Health Workforce Developments: 
Challenges and Opportunities to Secure Universal Health Coverage in Uganda

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Key Messages

• The government has a myriad of health workforce problems to fix in order to achieve adequate service coverage with well-constituted work teams at all levels of health care.

• Merely framing the problem of the workforce in Uganda as absenteeism is unlikely to generate the correct solution to pervasive workforce shortage and inadequate skill mix, poor motivation and labour market dynamics.

• The drivers of the workforce shortage – in particular the constraints on the wage bill and restrictive macro-economic rationales – need to be relaxed to effectively solve the workforce challenges in production, deployment and retention.

• Training policies and institutions need to be enhanced to sustainably generate adequate, appropriately skilled, fit-for-purpose and well-distributed health workers.

• The governance of multiple agencies that espouse conflicting and adverse objectives with regard to the workforce developments need to be realigned with the overall aim of improving Uganda's health system performance and resilience.
The major lever for the alleviation of workforce shortage is wage bill increase, which would stimulate production and guarantee attractive remuneration for health professionals entering employment, coupled with improved provisions for workforce performance to improve and sustain service coverage.

**Introduction**

As Uganda seeks to improve the coverage and quality of services, the role played by an adequately skilled and well distributed health workforce becomes a central concern. Advancing Universal Health Coverage (UHC) is essentially a function of workforce density – i.e. the numbers of health workers in a given population to be served. The Joint Learning Initiatives (JLI) Report of 2006 and the World Health Report of 2006 provided the benchmarks for the workforce density necessary to improve national coverage of interventions like child survival and maternal mortality. The report states that “a 10 per cent increase in the size of the workforce per 1,000 population leads to a 2 to 5 per cent decrease in the mortality rate (1). This decrease is higher for maternal mortality and child mortality than for infant mortality” (page 154). Likewise, this report provided benchmarks for the workforce densities required to improve health service coverage. For instance, to improve skilled birth attendance to 80 per cent, countries needed to have between 2.02 and 2.54 health workers per 1,000 population. Although based on 2002 data, Uganda’s workforce density of 0.14 per 1,000 population at the time (Figure 12.1) of this analysis was among the worst on the global map – indicating the existence of a severe shortfall in the density and coverage. Estimates by these analyses showed that Uganda needed to increase its workforce threefold in order to meet this minimum standard of 2.5 health workers per 1,000 population (2).

In the last 15 years, since 2000, the national health system has attempted several solutions, albeit with significant implementation insufficiency, major shifts in direction and, most importantly, with dysfunctional coordination and governance of the workforce sub-sector. The journey to improve workforce density for essential health programmes in Uganda is characterised by major successes as well as challenges. This chapter highlights the major issues in workforce development that are vital in advancing the health coverage agenda in Uganda and similar countries.
To aid the analysis a framework (Figure 12.2) below is employed to organise the major workforce issues in four main domains of concern, as reflected in the labour market and the technocratic discourses for workforce planning and management. The concerns regarding the workforce have mainly focused on the performance, production and labour market issues as well as governance of the sub-sector. Addressing health workforce issues requires that keen attention is paid to the production of health workers, their effective deployment and, ultimately, their management for service outputs. At production level, issues of adequate enrolment, training standards, curricula that are fit for purpose and learning experiences are key areas of focus. In terms of achieving coverage and quality, equitable deployment, stability and mobility, and adequate wages need to be assured. For workforce management it is important to have adequate numbers in well constituted teams that are motivated and resourced to effectively execute their roles. These issues are reflected in the framework below.
Figure 12.2: Framework for health workforce assessment at national level

1. Production of Human Resources for Health

The production of the workforce is an intricate process that starts with the process of ensuring that enough good quality candidates are available for recruitment into the health-training institutions. According to the score card by the Uganda Science Education Programme (2012), Uganda’s long-term insufficient investment in teaching sciences in secondary schools has led to an educational system where only 30 per cent of learners pursue science careers out of the 47 per cent needed (Figure 12.3). The country has initiated policies to try to boost training in sciences across the country, among which are the science prioritisation policy and Vision 2040 to improve the quality of the teaching and learning of sciences(3). Nonetheless, gaps remain in the capacity to produce a pool of science-ready graduates to feed the health professional training pipeline.
Beyond the preparatory schooling systems (primary and secondary levels), the problem shifts to the carrying capacity of health-training institutions. Although some expansion has been made – thanks to donor grants – shortages remain in the infrastructure and learning resources such as tutors. The process of updating the training curricula has started, although these remain mostly rooted in the medical model, with less orientation towards health promotion demanded by the UHC agenda (4). The Uganda Health Systems Assessment (2010) found major gaps in the training processes, with insufficient tutors, tools and stock-outs for essential elements needed for the effective training of nurses and clinicians (5). These gaps create less than optimal training experiences and competencies. For instance, some schools training midwives and dentists have been threatened with closure owing to the existence of quality gaps (6). Managerial roles become prominent for health professionals yet this is not well articulated in the training curricula (4). Clearly, there are vital issues that need to be addressed in the production processes of health workers in Uganda.
The framing of workforce production concerns in Uganda has shifted over time. As we embark on the UHC agenda, the concerns have mostly dwelt on the privatisation of the production function of the workforce (7) and how major innovations in the training of nurses and midwives have been integrated into service delivery to improve quality and workforce size. The structural adjustment programmes of the 1990s provide a vital historical context of government actions for workforce production and the evolution of workforce management in the broader public services and the health sector in particular. These structural reforms, triggered by the economic shock of the 1970s, resulted in policy actions that slowed down the publicly funded production of health workers, led to privatised production processes and reduced the overall stock of health workers in the health system for three decades (8). These are briefly discussed below.

**Privatisation of training programmes**

Although symbolic financial provisions exist in the public financing of health-training institutions, these have experienced diminishing financial contributions over the years as the government prioritised free primary and secondary education. During the 1980s and late 2000s, the government divested itself of the role to train professional cadres like midwives and nurses by adopting a government-wide – albeit informal – policy of privatisation of health-training institutions. Although it takes about $12,000 to train a medical doctor in Uganda, government contributions have averaged only about $4,000 to this cost (9). Since the implementation of structural adjustments programmes, the financing of higher education generally and, in particular, the financing of health-training institutions has shifted from being predominantly government funded to increasingly private funded (7). Evidence shows that most of the production of health workers – especially the vital health system cadres such as nurses and midwives – is carried out in private institutions where tuition and training costs are mostly catered for from out-of-pocket contributions by the community and households. Faith-based sub-sectors have attempted to bridge the gap left by the government’s withdrawal from health workforce training functions. Estimates in the mid-2000s show that over 60 per cent of the nurses and midwives – the lynchpin of service delivery in Uganda – were trained in faith-based schools and with private financing (10). Private health-training institutions have increased exponentially in the 2010s to take advantage of the high demand for the
training of health workers in Uganda and globally. According to the Allied Health Professional Council in Uganda (40), 43 out of 52 recognised training institutions are private (AHPCU, 2017). For the nursing and midwifery course, out of the 84 recognised institutions, only 15 are government-owned, with 50 per cent of all schools being privately owned (41). Although this transfer of financing for health worker education from the government to the individual citizens can be perceived as a success in saving public resources, the implications it has had for the governance of the workforce have been less well articulated. For instance, over time the government has lost the legitimacy to deploy the workforce to achieve fair coverage – partly because health workers graduating from privately funded training programmes have a diminished obligation to serve public interests. The private motivation to recoup private investment (tuition etc.) during training partly explains why the Ugandan government has weaker tools to deploy health workers in hard-to-reach areas and retain them to improve service quality and coverage. It also explains why many health workers prefer to undertake private practice or dual practice in urban centres – where they work in public services alongside their private enterprises to earn more income (11).

Health workforce policy: Prioritising shortages

The 2006 Ministry of Health’s Human Resources for Health (HRH) Policy and the HRH Plan (2005-2020) missed the opportunity to set targets that correct the problem of workforce shortage. The projection scenario for workforce size adopted by the Ministry of Health (MoH) for the HRH Policy and Strategic Plan (2005 – 2020) was way below the 2.5 health workers for 1,000 population – a benchmark advised by the WHO. It was also below the workforce size estimated based on the workload in Uganda’s health system at different levels (12, 13). The 15 years covered by the HRH Plan indicate a marginal increase in the workforce (Figure 12.4) but does not correct the severe shortage that has been created by many years of divesting in workforce production, recruitment and deployment due to the structural adjustment policies of the 1980s and 1990s (14).

Figure 12.4 below shows the gap between the estimates of the workforce as adopted in the policy compared to the expected size calculated on the basis of the population growth and service requirements. According to the HRH policy provisions, the workforce gap is expected to widen over time – moving
from a deficit of 42,000 by 2005 to above 58,000 by 2020. This is despite a marked increase in the demand for health services. For example, estimates by the Uganda Demographic and Health Survey (UDHS) show that the number of childbirths in health facilities for the five years prior to the survey increased from 1.5 million in 1995 to 4.2 million in 2011 (15).

**Figure 12.4:** Gap between the WHO standard for workforce requirements and estimated workforce in Uganda

Despite a nearly threefold (300 per cent) increase in the workload, the number of midwives in the country has only increased by about 20 per cent during this period. This period has also been associated with a twofold expansion of the scope of work for midwives as more tasks for HIV screening, counselling including the whole programming of prevention of mother-to-child transmission (PMTCT), which was introduced in maternal care services (16).

In the early phase of the HRH Plan, the MoH instead prioritised short-term remedies. The involvement of community-level health workers such as Traditional Birth Attendants (TBAs), Village Health Workers (VHTs), on-the-job trained Nurses Assistants constituted interventions that attracted heavy investments aimed at fixing the workforce problem with cheap labour options. Unfortunately, even these community-level health workers are often focused on curative care (e.g. drug distribution) rather than emphasising health promotion to mitigate the cost and burden on the professional
workforce. The policy to decentralise the recruitment of health workers also weakened the capacity of the government to ensure fair distribution or deployment of the workforce. Experience shows that resource-constrained and remote districts are less competitive in attracting health workers and experience more problems of staff attrition and turnover (17).

Over the years, major gaps have emerged in the cadre mix in the workforce. Only a few schools have invested in training diagnostic cadres such as laboratory technicians, radiographers and similar professionals. When the health systems in the 2010s started to demand more diagnostic cadres to expand HIV-related treatment programmes, private and public training schools rushed to revamp the training of diagnostic cadres to address the critical shortages created over the last two decades.

Moreover, most curricula in these training schools have not evolved in tandem with emerging diseases, conditions and technology advances. For example, the training of care providers with special attention to injuries and non-communicable diseases has been grossly neglected, even though these are the services most increasingly sought after within the sector. With regard to technology, as more equipment and treatment protocols are introduced within the health care field, health workers require orientation training in the form of continuous medical education, an aspect which remains largely unstructured to meet the demands of the sector and the workforce.

**Failed innovation: Production of comprehensive nurses**

Amidst these production dilemmas, Uganda successfully integrated the training of nurses and midwifery – a strategy that was aimed at boosting the skill mix and efficiency in workforce performance and coverage. By 2005, insiders in the Ministry of Health were concerned about the implementation. As observed by Amandua et (2005).

Despite the relevance of a study programme and the intended graduates, a poorly conceptualised and planned implementation process can result in the failure of an otherwise good training programme in achieving its intended goals. It was evident that in the case of the enrolled and certificate comprehensive programme, stakeholder involvement at the onset of the programme was minimal, yet for effective programme outcomes, their involvement is critical at every stage of the programme planning and implementation process page (18, page 673).
Between 2001 and 2010, the Comprehensive Nurses Programme (CNP) was rolled out in all major nurse/midwifery training Institutions. Donor programmes came in to aid government in the strengthening of health systems and especially the workforce developments. Among the donors were the European Union, Irish AID, DANIDA and the US Government (19). These aid programmes aimed at expanding the infrastructure for training schools, modernizing the curricular and skilling tutors and managers as well as providing scholarships especially for trainees from remote and underserved communities. By 2015, over 30,000 comprehensive nurses had been produced. The paradox is that the government did not absorb or deploy these graduates for their intended purpose. Many graduates from CNP have found their way into the private sector.

Claims emerged from UNFPA and the International Midwifery Association that CNP graduates had inadequate midwifery competences compared to those trained in a traditional curriculum to become midwives. As the global agenda to reduce maternal death by expanding skilled birth attendants gained momentum, the definition of a skilled-attendant at birth became more controlled by external forces (IMA and UNFPA) –Uganda’s regulatory council – excluded CNP graduates from the bracket of skilled attendants (21, 22). As noted in the Nurse and Midwifery Policy document of MoH, the main challenges were: “Nurses and midwives with bachelor’s degree and postgraduate training are not recognized in the existing employment system of health care (and) graduates of the comprehensive nursing programme have not been accepted by public service and other stakeholders nor positions created for them in the scheme of services. (page 10) (22)

By implication, Uganda’s policy to produce comprehensive nurses has generated 30,000 graduates who were not deployed to contribute to improving health coverage. This strategy constituted a major waste of the health system resources and especially of private investments which enabled the training of these cadres, as well as the donor aid that propped up this workforce production process. This disconnect between policy and implementation provides an example of missed opportunities for the health system to improve the workforce density and scale-up of health programmes.

Overall, the inadequate workforce has left service gaps that are mostly perceived as “unfilled posts” or “vacancies” by technical actors and as “absenteeism” by those who are concerned with service quality from the community perspectives. Innovations like community reporting, attendance registers and technology for clocking-in and clocking-out at the workplace
are being expanded in the current Health Sector Development Plan (22). Unfortunately, these are not able to overcome the fundamental shortfall in the stock of the workforce that is rooted in deliberate choices in HRH policy and the HRH Plan of MoH. Re-defining the problem and reframing of the main workforce challenge as “inadequate stock and unbalanced skill mix” will help to re-direct policy interventions and investments to address the workforce production and diversification of the skill/cadre mix.

**Regulation of workforce production**

The new and urgent challenge is regulating health workforce production. This problem emerges from the private health-training institutions that have mushroomed to take advantage of the demand for training health workers. Reports show that the government is now concerned about addressing the regulatory weaknesses to ensure that these enterprises adhere to standards of training and produce competent health workers. Training institutions, both private and government-owned, have major quality gaps. As Kitanda (2008) observed:

> Critical tutor understaffing and the few present tutors working under great pressure to cover the workload was a direct threat to the quality of the training in the schools and to the subsequent quality of care. (6)

Understaffing is mostly due to non-appointment of tutors, compounded by underfunding from the government and private entrepreneurs. Disrupted mandates and institutional loyalties of tutors and health training schools from their parent MoH to different agencies such as the National Council for Higher Education (NCHE) and the Ministry of Education and Sports (MoES) (23) have also generated loopholes in the regulatory function (24). In her statement to the health sector annual review meeting (2015), the director of the Medicines and Health Service Delivery Monitoring Unit (MHSDMU) was quoted as saying:

> How can private schools produce 300 doctors a year without facilities like hospitals? Why haven’t the regulatory bodies been able to check this problem? Unleashing ill-trained doctors to the public is a problem that should be addressed. (Director MHSDMU at Annual Health Sector Review Meeting, 2015)
The establishment of the Uganda Nurses and Midwives Examination Board (UNMEB) in 2005 provided a positive development in the regulation of the production of the workforce. The examination board emerged in response to the problem of the emergence of many private training schools whose training programmes were less well controlled for quality assurance. Since 2013, prior to being registered for practice, all nurses and midwives have to pass the UNMEB examinations. These examinations also serve to provide vital information about the number and type of nursing and midwifery cadres entering the profession (see the figure below).

**Figure 12.5: Production and licensing of nurses and midwives 2006-2016**

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Source: UNMC, 2016 (41)

2. Managing Health Workforce Performance

Over the years, the performance of the workforce has emerged as a highly visible but contentious issue among technocrats and the politicians alike. While absenteeism is a common way to frame the issue of workforce performance among the politicians and communities, the technical leaders in the health sector have mostly framed the performance problem in terms of insufficient workforce stock (shortage), unbalanced skill mix and inadequate supplies for service delivery. Direct voices from the workforce itself indicate a wider set of issues that are responsible for inadequate workforce performance. Although largely ignored, the voices of health workers consistently identify
inadequacies in the support systems (inadequate work environment, insufficient tools and medicines and lack of complementary skill) to enable them to do their job properly as the main problem, closely followed by inadequate wages and remuneration (25). Among the many issues raised by health workers, absenteeism and the implications of its criminalisation of absenteeism are highlighted below.

**Absenteeism: Solving the wrong problem?**

From the community perspective, health workforce shortages manifest as a few staff available to attend to the clients, long-waiting times and inability to provide adequate staff coverage (26, 27). Coverage expectation from the community is for a 24-7 service, i.e. 24 hours for every day in a week, all year round. These are the standard expectations of health care delivery internationally (28). A close look at the workforce standards (establishment) within the health facilities falls short of providing the expected 24-7 service coverage. According to the population size to be served, Uganda needs to have a workforce stock of about 81,000 (nurses, midwives and doctors), according to the MoH standards, to achieve the expected coverage. The MoH HRH audit report in 2015 showed that the total workforce (across all cadres) was 54,864 – a shortfall of 32 per cent. If this gap is translated into a coverage gap or workforce absenteeism, the implication is that health facilities are expected to be “closed” for two days each week or seven hours each day! Unfortunately, powerful groups in national political circles and global health policy discourses have propagated the workforce “absenteeism” and other toxic rhetoric (25, 29) that blame the workforce for poor outcomes arising from deliberately ineffective policy choices (30).

Absenteeism has, however, degenerated into a negative spiral of policy and public discourse that has resulted in the toxic branding of health workers. Ill-conceived studies have portrayed absenteeism as fully due to wilful and illegal absence from work. Although illegal absenteeism exists to a small extent, a big part of this is contributed to by workforce shortage and legal prescriptions of labour laws governing all civil servants, including the health workers in Uganda. Universal labour laws and the rights of employees – including health workers – specify eight hours a day of work and rights to vacation, public holidays and sick leave. This has come to be ignored by both technocratic and political leaders in Uganda. Just like communities, the “landmark” studies examining absenteeism unreasonably expect 24-hour presence at the health facility from the few available health workers with no time off-duty nor vacation.
Methodologies for computing absenteeism have taken a radical but naïve view of absolute “presenteeism” – many going beyond the commonsense understanding of labour laws and all legitimate spaces for service delivery. For example, the main methods of inferring absenteeism in studies (26, 27, 31) – both funded by the World Bank Research Group – have revolved around “on-spot inspection” and “unannounced visits” to inspect the workers present on that day (usually morning hours) when the study team arrives at the health facility. This methodology ignores off-site functions such as staff working on outreach and administrative tasks that require health workers to function away from their facilities. Using the “factory floor” model as the method for evaluating absenteeism is part of the problem. It leads decision-makers to prescribe solutions to the wrong problem. More fundamentally, the methodology ignores the requirement for the three work teams required to cover the three 8-hour shifts in a 24-hour day and the right of health workers to be off-duty on weekends and public holidays, and to take annual and sick leave. To cater for these extra workdays, the estimation of the required workforce should take into account three-work teams per day to cater for service coverage at all times. These problems require direct actions to mitigate the workforce shortage and the related constraints on financing, and to optimise workforce production, recruitment, retention and provisions for performance.

Figure 12.6: Proportion and reasons provided for absenteeism – MoH study, 2016

Source: MoH Joint Review presentation, 2017
According to these statistics, (see Figure 12.6) a health worker who is in the community providing outreach services is categorised as absent from duty. Legal absence from work due to annual leave and legal off-duty hours are added to the computation of absenteeism to inflate the magnitude of the problem. This is contrary to the 8-hourly shifts that allow the deployment of the available workers to cover morning, evening and night duty hours. Unfortunately, these studies have been widely cited in policy circles – and in many cases used by decision-makers to arrive at wrong decisions or solve the wrong problem. For example, in Wakiso district, health workers were publicly paraded by the president at a public rally, with the president proceeding to then direct that they be “discharged with disgrace” for not being available all the time to serve the community (32). Similar studies have erroneously estimated that eliminating health workers’ absenteeism could save government close to USh. 30 billion (33, 34). These studies have added to the misguidance of decision-makers. Instead of advising that the root cause of the problem – the inadequate stock of the workforce – be addressed, these studies frame the problem of shortage of the workforce as illegal absenteeism that only needs managerial enforcement of “presenteeism”. It is ironical that the same actors that were responsible for decades of divestment in the workforce are the leaders of the enterprise to reframe the workforce shortage as absenteeism. If policy is developed on the basis of the problem framed as “absenteeism” of health workers, the solution space for policy interventions will focus on pressuring the current workforce to optimise “presenteeism”. Facility-based assessment of workforce “presenteeism” runs counter to the legitimate activities that require health workers to serve the communities through outreach platforms. Health promotion and universal health coverage goals will be under-served if the current preoccupation with facility-based “presenteeism” is enforced in a naïve manner. The management of illegitimate absenteeism should be grounded in health systems thinking alongside economic models from industries like airlines that are concerned with public safety and risks/errors that may arise from work overload and prolonged hours at work.

**Workload pressure**

The government has incrementally increased the workforce size in the public sector through sporadic initiatives to boost the recruitment of health workers in the public service. The MoH workforce audit 2009-2016 shows
improvement in the percentage of staffing over the years (Figure 12.7) – from 53 per cent to 71 per cent of the approved number of health workers in the government health facilities. As discussed below, recruitment has not been successful in solving the problem of an inadequate workforce.

**Figure 12.7: Percentage of positions filled in the government health facilities**

![Graph showing percentage of positions filled over years](image)

**Source:** MoH annual sector report, 2009-2016

Despite the increases in the trends of available health workers, the reference standards of the staffing norms are much lower compared to the workload burden at the health facilities (13). This calls for workforce redistribution in accordance with objective means such as workload and the expansion of the staffing norms to cope with the expanding burden for health services due to a rapidly growing population and emerging diseases and conditions. For instance, Namaganda et al. (2015) noted that health centres had a shortage of nurses and midwives, ranging from 42 per cent to 70 per cent (13). The study recommends increasing the investments to expand the stock of the health workers. It notes:

“The results highlighting discrepancies between Uganda’s actual staffing norms and the workload based requirements. When staffing levels are far below the minimum required to provide services of reasonable quality, the government and development partners should focus on increasing investments in health worker recruitment to reach the staffing standards. (Namaganda et al., 2015: 10)”
Unbalanced skill sets

The distinctive characteristics of clinical care are teamwork and team production. For instance, an outpatient client with malaria in a health centre ideally needs to make contact with at least five persons with different skills to enable effective diagnostics and treatment. These might include:

1. A receptionist to register, screen/triage and direct the client to the right place for clinical evaluation/consultation;

2. A clinical expert (clinical officer, nurse or doctor) for clinical assessment and prescription;

3. A laboratory technician if laboratory tests, e.g. malaria testing, are required;

4. A dispenser, who will be required to provide the medicines and explain their use; and

5. An injection room nurse, who is required if an injection is prescribed.

If one or more of the above skills are missing – for example if the laboratory person or the injection-room nurse is not available – the treatment process would be ineffective. This would cause delays in the treatment process or over-prescription of malaria or antibiotic medicines. Studies have shown that in the absence of laboratory tests, clinicians blindly prescribe more antibiotics or antimalarial medication – a situation that creates unnecessary costs of the medicines in the health system and makes coverage objectives costly to attain (35).

The scenario for in-patient care is of greater concern because the gaps in the skill sets are much wider, for example in the case of surgical services where a mix of both specialised and support skills is required. Among the smallest number of health professionals in the workforce are anaesthetists – responsible for pain management during surgical operations. The 2015 workforce audit by the MoH shows that only 238 anaesthetists are available compared to the 878 positions – a vacancy level of 73 per cent. Relatedly, an assessment of hospital and health centre IV functionality (36) found that surgical services were less available – mostly due to the insufficient availability of health workers with the essential surgical skills (doctors and anaesthetics) at this level. As illustrated in Figure 12.8 below, surgical services for family planning, dental care and C-sections are much less available compared to non-surgical services. Inadequate essential supplies for surgical services are also partly to blame for this problem.
Policy responses to improve workforce performance should prioritise the workforce shortage, intentionally seek to address the skill mix problem and ensure adequate geographical, population and service coverage with a view of achieving UHC.

3. Labour Market Dynamics and Strategic Governance

Governance in this respect broadly seeks to ensure that strategic frameworks exist to steer the workforce stakeholders and multiple interests that require coordination. Governance also seeks to optimise public value and goals by managing the interests of different stakeholders. Workforce production, performance and labour market management present a classical challenge of too many institutions whose interests require active governance to align them with the common public policy goals. The Annual Health Sector Report (AHSR) 2009/2010 observed:

Various organisations and agencies among the Health Development Partners have taken up interest in HRH issues and are providing financial, technical and infrastructure support to the government, and
PNFPs, (…). These include agencies such as the European Union, DANIDA, JICA, the World Bank, USAID, SIDA, Belgian Technical Co-operation and many more. This has brought in plenty of challenges – equity, duplication, uneconomical use of resources, ineffective delivery of services. This multiplicity of actors in HRH interventions, require coordination. (MoH AHSR, 2009/2010: 152)

The table below illustrates the number of institutions and their overriding objectives in the workforce governance space. In general, there are major conflicts in the objectives of agencies managing the different functions of the health workforce. Even within government, there are interests that run counter to the goal of providing an adequate stock of health workers. There are many dysfunctional objectives, for instance to export the health workforce to generate inflows of financial remittances from the workers in the Diaspora (37) despite a shortage of the current stock of the workforce to serve the health needs of Ugandans at home. Some of these dysfunctional objectives are championed by high-level political leaders, who are elected to represent under-served communities. This situation illustrates the lack of a shared vision among the political elites. As such, the role of governance in ensuring that health workers are adequate, well trained and distributed to serve all Ugandans has major contestations and competing objectives.

Working at cross-purposes is probably the major problem in the governance space for the workforce (see Table 12.1). The reforms in the production sector have made the costs of production move from the government to communities. Most training schools for nurses and midwives are in the private sector, where training costs are high, thus curbing the numbers that can be produced. If left to their own devices, the stakeholders are likely to continue working at cross-purposes and fail to improve the workforce situation in Uganda. Recent history has shown that there is marked potential in building coherence in government actions for health workforce management in Uganda.
Table 12.1: Conflicted objectives: Institutions and agencies involved in workforce governance

<table>
<thead>
<tr>
<th>Institution</th>
<th>Main role</th>
<th>Main objective(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of Health</td>
<td>Employer and steward</td>
<td>To overcome shortage, diversify the skill mix, ensure equitable distribution and boost performance</td>
</tr>
<tr>
<td>Ministry of Education and Sports</td>
<td>Production</td>
<td>To Finance and coordinate all training institutions at all levels.</td>
</tr>
<tr>
<td>National Council for Higher Education (NCHE)</td>
<td>Funding and regulating health-training schools</td>
<td>To provide standards and regulations for health-training institutions and similar others</td>
</tr>
<tr>
<td>Professional councils</td>
<td>Licensing, elevated standards</td>
<td>To elevate standards of entry into training and increase costs/wages to the system</td>
</tr>
<tr>
<td>Local governments</td>
<td>District service</td>
<td>To lead service delivery mandates but little control over inputs and support systems</td>
</tr>
<tr>
<td>Public service</td>
<td>Employer and payer</td>
<td>To provide fair wages across the public service, and to resist selective wage increases for health workers and create jobs</td>
</tr>
<tr>
<td>Ministry of Labour</td>
<td>Job creation and externalisation</td>
<td>To license and encourage the export of labour, including health workers</td>
</tr>
<tr>
<td>Ministry of Finance</td>
<td>Finance and planning</td>
<td>To control wages and stabilise the economy by restricting financing for inputs used for workforce performance</td>
</tr>
<tr>
<td>Private sector agencies and PNFP bureaus</td>
<td>Employers and producers</td>
<td>To provide alternative employment and work environments, and dual practice opportunities for supplementary earnings</td>
</tr>
</tbody>
</table>

*Source: Author analysis*
Competing labour markets

Another major issue is the growth of the private sector within Uganda and the opportunities it provides to expand the labour market for health professionals. For instance, the religious-based health provider networks employ about 12,000 health workers and contribute about 30 per cent to the combined Public-PNFP workforce. Ninety per cent of these are privately employed. The other 10 per cent comprise staff seconded by missionary congregations, the local governments, and the MoH (38). Since both the public and private sectors compete for the same limited numbers of health workers, the sector which is better able to pay has more leverage in the market share for the available workforce (17). Dual practice – multiple job holding or moonlighting – has become a commonly encountered phenomenon as health workers (both specialists and fresh recruits) seek to supplement their meagre incomes in the private sector alongside their employment in the public sector. Indeed, public sector management has at many levels been forced to adopt a non-critical stance with regard to dual practice. One argument put forth to justify this stance is that the health workers engaged in dual practice continue to provide services beyond their normal working hours, a practice which should be lauded rather than condemned (11, 39). Still, this practice needs to be monitored for its effect on the quality of care across both sectors, especially considering that dual practice continues to stretch the few health workers available.

International labour markets, too, have the capacity to poach the health workforce in Uganda if not controlled. Recruitment agencies from Trinidad and Tobago as well as from Libya have all excited the Ugandan health workers by providing them with the opportunity to earn a decent wage abroad that the Ugandan government has failed to offer at home. The famous policy of government – i.e. “market-led developments” and “externalisation of labour” (37) – should be re-examined in the light of the scarcity of the current workforce and the insatiable demand for professional health workers in the international labour markets.

Conclusion

The health workforce in Uganda has witnessed major policy and programmatic challenges. Despite some increases in the public and non-public sector workforce stock in the last 10-15 years, the deficit gap – between the minimum
standards for quality services and the current HRH policy provisions for staffing – is widening. The outstanding problem is shortage of the stock and skill mix of the workforce. However, the solution to this problem has been confused by unhelpful framing of the shortage of the workforce as a problem of absenteeism.

An effective balance must be struck between the apparent vigilance for the “presenteeism” of health workers at health facilities and the overall goal of keeping Ugandans in a state of good health and well-being. Community outreach programmes to promote health and well-being will require health workers to spend more time in the community – a situation that needs to be encouraged but not criminalised as absenteeism. Ultimately, good workforce governance with aligned policies and well-coordinated stakeholder efforts should be explored and invested in to advance universal health coverage goals.

Clearly, the Ugandan government has the problem of an inadequate stock of workforce to fix in addition to the need to undertake managerial interventions to address adequate service coverage with well-constituted work teams with the required skill sets and seniority for the expected quality of services. Still absenteeism, as a valid lever of workforce performance, needs to be understood from a systems thinking perspective grounded in legitimate labour laws and the diverse platforms available for providing health services.

The expansion of the population size to be served and the integration of more health interventions with heavy additional tasks such as HIV and NCD care are all indicators of an escalating workload. Strategic training of the workforce with due concern for emerging diseases and required skill sets is critical. Performance management strategies need to address the work environment besides increasing the stock and skill mix of the workforce. As opportunities expand for Uganda’s workforce to move out and work abroad, the government needs to invest in purposeful governance mechanisms to safeguard the interest of Ugandans by making the labour market attractive for professional health workers to choose to serve Ugandans and expand the service coverage and quality objectives of the health system at home. The major levers for the alleviation of workforce shortage are wage bill increases to stimulate the production of professional cadres and to ensure that greater numbers of professional cadres enter employment when attractive remuneration and supportive performance systems are available.
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