WHO/HSS/healthsystems/2007.4
WORKING PAPER No. 11

STRENGTHENING MANAGEMENT IN LOW-INCOME COUNTRIES: LESSONS FROM UGANDA

World Health Organization

Making health systems work

Available in this series:

Working paper 1	Strengthening Management in Low Income Countries *(Also available in French)*
Working paper 2	Working with the Non-state Sector to Achieve Public Health Goals *(Also available in French)*
Working paper 3	Improving Health System Financing in Low-Income Countries (Forthcoming)
Working paper 4	Opportunities for Global Health Initiatives in the Health Systems Action Agenda
Working paper 5	Improving health services and strengthening health systems: Adopting and implementing innovative strategies - An exploratory review in twelve countries
Working paper 6	Economics and financial management: What do district managers need to know? (French version forthcoming)
Working paper 7	Renforcement de la Gestion sanitaire su Togo: Quelles leçons en tirer?
Working paper 8	Managing the Health Millennium Development Goals - The challenge of management strengthening: Lessons from three countries
Working paper 9	Aid effectiveness and health
Working paper 10	Towards Better Leadership and Management in Health: Strengthening Leadership and Management in Low-Income Countries

The reference to the "WHO/HSS/healthsystems" series replaces the original "WHO/EIP/healthsystems" series.

Printed by the WHO Document Production Services, Geneva, Switzerland

MAKING HEALTH SYSTEMS WORK: WORKING PAPER No. 11
WHO/HSS/healthsystems/2007.4

STRENGTHENING MANAGEMENT IN LOW-INCOME COUNTRIES: LESSONS FROM UGANDA

A CASE STUDY ON MANAGEMENT OF HEALTH SERVICES DELIVERY

Dominique Egger
Elizabeth Ollier
Prosper Tumusiime
Juliet Bataringaya

Department for Health Policy, Development and Services
Health Systems and Services
WHO, Geneva

ABOUT THE 'MAKING HEALTH SYSTEMS WORK' WORKING PAPER SERIES

The 'Making Health System Work' working paper series is designed to make current thinking and actual experience on different aspects of health systems available in a simple and concise format for busy decision makers. The papers are available in hard copy and on the WHO health systems website.

Working paper 11:
Strengthening Management in Low-Income Countries: Lessons from Uganda
A Case Study on Management of Health Services Delivery

This case study is part of three country studies conducted by the Health Policy, Development and Services Department of WHO/HQ. The purpose was to gather evidence on the situation with service delivery management in low-income countries. This paper reviews and summarizes service delivery management at district level in Uganda using a core technical framework developed by WHO for analysis and evaluation of management strengthening actions.

The paper was written by Dominique Egger (WHO/HQ), Elizabeth Ollier (HLSP UK), Prosper Tumusiime (WHO/AFRO) and Juliet Bataringaya - Wavamunno (WHO, Uganda). It incorporated feedback from the Uganda Health Sector Technical Review Meeting in April 2006 and from the WHO Country Office. It was reviewed and edited by Delanyo Dovlo (WHO/HQ) and Catriona Waddington (HLSP UK).

Further comments and information
Those wishing to give comments, or interested in finding out more about activities outlined in this paper, should contact Dominique Egger (eggerd@who.int) or Delanyo Dovlo (dovlod@who.int).

For more information on the work of WHO on health systems, please go to:
www.who.int/healthsystems

TABLE OF CONTENTS

ABBREVIATIONS

AISPO	Assiciazone Italiana per la Solidarieta tra I popoli
AMREF	African Medical and Research Foundation
AVSI	Associazione Volontari Per Il Servizio Internazionale (International Service Volunteers Association)
CAO	Chief Administrative Officer
CARE	A private international relief and development organization
CIDA	Canadian International Development Agency
CORAID	Catholic Organization for Relief and Development
CUAMM	Centro Universitario Aspiranti Medici Missionari (University College for Aspirant Doctors and Missionaries)
DANIDA	Danish International Development Agency
DDHS	Director of District Health Services
DFID	Department for International Development (UK)
DHMT	District Health Management Teams
DHS	District Health Systems
DISH	Delivery of Improved Services for Health
DSC	District Services Commission
EDF	European Development Fund
EU	European Union
FDS	Fiscal Decentralization Strategy
GFATM	Global Fund against AIDS, TB and Malaria
HC II to IV	Health Centre II or IV
HIV/AIDS	Human Immune Deficiency Virus/Acquired Immuno-Deficiency Syndrome
HMIS	Health Management Information System
HR	Human resources
HSD	Health sub-districts
HSSP	Health Sector Strategic Plan
ICMI	International Christian Medical Institute
IPH	Institute of Public Health
JHU	Johns Hopkins University
LSHTM	London School of Hygiene and Tropical Medicine
MO	Medical Officer (at HSD level)
MoF	Ministry of Finance
MOFPED	Ministry of Finance Planning and Economic Development
MoH	Ministry of Health
MoLG	Ministry of Local Government
MPH	Master of Public Health (Degree)
MTEF	Medium Term Expenditure Framework
MUST	Mbarara University of Science and Technology
NGOs	Nongovernmental Organizations
NMS	National Medical Stores (NMS)
PHC	Primary health care
PNFP	Private not for profit
QAP	Quality Assurance Project
SCF-UK	Save the Children UK
SWAp	Sector-wide Approaches
TB	Tuberculosis
UHSSP	Uganda Health Sector Support Program
UMI	Uganda Management Institute
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNISA	University of South Africa
UPMB	Uganda Protestant Medical Bureau
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

Study overview

Weaknesses in managerial capacity in health, especially at local levels, have been widely cited as a constraint to scaling up health services and achieving the Millennium Development Goals (MDGs). In Uganda, decentralization of district health services management to local governments has re-emphasized a need for strengthened local management capacity because of a rapid increase in the number of districts and the creation of health sub-districts (HSDs).

In an initiative to collate experiences on management development in low resource settings, WHO carried out case studies in South Africa, Uganda and Togo to explore management development approaches in use and how these impacted on managerial and service delivery performance. Specific objectives of Uganda's case study were to review:

1. the scope, scale, and duration of health sector management development approaches implemented during the last five to seven years;
2. changes in management capacity at district level in the public sector;
3. changes in management performance at district level in the public sector;
4. other contextual changes that may have independently affected management performance;
5. trends in health service delivery outputs and determine whether these are linked to effects of management development.

Methodology

The study involved a desk review of country documentation (Annex 1) followed by a country visit for an in-depth exploration using key informant interviews (Annex 4) and direct observations of management practices at national and sub-national levels. Information was sought in relation to:

- changes in the numbers, recruitment and retention of health managers;
- changes in developing their management competences;
- changes in critical management support systems;
- changes in context and work environment of managers.

Five district health management teams selected for their prior involvement in management strengthening activities were visited for in-depth observation and discussions (Busia, Jinja, Masindi, Mpigi, and Mukono districts).

Data and documentation on health management programs and service delivery were generally lacking, and information obtained was mainly qualitative, based on respondents' perceptions and experiences. However, several clear themes emerged helping the case study to provide a “snapshot” of the service delivery management situation in Uganda.

National context

Uganda is a low-income country which has had positive economic growth since the late 1980s though some 38% of the population still lives below the poverty line. Malaria is the largest single cause of ill health and AIDS is the leading cause of death in adults though the initial generalized heterosexual HIV epidemic now shows significant decline.

The Local Government Act of 1997 mandated the decentralization of many sectoral functions to local authority in municipalities and districts. In the health sector, the central ministry of health (MoH) only retains responsibility mainly for policy formulation and national standards setting. The new "District Council Administrations" are headed by a "Chief Administrative Officer" to whom all sectors report to.

A new national health policy adopted in 1999 was followed in 2000 with a sector strategic plan which introduced a minimum health care package and redefined the care delivery system. However, health sector problems including several management-related ones such as centralized decision making, low morale, and motivation remain identified as constraints.

Managers at district level

Two types of managers are found at the district level. A "district director of health services" (DDHS) leading a district health management team (DHMT) and a "medical officer" (MO) who heads a "health sub-district" and is responsible for managing actual service delivery. MOs are usually recently qualified doctors with little or no management training while DDHS are mostly physicians with an MPH. There is good retention of DDHS but there is significant attrition of MOs for reasons that include a lack of a career pathway and emigration.

Main findings

Developing managers
Significant effort has gone into developing managers using long and short courses and placing "technical advisers" with DHMTs. A key feature in Uganda, however, is the multiplicity of training programs compounded by the lack of a national management competency framework. Moreover, management institutions have identified the absence of a specific MoH focal point for management policy as a problem.

Critical management support systems
Uganda has developed fairly sophisticated planning, budgeting, information and financial management systems that function quite well though at times they seem overly complex. For example, the Health Management Information System (HMIS) requires several forms to be filled in daily by busy clinic and HSD staff and often local priorities tend to be neglected as districts try to conform to strict national planning formats. Monitoring and supervisory systems demonstrate good practice especially in being well structured and having a supportive format. However, human resources management systems still seemed weak especially in the areas of performance management and staff discipline.

Context and environment
A good framework of policies and regulations are in place starting with Uganda's 1995 constitution which assures basic health services for the population and forms the basis of the national health sector policy and plan. In terms of management accountability, there seems to be a genuine understanding of the need for public accountability with information on district performance available in the national press, for example.

Managers' motivation is linked to the perceived status of the position and its accompanying career enhancement opportunities. However, the lack of career opportunities remains to be a concern for managers despite their having a relatively good salary compared to other public servants.

Changes in management practices
Annual performance indicators need to be improved to help establish performance trends and monitor management performance. However, persuasive circumstantial evidence suggests that management had improved in a number of areas:

- **Team-work** in districts was reported to be much more effective with improved coordination with local government units.
- A **strong planning process** now exists but needs better linkage between plans and budgets, and activities and actual expenditures.
- A good **supportive supervision** system exists which advises on issues important to managers and is not just a performance check.
- **Medicines management** has improved significantly with fewer "stock outs".
- Health services delivery is more **accountable to communities** and coverage performance information is widely circulated.

Analysis of the districts' performance illustrated a number of factors:

- Newly created districts perform less satisfactorily than older districts;
- Distance between a district and an urban centre correlated with reduced performance (the islands generally performing less sufficiently well);
- The war and civil unrest in parts of northern Uganda seemed to correlate with generally poorer performance though with some notable exceptions.

Conclusions

Uganda has made tremendous efforts at improving service delivery coverage and quality through improved management and filling of most critical management positions (e.g. DDHS posts). Opportunities exist for managers to develop appropriate skills but courses need to be better designed to produce the essential competencies needed. A health sector competency framework for managers will provide common performance objectives and standards in the sector.

Uganda does very well with its management support systems and has a good supervisory system. However, its detailed prescriptive planning formats could result in local priorities and decision making getting lost in the process.

The allegiance that district managers hold to both the local government and the national health system appears to be evolving and the role conflicts and dichotomy are likely to improve with time.

1 STUDY OVERVIEW

Weaknesses in managerial capacity in health, especially at local levels, have been widely cited as a constraint to scaling up health services and achieving the Millennium Development Goals (MDGs). In Uganda, the decentralization of district health services management to local governments has re-emphasized the need to strengthen management. Major challenges have also been tackled in developing local capacity partly because of a rapid increase in the number of districts (almost doubled since 1997) and the creation of new health sub-districts (HSDs) in 2000. Workforce planning done in preparation for the HSD concept did not take the supply and demand for managers into consideration.

WHO, as part of a wider program of work, has started an initiative to improve the knowledge base on management development in low resource settings. As a first step, rapid qualitative assessments were conducted using multi-country case studies from South Africa, Uganda and Togo. These case studies explored the range of management development approaches in use, and assessed if these had resulted in improved managerial and service performance. The aim was to get an overview of critical management problems in service delivery and the methods used to address them.

Objectives

The specific objectives of the Uganda case study were to review:

1. The scope, scale, and duration of the main management development approaches implemented during the last five to seven years;
2. Changes in management capacity at district level within the public sector;
3. Changes in management performance at district level in the public sector;
4. Other contextual changes that may have independently affected management performance;
5. Trends in health service delivery outputs and determine whether these are linked to effects of management development.

Methodology

The first step involved a desk review of available country documents and data. This was followed by a country visit for an in-depth exploration of various approaches based on key informant interviews and direct observations of management practices at national and sub-national levels.

This review of service delivery management used a core technical framework that was being developed by WHO as the basis for analysis and evaluation of management strengthening efforts. The framework proposes that for good leadership and management, there has to be a balance between four dimensions described as follows:

- Having adequate **number** of managers deployed to defined posts where needed;
- Managers with **appropriate competences** (knowledge, skills, attitudes and behaviors) and the means of acquiring these;
- Critical management **support systems** that function well (to manage finances, staff, information, supplies, etc.);
- An enabling **working environment** (organizational context, rules, supervision, incentives and motivators, relationships with other actors).

The study collected information (when available) on management strengthening in relation to the areas mentioned above and also evaluated trends (where possible) in changes related to recruitment and retention of managers, management competence development, critical support systems and work context, and incentives of managers. It examined various management programs that may have contributed to improved service results and possible constraints that may have produced adverse effects. In Uganda, in-depth interviews were held with key informants from the ministry of local government, ministry of health, the local

government finance commission, various development partners (including the WHO Country Office) and institutions providing management and public health training. Five district health management teams, selected for their prior involvement in management strengthening activities, were visited (see Annex 2 for a summary of visits made to Busia, Jinja, Masindi, Mpigi, and Mukono districts).

Limitations and constraints

The study focused on public sector health services at district level, though it did examine some interactions between the public and private sectors.

Time was a major constraint as the entire case study was carried out in less than two weeks. Five dispersed districts and their sub-districts were visited as well as several national departments and stakeholders.

It was difficult to get documentation on evaluations of past management programs and to track data over time in order to analyse trends. Inevitably, much of the information obtained was qualitative and, to some extent, were subjective perceptions and experiences. However, several clear themes had emerged that suggested general applicability of issues raised by respondents. Therefore, the case study does not claim to provide hard evidential data but uses the sample districts selected to provide a "snapshot" of the situation in Uganda.

2 BRIEF COUNTRY CONTEXT AND BACKGROUND

Uganda is a low-income country which has had positive economic growth from the late 1980s through the present. However, the proportion of the population living below the poverty line, which had been declining (52% in 1992 to 1993 to 35% in 2000), has risen slightly to 38% in 2003.[1] Poverty, though a largely rural phenomenon (96% of the poor lived in rural areas in 2000),[2] has began to show a disproportionate rise in urban areas.[3] Malaria is highly endemic in 90% of the country and is the largest single cause of ill health accounting for up to 40% of outpatient attendances. AIDS is the leading cause of death in adults and the main cause of falling life expectancy in Uganda. However, the generalized heterosexual HIV epidemic of this country now shows significant decline. The MoH, Uganda's HIV/AIDS sero-behavioural survey (2004-2005) showed an HIV prevalence of 6.4% among 15 to 49 year-olds.

Major political and economic reforms, including economic liberalization, privatization, public sector downsizing and decentralization, have taken place. The Local Government Act of 1997 mandated the decentralization of many functions to local authority entities such as municipalities and districts. In the health sector, the central MoH retained responsibility for policy formulation, national standards setting, quality assurance, resource mobilization and national coordination of services such as epidemic control. It provides technical support to district health authorities and most importantly, carries out monitoring and evaluation of overall sector performance.

At district level, health management teams have been re-designed to focus on core management and technical support roles, with responsibility for local resource mobilization, planning of services, supervision and coordination of HSDs. The direct management of service delivery is delegated to the HSDs which have a primary referral facility (for population of about 100 000 people) and is headed by a medical officer who is responsible for planning, implementing, monitoring and supervising service delivery in the area.

Other service delivery units that require managers are the hospitals (three types: national and regional referral, district/rural/general hospitals). Referral hospitals are managed

[1] *National Household Survey 2003*. Kampala, Ministry of Finance, Planning and Economic Development, Uganda.
[2] *Poverty Status Report 2000*. Kampala, Ministry of Finance, Planning and Economic Development, Uganda.
[3] *Poverty Eradication Action Plan 2004/5-2007/8*. Kampala, Ministry of Finance, Planning and Economic Development, Uganda.

independently of the districts where they are situated, but district/rural/general hospitals are designated as HSDs in their respective districts.

An ongoing public service reform has re-structured the local government to align its functions with newly devolved responsibilities and to create better accountability for services delivery. The new district council administrations are headed by a "Chief Administrative Officer" (CAO) who has the rank of "Commissioner" in the public service (equivalent to the head of a central ministry department) and is required to have a master's degree in public administration. All decentralized departments (including health) report to the CAO.

A new national health policy was adopted in 1999 and was followed in 2000 by a new health sector strategic plan which introduced a minimum health care package and re-defined the care delivery system. A second health sector strategic plan (2005/06-2009/10) is now being implemented. Many of the health sector problems identified were said to be management-related and included remnants of centralized management decision-making, staff mal-distribution and low morale, weak supervision and poor public and private partnership.

3 WHO ARE THE MANAGERS AT DISTRICT LEVEL?

This section examined the availability and typology of managers at district level. Unfortunately, the human resource (HR) information system listed health workers according to their original professional qualification and so it could not tell us how many played management roles and were qualified to do so. However, there is policy clarity as to who managers are and what roles they play at district level. Also, almost all DDHS posts were filled with persons meeting the official criteria.

Two types of managers are found at the district level in Uganda. A "district director of health services" (DDHS) leads a district health management team (DHMT) and supervises the health sector in the entire district. DHMTs may have "focal persons" who are responsible for technical programs and are appointed on the basis of their technical background (not managerial experience). Since 1997 all DDHS were required to have a medical qualification and a master's degree in public health (MPH). All district DDHS posts are currently filled and retention is not seen as a problem.

Each district has up to four "health sub-districts" (HSD). A health sub-district is led by a "medical officer" (MO) who is responsible for managing service delivery and supervising other (minor) health centers (II and III) in the sub-district area. The HSDs medical officer is based either in a "health center 4" or a general hospital. Each sub-district is now required to have two MOs to reduce the workload by separating their managerial and clinical roles. However, MOs are usually recently qualified doctors with little or no management training and though in theory they are also expected to hold an MPH, few have this qualification. The high retention of DDHS is countered by significant attrition of HSD medical officers. The two MOs in each sub-district have to compete for the very few DDHS posts that have become vacant. The high turnover and financial constraints to their employment pose a challenge to filling MO posts and emigration was also said to affect their retention.

The criteria for managerial appointments at district level (beyond the academic qualifications) are unclear and appear to be based on years of service rather than prior managerial training, experience or competency. Candidates from local communities in a district tend to have an advantage and are likely to be chosen over proven managers coming from elsewhere in the country. While this may favor retention, it can constrain the taking of unpopular managerial decisions.

Key Issues

- Senior district level management posts are currently confined to doctors because of the required academic qualifications.
- The career path of district managers is limited by lack of promotion opportunities beyond the DDHS position and this also limits the opportunities available for MOs serving in HSDs.

- Motivation: Isolation, lack of accommodation, lack of opportunities for income augmentation and inclement working hours are other factors said to affect retention of MOs.
- Managers who hail from the locality may tend to stay on in their communities but their willingness to take unpopular decisions may well be compromised.
- Selection criteria for managers do not go beyond academic qualifications and are not based on candidates having other desirable managerial attributes.

4 HOW ARE MANAGERS' SKILLS DEVELOPED?

Do district managers in Uganda have the appropriate competencies and how are these acquired? While it was difficult to do a competency assessment as part of the study, the team reviewed the criteria for selecting the managers and the types, methods and content of the training they receive, to see whether these matched with their role expectations. As with many other countries, health managers in Uganda are mostly clinicians (the majority are doctors) who have been promoted into management roles. Management training is therefore, essential to provide the required skills and competencies. Significant effort has gone into developing district managers using long and short courses (including distance learning) and the placement of "technical advisers" to support DHMTs and to transfer skills.

A key feature of management development in the last decade or so has been the multiplicity of activities in this area. This situation was compounded by the lack of a national competencies framework to guide the training of health managers. Indeed, institutions providing management training identify the absence of a specific MoH focal point for coordinating management policy as a factor in having multiple courses and materials that may not have met the sector's needs.

4.1 Management development approaches used in Uganda

Two broad types of management development were found in Uganda.

4.1.1 *Training programs for **individual** managers*. Significant local training takes place and several institutions run either specific management programs or courses with management aspects. Most courses appear to be "knowledge-based" rather than "competency-based", though some have used problem-solving and work-based learning approaches. The MPH degrees that are required of all DDHS were at the time of the review only offered by Makerere University. Some current managers (nine during this review) were taking distance learning MPH courses based outside Uganda. Donors have also funded external full-time long and short courses.

4.1.2 ***Team** strengthening initiatives.* There are several decentralization support initiatives, often part of special projects that have management strengthening aspects. These projects train the entire DHMT and have been supported by a range of international, regional and local agencies. Many such projects have since ended but it was difficult to find formal evaluations and it is doubtful whether lessons from such experiences have informed current practices.

Details of various management development approaches that were identified from key informant interviews are summarized in Annex 3.

4.2 Sources of Management Training

Three groups of management training providers were identified in Uganda. These were university academic programs, non-university organizations and government or MoH training programs. The main providers are described below.

University-based providers

Institute of Public Health, Makerere University, Kampala
The Institute runs an MPH program which is taken either as a two-year full-time course or by distance learning. The last revision of the curriculum was in 1999 but a new review is expected shortly. Its students are attached to districts and use problem-based approaches for public health training (not for the management aspects). The course is focused on clinical and epidemiological skills and though participants in the past have mainly been doctors, recent intakes have seen an increasing number of nurses.

The Uganda Martyrs University (UMU), Nkozi
The faculty at UMU is supported by an Italian Christian nongovernmental organization (NGO), Centro Universitario Aspiranti Medici Missionari (CUAMM), now called "Doctors with Africa", and the Catholic Organization for Relief and Development (CORAID). The following courses are run at the UMU:

- Diploma in Health Services Management: This one-year course targets mid-level managers ranging from district managers, hospital administrators, diocesan health coordinators, health centers in-charge to senior nursing managers and wards in-charge. Student intake is limited to 15 per course and majority of recent participants (34/51) have been female. Its 13 modules include a four-week field-based section.

- MSc in Health Services Management: This 12-month course is said to be aimed at developing managerial competencies with analytical and critical skills. The course content is based on needs identified from reports of the Catholic Medical Bureau and has a curriculum developed independently of the MoH. However, participants are exposed to the experiences of MoH officials, national and international organizations and institutions through attachments. It has 10 compulsory modules designed with learning objectives aimed at improved understanding of key management issues and providing practical skills such as computer use, presentations and writing skills. Emphasis on "soft" skills (e.g. advocacy, negotiation, team building and management behavior) is rather weak. A key feature is the mentoring provided by former students to new graduates. The course fees of 6.3 million Ugandan Shillings compare unfavorably with MOs starting salary of USh5 millions per annum. Majority of participants (42/52) are male (2001-2004).

- Certificate courses of five weeks duration are also run but these are "on-demand" ad hoc programs run as extra-mural courses procured by clients (e.g. Rakai district purchased programs in 2003 and 2004).

Uganda Protestant Medical Bureau (UPMB)/International Christian Medical Institute (ICMI)/Uganda Christian University, Mukono
UPMB was established in 1957. It is a private, non-profit organization representing over 160 faith-based health service organizations. It runs the International Christian Medical Institute (ICMI) which has since 1993 offered a diploma (aimed at mid-level managers) and a degree (for senior managers) in health administration (awarded by the Uganda Christian University). The diploma course originally run with donor support is now self-financing with a joint Ugandan and Canadian faculty. The courses use various adult learning methods with small interactive classes. A comprehensive evaluation said to have been conducted was however not available for review. The MoH is represented on the Bureau's Advisory Board.

Non-university providers

Uganda Management Institute (UMI)
The UMI was established in 1969 as the Institute of Public Administration and transformed in 1992 into a semi-autonomous degree-awarding body with a remit beyond the public service. It currently generates most of its income but receives a

subvention of about 10% of its income from government. It offers a repertoire of long and short management courses, and tailors special programs on request. Several specialist short courses (e.g. finance and planning) are run for health managers and a new course is aimed at developing mentoring skills for public sector managers at district level. The curriculum is comprehensive and appears to reflect international good practices. Emphasis is placed on building competencies of its staff in modern teaching methods and staff exchanges have taken place with institutions in South Africa, UK and USA. The courses use group work, action learning and problem solving and have a multi-disciplinary approach to studying. Evening programs have been created to assist students who work full-time and an e-learning program has also been started to cater for students living outside Kampala.

Manpower Development Centre, Mbale
This centre was formerly a public service (MoH) in-service training facility that in the past had provided courses mainly in clinical skills and was funded by CIDA through AMREF. Its recent programs have focused on developing skills at district level for training needs assessments and it also runs a distance learning course for district level managers. The centre's current position, accountability and roles are not very clear as government funding only covers salaries and not development and delivery of courses.

Government-run programs

Ministry of health short courses
WHO has supported the development of a training manual and three-week short courses on organization, and planning and management of health services in health sub-districts. The courses were run with facilitators from MoH, WHO and Mbarara University of Science and Technology (MUST) for core HSD teams (MO, health inspector, data assistant and chief nursing officer).

Ministry of local government short courses
The ministry of local government has capacity building programs for its personnel in planning, budgeting, resource management, administration, etc. Twenty six modules developed and approved in 2004 are used for the courses. It is funded by the World Bank and targets only local government staff, but it is not very clear if district health managers benefited from these programs.

4.3 Other capacity building approaches

Mentoring

District managers who were interviewed felt they had many benefits from coaching and mentoring received from more experienced managers, especially in terms of the "political" skills acquired. Peer mentors or "buddies" were specifically identified by new MOs as valuable sources of support which gave them the opportunity to explore difficult problems in a safe and confidential environment. However, mentoring and coaching approaches need to be well understood, organized and coordinated to be fully beneficial.

Technical advisers

Technical advisers have been attached to various district projects to provide support over the years but there is little evaluation or feedback on the success, or otherwise, of this approach. Sometimes, advisers have been drawn into direct service activity when under pressure to produce quick results as compared to the rather slow skills transfer and developmental roles expected from them. A much cited problem is the lack of sustainability when projects end and advisers leave.

Management in Disease Programs: Priority disease programs (e.g. AIDS, TB, and malaria) often provide training courses with management aspects. The likely duplication that this entails may result in conflicting messages on managers' roles and functions especially when a national competency framework is not available.

Key issues:

- A multiplicity of management training/development initiatives covering similar ground but at times using different methods, suggest a lack of national coordination. When previous experiences are not built upon, it has cost implications for both the MoH and district managers as each new course entails high development costs to repeat the program design, materials and tools.
- MPH courses are not management qualifications (the management modules are optional) and so may not deliver effective managerial competences. Potential managers should be required to take the management modules in order to qualify for posts.
- Soft skills' training (e.g. negotiation and advocacy) is needed but requires methods that are not found in many formal courses. Mentoring and coaching approaches need to be harnessed to provide these skills and the public sector mentoring skills development program run by UMI is a commendable program that can be incorporated into other programs.
- A nationally-agreed management competency framework is needed to ensure training content consistency and coordination and to assure that core standards are met. The MoH should also clarify responsibilities for management development strategy and training coordination.
- Technical assistance used for management development must be reviewed to minimize sustainability problems when projects end.

5 DO CRITICAL SUPPORT SYSTEMS FUNCTION WELL?

A third dimension of management capability is the systems and tools that facilitate management functions (e.g. planning, human resources, supplies, management information, etc.). Management effectiveness depends on well functioning support systems and in Uganda, decentralization to local government and the presence of some level of dual reporting and supervisory expectations may place a burden on the effectiveness of support systems. This section reviews the status of selected support systems at district level and how they impact on managers' functions.

5.1 Planning systems

All district departments operate under strict local government finance and accounting regulations. Efforts have been made to streamline different planning processes and provide coherent guidance to districts and HSDs. New national guidelines have been issued, training provided, and support visits paid to districts. Districts have been grouped and assigned a designated planner at the MoH as the focal point for planning support – a move that has strengthened planning and budgeting processes. However, the planning guidelines were seen as quite complex and the activities took too much of a manager's time (often months). Other problems include delayed issue of annual planning frameworks, unanticipated changes in budget allocations, delayed planning support visits and data difficulties. The process requires the filling of three different forms: a "budget framework" submitted to the local government; an "annual estimates of revenues and expenditures" also for local government; and an "annual health plan" submitted to the MoH (after agreement with the district health committee).

In practice, it appears that budgets are drawn by adding a percentage to the previous year's figures. The planning framework is quite prescriptive and may restrain local priorities from being adequately reflected. There is poor information on timing of activities of centralized disease control programs, NGOs and development partners.

The 2003 medium term review (MTR) had recommended new central planning guidelines to assist the disease programs in identifying core central functions of resource prioritization and technical coordination in order to streamline their activities into the established planning processes.

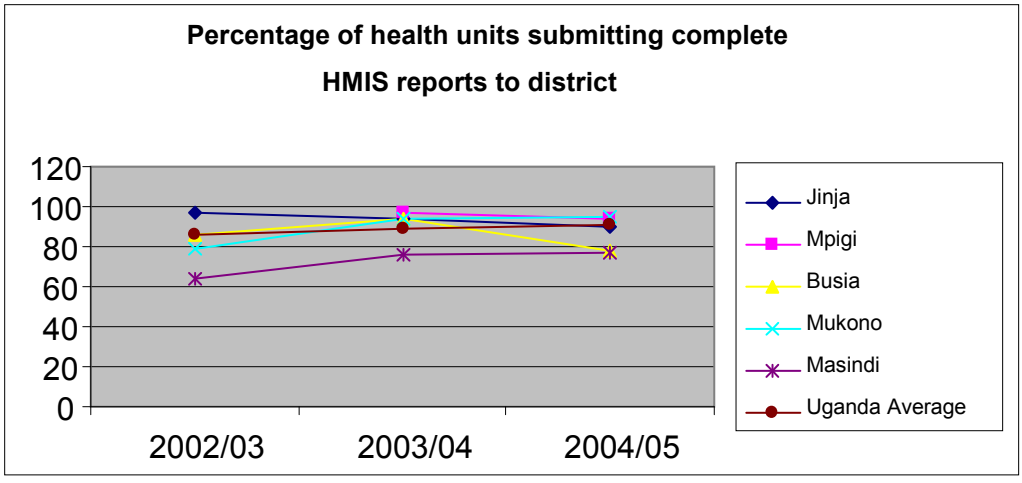
5.2 Health Management Information Systems (HMIS)

The HMIS was rolled out in all districts to collate information as a requirement of the annual planning process. However, despite attempts at harmonization, many disease programs still demand information parallel to the agreed HMIS. HMIS information requirements are very comprehensive which may be a bit unrealistic in view of staff shortages and lack of computing capacity to facilitate data collation and transmission. For example at clinic level, eleven separate A4 pages of documentation are to be filled each day (one clinic said it took eight hours). Despite these problems, timeliness and completeness of district reporting improved from 15.60% to 70% between 1999 and 2002.

District managers clearly understood the need for information though the perception from this review is that the information is primarily collected for the central MoH and not much of it is used locally. The planning process produces trend data which were regularly displayed in offices and public places. A lack of data culture meant that many managers interviewed could not back discussions with hard figures on their districts. Managers are assessed on completed and timely returns and not on how or if data is used. In addition, district managers cannot question overall HMIS data to compare information collated from their districts with those of others.

Figure 1 (below) illustrates the performance of the districts visited in terms of HMIS submissions as compared with the average for Uganda. Three of four districts with data available performed above average.

Figure 1. HMIS performance at district level (No 2002/03 data available for Mpiji)



Sources:
1. Ministry of Health, Annual Health Sector Performance Report FY 2002/03
2. Ministry of Health, Annual Health Sector Performance Report FY 2003/04
3. Ministry of Health, Annual Health Sector Performance Report FY 2004/05

5.3 Monitoring the health sector strategic plan

A number of indicators have been established to assess achievements in implementing the national health sector strategic plan, a process which operates in conjunction with agreed quality standards in all institutions. Indicators are set for both national and district levels with the results benchmarked in league tables that illustrate how well or poorly districts are performing. The selected indicators (which include both output and

process indicators) have agreed targets, and baseline data have been established against which performance is measured. This system covers only the public sector and faith-based NGO services and excludes the private-for-profit sector.

5.4 Financial management

Decentralization of financial management to districts was initiated with district "block grants" in 1993, followed by a "conditional grants" system for NGO hospitals in 1997. Currently the country is implementing a fiscal decentralization strategy (FDS) whereby local governments in districts receive full budget grants (including capital budget) for each sector, 10% of which (non-wage) can be re-allocated locally between sectors. This virement seems to affect the health sector negatively which could be due to a perception that the sector is well endowed compared to others and often attracts additional donor resources.

District health budgets are based on 4 core criteria: (a) geographical size, (b) poverty index, (c) "health need" calculated from infant mortality, and (d) population. Districts receive "budget ceilings" in advance on some items, and certain other funds are earmarked from national level for specific activities. Despite decentralization, DHMTs directly control only the relatively small amounts of money in their "operational" budget which cover staff allowances, meetings and supervisory visits; maintenance; fuel; and stationery costs. Other recurrent budget items (e.g. salaries, drugs, supplies) and development (capital) funds are centrally controlled and have fixed ceilings. However, unlike the public sector, faith-based NGO institutions that operate in collaboration with the MoH are allowed to generate and retain income from user fees.

Salaries, once discussed with the CAO, are transferred directly from the ministry of finance (MOFPED) to the local government and virement is not allowed. It was reported that with payroll responsibility now at district level salaries were usually paid on time (albeit at middle of the following month). Previous problems with salary delays were said to have damaged morale and affected retention.

Each year, districts open a bank account for receiving the budget and it is closed after reconciliation at the end of the year. Financial control is done by reconciling bank statements and cash books with the agreed workplan. No financial expenditure can be made outside of the workplan so in practice, the DDHS only exercises true financial management over very minor local purchases. A local government accountant (directly responsible to the CAO) provides financial administration support to the DDHS though he is not usually involved in the planning and budgeting process.

Feedback received indicated that release of funds is often not timely. For example, 6 weeks after the financial year started, allocations had not been received from the MOF by any of the district teams visited even though districts should normally receive an automatic release of funds for the first month of the financial year. Funds channeled through the local government are also delayed before being transferred into district health bank accounts.

5.5 Human resource management and planning

The decentralized human resource management is characterized by poor local capacity to undertake certain tasks (e.g. recruitment) and HR management functions at the central MoH level are somewhat constrained by a lack of collated data from decentralized units that will enable national strategic HR planning. A number of ongoing programs have been initiated to strengthen HR information with support from the EU and USAID.

The HR information system does not track managers as a component of the health workforce and apart from "hospital administrators", management posts are not formally identified and included in the data. For example, information on district managers'

profiles, recruitment, attrition and turnover rates, etc., which can be used to determine future needs, are absent.

Recruitment

Employment is done by the "Health Service Commission" for the national MoH and referral hospitals. Districts have a "District Service Commission" (DSC) for all local government departments which are made up of a mix of political appointees and representatives of the specific sector requiring staff. Recruitment is a lengthy process which was partly re-centralized when many districts did not have the funds to advertise, arrange interviews and pay DSC members. Established posts are only filled when funds are assigned from the ministry of finance after which the District Service Commission advertises the post and manages the selection process with the DDHS as a "technical" adviser.

The districts visited during the review estimated "staff at post" to "established post" ratios at a maximum of 50%. However, national average figures from the MoH gave 68%. Districts reported that they could now in theory vary their skill mix locally using the authority vested in the DSC upon advice from the DDHS.

Staff appraisal and performance management

A new public sector appraisal system was introduced in 2003 and district managers were trained to use it. Some were concerned about the amount of time the appraisal process took but it appears to be good for developing managers' skills in conducting staff performance appraisals. The review recognized a number of features that reflected good practice including the requirement of joint staff and supervisor identification of annual objectives linked to the district workplan, requirement for staff self assessments and their involvement in documenting work details and in planning future activities. Staff are appraised against a generic framework of critical competences (see Table 1 below). However, these competences may not be appropriate for all types of staff but are clearly relevant for managers. Adding assessments of "self management" and incorporating personal development planning will be good enhancements.

Table 1. Generic staff performance assessments

Staff performance generic criteria :

- Ability to apply professional/technical knowledge and skills
- Knowledge of job
- Planning and organizing
- Decision making
- Leadership
- Management of financial and other resources
- Communication
- Loyalty
- Integrity
- Ability to achieve desired outputs

Maintaining staff discipline

The ultimate responsibility for staff discipline is vested in the DSC with well documented procedures available. However, there are still reports that major disciplinary actions often failed because the appropriate procedures were not followed and formally recorded. This was thought to be due to managers' reluctance to take unpopular decisions in what is often a small community. Managers interviewed however mentioned an interesting and potentially more powerful disciplinary system that arises from the professional associations and can result in having one's registration suspended for incompetence or misconduct. The lack of effective

disciplinary authority frustrates attempts to get optimal performance from staff and provide little incentive for people to improve.

5.6 Medicines management

Medicine procurement is financed from PHC recurrent budget, credits established with the National Medical Stores (NMS), the Joint Medical Stores (JMS) and, to a lesser extent, user fees from faith-based NGO institutions. MoH guidelines require that at least 50% of districts' non-wage budget is spent on medicines at Health Centres II to IV, and 30% in hospitals but in practice, wide variations exist. When medicines are unavailable at the National Medical Stores (a common occurrence), districts are permitted to procure from the Joint Medical Stores and if this is not feasible, then from private sector sources. Stock outs appear to have decreased significantly when "credit lines" were introduced, but problems still exist about medicines actually reaching patients. A wide variation in expenditure on medicines exists between districts for which there seems no rational explanation. It ranges from a low of 11% to a very high 200% (possibly carried forward from previous years, or inclusive of medications from other sources and programs, e.g. GFATM) of recurrent budget.

5.7 Quality assurance, supervision and monitoring

The health sector's supervisory system is well institutionalized and integrated at district and sub-district levels. The system was originally introduced in 1994 as part of a quality management process led by a "Quality Assurance Department" in the MoH. It is now an integral part of the health system and has survived the changes brought about by decentralization. However, decentralization has perhaps made it even more important as this process has become the key link between district health offices and the central MoH. It is the main channel for delivering national support to DHMTs and for exchanging good practices and experiences between districts.

Its attributes include:

- It is designed to be a supportive and non-punitive process where supervisors are trained to establish trust with the units they supervise.
- The process has integrated routine service delivery monitoring with priority program assessments during the same visit and it is part of the annual workplan with specific time and budget allocated for it.
- Supervision cascades from national level to districts and sub-districts, and has become a core responsibility of district health teams since 2001.
- It enrolls all senior MoH staff into 10 multi-disciplinary teams, each with responsibility for supervising an assigned cluster of districts. Teams include staff with finance, planning, management, and engineering backgrounds. Some visits include local government officials and program specialists which enhances its inclusiveness.
- While certain critical items are monitored every six months (e.g. finance, planning), other areas (malaria, child health, etc.) are selected in rotation and the appropriate technical staff are added to the core team.
- The district teams get immediate verbal feedback after each visit and later summary reports highlight key issues and suggest actions requiring national intervention.

Some weaknesses do exist:

- Possibly due to staff shortages and high transaction costs, the cascade of supervision to the sub-district has not been fully implemented.
- Review of visitor’s books suggests that members of the supervisory teams changed frequently which may affect the building of good links between supervisors and the receiving teams.
- Despite integration attempts, some separate vertical program supervision visits still occur.

- Teams reported that little time was available to adequately carry out other support activities such as coaching.
- The impact of integrated supervision on actual quality of care has not been systematically assessed.

On balance, the impact of the integrated supervisory system has been quite positive on management at district level.

Key Issues

Planning

- Clear improvements have been achieved in the planning and budgeting process which needs to be sustained.
- Planning is well supported by the central level but there are complaints that may not be as timely as needed.
- The planning guidelines are rather prescriptive and thus local priorities may be insufficiently reflected in the final product.
- Managers tended to spend an inordinate amount of time on planning activities and training workshops and this raises the transaction costs of the planning process.

HMIS

- The rather sophisticated HMIS system is likely to be too complicated for current district level capacity. Some simplification may be needed.
- The planning system is in theory driven by information. However, managers interviewed did not appear to appreciate and internalize the core local data needed for decision-making. The information culture is weak and appears driven mainly by national level needs. Some managers could not give the data underlying certain basic service decisions when asked.
- Collecting the required data is very time-consuming for staff, and returns are frequently late and/or incomplete.

Monitoring

- There is a good high level tool used to monitor progress towards the sector's strategic goals. This tool is designed to recognize achievements as well as areas needing greater effort.
- An increased number of districts and a high staff turnover seem to have significantly increased the costs of monitoring.
- Quality assurance of data from monitoring seems minimal and this is detrimental to the recognition of local priorities. Some indicators also measure things that are beyond the control of the districts (e.g. medicine stock outs may reflect supply issues at the National Medical Store) and the weighting given to indicators may not reflect the true source of difficulties.

Financial

- Despite decentralization, there is relatively little financial autonomy at district health level. The authority of local government under the fiscal decentralization strategy is not fully used and may even go against health sector interests as DDHS usually has little negotiating power with district councils.
- Budgets allocated to districts do not adequately reflect some of the local priorities identified from the planning process.
- Faith-based facilities' authority to retain user fee revenue has enabled true financial management to occur. Public sector facilities could benefit from having similar authority.

HRH

- Core HR management systems are in place and managers have received training in their use. One difficulty however is that delayed release of finances creates difficulties for staff recruitment.

- The national HR information system currently lacks data on the numbers, deployment and qualifications of health sector managers.
- The local government system has an appraisal form which is quite comprehensive and incorporates excellent features such as a generic competence framework for managers. It can be adapted for health sector use though it is complex, which may limit its use to senior managers only.
- A key observation is the suggestion that managers were reluctant to use staff disciplinary procedures effectively due to a variety of cultural and other reasons.

6 WORK CONTEXT AND ENVIRONMENT OF DISTRICT MANAGERS

An enabling work environment is one in which managers know exactly what is expected of them from well communicated policies, job descriptions and technical guidelines supported with good performance management. These provide clarity of roles and enable the use of authority with responsibility and without fear. This section examines influences of the work context and environment on the district health manager's work in Uganda.

6.1 Managers' roles and responsibilities

Policies and regulatory frameworks. The 1995 constitution enjoined the state to provide basic health services to the population and this forms the basis for Uganda's "Minimum Health Care Package" derived from the national health sector policy and plan adopted in 1999 and 2000, respectively.

During the 5 years prior to this review, efforts had been made to streamline sector funding and operations through various modalities including sector-wide approaches (SWAp), donor budget support and an integrated planning and supervision process. Several national and local guidelines were developed for planning, budgeting, expenditure control and staff management. Furthermore, service delivery norms and standards have been published and are in use at operational level. However, formal job descriptions had not been developed at the time of this review.

Statutory documents such as the National Constitution (1995), the Local Government Act (1997) and the National Health Policy (1999) clearly define the structure and roles of decentralized units and district health managers. Operational guides such as the MoH draft manual on "Organization, Planning and Management of Health Services in the Heath Sub-District" (2001) and the "Report on Review and Restructuring of the Local Governments and Staffing Levels by the Ministry of Public Service" (2003) have helped in the design of district management functions.

The restructuring processes that created independent district health offices in 1997 separated hospital management from the routine district health management and clarified specific management responsibilities of various units. Also, the creation of HSDs enabled delegation of direct service provision and got district health teams to focus firmly on their core management responsibilities.

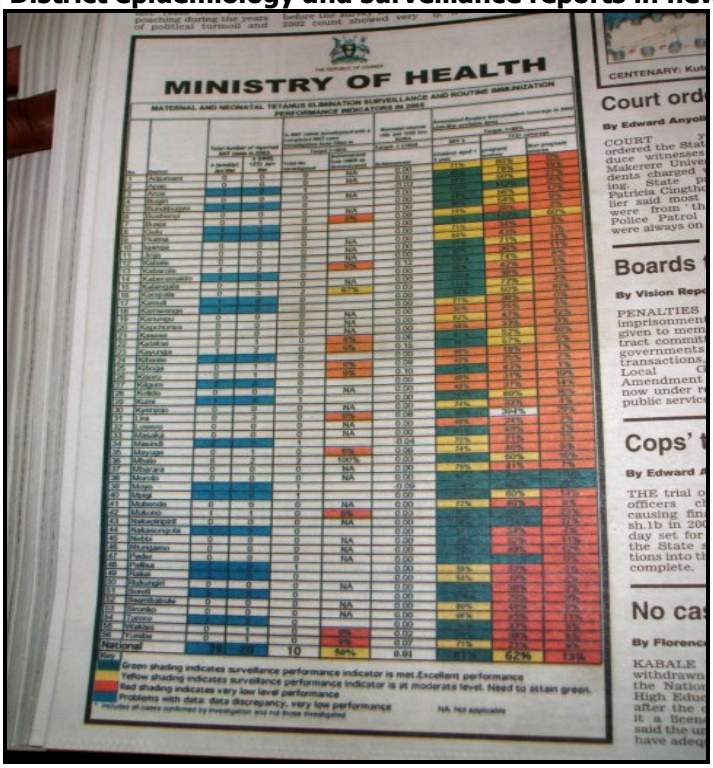
Roles and responsibilities however, remain unclear in a number of areas. The relationship between local government and DHMTs, and between regional referral hospitals and HSDs remain to be grey areas. Management and links with some technical areas such as school health (Ministry of Education); water and sanitation (Ministry of Water, Lands & Environment); and HIV/AIDS (Uganda AIDS Commission) also require better clarification and coordination.

District managers tend to feel that decentralization had limited their links with the national MoH and their inputs into national health strategy development. At the same time, though recognizing the benefits of decentralization, many also felt there were limits to their influence on local government especially in gaining an understanding of the budget needed to maintain health. Overall, the decision space of district health

managers is quite limited and may have shrunken further with the fiscal decentralization policy. Local government also carries out many management functions on behalf of all sectors at district level which reinforces to some extent perceptions of health managers that they lacked authority and influence. Management processes such as hiring and firing are handled by the DSC and the district personnel officer. Procurement of goods and services is effected by a "district tender board."

Accountability for service delivery: There is a genuine understanding of the need for health services to be publicly accountable, and information on the performance of services is made available in the national press (picture below) and at other forums. The monitoring and supervisory systems enhance a sense of accountability for service targets. However, this has not quite translated into enhanced customer focus for service delivery.

Figure 2. District epidemiology and surveillance reports in newspapers



The sub-title reads: "Ministry of Health: Maternal and neonatal tetanus elimination surveillance and routine immunization performance indicators in 2005"

The Yellow Star Programme: This programme evolved from the Quality Assurance project and was designed to give incentives when quality benchmarks were achieved. Though it is not an accreditation system, it monitors district performance against 35 standards – full compliance to which could qualify for an award of a plaque, which comes with significant recognition and publicity. This scheme (originally initiated with USAID support) is now active in 47 districts and managers take pride in displaying a yellow star on their facility.

The programme focuses on a few key standards and this may well affect the attention given to other critical issues that are sometimes of higher local priority. Furthermore, districts that are performing poorly do not receive much support and there is a need to invest in building better communication and trust between local facilities and national supervisory levels.

Incentives that drive managers: A manager's incentives are only partially about remuneration. It is also linked to the perceived status of the position, the degree of

autonomy managers have and career enhancement opportunities that are available. Both the appraisal and supervision systems recognize good performance but do not lead to any financial incentives for individual managers. Salary increments are administrative events that appear unlinked to performance and are limited to a specified number of increases (per annum) until the top scale is reached.

Senior health sector posts are comparatively reasonably well paid and salary levels exceed other public sector services (e.g. education, finance, armed forces and police).[4] The DDHS position is reasonably well rewarded and they are said to have significant status in the community. However, career progression beyond this position is limited and managers may have to remain in the same posts until retirement. The only real option, that of joining the national MoH, is quite limited and jobs are reportedly rarely advertised. Local government career posts such as Chief and Assistant Chief Administrative Officers require post-graduate qualifications that are not normally required in the DDHS training. Some DDHS do feel they should get appointed to CAO posts based on their management experience. Many district health managers are appointed to work in their home areas suggesting that many districts prefer to hire "*sons of the soil*." However, having strong social links locally may, for example, constrain the taking of hard decisions which affect relatives. Alternatively, it may foster good relationships with local opinion leaders as a key to success.

Other possible incentives are the training courses many managers attend although currently, training budgets are consolidated with local government finding funds for training much more competitive. Indeed, many DDHS and MOs pay for courses leading to promotion qualifications themselves. The cost of an MPH (the basic requirement to be a DDHS and HSD MO) can take about a third of their annual take-home pay. Staff on long term training have at times been removed from the payroll. However, allowances and other remuneration received when attending short courses could mean that managers spent a considerable amount of time in training workshops.

Uganda holds national health assemblies in which District Health Committee chairpersons, Chief Administrative Officers, District Secretaries for Health, the DDHS and selected health unit managers participate. These assemblies serve as a forum to solicit local government support for health plans. Based on the assessment of performance of the various districts, good performers receive plaques of recognition which have served as powerful incentives to improve rankings. While some teams found the plaques rewarding, others are cynical, and feel that receiving tangibles like transport or computers would have been real incentives.

Key Issues:

- Salaries are relatively attractive compared to similar public sector positions and the social status of local health managers is quite good.
- There are limited forums for peer-to-peer exchanges between DDHS and to help articulate common concerns. Having health managers' newsletters, for example, can help to reinforce status and provide updates on good practice.
- Decentralized appointments mean that managers have limited career options and little opportunity to be posted in other districts.
- There are few financial incentives although supervision and monitoring systems clearly recognize good performance.
- The tendency of districts to recruit natives of the area, while having some advantages, may also have distinct disadvantages.

6.2 Management practices changes at district level

It was difficult to obtain accurate quantitative data which demonstrated whether sustained improvements had taken place in management practices. It is generally

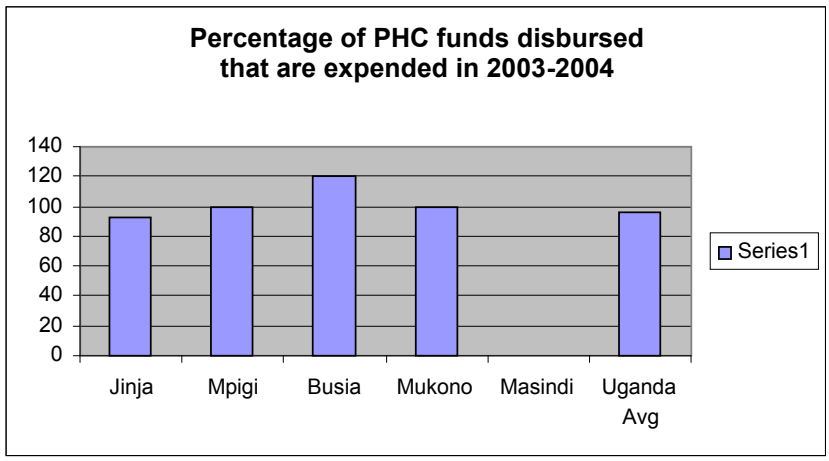
[4] It is reported however, that some DDHS and MOs operate private practices after official hours or even during working hours.

difficult in any case to attribute improved service delivery and health status changes to management development. However, annual performance indicators currently in use by the health sector may, with some refinement, help to establish trends that can demonstrate changes better. Interviews with district managers did give persuasive circumstantial evidence that management functions had improved in a number of areas, notably:

- Team-work in the districts visited was reported to be much more effective with improved coordination with other local government units.
- A strong planning process now exists despite somewhat tenuous links between plans and budgets, and activities and actual expenditures.
- A good supportive supervision system has been established that relates to issues important to managers and is not just a performance check.
- Medicines management improved significantly with fewer "stock outs" due to the new "pull" system and better planning.
- There is more accountability of health services delivery in communities served with performance information widely circulated in facilities and through the media.

As the five districts visited were selected on the basis of having benefited from certain management development programs, efforts were made to look at whether these districts also showed improvements in certain management functions and outcomes in quantitative ways. One selected indicator is illustrated below while others are displayed in Annex 5. Clearly, more accurate data including inputs, timings and results are needed to even begin to make a link but the graph below (Figure 3) gives an example of how such indicators may point to performance trends. Some management-related indicators showed mixed results in comparison to the national average but there are a number of downward trends over the past couple of years that need further investigation. Generally, only one of the four districts with data was persistently below the national average.

Figure 3. Expenditure as a proportion of agreed budget



(No data available for Masindi. Busia may have leveraged additional funds from its local government.)

Source: Annual Health Sector Performance Report FY 2003/04. Kampala, Ministry of Health, Uganda.

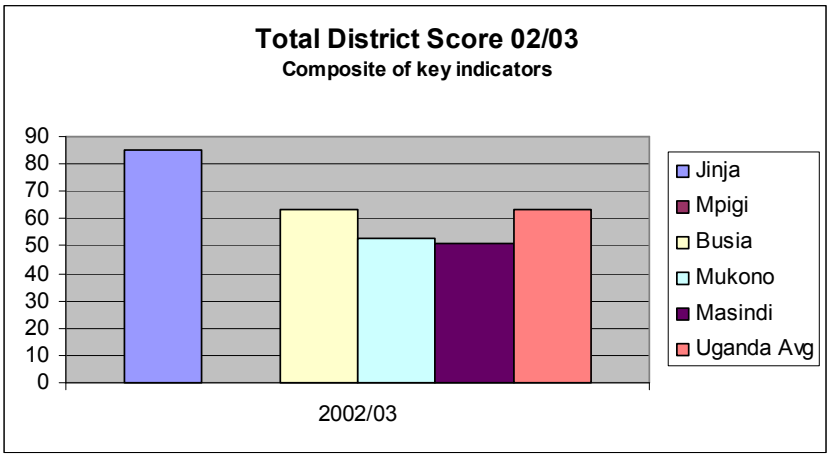
6.3 Health service outputs and management

This study avoided linking management improvement interventions and health service coverage as it is a difficult task given the multiple factors that influence service coverage. The core indicators of the 2003-2004 Uganda health sector review showed significant variation in districts' performance but poor and rural districts were not necessarily the bad performers. Available analyses of the districts' performance illustrated a number of factors:

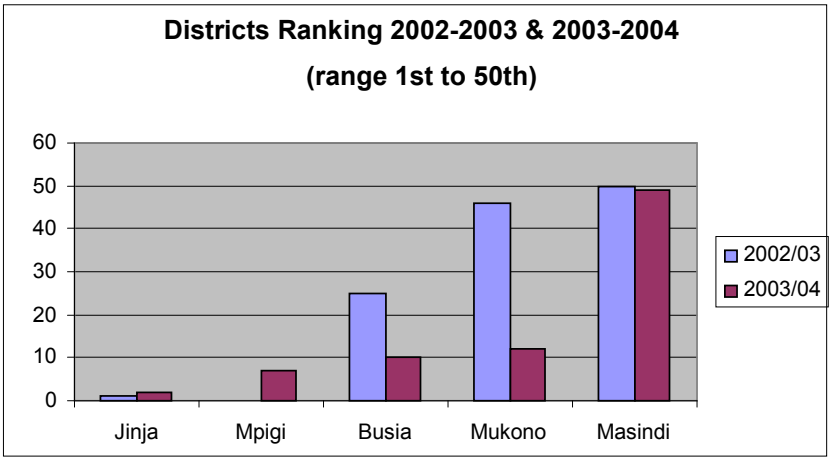
- The newly created districts perform less well than the districts that had been in existence for some time.
- Distance between a district and urban centres correlated with reduced performance – the islands generally performing less well.
- The war and civil unrest in parts of northern Uganda, as expected, also seemed to correlate with generally poorer performance though surprisingly one or two districts in this area (e.g. Gulu) were said to have persistently been top performers, a possible result of sterling DHMT leadership.

The study had planned to examine data trends over a five-year period but a general lack of data restricted trend data mainly to between 2002 and 2004. Composite service performance indicators (2002-2003) taken from the monitoring system showed two of the four districts were at or above national average (Figures 4) and the overall national ranking of three of the five had improved between 2002-2003 and 2003-2004 with Jinja, often a highly ranked district, declining slightly. The study was unable to determine if the falls in coverage found in these districts simply mirrored countrywide trends.

Figure 4. District monitoring composite indicators and ranking



(Data for Mpigi unavailable. Top score = 100)
Source: Annual Health Sector Performance Report FY 2002/03. Kampala, Ministry of Health, Uganda.



Sources:
1) Annual Health Sector Performance Report FY 2002/03. Kampala, Ministry of Health, Uganda.
2) Annual Health Sector Performance Report FY 2003/04. Kampala, Ministry of Health, Uganda.

Key issues:

- Health service managers spend 65% to 80% of their time preparing plans, writing reports, and attending workshops, leaving little time for supporting implementation of health activities in the district.
- Little true prioritization takes place at local levels aimed at tackling the main health issues related to the locality.
- Local strategies are based on following national guidelines than on creative thinking and developing locally relevant approaches.
- DDHS are still not sufficiently empowered to carry out their roles and responsibilities – there is a tendency to just carry out instructions. Being answerable to both the MoH and the local government may have caused split loyalties and some confusion.

7 CONCLUDING REMARKS

Uganda has made tremendous efforts at improving service delivery coverage and quality through improved management processes, systems and skills. Most critical management positions are filled (e.g. DDHS posts) and managers are well retained with little attrition except at the more operational level of HSD. Better efforts are needed to understand the trends in the management workforce and determine strategies to sustain the gains made.

Several opportunities exist for managers to develop appropriate skills and acquire needed qualifications. However, courses need to be designed to include essential soft skills and to use methods that enable these competencies to be gained. A health sector competency framework for managers will greatly enhance having common objectives and standards across various courses and ensure that the sector gets the right management competencies developed.

Uganda does very well with its management support systems especially in the area of planning, budgeting and financial management. The supplies system has improved and a good supervisory system is in place. However, the need to set up structured national systems have suffered setbacks due to time spent on detailed planning, for example, and the likelihood that local priorities and decision-making were overlooked in the process. Data use for local decision making must be strongly encouraged for communities to reap more benefits from the decentralization process.

District managers serve in a rather fluid environment of allegiance to both a local government and a national health system. The situation appears to be evolving and is likely to improve with time. Attention needs to be paid to the non-financial motivators that encourage good management performance and to the factors of local recruitment that may discourage the same.

Overall, these five districts showed service performance near or above national average. Whether these results reflect management effectiveness cannot really be determined but the overall impression has been one of improved systems with qualified managers in the critical district posts. However, other areas such as the way management competencies are developed and how managers are motivated by their work environment need to be improved.

Annex 1. Bibliography

1. *Health sector strategic plan (2000/01-2004/5): Midterm review report.* Kampala, Ministry of Health, Uganda, 2003.

2. *Annual health sector performance report: Financial year 2003/04.* Kampala, Ministry of Health, Uganda, 2004.

3. *World development indicators*. Washington, D.C., World Bank, 2005.

4. *Local government statute*. Kampala, Government of Uganda, 1993.

5. *Local government act of 1997.* Kampala, Government of Uganda, 1997.

6. *Health sector strategic plan 2000/01 – 2004/05*. Kampala, Ministry of Health, Uganda, 2000.

7. Owarwo V, Murindwa G, Erickson S. *Providing support to district health services under decentralisation and sector-wide approaches. A pre-workshop draft synthesis paper on experiences in Uganda.* 2002.

8. *Health sector guidelines for preparing annual workplans for district health services.* Kampala, Health Planning Department, Ministry of Health, Uganda, 2004.

9. *Health budget framework paper for health sector. 2004/05 to 2006/07.* Kampala, Health Planning Department, Ministry of Health, Uganda, 2004.

10. *Final report on the review and restructuring of the local governments and staffing levels*. Kampala, Ministry of Public Service, Uganda, 2003.

11. *Guidelines for health sector conditional grant 2004-05.* Kampala, Ministry of Health, Uganda.

12. *Annual health sector performance report: Financial year 2002/03*. Kampala, Ministry of Health, Uganda, 2003.

13. *Area team reports: March-April 2004, Sept-October 2004, March-April 2005.* Kampala, Ministry of Health, Uganda.

14. *Makerere University. Programme Handbook*: Masters in Public Health 2003/04.

15. *Uganda Management Institute Prospectus 2005/2006.*

16. Pearson M. *DFID Uganda country health briefing paper.* 2000.

17. *Organization, planning and management of health services in the health sub-district.* Kampala, Ministry of Health, Uganda, 2001.

Annex 2. Summaries: District case studies

District	Who are the managers?	Competency development & systems strengthening?	Changes in management practice & management systems?	Changes in work environment?	Lessons learnt:
Masindi with Buruli Health Sub-District: • A poor/rural district in Northern Region • Population: 500 000 • Sub-health Districts: 4 • One of the 10 poorest district performers on League Table [see Health Sector Performance Report 2002/03]	DHMT: • DDHS (9 months), Health Visitor; Health Educator; Health Inspector; Assistant Health Inspector for Drugs; Sr Nursing Officer • Focal points: HIV/AIDS (also Dep. DDHS); TB/Leprosy; Malaria Control; HMIS; Epid. Surveillance; Distance Learning (AMREF).	• DHMT members with MPH; adv diploma in Public Health • MoH workshops & seminars (most recent VCT coordination) • WHO/NORAD project on SDHS. HSD with tool for situation analysis & planning + info-based priorities. US$100 000 in 2004 for implementation.	• Planning improved in the last few years (better info used from HMIS). Planning was late as new fiscal year started in July (more than 1 month). • Sub-district feels support received from WHO/NORAD project allowed innovative strategies (e.g. establish community support groups at sub-county level to promote ANC services & high risk deliveries in health facilities.	• Each DHMT member spends average of 60 working days on workshops and seminars, (usually by MoH departments.) • National level visits frequent, (especially technical programs). • Supervision & support were not regular but appreciated, (especially planning visit). • WHO/NORAD SDHS project gave equipment, (solar panels, and computers) for health centres.	• Good situation analysis & careful selection of strategies essential to success. • Continuing ext. support, i.e. mentoring and coaching useful. • Ownership of problems and solutions - key to action and change. • Info/planning - good but takes up a lot of the DHMT's time.
Mpigi district: Mawokota South health sub-district • Mpigi: poor rural district, in southwestern Uganda • Population: 415 000 • Sub-districts: 4 • One of the 10 best performers on League Table [HSR 2002/03]. Mawokota South sub-district • Population: 100 000 • Catholic Hospital: 100 beds	• HSD Head is also the Hospital Superintendent. • Core HSD team carries out Hospital & PHC functions. • Team: Dep. Med. Supt., Sr. Nursing officer, Hosp. Administrator & Hosp. Accountant • HSD inter-sub-county team: incorporates heads of other health units, health inspectors & focal points for PHC, injection safety, malaria & immunization	• MoH workshops mainly on diseases mgmt. • No mgmt team member enrolled on available distance learning programme. • 3 HSD staff attended 3-week course on health sub-districts (2002/03). • WHO/NORAD project on SDHS. HSD with tool for situation analysis & planning + info based priorities. US$100 000 in 2004 for implementation. • Motivation by Yellow Star Programme	• Planning with data use improved & was results-oriented. • Service coverage info displayed in facilities to motivate staff. • Financial mgmt: local user fees used if funds are delayed (usually in PNFP units only). • Supervision & support done regularly as a team. • Work with international & local NGOs (4 NGOs in HSD) intensified (in community-based HIV/AIDS services, NGOs provide testing kits & financial incentives for voluntary counselors.	• Gov't funds for Hospital PHC conditional grants decreased. • The PNFP hospital salaries paid out of their grants & topped up with hospital-user fees. • HSD budget is approx 10% of hospital grant but gets 5% to cover expenses (3 items: allowances, Equipment, stationery fuel, maintenance, • Wage & drugs budget is centralized. • Planning: The HSD team spends 20 days preparing plans. • District supervisory visits were infrequent but appreciated.	• Uncoordinated NGO & HSD planning results in duplication & inconsistency in services (e.g. VCT, testing, PMCT). • The Health Units Management Committees are much less active and involved since user fees have been abolished. • High staff turnover when PNFP and gov't salaries are different. • Using in-depth situation analysis (WHO/NORAD project) was "eye opener" on real service constraints).
Mukono health district • Est. Population: 830 000 • Health facilities: 72 • (49 government & others, PNFP) • (5 Hospitals, 4 Health Centre IVs, 24 HC IIIs and 39 HC IIs)	**Financial systems** • District "collection account" for central budget funds before allocations to sectors. • District health care account has Exec Officer- Accounts but accountable to the LG CAO.	**Information systems** • Staff received HMIS training (collection/ interpretation). • District registry to handle facilities data. • In 2002/3 Mukono submitted 81% of information on time. 100% in 2003/4.	**Factors identified as strengthening management** • Motivation (payment of salaries on time, supervision, training, management tools/ systems, recognition of good performance)	**Problems faced by managers** • Low motivation of personnel & high attrition • Demands of vertical programs	**Key issues** • Mukono improved significantly in performance between 2003/4 and 2004/5. • The District has clearly been motivated to improve and has found the national league tables a spur to meeting targets.

District	Who are the managers?	Competency development & systems strengthening?	Changes in management practice & management systems?	Changes in work environment?	Lessons learnt:
Mukono health district • Total of 7 HSDs, including one on Buvuma Islands on Lake Victoria	**Financial systems** • Standard financial tools used (vote book, cash book, bank statements, and reconciliation, quarterly reports). • DHMT thinks that "collection account" unnecessary bureaucracy. • Budget was 7 wks late for the financial year. • Requirement to close old accounts & open new ones each year has major transaction costs.	**Information systems** • Quality checks are part of supervisory visits. Data are collected daily & reported weekly/monthly. • There are also separate disease surveillance reports, e.g. acute flaccid paralysis. • TB, HIV/AIDS, RH have special data forms. • Finances of vertical programs are not well captured. • Feedback in Newspaper, MoH quarterly, and at annual district reviews • Indicators (PEAP), in 2002/3 Mukono was 46th in the national league table but by 2004/5 it had improved to 12th. **Research** • Small research budget (Ushs 6 million per year).	**Factors identified as strengthening management** • Technical support national TAs & vertical programs • Improvement on information in-service training distance education • Setting of standards for outputs support systems like personnel admin, works, etc. in MoLG • Result-oriented mgmt tools: introduced in 2002	• Political interference in management/recruitment • Inability to address competence gaps Target budget was Ushs14 million)	
Jinja district • Population: 426,645 • 4 sub-districts, 3 hospitals (total: 50 facilities) • Rated 2nd best district in 2003/4 • DHMT identified problems as funding & HR resources.	**Human resource challenges** • Excess of staff above norm in 2003/4 but a perception of shortages • Real concerns about the demotivating effect of similar posts in regional hospitals and district posts. Hospitals received salaries on the 22nd of each month but district staff did not get paid until the 10th of the following month. • Funding of trainings is contentious. Staff self- fund MPHs at 660,000USh per semester.	**Enabling environment** **Finance** • Fiscal Decentralization Scheme comprised 10% of the health budget reallocated to LG? • Fungibility of GFATM funds • Expenditure on utilities rising. **Total budget $4 per head** • District staff see less funds received once performance improves (e.g. per diems for supervision). There is very good use of financial systems, e.g. cost codes, quarterly electronic reports to MoF, etc. **Decentralization** • Concerns about link with MoH & perceived isolation compared to Reg. hospital. As are monitored by the MoH but managed by LG at District	**Factors contributing to improved performance** • Strong performance attributed to supervision & monitoring system, common vision & priorities. • Strengthened links with district colleagues. • Skills gained in negotiation, influencing useful. Result of mentoring; good training opportunities & encouraged personal development	**Problems experienced** • Lack of electricity, poor communication (e.g. radio network) • Poor staffing levels • Health centres not fully equipped • MoH support focused on HSDs and reduced to the DHMT	**Key issues** • Good working relations with local gov't administration Minimum interference • Improved performance due to planning process, supervision, targets • District officers relatively disadvantaged compared with hospital doctors • Projects e.g. Rural Water & Sanitation (RUWASA) and DISH successful in improving performance • HR training in staff management & appraisals helpful

Annex 3. Summary: Management development interventions

Nature of Intervention	Beneficiaries	Provider	Duration	Evaluation Surveys?	Funder(s)	Comments
1. Management programmes for individual managers						
Long Courses/Masters programs						
Masters courses: Health policy, planning and finance (a part of DHS program, see below)	Mainly MoH staff	Nuffield Leeds York Univ. LSHTM	Period btn 1996-2001 1 year	No	World Bank	
Masters in Public Health (MPH)	All DDHS & now extended to MOs at HSD level. Also available to other senior managers	IPH, Makerere	Two year course and an ongoing program		Development Partners, LG training funds & self finance	MPH is required to be DDHS. (Only 3/21 modules cover management.)
Diploma, Masters in Health Services Management	Mid & senior level services managers	Faculty of Health Sciences, Uganda Martyrs Univ,	One year for both courses	No	Catholic Church CUAMM CORAID	See text below
Short Courses/certificate programs						
Short courses: health policy, planning, finance (DHS programme)	Mainly MoH staff	Nuffield Leeds York Univ. LSHTM	Period btn 1996-2001 1 year	No	World Bank	Absence of local management courses at the time
Short course for hospital managers	Medical Supts. District Administrators Nursing Officers	Uganda Management Institute	2 weeks started in 2005		MoH / Dept of Clinical Services	See text below
Mentoring skills course	Senior local gov't officers	Uganda Management Institute	2005			See text below
Management and public administration courses	Middle level local gov't officers including health personnel	Protestant Medical Bureau	1997-present		Initial 5-yr Canadian support Now MoH, local gov't & fees	High on organizational behavior, etc. Accredited by Uganda Christian Univ.
2. Management development for teams						
Short courses: managerial & clinical topics	Individuals and teams at district level	Ministry of health	Various	Not available	Internal/ WHO and other development partners	Multiple short courses - wide range of topics. Takes much time but not based on needs assessments
Short courses on managerial and technical issues	Individuals and teams at district level	Ministry of local government	Various	Not available	Not known	
Development partner support to district strengthening						
DHS Project (in all districts) a) Development of integrated systems b) Logistics support c) Capacity building in planning d) Post-grad mgmt training e) Introduction of QA Department	Ministry of Health and Districts MoH MoH staff DDHS MoH	UK institutions IPH, Makerere	1996-2001	Yes	World Bank	

Nature of Intervention	Beneficiaries	Provider	Duration	Evaluation Surveys?	Funder(s)	Comments
West Nile Health Project, District-based advisers, Capacity building with MPH & Study tours	Arua, Nebbi, Yumbe, Adjumani, Moyo	Technical Advisers (CUAMM, SCF-UK)	1996-2002	Yes	EU	
UHSSP (Uganda Health Sector Support Program)	Districts in the North: Initially 3 Extended to 17	AMREF, AVSI and CUAMM	1997 to	>2001	DANIDA	District-based TA for reform agenda & intro of basic PHC package
District Support Programmes	DHMTs in Masindi and Mpigi districts	Advisers from WHO country team	2003 up to present	Not known	WHO	Support DHMTs' mutually agreed activities
District Development Project	Kumi and separately Kiboga and Kibaale	TA (AIPSO) AMREF		Not known	Ireland AID	1 expat adviser and 1 Ugandan
District support	Kitgum, Pader, Karomoja, West Nile	TA (AVSI and CUAMM)		Not known	Italian cooperation	
Delivery of Improved Services for Health (DISH)	12 districts (central and south west)	JHU		Not known	USAID	
District support programme (Five districts)	District and sub-district staff	AMREF, AVSI, CUAMM		Not known	DANIDA	Three Ugandan TAs. Focus on planning and implementation
Kumi district health project	District level	CARE		Not seen	DFID	Support: 1 expat Project Director + 3 Ugandan TAs
Ugandan Family Health Project (4 districts)	District staff	CARE		Not seen	DFID	Support: 3 expat advisers + 2 Ugandan TAs
Rural Health Program (12 districts in SW)	District staff	MoLG and MoH		Not seen	EDF	I expat adviser and 2 Ugandan TAs

Annex 4. Persons met and interviewed

NAME	DESIGNATION	INSTITUTION
(1) Ministry of Health / KAMPALA		
Dr Francis Runumi Mwesigye	Commissioner Health Services Planning	Ministry of Health HQ, Plot 6 Lourdel Rd Nakesero P.O. Box 7272, Kampala, Uganda
Dr George Bagambisa	Assistant Commissioner Planning Former DDHS	Ministry of Health HQ Kampala, Uganda
Mr Charles Matsiko	HRH Dept	Ministry of Health HQ Kampala, Uganda
Mr Moses Arinaitwe	Principal Personnel Officer	Ministry of Health Kampala, Uganda
Dr Henry G. Mwebesa	Assistant Commissioner Health Services (Quality Assurance), & Project Manager, Support to Health Sector, Strategic Plan Project (SHSSPP)	Ministry of Health HQ Kampala, Uganda
Dr Christine Kirunga Tashobya	Public Health Advisor, DANIDA Health Sector Programme Support	Ministry of Health HQ
Local Government		
Mr Lawrence Banyoya	Commission Secretary	Local Government Finance Commission The Workers Building, P.O. Box 2314, Kampala
(2) Training Institutions and Organizations		
Mr David M. Serwadda	Director	Institute of Public Health, Makerere University P.O. Box 7072, Kampala
Mr George W. Pariyo	Ag. Head, Department of Health Policy Planning and Management	Institute of Public Health Makerere University
Dr Olico-Okui	Department of Health Policy Planning and Management	Institute of Public Health Makerere University
Dr Lule Konde	Distance Learning MPH Programme Head of Epidemiology and Biostatistics Department	Institute of Public Health Makerere University
Mr Enock Mugyenyi	Deputy Director	Uganda Management Institute Plot 44-52 Jinja Road, P.O. Box 20131
Dr John Odaga	Deputy Dean, Faculty of Health Sciences	Uganda Martyrs University (in Nkozi) P.O. Box 5498, Kampala
Dr Egune	Head	Manpower Development Center, Mbale
Sr Priscilla		Manpower Development Center, Mbale
Dr Edward Mukooza	Programme Coordinator	International Christian Medical Institute (ICMI). UPMB Building, Plot 877, Balintuma Rd. Mengo P.O.Box 4127 Kampala

	NAME	DESIGNATION	INSTITUTION
(3)	**Development Agencies and Organizations**		
	Dr Rosamund Lewis	Acting WHO Representative	WHO Plot 4, Nile Avenue, East African Bank Building PO Box 24578 . Kampala
	Dr Juliet Bataringa-Wavamunno	NPO Health Systems Development	WHO
	Dr Juliet Nabyonga	NPO Health Economist	WHO
	Mr Klas Rasmusson	First Secretary	Embassy of Sweden, 24 Lumumba Avenue, Nakesero, P.O. Box 22669, Kampala
	Mr Olle Henriksson	Financial Management Advisor, based in the Department of Finance, MoH	SIDA-Sweden P.O. Box 7822, Kampala
	Ms Brigitta Sund	Health Services Management Advisor, based in the Department of Planning, MoH	SIDA-Sweden
	Mr Claes Ortendahl	Consultant	SIDA-Sweden
	Ms Elisabeth Ongom		EU
	Dr Peter L. Petit	Team Leader, EU Project: Developing Human Resources for Health (DHRH) Project	Kisozi House, Room 9 , Block B, 2nd Floor, Off Kyaggwe Rd Nakasero, P.O. Box 10610. Kampala
	Dr Peter Ogwang Ogwal	Programme Officer,	Royal Danish Embassy Plot no. 3, Lumumba Avenue, P.O. Box 11243, Kampala
	Dr Jessica M. Kafuko	Project Management Specialist	USAID / Uganda Plot 42 Nakasero Road, P.O. Box 7856, Kampala
	Mr Joshua Kyallo	Country Director	AMREF Plot 29 Nakasero Rd. PO. Box 10663, Kampala
	Dr Francis Olupot Oriokot	Head of Programmes	AMREF
	Dr Edward Kanyesigye	Primary Health Care Training Manager	AMREF
	Dr Sam Okuonzi	Executive Director	National Council for Children
	Dr Lorna B. Muhairwe	Director	Uganda Protestant Medical Bureau. Plot 877, Balintuma Rd. Mengo, P.O.Bo 4127 Kampala
	Dr Vincent Owarwo Mugumya	Project Director, Monitoring and Evaluation of Emergency Plan Progress (MEEPP)	Social & Scientific Systems Plot 51, Mackenzie Vale, Kololo, P.O. Box 12761, Kampala
(4)	**Masindi District**		
	Dr John Turyagaruka	Director of District Health Services	Masindi Health District
	Sr Beatrice Kakongoro	Senior Nursing Officer In charge of Community Initiatives	Masindi Hospital, Buruli Health Sub-District
(5)	**Mpigi District**		
	Ms Ritah Loy Kazinda	Nursing Officer	DDHS Office; P.O. Box 161, Mpigi
	Mr Godfrey Kaggwa	Diseases Surveillance Focal Point	DDHS Office, Mpigi

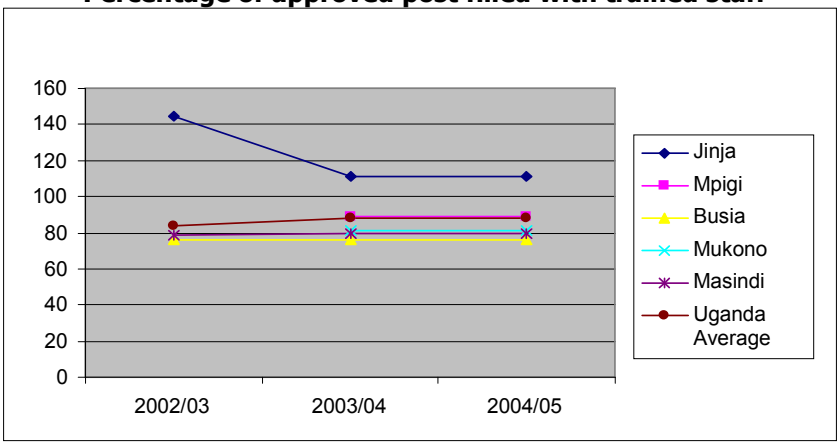
NAME	DESIGNATION	INSTITUTION
Meeting in Mawokota South health sub-district		
Dr Martin Ssendyona	Medical Superintendent Medical Officer in charge of the Health Sub-District	Nkozi Hospital, P.O. Box 4349, Kampala
Sr Elizabeth Nalumansi	Senior Nursing Officer	Nkozi Hospital
Ms Florence Linda Nassali	Enrolled Midwife, Team PHC Coordinator	Nkozi Hospital
Sr Josephine Nalaberu	Hospital Accountant	
Mr Desire Mugerwa	Record Assistant	Nkozi Hospital
Ms Josephine-Jackie Kazaga	Secretary	Nkozi Hospital
(6) Jinja District		
Dr D.W. Kitimbo	DDHS	
Dr Sara Byakika	Deputy DDHS	
Dr Felix Onzima	Medical Officer	
Mr Boniface Nfalo	D.H.E.	
Mr Chris Wagolere	DHI	
Dr Martin Ruhweza	MPH Officer	
Mr Christopher Msubura	DPPPHC	
Dr Isaye Musingizi	DDHE	
Mrs Joyce Isiko	D.H.V.	
Mr Gilbert Barayenda	D.V.C.O. , Malaria focal person	
Ms J.E. Lumala	SNO/DSFP	
Mr Gison M. Gidudu	P.H.I. / JMC	
(7) Mukono District - Meeting at District Level		
Mr Yossa Kazimoto	D.H.I.	
Ms Sarah Katumba	District Nursing Officer	
Dr Antony KKonde	i/c Mukono North HSD	
(8) Busia District - Meeting at District Level		
Dr G.B, Oundo	DMO	
Mr Malowa Charles Kudechi	Chair Person Standing Committee for Health Education & Social Services	
Ms Judith Mary Aguttu	Member - Health, Education & Social Services Committee	
Ms Hope Akongo	Secretary for Gender & Social Services	
Mr Margerie D.A. Mudiko	Member, District Health Committee	
Ms Christine Ichuum	District Women Councillor	
Ms Anna Mary Nabwire	District Women Councillor	
Dr Oddoba Wanyonga	Senior Medical Officer	
Mr Robert Muzimba	DVCO	
Mr Alex Ogwal	DHI	
Mr Joseph Bwire	HMIS	
Dr Ibrahim Kirunda	MPH Officer	
Ms Monica Egessah	Registered Nurse	

Annex 5. Other examples of district performance measures

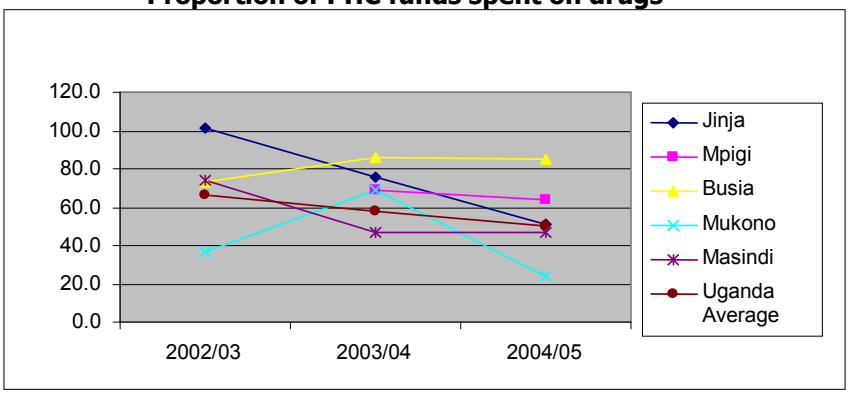
The following charts are derived from national health statistics/indicators to compare the performance of districts visited with the national averages.

A. Other management and district indicators

Percentage of approved post filled with trained staff[5]



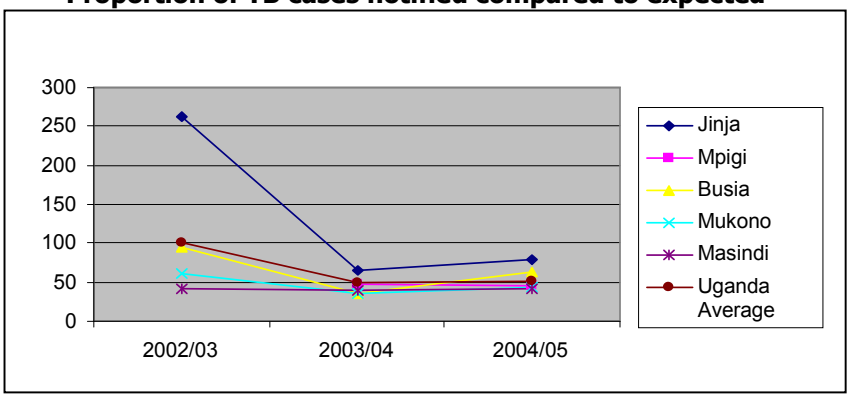
Proportion of PHC funds spent on drugs[5]



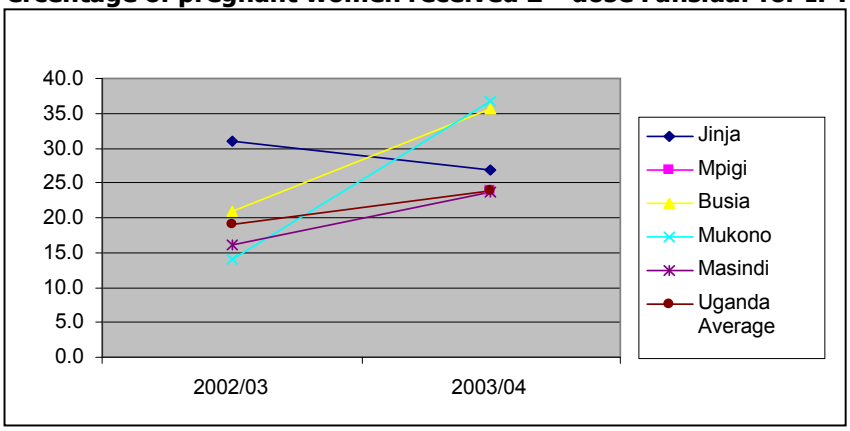
[5] Annual Health Sector Performance Report FY 2002/03, 2003/04, 2004/05. Kampala, Ministry of Health, Uganda.

B. Service delivery/Coverage performance indicators

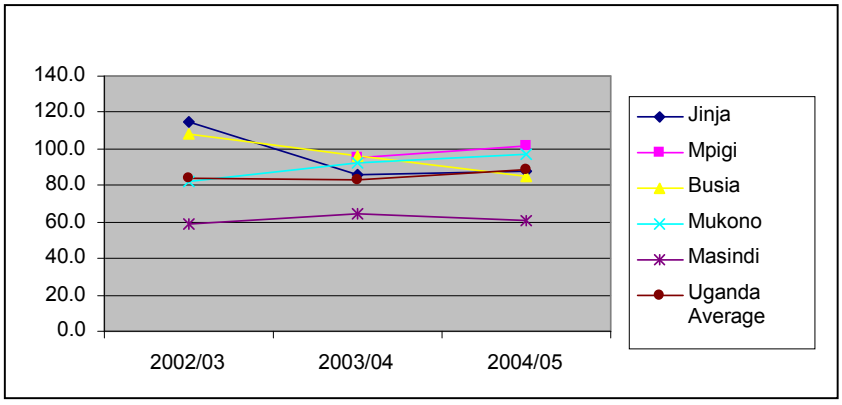
Proportion of TB cases notified compared to expected[6]



Percentage of pregnant women received 2nd dose Fansidar for IPT[7]



Percentage of children <1 who received 3 doses of DPT according to schedule[8]

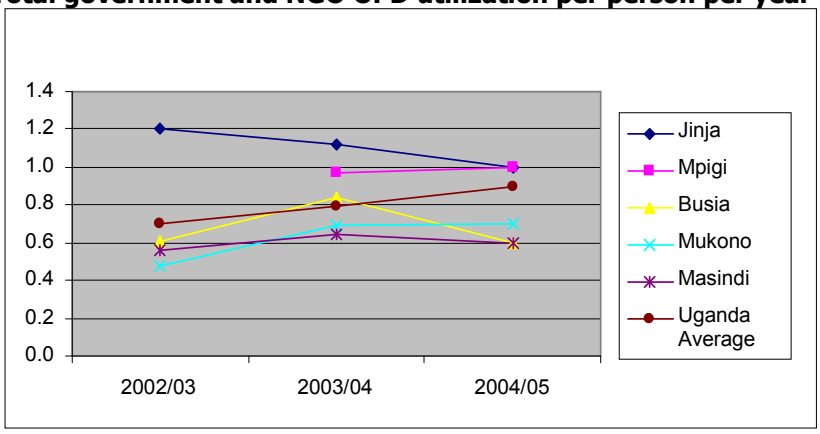


[6] Ibid.

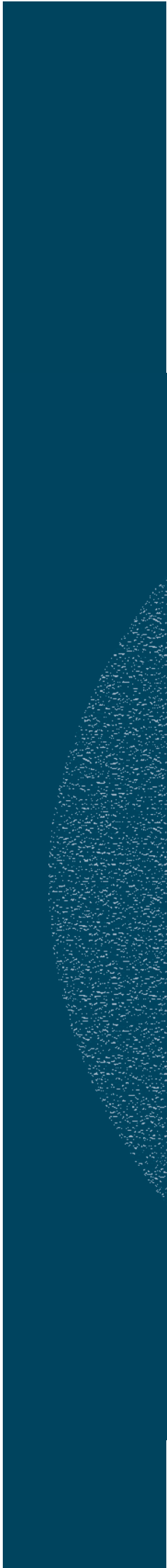
[7] Annual Health Sector Performance Report FY 2002/03, 2003/04. Kampala, Ministry of Health, Uganda.

[8] Annual Health Sector Performance Report FY 2002/03, 2003/04, 2004/05. Kampala, Ministry of Health, Uganda.

Total government and NGO OPD utilization per person per year[9]



[9] Ibid.



World Health Organization
Geneva
http://www.who.int