

Progress Report 2

Rapid Assessment of the Human Resource Implications of Scaling Up HIV/AIDS Services in Uganda

Summary of Issues and Recommendations for greater health system

[This short report should be read alongside the previous longer report by MSH team of consultants on HR issues specific to HIV/AIDS services. The two reports are complementary.]

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**Ummuro Adano, MSH Nairobi
Elena Decima, MSH Boston
Mary O'Neil, MSH Boston
William Kiarie, Crystal Hill, Nairobi
Penina Kyoyagala, Kampala**

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Acronyms

ART	Antiretroviral Therapy
ARV	Antiretroviral
DANIDA	Danish International Development Agency
DFID	Department for International Development, UK
EU	European Union
HCD	Human Capacity Development
HR	Human Resource(s)
HRH	Human Resources for Health
JCRC	Joint Clinical Research Centre
MOE	Ministry of Education
MOF	Ministry of Finance
MoH	Ministry of Health
MOPS	Ministry of Public Service
MSH	Management Sciences for Health
PEPFAR	US President's Emergency Plan for AIDS Relief
PNFP	Private not for Profit (FBOs)
TASO	The AIDS Support Organization
UAC	Uganda AIDS Commission
USAID	United States Agency for International Development

Glossary of Key Terms

Human Capacity Development (HCD): A comprehensive and integrated process of creating the will, skills, capabilities, and human resource management systems to enable countries, sectors and organizations to respond effectively to the human resources for health crisis. In the health sector, the goal of HCD is to strengthen the ability to lead, plan, implement, monitor and evaluate expanded HIV/AIDS prevention, treatment and care programs.

Human Resource Management (HRM): The integrated use of systems, policies, and practices to plan for necessary staff and to recruit, motivate, develop, and maintain employees in order for the organization to meet its desired goals.

Human Resources for Health (HRH): The stock of all individuals involved in safeguarding and contributing to the promotion and protection of the health of the populations. This includes skilled and unskilled persons working in formal (public, private, FBOs) and informal health care sectors, including traditional healers, volunteers and community care givers. Non-medical staff providing administrative, management, planning, monitoring and evaluation services are also included.

Workforce planning: A process to establish the quantity, quality, different cadres and location of health workers required to meet the HR requirements of the organization. It also involves a strategy for the recruitment, deployment and retention of those workers.

Stakeholders: The diverse group of organizations and actors that have a responsibility for or vested interest in health sector human capacity in Uganda. In this case, stakeholders are not restricted to the health sector (public, private, PNFP, NGOs) but also include the Ministries of Finance, Public Service and Education as well as community and civil society groups and the donor community.

Context and Background

USAID, in collaboration and with additional support from DFID Uganda requested the Management and Leadership Development Project of Management Sciences for Health to conduct a rapid assessment of the human resource (HR) implications of scaling up HIV/AIDS services, with a focus on ART, in the health sector in Uganda and also provide a summary of how this impacts the wider health system. MSH assembled a multi-disciplinary team of four consultants and a planning and logistics assistant to undertake this intense assignment in August 2004.

Like most other countries in sub-Saharan Africa, Uganda has always suffered from shortages of skilled health workers and managers. But over the years, the situation has become a crisis largely because of the crippling effects of HIV/AIDS. Staff attrition rates are on the rise due to HIV infection, illness and death, as well as out migration of staff. Vacancy rates in public and private-not-for profit organizations are on the rise, with only 58% of even the HSSP 1 staffing norms having been met for public institutions.

Limitations on human capacity development is the most severe constraint, not only to achieving ART targets, but to the achievement of Uganda's long term health objectives. Clearly there already exists in Uganda a considerable body of data and knowledge about the dimensions and determinants of the HR crisis in the health sector. The challenge now is to begin to take concrete steps to address short term priority issues, and to begin the process of tackling long term systemic HR constraints in order to have a sustainable supply of adequately trained health staff.

This short report provides a summary of the impact of scaling up HIV/AIDS and ART on the broader health services in Uganda and outlines potential solutions to address these challenges.

Key findings:

1. Broader health services are being negatively impacted in the short term as doctors, nurses, lab technician and dispensers already in the system are being assigned on either full or part time basis to HIV/AIDS clinics. Health services that seem to be disproportionately impacted include:

- Malaria prevention and control
- Maternal and Child Health
- Health Promotion
- Nutrition
- Non-communicable diseases.

The challenge for Uganda is to respond to HIV/AIDS without losing ground in services that target the health of children and women, particularly child and reproductive health/family planning services.

For example, the table below demonstrates cadre-specific staffing gaps in reproductive health services at a high volume referral hospital:

		Actual	Norm	Variance
Snr. Consultant (Obs. & Gyn.)	U1	4	10	-6
Snr. Consultant (Gynecology)	U1		1	-1
Consultant (Obs. & Gynae)	U1	4	10	-6
MOSG(Obs. & Gyn.)	U3	16	10	6
Sen. Nurs. Off. Gr.II (Midwife)	U5b-a	5	2	3
Nursing Off. Gr.I (Midwife)	U5c	20	36	-16
Nursing Off. Gr.II (Midwife)	U6	64	78	-14
Enrolled Midwife Gr. I	U6		37	-37
Enrolled Midwife Gr. II	U7	228	218	10

Source: MOH/DANIDA Uganda

Life time risk of maternal death for a woman in Uganda is 1 in 11; this coupled with a fertility rate of 6.9 average per woman (highest after Somalia) and infant mortality of 88/1000 calls for urgent measures to staff and improve safe motherhood and child health programs. The solution will involve not losing sight of the “big picture” and placing more emphasis on comprehensive workforce planning, speedy approval of new staffing norms, streamlining the recruitment process and unlocking the necessary funds to fill new and old vacancies.

2. In Uganda, plans for the provision of an expanded ART Program are in the final stages, but there are deficiencies in the quality and quantity of health staff currently on the ground to implement these plans. This focus on the rapid scale-up of ART, while of critical importance, obscures the need to also focus on strengthening the broader HRM systems. The solution lies in the ability of the government of Uganda, appropriate ministries and donors to rapidly foster political and technical dialogues in order to invest in wider HRM reform instead of focusing solely on the HR requirements for scaling up HIV/AIDS services.
3. Pre-service education and in-service training programs are stretched beyond capacity and seem to be operating independently from other parts of the health sector and from each other. This weakens the country’s ability to reach its health objectives. The management of training is also weak, resulting in some cases in outdated curricula, poor training approaches, and ultimately in providers without the needed skills and competencies. Further, the ad-hoc approach to ART training results in people being away from their posts in large numbers. The solution lies in building capacity in pre-service and in-service training institutions with a focus on multi-tasked cadres (comprehensive nurses, lab technologists, nurse-counselors, dispensers) that are less likely to migrate out of the country.
4. Rapid national scale-up of ART using an emergency, “do as you learn” philosophy

prevents a needed focus on systematic strengthening of health systems that will lead to the effective coverage of essential health interventions and the realization of health system goals. The solution lies in a comprehensive strategy that will make HCD the center piece of health system strengthening.

- 5 Historical imbalances (for example urban – rural, cadres and specialty imbalance, institutional and services imbalance) in the distribution of health workers and health services remain an important area of concern. At the national level, there is currently some effort to collect and analyze HR data and workforce statistics. But the solution is to use these data to improve knowledge about, and management of, staffing norms; and to develop and implement policies, actions and incentive schemes to address health workforce imbalances.

Recognizing the HR Crisis and Developing Agenda for Action

This section of the report provides a framework to look at and analyze human capacity development as an issue that requires a comprehensive, multi-sector response. Fragmented and piecemeal action will not work as the MOH, the MOE, the MoPS and the MOF all play a role in human capacity development in Uganda. This section offers practical suggestions and actionable recommendations that policymakers, program managers, donors and influential stakeholder groups can take to address this crisis in a more comprehensive and sustainable way.

HCD Policy and HR Champions

Because of the urgent need to scale-up ART, HCD issues are now slowly receiving the attention of different offices in the Government and the donor community. At the same time there are many other issues competing for attention and resources at national and district levels. As such, maintaining the current prominence of HCD will require strong advocacy by all stakeholders. It is important that the stakeholders advocating for resources for scaling up ART also work to put systems in place to sustain the broader health service. Prominent among these stakeholders are the Uganda AIDS Commission (UAC) and the Health Policy Advisory Committee (HPAC) of the Ministry of Health.

Because the UAC has a mandate to mobilize resources for an expanded national response to HIV/AIDS, it is suggested in Part 1 of this report that UAC be in the vanguard of developing an overarching mechanism, or HCD Working Group to develop a fast track arrangement or ‘HCD Rescue Package’ in order to put staff in place to support the scale-up of ART. This HCD Working Group would include decision makers from the Ministries of Health, Education, Public Service, Finance as well as the Health Service Commission and the PNFP.

A ‘rescue package’, by definition, will need to short-cut the current fragmented and time consuming employment process. But, gaining agreement to convene a multi-sector HCD

Working Group provides an important opportunity to begin the process of reforming the employment process and developing a sustainable HCD strategy that will benefit all health services.

Recommendations:

1. Uganda AIDS Commission to provide an overarching leadership and develop a multi sector HCD Working Group to develop a ‘rescue package’ to fully staff the ART sites in Uganda. Decision makers from the Ministries of Health, Public Service, Education, Finance Health Service Commission, PNFP and donors will need to be established, trained and tasked primarily with the responsibility for developing a plan, or rescue package to staff ART sites.

It is recommended that this HCD Working Group also begin preparing a long term human capacity development strategy for health and mobilizing resources for its implementation. UAC shall lead and coordinate the work plan of this inter-agency group, and will require donor funded technical assistance to help them manage this new coordination challenge as well as technical assistance in effective HRM systems.

The UAC led inter-agency HR group will need to focus on the following priority actions, amongst others:

- **HCD policy improvements and implementation:** Begin to aggressively advocate for a streamlined HR planning, recruitment and management systems for the health sector;
- **Training and supply of health workers: Advocate for increasing the capacity of pre-service and in-service training institutions and reform the in-service training process.**
- **Compensation, benefits and allowances: Take action to advocate for a living wage for health staff and to ensure compensation, benefits and allowances are equitably distributed. Develop an ‘incentive package’ to introduce effective changes in deployment of essential cadres to rural areas.**
- **Gender issues:** Develop workplace policies that promote gender equity;
- **External migration** – Collect evidence on external migration and the flow and destination of migrant Ugandan health workers. Develop workplace and benefits policies that encourage staff retention and effective re-entry of staff who return to Uganda.
- **HIV and AIDS and the health workforce:** document the numbers of health workers infected; develop work place prevention programs to

protect and ensure the safety of the uninfected and develop practical strategies for treating those infected.

2. There is a severe shortage of qualified HRM specialists working in the public health sector in many developing countries, including Uganda. Headed by an Assistant Commissioner, the HR Department of the Ministry of Health contributes in many areas to HCD, but it is limited in its authority under the current employment and education structure. Consideration should be given to how this central office can be better utilized to address the staff shortages and support the District Health Management Teams to train and manage the performance of health staff. In addition to internal realignment, the HR Department could benefit from targeted technical assistance in HCD management and leadership.
3. One significant challenge is to maintain staff who provide other important services such as child survival, family planning/reproductive health services when there is such pressure to focus on HIV/AIDS services. Possible interventions include improving cooperation between public and private sector providers, re-aligning duties among available cadres, and re-evaluating the capacity of community groups and primary providers to perform duties previously reserved for higher-level providers.
4. A critical component of sustained improvements in HCD planning and management is creating an effective HR data system. Donors will need to assist public, PNFP and other providers to promote information use in HR policy design and decision-making. This will involve the following activities: encouraging communication between data users and data producers to determine what information is needed, how it should be presented, and in what timeframe; offering “hands-on” courses to develop skills for workforce planning and human resources management.

Human Resource Management (HRM)

Rather than having strong policies and systems to attract and retain qualified, high performing workers in areas where they are most needed, most countries in sub-Saharan Africa including Uganda are burdened with and suffer from systems that actually do the opposite.

The Ministry of Health does not consider Human Resource Management a professional specialization area. Although decentralized, there is no clear or unified responsibility for managing the health workforce at all levels including training, deploying and monitoring the performance of health workers. The supervisory system is weak, and although an annual staff appraisal system exists, there are few rewards for or recognition of good performance. In fact, there are other disincentives for performance, such as seniority in ranking or longevity over skills or performance as the factor in promotions. Current practices in hiring, confirmation of employment and disciplinary action also result in

disincentives for both staff and management. The emphasis on outdated personnel rules (Standing Orders) that no longer meet the needs of the health system needs to be changed.

HRM is one of primary building blocks of a comprehensive HCD strategy. Effective HRM is more than the administration of personnel rules and procedures. The goal of an effective HRM is to develop systems, capacity and authority to create conditions that foster adequate staffing, equity, retention, team work, and performance. Some of the factors that contribute to this goal include:

- HRM capacity,
- human resource planning and staff allocation,
- staff retention strategies,
- training,
- human resource information systems.

In any organization, the work of individuals carrying out the above functions will not result in a productive workforce if these functions are not integrated into an effective HRM **system** that includes an appropriate delineation and “de-centralization” of authority and clear lines of supervisory responsibility. At the present time, the HR functions in the Ministry of Health are not only “invisible”, fragmented and dangerously weak; but also not integrated into a comprehensive system. Basic HR functions are spread over a few agencies, departments and post holders. Not only does this fragmentation result in inefficiency and ineffectiveness, but most of staff interviewed expressed frustration over breakdown in communication in facilities and between the districts and the centre; and endless delays in meeting basic requests and functions needed to support the workforce.

None of the sites visited by the assessment team had a human resource manager who could take on the critical tasks of HR planning, staff deployment, retention, motivation and training. These issues were either not being addressed or were being done piecemeal by the Medical Superintendent, Hospital Secretary, Matron, or other clinical staff as part of their overall duties. Most of these health professionals lack any formal training or skills in HR planning or management.

Simple but effective examples of good HRM system such as getting new staff on the payroll, salaries or retirement benefits paid on time and rapid response to complaints can all work to prevent staff from becoming frustrated. Similarly, effective responses to common problems such as drug-stock outs and equipment shortages are important measures to provide a supportive work climate that will maximize performance and productivity.

Recommendations:

1. HRM is most effective in any organization when its authority is located at the senior management level. It is therefore suggested that the HR Department is led by staff at the level of Commissioner and its authority clearly delineated. The

Department will then need to be strengthened to improve the planning, coordination and evaluation of core activities under its authority such as supervision and performance appraisals, management of in-service training, pre-service-in-service coordination, leadership development and improvements in work climate.

2. Conduct a review of the staff performance evaluation process, so that employees are appraised on a continuous basis and feedback provided in a timely fashion. Facility-based supervisors should also be trained on the best way to carry out an effective appraisal.
3. Devolve and streamline the recruitment process to the facilities in collaboration with both Health and District Service Commissions. This will also involve empowerment of hospital administrators to handle HR functions and act as anchors for an effective facility-based HRM system.
4. HRM should be at the core of health sector reform and all efforts to strengthen health systems. This should also be made a requirement for all donor funded programs/projects.
5. Develop and implement formal staff retention strategies.
6. Collaborate with the ongoing EU project to harmonize pre-service, in-service and continuing education, allowing health workers to be lifelong learners and stay up-to-date in their practice areas.

Leadership development

As noted, public health facilities in Uganda are facing difficult and daunting challenges in staff shortages, high workloads, low morale and burn-out on the job, chronic shortages of drugs and supplies as well as shrinking budgets. Implementing new health services such as ART programs effectively poses a tremendous challenge for facilities that have been chronically under-resourced. The reality is that scaled-up ART programs will put pressure on all existing systems and cadres of a health facility.

In the face of these challenges, effective leadership is critical. Effective leadership is defined as “enabling work groups to face challenges and achieve results”. In other words, effective leaders are able to achieve significant results despite complex and challenging work environments such as the public sector in Uganda. Effective leaders are also seen as valuing integrity, relationships, risk taking and learning. They routinely practice the four leadership functions of **scanning** the environment for challenges and opportunities, **focusing** the organization on its most critical challenges, **mobilizing** and uniting key stakeholders around common organizational goals and **inspiring** all staff to perform to the best of their ability, innovate and create effective solutions to work place challenges.

Although there was evidence of good teamwork and positive cooperation amongst facility based teams, examples of poor management and leadership practices were also observed in nearly all the facilities that were visited. Now more than ever before, good management, with effective leadership, is critical for health organizations. Carefully designed leadership development programs that are based on local realities and cultural constructs can strengthen local managers' abilities to achieve results in these difficult situations.

Recommendation:

1. Design and implement a leadership development program ("Leading for Results") tied to improvements in service results for all referral and district facility health management teams, starting with the facilities that will be providing comprehensive HIV/AIDS services including ART. The same program should be offered for senior management at the central level in order to ensure congruence of values and daily actions and to strengthen leadership and teamwork at critical levels of the health system.

Establishing Partnerships

In Uganda, staff shortages result in nurses assuming the roles of counselor and social worker, especially in staffing HIV/AIDS programs. This added burden contributes to staff overload and takes away from the provision of broader health services. It is unrealistic to expect that the formal health sector can assume all of the responsibility for care and treatment and especially adherence when much of this activity takes place in the community.

As it is, the current HCD crisis is larger than the Ministry of Health or even the public health sector. Sustainable solutions to the HCD crisis will not be found in any one sector. Indeed no single player can face this challenge alone and achieve significant results, hence the importance of establishing and sustaining partnerships, especially with the community. Effective community partnerships will translate into additional and much needed 'human capacity.'

There is also an urgent need to foster a collaborative effort across government and the private sector (including PNFPs and NGOs) to increase the number of health workers and services, especially in remote, hard-to-reach areas that remain under-served.

An important strategy would be to ensure that the public, private sectors (including PNFPs) and community groups collaborate to realize the significant potential that exists for improving access and use of health services by aligning HR and other resources. The PNFPs and NGOs such as Mild May, TASO and JCRC have several innovative training and service delivery models which can be scaled up with modest financial and technical support.

Recommendations:

1. Conduct a “mapping” of private sector, PNFP and NGO HR resources, systems and practices as a first step in fostering coordination and collaboration between these players and the public health sector.
2. Collaborate with the Public-private Partnership Project to share the mapped information and discuss opportunities for collaboration across the areas of HCD policy reform, joint planning, education and training (pre-service, in-service and continuing education), workforce management, supervision and support systems.
3. Identify and support the scale up of promising staff retention and performance support systems from PNFP and NGO sectors.
4. Strengthen PNFP, NGO and private sector efforts to ensure that services are properly coordinated with the public sector to maximize coverage and use.
5. Develop formal partnership arrangements with community groups and volunteers, including home-based care givers so that this excess capacity can be used more effectively to off-load some of the burden currently borne by facility based providers. These community based actors are central in reaching the high-needs areas or providing the highest-priority services, but some creative mechanisms for utilizing them would need to be identified and implemented as a matter of urgency.

Conclusion

Effective human capacity development is a complex issue, but not an unsolvable one even in resource-constrained settings. This report has attempted to lay out recommendations under the four broad components of the HCD framework:

- HR Policy
- Human Resource Management (including Training)
- Leadership, and
- Partnerships

It is recognized that all of these recommendations cannot be undertaken at once, but it is important to begin a process that takes all of these components into account. In the long run, it is the only way to start down the path to ensuring a stable and high performing workforce for the health sector in Uganda.

Major Recommendations According to the Human Capacity Development Framework

<p>1. POLICY – LEGAL – FINANCIAL REQUIREMENTS</p> <ul style="list-style-type: none"> - establish UAC led inter-agency HCD Working Group. - develop a “rescue package” to fully staff the ART sites. - prepare a long term HCD strategy to accomplish greater health sector goals and mobilize resources for its implementation. - realign and strengthen HR Dept at central office to address the staff shortages and support the District Health Management Teams to train and manage the performance of health staff. - Maintain staff and upgrade skills of those who provide child and maternal health service services. - Unlocking necessary funds and simplifying recruitment process to implement staffing norms. 	<p>2. HUMAN RESOURCE MANAGEMENT</p> <ul style="list-style-type: none"> - appoint Commissioner to head HRM department and delineate authority and functions. - review staff performance evaluation process and train staff and supervisors in its use. - place HRM at the core of health sector reform. - develop and implement staff retention strategies - strengthen pre-service-in-service coordination and support life-long learning.
<p>3. LEADERSHIP</p> <ul style="list-style-type: none"> - Design and implement a leadership development program (“Leading for Results”) tied to improvements in service results for all referral and district facility health management teams. - Offer similar leadership and team building program for central senior level managers. 	<p>4. PARTNERSHIPS</p> <ul style="list-style-type: none"> - Conduct a “mapping” of private sector, PNFP and NGO HR resources, systems and practices to foster coordination and collaboration between these players and the public health sector. - Share the mapped information and discuss opportunities for collaboration across the areas of HCD policy reform, joint planning, education and training (pre-service, in-service and continuing education), workforce management, supervision and support systems. - Develop formal partnership arrangements with community groups and volunteers, including home-based care givers so that this excess capacity can be used more effectively to off-load some of the burden currently borne by facility based providers.