Nursing and Midwives Council
Chota, Margaret	Commissioner of Nursing
Okinyal, Eng Francis	Commissioner, BTVET, Ministry of Education
Kaggwa, Dr. Lawrence	Director, Planning and Development, MOH
Jacinto _____	Commissioner of Clinical and Community Services, MOH
Kirya, Professor George	Chairman, Health Services Commission
Kenya-Mugisha, Dr. Nathan	Director of Clinical and Community Services, MOH
Matte, Tom	Director of Local Government
_____	District Health Officer, Kampala City Council
Mpangu, Denis	Acting Assistant Commissioner, Ministry of Public Service
Opio Stephen Okiror	Assistant Commissioner of Personnel, Mulago Hospital
Byakika, Dr. Sarah	Deputy District Health Officer, Jinja District
Okiror, Iporotum	Chief Administrative Officer, Jinja District
_____	Chief Administrative Officer, Gulu District
Onek, Dr. AP	District Health Officer, Gulu District
Oboni, Alfonse	Principal Personnel Officer, Gulu District
_____	Visiting Nurse, Oyam District

The Capacity Project is an innovative global initiative funded by the United States Agency for International Development (USAID). The Capacity Project applies proven and promising approaches to improve the quality and use of priority health care services in developing countries by:

- Improving workforce planning and leadership
- Developing better education and training programs for the workforce
- Strengthening systems to support workforce performance.

The Capacity Project Partnership

The Capacity Project
IntraHealth International, Inc.
6340 Quadrangle Drive
Suite 200
Chapel Hill, NC 27517
Tel. (919) 313-9100
Fax (919) 313-9108
info@capacityproject.org
www.capacityproject.org