



Health worker incentives during and after the conflict in Northern Uganda: A document review

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EXECUTIVE SUMMARY

Introduction

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

Methods

A total of 59 documents, largely government health policy documents were reviewed. The search focused on: health policies and overarching legal documents; HRH-specific policies, national plans, strategies, audit reports and annual health sector performance reports, programme documents (by local and international NGOs as well as donor agencies with a focus on HRH incentives); and mid-term and end of project evaluations of particular interventions on health worker incentives in post-conflict Northern Uganda. Apart from one document (the constitution of the Republic of Uganda), all documents which were reviewed had a publication date between 1999 and 2014 and were in English. The study also included print and electronic media articles on HRH incentive issues in Uganda for the period 2011- 2014.

After identification, data was extracted using a matrix developed by the research team and analysed in order to identify recurrent themes, areas of convergence and divergence of ideas, practices and findings, and significant gaps. This report is based on this document review.

Findings

HRH challenges during and after the conflict in Northern Uganda

There are numerous challenges for human resources for health in Uganda during and after the conflict in Uganda. These can be categorised into recruitment challenges, distribution challenges, retention challenges, and performance challenges (pay, motivation, management

etc.). While these challenges cut across the country, the conflict in northern Uganda exacerbated them.

Policy responses to the HRH challenges during and after the conflict

Over time, the Ministry of Health and its health development partners have developed numerous policy frameworks and interventions in response to HRH challenges countrywide. Many of the policies are linked to other national overarching frameworks and are often built upon earlier policies. The policy responses are categorized into nationwide policies as well as policy and programme responses specific to Northern Uganda.

Although most of the broad health sector policies mention something about health worker incentives, the actual incentive package is rarely specified. In general, the main focus of most policy responses is training of health workers and health worker remuneration. A few of the policies focus on improving staff living conditions. Prominent activities are related to building health centers and housing units for health workers in the areas formally ravaged by war.

Additionally, most documents focus on the effects of the policies on the broader health system. However, they are silent on how these responses were supposed to or have improved health worker performance and how the health workers perceived them.

Effectiveness of policies to date

A few of those policies (the HSSPs, the PRDP and all the donor funded responses in Northern Uganda) have been reviewed mid-term or annually while others seemed not to be evaluated at all. This category includes the motivation strategy, the national health policy and hard to reach allowance policy.

There are pockets of improvements. However, these are still far from the planned targets both at national level and in conflict-affected areas. Hence, the (identified) HRH challenges have persisted. Effectiveness of the policies has mainly been hindered by limited funding, limited capacity of some actors, poor coordination, and limited or lack of support and supervision, among other factors.

Lessons learnt

- Implementation of effective incentive policies and responses requires a sector wide approach but this in turn requires good coordination skills, well built capacity and commitment from all actors involved.

- For incentive policies to work, they need to be holistic rather than piece meal.
- If the capacity of the districts is strong, then they will participate better in implementation of the incentive policies at the local government level. This is crucial given that all policies are implemented under the decentralisation framework.
- The effort invested in implementing HR incentives responses needs to match that invested in their planning, otherwise resources will be wasted.
- It is not the number of policies that are put in place overtime that is most important, rather it is the impact that these policies have on reduction of HRH challenges in the country that is most important. Proper planning of HRH interventions and policies needs to go hand in hand with making funding available, if anything is to be implemented.
- When evaluating the impact of policy responses, it is not enough to count numbers. We also need to consider the things that may be challenging to count but are crucial. For instance, health workers experiences and views on how these responses affect performance and motivation need to be solicited.

ACRONYMS

AHSPR	Annual Health Sector Performance Report
AHWO	African Health Workforce Observatory
AIDS	Acquired Immune Deficiency Syndrome
CAO	Chief Administrative Officer
CBO	Community Based Organisation
CORPS	Community Resource Persons
CSO	Civil Society Organisation
DFID	Department for International Development
DHO	District Health Officer
DSC	District Service Commission
GOU	Government of Uganda
HC	Health Centre
HIV	Human Immune Virus
HMIS	Health Management Information system
HRDD	Human Resource Development Department
HRH	Human Resources for Health
HRM	Human Resource Management
HSC	Health Service Commission
HSD	Health Sub district
HSSP	Health Sector Strategic Plan
HW	Health worker(s)

HWF	Health Workforce
IDP	Internally Displaced Persons (People)
LRA	Lord's Resistance Army
MOES	Ministry of Education and Sports
MOH	Ministry of Health
MoLG	Ministry of Local Government
MOPS	Ministry Of Public Service
NDP	National Development Plan
NGO	Non Government Organisation
NHP	National Health Policy
NUMAT	Northern Uganda Malaria Aids and Tuberculosis Programme
NURP	Northern Uganda Reconstruction Programme
NUSAF	Northern Uganda Social Action Fund
PEAP	Poverty Eradication Action Plan
PFP	Private for Profit
PNFP	Private Not for Profit
PRDP	Peace Recovery and Development Plan for Northern Uganda
PS	Permanent Secretary
RC	Resistance Council
UBOS	Uganda Bureau of Statistics
UCMB	Uganda Catholic Medical Bureau
UKPCDP	United Kingdom Post-conflict Development Programme

UN	United Nations
UNICEF	United Nations Children's Fund
UNMHCP	Uganda National Minimum Health Care Package
UPMB	Uganda Protestant Medical Bureau
USAID	United States Agency for International Development
VHT	Village Health Team
WHO	World Health Organisation
JSI	John Snow Incorporated
UK PCDP	UK Post-conflict Development Programme for Northern Uganda

1.0 INTRODUCTION

Makerere University School of Public Health, in collaboration with the Liverpool School of Tropical Medicine and Queen Margaret University, Edinburgh, conducted a document review on health worker incentives in post-conflict Northern Uganda. This document review is one of four data collection tools used in the health worker incentives study by the ReBUILD Consortium. This study aims to understand the evolution and effects of government and donor policies supporting health workers during and after the conflict in Northern Uganda, and to derive recommendations on how to improve their effectiveness and sustainability. This report reviews written evidence on the evolution of policies and programmes to support health workers at national level and in post-conflict areas. The review starts from 1999 since the majority of policies that are under review have built on the national health policy, which was developed in 1999. The report also indicates the objectives and focus of each policy, any linkages to other policies, sources of funding, actors, drivers of change, implementation strategies, challenges and achievements, where possible.

2.0. JUSTIFICATION FOR THE REVIEW

There are few studies on health worker incentives in Uganda, and the ones in existence are limited in terms of scope and coverage. This is particularly the case for health worker incentives in post-conflict Northern Uganda, given that current health system research has tended to ignore post-conflict areas in general.

The dynamics of the health workforce in a fragmented post-conflict situation is inadequately understood, yet it is key to restoring a well-coordinated and functioning health system. Building a sustainable health system that is responsive to the needs of the population in a post-conflict setting is critical, because providing appropriate and good quality health services to the population not only reduces morbidity and mortality but also serves as an important entry point for engagement between the government, development partners, civil society, and the community. The reconstruction of systems in post-conflict areas has far-reaching effects on health worker management and ultimately, performance.

A review into incentives and staff retention in rural areas of 16 African countries showed that there was no incentives package that was suitable for all contexts (Dambisya, 2007). McCaffery (2009) found that although financial incentives form an important component of many incentive packages, they only offer part of the solution. Incentives that attract and retain

health workers need to be identified and an appropriate package tailored for the post-conflict setting in Uganda.

Although organisations have collected data on incentives for programmatic purposes, the range of information collected is not well known and/or synthesised to provide a broader picture about ongoing and completed research, gaps in knowledge, and best practices in addressing health worker incentives. Several studies have been carried out, often with support of international agencies, international and local NGOs, government institutions, and research actors. However, results from many of these studies remain unknown to the broader HRH community.

The lack of comprehensive evidence on the implementation of policies related to health worker incentives reduces the ability of the government and other stakeholders to make informed policy and programmatic decisions around the motivation, retention, and performance of health workers in post-conflict northern Uganda and beyond.

This study focused on characterising changes in health worker incentives and their drivers, documenting the processes for implementing them, and identifying appropriate incentive packages for health worker motivation in the post-conflict health system. This information will be critical in informing policy makers and health managers involved in instituting incentives that may improve the performance and retention of health workers in the post-conflict setting in Northern Uganda.

2.3. OBJECTIVE OF THE REVIEW

The main objective of this review is to document the evolution of government and donor policies related to incentives for health workers in Uganda, with a particular focus on post-conflict northern Uganda. It is one component of a wider study.

3.0 APPROACH TO DOCUMENT REVIEW

Access to documents: Access to government archives was granted by the National Council of Technology and Office of the President. The Ministry of Health library was visited to access hard copies of documents and soft copies were obtained from the Ministry of Health website. Other documents, such as programme and evaluation reports, were acquired by searching online or by using snow balling methods by asking respondents at national and district levels. Hard copies

of some documents were obtained from key informants at national and district level. Key informants also gave recommendations of documents to review.

The document review proceeded through the following stages:

Stage 1: Establishing broad inclusion criteria to guide the search for relevant documents. For purposes of focus and manageability, the search was limited to:

- Documents published from 1999 to 2012
- English language documents
- Health policies, legal documents and implementation strategies which include, or have sections focused on, HRH.
- HRH-specific policies such as HRH strategic and operational plans
- HRH audit reports
- Programme documents (by local and international NGOs as well as donor agencies with a focus on HRH incentives)
- Midterm and end-of-project evaluations of particular interventions on health worker incentives in post-conflict northern Uganda
- Print and electronic media articles on HRH incentive issues from 2011- 2014

Stage 2: All documents that met the above criteria underwent a review and data was extracted according to our themes of interest. Each selected document was reviewed using a matrix that included five categories of information

- Document description (e g, title, source, language, publication status, intervention context)
- Scope (national or regional)
- Thematic focus (with the guidance of a document review framework annexed at the end of this document)
- Evaluation of discussions and implications for policy and practices, with specific relevance for our HRH objectives

Stage 3: The documents were then reviewed and analysed in order to identify recurrent themes, areas of convergence and divergence of ideas, practices and findings, and significant gaps. The research team then prepared a desk review report based on the reviewed documents.

FINDINGS

4.0 HUMAN RESOURCES FOR HEALTH (HRH) CHALLENGES DURING AND POST-CONFLICT

For the purposes of this report, HRH challenges in Uganda and post-conflict northern Uganda are categorised into: distribution challenges, recruitment challenges, retention challenges, and performance challenges (pay, motivation, management etc). A detailed discussion of these issues is presented in the next sections.

4.1 Distribution challenges

Distribution challenges for HRH in Uganda include disparities between rural and urban areas as well as regional differences, both for overall numbers and skills mix. The present number of health staff (doctors, nurses, midwives) available in the country, including the PNFP sector, amounts to 59,000, with a ratio of 1 to 1,818 people (MOH, 2010). This is below the WHO recommended minimum standard¹. Uganda was among the 57 countries with a critical shortage of health workers (WHO, 2006). Reasons for the shortage of HRH include deaths due to the HIV pandemic and other illnesses, international migration, recruitment problems, retirement, and cross sector migration (MOH et al., 2012). Additionally, there are rural/urban inequalities in the distribution of health workers, with the situation worse for rural areas. For example, the central region, which is predominantly urban, has 71% of the doctors, 64% of the professional nurses and midwives, 76% of dentists, and 81% of all pharmacists (AHWO, 2009; MOH, 2006; MOH, 2010; MOH et al., 2012).

Additionally, there are inequalities in the distribution of health workers between lower and higher levels of health facilities, with more staff and skilled health workers at hospital and health sub-district level than at lower level health facilities. HCIIIs and HCII facilities are the ones most affected by understaffing. For instance, most of the HCIIIs have nursing assistants, who only receive short periods of training ranging from 1 week to three months, while some cadres are appointed to positions beyond their qualifications (AHWO, 2009, MOH, 2012, MOH et al., 2012). The situation is often much worse in hard to reach areas, including post-conflict Northern Uganda. For example, in the Acholi sub-region many health workers, including higher level cadres, fled to safer places for fear of being abducted or killed, leaving low cadres to manage the health facilities (Namakula et al., 2014). This affected the workload of the remaining health workers and the quality of care they could provide.

¹ WHO recommends that countries with less than 1 doctor, nurses or midwife per 439 people are in critical shortage of health workers. See WHO world Health report, 2006.

A survey into the status of human resources indicated that districts in Acholi sub-region fared poorly in terms of HRH status. Gulu district seemed better off, but the rest of the districts, particularly Lamwo, Nwoya and Kitgum showed dismal staffing levels (MOH, 2010). The availability of HRH in these districts is sometimes worsened by absenteeism due to a lack of accommodation on site, low morale due to low payment and poor HR management, sickness, study leave, annual leave, and attendance at workshops and trainings away from the health facilities (Matsiko, 2010; AVSI, 2011). Apart from affecting distribution, absenteeism also affects the performance of health workers.

Table 2 shows a summary of HRH status by district in the Acholi sub-region and a few selected districts from other regions for comparison purposes. The results of this survey indicate an improvement compared to the findings of the 2010 HRH report audit report (MOH, 2010). However, the number of actual filled positions is still poor compared to staffing norms. Table 2 shows that out of the seven districts in Acholi sub-region, only three districts (Agago, Amuru and Gulu) are above the staffing level target of 65% of sanctioned posts filled (set in the second Health sector strategic plan) (MOH, 2006).

Table 2: HRH status in selected districts of Acholi sub-region and other selected districts, June 2010 and June 2013

District	District HRH status as of June 2010						District HRH status as of June 2013					
	No of Units	Total Norm ²	Filled ³	Vacant	% Filled	% Vacant	No of Units	Total Norm	Filled	Vacant	% Filled	% Vacant
Agago	N/A* *4	N/A*	N/A*	N/A*	N/A*	N/A*	33	379	272	107	72%	28%

² Norm refers to number of total positions

³ Filled column refers to the number of norms filled

⁴ All districts with N/A* did not have HRH survey data available for the year 2010. This is because these districts were not yet split from their mother districts. Although Nwoya split from Gulu in 2010, it was in July after the survey had been conducted. Similarly, Agago also split from Pader in late 2010. Lamwo district was split from Kitgum in late 2009, but started functioning as a fully fledged district in 2010. It is possible that during the survey, Lamwo was counted as part of the greater Kitgum.

Amuru	29	539	318	265	59%	41 %	28	369	259	110	70%	30%
Kitgum	20	478	269	241	56%	50 %	19	473	276	197	58%	42%
Gulu	42	587	419	175	71%	30 %	45	585	508	77	87%	13%
Lamwo	N/A *	N/A*	N/A*	N/A *	N/A *	N/A *	23	343	111	232	32%	68%
Nwoya	N/A *	N/A*	N/A*	N/A *	N/A *	N/A *	15	348	170	178	49%	51%
Pader	59	710	464	276	65%	39 %	33	434	268	166	62%	38%
National average	N/A * ⁵	N/A*	N/A*	N/A *	56%	44 %	N/A*	N/A *	N/A *	N/A*	57.6 %	43.3 %

Source: MOH 2010 HRH audit report 2010 and MOH 2013 Human resources for Health Bi-annual report

4.2 Recruitment challenges

Recruitment challenges include financial constraints (limited funding for recruitment), the wage bill ceiling, recruitment ban, and the weak functionality of district service commissions.

Limited funding for recruitment results in delayed recruitment and leads to persistent increases in vacancy levels (MOH, 2010).

Wage bill ceiling: Although the shortage of different cadres of health workers has been well documented in various HRH survey reports and workforce projections, financial constraints continue to hinder recruitment to solve the problem (MOH, 2006; MOH, 2007; MOH, 2011; MOH et al., 2012; MOH, 2012). For instance, a total of Ug Shs 79.9 billion would have been required to reach the staffing norms for selected cadres, as well as to pay for salaries and

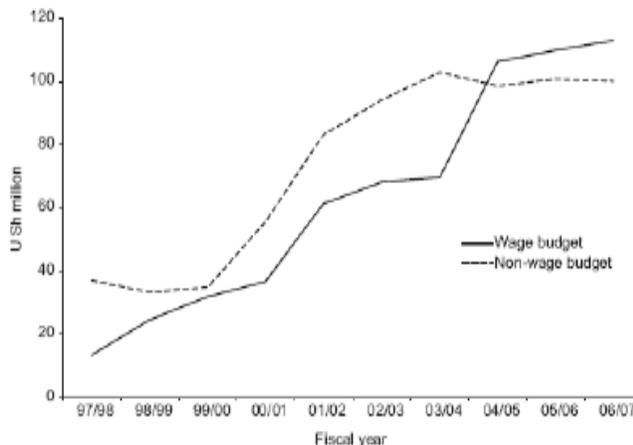
⁵ N/A* on the national average row means we could not find the figures.

allowances in the financial years 2012-2014 (MOH, 2012). This amount was way above the available budget.

According to the health systems assessment (2011), the wage bill ceiling has a huge influence on recruitment as it limits the ability of the public sector to fill its vacant positions and to absorb the increasing numbers of health workers produced; it is thus a major bottleneck to the performance of the entire health system (MOH et al., 2012). Although wage expenditure is always rising (see figure 4.2), the wage bill ceiling is centrally controlled, meaning budget-holding centres in the public sector, including district local governments, *“have to conform to ‘ceiling’ and ‘floor’ guidelines within which to fit their budgets”*(MOH et al., 2012).

Recruitment ban: The recruitment ban is also one of the factors contributing to recruitment challenges in Uganda. The recruitment ban for civil servants, which is also linked to the wage bill ceiling, was instated to deter the recruitment of all civil servants, including health workers, for the financial year 2012/13, with the exception of the replacement of those who leave service (Parliament of Uganda, 2012; Walubiri, 2012). Although there has not been official communication about the removal of the ban, some arrangements have been made since the end of 2013 to the current period to recruit health workers under various programmes. Some of these have been highlighted in section 5.2 of this report.

Fig 4.2: Wage and non-wage expenditure trends for the health sector, 1997/98 - 2006/7



Sources: Okwero et al., 2010; MOH et al., 2012

A parliamentary committee report on the ministerial statement for the health sector for the financial year 2012/2013 indicated that the recruitment ban frustrates other policies like decentralization/district splitting, which requires new staffing. Additionally, it results in staff

shortages at health facility level, which in turn has a spiral effect of burnout, absenteeism, abscondment, stress, depression, lack of morale and eventually affects the quality of services provided (Parliament of Uganda, 2012,). The recruitment ban also renders HRH policy plans and strategic objectives useless (MOH, 2006; MOH, 2007).

Previous efforts to lift the ban on the recruitment on health workers were futile, although there are recent attempts to open recruitment once again (Walubiri, 2012).

Functionality of district service commissions

District service commissions (DSCs) were formulated under Article 198 of the Constitution of Republic of Uganda (1995). They are regulated by the Public Service Commission which is mandated to handle human resource needs such as recruitment, appointment, posting, and remuneration of civil/public servants for all of the Ministries in the country (Government of Uganda, 1995). Article 198, as well as the decentralization act of 1997, recognizes DSCs as the organ delegated by the Public Service Commission to conduct the above mentioned duties on its behalf at the district level (Parliament of Uganda, 1995; Parliament of Uganda, 1997). Given their role, the success of recruitment processes in districts depends on the functionality of the DSCs.

However, an assessment of 144 districts of Uganda showed that the DSCs are at differing levels of functionality, with few well equipped to handle the planned recruitment, and the rest needing support in order to adequately handle the recruitment of staff in local governments (MOH, 2012). The five parameters assessed for the functionality of DSCs included; having an approved chair person and four commission members; having a quorum to transact business; having less than three committee members properly inducted; DSC about to expire in three months time or less and DCS with no substantially appointed secretary to the commissions. The districts in the greater north, including Acholi sub-region, were in the cluster that performed poorly for these parameters, except for Gulu district, which, for instance, had a fully constituted Committee (MOH, 2012).

4.3 Retention challenges

Available literature shows that retention challenges exist within both public and private sectors country-wide, with high rates of attrition for various reasons. Common factors raised for high attrition in the public sector are poor and often delayed payments; lack of promotion, training

opportunities and career progression especially under local government; poor leadership with harassment and lack of transparency; lack of decent accommodation and poor working conditions (AHWO, 2009). Doctors, midwives, pharmacists, and radiographers are difficult to retain (Matsiko, 2010; MOH, 2010). There is limited evidence on actual numbers of staff leaving the public sector.

Over the years, attrition and turnover has continued to create HRH challenges for the UCMB network as one of the PNFP sectors (AHWO, 2009; UCMB, 2012). The situation is worse in lower level health facilities, facilities in hard to reach areas, and among key staff e.g. doctors and clinical officers (UCMB, 2012).

Table 4.3: Attrition for selected key cadres in UCMB hospitals in hard to reach districts 2007/8-2011/12

Key cadres	2007/8	2008/9	2009/10	2010/11	2011/12
Medical Officers	54%	35%	39%	34%	37%
Clinical officers	39%	27%	34%	37%	41%
Enrolled Midwives	39%	44%	23%	32%	30%
Enrolled nurses	43%	28%	23%	35%	32%

Source: UCMB Bulletin Jan-Dec 2012

Similar to the public sector, desire for better pay also contributes to attrition in the PNFP sector. Other factors include end of contracts or end of bonding agreements, further studies, and domestic or personal issues (UCMB, 2012). Many health workers move to the public sector, NGO sector or go into private businesses.

Another study also found that human resources challenges are much worse in areas like northern Uganda, a post-conflict setting where there is poor retention of health workers (Ciccio et al., 2010). The study indicated that factors affecting the retention of health workers in post-conflict northern Uganda included: insecurity, poor living conditions, poor working conditions and limited incentives on offer. There are limited studies on retention trends in the region.

4.4 Performance challenges

Although there are limited studies on the performance of health workers, there is a general perception that performance is poor with low productivity. According to the HRH strategic plan, factors affecting performance include under-funding, red tape, poor skills mix, inequitable distribution, inadequate equipment and supplies, weak HRH management, and occupational health and safety, especially in hard to reach areas (MOH, 2007).

The Uganda health system assessment report categorised factors affecting health worker performance into direct and indirect system factors (MOH et al., 2012). Such factors are related to the working environment e.g. a shortage of medicines and supplies to perform tasks, understaffing leading to heavy workload, a decline in knowledge and skills overtime, and hostility from patients (VSO, 2010; MOH et al., 2012).

Other factors responsible for the perceived low productivity include infrequent and inadequate supervision, poor motivation due to low incentives and poor facilitation, inappropriate disciplinary actions, harassment from seniors, poor enforcement of the ethical code, and language barriers between service providers and clients (AHWO, 2009).

As indicated above, the available literature on performance related challenges is generalised for the whole country, rather than being region-specific.

Although lacking a clear demarcation between those affecting Northern Uganda and the country at large, current anecdotal evidence indicates a continuation of factors that affect performance. For instance, poor pay roll management and delayed salaries affect all civil servants. Some civil servants are deleted from the pay roll maliciously due to 'personal reasons with personnel officers'⁶ or when they are transferred or during the pay roll update process (Karugaba, 2014). Although the promise to pay the arrears had been made, it is not clear when this will be put into action.

⁶ This was said to be most common for female civil servants, particularly young women, who may be deleted from the pay roll because they have not given in to the male officers who manage the pay roll.

4,000 civil servants to get salary arrears on March 28

By Mary Karugaba

A total of 4,009 public servants who have not received salaries since September last year will be paid arrears on March 28, MPs heard yesterday.

According to the Ministry of Public Service, the civil servants are set to be paid include teachers, nurses and Police officers in different parts of the country.

There are over 20,000 unpaid public servants in the country.

Appearing before the parliamentary committee on public service and local government yesterday, state minister for public service Ssezi Mbaguta attributed the

delay in paying civil servants to the late updating of the payroll by accounting officers.

"I am very committed on this. We must pay these public servants by March 28. So as Ministry of Public Service, we have given all accounting officers up to Friday this week to organise their payroll documents to enable us pay these people," said Mbaguta.

She warned that civil servants, whose names will be left out during updating of the payroll by accounting officers, will have to be paid next month.

She explained that some people were not on the payroll as a result of transfers or death.

"I am very committed on this. We must pay these public servants by March 28."

Mbaguta

"The payroll management is very dynamic; it changes every



day, because people are dying, abandoning their jobs while

others are being transferred," explained Mbaguta.

She, however, told MPs that some accounting officers were deliberately deleting some civil servants from the payroll due to personal issues.

"All accounting officers need to have integrity. There are some officers who only include people they like and for the young women it is worse. Some are removed from the payroll just because they have not given in to these officers," added Mbaguta.

However, the committee, chaired by Zombo district Woman MP Grace Kwiyuwin, asked the ministry to submit to Parliament a list of civil

servants with salary arrears and the amount to be paid.

"All the arrears should be reflected. Some people have not been paid since September last year," she said.

"We also need to know which civil servants have been deleted from the payroll. Where does their money go?" asked Kwiyuwin.

The Government has since December last year been promising to pay the civil servants salary arrears, but it has to date not been able to honour its pledge, citing delays in updating the payroll, wage shortfall in the budget and changes in the payment system.

New Vision, Wednesday, March 12, 2014
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Figure 1 Source: New vision, Uganda's leading daily newspaper, March 12th 2014

5.0 POLICY RESPONSE AND INTERVENTIONS IN RESPONSE TO HRH CHALLENGES OVER TIME

The document review found two categories of policy response: nationwide policies and policies specific to northern Uganda. In this section, we will first discuss the nationwide policy responses and then return to the policies related to northern Uganda.

5.1 Evolution of nationwide policies

Over time, the Ministry of Health and its health development partners have developed numerous policy frameworks and interventions in response to HRH challenges country-wide. Many of the policies are linked to other national overarching frameworks and are often built upon earlier ones. For example, the health sector strategic and operation plans were set up to implement the National Health Policies as well as strengthen the achievements of the earlier health sector strategic plans. The success of the health sector strategic plans is often evaluated in the new plans and 'new' strategies suggested. Additionally, the annual health sector performance reports (AHSPR) build on the assessments conducted in the fourth year of the health sector strategic plans.

The majority of the general health sector policies had at least a sub-section on HRH. In addition, five were specific to HRH. From all policies, it is clear that improving the HR situation is not an end in itself but a means to achieving success of the Uganda minimum health care package.

Below is a list of the general health sector policies and HRH policies which will be discussed in this section. Issues to be discussed include: the objectives/focus of each policy, linkage to

other policies source of funding, actors, drivers of change, implementation strategies and challenges as well as, impact/achievements where possible

The following are the main HRH-relevant policies and implementation plans in Uganda from 1999-2012:

- a) The first National Health Policy (NHPI), 1999
- b) The first Health Sector Strategic Plan (HSSP I) 2000/01-2004/05
- c) The second Health Sector Strategic Plan (HSSP II 2005/06-2009/2010)
- d) Uganda Human resources for health (HRH) policy 2006
- e) Uganda human resources for health strategic plan, 2005-2020
- f) Uganda Human Resources for Health Operational Plan 2006/07-2009/2010
- g) Motivation and retention strategy for human resources for health October 2008
- h) The third Health Sector Strategic and Investment Plan (HSSIP III 2010/11-2014/15)
- i) The Hard to reach allowance policy (2010)

The following are the policy responses/interventions specific to Northern Uganda after the conflict (2006-2015):

- a) Northern Uganda Malaria, AIDS and Tuberculosis Programme (NUMAT) 2006-2011
- b) The first Peace, Recovery and Development Plan (PRDP 1) for Northern Uganda 2007-2010
- c) 30% top-up of health workers' salary in Northern Uganda 2007
- d) The second Peace, Recovery and Development Plan for Northern Uganda PRDP II (2010)
- e) Northern Uganda-Health Integration to Enhance Services (NU-HITES) project 2012-2017
- f) UK post-conflict development programme for Northern Uganda (UK PCDP) 2010-2015

National Health Policy (NHP I) 1999

The NHPI was developed in 1999 with the objective of 'reducing mortality, morbidity and fertility, and the disparities therein'. This would be done mainly by ensuring that Ugandans have access to the Uganda National Minimum Health Care Package (UNMHCP)⁷ (MOH, 1999).

⁷ The UNMHCP is aimed at tackling the major causes of the burden of disease and to develop cost-effective interventions. It was mainly developed for public health sector facilities and consisted of five core areas: control of

Among the many issues tackled, a section is dedicated to human resources, under which the NHP1 provides an overall objective of “strengthening human resources management at all levels” and “promoting equal opportunities for both men and women in health professions”. Additionally, three specific strategies in relation to health worker incentives are provided;

- Develop and promote incentive schemes for equitable deployment and retention of health workers, especially to the rural areas
- Establish and maintain mechanisms for assuring relevant continuing education for, and supportive supervision of all health personnel
- Decentralize in-service training, including its funding to the district level (MOH 1999)

The development of NHPI took into account existing laws like the 1995 Constitution of the Republic of Uganda (1995), the Local Governments Act (1997), the National Poverty Eradication Programme (2004) and the Alma Ata Declaration of Health for All (1978).

As indicated earlier, the NHP was to be implemented through the first Health Sector Strategic Plan (HSSPI) 2000/01-2004/05. Hence, the implementation challenges as well as the effects of the NHP can be only identified through an evaluation of the HSSPI. The NHP1 was for the overall country and not specific to any region. It does not contain any cost estimates.

The Health Sector Strategic Plan I (HSSPI) 2000/01-2004/05

The HSSPI was the implementation strategy for the 1999 NHPI and the health section of the PEAP, and involved various stakeholders. Its main objectives were to “improve access of Ugandans to a good quality UNMHCP and reduce inequity in access to good health services in the population” (MOH, 2001).

The HSSPI clearly detailed how the UNMHCP was to be implemented, using a logical framework, expected outputs, verifiable indicators, means of verification and key assumptions. One of the aspects that the HSSPI pledged to focus on was “training, recruitment, rational deployment, motivation and retention of qualified staff across the country” (MOH, 2001). In recognition of the staffing gaps, the HSSPI set the objective of achieving at least 75% of the required minimum staffing within the different health sector levels in the districts (MOH, 2001).

communicable diseases; integrated management of childhood illness; sexual and reproductive health and rights; other public health interventions (e.g. immunisation, environmental health, etc); and strengthening mental health services (MOH, 1999).

Similar to the NHP I, under the HSSPI, there was a section for human resource development. The four main objectives included: improving management of personnel and their technical skills; increasing their accountability and productivity; enacting the policy on continuing education; setting up incentive schemes that would work and drawing well trained personnel to work in areas that were underserved (MOH, 2001).

Furthermore, the plan indicated that districts were to be given support to help them deal with problems related to low and late payment as well as other such factors that cause loss of morale among health personnel. However, the type of support was not elaborated on. Instead, for both incentives and district support, districts were given the mandate to develop activities and indicators in detail, as well as means of verification and key assumptions. While this gave them the chance to develop what is most appropriate to their situation, it may have also left them in limbo, or caused procrastination. The HSSPI had good intentions for all health professionals countrywide, no specific strategies were given for the areas going through conflict.

As a result of the implementation of the HSSPI, more trained personnel were deployed to districts, with 68% of the posts filled compared to the target of 75%. Additionally, health centres were upgraded or constructed, thus increasing access for the population (MOH, 2006b). The challenges faced during the implementation of the HSSPI were indicated in the HSSPII and these included: insecurity, particularly in the north and north east of Uganda, as well as continued challenges with staffing due to shortage of funding towards recruitment. For instance, 56 of 568 GOU & PNFP HC IIs were unstaffed by the end of 2003 and 32% of the remaining 812 HC IIs were exclusively staffed by nursing assistants (MOH, 2006b).

Health Sector Strategic Plan II (2005/06-2009/2010)

The overall objective of the HSSP II was 'to have less sicknesses and deaths and reduce disparities, by delivering four clusters of the UNMHCP' (MOH, 2006b).

The main focus of the HSSP II was the training of health workers. HSSP II also recognised that the shortage of trained health workers was causing a crisis, and provided the objective of ensuring that more training and motivated staff are available and deployed in the country in an equitable way (MOH, 2006b). A specific objective was incorporated for training: *'To ensure that training for health workers is relevant and that health workers' competencies and performance are upgraded'* (MOH 2006b). As part of the wider strategies for implementation of the HSSP II, one of the intentions was to ensure that in conflict and post-conflict areas, 'appropriate' health

services were put in place (MOH, 2006b, p. 87). What is meant by appropriate was not elaborated on.

To enable the implementation of the above objective, the HSSPII provided coordination and participation among the various partners involved in improving the situation. Key actors included were; MOH, Ministry of Education and Sports (MoES), Ministry of Local Government (MoLG), Health Service Commission, Ministry of Public Service and PNFPs. Roles were also assigned, with the MOH responsible for setting standards, deciding on the numbers for training, and which types of health workers were necessary. The MoES was responsible for developing the curriculum and training.

HSSP II recognised the fact that the war in northern Uganda was getting worse, with about 1.7 million people living in over 180 camps, and a worsening health situation. As a result, they implemented some special strategies to strengthen the health system in Northern Uganda through 'ensuring equitable access to healthcare and provision of appropriate UNMHCP' (MOH, 2006b). Such strategies included those aimed at improving infrastructure and logistics as well as HRH (specifically the provision of appropriate staff remuneration, including accommodation, transport, and special allowances for regions with greatest shortage) (MOH, 2007a, pp. 95-96). In the course of the HSSPII, a number of districts including Gulu, Kitgum and Amuru were recognised as part of the 'hard to reach areas'. The hard to reach policy under the Ministry of Public Service (MoPS, 2010) was identified as a key strategy to retain health workers in such areas. Additionally, districts were guided to submit recruitment plans to fill the target of up to 65% of vacant positions for the financial year 2010/2011 (MOH, 2010, p. 6).

The main challenge for the implementation of the HSSP II was low or stagnant levels of funding from the government budget, and increasing but unpredictable and earmarked funds from donor projects and Global Health Initiatives (MOH, 2006, piii). In spite of the efforts in relation to HRH, by the end of its implementation period the health sector still faced the following challenges: poor attraction and retention of health workers; limited availability of funds for recruitment; and demotivation of health workers due to lack of equipment (MOH 2010).

An evaluation of the impact of the HSSP II was done annually from 2006 to 2010 via annual health sector performance reports for the financial years 2006/07; 2008/9 and 2009/10 (MOH, 2007a; MOH, 2009; MOH, 2010). Achievements of the HSSP II included: development and maintenance of an HRH policy and strategic framework; a study on the retention of health workers, although the results are not mentioned; strengthening capacity for HR planning and management; as well as upgrading health worker skills through continuous professional development (MOH, 2010, p. 6).

By the end of the HSSPII timeframe, there was some progress made in relation to increasing the number of health workers, with 56% (against the planned 65%) of the posts filled (MOH, 2010, p. 6).

Uganda Human Resources for Health (HRH) Policy, April 2006

The main objective of the HRH policy was to provide a framework and guidance for ensuring that there was an adequate and appropriate human resource capacity to support the effective and efficient implementation of the National Health Policy in pursuit of the Government of Uganda's development goals (MOH, 2006a, p. 11).

The development of the HRH policy was a result of consultations with various stakeholders including but not limited to; government institutions, private and private not for profit providers, health workers, clients and community members (MOH, 2006a, p. 22). The HRH policy was developed in the context of global, regional and national policies. The HRH policy was linked to the HSSP I in such a way that the former would guide the development of the human resources for health strategic plan 2005/6-2009/10 (MOH, 2006a, pp. 7-11).

Implementation of the HRH policy was intended to be within the context of the Sector Wide Approach with close linkage to the budget process, the long and medium term expenditure frameworks. A solid institutional framework was important to ensure continued implementation and monitoring of the policy and also ensure that all HRH functions (i.e. planning, development and management) were holistically catered for. (MOH, 2006a, p. 17).

The Ministry of Health was to take a lead role in these developments, but would work in close collaboration with other stakeholders. Other stakeholders in the implementation of the HRH policy included: relevant ministries (education and sports, public service, finance and economic planning), local governments, service commissions for education, health professional councils, professional associations and other stakeholders (MOH, 2006a, pp. 17-21).

Monitoring of the HRH policy implementation was to be based on a set of agreed relevant indicators highlighted in the human resource strategic plan and harmonised with the Health Sector Strategic Plan monitoring framework. Progress reports would be provided by the Human Resource Working Group of the Health Policy Advisory Committee and submitted to Annual Joint Review Missions and the National Health Assembly. At least once in every five years, the HRH strategic plan was to be subjected to detailed attention by means of a Technical Health Sector Review of Human Resources. This was done in anticipation of policy revision and updated when necessary (MOH 2006a, p. 21). However, to date, no documented revisions or

updates have been made to the HRH policy. All documents are being linked or implemented within the framework of the HRH policy of 2006. There was no information on how the implementation of the policy would be financed.

Uganda Human Resources for Health Strategic Plan, 2005-2020

This plan was developed to respond to the second HSSP (HSSP II) and operationalise the HRH policy 2006. The plan aimed at *'supplying and maintaining an adequately sized, equitably distributed, appropriately skilled, motivated, and productive health work force'* (MOH, 2005).

The plan also envisaged changes in the skills-mix and distribution of the workforce to correct inequalities among different regions and across urban and rural settings (Ssenooba et al., 2009). In order to ensure the achievement of its objective, the plan aimed to have 41000 workers trained and recruited into the health system by 2020 (Ssenooba et al., 2009).

A major implementation challenge for the HRH plan was limited availability of funds to implement the planned actions (Ssenooba et al., 2009; Orach, 2007). For instance, the recruitment and motivation of staff implied a need to boost the 'low' salaries, hence requiring the wage bill to be doubled from US \$151 million in 2005 to US \$307 million in the year 2020 (MOH, 2007a, p. 37). Additionally, the annual training costs to produce the required staff numbers was about 11 million US dollars or equivalent to 7 to 10 percent of the annual wage bill (Hisali et al., 2007). Such a wage bill for the health workforce would be too high, leaving other budget lines with no funds at all (MOH, 2007a).

Uganda Human Resources for Health Operational Plan 2006/07-2009/2010

This plan was particularly created to operationalise the first 3 years of the 15-year HRH strategic plan and the HRH policy (2006). The HRH operational plan has seven strategic objectives which are further broken down into six sub-sections, three of which are focused on: equitable distribution; strategies for sustainable retention of health workforce; and improved accommodation for health staff in hard to reach and underserved areas (objectives 4.2; 4.3 and 4.6 respectively). The rest of the subsections under the human resource strategic objective generally focused on the country as a whole. They included: strengthening recruitment mechanisms and development of available human resources (4.1); capacity building for improved performance management (4.4); and ensuring a conducive and safe work environment for health workers (4.5) (MOH, 2007b).

The main advantage of the HRH operational plan was that it had an implementation matrix which summarised specific objectives, expected outputs, responsible units and means of implementation. This not only helped guide the implementation but also made the tracking and evaluation of progress on individual planned activities easier.

The HRH operational plan also enlisted a number of government ministries, autonomous bodies and local government units as responsible entities to oversee the execution of various activities, according to their specialities. Such an approach aimed to ensure collective ownership of results as well as maximum quality.

While the HRH operational plan provides for the hard to reach areas, in some areas the plan is vague. For instance, in 4.2.3 it mentions supporting hardship areas to be competitive, but does not mention what kind of support is necessary for this to happen. The *'means of implementation'* for the various activities are concentrated around three main categories: provision of guidelines, conducting research and assessment studies, and trainings and workshops. Such means of implementation can be good but do not indicate direct and clear efforts to address HRH challenges on the ground.

Motivation and retention strategy for human resources for health, 2008

The motivation and retention strategy was developed in response to the HRH challenges identified in a HRH motivation study conducted by the Ministry of Health in partnership with the Capacity Project (MOH and Capacity Project, 2007). This study⁸ found low job satisfaction among health workers, poor living conditions and terms of service, inequitable distribution, and many other challenges. Similar results had been revealed by the mid-term review of the HSSP II. The HRH motivation and retention strategy was developed with the goal of *'strengthening the capacity of the health system to improve the attraction, retention, equitable distribution and performance of the health workers'* (MOH, 2008).

The HRH motivation strategy had three major implementation strategies: enhancing salaries and other financial incentives for health workers; giving non-monetary benefits; and development of leadership and management. It emphasised that both financial and non-financial incentives must be considered relevant and useful by the health workers or they will

⁸ The study was conducted across 9 randomly selected districts which were grouped according to the seven regions, as defined by the Uganda 2006 district information handbook. The districts were stratified to ensure that hard to reach areas were also included.

not succeed, and may actually become disincentives (MOH, 2008). In response to the challenge of poor motivation as a result of low salaries, the strategy suggested mainly financial incentives in the form of development of an appropriate salary and remuneration package with periodic reviews. Special allowances were also suggested, e.g. for hardship, lunch, pay-for performance. Additionally, non-monetary benefits were intended to supplement the financial incentives.

The implementation of the salary review has been problematic, however, since it is more of an ad hoc activity rather than based on a clear framework.

Additionally, the strategy suggested giving non-financial/non-monetary benefits to supplement the financial incentives. These non-financial benefits were to include: provision of basic amenities such as electricity, water, transport and rent for houses where needed; strengthening of fair and equitable in-service training and continuing professional development; improvement of support, supervision, and performance assessment and review techniques and development of leadership and management.

The above strategies in the plan are not just for health workers in post-conflict areas but health workers countrywide. Needless to say, a number of them required considerable funds from the government, and support from other stakeholders and donors. The major implementation challenge for the motivation strategy was the limited availability of funds to operationalise the strategies.

National Health Policy II (NHP II 2010/11-2019/20)

The NHP II was developed as a follow-up and improvement to the NHP 1. The main difference between the NHP1 and the NHP II is that the former was set for a period of only one year while the latter was to be operationalised for 11 years.

However, the two plans were linked to policies. For instance, just like the NHPI, the NHP 2 also follows recommendations on prioritising the Uganda National Minimum Health Care Package (UNMHCP) as provided in the National Development Plan (NDP), which is the overall development strategy for the Government of Uganda (MOH, 2009). Other over-arching frameworks considered during the development of the NHP II were the Constitution (1995), the Local Governments Act (1997) and the PRDP (2007).

Development of the NHP II was a participatory process involving stakeholders from the public, private and civil society sectors, while the development partners and donors played a crucial

role in financing the development and implementation of the plan as well as providing ideas through consultation.

The NHP II was very HRH oriented. The document recognised the fact that human resources for health were in a terrible condition at the time. For instance, by November 2008, only 51% of approved positions were filled, especially hard to reach, conflict and post-conflict areas. Reasons for this included health workers' migration to other countries in search of better pay; poor pay, especially in public and PNFP sectors; poor working conditions, especially in public and PNFP sectors; poor leadership and management of human resources; inequitable distribution of health workers; and accommodation problems. These challenges had already been identified in the preceding policies but there seemed to be no major change improvements.

The objectives of the NHP II were grouped into four main areas of focus: improvement of infrastructure for the wellbeing of health workers; improvement of human resource management and development; increasing performance of health workers; and a pledge to provide the health sector with sufficient resources.

Among the many strategies identified in the NHP II, only one focused on improving the wellbeing of HRH in post-conflict and war ravaged areas like Northern Uganda as well as underserved areas. According to this strategy, new accommodation was to be constructed for staff, and new health facilities constructed, while the existing ones were to be renovated.

Health Sector Strategic and Investment Plan III 2010/11-2014/15

The third Health Sector Strategic Investment Plan (HSSIP III) was developed with the intention of operationalising the NHP II. Similar to the previous policies, the HSSP III was also developed in line with the National Development Plan (NDP), prioritising the UNMHCP and also lasting for six years. However, the main difference between the HSSIP III and its predecessor the HSSP II was the former underscored the importance of 'Investment' (hence the inclusion of the letter 'I' in its acronym). The HSSIP III was also developed by the Government of Uganda in consultation with partners from academia, private sector, donors, civil society organisations etc. (MOH, 2011).

The HSSIP III was aimed at *"attaining a good standard of health, thus a productive and healthy life for all Ugandans"* (MOH, 2011, p. 63). The HSSP III discusses the achievements and challenges of the HSSP II. For example, although more health centres were built and others upgraded during HSSP II, one of the major issues was shortage of staff accommodation,

especially in hard-to-reach areas, which may have included conflict and post-conflict districts. Other challenges mentioned included: the limited availability of human resources; the poor skills mix; and the presence of numerous institutions involved in training health workers, leading to confusion and unclear responsibilities, as well as further increasing the vacancies.

In response to the above challenges, the HSSIP III recognised that strengthening the health system is necessary. This would be done through different ways including dealing with the shortage of human resource through recruitment of adequate numbers and retention as well as training of health workers. The HSSIP III further pledged to make HRH stronger by attracting health workers, properly paying and motivating them, and ensuring they work in a professional manner (MOH, 2011).

However, although the HSSIP III gave plans on attracting, recruiting, retaining and incentivising health staff, it did not make suggestions as to how exactly this would be done, aside from better pay and housing, especially in hard-to-reach areas. Health workers in conflict and post-conflict areas were not specifically mentioned.

The impact of the HSSIP III was evaluated in its first year of implementation through the Annual Health Sector Performance Report 2010/11. By the time of the health sector assessment in 2010, the HSSIP III had not yet made recognizable improvements to the situation of the HRH. For instance, the proportion of approved posts filled by health workers remained at 56% and was worse at district health units (MOH, 2011, pp. 42-43). Other HRH challenges remained unchanged. It could be argued that the period of evaluation (in the first year) was still too short to recognise or assess the impact of the HSSIP III. A mid-term review of the HSSIP III was conducted by the MOH in collaboration with WHO. This review indicated that although there had been a gradual improvement in the key indicators for the HSSIP III, these were still below the set targets (MOH & WHO, 2013).

Performance of HSSIP III over the years in relation to set targets (2009- 2013)

Indicator	Baseline (2009/10)	2010/11	2011/12	2012/13	Target 2014/15	Status / comment
Core HSSIP 2010/11 – 2014/15 indicators						
Proportion of approved positions filled by trained health professionals	51%	53%	55%	60.5%	75%	Positive trend but below HSSIP target
Annual reduction in absenteeism rate	Absenteeism rate: 46%	1% increase (Abs. rate = 47%)	No data	No data	20% reduction	No data available

Source: MOH & WHO (2013) mid-term analytical review of the performance of the Health Sector Strategic and Investment Plan III (2010/11-2014/15), p. 107

The main implementation challenge for the HSSIP III was the limited availability of required funds for the intended /planned activities, hence the recommendation in the AHSPR 2010/11 to increase funding (MOH, 2011).

Hard to reach allowance policy, 2010

The hard to reach allowance policy⁹ was introduced in 2010 as a result of the Public Service Reform Programme (PSRP), whose main objective was to enable the government to attract and retain adequate numbers of skilled and capable personnel in the public service, particularly teachers and health workers (MOPS, 2010, p.1). The hardship allowance was guided by the hardship framework which includes many other short-term, mid-term and long term interventions (MOPS, 2010, p. 2).

Areas under this intervention were classified as ‘hard to reach’¹⁰, encompassing elements of hard-to-stay and hard-to-work-in. A total of 24 districts were designated as hard to reach, including all 7 districts of the Acholi sub- region, particularly Pader, Kitgum, Gulu, Amuru, Nwoya and Lamwo. In addition to having low numbers of health workers compared to the rest, three areas are remote, insecure and have poor infrastructure (MOPS, 2010, p.1; AHWO 2009). Other districts are located in the Karamoja region, islands in east and central Uganda and south western Uganda.

⁹ This policy is officially known as Hardship allowance(MOPS 2010: Hardship allowance circular)

¹⁰ Hard-to-reach areas are those where “Local Governments have consistently failed to attract and retain skilled and capable personnel, leading to inadequacies and gaps in the delivery of services” (MOPS 2010, P.1).

According to the circular, the hard to reach framework had set out to implement two interventions: a 30% top-up of basic monthly salary was to be paid to all public officers living and working in the designated hard to reach areas. Additionally, it would include infrastructure improvement in health facilities and schools through the provision of more funds or the construction of teachers' and health workers' houses.

Although the hard to reach allowance policy was developed five years ago, no evaluation has been conducted to evaluate its impact. In 2011, one article reported that the hard to reach allowance was being abused by health workers who were perceived to have 'become lazy, resorted to alcoholism and reinvested the money in other businesses while abandoning their workstations'. However, in the same article, some health workers reported that they were putting the money to good use e.g. by paying school fees for their children (Okudi, 2011)¹¹. A study on health worker incentives conducted by the ReBUILD consortium in 2012 reported that the allowance was perceived to be low and inconsistent and lacking in clarity in its application (Namakula et al., 2014).

5.2 Other nationwide policies and programmes, 1999 - 2014

In addition to these main policies, the government has put in place many more specific policies and programmes over the period. These have been summarised below:

2001/2002: Centralisation of the payroll for health workers. In 2001/2002, the responsibility for paying health workers was brought back to the central government, to ensure that salaries were paid regularly, and also to increase the amount paid (Tashobya et al., 2006).

2003: Consolidation of lunch allowances. As a result of pay roll reforms in 2003, lunch allowances (a total of Ug Shs 66,000 per month) for workers on salary scale U5b¹² and above were consolidated into their salary. Previously, this allowance was separated from the salary. Whereas the lunch allowance has been credited for reducing agitation and creating industrial peace among health workers, its successful implementation was hindered by taxation and lack

¹¹ See annex 2

¹² This is the fifth lowest in rank of salaries according to the salary scale of civil servants as stipulated by the Ministry of Public Service. In order, the salary scales are U1, U2, U3, U5, U5, U6, U7, U8 and support staff. The number against the letter U indicates the level of the civil servant. Those at scale U5 are still at the lowest end. Consolidation of lunch allowance would increase their salaries by Ug shs 66,000.

of reliable data at the local government level for budgeting purposes ¹³ (Kanyesigye & Ssendyona, 2004).

2012: Decision to increase salaries of doctors at HC IVs to Ug Shs 2.5 Million (New Vision, 2012).

2013: Scholarships advertised for various cadres of health staff, with support provided for in-service training and improving skills of health workers through courses ranging from one to three years (New Vision, 2013, pp.43-48; Daily Monitor, 2014, pp.32-33).

March 2013: Pay roll updates, payment of arrears for all civil servants including health workers

Capacity project 2006-2009

The Capacity Project in Uganda is another nationwide project. The project was a five year USAID funded project which was implemented by Intrahealth International. The project, which targeted a number of districts countrywide (including the Acholi sub- region), aimed to; enhance HRH policy & planning; strengthen performance-based workforce planning; and promote practices for improved performance and retention (Omaswa & Okuonzi 2010, p.14; Mitchell group 2010, pp. iii-iv)

Two main evaluations of the Capacity Project were conducted in the same year. An end of project evaluation showed an increase in the number of health positions filled in districts where they offered support, including Apac, Oyam, and Lira, as well as an improvement in service delivery, reflected in the league table performance of the implementing districts (Omaswa & Okuonzi, 2010, p.14) However, evaluators also argued that project *'had no focus on leadership and had been too narrow to address HR issues'* (Omaswa & Okuonzi 2010, p.14)

The end of project evaluation conducted by the Mitchell Group found that in addition to improved service delivery, the Capacity Project also had several other achievements; improved HR information systems, audits and planning; trained managers; and new tools which were developed for planning & management (Mitchell Group, 2010, pp. iii-iv). Nevertheless, by the time the project ended, these achievements had not been attained to maximum.

¹³ According to Kanyesigye and Ssendyona (year), consolidation of Lunch allowance took place in 2000/2001 but the lunch allowance had been earlier introduced in 1996. When the allowance was consolidated, it became taxable. The tax further reduced the salaries.

Challenges to the implementation of the capacity project included; weak government IT infrastructure and support systems; inadequate funding for routine health systems operations; inadequate equipment and supplies in health facilities; and high staff mobility and absenteeism (Mitchell Group, 2010).

5.3 Evolution of policies specific to Northern Uganda

Northern Uganda Malaria, AIDS and Tuberculosis Programme (NUMAT) 2006-2011

NUMAT was a six year USAID/PEPFAR-funded programme with a total budget of USD \$30 million. The programme aimed to *'support expansion of access to and utilization of HIV & AIDS, TB and malaria activities'* in 9 districts of Acholi and Lango sub-regions¹⁴.

Whereas NUMAT had various achievements, in this report the research team only concentrated on the HRH-specific achievements. A detailed write-up of the achievements of the NUMAT project in relation to other non-HRH objectives can be found in the 'NUMAT programme story book' (JSI, 2012). Some HRH-related activities focused directly on HRH development and motivation or while others were on improvement of the work environment with the intention of increasing HRH motivation.

At the end of each of each year, the programme had an annual report indicating progress of the programme. A mid-term evaluation conducted by the Mitchell Group revealed that through its various activities, the NUMAT project was on course with many of its direct HRH-related objectives:

"The project had supported staff recruitment by funding districts to conduct interviews. Other impacts of the projects included; induction of 242 newly trained health workers in Kitgum, Gulu and Pader; and boosting staffing in peripheral health units through supporting 157 medical students from Makerere and Gulu universities to undertake their field attachments there. NUMAT also partnered with the Capacity Project, MOH and other partners to improve staffing, performance improvement and pay roll management" (Mitchell Group, 2009, p.19)

¹⁴ See NUMAT General Brochure for details. Available: from <http://numat.jsi.com/Resources/Docs/NUMATgeneralinformationleaflet.pdf>. In Acholi sub-region, the project was implemented in 4 districts; Gulu, Kitgum, Amuru and Pader in Lango sub-region implementation was in 5 districts, namely Lira, Dokolo, Amolator, Apac and Oyam.

Some of the implementation challenges faced by NUMAT were similar to those of the Capacity Project (2006-2009). For example, they included: high drop-out rates of recruited health workers due to delayed payroll, lack of housing and social amenities, and poor supplies/equipment in most health units; poor payment; attrition as many health workers sought employment in NGOs; and inequitable and inconsistent transfers of health workers to areas where their skills might not be required (Mitchell Group, 2009).

An end of programme evaluation which was conducted also indicated positive results in relation to HRH. The report indicated that as a result of NUMAT, 1500 health staff had been trained, 28 laboratories had been refurbished with trained staff to provide comprehensive laboratory services (Ibid, p.10).

Peace, Recovery and Development Plan (PRDP 1) for Northern Uganda 2007-2010

The PRDP 1 was formulated in 2007 as a comprehensive development framework, as well as strategy to eradicate poverty and bridge the gap between Northern Uganda and other parts of the country (PRDP, 2007). The PRDP 1 is directly linked to the Poverty Eradication Action Plan (PEAP, 2004), which proposes an overarching framework to guide public action to eradicate poverty. For instance, the PRDP 1 elaborates and contributes to the PEAP pillars 1-5 and is a framework for all interventions in Northern Uganda (Government of Uganda, 2007, p.18). Through the PRDP 1, a set of coherent programmes were implemented by stakeholders in the region.

The main actors under the PRDP 1 include: the government (represented by the Office of the Prime Minister and Ministry of Finance), districts, civil society, development partners as well as local communities.

The total cost of the PRDP I was estimated at USD\$606,519,297 spread over investments of three years. Implementation of PRDP 1 was funded through three funding modalities: a PRDP budget grant¹⁵, on- budget special donor funded projects¹⁶ and off budget funding¹⁷.

¹⁵ This is a basis of the government grant on the regular budget allocations of the benefiting districts and central government agencies benefiting from the PRDP

¹⁶ These are projects funded by donors but managed by government. They include Northern Uganda Social Action Fund (NUSAF) funded by world bank and DFID; the Karamoja Livelihoods Programme (KALIP) and Northern Uganda Agriculture Livelihoods Recovery Programme (ALREP) funded by EU

¹⁷ These are funded by donors and development partners and are implemented by donors and development partners(through NGOs and CSOs) without the involvement of the government

Amongst the 14 stated priority programmes of the PRDP, the main direct HRH related focus of the PRDP was on improvement of infrastructure (in terms of building new facilities, rehabilitating and quipping old ones), as well as construction of staff houses (Government of Uganda, 2007, p. viii).

According to the AHSPR 2009/2010, development of health infrastructure was given funds under the PRDP, specifically for building/rehabilitating the health units and houses of health personnel. For example in Amuru district, 8 staff houses were almost complete at the time of the report. Although the number of health workers had increased, it was still inadequate. Therefore, as part of the planned activities for financial year 2010/2011, the attraction and retention of health workers was to receive attention (MOH, 2010a).

However, a mid- term evaluation for the PRDP 1 revealed that although construction of health facilities (as well as schools and water points) under strategic objective 2¹⁸ would help improve some socio-economic indicators related to health and education, it would not reduce income poverty in Northern Uganda (Office of the Prime Minister, 2011).

30% top-up of health workers' salaries in Northern Uganda, 2007

The United Nations, under its humanitarian response initiative for consolidated appeals process (CAP) for Uganda, initiated a pilot intervention to top up of health workers salaries (United Nations, 2006).

Under this initiative, donor agencies agreed to contribute resources into a pool, which would be managed by UNICEF. This initiative involved paying a top-up equivalent to 30 percent of their monthly salaries to both existing and new staff in public and PNFP facilities in northern Uganda for six months in order to motivate them. According to Matsiko (2010), more health workers were attracted and recruited to northern Uganda as a result of this intervention. However, he also argued that the 30% top-up was a *'one-off activity which was not able to retain health staff permanently. In fact, health workers moved away to other regions when allowances stopped coming'* (Matsiko, 2010, p.29). Questions about the sustainability of this intervention were raised by others too (Rowley et al., 2006).

¹⁸ Strategic objective 2 (referred to as SO2) within the PRDP programme document) focuses on 'rebuilding and empowering communities (see PRDP 2007, p.viii).

Peace, Recovery and Development Plan for Northern Uganda II (PRDP II) (2010-present)

The PRDP II built upon the programmatic framework established under the PRDP I, while incorporating the recommendations from the mid-term review conducted in 2011 (Government of Uganda, 2012).

The objectives remained the same but the focus and content of each strategic objective was adjusted at programme level in line with the evolving needs of the north, as identified through the stakeholder consultations at central and regional level. For instance, among others, health, education and water were officially added as programme areas under the strategic objective 2 (Government of Uganda 2012 p. 1-2).

The funding modalities and key institutional frame work for the PRDP II was to remain as that for PRDP I (Government of Uganda 2012, pp. 3- 4). A mid-term evaluation of the PRDP II is yet to be made.

Northern Uganda-Health Integration to Enhance Services (NU-HITES) project 2012 - 2017

The NU-HITES project is a six year, \$50 million project funded by USAID. The project, which is implemented by IntraHealth International as the main subcontractor, aims to make health services in Northern Uganda more widely available and improve their quality through strengthening the health workforce. The project intends to strengthen the health workforce via the training of health workers, improving the information systems for personnel, and training managers on how to best recruit and retain their employees (Intrahealth, 2012). The project is ongoing and so far no known evaluation has been made.

UK post-conflict development programme for Northern Uganda (UK PCDP) 2010 -2015

The UK Post-Conflict Development Programme for Northern Uganda (UK PCDP) is a six-year DFID funded programme worth GBP £100 million, which was set up to support recovery in Northern Uganda. The programme's goal is to *'build a peaceful, vibrant northern Uganda with increased opportunities for the people of the north and reduced poverty for all of Uganda'* (UKPCDP 2013, p. 1).

The UKPCDP is also linked to other overarching plans for recovery and poverty: the PRDP and the Poverty Eradication Action Plan (PEAP) respectively. It is complementary to other planned and ongoing DfID Uganda programmes and is also linked to other development partners' plans in Northern Uganda, particularly through funding.

For instance, DfID, through UKPCDP, contributed GBP £24 million to the World Bank Northern Uganda Social Action Fund (NUSAF2) programme to cover the building of 4,000 houses for

teachers and health workers. Other programmes funded through UKPCDP include: the PRDP; and the resettlement programme which was implemented by the United Nations High Commission for Refugees (UNHCR) and private sector foundations.

Three main implementation challenges were identified: mismanagement of funds; anomalies between logical frameworks and memorandums of understanding; and slowed implementation due to rigorous accountability mechanisms. The mismanagement of funds was reflected in the corruption scandal in the Office of the Prime Minister (OPM) in July 2012. This provided lessons in relation to aid effectiveness and informed major changes in relation to channeling of funds for various activities, particularly the youth development fund. The second challenge identified was the anomaly between the targets set in the original UKPCDP log frame and those agreed between DFID and the World Bank in the NUSAF 2 financing agreement. The third challenge was the unintended consequence of the rigorous accountability mechanisms, which were introduced to guard against corruption but in turn slowed down implementation (UKPCDP, 2013, pp. 3-4).

Despite these challenges, the annual review report for the UKPCDP indicated a number of achievements, including improvement of health workers' living conditions through construction of houses. However, the review also indicated that by December 2012, only 75 houses were built, with a total of 1127 still under construction ¹⁹(UKPCDP 2009; UKPCDP 2013, p. 4). This is still far below the planned number. Additionally, the impact of these houses on the conditions and performance of health workers is yet to be evaluated.

¹⁹ This number may include a double count for houses constructed under PRDP and NUSAF and should therefore be considered with caution.

6. GAPS IN THE DOCUMENTARY EVIDENCE

Based on this review of official documents, some observations on gaps can be made:

- Although most of the broad health sector policies mention something about health worker incentives, the actual incentive package is rarely specified.
- Most documents focus on the effects of the policies on the broader health system. However, they are silent on how these responses improve health worker performance and what the health workers' perceptions are. This gap could be filled by information generated using other tools in the ReBUILD project, such as health worker life histories and key informant interviews.
- Although the research team managed to access some documents on incentives by donors, a few of the documents could not be accessed.

7. CONCLUSIONS

7.1 How has policy evolved during the pre-conflict period?

Since 1999, Uganda has had various policy frameworks and responses to the prevailing HRH challenges. These policy frameworks are categorised into policies, strategic and operational plans and implementation strategies.

There is a clear linkage between the plans and other overarching national frameworks, which include the Constitution of 1995, the Decentralisation Policy, the Decentralisation Act, the Poverty Eradication Action Plan and most of all, the Uganda Minimum Health Care Package and the National Health Policy. This is indicated in the timeline (see p. 38).

The document review also found that there is a linkage between each policy and between policies and plans, which build upon challenges identified in previous phases. The health sector strategic plans (HSSP I, HSSP II and HSSIP III) are evaluated through the Annual Health Sector Performance Reviews, though the timing was varied. The HSSIP III is slightly different from its first two counterparts in that it implies a focus on emphasis of investments for various health indicators including health worker incentives. In spite of this, within the actual document, there are no clear budget totals.

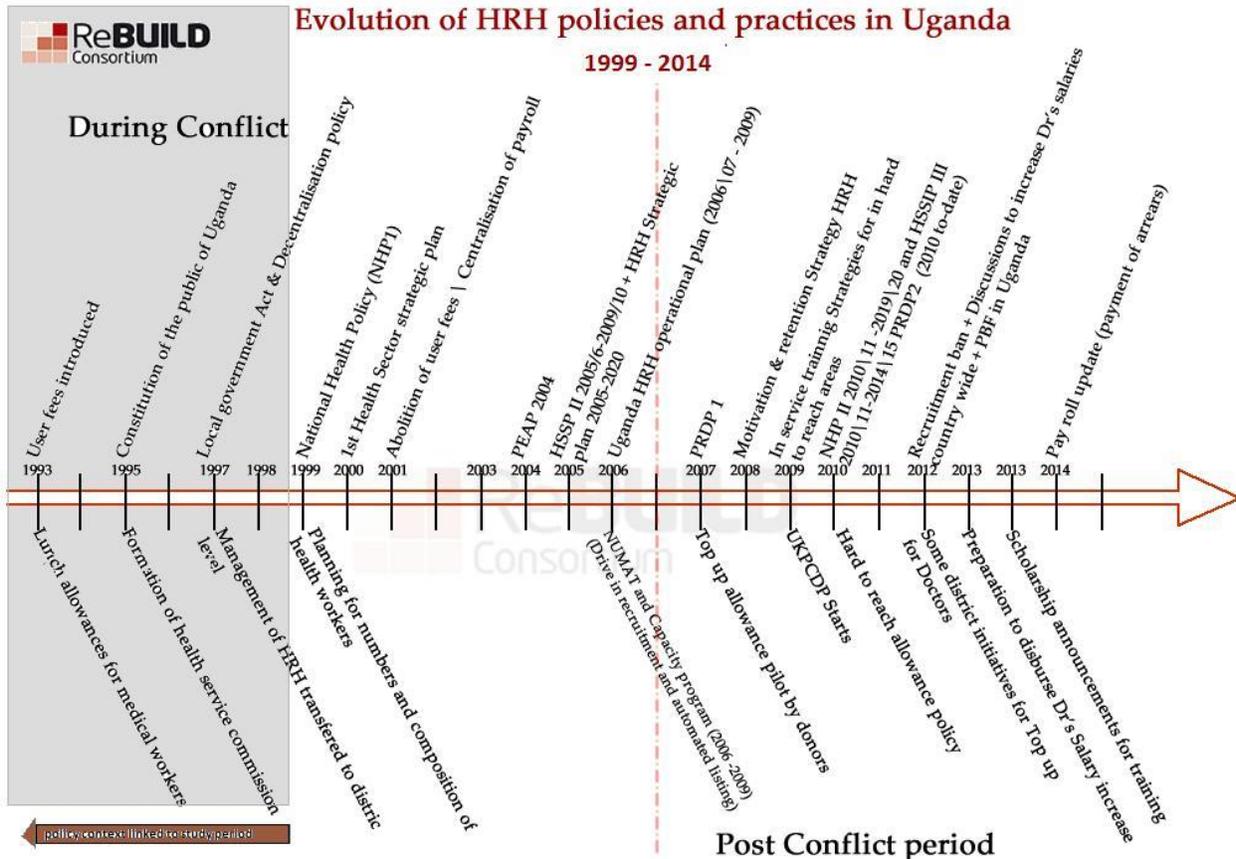
The period 1999- 2005 was mainly characterised by national policies and plans, which did not necessarily focus on human resource incentives but instead the health sector at large. However, these policies had subsections on human resources where a range of human resource related issues were grouped together. Most notably, in cases where HR incentives were

mentioned, the actual incentive package was not clarified. No document considers the post-conflict areas.

7.2 How has policy evolved post-conflict?

From 2006, the interest in post-conflict areas begins to emerge in national policies. This was initiated by the second Health sector Strategic Plan (HSSP II 2006/7-2009/10). Four years later, this was then followed by some HRH-specific interventions of national scope, which include the hard-to-reach allowance policy (2010), the drive to motivate doctors who are in health centre IVs (2012), the scholarships for health workers advertised by the health systems strengthening project (2013), the promotion of health workers by the Health Service Commission (2014), and the current process to update the payroll and salary payment systems for civil servants.

From 2006, there was a drive to introduce policy responses/ interventions with a specific focus on post-conflict Northern Uganda. All of these policy responses are implemented under an overarching framework called the Peace Recovery and Development Plan (PRDP 2007). Unlike the national policies, whose funding often includes government contributions, these interventions are exclusively donor funded, with budgets clearly indicated, and the government as well as districts being brought in as implementers.



7.3 Effectiveness of policies to date

Over time, there have been numerous efforts to identify HRH related challenges. In turn, numerous policies and interventions have been put in place to address these problems. Although there seem to be pockets of improvements (housing, allowances and payroll clean-out), these are still far from the planned targets both at national level and in conflict affected areas. Hence, the (identified) HRH challenges have persisted. Effectiveness of the policies has mainly been hindered by limited funding, limited capacity of some actors, poor coordination, and limited or lack of support and supervision, among other factors.

A few of those policies (the HSSPs, the PRDP and all the donor funded responses in Northern Uganda) have been reviewed mid-term or annually while others seemed not to be evaluated at all. This category includes the motivation strategy, the national health policy and hard to reach allowance policy.

8. LESSONS LEARNT

- Implementation of effective incentive policies and responses requires a sector wide approach but this in turn requires good coordination skills, well built capacity and commitment from all actors involved.
- For incentive policies to work, they need to be holistic rather than piecemeal.
- If the capacity of the districts is strong, then they will participate better in implementation of the incentive policies at the local government level. This is crucial given that all policies are implemented under the decentralisation framework.
- The effort invested in implementing HR incentives responses needs to match that invested in their planning, otherwise resources will be wasted.
- It is not the number of policies that are put in place overtime that is most important; rather it is the impact that these policies have on reduction of HRH challenges in the country that is most important. Proper planning of HRH interventions and policies needs to go hand in hand with making funding available, if anything is to be implemented.
- When evaluating impact of policy responses, it is not enough to count numbers. We also need to consider the things that may be challenging to count but are crucial. For instance, health workers experiences and views on how these responses affect performance and motivation need to be solicited.

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10. ANNEXES

Annex 1: Example of anecdotal evidence on hard to reach allowance



Annex 2: Example of district-led incentives to attract health workers

Kitgum treats missing doctor problem with extra cash

Incentive scheme shows promise. A year after a scheme to attract doctors was started, two new recruits show that money talks, after all.

BY JAMES ERIKU
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KITGUM. How do you get qualified medical doctors, who can work in the comfort of private hospitals in the big cities, to come work in a remote, hard-to-reach district?

Two years ago officials in Kitgum District proposed a Shs500,000 top-up allowance to doctors who agree to work in the district.

For more than 10 years the district had failed to attract doctors to offer specialised medical treatment to patients, even after repeatedly advertising jobs in the media. The situation severely hampered health service delivery in the district still reeling from the effects of war.

It now appears that the incentive scheme is working. Two doctors have since been recruited a year after the special allowance was introduced to attract and retain doctors.

The recruitment of the duo has tripled the number of medical doctors in the district and brought relief to the lone doctor, who also doubled as the district health officer.

Kitgum has 35 health facilities of which 28 are in use. Most of the non-functional health units have either just been completed and are yet to open to the public or have no staff posted to run them -- or any willing

to come work in the district.

The district chairman, Mr Luka Nyeko, said the two new doctors were already making a difference in the area by treating complicated cases that had previously been referred to hospitals outside the district.

Better delivery

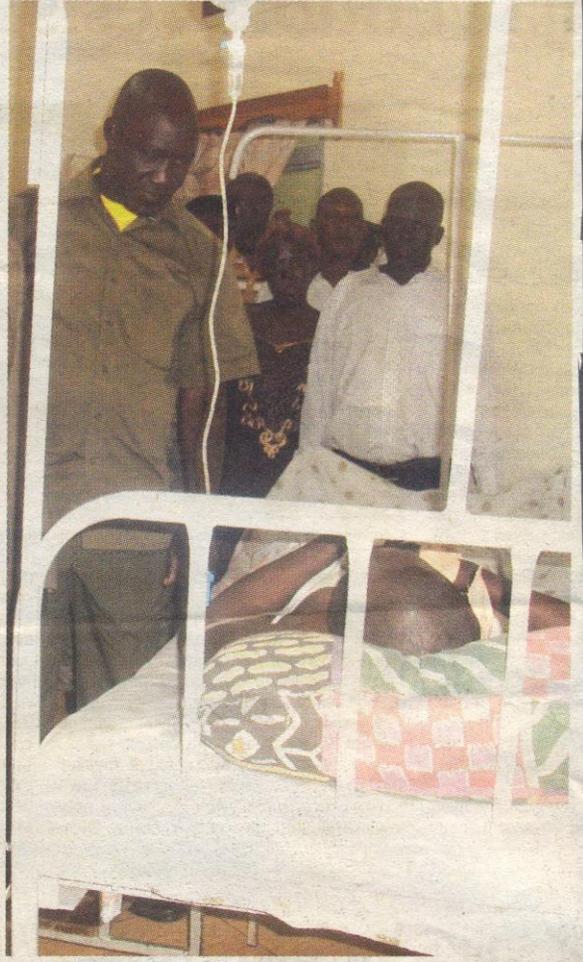
"It's a big relief for the district to get two more doctors to support the only one who has been battling alone all these years after departure of his colleagues. Actually, we have been experiencing a big change in service provision of recent," Mr Nyeko said.

He added that previously patients used to queue for operations but owing to the current absorption, the district hospital will deliver more at a faster time.

The District Health Officer, Dr Alex Olwedo, had earlier said poor pay for doctors had forced some of the medics in the district to leave for neighbouring South Sudan which pays better salaries.

Doctors in public hospitals are paid about Shs700,000, which is about a third of what their counterparts in private health facilities are paid. While several challenges remain, the initiative in Kitgum proves that the disease of missing medical personnel is one that can easily be treated with a little bit more cash.

Monitor, Friday Sept 15, 2011



Disaster Preparedness Minister Musa Eweru visits a patient at Gulu Hospital recently. Most government hospitals do not have the required staff to handle health needs effectively. PHOTO BY CISSY MAKUMBI

THE HEALTH CHALLENGES FOR KITGUM

Disease burden. The health sector in Kitgum operates with less than 70 per cent of its recommended staffing level.

Brain drain. The growing number of health workers leaving Uganda for greener pastures exacerbate the shortage of health care personnel.

More staff. Kitgum still desires more doctors and is looking at generating more revenue to foot retainer allowances for those the district will contract.

National staffing. The current ratio in Uganda is only one doctor per 24,700 patients.