Policy Brief

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The state of Human Resources for Health and its implication for policy in attaining UHC targets in Uganda.

Authors: *S. Kiwanuka[1*], Eric Ssegujja[1], E. Rutebemberwa[1], F. Ssengooba[1]*

1 Makerere University School of Public Health, Department of Health Policy, Planning and Management

For more information contact:

Suzanne Kiwanuka

Tel: *+256 0772886377,* ***Email:*** *skiwanuka@musph.ac.ug*

Key Messages:

1. *The current level of training for the workforce is adequate to implement the three policy domains assessed in the PIB survey;*
2. *Challenges still exist with the workforce adequacy and equitable deployment across workstations;*
3. *With regards to support systems for the workforce, essential guidelines are adequate to implement the three policies;*
4. *Salaries and the tools to use while implementing the three priority policies are still inadequate.*

Introduction

Human resources for health are said to be the lynchpin of a functional health system. Human resources form both an input but also the process which steers (brings together) all the other inputs. Despite their importance, human resources for health are rarely factored into policy formulation as both a resource and an input. Moreover available evidence suggests that even less attention is accorded to them during the evaluation of policies (Cailhol et al 2013). Without addressing HRH issues within the health sector, it is unlikely that sector policy targets will be achieved.

The problem

In ideal situations, policy objectives and subsequent implementation plans ought to match the status of the existing health workforce that will be charged with guiding and implementing the policies. However, despite their importance, human resources for health are rarely factored into policy formulation as both a resource and an input; its prioritization prior to policy implementation is rarely done. Difficulties affecting health workforce have for long been a pressing issue towards the realization of better health outcomes in many of the sub-Saharan African health systems. These stem from inadequate funding to the health sector while others originate from the poor planning, in part due to inadequate skills. Scenarios of a disconnect between training, recruitment, management, retention as well as forecasting for future workforce requirements are a common feature of many health systems.

Nonetheless, several efforts have been tried in an attempt to address the health workforce challenges. These have ranged from short-term such as motivation of the existing workforce to the long-term strategies like pre-service training for hard-to-get health workforce. To date, many of these endeavors have fallen short of mitigating the health workforce challenge. Some have been deemed irrelevant to the implementation contexts while others have been characterized by disjointedness with a lack of a longer-term focus. In the end, new workforce problems emerge where previous interventions were implemented. Different financial motivation schemes have, for example, been highlighted elsewhere as having led to the breakdown of the health workforce other than building it. The same goes for efforts to integrate development partner activities into routine services at the frontline which led to health workers prioritize these activities and abandon core duties. In other instances, government efforts to recruit health workers for rural health posts without adequate housing instead, led to high levels of absenteeism because of daily commuting to workplace.

SPEED conducted the PIB survey to generate data that would support the strengthening of capacities for policy analysis, advice and influence to accelerate progress

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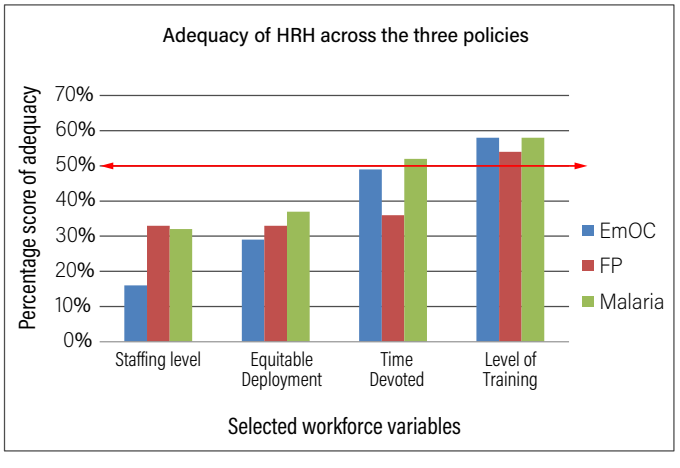
towards UHC and health systems resilience in Uganda through providing evidence to engage government by monitoring the implementation of policies. It assessed the adequacy of the health workforce with the first round conducted in 2016 acting as a baseline from which subsequent comparisons would be done.

Results

Staff adequacy across the 3 policies (staffing level, equitable deployment, time devoted and level of training

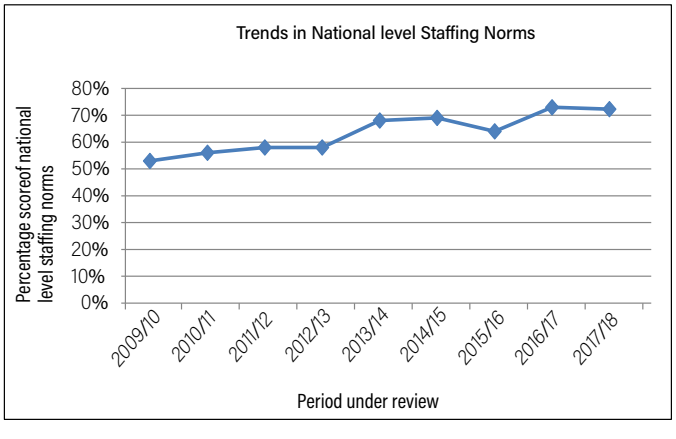
Our main findings indicate that with regards to HRH status, whereas the level of training was adequate across the three policies. The time devoted to implement programs were adequate for malaria and EmOC but not Family planning. The staffing levels and equitable deployment were perceived as inadequate across the three policies reviewed as seen **Figure 1** below.

Fig 1: Adequacy of HRM across the three policies.



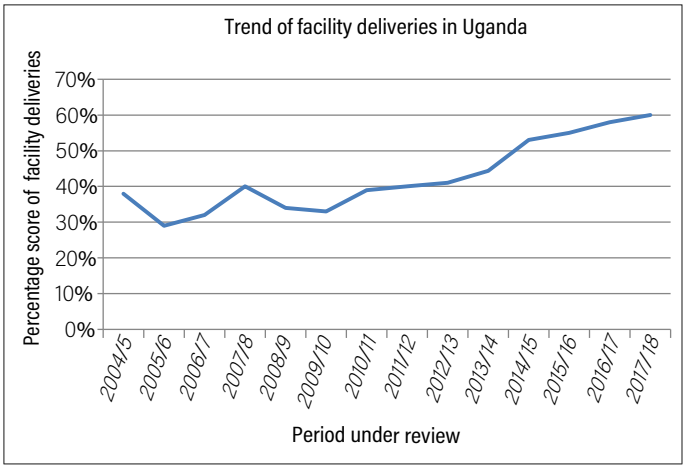
Although staffing was perceived to be inadequate across all three policies, it was observed that in the ten year period preceding the PIB, staffing levels have been increasing every after year with a slight decline noted around 2012/2013 and 2015/2016.

Fig 2: Trends in National Level Staffing Norms.



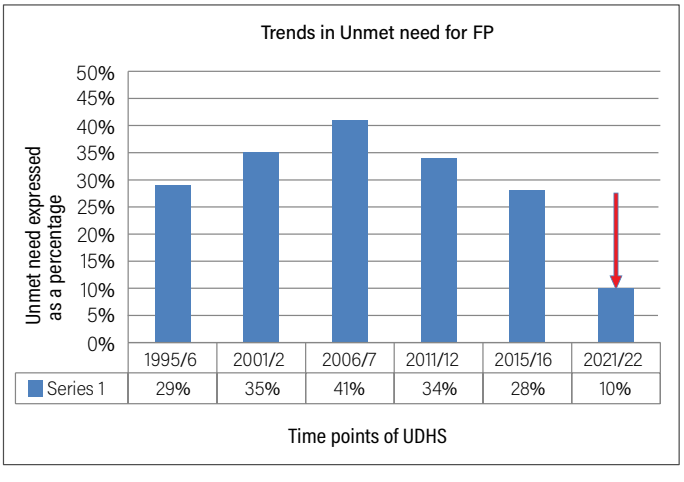
With regards to equitable deployment, results from secondary data confirm that health workers tend to favor deployment at tertiary level institutions and urban based facilities. Although facility deliveries have been increasing according to MoH statistics, the staffing levels/norms have not changed since it was last updated in 2004 hence confirming our results that the staffing levels implementing the EmOC policy is inadequate

Fig 3: Trend of facility deliveries in Uganda.



The staff implementing Family Planning was reported as inadequate and this could be explained by the levels of unmet need for FP where the country has twice in the recent years failed to meet the national target.

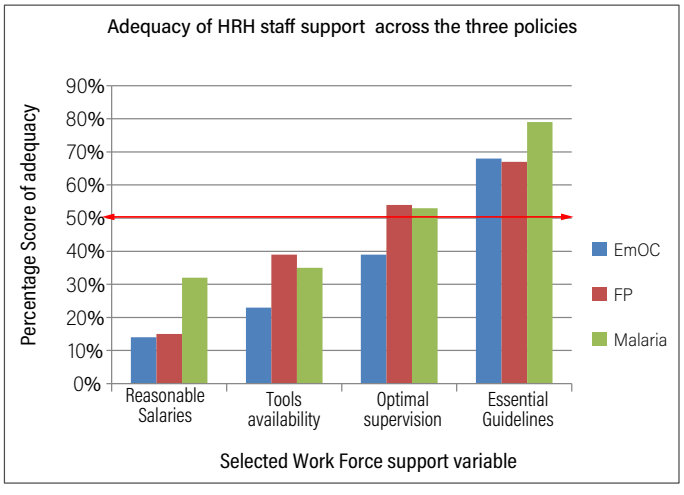
Fig 4: Trends in Unmet need for FP.



Existence of conducive work environment across the 3 policies (reasonable salaries, tools availability, optimal supervision and essential guidelines)

The level of staff support to implement the three selected policies indicates that the HRH challenges are similar across all the three policies. However, malaria is perceived to be better in having guidelines and staff salaries/allowances - partly likely due to donor support of the agencies participating in programs for malaria policy. Otherwise the government/public service salary structure hasn't been revised in a long time despite the rising inflation. For FP the tools for administering long-term methods are not readily available, the percentage of HCIVs with a fully functional operating theatre is just increasing of late while the change in malaria treatment policy to parasite based diagnosis hasn't fully been matched with equipping these facilities to perform parasitological based tests.

Fig 5: Advocacy of HRH across the three policies.



Implications for policy

1. Time to revise the staffing norms to match population growth/demand
2. Deliberate and coordinated strategies with a longer term focus to attract and retain staff in lower level and rural facilities for equity in deployment
3. Revise the salary structure to match the market value of health workers
4. Match policy revisions/changes with tools to support their implementation
5. For Malaria efforts should be made to integrate partner support to address HRH gaps
6. For Family planning efforts should be made to avail HRH especially to administer long-term methods
7. For Maternal health efforts should be made to increase production of midwifery cadres

This brief is based on results from a draft manuscript titled "Human Resources for Health Adequacy for Implementing three tracer policies towards UHC in Uganda: Results from the Policy Implementation Barometer"

SPEED Brief

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For details about SPEED

Makerere University School of Public Health, College of Health Sciences
Level 3, School of Public Health Building, Mulago Hospital Complex
Office: *Room 323, MakSPH Building* ***Website:*** *speed.musph.ac.ug* ***Email:*** *speed4uhc@musph.ac.ug*
Tel: +256 772-509316 *@SPEED4UHC* *@SPEED4UHC*