Country Report

Uganda

Improving health workforce performance
## Key project information

<table>
<thead>
<tr>
<th><strong>Title of research programme:</strong></th>
<th>Supporting decentralised management to improve health workforce performance (PERFORM)</th>
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<tr>
<td><strong>Reference number:</strong></td>
<td>266334</td>
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</table>
| **Partners:**                    | School of Public Health, University of Ghana  
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                                 Switzerland  
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### Acronyms

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<th>Definition</th>
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<tbody>
<tr>
<td>ADHO</td>
<td>Assistant District Health Officer</td>
</tr>
<tr>
<td>AFENET</td>
<td>African Field Epidemiology Network</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>AMREF</td>
<td>African Medical Research Foundation</td>
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<tr>
<td>ANC</td>
<td>Ante Natal Care</td>
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<tr>
<td>AOB</td>
<td>Any Other Business</td>
</tr>
<tr>
<td>AR</td>
<td>Action Research</td>
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<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
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<tr>
<td>BTC</td>
<td>Belgium Technical Cooperation</td>
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<tr>
<td>CAO</td>
<td>Chief Administrative Officer</td>
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<tr>
<td>CBO</td>
<td>Community Based Organization</td>
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<tr>
<td>CDC</td>
<td>Centres for Disease Control</td>
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<tr>
<td>CHC</td>
<td>Communication for Healthy Communities</td>
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<tr>
<td>CPD</td>
<td>Continuous Professional Development</td>
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<tr>
<td>CRT</td>
<td>Country Research Team</td>
</tr>
<tr>
<td>DADI</td>
<td>District Assistant Drugs Inspector</td>
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<tr>
<td>DEC</td>
<td>District Executive Committee</td>
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<tr>
<td>DHE</td>
<td>District Health Educator</td>
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<td>DHI</td>
<td>District Health Inspector</td>
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<td>DHMT</td>
<td>District Health Management Team</td>
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<td>DHT</td>
<td>District Health Team</td>
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<td>DMO</td>
<td>District Medical Officer</td>
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<tr>
<td>DP</td>
<td>Development Partner</td>
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<tr>
<td>DSFP</td>
<td>District Surveillance Focal Person</td>
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<tr>
<td>DVC0</td>
<td>District Vector Control Officer</td>
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<tr>
<td>EP</td>
<td>European Partner</td>
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<tr>
<td>EPI</td>
<td>Expanded Programme on Immunization</td>
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<td>EU</td>
<td>European Union</td>
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<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
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<tr>
<td>GAVI</td>
<td>Global Alliance for Vaccines and Immunization (The Vaccine Alliance)</td>
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<tr>
<td>HCII</td>
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<td>HCIII</td>
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<td>HIV</td>
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<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
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<td>Health Management Information System Focal Person</td>
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<td>HQ</td>
<td>Headquarters</td>
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<td>Acronym</td>
<td>Definition</td>
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<tr>
<td>HR</td>
<td>Human Resources</td>
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<td>HRH</td>
<td>Human Resources for Health</td>
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<td>HRIS</td>
<td>Human Resources Information System</td>
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<td>HRM</td>
<td>Human Resources Management</td>
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<tr>
<td>HS</td>
<td>Health System</td>
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<td>HSD</td>
<td>Health Sub District</td>
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<td>HSS</td>
<td>Health Systems Strengthening</td>
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<td>HSSIP</td>
<td>Health Sector Strategic and Investment Plan</td>
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<td>HUMC</td>
<td>Health Unit Management Committee</td>
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<tr>
<td>ICB</td>
<td>Institutional Capacity Building</td>
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<tr>
<td>IDI</td>
<td>In Depth Interview</td>
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<tr>
<td>IDST</td>
<td>Institute for Development Studies Tanzania</td>
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<tr>
<td>IFMS</td>
<td>Integrated Financial Management System Tanzania</td>
</tr>
<tr>
<td>IPT</td>
<td>Intermittent Presumptive Treatment</td>
</tr>
<tr>
<td>JCRC</td>
<td>Joint Clinical Research Centre</td>
</tr>
<tr>
<td>LC</td>
<td>Local Council</td>
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<tr>
<td>LSTM</td>
<td>Liverpool School of Tropical Medicine</td>
</tr>
<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry Of Health</td>
</tr>
<tr>
<td>MSH</td>
<td>Management Sciences for Health</td>
</tr>
<tr>
<td>MUSPH</td>
<td>Makerere University School of Public Health</td>
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<tr>
<td>NGO</td>
<td>Non-Government Organization</td>
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<tr>
<td>NMS</td>
<td>National Medical Stores</td>
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<tr>
<td>OPD</td>
<td>Out Patient Department</td>
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<tr>
<td>OVC</td>
<td>Orphan and Vulnerable Children</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>President’s Emergency Plan For AIDS Relief</td>
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<tr>
<td>PFP</td>
<td>Private For Profit</td>
</tr>
<tr>
<td>PHAs</td>
<td>People living with HIV/ AIDS</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>PI</td>
<td>Principal Investigator</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
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<td>PMP</td>
<td>Performance Monitoring Plan</td>
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<td>Post Natal Care</td>
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<td>PNFP</td>
<td>Private Not For Profit</td>
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<td>PREFA</td>
<td>Protecting Families Against AIDS</td>
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<tr>
<td>QI</td>
<td>Quality Improvement</td>
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</table>
RDC  Resident District Commissioner
RED  Reach Every Child
RHU  Reproductive Health Uganda
SDS  Strengthening Decentralization for Sustainability
SMC  Safe Male Circumcision
SMS  Short Message Service
SPHG  School of Public Health, University of Ghana
SS  Supportive Supervision
SSA  Sub-Saharan Africa
STPH  Swiss Tropical and Public Health Institute
SURE  Securing Uganda’s Right to Essential Medicines
SWOT  Strengths Weaknesses Opportunities and Threats
TASO  The AIDS Support Organization
TB  Tuberculosis
UK  United Kingdom
UNEPI  Uganda National Expanded Programme of Immunization
UNICEF  United Nations Children Fund
UNMHCP  Uganda National Minimum Health Care Package
URL  Uniform Resource Locator
UGX  Uganda Shilling
USAID  United States of America International Development Agency
VHT  Village Health Team
WHO  World Health Organization
WISN  Workload Indicators of Staffing Needs
Executive Summary

Introduction

The single biggest barrier for countries in Sub-Saharan Africa to scale up the necessary health services for addressing the three health related Millennium Development Goals and achieving Universal Health Coverage is the lack of an adequate and well-performing health workforce. This deficit needs to be addressed both by training more new health personnel and improving the performance of the existing and future workforce. However, efforts have mostly focused on training new staff and less on improving the performance of the existing workforce.

The PERFORM research project was conducted in three districts in Uganda (and Ghana and Tanzania). These countries face problems in the development of its health workforce both in terms of shortages and performance of the existing workforce. They have decentralised management structures that offer district management teams greater decision-making opportunities, including in the management of human resources. This research studied how management strengthening interventions can be used to enhance workforce performance. This document reports on the Uganda study.

Methodology

The PERFORM project uses a participatory action research approach to strengthen district health management teams’ (DHMT) capacities to improve workforce performance in Uganda.

District selection: Kabarole, Jinja and Luwero districts were selected as they provided a mix of rural and urban districts, were assessed as either average or good in the National League Table for Performance, and were willing to participate.

Initial situation analysis: The researchers supported the DHMTs to conduct a situation analysis where they identified health workforce performance problems in their districts.

Problem analysis: In a series of facilitated meetings and workshops, the DHMTs prioritised the problems and then analysed the root causes of these problems.

Development of bundles of strategies to address problems: In a facilitated workshop, the DHMTs then developed bundles of human resource (HR) and health system strategies to address these problems.

Implementation of the strategies: The strategies were implemented over a period of 18 months. DHMT diaries, visits by the research team, inter-district meetings were used to facilitate observation and reflection of the implementation of the bundles and their effects on workforce performance.

Evaluation: In each district, qualitative and quantitative research methods were used. Qualitative data collection and analysis: focus group discussions with DHMT members, in depth interviews with DHMT members, health facility managers and staff, and stakeholders were conducted. The recordings were transcribed verbatim, and analysed thematically with support from the NVivo software. Documents such as district annual workplans, budgets and reports, workshop reports and DHMT diaries were analysed thematically. Quantitative data collection and analysis: selected health systems and health services indicators were collated at the DHO office from the HMIS.
Findings

The management strengthening intervention of facilitated action research based on real workforce performance identified by the DHMTs has enabled them to develop plausible plans for improving workforce performance based on more thorough problem analysis than would usually be done. These plans are being implemented and are showing some positive results in a range of areas of performance management. Most plans include the strengthening of existing performance management systems, such as supervision, appraisal and monitoring absenteeism that will improve the efficiency of the existing workforce, thus helping to mitigate the impact of staff vacancies. During the implementation period the plans were modified as more or different needs became apparent and should lead to wider improvements in performance management. For example, Luwero DHMT reactivated the QI teams; Jinja started to recognise best performing staff and facilities and introduced the attendance book; and Kabarole introduced spot check supervision visits.

DHMT members were engaged in and liked the management strengthening approach used to identify and analyse problems and develop relevant strategies. The DHMTs were already familiar with some of the elements of the approach, but generally not the freedom to apply them to their priority problems. The fact that some DHMTs are adapting the approach to their routine work indicates that they find it appropriate for their situation. Some DHMT members would like more continued support with this approach and more facilitated communication between participating districts.

Because the DHMTs are in control of the problem selection and analysis process and plans they develop, they have learnt to work within their ‘decision space’ and resource limitations and even found this discipline beneficial for other areas of management.

The study has been able to document the process of developing and implementation of the bundles of HR and health systems strategies. It is too early to comment on the effects of the strategies on health workforce performance, and little baseline data was collected. However, through the process of reflection, DHMTs have recognised the importance of having robust data to monitor the effects.

Conclusions and Recommendations

The management strengthening approach appears to be acceptable, effective and viable at district level in Uganda. There is now a critical mass in the DHMT with improved problem solving and planning skills and a better understanding of workforce performance problems and appropriate strategies. The following recommendations describe how the Ministry of Health and local councils could build on the substantial gains made by this project:

1. Ways of providing at least some ongoing support for the next annual budget cycle to the three participating DHMTs should be investigated, so the teams can consolidate their skills for improving the management of workforce performance. Particular support should be provided for monitoring the effects of the strategies and continued information exchange between districts.
2. The potential and benefits for using this approach in other districts should be explored. Clustering of districts could be considered to make external facilitation and inter-district exchange more efficient. PERFORM facilitation materials could be used with modifications if necessary.
3. The critical mass of DHMT members who have participated in the PERFORM approach could be drawn on to develop a pool of facilitators to support new districts wishing to use this approach for management strengthening. The participating districts could also host orientation visits for DHMTs from other districts wishing to learn more about the approach.

4. Effective methods of improving workforce performance within the financial and decision-making constraints of the DHMT could be reviewed with the intention of further dissemination by the relevant departments of the Ministry of Health and the Ministry of Local Government and other partners involved in supporting workforce performance improvement.
1. Introduction & Background

Project overview and members of the consortium

The single biggest barrier to scaling up the necessary health services for addressing the three health related Millennium Development Goals for countries in sub-Saharan Africa (SSA) is the lack of an adequate and well-performing health workforce. Funding constraints are increasingly being addressed through international initiatives. However such funding, to be effective, requires the availability of health professionals performing appropriately; this remains a major challenge for sub-Saharan Africa. The deficit in health professionals needs to be addressed both by scale-up through training more new health personnel and by improving the performance of the existing and future workforce.

Most development and research emphasis has been on the first of these – increasing numbers (such as the PEPFAR programme to train 140,000 new health workers in Africa). There has been a serious neglect of initiatives to address the complex area of workforce performance. Examples of poor workforce performance include high vacancy and turnover rates at the management level and poor clinical behaviour and frequent absenteeism at the individual level. The PERFORM project focused on this aspect of the human resource challenge by providing new knowledge as to how district managers can effectively intervene within their current constraints to improve the performance of their staff as a response to the workforce crisis.

A number of complex factors affect workforce performance. Of particular importance are the mal-distribution of staff, inappropriate task allocations and poor working conditions (including training, management and support). These factors also lead to high staff losses (brain drain) from the public sector to other employers (particularly the private sector) or other countries. Understanding the nature of these factors and developing appropriate responses will both improve the performance of the existing workforce and reduce staff losses. It will also increase the effectiveness of future new health personnel trained and deployed under scaling up investments.

There are a wide range of measures which managers use to address human resource (HR) issues. Research has shown however, that these HR strategies may be more or less effective according to the nature of the factors that influence employee behaviour e.g. gender, career stage, level of responsibility. It is therefore necessary to select strategies that respond to the factors that influence the behaviour of particular health personnel.

In addition to choosing the right strategies, there is also a need for integration across human resource management (HRM) practices. For example, the effectiveness of the recruitment system may benefit from changes in the remuneration system. Current thinking on health systems strengthening suggests integration of health workforce strategies with the five other health system building blocks (i.e. service delivery, information, financing, leadership & governance, medical products, vaccines and technologies). It is imperative to consider potential unintended as well as intended consequences of a strategy within the wider health system.

The most effective management strengthening approaches address real problems and use planning and management tools that managers are familiar with and for which they are likely to get support in future. The management strengthening intervention employed locally available tools and drew on the concepts of action research. In particular the district managers were supported in the conduct of a situational analysis of the workforce problem, identification of appropriate local strategies to respond
to this, implementation of such strategies and evaluation – leading where appropriate to a redesign of the strategies. The research assessed the effectiveness of such an approach.

Health systems in SSA are increasingly decentralising authority to lower levels, and in particular to districts, in planning and management. Research has been conducted to understand how to allocate resources more efficiently at this level. However, there has been no equivalent research to understand how such decentralised authority can be effectively used, within available resources, to improve health workforce performance at district level. This research project was designed to enhance our understanding of how, and under what conditions, a management strengthening intervention can improve workforce performance within their districts.

The theory of change for PERFORM project is: action research in decentralised decision making environments provides DHMTs with facilitation and space to focus on human resource and health systems management by using a systematic process of identifying relevant problems and developing customised strategies to improve workforce performance; action research also provides opportunities for reflecting on successes and failures in planning and implementation, and if sustained and coupled with adequate “decision space” ultimately strengthens managerial competences of the DHMT for improving workforce performance and areas of health management.

The research has been conducted in Ghana, Tanzania and Uganda. Each of these countries face major problems of inadequate health workforce. They also have decentralised management structures that offer management teams greater decision-making opportunities including in the area of human resources. The research was designed to study how management strengthening interventions can be used, and under what conditions, to enhance workforce performance. A comparative analysis of the findings from three study districts in each country adds new knowledge as to the effect of different country contexts on these interventions. This provides insights into the application of the new approaches in different district contexts. The overall structure of the research project is summarised in Figure 1.

**Figure 1: Overview of the research concept**
Project partners

The PERFORM Consortium is made up of six partner institutions. Each partner is experienced in health systems strengthening and brings different research expertise to the Consortium.

The partner institutions are:

1. Liverpool School of Tropical Medicine, United Kingdom (LSTM).
2. School of Public Health, University of Ghana (SPHG).
3. Institute of Development Studies, University of Dar Es Salaam, Tanzania (IDST).
4. School of Public Health, Makerere University, Uganda (MUSPH).
5. Swiss Centre for International Health, Swiss Tropical and Public Health Institute, Switzerland (STPH).
6. Nuffield Centre for International Health and Development, University of Leeds, United Kingdom (UNIVLEEDS).

Objectives of the project

Aim

The overall aim of the PERFORM project is to identify ways of strengthening decentralized management in order to address health workforce inadequacies by improving workforce performance in three districts each in Ghana, Tanzania and Uganda.

Objectives

The specific objectives are:

1. To conduct a participatory situation analysis of the health system especially the health workforce and DHMTs and with particular focus on health workforce performance in each study district.
2. To identify, from the results of the situation analysis, areas of workforce performance which need to be improved in each district.
3. To develop and test context-specific management strengthening interventions and processes focused on the areas of workforce performance in need of improvement.
4. To monitor the implementation of the strategies and evaluate the intermediate processes and impact on health workforce performance, and the wider health system.
5. To conduct comparative analyses across districts and countries of the management strengthening intervention, the processes of implementation as well as the intended and unintended effects on health workforce performance and the wider health system.
6. To provide ongoing communication of the research process, findings and conclusions, in order to raise awareness and change attitudes of sub-national, national and international stakeholders.
7. To consolidate research capacity of research partners on integrated approaches to workforce performance improvement and contribute to strengthening capacities of decentralized management of district health systems.

8. To establish and maintain effective partnerships amongst academia, civil society, policymakers and health managers in study countries and amongst partners.

Country overview, location and demography

Uganda is in Eastern Africa, surrounded by South Sudan in the North, Kenya in the East, Tanzania in the South, Rwanda in the South West, and Democratic Republic of Congo in the West. It lies along the equator. Uganda has an estimated population of 34 million and a population growth rate of 3.2%. According to the 2002 national population census, the ratio of females to males was 51:49. The majority of the population are children aged below 18 years.

The majority (80%) of the population lives in the rural areas mainly practicing agriculture which is largely subsistence. Agriculture is a source of livelihood for most Ugandans; majority are poor with 38% living in abject poverty (below the purchasing power parity of 1US$).

PERFORM districts (Kabarole, Luwero and Jinja) in Uganda are highlighted on the map of Uganda below in Figure 2.

Figure 2: Map of Uganda showing project districts
Description of Country health system and decentralisation

Uganda’s health service delivery is organised in 6 layers i.e. national Referral hospital, Regional referral hospital, general hospital, health centre IV, Health centre III and Health centre II. There is a village health team below health centre II. Each level provides specific health as stipulated in the health sector strategic and investment plan (MOH, 2010/11-2014/15) and National Minimum Health Care Package.

Health services providers include both government and private providers. The private providers include: private not-for-profit, private for profit, and complementary health providers. There is a Public-Private Partnership policy that brings all providers together.

There is a health referral system but in practice this does not function adequately partly because of lack of needed services at the different levels of care that cause clients/patients to bypass certain levels, and partly due to quality concerns.

Nationally the provision of medicines and supplies has been reformed. All districts receive medicines from the national medical stores (NMS). The hospitals and health centre IV use a pull system (requisition) while the rest of the health centres use the push system based on a standard medicine kit for health level. Delivery of medicines follows a 2-month delivery schedule from NMS. Districts are clustered for the purpose of medicines delivery from NMS. Within the districts, private transporters deliver the medicines to the respective health centres. Communities have been mobilised to participate and monitor medicines use at the facility level. At national level, there are a number of innovations to 1) curb mismanagement, 2) ensure rational use and 3) improve distributions.

Uganda has implemented a decentralisation policy since 1993 and the health service delivery system is decentralised from the Ministry of Health to the District Local governments. This has further been decentralised to the Health sub-District level. Districts are responsible for the implementation of national policies and make byelaws relevant to their local situation. Districts can make decisions on budget allocation, but most of the funding comes from the centre as conditional grants. Overall, districts receive most of the health funds from the central government and donor programs. On the average per capital health expenditure is about $26 but most is earmarked for HIV programs. Districts are expected to recruit staff through the district services commission, develop and manage human resources.

There are Health Unit Management Committees at every health centre and hospital management Committees at hospitals. There are community representatives on all of these committees.

Other on-going projects on HRH in the country

(i) Government supported projects

a. Performance based contracts for senior managers (e.g. CAO, DHO and Heads of departments) is currently being rolled out.

b. Barazas and community dialogues. The Barazas provide an opportunity for communities and health workers at particular health care levels to discuss health related issues facilities
(ii) Development Partner supported projects

Most of the development Partners prioritise specific programs. They include:

a. Uganda Capacity program work at national level and in a few districts supporting HRIS, recruitment processes, periodic surveys of HWs, organizing stakeholders forum, supporting districts to develop HR plans, training in HR leadership

b. Belgium Technical Cooperation to support leadership skills development through coaching and mentorship.

c. Baylor (recruited and coached additional health workers)

d. USAID and Global Fund support recruiting of staff

e. USAID supports hiring of emergency staff

Purpose and structure of the report

As a country report, this document aims to provide the reader with an in-depth analysis of the outcomes of the PERFORM research project in Uganda. In order to do this, the reader will first be provided with an overview of the research design and methodology followed by a description of the process of identifying problems in the district and selecting interventions to address these problems. The report will also present the findings in terms of district management strengthening, human resource management and health systems improvements while analysing these in view of the contextual factors at play in the country. A comparison of outcomes linked to the problems addressed by each district before and after the interventions were implemented should shed light on any areas of improvement in health workforce performance. Inter-district comparison has been undertaken in order to highlight similarities and differences in outcomes based on the interventions implemented. Based on the findings, the reader will be provided with conclusions and recommendations on how to improve district management and workforce performance in Uganda.

The remainder of the report is made up of the following chapters:

Chapter 2- Methods
Chapter 3- Findings
Chapter 4- Discussion
Chapter 5- Study conclusions and recommendations
2. Methods

Overview of action research approach
The PERFORM project used an action research (AR) approach. The definition of AR that we applied during PERFORM is given below.

“Action Research (AR) is an enquiry which is conducted by a group on a problem which is of importance to them. Its aim is two-fold; to improve practice and to generate knowledge about the processes and strategies that work best to create that improvement.”¹

The project worked through systematic cycles of planning, acting, observing and reflecting to:

- Describe and analyze the problem they face
- Identify and plan strategies to improve situation or solve problem
- Implement the changes needed
- Observe, explain and reflect on the process and the effects of changes made.

They then continued with subsequent cycles to continue to create improvements. External facilitators worked with the group to build participation, provide research methods support during observation phases of the cycles, and to record and analyse the process and strategies of change.

At the core of AR studies is the cycle presented in Figure 2. This cycle was first described by Kurt Lewin (1958)² who many see as the founder of AR:

Figure 3: The classic Action Research Cycle

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Successive cycles are beneficial as they can deepen the learning about a problem and its solutions. In practice these may be more like a spiral, or a cycle with smaller cycles spinning off and feeding back into the main study.

The project started with a situation analysis. The aim of this phase was to collect evidence about the nature of the problem to be addressed in the AR cycles. It also provided a base line against which to compare any subsequent changes.

Aspects of AR in PERFORM to build research evidence:

- An initial situation analysis to collect research data on the problem, this feeds into the first cycle of AR.
- Robust use of research and analysis methods during the observation phases of the AR cycle(s) guided by the CRTs.
- Record and reflect on the change process throughout AR cycles using diaries.
- Recollect core data for evaluation including context, to identify within-district changes.

Overview of research process

Phase one

District selection

The study will take place in three districts each in Ghana, Tanzania and Uganda. Each district was selected using pre-defined criteria. Because of the collaborative nature of the management strengthening intervention, one important criterion for the selection of study sites was a motivated and reasonably staffed district management team with which to work. A second criterion was the inclusion of a mix of types of districts reflecting different contexts including a mix of rural and urban. Table 1 below lists the study sites in each country.

<table>
<thead>
<tr>
<th>Country</th>
<th>Selected districts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ghana</td>
<td>Kwahu West District</td>
</tr>
<tr>
<td></td>
<td>Akwapim North District</td>
</tr>
<tr>
<td></td>
<td>Upper ManyaKrobo District</td>
</tr>
<tr>
<td>Tanzania</td>
<td>Kilolo District</td>
</tr>
<tr>
<td></td>
<td>Mufindi District</td>
</tr>
<tr>
<td></td>
<td>Iringa Urban District</td>
</tr>
<tr>
<td>Uganda</td>
<td>Jinja District</td>
</tr>
<tr>
<td></td>
<td>Kabarole District</td>
</tr>
<tr>
<td></td>
<td>Luwero District</td>
</tr>
</tbody>
</table>
In Uganda, district selection took into consideration: overall performance of the district in comparison to the country average over the last 3 years (performance rank in the Ministry of Health league table), urban-rural mix, distance (km) between the district headquarters and the national capital, accessibility of the district for higher authorities, a strong interest of the DHO in this research project, and presence of other ongoing Health sector projects or programmes in the selected district.

The process of district selection in terms of meetings and decision-making involved (see Table 2):

- Stage 1: Identify level of performance from the league table;
- Stage 2: Telephone contact to explain PERFORM project to the district and seek acceptance;
- Stage 3: Ministry of Health to seek its support.

### Table 2: Criteria used for selection of study districts

<table>
<thead>
<tr>
<th>Study Districts</th>
<th>Selection criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selection criteria</td>
<td>Jinja</td>
</tr>
<tr>
<td>Urban / rural</td>
<td>Urban</td>
</tr>
<tr>
<td>Distance between district HQ and capital</td>
<td>80km</td>
</tr>
<tr>
<td>Accessibility of the district for higher authorities</td>
<td>Good</td>
</tr>
<tr>
<td>Overall performance of the district in comparison to the country average over the last 3 years.</td>
<td>Good</td>
</tr>
<tr>
<td>Strong interest of the DHO in this research project</td>
<td>Yes</td>
</tr>
<tr>
<td>Presence of other ongoing Health sector projects or programmes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

No ‘control’ districts were selected. However, information about wider contextual changes that needed to be considered in assessing the impact of the interventions was captured using appropriate methods and tools.

Each district selected is managed by a district health management team (DHMT) or their equivalent. The DHMT (or their equivalent) is the main collaborator in each district with the Country Research Teams (CRTs). The composition of the DHMT may vary from one country to another but their function is essentially similar across all three participating countries.

The DHMTs have responsibility for planning and coordinating health activities in the district. They do this by ensuring that health policies are implemented, resources are well utilized, quality standards are upheld, and performance is monitored and evaluated for better results. Because of the action research approach employed in this project, DHMTs are not considered to be ‘study participants’ in
the traditional sense of the word. Rather, the DHMTs are considered to be ‘co-researchers’ and partners in achieving the objectives of the study.

At the beginning of the project, orientation meetings were held with the relevant management teams to explain the project, clarify the level of involvement required and to agree roles of the management team and researchers. To ensure clarity and to increase the level of ownership of the project, the national research partners signed a memorandum of understanding with the DHMTs.

**Finalisation of research methods**

During Phase One, the methodology was further developed with input from all partners resulting in the production of a methodology manual (Deliverable D1.1). The overall management strengthening intervention using concepts from health systems thinking and action research applied within the district context was agreed in this phase. The methodology and agreement is based on a common understanding amongst all members of the research teams of the proposed research approach.

Ethics approval in each of the three study countries and for the European partners was sought and obtained during this phase of the project.

**Phase two**

**Initial situation analysis**

The purpose of the initial situation analysis was to:

1. Serve as the baseline for the project as well as
2. Inform the subsequent action research cycles in each district through identification of priority challenges to be addressed.

The initial situation analysis included some common core HR and health systems indicators across districts and countries to allow for the comparative analysis. As much as possible, these indicators used routinely collected data and performance indicators (gender disaggregated) to simplify the collection process, minimize disruption and to increase the chance of expanding and sustaining such an approach beyond the project period.

The objectives of the (initial) situation analysis were:

a) To identify major areas of exceptional performance (good or poor) in service delivery.
b) To identify the major areas (geographical and/or service delivery) of staffing shortage.
c) To identify key problems of health workforce performance (retention, distribution and effectiveness)
d) To identify key health systems factors (e.g. resources, processes, gender or other forms of discrimination) affecting (positively or negatively) health workforce.
e) To identify key contextual factors at the district (e.g. political situation, leadership, conflicts), regional and national levels affecting workforce performance.
To identify current management and communication processes used by the health management team, dynamics of the DHMT (e.g. roles, power and gender relations among the team) and how these may affect levels of management performance

**Overall output from the Initial Situation Analysis**

The information collected during the initial situation analysis formed the basis of a draft report. Each country produced one report. This allowed the information in the three districts in each country to be viewed and interpreted alongside each other. The report was written by the CRTs with input from the DHMTs. This draft report was presented at National Workshop 1 in each country.

The objectives of the National workshop were:

- To review the data for each study site
- To review the problem analysis based on findings from initial situation analyses in each district and subsequent problem identification and prioritization
- To identify possible HR/HS bundles for addressing the workforce performance problems appropriate for each study site
- To review lessons learnt from the situation analysis process
- To build capacity in doing action research.

National Workshop 1 was conducted in Jinja district 15th – 16th October 2012 (one and a half days). It was attended by 17 members of the DHMTs involved in the study, the CRT, the EU paired partner

**Data collection sources and methods for the Situation analysis**

**Methods**

The initial situation analysis was a two-step process in each district. Step One was to collect information on the structure, staffing and health service activities of the district. The purpose of Step Two was to identify human resource problems and their causes. The method used in step two was group discussion involving DMHT members to lead discussions and facilitated by the CRT. Information from step one was used for discussions. Brainstorming was the method used to generate a list of HR problems. Discussions helped to prioritize problems through ranking and in-depth discussion to understand the problem. Prioritization was guided by the capacity of the DHMT to make changes or influence changes. This generated a list of things districts are able to do and what they are not able to do or other levels can do. 4-5 issues were prioritized and these provided the basis for generating additional data and later for developing problem trees.

**Data collection**

Data was collected in the three districts during several visits by the CRT between August and September 2012. As part of the action research approach, the DHMT members worked with the CRT to collect the data for the situation analysis. The CRT made several visits to the districts between July
and August 2012. A generic questionnaire was used to collect data on the health workforce, DHMT, health system, local and national contexts. The CRT in consultation with the European partners concurred that some additional customized data collection tool was necessary to collect data missed by using the generic data collection tool. A customized data collection tool focusing on the specific district contexts was used to collect the missed data. Data was also extracted from reports and databases held at the district.

Data Analysis

Data analysis was done by the DHMTs with the support of the CRTs. This offered an opportunity for the DHMTs to learn or improve their skills in analyzing data. Both the DHMTs and CRTs reflected on the data and emerging issues such as power dynamics in the DHMT, district problems, decisionmaking, and verification of data. These were valuable indicators in which aspects of the health workforce situation to focus on in step two of the situation analysis. Triangulation of secondary data, and the data generated through discussions was intended to strengthen understanding of the district situation and provide a firm basis for the next step of the initial situation analysis.

Problem identification and prioritisation

The process of problem identification started during Step 2 of data collection for the Situation analysis. The process of analysing root causes had also been started. At National Workshop 1 in October 2012 the DHMTs presented the findings of the situation analysis and their initial problem analyses to the plenary. Participants in the audience were given a checklist that included identifying findings they found surprising, further data needed for the analysis and fed this back to the presenting teams. On Day 2 (because the first day had started late) some guidance was given on refining the problem trees and prioritise the problems to be addressed. The first set of key problems is identified in Table 3.

### Table 3: Problems identified in each district

<table>
<thead>
<tr>
<th>District</th>
<th>Key problems</th>
</tr>
</thead>
</table>
| Kabarole | 1. Weak leadership and management of team leaders  
2. Weak support supervision  
3. Poor health workers’ commitment  
4. Poor working environment |
| Jinja    | 1. Ineffective use of the traditional control mechanisms  
2. Low staff motivation  
3. Inadequate support supervision  
4. Staff training that is not guided by available opportunities in the district |
| Luwero   | 1. Lack of professionalism  
2. Poor communication  
3. Inadequate capacity building  
4. Inadequate medicines/equipment/supplies  
5. Inadequate support Supervision |

(Report of National Workshop 1)
The DHMT participants from Kabarole, Luwero and Jinja (4, 4 and 9 respectively) took their new lists of problems back to the full DHMTs for discussion and further refinement.

National workshop 2, held in Fort Portal (Kabarole District) from 11th-13th February 2013, started with a whole day working in their respective district teams but getting feedback from other participants to refine the problem analysis further to ensure that the true root causes had been identified. These are described in the findings section.

**Description of the process of selecting HR/HS bundles**

The concept of the action research process had been explained to the DHMTs from the first exploratory visits in early 2012 and then during later visits the DHMT manual which explained the action research processes was shared. An additional section (based on Deliverable 7.2) was later added to provide guidance on selecting appropriate human resource and health systems strategies to address problems identified and is summarised in the following box.

**DHMT Manual: summary of guidance on selecting human resource and health systems strategies**

Given the variety of human resource management (HRM) strategies to improve performance linked to ‘direction’ (e.g. job descriptions, work plans) and ‘competencies’ (e.g. in-service training, supportive supervision) and the provision of rewards and sanctions (e.g. praise or disciplinary action) it is essential to have some coordination as it is usually necessary to have more than one HRM strategy (for example in-service training followed by supportive supervision to help staff put new skills into practice). Where there are several strategies they are often referred to as "bundles" of HRM strategies.

In addition, there may also be problems of resources that affect performance. The problems relate to the wider health systems (HS) - for example, supplies or information systems. So there is a need to combine HR and HS strategies to address problems of performance. These also need to be coordinated bundles of strategies. So they are referred to as bundles of HR/HS strategies.

**Selecting strategies and making plans**

There is a wide range of strategies that can be used to improve workforce performance, depending on the particular problem(s) you are trying to address. The challenge is to identify those strategies that are possible to implement (i.e. within the DHMT’s boundaries of budget and authority and should whenever possible be aligned to annual priority/activity planning of districts) and are likely to be effective in your situation. An additional challenge is to ensure that strategies selected complement each other and are not contradictory.

The problem trees and statements developed during the situation analysis phase served as starting point for the selection of the HR/HS bundles to improve workforce performance.

Based on the key areas for managing performance, the DHMTs decided which of the following areas they needed to address in their district:

1. Availability (of staff)
2. Direction (on what work to do, when and how)
3. Competencies (to carry out required tasks)
4. Rewards and sanctions (to influence staff behaviour)
5. Other health systems components (to support the implementation of the work).
The manual also contained a reference table with about 40 strategies to address the five areas above, each with sample activities, possible indicators for monitoring and evaluation and suggestions of how each strategy might be linked to other HR or health systems strategies to improve integration both within the bundles, but also with wider plans.

These concepts were briefly introduced on Day 2 of National Workshop 1 and participants had a rapid chance to use these guidelines to develop some strategies to address their problems. The aim was to give participants the exposure to this approach rather than develop strategies to be implemented, as this was planned for National Workshop 2.

With the detailed problem analysis completed on Day 1 of National Workshop 2, the whole of Day 2 was devoted to the development of the integrated bundles of human resource and health systems strategies to address the problems identified. After a brief presentation based on the material above, the participants worked in their district team to:

1. Identify problems to be addressed
2. Review options of strategies in the table in the DHMT manual
3. Put selected strategies into a planning template provided

Plans were then subjected to peer review and then eventually incorporated into district planning frameworks that the DHMTs had brought with them – mostly on their laptop computers. The plans for the districts are summarised in Table 4 below.

**AR process recording**

Diaries were used to record and reflect on the change process throughout the AR cycles. The importance of the learning developed in particular from the observation and reflection parts of the action research cycle was explained on the final day of National Workshop 2 and the DHMTs were all given diaries to keep a record of the implementation of the plans they had developed and in particular their reflection on the implementation.
### Table 4: Description of the bundles developed in National Workshop 2

<table>
<thead>
<tr>
<th>District</th>
<th>Performance area/broad objective</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Luwero</td>
<td>Improve understanding of daily/weekly + feedback on performance</td>
<td>Use of work plans</td>
</tr>
<tr>
<td></td>
<td>Improve staff understanding of general work + feedback on performance</td>
<td>Ensure that staff have updated job descriptions</td>
</tr>
<tr>
<td></td>
<td>Improve staff understanding of general work + feedback on performance</td>
<td>Induction/orientation of new staff</td>
</tr>
<tr>
<td></td>
<td>Increase number of staff present at work place</td>
<td>Regular open appraisal</td>
</tr>
<tr>
<td></td>
<td>Increase number of staff present at work place</td>
<td>Regular supportive supervision</td>
</tr>
<tr>
<td></td>
<td>Rewards and sanctions</td>
<td>Attendance monitoring</td>
</tr>
<tr>
<td></td>
<td>Rewards and sanctions</td>
<td>Rewarding good attendance</td>
</tr>
<tr>
<td></td>
<td>Health systems</td>
<td>Introduce team incentives</td>
</tr>
<tr>
<td></td>
<td>Health systems</td>
<td>Give staff additional responsibility</td>
</tr>
<tr>
<td></td>
<td>Health systems</td>
<td>Issue verbal + written warnings</td>
</tr>
<tr>
<td></td>
<td>Health systems</td>
<td>Withhold pay</td>
</tr>
<tr>
<td></td>
<td>Health systems</td>
<td>Dismiss or recommend for dismissal</td>
</tr>
<tr>
<td></td>
<td>Health systems</td>
<td>Ensure equipment, drugs &amp; supplies available</td>
</tr>
<tr>
<td>Jinja</td>
<td>Strengthen support supervision</td>
<td>To ensure monthly support supervision</td>
</tr>
<tr>
<td></td>
<td>Strengthen support supervision</td>
<td>Building competences of supervisors</td>
</tr>
<tr>
<td></td>
<td>Strengthen support supervision</td>
<td>Ensure regular follow up and feedback on action points</td>
</tr>
<tr>
<td></td>
<td>Strengthen appraisal mechanism</td>
<td>Regular appraisals of all health workers</td>
</tr>
<tr>
<td></td>
<td>Strengthen appraisal mechanism</td>
<td>Build competences of managers on appraising staff</td>
</tr>
<tr>
<td></td>
<td>Strengthen appraisal mechanism</td>
<td>Ensure transparency and honest for all staff</td>
</tr>
<tr>
<td>Kabarole</td>
<td>Increase number of supervisors</td>
<td>Select and develop a team of supervisors</td>
</tr>
<tr>
<td></td>
<td>Increase number of supervisors</td>
<td>Retention and incentives</td>
</tr>
<tr>
<td></td>
<td>Increase number of supervisors</td>
<td>Develop partnership with existing partners</td>
</tr>
<tr>
<td></td>
<td>Increase number of supervisors</td>
<td>Engagement of HUMC in Supervision</td>
</tr>
</tbody>
</table>

### Implementation of HR/HS bundles

The implementation of the HR/HS bundles phase was from March 2013 (after National Workshop 2) until September 2014 (the evaluation). Sections 3 describes the implementation of the bundles in detail.
Phase three

Evaluation of management strengthening and HR/HS bundles
In order to build the knowledge base of the overall effectiveness of the approach used in PERFORM, ongoing data collection and analysis is needed. Two stages of analysis were being undertaken.

1. Analysis of data collected by the CRTs in collaboration with the DHMTs throughout the project as part of the action research cycle.

2. Overall evaluation which will include comparative analysis following the period of implementation of the HR/HS bundles (end of phase 2).

The evaluation took place in September 2014 after the HR/HS bundles had been implemented for about 17 months. This situation analysis was a one stage process, with data on the health workforce, DHMT, HS, local and national context being collected.

Methods
The evaluation sought to document processes of both the management strengthening intervention (the action research cycle) and the development and implementation of the bundles of HR/HS strategies. It also aimed to identify the effects (both intended and unintended) of the management strengthening and bundles of HR/HS strategies. The study, using qualitative methods, gathered the perceptions of a mixed group of stakeholders (the DHMT, sub-district managers, health staff and relevant stakeholders and the researchers themselves) to obtain a retrospective account of processes and change. Obtaining the perceptions of community members was originally considered, but rejected after piloting because all HR/HS bundles were addressing health workforce performance problems for which the impact at the level of service delivery after a period of 18 months were not easily detectable.

A range of documents produced during the project (such as CRT visit reports, DHMT diaries, workshop reports) were analysed for information on processes and effect.

Selected health systems and health services indicators were used to see whether any before and after effects could be identified or associations of impact made through linkages to the qualitative data.

Sampling
In depth interviews with DHMT members: 4-5 members were purposively selected ensuring a range of participants with regard to gender, length of service in DHMT and position in DHMT.

Focus group discussion with DHMT members: 6-8 members were purposively selected ensuring a range of participants with regard to gender, length of service in DHMT and position in DHMT.

In depth interviews with sub district managers: two sub districts were selected in each district, and then within each sub district one health centre IV, one health centre III, and one HC II were selected. The manager from each of these facilities was selected for interview.
In depth interviews with sub district staff: using the same facilities as outlined in the sampling for the in depth interviews with the sub district managers, one health worker from each facility was selected, ensuring a range of participants across the sample for the district with regard to cadre, gender and length of service.

In depth interviews with stakeholders: the Local Council human resources officer, a Health Unit Management Committee member, a development partner and the council secretary for health were selected in each district.

A total of 61 interviews and 3 FGDs were conducted. Details are provided in Table 5.

Table 5: number of interviews and FGDs by district and respondent type.

<table>
<thead>
<tr>
<th></th>
<th>Kabarole</th>
<th>Jinja</th>
<th>Luwero</th>
</tr>
</thead>
<tbody>
<tr>
<td>IDI DHMT</td>
<td>4</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>FGD DHMT</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>IDI sub-district manager</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>IDI sub-district staff</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>IDI stakeholders</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>21</strong></td>
<td><strong>22</strong></td>
<td><strong>21</strong></td>
</tr>
</tbody>
</table>

In-depth interviews were carried out with the CRT (Uganda team) and the European partner (LSTM team) to explore in particular about the support provided between the paired partners and to the DHMTs.

All relevant documents were reviewed. These included the DHMT and DHT management meetings, work plans, CRT visit reports, diaries, inter-district meetings, national workshops and partner visit reports.

**Data collection tools**

The data collection tools were developed based on an analysis of key questions about the process and effects of the management strengthening and workforce improvement components of the intervention. These included: topic guides for the FGD with DHMT, the interview with DHMT, the interview with manager, the interview with staff, interview with stakeholder; and data collection tool for health systems and health services indicators. With the exception of the DHMT topic guide, all tools used at district level were piloted in May 2014 in Luwero district and modified in consultation with all PERFORM consortium members. These tools are included in Annex 1.

**Data collection**

The CRT visited each district during September and October 2014 and carried out the data collection using the tools.
Interviews and FGDs: the FGDs were conducted in the DHO meeting rooms and lasted approximately 2 hours. The interviews with sub district managers and staff were conducted in a quiet room within the health facility. The interviews lasted between 30 and 60 minutes. The interviews with the stakeholders were conducted in their offices, apart from the HUMC members who were interviewed in a quiet room in the health facility. The interviews lasted between 30 and 60 minutes. Before each interview and FGD, the CRT went through an informed consent process and obtained written consent from each participant, which included recording of the interview or discussion.

Selected health systems and health services indicators: data on the district was collated at the DHO office from the HMIS and in discussion with the biostatistician, DHO and accountant; data on the health facilities was also collected from the HMIS, and where gaps were identified, the CRT and biostatistician telephoned the health facility managers.

Document review: documents were collated from the DHO office which included: the DHMT diary; and the District annual health work plans and reports, DHMT minutes and DHT minutes for years 2011, 2012, 2013 and 2014. In addition to these district level documents the following national and international level documents were collated: National Workshop Reports, Inter District Meeting Reports, CRT visit reports and Consortium Workshop Reports.

Data Analysis

Interviews, FGDs and documents: the recordings were transcribed verbatim and checked for accuracy by the CRT. All documents were then uploaded to NVIVO qualitative analysis software (Version 10). A coding framework (see Annex 2) was agreed by the consortium, based on the questions relating to the management strengthening and workforce performance improvement interventions, after all data had been collected. All documents were coded using this framework. Next, queries were made to extract the data by parent and child node by district and then summarised with key supporting quotes. These were then combined to compile the reports for each of the districts. Finally these were combined to allow for inter district analysis and to produce an overall set of findings and recommendations.

Health systems and services indicators: data analysis is currently being conducted and will be included in Version 2 of this report, following verification of the data analysis and interpretation by the DHMTs.

Output from the evaluation

This version of the report is being submitted as a time-bound deliverable to the European Commission. However, the findings will be presented to the DHMTs at National Workshop 3 both for the purposes of validation and as part of the research communication process.

Ethics approval

The project received ethical approval from international and national ethics review boards. In addition to the approval (Protocol Number 162) received from the (Makerere University, College of Health Sciences, School of Public Health, Higher Degrees, research and Ethics Committee), the project was approved by the Faculty of Medicine and Health Research Ethics Committee at the University of Leeds (HSLTLM/11/053) and the LSTM Research Ethics Committee (12.09) – both in the United Kingdom.
3. Findings

Communication, assistance and capacity building within the research team

Communication and assistance

Uganda and LSTM teams reported that throughout the project they communicated frequently. They gave several purposes for the communication: monitoring progress, problem solving, planning visits and workshops, and identifying areas requiring assistance. Areas for assistance included: designing and facilitating workshops, data collection for initial and final situation analyses, data analysis, discussing findings, and development of reports.

“...it was generally planning, discussing progress and to some extent discussing findings.” (Interview with LSTM team)

“...also identifying any problems that were happening and if there were you know trying to find solutions for those problems and also what support could be given from our side about those sorts of things. When I think requesting visits to help with workshops was one of them, to help them sort of design it and help facilitate those workshops with the CRT.” (Interview with LSTM team)

“...also helping with the situation analysis report you know the initial one and commenting on the report and giving feedback about that.” (Interview with LSTM team)

“...and we helped with the piloting of the tools and we were able to go and we helped with... XXX went for the first week of the actual data collection and the team are coming to Liverpool next week. So we are going to continue helping with the analysis.” (Interview with LSTM team)

“...one of the main purposes is to update ourselves on the progress. ...and make plans say like in case there is a meeting going to take place we make preliminary arrangements. ...when they are giving us guidance, like when they are in the country giving us guidance on how we need to do certain things. ...they write reports and then we usually sit in the meeting like the debriefing where we agree on what they have observed and what is going on.” (Interview with Uganda team)

“The overall objective of the visit is to work with the Uganda country research team to plan for and deliver National Workshop 2.” (Field Visit Report February 2013)

EU partners having clear objectives for their field visits and producing reports afterwards was perceived as a good way of monitoring process by the Ugandan partners:

“I think there is monitoring like when they are coming to Uganda they would come with terms of reference which reflect the activity they have come to do and they indicate us their [expected] outputs... they write reports and they we usually sit in the meeting like the debrief where now we agree on what they have observed and what is going on.” (Interview with Uganda team)

The main means of remote communication between European and African partners were Skype and email (and eventually telephone). Skype contacts were initially held more often with the Ugandan PI but other means of communication like email was more often used to address the wider team (EU and CRT). Visits
by the EU partners to Uganda and international workshops attended by both EU and the African partners constituted the main opportunities for face-to-face communication.

“...the Skype meetings that we’ve had they’ve only been generally with Sebastian and us, but the other forms of communication like email have been to the wider CRT so Saul and Freddie and Millie and also when we’ve done the visits and the meetings during the visits they’ve been with the wider team...” (Interview with LSTM)

“...then at times they come down and we do direct talking, face to face interaction... well not only coming down but when we meet during consortium workshops or during national when it’s a paired partner CRT meeting in our country.” (Interview with Uganda team)

Regarding frequency of communication between EU and African partners initially one monthly contact with the Ugandan PI was established as a minimum but depending on specific planned activities this frequency was increased as required.

“...it wasn’t completely regular but I would think at least once a month... most of the time, sometimes a bit you know as we got closer to say a visit it might have been a bit more frequently...” (Interview with LSTM team)

In general communication was considered effective by both partners.

“I think it was very relevant... ...and it was effective in the sense that it was two way.” (Interview with Uganda team)

“(one respondent) I think all communication there could always be more of it, efficient was it effective and efficient... sufficient. (another respondent) ...yes, but I think it was effective to some extent.” (Interview with LSTM)

Capacity building of research teams

Capacity building was provided in different ways and most often during workshops and field visits. The Ugandan partners reported that capacity building on Action Research was provided by the EU partners at the beginning of the project.

“...the partners came in to refine how are the programmes development of the bundles and I believe also building capacity for the CRTs in addition to the DHMTs, me personally wasn’t really action research I came across it when I came into Perform and I found it interesting, I think I can now apply it in other areas...” (Interview with Uganda team)

Capacity building needs were sometimes identified during National Workshops or field visits as reported for instance during the field visit undertaken by EU partners to Uganda in May 2012. In this case capacity building on communication skills was identified.

“Capacity development – it has been highlighted by the Communications Officer that the CRT may benefit in some training to support their delivery of some of the communications activities – this has been taken into consideration and included in the activity plan.” (“Activities Completed” section in Field Visit Report May 2012)

Some of the planned capacity building activities were targeting both CRT and EU partners like the NVivo training received during the Consortium Workshop 4 held in Leeds in November 2014. There were mixed
views about these capacity building activities. Some felt that it was very beneficial and others perceived that it was not sufficient.

*To develop skills for analysing qualitative data*
*To develop skills for using NVivo*
("Objectives" section in Consortium Workshop 4 Report November 2014)

“What could be improved about the workshop? More capacity building for our CRT roles”
(Evaluation section Consortium Workshop 3 18-22 November 2013)

"Topics were well covered and the capacity built will be applied even to other areas outside the PERFORM PROJECT"(Evaluation section Consortium Workshop 3 18-22 November 2013)
3.1 Kabarole District

Findings from the situation analysis

Geography and demography of Kabarole District

Kabarole district is located in Western Uganda (see figure 1) 319 km from Kampala. It borders with Kasese, Kamwenge, Kyenjojo, Bundibugyo and Ntorko and Kibaale districts. It has a population of 415,600. The main economic activity is subsistence farming. The main food crops include bananas maize, cassava, beans and groundnuts and the main cash crops are coffee and tea. Dairy farming is practiced in all parts of the district.

Health Infrastructure

Kabarole is made up of 3 counties and has 3 health sub-districts (HSD); Burahya, Bunyangabu, and Fort Portal Municipality. The district hosts a regional referral hospital which is under central government administration (Ministry of Health). The number and type of facilities in Kabarole district by provider are shown in Table 6.

<table>
<thead>
<tr>
<th>Type of facility</th>
<th>Government</th>
<th>Other/NGO</th>
</tr>
</thead>
<tbody>
<tr>
<td>District hospital</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other hospital</td>
<td>1 Regional Referral hospital</td>
<td>3 (2 PNFPs &amp; 1 PFP)</td>
</tr>
<tr>
<td>Health centre VIs</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Health centre IIIs</td>
<td>18</td>
<td>6</td>
</tr>
<tr>
<td>Health Centre IIs</td>
<td>22</td>
<td>11 (7 PNFP &amp; 4 PFP)</td>
</tr>
</tbody>
</table>

PNFP = Private Not For Profit; PFP = Private For Profit

Health facilities in the district provide services according to the level:

a. HCIls offer OPD and preventive health services
b. HClIIIs offer OPD, preventive health services and delivery services. However some health centre IIIs were not providing delivery services as they lacked infrastructure, staff or the required supplies and equipment.

c. HClIIVs offer OPD, preventive health services, delivery services and uncomplicated surgery.

Most Common Diseases

The five most important disease problems in Kabarole district are shown in Table 7.
Table 7: Five most important disease problems in Kabarole district (2012)

<table>
<thead>
<tr>
<th>Disease priorities</th>
<th>Adults</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Malaria</td>
<td></td>
<td>1. Non pneumonia – cough and colds</td>
</tr>
<tr>
<td>3. Intestinal worms</td>
<td></td>
<td>3. Intestinal worms</td>
</tr>
<tr>
<td>4. Urinary Tract Infections</td>
<td></td>
<td>4. Skin diseases</td>
</tr>
<tr>
<td>5. Gastro intestinal disorders (non-infective)</td>
<td></td>
<td>5. Diarrhoea (acute)</td>
</tr>
</tbody>
</table>

Human resources

Staffing: numbers, distribution, recruitment and transfers

Kabarole district has 58% of the approved staffing positions filled. Central government decided to recruit up to 100% for specific health worker cadres at health centre IIIs and IVs in 2013. In the district the ratio of health worker to population is: 1 doctor to 207,800 people; 1 nurse to 15,468 people, and 1 midwife to 15,985 people. These figures do not include health workers working in the Regional Referral hospital, Fort Portal Municipality, PNFP and PFP health facilities in Kabarole district as they are not managed by the DHMT. The numbers of professional staff by level of health facility is shown in Table 8.

Table 8: Numbers of professional staff by level of health facility (2012)

<table>
<thead>
<tr>
<th>Level</th>
<th>Professionals</th>
<th>Total work force</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>DHO</td>
<td>9 (81.8%)</td>
<td>2 (18.2%)</td>
</tr>
<tr>
<td>HCIV</td>
<td>14 (32.6%)</td>
<td>29 (67.4%)</td>
</tr>
<tr>
<td>HClII</td>
<td>28 (26.7%)</td>
<td>77 (63.3%)</td>
</tr>
<tr>
<td>HCII</td>
<td>10 (28.6%)</td>
<td>25 (71.4%)</td>
</tr>
</tbody>
</table>

Disaggregation of the existing health professionals by gender shows that the majority were females compared to males at all levels of care in the district. However, majority of clinical officers were male while majority or almost all nurses and midwives were females, and all the doctors were males. The district has an acting DHO and two (2) acting Assistant DHOs.

Within the previous 12 months of the Situation Analysis (September 2012): there were no new staff employed in the district; there was no information on staff that resigned or left for other reasons apart from transfers, illness or job termination; there was no information on staff transferred in and out of the district or transferred within the district (e.g. from one health facility to another within the same district).

Training and Education

The DHMT does not control a training budget although there is a capacity building fund to support in-service training for the whole district organized by the district council. The health department has never
been considered a priority when it comes to in-service training, and usually other departments benefit from the capacity building fund. The district does provide induction for newly recruited staff.

There are many Continuous Medical Education events for health workers. Vertical programs provide courses/training opportunities for district health workers. They provide the majority of the trainings in the district but these are in specific areas like maternal health, malaria or HIV/AIDS. The national level provides courses/training opportunities for district health workers. There is a national arrangement to train health workers in safe male circumcision. There are specific Human Resource or Business Management trainings for DHMT members. There was HR leadership course held in Mityana facilitated by the Capacity Program (Uganda) where some DHMT staff attended. However, the trainings are rarely documented, nor the learning shared amongst the staff. It has been discussed and agreed that facility in-charges use open registers where health workers can record CMEs.

There are a number of health training facilities in the district, which are shown in Table 9. These health training facilities are involved in the provision of Continuing Education in the district. Their presence within the district has provided training opportunities for health workers. For example, they offer registration training for enrolled nurses/midwives in the district; and some nurses have joined the Clinical Officers’ school to upgrade and change career to clinical officers, Mountains of the Moon University has started an undergraduate degree in public health. These institutions rarely collaborate with the district to support further training. Students use private sources of funding to undertake training at these institutions. The staff of these institutions do not serve as resource persons to support district activities except in rare situations like during mass campaigns.

Table 9: Number and type of health training facilities in the district (2012)

<table>
<thead>
<tr>
<th>Type of institution</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse training schools</td>
<td>2</td>
</tr>
<tr>
<td>Midwifery training schools</td>
<td>2</td>
</tr>
<tr>
<td>Clinical Officers training school</td>
<td>1</td>
</tr>
<tr>
<td>Laboratory school</td>
<td>1</td>
</tr>
</tbody>
</table>

**District Management Structure**

There are several management structures in Kabarole district that have a role in the health sector.

a. District Development Committee
There is a District Development Committee. It has guidelines on its function and responsibilities. There were several meetings in the past 12 months prior to the situation analysis in September 2012. There were records of these meetings. The structure has authority to make decisions on:

- District health plans
- District health budget
- Personnel e.g. recruitment, posting or transfers
- Purchase of drugs and other medical supplies.
b. District Executive Committee
There is a District Executive Committee (DEC). It has guidelines on its function and responsibilities. There were several meetings in the past 12 months prior to the situation analysis in September 2012. There were records (i.e. minutes) of these meetings. The DEC has authority to make decisions on:

- District health plans
- District health budget
- Personnel e.g. recruitment, posting or transfers
- Purchase of drugs and other medical supplies.

c. District Health Management Team
There is a District Health Management Team. It has guidelines on its function and responsibilities. There were many meetings in the past 12 months prior to the situation analysis in September 2012. There were records of these meetings. The structure has authority to make decisions on:

- District health plans
- District health budget
- Request, post or transfer personnel on behalf of the Chief Administrative Officer (CAO)
- Purchase of drugs and other medical supplies.

District Health management Team
Composition

The District Health Management Team (DHMT) as prescribed by policy should be made up of the District Health Team (DHT), in-charges of health sub-districts and health development partners (e.g. NGOs and other stakeholders). The DHT should be composed of the District Health Officer (DHO), Deputy DHO (Maternal and Child Health), Deputy DHO (Environmental Health), District Nursing Officer, District Health Inspector (DHI), District health Educator, Biostatistician and District Assistant Drug Inspector (DADI).

However, this is not the case in Kabarole district. A list of the members of the District Health Management Team, their roles and gender are shown in Table 10. There is a conspicuous absence of the health development partners (e.g. NGOs and other stakeholders). However, PNFP health providers were invited to participate in mass campaigns such as immunisation. The District Assistant Drug Inspector (DADI) is the only DHMT member changed during the previous 12 months to the situation analysis in September 2012. The Acting DHI was also acting as a DADI. There were many vacancies in the DHMT that have not been filled over the past 12 months. They included the positions of DHO, two Assistant DHOs, DADI and District Health Inspector (DHI).
Table 10: Members of the DHMT, roles and gender (2012)

<table>
<thead>
<tr>
<th>DHMT Post</th>
<th>Role(s)</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Officer (acting)</td>
<td>Leadership of the health department in the district</td>
<td></td>
</tr>
<tr>
<td>Nurse Officer (also D. Health Visitor) (acting)</td>
<td>MCH, home visiting, cold chain, immunization services</td>
<td>✓</td>
</tr>
<tr>
<td>Health Educator</td>
<td>Health promotion and education</td>
<td>✓</td>
</tr>
<tr>
<td>Health Inspector / Assistant drug inspector (acting)</td>
<td>Environmental health programs</td>
<td>✓</td>
</tr>
<tr>
<td>Biostatistician</td>
<td>Health information management (complies and analyses HMIS data)</td>
<td>✓</td>
</tr>
<tr>
<td>HMIS Focal person</td>
<td>Health information management (complies and analyses HMIS data)</td>
<td>✓</td>
</tr>
<tr>
<td>Accountant</td>
<td>Management of finances – budgeting, budget tracking and accounting</td>
<td></td>
</tr>
<tr>
<td>67 In-charges of health facilities</td>
<td>Leadership of health facility, makes duty rosters, supervises staff, compiles HMIS data and submits it to above level, participates in service delivery.</td>
<td></td>
</tr>
</tbody>
</table>

Functions of the DHMT

The functions of the District Health Management Team include:

a. Building collective responsibility and support to one another
b. Sharing information of what is happening in each department
c. Budgeting for the health services or district health operations and activities.
d. Implementing the national health policies
e. Providing supportive supervision
f. Human resource leadership and management

Issues discussed at DHMT meetings were:

a. Sharing of information of what is happening (performance) at different health services levels
b. Review of funding from the government and partners
c. Review of programs e.g. immunization, surveillance
d. Discuss staff welfare, discipline, complaints, and deployments if major staffing gaps arise; make recommendations about staff and facility performance
e. Review collaboration with partners e.g. Baylor College, PERFORM, etc.
f. Report on action point set in the previous meeting and follow-up of action points required after DHMT meetings.
All members of the DHMT have job descriptions which describe their roles as members of the DHMT. The roles are for the whole team not individual members. There are also terms and conditions which are used for induction.

The information on the average percentage of a 5-day working week the DHO spend undertaking the following management tasks - attending meetings within the district, attending meetings outside the district, visiting health facilities, supervision/mentoring, receiving visitors, and others - was not available.

DHMT members hold meetings with health facility and community representatives. There is a quarterly schedule for such meetings but it is hardly adhered to. Health Assistants hold community dialogue meetings and a member of the DHT attends the meeting. Holding such meetings is demand driven for example when there is a crisis; the HUMC invites the DHMT to conduct those meetings. Then the DHT receives a report about it.

**Decision making processes within the DHMT**

The process of decision making by the DHMT involves several steps:

a. Section heads identify areas that need a decision from the DHMT. The issues are presented to the DHO to be put on the agenda for the DHMT’s consideration in the next meeting. It is then discussed and decisions are made. Then DHO submits the decision to the Chief Administrative Officer who presents it to the district council meeting for consideration.

b. Sometime there is lobbying so that the issue and decision are given due consideration at the DHMT and Council meetings.

c. For issues which can be addressed at the DHMT level, the DHMT meeting can resolve, for example, recommend staff for transfer to improve performance and the CAO will be notified.

The national level can influence how and which decisions are made by the DHMT, for example:

a. Districts receive instructions/programs from the national level (MOH) to be acted upon e.g. national immunization days

b. Treatment protocols e.g. PMTCT come from the centre and are adopted by the district

c. Communication and advice about the distribution of essential medicines and supplies.

d. The Yellow Star Program (focuses on supervision), operating in the district is based on the national level performance indicators.

Members of the DHMT did not have the resources needed to perform their routine duties during the three months prior to this study (September 2012). Facilitation or funds for allowances, transport and other materials is never timely and sometimes lacking. In some situations, health workers hold meetings without lunch allowances and transport refund. They do it willingly, because management recognizes their efforts in other ways like secondment (support) to attend workshop where one can earn some allowance bigger than the traditional Uganda Schillings (UGX) 12,000 safari day allowance paid by government.
The DHMT and Performance Management

There are a number of performance management activities happening in the district. There are job descriptions for health workers. Mentoring has also been conducted. Performance appraisals have recently been introduced to health centres III and IV as part of the Uganda Capacity Program. There is no system for allocation of financial incentives to staff based on performance. All money is attached to specific activities and there is nothing for additional pay.

The role of the DHMT in managing conflicts between staff in the district depends on the issue(s) being addressed. The DHMT finds a solution to the cases and forwards the matter to the Principal Personnel Officer at the Council if things fail to work out.

In the case of misconduct, the DHMT can take disciplinary action. First the staff member will receive a warning letter. If this fails then the staff member must attend a disciplinary committee (made up of political and technical representatives). It is difficult to dismiss a member of staff, as if it is overturned, then the district will have to pay court costs and compensation. The district has experienced this and lost a lot of money. The DHMT perceived that staff rights override the performance expectations of the district as an employer.

Supportive supervision

Supervisors in the district

The criteria for choosing supervisors are:

- Performance history of an individual
- Commitment to work
- Morals and social integrity
- Seniority based on the level of training (diploma and above) plus the years of service.

Once supervisors have been identified, they are invited to DHMT meetings, assigned tasks like joining a team to investigate measles and writing a report. If there is an opportunity, they are trained in leadership and management, and deployed as in-charges or focal persons. Current staffing, number of supervisors and their competencies are shown in Table 11.
<table>
<thead>
<tr>
<th>Level</th>
<th>Staff who are supervisors</th>
<th>Competences</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHMT(^3)</td>
<td>16</td>
<td>All competent and subdivided into 5 Supervision zones each composed of 4 members. This is customized to meet the local needs.</td>
<td>Focal persons are given desks at the DHOs office. They are brought closer to share the vision, mission and objectives of the district health sector. They are engaged in support supervision, and writing reports. Focal persons are co-opted from health centres where they work as in- charges; they coordinate activities across the district. Usually they spend 2 days at the DHO and 3 days at their facility per week. All focal persons are at health facilities by appointment, are invited to attend district leadership meetings to observe, be monitored, and sometimes chair meetings. This is the way leaders are identified.</td>
</tr>
<tr>
<td>HSD/HCIV</td>
<td>In-charges of 4 Departments (nursing, maternal, theatre, laboratory and ART)(^4) do supervision</td>
<td>Competent</td>
<td>There is a need to strengthen HSD supervision. It requires more in terms of numbers and maintaining good supervisors. We hope to address this by the new recruits. There is no transfer of good support supervisors at HSDs</td>
</tr>
<tr>
<td>HC III</td>
<td>As for HCIV but no theatres at HClIIs.</td>
<td>Competent</td>
<td>No theatre at HClIIs</td>
</tr>
<tr>
<td>HC II</td>
<td>1 in-charge</td>
<td></td>
<td>They are a few and operate as dispensaries. Officially HCIIIs are supposed to offer ANC but in practice, they also conduct deliveries.</td>
</tr>
</tbody>
</table>

**Supervisory visits**

There is a schedule for supervisory visits within the district. This schedule is developed by the DHT who ask partners to support the supervision activities and the partners ask the DHT to develop the schedule. This schedule was not available for viewing. The number of supervisory visits made within the district in the six months prior to the situation analysis is shown in Table 12. The DHMT supervises the HSD; the HSD supervises the HClIIs; and then the HClIIs supervise the HCIIIs.

\(^3\) Five support supervisors from the DHMT supervise HCIV/HSD and HClIIs only. Hospitals, HCIV and HClIIs are supervised monthly while HCIIIs are supervised quarterly.

\(^4\) These are for internal support supervision.
Table 12: Number of planned and actually undertaken supervisory visits in the six months prior to the situation analysis

<table>
<thead>
<tr>
<th></th>
<th>Number of visits planned</th>
<th>Number of visits actually carried out</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSD/HCIV</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>HCIII</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>HCII</td>
<td>unknown</td>
<td>unknown</td>
</tr>
</tbody>
</table>

Feedback and reporting supervision visits

The DHMT has a supervisory protocol/checklist which was used when the supervision was still integrated. The checklist has since been modified to fit the district activities. With limited financing, most of the support supervision is technical and this does not cover all district programmes/activities. During the supervision visit, the supervisors provide “on the spot” feedback, or by telephone following the visit. The feedback provides a basis for follow up visits.

The supervisors write a report on the supervision visit which is also recorded in the supervision book. This report is shared at the monthly DHT meetings; the DHT compiles the reports and submits a joint report to the CAO. Heads of departments make weekly reports to the DHO.

Facilitation of supervision

The sources of facilitation for supportive supervision are: Primary Health Care non-wage budget that each district and facility receives from the Central Government and Baylor College of Medicine (Uganda). Facilitation of support supervision at the different levels in the district health services’ delivery system are shown in Table 13.

Table 13: Facilitation of supervision at different health system levels

<table>
<thead>
<tr>
<th>Level</th>
<th>Type of transport</th>
<th>Allowances</th>
<th>Guidelines/checklist</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHMT</td>
<td>6 vehicles</td>
<td>UGX 12,000</td>
<td>But adapted the national checklist and modified it to suit the district</td>
<td>4 ambulances*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4 other vehicles but only 2 are accessible by the DHMT for support supervision, 1 used by CAO, 1 by the LC 5 Chair. DHMT – use pre-paid fuel</td>
</tr>
<tr>
<td>HSD/HCIV</td>
<td>Ambulances Motorcycle</td>
<td>UGX 12,000</td>
<td>These run their own budget which they control with the HUMC</td>
<td></td>
</tr>
<tr>
<td>HC III</td>
<td>Some motorcycles</td>
<td>UGX 12,000</td>
<td>Few HCIIIIs do support supervision of HCII. These run their own budget which they control with the HUMC</td>
<td></td>
</tr>
<tr>
<td>HCII</td>
<td></td>
<td>UGX 12,000</td>
<td>Only do internal support supervision for the present staff at the health</td>
<td></td>
</tr>
</tbody>
</table>
Role of stakeholders in supportive supervision

There are many stakeholders involved in supportive supervision (Table 14). Their roles in supervision are varied, but most provide supervision for specific programmes such as HIV/AIDS or malaria. The professional bodies also participate in providing technical guidance and supportive supervision. The DHO’s office hosts the regional office of the Uganda Allied Health professionals.

Table 14: Stakeholders in supportive supervision and their roles

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Roles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government</td>
<td>Recruit and pays staff, funds supervision through PHC non-wage</td>
</tr>
<tr>
<td>Baylor College of Medicine (Uganda)</td>
<td>Mentorship of health workers at health facilities. The mentorship team can spend 2 days in a health facility mentoring the staff working in the HIV/AIDS clinic. They provide mentorship reports.</td>
</tr>
<tr>
<td>SURE</td>
<td>Management of Drugs</td>
</tr>
<tr>
<td>SURG - PHARM</td>
<td>Integrated Management of Malaria in Private Health Facilities</td>
</tr>
<tr>
<td>PACE</td>
<td>Supporting VHTs in 5 Sub-counties in the area of HIV. Operates through a CBO called Hakibaale.</td>
</tr>
<tr>
<td>JCRC</td>
<td>HIV/AIDS, TB</td>
</tr>
</tbody>
</table>

Factors facilitating supportive supervision

There are several mechanisms in place to ensure continuous supportive supervision and mentorship for supervisors which include:

1. There is a structured supervision report format for supervisors to use. There is also a support supervision book in which the write their findings and recommendations. Reports are shared in DHMT meetings and action points are debated to reach a practical consensus.
2. The Ministry of Health also provides routine quarterly supportive supervision, and there are guidelines in form of checklists which Kabarole has customized to meet the district needs.
3. Facilitation comes from the PHC funds which is not project tagged.
4. To increase supervision, most long serving staff have been promoted to senior positions and taken the role of supervisors. Focal persons at HSD/HCIV have been identified to provide supervision. Senior Clinical Officers at HCIIIs are expected to supervise HCIIIs.
5. The district has been divided into zones so that all health facilities are supervised.
6. A supervision schedule has been developed which includes the composition of the zonal teams, dates and location of the visits.

7. Supervisors are provided a daily allowance of 12,000 UGX.

8. Empowerment by the DHO to do support supervision and make decisions.

9. Self-driven individuals do supervision to maintain the district position in the Ministry of Health Performance Ranking League Table.

10. Fear that communities will report to higher authorities.

**Challenges in providing supportive supervision**

1. There is a lack of transport, for example the district health directorate has 4 vehicles but only one, which is in a poor condition, is available for support supervision.

2. Only 2 out of five teams have been able to make visits as a team. Supervision is often linked to other activities e.g. focal person visits a facility for surveillance but also conducts supervision at the same time.

**Health Systems Building Blocks and their Relationship to Human Resources**

**Health Management Information System**

HMIS reports for the 12 months before this situation analysis were available. The district health plan was prepared using the data from the HMIS. A biostatistician has recently been recruited to the DHMT and is funded by a development partner. The district has also got a workload indicator of staffing needs (WISN), an indicator used in workload assessment. There is a system for recording human resources data in the district (HRIS) which was developed with support from Capacity Program (Uganda).

**Service Delivery**

Services provided depend on the health centre/facility level. Services provided at different levels are standard and are shown in Table 15.

**Table 15: Services provided by facility level**

<table>
<thead>
<tr>
<th>Type of facility</th>
<th>Services provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health centre IVs</td>
<td>General consultations, mother and child health, vaccinations, deliveries, family planning, information and education for health, laboratory services, theatre</td>
</tr>
<tr>
<td>Health centre IIIs</td>
<td>General consultations, mother and child health, vaccinations, deliveries, family planning, information and education for health, laboratory services.</td>
</tr>
<tr>
<td>Health centre IIs</td>
<td>General consultations, mother and child health, vaccinations, family planning, information and education for health.</td>
</tr>
</tbody>
</table>
Data on the number of occupied bed days in the 12 months per health facility prior to this situation analysis was not available, but DHMT provided some information about some facilities (Table 16).

Table 16: Number of occupied bed days in the previous 12 months per health facility

<table>
<thead>
<tr>
<th>Name of health facility</th>
<th>Number of occupied bed days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bukuku Health Centre IV</td>
<td>The in-patient ward has just been opened.</td>
</tr>
<tr>
<td>Kibiito Health Centre IV</td>
<td>The ward was taken by a storm and the beds are not used. 18 beds for maternity and 9 for the general.</td>
</tr>
<tr>
<td>Kataraka HC IV</td>
<td>They have a maternity ward only.</td>
</tr>
<tr>
<td>HC IIs</td>
<td>Some health centre IIs are said not to be delivering just because they lack infrastructure, staff or the required supplies and equipment.</td>
</tr>
</tbody>
</table>

Information on the patients discharged from the district hospitals in the previous 12 months, outpatients seen in the previous 12 months per health facility, numbers of deliveries (normal births and caesarean section) conducted in each facility in the previous 12 months was not available during this situation analysis.

The number of DTP3 vaccinations that took place in the district in the last 12 months was 14,869.

Supplies and Technology

The National Medical stores supplies directly to the health centres II and III using a ‘push system’ bimonthly. Hospitals and health centre IVs make requisitions (Pull system) and the National Medical stores supplies. Information on the stock out of the five most frequently used medicines in the district is provided in Table 17.

Table 17: Stock out of the five most frequently used medicines in the district

<table>
<thead>
<tr>
<th>Five most frequently used drugs in the district</th>
<th>Number of days in the previous year when drug was out of stock</th>
</tr>
</thead>
<tbody>
<tr>
<td>First line anti-malaria drugs</td>
<td>Coartem supply is stable especially with the bringing in of RDTs</td>
</tr>
<tr>
<td>Quinine</td>
<td>No stock outs</td>
</tr>
<tr>
<td>Oral rehydration salts</td>
<td>Erratic supply</td>
</tr>
<tr>
<td>Cotrimoxazole</td>
<td>Sometimes can be out of stock but stocks have improved</td>
</tr>
<tr>
<td>Measles vaccine</td>
<td>Was out of stock in September 2012.</td>
</tr>
<tr>
<td>Fansidar for IPT</td>
<td>As for quinine. There are no stock outs. It is mainly used for intermittent presumptive treatment of malaria in pregnancy. One tin of fansidar is enough for a high volume facility.</td>
</tr>
</tbody>
</table>
Health facilities in the district with a functioning oxygen tank and supporting equipment for resuscitation (for both adults and children) are shown in Table 18.

<table>
<thead>
<tr>
<th>Name of health facility</th>
<th>Oxygen tank and supporting equipment - present or absent?</th>
<th>Oxygen tank and supporting equipment- functioning or not?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bukuku Health Centre IV</td>
<td>Oxygen concentrator</td>
<td>Functioning</td>
</tr>
<tr>
<td>Kibiito Health Centre IV</td>
<td>None</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Kataraka HCIV</td>
<td>None</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Virika (PNFP)</td>
<td>Oxygen concentrator + 1 tank</td>
<td>Not known</td>
</tr>
<tr>
<td>Kabarole Hospital (PNFP)</td>
<td>Not known</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Regional Referral Hospital</td>
<td>Several machines</td>
<td>Functioning</td>
</tr>
<tr>
<td>Kida Hospital (PFP)</td>
<td>Not known</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

**Governance and Leadership**

There are several health governance and leadership structures in Kabarole district (see 1.1.5 for a description of the District Development Committee and the District Executive Committee; and 1.1.6 for DHMT).

In addition to these bodies, there is the Health Unit Management Committee (HUMC). All HUMCs that exist in the district are functional. They are facilitated from the PHC fund. PHC funds are used to facilitate HUMC meetings. Partners also facilitate HUMC meetings e.g. Baylor has annual budget for HUMC. The membership of HUMCs is standard throughout the country and varies with the level of health facility (Table 19).

The HUMCs are required to:

1. Supervise health facilities to ensure accountability in terms of time, attendance by health workers, and how well in-charges manage personnel
2. Make decisions on behalf of the health facility
3. Link the health facility to the community
4. Give feedback to the leadership on events at health facility
5. Handle disciplinary issues.
Table 19: Membership of HUMC by level of facility

<table>
<thead>
<tr>
<th>Health centre II</th>
<th>Health Centre III</th>
<th>Health Centre IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Respected person with high integrity, not holding a political position, able to read and write -Chair person</td>
<td>1. Respected person with high integrity, not holding a political position, with at least an ‘O’ level certificate or its equivalent - Chair person</td>
<td>1. A prominent educated public figure with high integrity, not in a political position with ‘A’ level certificate and above Chairperson</td>
</tr>
<tr>
<td>2. In-charge of health centre II - Secretary</td>
<td>2. The in-charge of health centre III - Secretary</td>
<td>2. The In-charge of HCIV - Secretary</td>
</tr>
<tr>
<td>3. Two literate community representatives of high integrity - Members</td>
<td>3. Three literate community representatives of high integrity - Members</td>
<td>3. The head of Nursing Division - member</td>
</tr>
<tr>
<td>4. Staff representative – Member</td>
<td>4. Staff representative – as Member</td>
<td>4. Four community representatives who are literate and of high integrity (elect a vice chair from these four and other three will be members)</td>
</tr>
<tr>
<td></td>
<td>5. Head-teacher of the nearest school – Member</td>
<td>5. Staff representative (member)</td>
</tr>
<tr>
<td></td>
<td>6. The Assistant Secretary in charge of the sub-county – Member</td>
<td>6. Assistant Chief administrative Officer in charge of the county or Assistant Town Clerk in case of municipality member.</td>
</tr>
<tr>
<td></td>
<td>7. LC1 Chairperson of a required village co-opted when necessary and with a written invitation for a designated meeting as an Ex-official.</td>
<td></td>
</tr>
</tbody>
</table>

Kabarole has got a district health plan which covers a financial year. Once in a week (usually on Monday), the DHT holds a meeting from 8:30 – 9:30 to develop a plan for the coming week. There is also a district human resource (HR) plan. The plan is based on a financial year, and it appears as a section of the district health plan. It includes staff to be recruited in a year, staffing levels and the SWOT analysis. The CAO is in charge of postings and transfers based on recommendations made by the DHT through the DHO.

The district has a personnel handbook which includes conditions of service, policies on gender and equity of treatment of staff (i.e. non discrimination based on religion, HIV status, gender, sexuality). They are also in possession of a code of conduct printed and disseminated by the Ministry of Public Service. There are few copies, but both the DHO and District Personnel Officer have copies.

**Finance**

Kabarole district has a district health budget. The sources of funding for the district health budget are: national transfers (central government), District Council, and development partners. The district health budget preparation process involves all stakeholders. All unit heads prepare a list of their requirements and present them to the DHT meeting for consideration. These needs are adjusted according to indicative budget figures provided to the district by the centre (Ministry of Finance, Planning and Economic Development). The DHMT has a limited role in the allocation of funds to activities for the current financial year. The level of authority the district has got to use its budget for specific areas is shown in Table 20.
Kabarole district has financial monitoring systems in use for monitoring execution of the district health budget as shown in Table 21.

### Table 21. Financial monitoring systems in use monitor execution of the district health budget

<table>
<thead>
<tr>
<th>Systems</th>
<th>Existence</th>
<th>Actual use</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Financial records</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>Accounting procedures</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>Financial reports</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>Periodic auditing visits</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>Value for money verification</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>Medicines monitoring and the new MTRACK</td>
<td>❌</td>
<td>❌</td>
</tr>
</tbody>
</table>

Information on the breakdown of the health expenditure of the district for the past financial year was not available to show how the money is spent when it reaches the district. Salaries are wired directly to individual health workers’ bank accounts from the central treasury, money for medicines and supplies are sent directly to the National Medical Stores from central treasury.

There is a budget allocation for staff salaries and allowances, PHC wage bill (salaries), and PHC non-wage (conditional grants). There is a budget for financial incentives for staff. There are allowances for out of station activities (safari day allowance). There are no financial incentives paid in recognition of good performance. The input of the DHMT into the planning of the salary budget for district health staff is to indicate the current staff, those who dropped out and those to be recruited or promoted.

**Key Assets and Challenges on Human Resources within the District**

**Key Assets**

The main key assets with respect to human resources within the District are ongoing local and national projects that can be positively exploited to address some of the issues related to health workforce (Table 22).
### Table 22: Projects implemented in Kabarole District

<table>
<thead>
<tr>
<th>Name of Project</th>
<th>Project focus</th>
<th>Dates: From</th>
<th>Dates: To</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baylor</td>
<td>Saving mothers giving life</td>
<td>2009</td>
<td>To date</td>
<td>Pays salaries, training, supervision of program activities</td>
</tr>
<tr>
<td>Catholic Relief Service</td>
<td></td>
<td>2007</td>
<td>Closed in 2012</td>
<td>Pays staff in PNFPs like Kabarole and Virika hospitals</td>
</tr>
<tr>
<td>Intra Health and Uganda Capacity Project</td>
<td>Training staff in Leadership and Management, HRIS and the WISN</td>
<td>2010</td>
<td>To-date</td>
<td>This programme provided the HRIS software.</td>
</tr>
</tbody>
</table>

### Key challenges

At health facility level:
1. Facility in-charges have limited authority as they are informally assigned this role
2. No job descriptions for staff
3. Facility in-charges are not taught how to conduct support supervision
4. Lack of orientation for the new in charges

At the district level:
1. Inadequate supervision: limited numbers of staff at the district and the reduction in primary health care funding has reduced the frequency of supervision.
2. Understaffing – staffing is dictated by the centre and the wage bill will not allow for recruitment of more health workers.
3. High attrition of staff that reduces the motivation of the few who remain.
4. The district continues to lose staff to the municipal council, and central government (including Fort Portal Regional Referral hospital) because the district is unable to motivate them, especially those who return from further training.
5. Lack of a substantive District Service Commission to perform functions like recruitment and disciplinary actions
6. The Human Resource Officer is too busy to attend to daily human resource needs
7. Lack of career development plan
   i. Lack of promotion after further training
   ii. Lack of knowledge to access district capacity building fund
   iii. Lack of guidelines on the minimum requirements for promotion
8. Appraisal: staff do not complete appraisal forms as they perceive that there are no opportunities for promotion
9. Limited staff accommodation
10. Inadequate transport for health workers
11. Inadequate skills among health workers
12. Lack of communication at all levels
13. Rigid structures – the district must implement policies made by the centre and there is no scope for adapting to the local situation.

Findings from the evaluation

Management strengthening: processes

Support given to the DHMT

DHMT members reported that the PERFORM project supported the DHMT in a variety of ways. They explained that the PERFORM project built their capacity to identify problems in their district and analyse them in depth, and then find solutions that they could implement. DHMT members, CRT and EP described several ways that the CRT supported the DHMT.

Inception meeting

The DHMT members described the inception meeting where the country research team explained the purpose of the PERFORM project, how it will be implemented in the district and the role of the DHMT in the project.

National workshops

The DHMT members described the two national workshops (4 members attended the first workshop in Jinja and 13 members attended the second workshop held in Kabarole) where the problems were analysed and prioritised, and solutions identified and selected for implementation.

“Yes, PERFORM has made us in fact become also managers because at the beginning we could just generalize problems, we could not look at the real root cause, what is the real root cause? If the facility is not working are the drugs there and if they are not there who should be responsible for making sure the drugs are there? So that gave us a way of looking at how things are done right from the national level to the district level then to the facility. Through PERFORM I realized that before you start crying of a problem you first identify what the problem is, find out what is the root cause and if you find one root cause don’t say that is that, go deeper, think about it deeper.” (KDHM IDI 02 UG)

“We had gaps but we ourselves were not having the capacity to look at those problems and be able to identify what and how we can approach them but with our first meeting and our first guidance from PERFORM we came out with the idea of the problem tree and then the problem tree helped.” (KDHM FGD UG)

“In regard to problem analysis actually the coming in of PERFORM helped us so much I would say they did a very good job especially when they took us, they combined us with the other sister districts and where we shared experience. We learnt a lot actually in the first inter district meeting in Jinja. It was very good for use at the district level. The country research
team helped us to identify our problems, analyze them and then when we joined the other districts in analyzing, we realized that we learnt a lot, that is when we had the bundles, looking at the bundles and then identifying and prioritizing possible solutions, it was actually good process and the country research team helped us a lot really; thank you.” (KDHM FGD UG)

A few DHMT members commented on the way that the workshops were run: they appreciated that the facilitators encouraged interaction between the participants and group work rather than the facilitators just providing information; they also recognised that the workshops allowed many DHMT members to participate; they wished that these methods could continue.

“Regarding the workshop facilitation for me I will say it has been very good because first of all if you look at the interaction it is more like, it is not this workshop where you go and you expect to get stories or presentations from the people you are listening to but this is where you move you actually see ideas and I feel the approach of organizing a workshop is very nice because at the end of day actually you come”. (KDHM FGD UG)

“Members from PERFORM have a way of, had a way of facilitating, whereby they emphasize the issue of participation right from the way they introduce their topics I think members will even agree with are, uuu, right from the word go these people have been calling in all the members; they don’t leave anyone behind and that method of facilitation I really think it is a great method, thank you.” (KDHM FGD UG)

National workshop 1 report described that DHMTs were facilitated by the CRT and the European paired partner to refine their problem statements and to identify additional data requirements for their situational analysis reports. DHMTs appeared to value the support given to refine the problem analysis, finish their reports, and looked forward to the next workshop.

In National Workshop 2 report, a plan for communication between the DHMT and CRT was developed as it was recognise that communication was important during the implementation phase of the project. This included: visit by CRT 6 weeks after the workshop, 6 monthly inter-district meetings, weekly telephone communication by CRT, creation of a Facebook page and e-mail newsletter to enhance sharing of experiences and lessons learnt amongst the DHMTs.

Inter-district meetings

Many DHMTs reported that PERFORM project provided a platform for benchmarking and sharing of experiences across districts through the inter-district meetings: many members attended and they were able to share their problems and learn about possible solutions that have been implemented in other districts. They identified that the purpose of the meetings was to promote sharing of ideas and experiences amongst the districts, create and identify opportunities for improvement in weak / less performing district health indicators, and develop action points and learn best practices from other districts.

“PERFORM project has exposed very many of the DHMT members to other areas in the management, the inter-district meetings where very many people were able to attend. People get exposure and learn what is happening in other districts. People are now thinking outside the box. This was made very possible because of the PERFORM.” (KDHM IDI 04 UG)
“The inter-district meeting have helped members to understand the objectives of PERFORM project and owing the project. In the last one year the district realised some achievement in performance i.e. some DHT members and administrators were trained in leadership and management.” (DHMT diary 24/7/14).

“PERFORM helped us to share experience with other districts because when we would meet in the inter district meetings we would share with other districts what they are doing and they would sometime copy from us what we’re doing so PERFORM helped us.” (KDHM FGD UG).”

Inter district reports described the objectives of the workshop as enabling DHMTs to share progress and experience with implementation of the bundles, sharing lessons learnt about problem solving and improving HR performance, developing an action plan to improve the implementation of the bundles.

The CRT and EP reported that the DHMTs, despite being very busy, managed to get together and communicate effectively face to face during inter-district meetings which were organized by the CRT. The good relationship and fluid communication that the CRT had with the three DHMTs helped in achieving good attendance to these meetings.

“One of the CRT talked about was that these inter district meetings when the DHMTs came together, 3 of them the 3 teams came together and a lot of them came to those meetings and I know that one of the other development partners had commented that ‘how on earth do you get those DHMTs to come to these meetings because we haven’t been able to do that’. So somehow you know the [good] relationship between the CRT and the DHMTs has enable these meeting to happen and I think that is probably due, well maybe partially due to good communication with them, good relationships with them and I think also the way that those meetings happened and the way that the DHMTs communicated with each other in that meeting and the way that CRTs were facilitating that process was very useful and very effective I think.” (Interview with LSTM team)

**CRT visits to the district**

DHMT members, CRT and EP explained that the CRTs made regular visits to the district to find out about the implementation of activities. They valued this kind of monitoring.

“PERFORM team helped us to implement because of their continuous monitoring because every time we would be running to close it before we sleep we see a message from Kamukama or Baine, we are coming to Fort Portal we need to see how far you have gone and that was a very great factor in our implementation” (KDHM FGD UG).

The visit reports described the purpose of the CRT visits to the district which included to document progress with implementation of the bundles, reflect on successes and challenges, and identify changes in the district e.g. new programmes or partners.

“They were communicating with them to some extent by email but it sounded like the most effective way was by phone and visiting. They visited several times in the very early stages and we went on the second visit after the Iringa workshop and I think they would sometimes meet
them when they were in Town in Kampala and there was some communication.” (Interview with LSTM team)

Use of the diary

Several DHMT members explained that the PERFORM project facilitated the documentation of the research process using a diary. Kabarole DHMT initially used their meeting minute book to record activities related to PERFORM then adopted the use of the diary later when they heard that the other two districts were using it. However, there were several problems with the diary including how to ensure that all DHMT members including at the sub district level could record in the diaries, and not being clear about what to record. The DHMT adapted the format of the diary and found ways to transport the diary around the district.

“Now what happened when PERFORM project came they came with a book and this book was called a diary. This diary contained this information but the problem was, how can we got this information from the diary and we were able to get it on the ground so during those meetings we said ok, what if we got this format from the diary and we were able to look out from the diary that people can move with the facilities, people can move with even to their homes, people can move with even to their offices and they are able to use and make objective reports and yes it works because the information from that diary, those columns from the diary are the same columns we are having in our reporting tools” (KDHM FGD UG).

“Then the diary, people still need so more information on the diary because up to now I don’t know if the word was used to describe the book did not match well with what was in the book. May be they would have loved it to may be call it a supervision book or supervision book or minute book but still some people need some more information on that” (KDHM IDI 03 UG).

Telephone and e-mails

The visit reports also revealed some problems with communication between CRT and DHMT. E-mail exchange was irregular and some DHMTs sent e-mails but received no response. CRT agreed to develop a group e-mailing list so that all DHMT members are included. There were not enough visits to the district or telephone calls by the CRT, and more were requested by the DHMTs.

Electronic newsletter and Facebook

In an attempt to promote inter-district communication the CRT had the initiative to use social media and also a periodical newsletter was published. The report also stated that Facebook may not meet the needs of the DHMT.
“Millie set up a Facebook page and a newsletter and to some extent you could say that was also a method of their communication but I think that’s probably all the methods.” (Interview with LSTM)

Other

One DHMT member described that the PERFORM project provided technical support to the DHMTs, rather than money, so that they could identify problems and find solutions within existing budgets rather than rely on external funding.

“PERFORM has in fact applied a very good strategy, for them they want you to use your own initiative, you identify your problem and also find a possible solution and PERFORM has taught us not to be so much expectant about money, thinking that every project that comes there should be money invested for you to perform, but they can also give you technical capacity and guidance and you do your own things using the minimal available resource. So I commend the PERFORM research team and I also request that they continue, may be they continue for more other years so that we can really stabilize and have the best performance in the district” (KDHM IDI 02).

Analyses of problems that DHMT face

The DHMT perceived problem analysis to be a strong managerial tool but they also recognised it as a useful tool to use outside the work environment such as at home.

“Yes it is very very useful, problem analysis is very useful. …First of all highlighting the problems you have and looking at their root causes and also measuring how big one problem is and comparing which one to deal with first, is very key. And this kind of approach is not only good for managerial positions but I would say even to an individual person in your daily work and even in our settings in our home settings because it’s very good to know that I have this problem which one should I deal with first?, what could be the root cause of it? So it is very important it’s a very good approach that people should adopt in solving some of the problems.” (KDHM IDI 02 UG).

Main problems identified (initial problem analysis)

The main problems identified were absenteeism, weak supervision and poor capacity among the facility managers.

“…we were under performing because of some problems like absenteeism lack of support supervision and the in-charges of facilities did not have also the skills to manage…” (KDHM FGD UG)
One of the problems reported is absenteeism. Cases of persistent absenteeism are shared during the DHMT’s meetings and often a team is organized to visit the health facility concerned and analyse the problem on the ground and find the causes for workers not to attend their duties.

“...recently XXX health centre they had a problem with a cleaner and a what? and a clinical officer so we had to send the in charge of the health centre 4 he was on our DHMT meeting to really find out what could be the problem. And then we were able to find out that the clinical officer has some health problem that’s why he is not attending duty regularly and the cleaner has I think social problems that that don’t allow him to do what, to keep attending to duty.” (KDHM IDI 01 UG).

The DHMT, through the process of problem analysis, was able to link different issues. For instance some problems with health service productivity were also identified and the DHMT was able to link this problem with absenteeism.

“...you could find like one facility delivering like three [babies?] midwives in a month, there, in that meeting, you discuss what could be the problem, why is this happening and in that meeting you [also] decide to say now let’s formulate a team to go and visit that particular facility and look at the area of delivery. What is happening?, is it the midwives coming?, are they there?, are they not there? Is the in charge incorporating in good relationship with the midwives?” (KDHM IDI 02 UG).

There are also problems of shortage of specific clinical staff such as midwives and clinical officers as this manager suggests:

“...because of the increased numbers of mothers delivering and the project of safe mother giving life project phase II we have lobbied for more midwives ... ...And then they realized that because of the problem of analysis they also realized that we are lacking a clinical officer.... ...And they have so realized that after constructing a very good facility at XXX we need more cleaners...” (KDHM IDI 02 UG).

But shortages are not only affecting specific cadres but also some specific skills. Shortage of staff able to undertake supervision was reported to be one of the problems identified during the initial situation analysis as a priority and for which a bundle of interventions was developed including scaling up the number of health workers with supervisory skills:

“...after PERFORM came in and recognized our gap as being supervision, that team looked very small so that’s when we decided to increase the team.” (KDHM IDI 03 UG).

High staff turnover was mentioned to be a problem. Some causes of attrition mentioned during interviews with managers are unavoidable like retirement, death and disease but they also mentioned others such as outmigration on which there is some scope for intervention (e.g. introducing strategies to increase retention).

“...people are going for greener pastures, some of them are leaving, others are retiring, others dying, others are getting bed ridden...” (KDHM IDI 02 UG)
Sources of information about problems

Information about problems was gathered from either institutional or community based sources.

Institutional sources

Within the district health system DHMT meetings represent the main forum where problems are shared and discussed by the team

“Most of the problems we identify them through such meetings the DHMT meetings, the DHT... ... in DHMT at times we share reports, we share reports and the District reports... ...It is all identified during the meetings.” (KDHM IDI 02 UG).

Supervision of health services by the DHMT was another institutional source of information about problems. During supervision sessions both, staff working in the health facility and the community served, are able to rise issues that concern them.

“Then also we have been able to identify challenges when we go for to support supervision, support supervision staff and the community raise several points as far as that one is concerned.” (KDHM IDI 01 UG).

“...when we go for supervision we get reports, we write reports, an individual person who has gone for supervision, or if you are a team you write a report and in the report you share with the team members.” (KDHM IDI 02 UG).

“...during supervision a number of issues are identified some problems are solved during the meetings that we hold during the support supervision well as others are carried those which are carried are discussed in the DHT and then we can always find a way and that’s how we can identify problems.” (KDHM IDI 03 UG).

Analysis of data generated in the district was another main source of information for problem identification.

“...of course we get the reports from using our data. You may realize we have the weekly reports, we have the monthly reports, now we have developed the culture where we actually meet every quarter to review our progress.” (KDHM IDI 04 UG).

Health Unit Management Committees represent another important source of information. They either report directly to the DHMT or are enquired by them about specific problems during supervisions or ad-hoc visits.

“...we also interface with the Health Unit Management Committees. We also sometimes they report to us direct but we also sometimes go to them.” (KDHM IDI 01 UG).

Health facilities managers (“in-charges”) meet quarterly to share problems identified and propose solutions.
“Then we have quarterly meetings of in-charge. And it is at these meetings that... those key issues come up, the solutions are proposed and then we move out to implement them” (KDSUake IDI 04 UG).

Uganda ranks districts by their performance in a National League Table. The DHMT used this information to identify which were the most important problems in Kabarole.

“...for instance we have used the national league data when we are ranked as number let say two or three we get the reasons why we are ranked like that and we use that as a source and identify the problem...” (KDHM FGD IG).

**Community-based sources**

Community participation in problem identification was achieved through different means. Community representatives can send their comments about health services through mobile phone to the DHMT or call to a toll-free hot-line for users’ complaints.

“...another way which we get our problems is reports from communities as we now have a toll free line where community can call our office to tell, to tell us the challenges they are facing in the communities usually these associate with health facilities, they say maybe this cleaner, they say maybe we went to this facility we find the place very dirty, maybe the health worker are not working here, what’s the problem? So that’s how another way how we get to identify our problems.” (KDHM IDI 04 UG).

There are also community dialogue meetings in which community is able to raise issues about the health services.

“Then number two we hold community dialogue meetings where we go, especially health assistants...” (KDHM IDI 01 UG).

The Health Inspectorate also holds regular meetings with community representatives where they express their concerns about health services.

“...or the Inspectorate, Health Inspectorate, they hold meetings with community members [where they] are able generate community problems as far as service delivery is concerned.” (KDHM IDI 01 UG).

Village Health Teams also report their complaints to the DHMT either directly or through the mobile telephone system established for this purpose.

“...also the VHTs also they have been able to give us information am actually they are major people who use that anonymous messages system where they send me their problems or challenges as far as service delivery in our facilities is concerned.” (KDHM IDI 01 UG).
Politicians provide also feed-back to DHMTs about their concerns with health services

“...of course the political leadership has been vital in giving us feedback on the challenges in the service delivery.” (KDHM IDI 01 UG).

The media was also found to be a good source of information as people use it to complain about health services.

“...but also sometimes we had in the hard way through the media complaining that such a facility is not performing (laughs)so it also happens you hear in the media people calling in and giving feedback sometimes very negative, most especially negative.” (KDHM IDI 01 UG).

**DHMT response to problems reported**

When reports of problems reach the DHMT they react by sending a team to the facility concerned and gather more information about the problem.

“...when they report that there is a crisis in a certain facility we usually send a team on the ground and we normally try to find out what could, what is the cause.” (KDHM IDI 01 UG).

**Prioritisation and analysis of problems**

Problems identified during the situation analysis (see Table 23) were reviewed during National Workshop 1 in October 2012.

**Table 23: Key problems identified during the situation analysis**

<table>
<thead>
<tr>
<th>District</th>
<th>Key problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kabarole</td>
<td>1. Leadership and management of team leaders</td>
</tr>
<tr>
<td></td>
<td>2. Strengthening of support supervision</td>
</tr>
<tr>
<td></td>
<td>3. Enhancing health workers’ commitment</td>
</tr>
<tr>
<td></td>
<td>4. Improving working environment</td>
</tr>
</tbody>
</table>

(National Workshop 1 Report)

During National Workshop 2 held in February 2013 in Kabarole District, the DHMT further refined their problem tree before going into developing bundles to address them. This time they included the areas for reward and sanctions and weak appraisal system, but decided to focus on supervision during the workshop (see Fig 4 below).
Problem analysis involved an iterative process of identifying causes of the problems and then looking for root causes before identifying possible solutions as this DMHT member explains:

“What worked well, the DHT sat down we designed, we discussed about why we are not performing well, we looked for root causes, then after looking for root causes we had to look for the solution and the solution is lobbying funds and then coming up with support supervision.” (KDHM FGD UG)

DHMT members recognised that problem analysis was helping them in setting priorities within the district planning process.

“Yes, ah you see now, when you are able to identify problems, when you are able to analyse the cause of the problems, then it will give you, especially when it comes to planning, it gives you where to put your money...”(KDHM IDI 04 UG)

Working as a team during problem analysis was perceived as helping with undertaking more objective assessments as DHMT members with different backgrounds and working in different programmes need to agree on priority problems.

“To me, the factor which has helped is the unity which I have seen within my DHMT and there is that concern, everybody seems to be concerned about what is happening, they don’t leave it as if it is somebody’s business or if you are like a focal person in HIV, will get concerned on what is happening in like in malaria sector, what is happening in laboratory, what is happening” (KDHM IDI 04 UG)

The evaluation of National Workshop 2 showed that participants found the problem analysis processes helpful “It was very good and important for the team to get a logical flow of the problem trees” and timely, and there was strong agreement that the objective of refining the problem analysis had been achieved.
Issues faced by DHMT in gathering information about problems

Time constraints and lack of transport to visit the facilities are two of the problems reported by DHMTs trying to gather information about performance of health services in the district.

“...I think other conflicting priorities and so you find sometimes you don’t have enough time conduct activity. Then of course... ...sometimes we don’t have transport in terms of vehicles.” (KDHM IDI 01 UG).

Sometimes there are problems of delay in reporting from some of the facilities. There is a tracking system where HMIS managers can identify the facilities that are having problems. In this regard HMIS staff hold regular meetings to identify the facilities that are having problems of delay with reporting, discuss their problems and try to find solutions. Reasons for delayed reporting are sometimes simple technical problems in sending emails but there are also problems of neglect.

“Now every week the biostatistician and HMIS focal person they sit they look at facilities that are not reporting and when those people are identified, then yes, that’s another issue where we need address... ...We have a track system where we can be able to communicate to these people we tell them this facility has not reported. They get concerned, come here with the message they have tried to send and then you realized they just missed a figure or missed a full stop and the message does not go... ...we realized that many people were not reporting because they did not want to report, and some were willing but did not know how to report.” (KDHM IDI 04 UG).

They also reported having problems in obtaining data from private facilities. Private providers including NGOs or FBOs only report to their donors. Some said they were unaware of the district reporting system.

“Another problem was the private (facilities) were equally not reporting. They only reported to donors who fund them. Many of them were actually not knowledgeable on how to report.” (KDHM IDI 04 UG).

Selection of bundles

Selection of initial bundles of interventions

The DHMT members described the way that they selected the initial bundles of interventions. During the workshops, the Kabarole DHMT worked together as a team to identify possible solutions. The DHMT members reported that the in-depth problem analysis, whereby they identified the root causes of the problems and specified the problems in detail, helped them to identify the specific activities to help solve the problems. They gave an example, of describing the problem in detail so they could identify who should be trained and the content of the training. In the workshops they developed bundles of interventions alongside the problem trees. They also heard from the other districts about how they had managed similar problems.
“The workshop approach was helping us to come together in our place we identify our problems we made the bundles during the workshops and then we had to look for solutions of the problems. All those were done during workshops.” (KDHM FGD UG)

“So really workshops help us to address and harmonize our problem and you come up with solutions as a team”. (KDHM FGD UG)

“Using workshops to identify solutions and may be identify problems is number one, when you look at your meeting with other districts some time actually you move here with a problem but actually you came up with solutions here and there because what the other district are doing you will find it answers, it gives a direct answer to a problem which you are facing as a district and therefore you don’t need to work extra hard to get solutions but also meeting as a team sharing problems gives people even better opportunity. May be you may find some district can be boosted because people come with better suggestions on how we can move up together.” (KDHM FGD UG)

“When you are able to analyze the cause of the problems, then it will give you, especially when it comes to planning, it gives you where to put your money, unlike if you say this blanket statement of we need training, we need this, but you are able to go deeper and say actually who needs the training, and even training on what. You are even able to select the particular people and not like where like they organize a training and people send people who are not even concerned because it’s a training, the facility is supposed to be represented then somebody just comes there and attend the training. But this time you are able to say, we are calling for such and such and such people to come for this, because you are able to analyze, you are able to put your money very well.” (KDHM IDI 04 UG).

The bundle of interventions was developed alongside the problem analysis (see Figure 5 below) then written up into a table before incorporating it into the district annual plan.

Figure 5: Kabarole DHMT developing the bundle of interventions

(National Workshop 2 Report)

The main strategies of the plan are given in Table 24 below and the full plan using the template provided in the workshop which includes supporting activities, indicators linkages to other relevant HR or health systems strategies is given in Annex 3.
Table 24: Main strategies of bundle of strategies to improve supervision developed at National Workshop 2

<table>
<thead>
<tr>
<th>A. Performance area/broad objective</th>
<th>B. Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase number of supervisors</td>
<td>Select and develop a team of supervisors</td>
</tr>
<tr>
<td></td>
<td>Retention and incentives</td>
</tr>
<tr>
<td></td>
<td>Develop partnership with existing partners</td>
</tr>
<tr>
<td></td>
<td>Engagement of HUMC in Supervision</td>
</tr>
</tbody>
</table>

(National Workshop 2 Report)

**Selection and modification of follow up interventions**

The DHMT members reported that they made some adaptations to the bundles of interventions, so that they would better achieve the anticipated outcome. They gave several examples of adaptations to bundles: introducing spot check supervision visits to address absenteeism; and rewarding individuals and facilities that are performing well, instead of just focusing on giving sanctions.

“As we implemented we identified certain changes that were necessary and we were able to make those changes to make the implementation even better.” (KDHM FGD UG)

“Then the other one we identified was the absenteeism among our staff and realized that the root cause of that was lack of supportive supervision; regular and spot (supervision) because if people know that every month you come they will be prepared for you. We decided also to have spot supervision at very awkward time and this one also improved the presence of our people at our facilities.” (KDHM IDI 01 UG)

“The other thing is establishment of the reward and sanctions committee. This was established not only to discipline undisciplined individuals but also reward the best performing individuals. We recognize a healthy facility that is doing very well and we started that by recognizing at our end of year get together party where we exhibit highest team work where people collect some money. This is not in our work plan.” (KDHM IDI 01 UG)

“In that meeting we recognize the best performers by awarding them certificates, some of them we mention their names and then clap for them and then facilities we also give them certificate of performance and that has also given people courage to work even beyond their efforts and even beyond, to work even during beyond the working time.” (KDHM IDI 01 UG)

In the diary, the DHMT reported that in a meeting with DHMT members, they decided to allocate mentors to the new supervisors in order to improve supervision.

“It was agreed that following recruitment, the new supervisors be attached to mentors. The criteria for selecting mentors was reached which included: qualification – diploma and above, in senior position, exemplary character, experience and clean performance record and others. The activity was meant to improve capacity of supervisors and promote retention of health workers”. (DHMT diary, 12/05/13).
The DHMT members also said that some activities were delayed. They gave two reasons for the delays: the resources were not available; and other priorities arose.

“Yes recently we had planned for activities and I will just give an example we had planned for so many activities; performance review, health assembly, and training more health management committee members but along the way they changed the data tools for HMIS data reporting. So we felt much as it was in a work plan but for maybe later alone we prioritized and changed. So we have at least had times of changing the work plan to prioritize activities that are required very soon to meet our standard like to meet our performance standards.” (KDHM FGD UG)

“Still not so much deviating yes and no, yes for the plan for like activities that have been scheduled and every necessary things required was availed and they were implemented as planned in the time frame. But those that were not availed in timeframe of course we had to wait and probably implement whenever resources are available”. (KDHM FGD UG)

Integration of bundles into the work plan

The DHMT members reported that some of the bundles of strategies were already part of the district annual work plan while others were new and had to be included. The DHMT tried to include bundles of strategies that could be implemented without requiring extra funding and those strategies that required extra funding took longer to be included in the work plan. Development partners provided extra support in the implementation of bundle strategies. Having the bundle strategies in the work plan helped in directing partners’ support to the district. The DHMTs described writing proposals about the bundles, submitting them to the partners such as Baylor, BTC, Capacity program, and lobbying them for funding to implement the bundles of strategies.

“We identified the problems, we actually in the beginning what we started with was to bring our district work plans and put them on table and then we looked at amongst the challenges we identified what is catered for in our district plan.” (KDHM FGD UG)

“But there were some problems that we identified that were not actually in our district plan so we said what can we do about these so we also did not stop there but we designed solutions. What were the solutions one of them was to look around for the partners (Baylor, BTC, Uganda Capacity Program) that are within the area and share with them which one of these can they handle.” (KDHM FGD UG)

“We were able to identify which one to start with prioritizing the problems then looked at ourselves what resources do we have and what do we need so like when we had that we had a problem with supervision we said what resources do we have to do support supervision we saw we have people they were few in numbers, what can we do we identified more and trained them and made them supervisors of supervisors, what do we need, we need transport, we need fuel and what to facilitate this one what do we do we don’t have money can we identify a partner to support this which we did”. (KDHM FGD UG).

“When you are lobbying you have to go with a district work plan is it in the district work plan so we integrated them in the district work plan that is why you see PERFORM in other partners like BTC they are helping us do some of these things, partners like Uganda capacity
program we had to put our things in the district work plan then we were able to have solutions at the same level”. (KDHM FGD UG).

“We identified that some implementation of the plans, some of them needed some funding which was not ready at the district at that time so it involved lobbying......we lobbied with one of the partners, they could not handle so we had plan to implement it in was it quarter three 2013, it did not happen so it over run to actually we did it in the second quarter 2014 so some of those like availability of funds did not enable us to implement according to what we had planned in time if you say maybe clearly or way be in time, it was not timely because of lack of funding”. (KDHM FGD UG)

One of the objectives of National Workshop 2 was to integrate the bundles of strategies into the district work plan. In the workshop evaluation, the participants perceived that this had been achieved, and that the workshop was timely as the districts were in the process of developing work plans 2013/14.

However, the CRT felt that as the bundle selection started in the middle of the financial year, it was difficult for the district to incorporate the bundles into the district plans. Nevertheless one participant of the workshop said in the evaluation; “The workshop was timely in a sense that the districts are in the process of developing work plans 2013/14”.

During the inter district meeting in July 2014, the DHMT explained that they had integrated the bundles of strategies into the district work plan through the objective “improve managing performance”. Within that objective, they included the strategies of individual performance planning, performance improvement/quality improvement, performance monitoring, and performance assessment. (Kabarole presentation at the inter-district meeting 24th July 2014).

Management strengthening: Effects

Effects on DHMT

DHMT decision making practices
The DHMT receives and discusses submissions from its members or partners before decisions are made. The DHMT in Kabarole meets every week to plan and review health sector performance and follow up on progress in addressing problems identified.

“As a group we now normally meet monthly as a group but however the smaller DHMT meets every week, every Monday but the extended DHMT is usually monthly and we thought that that one is more effective”. (KDHM IDI 01 UG).

Since PERFORM started DHMT has adopted the problem tree as a tool for problem identification and analysis.

“I mentioned that in the beginning of the statement that after PERFORM came, we because actually the first thing PERFORM taught us was to identify those problems using problem tree so from there now we said fine and we realized the benefits of using the problem tree so the problem now would be identified we can decide to draw a problem tree and see.” (KDHM IDI 03 UG)
The team perceives that there have been improvements in the process of problem solving.

“I realize that, aa, the the analysis of the of the problem at hand and being able to provide solution or achievable solution has improved in our meetings. So I think that way we can attribute that one to PERFORM project.” (KDHM IDI 01 UG)

The frequency of DHMT meetings has changed since PERFORM started being now weekly instead of monthly which is perceived as having improved their decision making process.

“...we have DHT monthly meetings and for us of course as a district because of PERFORM that it has natured us so well to identify our problems we decided also to have weekly meetings which also creates platforms for us to discuss some key issues and take decisions”. (KDHM IDI 02 UG)

The dynamics of the DHMT in terms of agenda setting seems to be relatively systematic as reflected in this annotation from the DHMT’s Diary:

“DHT Review Meeting:
- Review the previous week
- How much more was done
- Bring everyone on board
- Plan the next week” (Diary 05/08/2013)

Discussions are guided by documents like the annual work plan and the national strategy.

“First of all we are guided by the annual work plans, it’s a requirement of the district to be able to make annual work plans so when activities do come we discuss within am the guidelines of the annual work plan and then we are able to implement them but however before that we usually make these work plans every year and then they are on table before so we able to refer to them” (KDHM IDI 01 UG). Every member participates freely and decisions are made democratically.

“Our meetings here are like family, they are very open so every member participates so every member contributes and they are very interesting because they are like family actually yes these people just say everything they are very open” (KDHM IDI 03 UG)

“...its usually in a meeting where everyone is given the opportunity to discuss and after discussion we usually make decisions as a way forward but of course it’s democratic so it’s majority to decide. So we vote if it doesn’t require voting if we all agree then that’s fine but if we all do not agree then we have to take the majority’s decision yes” (KDHM IDI 03 UG).

The DHO has a pro-active approach to problem solving and search for quality as reflected in this note from the reflective diary where the criteria for the selection of mentors for the new supervisors are defined:
“The DHO called a meeting of DHT members where he suggested ways we can employ to improve supervision. It was agreed that following recruitment the new supervisors be attached to mentors. The criteria for selecting mentors was reached which include:

- qualification: diploma or above
- in senior position
- exemplary character
- experience
- clean performance record

Their activity was meant to improve capacity of supervisors and promote retention of health workers.” (Diary 12/05/13).

**DHMT composition**

The composition of the DHMT is variable across districts. As extracted from the report of the 1st National Workshop.

“A major gap in the information presented was on the size and roles of the DHMT. It seems that the concept of DHMT is actually quite fuzzy, and it was good to acknowledge this in the workshop. More work needs to be done on this!” (National Workshop 1 Report).

The DHO is the head of the DHMT and normally chairs meetings supported by the secretary who normally takes minutes of the meetings and an assistant DHO. Other members include a health educator, district health inspector, surveillance focal person, biostatistician and officers from the different programmes (e.g. TB, HIV/AIDS, MCH, etc.).

“...usually in our DHT, we have the DHO is always the chair even though they might be able to delegate that work and sometimes they might be able to delegate that work when they are there as a method of mentoring other people to take up leadership positions... ...And the other members the other members on the district that is the district health educator that is the district health inspector the surveillance focal person and TB focal person then the HIV/AIDS focal person the assistant DHO in charge of maternity health services they are always there and their secretary is the Bio statistician. Yeah the biostatistician also comes with the records assistant they are always members those are always members.” (KDHM IDI 03 UG).

Kabarole had some problems of high turnover in the position of DHO which may have affected the implementation of the bundles. However the fact that the acting DHO was a former member of the DHMT may have mitigated this risk.

“The DHMT composition has changed with the coming in of another Acting District Health Officer after the former went for further studies and the position of the Biostatistician had been filled after the former left for a job abroad. The Acting District Health Officer is a former member of the DHMT who had been serving in the Health Sub District (HSD). The new biostatistician is supported (including payment of his salary) by a USAID project, Strengthening Decentralization for
DHMT include also different stakeholders from different levels in the system.

“...a DHMT this one is, comprises of stake holders, different stake holders including the hospitals, the NGOs that are working with us, the CBOs and then we also look at our facilities right from the health sub district, Health Center IIIIs, we have some senior staff, but for us we are brought on board, the DHMT and then we also have the District leadership then some members of the health Management committees. Also part there are some influential members on health management committee that we have brought closer to us and during such meetings they take part.” (KDHM IDI 02 UG).

The initial composition of the DHMTs was expanded as a result of the problem analysis undertaken at the beginning of PERFORM project

“So it is out of this performance we looked at our problem, looked at our gaps and we realized we needed more, we needed more combined effort from different individuals at all levels looking at IPs, looking at PNFPs, looking at CBOs of our facilities plus our healthy workers to form a DHMT and that I think has enabled us work better than before.” (KDHM IDI 02 UG).

Another important addition to the DHMT was the performance management focal person for which a senior staff member with broad experience in the district was appointed.

“...but now after recognizing that after PERFORM came in and recognized our gap as being supervision, that team looked very small so that’s when we decided to increase the team when we increased the team then we decided to call upon other focal person that’s when the focal person from the performance management was called upon...” (KDHM IDI 03 UG).

Depending on the issues to be discussed the DHMT invites external people to the meetings, particularly when proposals on how to address specific issues involve decisions beyond the DHMT’s responsibilities. For instance the District Chief Administrative Officer, Secretary for Health or the District Human Resources Officer were mentioned during interviews.

“Then ah ideally we have, many times we extend to people of interest, when we look at issues which we are going to discuss we feel we need to have some people, we co-opt and usually we call the chairperson who is the secretary for health also social services, then we call the CAO and the human resource officer that is if the issues we are discussing pertain human resource.” (KDHM IDI 04 UG).

In order to ensure that all necessary skills are available among the DHMT members CPD is offered as reflected in this annotation in the DHMT’s diary in Table 25:
Table 25: Annotation in DHMT’s diary

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
<th>Cause</th>
<th>Effects</th>
<th>Reflection</th>
<th>Way forward</th>
</tr>
</thead>
</table>
| 30 & 31 May 2013 | Training of DHT in M&E and decision support systems | Failure of data managers at facility level:  
- Inadequate training of data managers (records assistant)  
- Failure to submit reports on time  
- Inadequate computer skills among r/assistants. | - Failure to analyse data  
- Failure to plan basing on data  
- Incomplete & inconsistent data  
- Lack of training of r/assistants in computer knowledge & skills | Training of 3 DHT members:  
HIV focal person,  
HMIS focal person, DHO in M&E and decision support systems  
Sharing district reports with other districts in the region (e.g. Bundibugyo, Kamwege, Kyenjjoyo) | All DHT in M&E and decision support system  
- All r/assistants should have a training in basic computer applications  
- On recruitment it should be a requirement for R/assistants to have computer knowledge  
- All in-charges at facility level should plan using their generated data in their reports and also develop PMP |

(Diary 30-31/05/2013)

**DHMT learning from other districts**

Learning across districts was most recognised in the inter-district workshops under the PERFORM project. In fact sharing experiences was one of the specific objectives of these workshops:

*The objectives of the Inter-district workshop 2 were:*

- To enable the DHMTs share progress and experience with the implementation of the HR/HS bundles agreed on during their national workshop 2 February 2013
- To share any lessons learnt relating to problem solving in general and to improving HR performance in particular
- To enable each DHMT to develop a set of actions to improve the implementation of their HR/HS bundles
- To brief the DHMT on the evaluation and develop a tentative plan for the activities” (Interdistrict workshop 2 report).

The district learned best practices from other districts and was in turn consulted by other districts about issues that were working well in Kabarole. Even districts that were not included in the PERFORM project consulted and benchmarked Kabarole for its good performance.

*“...the other time like a month ago we received a team from Nwoya. Nyowa is a district in northern Uganda, one of the new districts, so when they came here, one of the, they came here they were so interested, they actually picked our work plan” (KDHM IDI 04 UG)*

*“Yeah with the help of PERFORM it helped us to share experience with other districts because when we would meet in the inter district meetings we would share with other districts what they are doing*
and they would sometime copy from us what we’re doing so PERFORM helped us very much thank you…” (KDHM FGD UG)

Inter-district learning was explicitly promoted as a means to improve performance as indicated by this extract of a report from National Workshop 2.

“He also pointed out that much as Kabarole has made such progress to top the League Table, there are still challenges, emphasising the need for districts to learn from each other using the platform provided by PERFORM.” (National workshop 2 Report)

DHMT members and staff reported that inter-district comparability can stimulate performance. Districts can now compare their performance to that of other districts which helps them to see where they are in comparison with other districts. This “competition” is perceived as positive as this staff member expressed during his interview:

“And also you come to know that I can be compared with other districts because when we are giving in our recommendations, we compare and see which district has performed better. So it is a very good initiative.” (KDStaff IDI 04 UG)

“…they combined [compared?] us with the other sister districts and when we shared experience we learnt a lot actually the first inter district meeting in Jinja it was very good for us” (KDHM FGD UG)

DHMT human resource practices

The DHMT has a HRM function which deals with diverse functions such as planning, deployment, supervision, performance management, motivation, promotions, rotation, capacity building and advocacy.

“...we do our performance plans, performance monitoring, we distribute the tools; we train staff and then make appraisals” (KDHM IDI 03 UG)

They also mentor, reward and discipline workers under their responsibility. DHMTs engage higher authorities like the CAO if decisions to be made are beyond their mandate. The CAO through the Human Resources Office endorses DHMT decisions like disciplinary, promotion or transfers.

“We call the CAO and the human resource officer - that is if the issues we are discussing pertain human resource” (KDHM IDI 04 UG)

Within performance management DHMTs set targets, monitor performance and appraise individual workers linking the results of the appraisal to rewards or sanctions.

“Rewarding the good performance and sanctioning those that may not be performing well. And this one has seen, we have seen it, it is working. Those who are not performing well, we are able to bring them on board. But also advocate, as a team we have always advocated for the workforce capacity building” (KDHM IDI 04 UG)

“...one worker, an askari (security guard) who applied and wanted transfer actually had been recommended by other supervisors but the in-charge had not recommended that
person because that person had faced the rewards and sanctions here made commitments but was not able to fulfil the commitments.” (KDHM IDI 03 UG).

The importance of the use of an attendance book to control the high level of absenteeism identified was reported after Inter-district workshop 2:

“All supervisors have been mandated to ensure that priority on their field activities is to; ensure that the health workers are coached, mentored and sensitized on the benefits of using the attendance book and how to use it.” (Inter-district workshop 2 report).

Integration of facility managers from sub-district levels in the DHMT has contributed to strengthen management at lower levels of the system. Health facility managers and staff feel part of the decision making process increasing their ownership and responsibility about performance at that level.

“Because people before used to take government… “aaaa, this is government work.” You find a person doing something without a target because the government sure will pay. But now you find at least when you are doing work you feel I should do it in the right way, not to do it for your sake…” (KSDstaff 04 UG).

Bundles’ implementation has had a relatively important impact on the way DHMT works. For instance in appraising health workers, the better understanding of the benefits of having a good appraisal system in identifying areas where employees require support was mentioned in the report from one of the workshops:

“The DHMT was able to change the norm of appraisal – “health workers filled appraisal forms only when one needed to be promoted”. Majority of the appraisals happen a little lower than where members of the DHMT members sit. Previously appraisals were a ritual and there was a tendency to award good marks – which was quite challenging because it was hard to discover those who needed assistance. Today appraisal provides an opportunity for the supervisee to share her/his work challenges with the supervisor and they both agree on improvement plans.” (Inter-District Workshop 2 Report)

Improvements in assessment of staff requirements according to workloads allowed the DHMT to request authorities to allow recruitment of new staff. Since then health facilities can collaborate more easily with each other in case of need by shifting staff from facilities with less workload.

“Sometimes there are disaster crisis the break out of a disease in a given area so like I already told you we normally borrow staff from other units with lesser workload but with more employees as far as establishment and then we deploy tentatively to handle such challenges within a given time then they are taken back to where they were subtracted from”. (KDstake IDI 02 UG)

Managers who reported problems with specific issues are followed up by members of the DHMT as reflected in this note in the diary:

“A follow up was made to see if the leadership in XXXX is following the meeting with the Sanctions and Rewards Committee. They actually involved a meeting at the facility and talked to the in-charge and quality officer.” (Diary 17/01/2014)
DHMT use of action research in management

Links between action research steps

Some DHMT members described how they used the action research steps in planning and implementing the strategies. They explained that the in-depth problem analysis identified the root causes of the problem, which enabled them to find possible solutions. As they implemented the solutions or strategies, they observed for changes, recognising that small changes are important and that changes may take time. They reflected on the changes and the implementation and identifying any modifications to the strategies that are needed. Others described that following the problem analysis, they developed plans with clear targets, and once those targets were met, identified other problems to tackle. One stakeholder reported that during the regular meetings of the facility managers, they identify problems and possible solutions, implement the activities and reflect on their effectiveness.

“Through PERFORM I realized that before you start crying for a problem you first identify what the problem is, then once you have known the problem, find out what is the root cause and if you find one root cause don’t say that is that, go deeper, think about it deeper... and then you start thinking what are the possible solutions for this. So for me as a person I have learnt a lot because even I sit on the disciplinary and sanction committee and people, I see people are appreciating when we call them here they don’t get annoyed they have not hated us, in actual sense they have appreciated and say “eeth you helped me now I am going to change” but for those that are hurt, are hard hearted they are also there, they are not changing but we don’t give up and PERFORM taught us to be patient. In fact you are implementing this problem analysis, you don’t have to be so ambitious you have to be patient, you have to take time, you have to continue observing and any small change that takes place you must appreciate because as you go on you find the changes are becoming bigger and bigger and then in the end you can appreciate.” (KDHM IDI 02 UG).

“We usually keep on modifying here and there because you may realize ah if you did something well this time you may want to keep it, but if you realize you did not actually do well in some area, you may want to revise” (KDHM IDI 04 UG).

“In a process of making the problem tree what worked well I think to me as a person setting target and achieving the target and after achieving the target usually the good thing is as a team we don’t stop there. Once a target is achieved we identify another problem so in other words it has opened our minds to keep on identifying problems that achieve our targets and find more problems.” (KDHM FGD UG).

“Then we have quarterly meetings of in-charges. And it is at these meetings that we pick out those what you call bundles. That those key issues come up, the solutions are proposed and then we move out to implement them. Then we review them at our next meeting. Then we see what worked and what did not work. But many times we have people who are quite active and pro-active. Many times what we propose, works.” (KDstake IDI 05 UG).
In the diary, there is evidence of the DHMT going through the steps in the AR cycle. For example, they identified a problem with the capacity of new supervisors to provide good quality supervision. They therefore identified mentors who were experienced and respected staff who could support each supervisor. They reflected that the mentors did not fully understand their role and responsibilities, and so held discussions with them to clarify.

“In the beginning some members did not understand the mentorship well. But after the discussions all members were in agreement and welcomed the mentorship idea” (Diary, 12/5/13).

Another example is seen with appraisal, where supervisors were guided in helping staff to self-evaluate their own performance, and develop individual performance plans. The DHMT members observed that most staff continued to believe that appraisals should be completed just for submitting to the higher levels and when there is promotion. The DHMTs then discussed with the staff about the role of regular appraisals in performance management. They decided:

“all staff to develop individual annual performance plans and file them at the facility; plans to be monitored at least quarterly to identify gaps and fix them in time; and share successes of staff amongst themselves during quarterly meetings” (Diary, 12/8/13).

Another example is seen in the operation of the rewards and sanctions committee. The DHMT reported that they called 3 managers from poorly performing health facilities to the committee to present their perspective of the problems at the facilities. They then discussed leadership and management skills, developed a plan of action, assigned a mentor to support them, and agreed dates for follow up visits. The DHMT reflected that encouraging the managers to discuss their own challenges enabled them to find their own solutions which they could implement. They found that record keeping was improved, meetings were being held and documented and staff reported improvements in interpersonal relationships.

“This method worked well – when a staff is identified as a poor performer, call him / her, talk to them, let them identify their own challenges, then guide them into the identified solutions, then follow up on the agreed actions.” (Diary, 17/01/14).

Another example is seen in the activities surrounding the Health Unit Management Committee. Members of this committee were trained in their roles and responsibilities, they then went on to prioritise the needs of their communities to be included in the health facility plan. Through this process they developed an awareness of the health facility plan and skills in planning. However, the DHMT reflected that the length of time for the training / facilitation was not enough as some members still needed assistance, and some activities were not funded. The DHMT members identified that the health facility plans need to be submitted to the health sub district and district on time, so that they are more likely to be funded.

Lessons learned from action research cycle

The DHMT members reported several lessons learned. First, changes in health workforce performance can take time, and therefore it is important to observe carefully, be realistic about what can be achieved and be patient.
Second, they implied that the reflection part of the action research cycle is more challenging, and identified that they needed more support in recording reflection. Reflective diaries was introduced in National Workshop 2. The purpose of these diaries was for the DHMT members to record their experiences and any learning from these experiences. These can then be shared with other DHMT members who can also learn from them. Over the course of the project, the DHMT adapted the diary so that they could use it to record their experiences, reflections and learning.

“And I was also requesting that if that book was not just a book that they make a format with those headings included inside work book may be that would help.” (KDHM IDI 03 UG).

Third, DHMT members identified the challenge of getting good quality data to inform planning and adjusting work plans.

“Another challenge is that when we have done the reports, the work plans I mean and after maybe the exercise or after implementing the work plan in most cases we don’t utilize the data which you have generated at that level to make improvements, so far that case you find that the data which we generate it can be maybe of poor quality, still we always encourage them to, that there is room for improvement but you find that, that data is not well utilized to improve the services at that level.” (KDHM FGD UG).

Fourth, DHMT members reported that through the process of problem analysis and bundle selection, implementation and reflection, they were able to identify where they could rely on their own skills and knowledge to solve problems, and where they needed external support.

“In the journey with PERFORM we have actually achieved much as I can see because in that meeting there actually the first meeting it was hard to see how to handle or how to go about improving our performance so as we reviewed our problem trees we realized we had a lot of strength within ourselves we did need actually external support to manage some of the problems which was there at that time, however we could not identify before PERFORM came in we could not identify these problems and strength that we had at the district and the weaknesses and where we need to support”(KDHM FGD UG).

In the second inter-district meeting, the Kabarole DHMT reflected on how they implemented the bundles of strategies and their effects on health workforce performance. This helped them to identify key learning points. Table 26 is extracted from the Kabarole presentation from inter district meeting in July 2014.
<table>
<thead>
<tr>
<th>Reflection</th>
<th>Learning</th>
</tr>
</thead>
<tbody>
<tr>
<td>During the reward and sanctions committee staff are allow to identify gaps, suggest workable solutions and service delivery improve.</td>
<td>Sometimes staff know their own weaknesses and they can identify their own solutions</td>
</tr>
<tr>
<td>During the HUMC training, the participants were ignorant about the H/Us annual work plan but by the end of the meeting participant were able to demonstrate the acquired skills by drafting the H/Us work plans.</td>
<td>Some in-charges and HUMC didn’t know their roles and responsibilities</td>
</tr>
<tr>
<td>Interaction between supervisor and supervisee during Support supervision, staff felt motivated and appreciated</td>
<td>Motivation is not only through monetary terms.</td>
</tr>
</tbody>
</table>

*(Inter-district workshop 2 report)*

The CRT members and paired partners reported some other lessons learned. They identified a need to provide more support to the DHMT in implementing the action research cycles. The researchers learned a lot during the PERFORM project and would apply this to other areas of work. Encouraging the DHMTs to identify their own problems within the district, increased their ownership of the project, which was crucial to the success of PERFORM. Continued support from the CRT over a long period of time through the workshops, visits, telephone calls and e-mails helped build relationships and understanding of how the DHMT works. The CRT were then able to help the DHMT reflect on the process of implementing and monitoring the strategies and learn from these experiences.

“I wonder whether having more sort of more presence within the district to facilitate the action research cycles a little bit more and especially on the reflection part of those cycles and whether having somebody more present in the district might help that. Although that brings challenges in terms of sort of disturbing the kind of working environment of a DHMT”. *(Interview with LSTM team)*.

“And then now the partners came in to refine how are the programmes development of the bundles and I believe also building capacity for the CRTs in addition to the DHMTs, me personally wasn’t really action research, I came across it when I came into PERFORM and I found it interesting, I think I can now apply it in other areas.” *(Interview with Uganda team)*.

“I think that I think also another strength is the continued support from the country research team. You know it’s not just a one off workshop, get on with it sort of thing its more this sustained kind of support and facilitation by the CRT that is quite, it’s difficult to do and it wasn’t perfect by any way I don’t think but I think it did help and was this sort of relationship building, talking with the DHMTs, understanding how they work, understanding what the challenges are within their districts and kind of learning from that and getting them to reflect on that process.” *(Interview with LSTM team)*.
Application of action research lessons

There were several examples of where the DHMTs have used the Action research cycles in other aspects of their work.

Some DHMT members spoke of integrating the PERFORM approach into his every day work. Others described how they visited other districts or districts visited them to learn about the approaches that have been used in PERFORM especially the problem analysis and selection of bundles of strategies.

“So personally I have learnt and in fact I like putting PERFORM into my daily activities I look at my table, I look at what could have gone wrong where can I get better what should I do things like that.” (KDHM IDI 02 UG).

“For everything we do, we try to get a baseline and to record the changes”. (CRT meeting Kabarole DHMT 24 March 2014, visit report).

“Participants kept acknowledging PERFORM project for either wakening them up to reflect on critical issues and areas that compromised health worker performance in their individual districts or PERFORM project introducing a unique methodology of addressing human resource issues and/or that could be extended to other health system interventions.” (Inter-district workshop 2 report, July 2014).

Workforce performance: process

Implementation of the bundles

In order to achieve the objective of increasing the number of supervisors, the DHMT developed four strategies. Progress in implementation was monitored regularly by the CRT during field visits.

Progress in bundle implementation was achieved as indicated in this section from the minutes of a meeting between the CRT and the DHMT in March 2014:

“The number of support supervisors increased and the number of support supervisions has also increased because more people were identified with skills. The number of support supervisors increased because of the mentoring. Secondly, the DHMT members who are assigned to health facilities as in-charges improve support supervision in terms of frequency and breadth”. (Minutes of CRT meeting Kabarole DHMT March 24th 2014)

However lack of funding was identified as a limiting factor impeding full roll out of the strategy and pushing the DHMT to prioritize and select activities to be implemented according to resource availability:

“Resources do not allow us to do adequate and timely support supervision. This requires us to prioritise and where there is a bigger gap is where we go first. Sometimes we summon the staff from the health facility instead of us the DHMT going to the facility. Some of the activities are identified for the ICB funding. We now have enough support supervisors and the challenge in finding the facilitation” (Minutes of CRT meeting Kabarole DHMT March 24th 2014)
Looking to the implementation of the four strategies developed to achieve an increased number of supervisors progress was relatively good in selecting and developing the supervisory team and involvement of HUMC in supervision. However strengthening partnerships to support supervision and retention/incentives seems to be more problematic.

Selection and development of a team of supervisors

The DHMT identified more than 20 staff with potential to be appointed as new supervisors. Health facility managers were trained on support supervision and started working with the support of more senior members of the management team.

"Initially, there were health worker shortages but there has been recruitment of critical cadres at health centres III and IVs. New health workers with a potential to supervise others were identified (the target was 20 but they are now more). All in-charge of health centres have been trained as support supervisors. They were trained and attached to senior mentors. The district health inspectorate was also brought on board to provide support supervision. Kamwenge district (Neighbouring district) has already invited supervisors from Kabarole district (DHMT) to mentor their health workers to be good support supervisors." (Report of the mentoring/supervision of CRT visit to the DHMT Kabarole District 01st October 2013)

Timeliness in reporting from sub-district facilities was identified as a problem during support supervision visits. One of the solutions adopted in line with the activities proposed in the bundle was to train facility managers dealing with information management on M&E skills as reflected in this note from the DHMT diary:

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 &amp; 31 May 2013</td>
<td>Training of DHT in M&amp;E and decision support systems</td>
</tr>
</tbody>
</table>

(Diary, 30-31/5/13)

Supervisors are trained on specific areas to improve their M&E skills for specific programmes as reflected in this annotation in the DHMT diary:

"Too congested immunization services by the MoH which has led to confusion to the public hence low uptake of immunization. Strengthening supervision in the area of immunization." (Diary, 10/6/13)

Retention and incentives

Implementation of this strategy was not possible due to lack of funding as suggested by this extract from the minutes of a meeting between the CRT and the DHMT in March 2014.

"Retention of support supervisors has not been implemented because of funding constraints.” (Minutes meeting between CRT and the DHMT Kabarole District 24th March 2014)
As a result there seems to be some attrition among supervisors as indicated in this extract from the minutes of the same meeting above:

“As fortunately some supervisors went out of the country but new ones have also joined.” (Minutes meeting between CRT and the DHMT Kabarole District 24th March 2014)

Engagement of HUMC in supervision

Lack of funding delayed implementation of this strategy which in March 2014 was still pending to be launched as indicated by the following two references in October 2013 and March 2014 respectively:

“Induction of HUMC members is pending availability of funds but a concept paper has been submitted to Capacity Program (Uganda) a key partner in HR related activities for consideration for financial support. This induction will include HUMCs at health centres IIs, IIs and IVs, and nongovernmental hospitals.” (Report of the mentoring/supervision of CRT visit to the DHMT Kabarole District 01st October 2013)

“...the orientation of HUMCs in support supervision will soon be effected with support from the ICB project.” (Minutes of meeting between CRT and DHMT, 24th March 2014)

Develop partnership with existing partners

DHMT approached existing partners to support activities included in the bundles. For instance the Belgium Cooperation (BTC) helped with recruitment of new staff which in turn allowed to increase the number of supervisors.

“...the other factor was cooperation from our partners, at least most of the successful implementation has been because of the facilitation that came from the partners, the first time when we communicated with the Capacity Program about the PERFORM plan that we had drown they immediately gave us a hand and of course that is a very good factors, it was one of the person responsible in the region by that time and she was very great importance that is the factor, including the other partners that were surrounding area; Baylor,BTC and the rest of it, then we had also the other factor was the increased number of staff, the increased number of staff played a very big role because we wouldn’t have achieved the increase in number of supervisors.” (KDHM FGD UG)

The DHMT showed initiative and creativity in searching for funding for orientation of newly recruited staff (which again in turn allowed for recruitment of new supervisors) when they approached potential partners in the private sector.

“The newly recruited health workers have already been inducted into their roles and responsibilities with financial support sent from the Housing Finance Bank (Uganda) Limited” (Report of the mentoring/supervision of CRT visit to the DHMT Kabarole District 01st October 2013)
Several partners are involved in supporting this strategy as indicated in this section of a report from a CRT field visit in October 2013:

“UNICEF, Capacity Program, Baylor College of Medicine, and Global Alliance Vaccine Initiatives (GAVI) have participated in closing critical gaps in the district health system such as social mobilisation and support supervision.” (Report of the mentoring/supervision of CRT visit to the DHMT Kabarole District 01st October 2013)

Problems with implementation of bundles

One of the main problems found in implementing the bundles at facility level is resource mobilization. This problem is reported from both DHMT and staff at facilities. Sometimes there are not sufficient resources to undertake supervision visits and sometimes there are delays with the release of funds which affects implementation, particularly at lower level facilities.

“I have not been so much involved in the district mentorships within, or giving support supervision. Probably I suppose the funds are not there to facilitate me to move in all these facilities.” (KSDstaff IDI 01 UG)

“The only challenges have been on the resource bit; delayed release, insufficient release, things like that but we have not had so much of any disagreements.” (KDHM FGD UG)

“Yeah, I know we are supposed to supervise health workers at health centre IIs but we do not.” (KSDstaff IDI 03 UG)

Stakeholders’ participation in bundle implementation

There are several relevant stakeholders in the district. They include development partners/implementing partners, district technical and political leadership, bilateral organizations, civil society organisation and non-governmental organisations.

“The relevant stakeholders we have are the political leadership, the RDCs, religious leaders, community members who use the services, implementing partners (IPs).” (KDHM IDI 01 UG)

“Stakeholders include; the human resource officer (personnel’s officers), the RDC (Resident District Commissioner), LCs (Local Councils) and LC5 (Local Council Level 5), District Service Commission, DHT and the health sub level district supervision teams, and Uganda capacity program.” (KDHM IDI 03 UG)

“The key stakeholders in the district are; the community, the different implementing partners we have are: Baylor Uganda, BTC, CHC, UNICEF, the different CBOs, PNFPs, the hospitals the regional referral hospital, the PHAS and the OVCs.” (KDHM IDI 02 UG)

“Relevant stakeholders, in the district are; Ministry of Health (Government of Uganda) is the biggest stakeholder and District Council.” (KDHM IDI 04 UG)
“They are very important because whatever we do concerns them; we need them and they need us, and whatever we do they must know and whatever they do we have to know and take charge.” (KDHM IDI 02 UG)

Stakeholders played different roles in the planning, implementation and monitoring of the bundles either directly or indirectly. They have been involved in the implementation of activities in the two bundles (e.g. strengthening supervision and skilling up managers). Support for addressing the problem of absenteeism was not mentioned during interviews although some of the activities supported in other areas such as supervision may have had an impact on this problem.

PERFORM doesn’t provide funding for operations therefore implementation of activities not included in the District Plan is sometimes financially supported by partners. For example the Belgian Technical Cooperation (BTC) provided resources to increase the number of supervisors but they were not involved in the planning process.

“PERFORM project helped us in the planning [process] but not in implementation. BTC provided resources to implement the bundles such as increasing the number of supervisors.” (KDHM IDI 01 UG)

Support from stakeholder was also requested to facilitate training for facility managers and to provide equipment

“BTC facilitated training of health unit management committees (HUMCs) and a meeting where all the lower level health managers interacted with the district health managers to make a plan at the beginning of the financial year.” (KDHM IDI 03 UG)

“Right now as we speak BTC has accepted to renovate and put furniture in this room where we are seated right now. This is going to be a skills building room with computers and then we will impact new skills to staff at health facilities.” (KDHM FGD UG)

Stakeholders, particularly local authorities or senior public administration officials, are sometimes requested to join the supervision teams in order for them to get a clear picture of the situation on the ground and to monitor activities that they support.

“When we are going out sometimes for integrated support supervision, a member of the political leadership and an official from the Chief Administrative Officer’s (CAO’s) office goes with us because they need to know what is going on the ground and the challenges so that they can advocate for some of the problems to be solved. Sometimes we hold integrated support supervision with the Implementing Partners (IPs) because they have supported activities and we want them to see the facts on ground.” (KDHM IDI 01 UG)

Recruitment of additional staff including clinicians and supervisors was also financially supported by stakeholders.

_Baylor Uganda has helped through recruitment of additional staff, especially midwives, doctors and clinical officers supporting Saving Mother, Giving Life project._” (KSDstaff IDI 04 UG)
“Other partners like Baylor Uganda have played role in the recruitment of new health workers and this has played a very big role in increasing number of supervisors.” (KDHM FGD UG)

“We get mentorships from Baylor Uganda and sometimes Baylor Uganda uses our staff at the health sub level district, and sometimes the district comes and does mentorship.” (KSDman IDI 03 UG)

**Workforce performance: effects**

**Perceptions of bundle design**

Regarding the perception of the bundles’ design there are several parameters that are considered important to consider bundle design. First DHMT members considered that the thorough problem analysis undertaken initially ensures the relevance and adequacy of the interventions proposed.

“*The problem tree helped us to identify the possible solutions which we can use to solve problems ourselves and those which we need some assistance from outside*” (KDHM FGD UG).

Interventions included in the bundles were perceived as adequate and aligned with the already existing district plan. In fact some of the interventions are not new and were already included in the district plans. What the DHMT has done since PERFORM started is to expand these activities further. Inclusion in the plan also strengthens the sustainability of the interventions.

“*Bundles had to fit in the district work plan. HR strategies were fixed in the work plan section concerning human resources management. Support supervision and staff appraisal were not new activities in the work plan except they were expanded to include more performance improvement strategies.*” (KDHM IDI 01 UG)

The whole process seems to have strengthened self-reliance. Now they find themselves more capable to mobilize resources independently when government funding is not available which contributes to strengthen sustainability. They actually use problems identified during the initial analysis to lobby for more support.

“*so first was to share with our district work plan, second was to share with the rest of the teams the health facility teams and the rest in their planning to include some of these challenges we identified them thirdly was to lobby, lobbying is ongoing up to now we are still lobbying but we are using these identified problems to keep lobbying.*” (KDstake IDI 02 UG)

The introduction of new tools such as a monitoring book for supervision will help interventions to consolidate within the normal managerial routines which will most likely contribute to sustainability. “*For support supervision, the DHMT introduced a supervision book at the health facilities to document feedback and track improvement.*” (KSDman IDI 01 UG)
Perceptions of effects of bundles

When discussing the effects of the bundles, the respondents focused on three areas: supervision, appraisal and training HUMC.

Supervision

DHMT members described how the supervision activities were implemented and what they achieved. The number of supervisors in the district was increased and this enabled supervision teams to be established. Supervision schedules were developed so that there were regular visits to all facilities. Supervision tools were developed including supervision reports, tools and a facility supervision book. Facility staff also explained about the supervision visit including areas of good performance, areas for improvement and recommendations.

“We have support supervision reports (uh) then we have support supervision team that we had formed although we keep re arranging them due to some people moving away and others coming in.” (KDHM IDI 01 UG).

“And then the other one was, we found that were supposed to have regular (supervision) and why as DHT we were very few people sitting in the DHOs office. In actual sense full time we were less than 5 and what we did the root cause we realized was we couldn’t conduct regular support supervision and then we thought that if we put more people on board as DHT members, identified senior staff committed staff at lower facilities like health centres IIs and IIIs and put them on board then the supervision will increase.” (KDHM IDI 02 UG).

“Like we said in the support supervision we were able to develop the supervision book, we were able to think that what shall /will we add to see that we have even seen a site, the person coming next, how will he know that there was supervision that was done before and what was agreed upon in the past we used to go and do supervision come back and make a report and at the end nothing remains there, you see, so when we realized that we needed to do something better through the deeper understanding of our problems and solution we actually implemented better” (KDHM FGD UG).

Respondents reported many positive effects of supervision. The DHMTs explained that during supervision visits they identified poorly performing facilities and weak managers, so they transferred the managers to other facilities where they could be more closely supervised and supported, and replaced with more effective managers.

“And for example we have xxx Health Centre, we had the in charge who was a very senior staff but very slippery, very unreliable, very contradictory, meaning we had to remove him.

We did not say, go away but we took him to another facility to work with another person who is a supervisor and then in his facility we took there another lady. And now I want to tell you that facility is now coming up. It was becoming a real problem in the district, every person was talking about it but because of the problem analysis and the approach of
perform project we managed now to put together and now there is some performance of staff. Even the other one is doing some work where he went and this one is also doing good work as a manager.” (KDHM IDI 02 UG).

“During support supervisions we identified some facilities where like the senior managers were not doing the required standard now we identified the junior people to take on the in-charge-ship. And at least we’ve had positive aa results especially in my sub district we had a facility called Karambi where there was a senior clinical officer who was not performing now we considered a junior clinical officer to take management and the senior clinical officer was transferred to another facility and that facility was actually not delivering. The maternity was not functional, staffs were always absent and we saw results there. And these were developed after support supervision you go there find the place as a deserted place.” (KSDMan IDI 01 UG).

Facility staff and managers reported that the supervision visits are more regular. During the regular supervision visits all areas of the facility were thoroughly checked and this enabled problem areas to be identified and recommendations for improvement made. They also perceived that as a result of better performance the number of clients seen in the facility increased.

“... what is improving we have we see a lot of the district health management team so very much in touch with the health centres because we have they have routine supervision quarterly throughout the district”. (KSDman IDI 01 UG).

“Yeah it is more regular; at least sometimes in a quarter we may even have 3 support supervisions from the district.” (KSDStaff IDI 01 UG).

“They go to the dispensary, to see how we are dispensing, whether we have trays, whether we have spoons, and the envelopes, plus dispensing logs if we are recording well. They go to the stores check whether the shelves are well organized, whether the drugs are well organized. Whatever they have come to do we show them. They see what we are doing they recommend, they recommend and then... because where we fall we ask them to, to guide us more so that next time they come and find everything is very okay” (KSDstaff IDI 02 UG).

“The population of clients has increased.” (KSDman IDI 04 UG).

Facility staff reported other positive effects of supervision: improved reporting to DHMT; improved completion of registers; improved knowledge due to increased number of clients with different health problems; as the supervision visits were reported in the facility supervision books, supervisors were able to follow up on problem areas and recommendations; improves staff attendance at facilities which helped the facilities to achieve their targets e.g. immunisation targets.

“Yes like when I used the antenatal register because this register when they brought in option B+ most people were getting problems in filling it but when one time my supervisors came they said ‘it was perfect’ there were some areas where people were making mistakes.” (KSDStaff IDI 05 UG).

“Because since we are getting now a number of patients and we are getting now different cases really it improves on my knowledge because when I see a new case I go to the
supervisor and ask “What is this case? What could be the cause” so he explains to me more so that can improve on the knowledge, yeah.” (KSDstaff IDI 02 UG).

“Why this book is very important to us? 1, You write there what you have found at the facility. So next time when you come, you review what you found that time and what you have seen that very day. So you compare notes. Because since you gave them recommendations, you see the areas that they had not improved...are they improving? So if they have not improved, you also advise them. Now like you can find like the motorcycle is not having..... I mean the health facility is lacking transport means. So we can liaise with the DHO’s office....at times we get partners... then you find they come in to help. So that’s how we can manage.” (KSDstaff IDI 04 UG).

“For example we set targets for our services, so if you take an example like immunization we have a target for the whole year so because of the frequency attendance of the staff we achieve that number so at the end of the year or at the end of the month, we assess and see that, if we have achieved the target or we are below and we see how we can improve it in the meeting.” (KSDman IDI 05 UG).

However, one staff respondent reported that the supervision visits did not make any difference to the way that he worked. He explained that despite informing the supervisors about the problems he was facing in dispensing drugs, they did nothing about these problems.

“They (supervisors) don’t help me, they go I tell them my problem, aah, they just go then they say ok next time and am not seeing anything.” (KSDStaff IDI 06 UG).

The CRT reported that supervision was strengthened during the PERFORM project. The DHMTs took advantage of new staff being recruited in the district.

“It really improved greatly deal because during the presence of PERFORM. They were fortunate the government recruited even more staff...and they exploited the presence of new staff to increase the number of support supervisors...so they coached them, they mentored them” (Interview with Uganda team).

From the CRT visit reports to the district, it was clear that improvements had been made in supportive supervision. The number of supervisors had increased as newly recruited staff who showed signs of being good leaders were identified to be in-charges of facilities and then trained and mentored to become supervisors. The number of district level supervisors has increased from 4 to 14, and the number of sub district supervisors has increased from 2 to 9. This increase has reduced the supervision workload of the DHMT so that they can also attend to other duties. In addition to the supervision responsibilities, the health facility in-charges are also obliged to attend the quarterly extended DHMT meetings where they discuss performance management. The DHMT members also reported a reduction in complaints from the community which they thought was due to supportive supervision. They observed greater confidence amongst health workers because of the support that health workers received from their supervisors.

“Having more support supervisors have made it possible for the DHMT to reach out to the multitude of obligations. We are able to send out support supervisors and others stay to carry on with office work at the district. It is easier to identify an officer to oversee an
In the diary, the DHMT members reported that supportive supervision had helped staff in facilities improve. This was evident from their reflection on supportive supervision which focused on record keeping.

“It was noticed that data were incomplete in all registers and files. Supportive supervision stimulated staff to talk of their mind and challenges, good interaction with staff, remove the fears and doubts among staff and appreciate the support supervision. Attitude of the health workers towards records and its use in planning and implementation” (Diary 1/7/13).

Appraisal

The DHMT members reported that the proportion of staff with individual performance plans had increased, and this was partly due to a human resource focal person being appointed in the DHMT. His role was to improve the appraisal process. Facility staff and managers reported that during the appraisal process, the supervisor assessed the performance of the member of staff, and then set targets for the coming year. They felt that if they achieved low scores then this would encourage them to work harder. Setting targets was perceived as being useful as this encouraged them to try to reach the targets.

“Yes it has helped us in that facilities are better supervised um but also um there is performance management and monitoring through the appraisal system and performance plan, individual performance plan that has improved, we have realized a what? aa a better percentage of people who are making individual performance plan.” (KDHM IDI 01 UG)

“Also the performance appraisal also because of the Human resource focal person, so many people were taking so many years minus being appraised. You could go to their file and find there is nothing and yet appraising is also part of motivation and making a follow up of an individual performance. So because of the Human Resource focal person I am sure the appraisal system now we are at a certain percentage we were very, very low but now I am sure we are at a certain percentage.” (KHDM IDI 02 UG)

“Whether you have done well and you have done poorly so he recommends by ticking, by ticking there is one, two three, four and five, I think if you have done poorly maybe he can give you one, if you have done well, fairly he can give you three, four, if you have done well he gives you five. This year, for OPD at least I am working at least to improve, to improve up to 500 clients per month. I have to try so that, so that I reach my target, yeah.” (KSDstaff IDI 02 UG).

“The reason why am saying that is has improved the performance because when somebody is scored low automatically has to take caution, I have performed poorly here, next time you have to do it better so that he should not be scored low.” (KSDman IDI 02 UG).
During the inter-district workshop, the DHMT members discussed appraisal. They recognised that appraisal was only done when someone was seeking promotion. Now appraisal provides an opportunity for the supervisee to share her/his work challenges with the supervisor and they both agree on improvement plans.

In the diary, the DHMT members reported that meetings were held in 8 facilities to discuss appraisal. Staff were guided on how to use self-evaluate, the previous year’s plans to assess performance, and develop performance plans. As a result, staff identified their own gaps in their performance, and performance plans were developed.

**Training Health Unit Management Committees**

DHMT members reported that HUMC secretaries and chairpersons were trained in their roles and responsibilities. DHMTs and managers felt that HUMC has been unclear about how they could support the health facility, but now understood that they should take an active role in supporting the facility, and helping the manager and staff to find solutions to problems.

“We identified that we had to have management committee people, trained and able to implement but we trained the secretaries and the chairpersons and we still have some members of the management who are not trained who are in the new plan”. (KDHM IDI 03 UG).

“Another issue which we actually directly got from PERFORM was training Health Unit Management Committees. This was an idea we got after interacting with PERFORM realizing that yes you can have managers but unless they know what to do they will not do to their expectation. Now this has actually helped a lot to the facilities down there because previously these health committee members did not know what their roles were. For them they actually thought that their role were to go to the facility and blame the in charge of the facility for whatever gaps are there. But I think after the training they acknowledged that they are a part of the people who should solve these problems. For instance if maybe a facility has no power it is the work of the Health Unit Management Committee to lobby for whatever funding wherever they can get funding and plan to avail a facility with power or may be avail a facility with a fence. So I think that has been an achievement directly for the lower centres from perform. (KSDman IDI 01 UG).

DHMT presentation at the inter-district meeting revealed that a proposal to train HUMC was funded by BTC, and 70 HUMC members were trained.

**Reward and Sanctions Committee**

There were no references to the rewards and sanctions committee in the interviews and FGD. However, the DHMT presentation at the second inter-district meeting explained that the Reward and Sanctions Committee was formed and held meetings to provide rewards and sanctions to individuals and facilities. The DHMT members reported in the documents that individuals and facilities who were
summoned to the committee had since improved their performance, and one health facility received an award.

**Introduction of the attendance book**

During the second inter-district workshop, DHMT members discussed the value of the attendance book. They explained that the book was introduced as evidence for staff attendance at the facility in order to recognise their effort and service, rather than a monitoring tool. Supervisors can assess the proportion of staff attending duty and find out reasons for non-attendance.

One health care staff reported that attendance registers were now being used in the facilities in Kabarole (though this was not included in the original bundle of interventions), but did not elaborate on experiences or perceptions of this approach. A stakeholder reported that the attendance book was customised and responsibility was given to the manager of health facility to monitor attendance of all staff on a monthly basis. One manager explained that the attendance register has been used for many years, but recently the supervision team has started to review the register carefully.

“Now like the staff attendance, at the end of the month we have to bring the monitoring team from personnel, so they usually come and check in the attendance book and see, how many days have the staff attended, they keep on making reports on the attendance every month.” (KSDman IDI 05 UG).

“Yeah I should say the attendance traditional system the attendance traditional system is really, not dependable when you make support supervision you follow up and you find people sign but then the dependability of that information is questionable. So what we did we customized forms we customized forms and we gave the responsibility to in charges at the end of every month they summarize the attendance of every individual so the days attended and then the days missed and then the remarks. So there are those summaries that we pick at the end of the month and then we look at those who have issues and we address them and basically we write to them requesting them to explain and.” (KDstakeIDI02UG).

**Context**

**Health system**

Respondents identified several contextual issues related to the health system that are relevant to the PERFORM project. First, recruitment of staff must be agreed by the central level ministry of finance and economic development. The district health management team must then apply to the district service commission, who then interviews and recruits staff and forwards names on to the CAO. The CAO then appoints staff to the department.

“The process seems to be lengthy but we used to write to ministry of Public Service to approve but am told now ministry of finance and economic development has taken up the issue. So they are the ones who give us the recommendation because they have to look at the wage bill to see if our district is able to recruit more. But number is still something
which we are advocating because we are aware some critical gaps have not been filled well because the district has failed to attract especially if we were to functionlize theatres we may realize anaesthetists are not there and yet you can have the doctor, you have the rest of the team but without the anaesthetist the theatre become non-functional. So we have been advocating this but of course through partners they have been able to support us some. Of course this is not sustainable but partners like Baylor Uganda have been able to support us with some of these critical human resource.” (KDHM IDI 04 UG).

“Now for us to get human resource, we apply through the district service commission...It is the interviewing body. After interviewing, they forward your names to the CAO. The CAO is the appointing authority. After that, then they refer you to your department after getting an appointment letter.” (KSDstaff 04 IDI UG).

Second, there are a designated number of established posts in each type of facility. Although the DHMT has some authority to decide if the number of staff are adequate for the workload, the CAO has the final say.

“We cannot influence some posting of staffs because they say at a certain given level of health facility you must have like two or three midwife if you put there the forth one during the validation exercise there is a lot of questions so that one has not made us so comfortable to change some things because you could look at some facilities we have high volume facilities like health centre threes you really see that they are having very many mothers and you feel clinical officers with five midwives but the policy does not allow that when you do it then you are questioned.” (KDHM FGD UG).

Third, there was a nationwide recruitment of staff during the lifetime of the PERFORM project.

Fourth, staff training is generally managed by the human resource department of the Local Council – all staff have to apply for training through this department.

“We have only 49 million shillings in the whole district so we just pick all in all but we do participate in the training assessment and handle the most critical the rest most of the partners are giving assistance.” (KDStake IDI 02 UG).

Fifth, there have been significant problems with the payroll, resulting in many staff either not receiving salary or receiving partial salary. These problems were perceived to impact on: how staff can be managed especially in terms of attending their workstations and motivating them to perform; service delivery; and district position within the national league table. This challenge was also identified during the CRT visits to Kabarole district.

“We were being disturbed by the problem of payroll in the past year, but I have seen a change in that they are decentralizing the payroll system so it’s going to be handled at district level and we are hopeful that it’s going to solve most of the problems that we have been facing. Challenges, coz there was a breakdown in service delivery, so after that breakdown we are hoping that it is all going to work better because in the past, the last month, we were, the payment to our health workers was more effective than the past year.” (KSDstaff IDI 01 UG).
“And then the other one is irregular, irregularities in our salary payments, has also let us down because as much as we may want people to work they should be facilitated, their salaries must be on time and again the welfare accommodation, transport all those the environment where they are working from also has not been so good in facilitating the possible solutions and decisions we would want or wanted to take towards improving our performance in our health service delivery.” (KDHM IDI 02 UG).

“What worked less well we had worked well like at the national level we had performed well, I remember by the year 2010-2011 the district was at the position of fifth then the 2011-2012 the district was at the position of second. 2012-2013 we were the first but this year we may not work well because we have been having a challenge with the salary payment, the staffs have not been getting their salary it was a national problem so this may hinder our performance and which we hope by next year since people have started getting their salary well we will achieve well after this year.” (KDHM FGD UG).

“Another thing is working with a group that is demotivated, demotivated in a sense that people have stayed for a long time without getting salaries, other don’t have accommodation at the unit that they are required to, work twenty four hours so you find those problems and also when it comes to the part of managers you don’t really enforce the way how they would have enforced, you know I am having a humanitarian heart when at the back of your mind you know that this is not motivating”. (KDHM FGD UG).

“The country is facing a payroll problem whereby some workers are receiving fractions of their salaries, others have been deleted and there are those whose salaries delay to come. This is thought to be arising from the routine payroll updating by the Ministry of Public Service. The Kabarole DHMT revealed that most health workers including those in lower health facilities have lost their morale to perform as a result of this situation. The payroll system has not been responsive to quickly rectify the problems. As a result, this compromises performance as the individual health workers chase up their salaries. The DHMT has since assigned one of its members the role of handling the affected health workers’ complaints.” (CRT Meeting Kabarole DHMT March 2014).

Sixth, there are significant transport issues which include lack of fuel and challenging road conditions. This was perceived to have an effect on ability to provide supervision and outreach work.

“Those areas are: 1- the transport system because we are not all that in a good mechanical condition. 2- You find at times we don’t have fuel. We plan to move away, you find we don’t have fuel. So you find it’s also a very big challenge. Then 3: our weather. Some of the roads you can’t go freely. So you find it’s also a very big challenge.” (KSDstaff IDI 04 UG).

Seventh, quality improvement teams have been established in health facilities and at the district level approximately one year ago. This was supported by USAID but is now self-driven.

“We have the quality improvement committees which were brought in place for health centres even at the district level for institutions to assist themselves and see ways of improving where there are gaps.” (KSDstaff IDI 03 UG).
Other projects

The district has a number of projects although very few are working to improve health workforce performance as their purpose. Some projects are investing in systems strengthening while others are programme specific like quality improvement, maternal health, occupational health. To improve service delivery, some projects end up supporting HR functions like recruitment of additional staff, mentoring, supervision and motivation. Baylor Uganda has been working in Kabarole district in the area of maternal and child health and HIV. They support human resources by recruiting more staff such as midwives, doctors and laboratory technicians, provide training, supervision and mentoring. BTC has provided funding for supportive supervision activities. SDS has provided funding for a biostatistician to work in the DHMT.

“Our project is involved in building capacity, in planning leadership and management” (KDstake IDI 03 UG)

“Partners like Baylor Uganda have been able to support us with some of these critical human resource” (KDHM IDI 04 UG)

“We have also communication for Health community project has also come on board, looking at having right information for our communities and in all health related programmes they are also here to work with us we will work within the region and then BTC I had mentioned and UNICEF is still with us and plus small, small CBOs like Yawe, SIFA all those are doing good work, KAANA foundation they are doing some work implementing on our performance.” (KDHM IDI 02 UG).

“The district is a beneficiary of the Belgian Technical Cooperation (BTC) Institutional Capacity Building (ICB) Project and in their agreement; ICB will facilitate the training of HUMCs, medical reporting and employing of the HMIS focal person). The first requisition had been released and the DHMT was to hold another meeting to discuss this further.” (CRT meeting Kabarole DHMT March 2014).

Other issues

There are some health centre IIs that operate as health centre IIs. This has improved service delivery in terms of provision and utilisation of services.

“In those previous years of course we didn’t have much work like we have now, it was health centre II may be we would work on patients and they go but these days services have improved because now we have antenatal, we have HIV testing and others”(KSDstaff IDI 02 UG)

Unintended effects

DHMT members and stakeholders identified that DHMTs became much better at writing proposals for funding and lobbying partners. Some of the activities selected for the bundles were not funded by the government, so the DHMTs put together proposals for funding from development partners. They were successful in receiving funding for HUMC training and appraisal training.
“Handling stakeholders has improved which is what we wanted and yeah, being able to attract donors, being able to attract different partners and even how to handle and interact with them has even improved so that’s what we are looking at strengthening how we are able to handle different partners which has improved very much so, because even the other day they were having the First Lady here.” (KDstake IDI 03 UG).

“Because by identifying our problems we really had to think harder to lobby and in lobbying we had also to write some proposals, we had also to make some phone calls and through meetings we had to make a lot of noise in some stakeholders meetings and in that way we have managed to attract some funding. That is like now when we talk of Support supervision BTC is doing that, they give us some money to go down and do support supervision.” (KDHM IDI 02 UG).

“We are receiving more resources or ah, basically more resources. This resources basically when you look at it, how they come, it originates from what is being thought at the DHMT level because we are able to identify problems. And you submit these problems in form of proposal to partners and they are able to bring in resources. Actually this has been very big boost for the department really, the ability of thinking, and able to come up with something, then presenting it to partners, then being helped.” (KDHM IDI 04 UG).

The CRT reported that the DHMT members were better able to mobilise resources. First, prior to PERFORM, resources from other projects were used exclusively for activities related to those specific projects. After PERFORM implementation, DHMTs were more able to share these resources for other activities - a more cost effective approach to using resources. Second, DHMTs were able to generate new resources by approaching private institutions, for example. These new resources were invested in improving important areas such as induction of new employees.

“They started also thinking of how to exploit the resources brought in by the development partners although they would be different they would like specified for certain interventions...but still they could do find a way of using the same resources for example if say an HIV supporting NGO they would be having transport facilities so when they are going to do their business at the health facilities... the DHMT members can use the same transport to reach the facilities” (Interview with Uganda team).

“In one district they were able to approach a bank which has given them funds to support induction of the new health workers” (Interview with LSTM team).

DHMT members reported that other DHMTs visited their district to learn about how they were working, and share their experiences, successes and challenges.

“Yes we even have had teams coming from as far as Mukono. Recently we had a had a team from Mukono just to come to share experience, we even had teams from as far as Kibale they came here to share an experience and a number of times members of our DHMT/DHT have been called to go and share with other districts the experiences because the district has been successful using those strategies. We have ranked number one number 2 number 3 in the successive three years when we are implementing in the National league table.” (KDHM IDI 03 UG).
Stakeholders identified several positive effects of the bundles: improved routine reporting from facilities – the reports were more complete and on time; the DHMT was more able to work together with the Chief Administration Officer and the Local council leaders.

“There has been an improvement in the time and completeness of the reporting which uhh was a challenge before.” (KDstake IDI 03 UG).

The DHMT presentation at the second inter-district meeting, revealed that by recruiting health information assistants, the timelines and completeness of health facility reporting was greatly improved.

An unintended effect of recruiting new supervisors was the generation of some tensions in the health facilities between junior and more senior staff members as suggested by this reference:

“…using the newly recruited staff met some friction in some facilities especially with the most qualified staff that were not chosen to be supervisors.” (Minutes meeting CRT with DHMT Kabarole 24th March 2014)

Conclusion and Recommendations for Kabarole

Summary of findings for Kabarole

• The DHMT was able to develop plausible plans for improving workforce performance based on more thorough problem analysis than would usually be done.

• These plans are being implemented and are showing some positive results in improving supervision. The plans have been modified and added to as more or different needs became apparent and should lead to wider improvements in performance management.

• DHMT members like the approach used to identify and analyse problems and develop relevant strategies. They are adapting some of the approach to their routine work, but some would like more continued support with this approach.

• In spite of external constraints on the DHMT, they do have sufficient room for manoeuvre to address many problems they face at district level. There is now a critical mass in the management team with improved problem solving and planning skills.

Key recommendations for policy makers or DHMT for Kabarole

• Ongoing support should be provided to the critical mass of DHMT members to continue using the action research approach.
• The possibility of extending to the approach to other districts, or showcasing it to visiting DHMTs should be explored.
• The extension of the approach to other districts in a similar programme in Ghana in the early 1990s was achieved through developing a team of facilitators from DHMTs already using the approach. Training of selected DHMT members in Kabarole in appropriate facilitation skills and use of PERFORM materials could be considered.

3.2 Jinja District

Findings from the situation analysis

Geography and demography of Jinja District

Jinja District is located in the South East of Uganda (see figure 1). Her neighbours are; Mayuge, Luuka, Kamuli and Buikwe districts, and Lake Victoria in the east, north, west and south respectively. It has a projected population of 488,300 people with 79.1% living in rural areas.

Health Infrastructure

The district hosts a regional referral hospital which is under central government (Ministry of Health). The district hospital is under construction. Jinja district has 5 Health Sub-Districts, 5 government HCIVs, 12 government and 4 private (NGOs) HCIIIs and 34 government and 8 private HCIIs as detailed in Table 27.

Table 27: Number and type of facilities in the district by provider.

<table>
<thead>
<tr>
<th>Type of facility</th>
<th>Government</th>
<th>Other/NGO</th>
<th>Number of beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>District hospital</td>
<td>Under construction</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Other hospitals</td>
<td>1</td>
<td>2</td>
<td>Unknown</td>
</tr>
<tr>
<td>Health centre IVs</td>
<td>5</td>
<td>0</td>
<td>Unknown</td>
</tr>
<tr>
<td>Health centre III</td>
<td>12</td>
<td>4</td>
<td>Unknown</td>
</tr>
<tr>
<td>Health centre II</td>
<td>34</td>
<td>8</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

Different levels of health facilities provide different health service packages according to the Health Sector Strategic and Investment Plan (HSSIP):

a. Health centre IVs provide general consultations, mother and child health, vaccinations, deliveries, family planning, information and education for health, laboratory services, and theatre services.

b. Health centre III provide general consultations, mother and child health, vaccinations, deliveries, family planning, information and education for health, and laboratory services

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5 Personal communication from Dr Dela Dovlo, Director HSS, WHO AFRO
c. **Health centre IIs** provide general consultations, mother and child health, vaccinations, family planning, information and education for health. The district has innovatively deployed midwives at health centre IIs to expand the coverage of facility deliveries.

**Most Common Diseases**

The five most important disease problems in this district are shown in Table 28. Malaria is a major cause of mobility and mortality in both the adults and children in the district.

**Table 28: Five major causes of mobility and mortality in Jinja district (2012)**

<table>
<thead>
<tr>
<th>Disease Priorities</th>
<th>Adults</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Malaria</td>
<td>1. Malaria</td>
<td></td>
</tr>
<tr>
<td>3. Pneumonia</td>
<td>3. Skin diseases</td>
<td></td>
</tr>
<tr>
<td>4. Acute diarrhoea</td>
<td>4. Acute diarrhoea</td>
<td></td>
</tr>
<tr>
<td>5. Intestinal worms</td>
<td>5. Intestinal worms</td>
<td></td>
</tr>
</tbody>
</table>

**Human resources**

**Staffing: numbers, distribution, recruitment and transfers**

Jinja district has 58 percent of the approved health staff posts filled. The ratios of the different professional groups to people in the district are; 1 doctor to 81,383 people, 1 nurse to 6,104 people, and 1 midwife to 5,366 people. These ratios do not take into account the health professions working in the regional referral hospital and Private (PNFP and PFP) health facilities.

There were 3 vacancies for Senior Medical Officers, 1 for Medical Officer, one Nursing Officer, 26 enrolled nurses for HCIVs and HCIIIs, 2 laboratory technicians and 2 laboratory assistants. The district has enough midwives (more than the established positions) and enough Clinical Officers.

A record or list of the total number and type of government health staff employed in the district was available. There were no staffs employed by the government transferred within the district within the 12 months prior to this situation analysis. There were only short term rotations to health facilities in emergency situations or need e.g. when health workers unexpectedly moved out of the district causing a serious human resource gap. The position of District Assistant Drug Inspector (DADI) was vacant in the 12 months prior to this situation analysis. A pharmacy technician from a HC IV was doubling as acting DADI.

Jinja district has a district human resource (HR) plan. This is made annually as part of the district health plan. The HRH plan was developed using information from the Human Resource Information System (HRIS). Capacity Programme helped the district with a computer software that is used to generate necessary information for HR planning. The summary pages of the software indicate the vacant
positions, the skills and these are usually embedded in the plan. It was easier to have a plan per facility. The plan also indicates positions prioritized for filling. However, due to staff ceilings and the ban on recruitment, the vacant positions stay on for a long time even when they are critical.

The challenge was costing of this plan which is not based on this information. Plans were revised basing on the available recourses. There was no budget for career development or even in-service training.

The District Health Officer (DHO) is in charge of staff transfers within the districts. According to the local government procedures, the DHO can post staff and transfer them on behalf of the Chief Administrative Officer (CAO).

**Training and Education**

The DHMT has some control over the training budget at the district level. Money for continuing medical education (CMEs) is controlled by the DHO for all the facilities. CMEs are conducted quarterly at health sub district level and health workers from the HCs IV, III and IIs are invited. The budget facilitates production of training materials and transport refund for health workers coming from lower level health facilities. There are also workshops and on-job training where participating health workers receive training.

The district does not have resources to support in-service training for health worker pursuing further studies. The DHMT also faces the challenge of providing career guidance and permitting leave for staff that are going for further studies. This has partly contributed to staff financing themselves and undertaking less relevant trainings.

Within the DHMT, there is an officer charged with training responsibilities. But also during meetings especially those held weekly to review performance, the DHMT members share the newly acquired knowledge and information from workshops that they have attended.

There is no specific Human Resource or business management training for DHMT members. Vertical programs provide courses/training opportunities for district health workers e.g. PMTCT and immunization programmes. The national level sometimes provides courses/training opportunities for district health workers. Last year (2012), three people went for management training. Ministry of Health also does some training like the UNEPI training on immunization and the reproductive health programmes. Some programmes cluster districts by region and Jinja is in the cluster of Busoga.

Number and type of health training facilities in Jinja district, which only train up to diploma level, are shown in Table 29.

<table>
<thead>
<tr>
<th>Type of institution</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse training schools</td>
<td>2</td>
</tr>
<tr>
<td>Midwifery training schools</td>
<td>2</td>
</tr>
<tr>
<td>Laboratory training school</td>
<td>1</td>
</tr>
</tbody>
</table>

Health training schools are not involved in the provision of Continuing Education in the district. Health workers do apply for admission to these schools but they have to pay tuition and meet other scholastic...
needs on their own. Staff from these health training schools do not serve as resource persons to support district activities.

**District Management Structure**

There are several management structures in Jinja district that have a role in the health sector.

(i) **District Development Committee**

There is a District Development Committee (or equivalent). It has got guidelines on its function and responsibilities. Held meetings in the past 12 months prior to the situation analysis in 2012. There are records (i.e. minutes) of these meetings. It has authority to make decisions on:

- district health plans,
- district health budget,
- personnel e.g. recruitment, posting or transfers, and
- purchase of drugs and other medical supplies

(ii) **District Executive Committee**

There is a District Executive Committee. It has guidelines on its function and responsibilities, and held meetings in the past 12 months prior to the situation analysis in 2012. It has authority to make decisions on district health plan, budget and personnel e.g. recruitment, posting or transfers.

(iii) **District Health Management Team**

There is a District Health Management Team. It has guidelines on its function and responsibilities, and held meetings in the past 12 months prior to the situation analysis in 2012. There are records (i.e. minutes) of these meetings. DHMT prepares a district health plan and budget. It has the authority to post and transfer personnel within the district.

**District Health Management Team**

**Composition**

The Jinja DHMT is composed of DHO and all heads of sections in the district health office i.e. the DHO, District Nursing Officer, District Health Educator, District Health Inspector, Biostatistician and the in-charge of Vector Control, private-not-for-profit health providers (PNFPs), development partners, major NGOs, and politicians. The positions of Deputy DHO (Maternal and Child Health), Deputy DHO (Environmental Health), and District Assistant Drugs Inspector were vacant at the time this situation analysis was done and were filled by officers in acting positions. The Principal Health Inspector who was working as ADHO (Environmental Health) and the TB and Leprosy Focal person retired during the period this situation analysis was being conducted. Members of the DHMT, their roles and gender are shown in Table 30.
Table 30: Members of the DHMT

<table>
<thead>
<tr>
<th>DHMT Post</th>
<th>Role(s)</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>District Health Officer (acting)</td>
<td>Overall Manager and health department head</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>District Nursing Officer (acting) (also District Health Visitor)</td>
<td>MCH, HIV focal person, PMTCT, Surveillance, Health Visitor, Cold Chain</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>District Health Educator</td>
<td>Health promotion + education</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>District Health Inspector</td>
<td>Environmental health programs+</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>District Biostatistician</td>
<td>HMIS, service data + analysis reports</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>District Cold Chain Technician</td>
<td>Cold chain management</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Representatives of private sector</td>
<td>Private sector providers</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The TB and Leprosy focal person position was phased out according to the current staffing establishments. One District Assistant Drug Inspector (DADI) was recruited but had not reported.

The DHO is the leader of the DHMT. Table 31 provides an estimate of the DHO’s time spent on management and management-related activities.

Table 31: Distribution of DHO’s time on management and management-related activities

<table>
<thead>
<tr>
<th>Management task</th>
<th>Percentage of time spent</th>
<th>comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending meetings within the district *</td>
<td>about 50 percent</td>
<td>It varies. There are many meetings with the DHT, partners and district leaders. 1hr @ week for DHT meeting</td>
</tr>
<tr>
<td>Attending meetings outside the district</td>
<td>5 days in August 2012 (25%)</td>
<td>It varies a lot. DHO has an invitation for 5 days in August.</td>
</tr>
<tr>
<td>Visiting health facilities</td>
<td>About 20 percent</td>
<td>1 day out of five last week</td>
</tr>
<tr>
<td>Supervision/mentoring</td>
<td>[included as meetings within district]</td>
<td>[The tool need to be revised about this overlap]</td>
</tr>
<tr>
<td>Receiving visitors</td>
<td>[Included as meetings within district]</td>
<td></td>
</tr>
</tbody>
</table>

* Meeting can be at DHO’s, CAO’s office or the district council.

They are a mixture of females and males

Functions of the DHMT

The functions of the District Health Management Team include:

a. Sharing information of what is happening in each unit (“avoid acrimony in the past”);

b. Build collective responsibility and support each other where necessary;
c. Allocation/sharing of funds (i.e. from Donors), transport and other resources especially for district operations and activities.

d. Motivation aspect e.g. getting together and filling gaps

Jinja has a district human resource (HR) plan. However, there was no personnel handbook bearing the conditions of service, policies on gender and equity of treatment of staff, (i.e. non-discrimination based on religion, HIV status, gender, sexuality) except the public service standing orders. Even the code of conduct book is hardly read by the health workers. The books are only available for the administrators.

The DHMT is supposed to meet every three months but no meetings had been held for a long time due to lack of funding which is partly due to overdependence on the PHC funds. Part of the PHC funds is used to facilitate the activities of the DHMT like quarterly meetings, monitoring of health services delivery and surveillance.

Issues discussed at DHMT meetings were:

- Accountability for funds provided by partners and government
- Cold chain and immunization – “We have just concluded a national immunization campaign”
- Staff welfare, discipline, complaints and deployments if staffing major gaps arise; (meeting also makes recommendations about staff and facility performance)
- Collaboration with partners, new projects like perform and reports
- Review and implementation of action points made in the previous DHMT meetings.

The core DHT meet every Monday of each week in the DHO’s boardroom. HC IV in-charges and programme focal persons have been co-opted to the DHT activities. Every quarter, the district holds a health facility in-charges meeting to among other things review the sector performance.

**Decision making processes within the DHMT**

The DHMT decision making process involves;

- Section heads make requests to DHO or to project (i.e. Baylor) and these are discussed and approved;
- Sometimes there is lobbying in the meeting for some activities or resources for activities;
- The team can decide to present the issue – e.g. funds for supervision to a project to fund;
- The meeting can recommend staff for transfer to improve performance – opinion of others i.e. the DHI or health inspectors can be solicited, but transfers are few.

The national level can influence how and which decisions are made by the DHMT, for example:

- Instructions from the centre are always received and acted upon accordingly. “Recently we had national immunization days”.
- Protocols of how to treat cases – like ARVs come from the centre and are adopted by the district for implementation.
- Communication and advice about the distribution of supplies – now we have medicines supplied from the centre.
d. We also have a yellow star program (supervision) which is based on the national level performance indicators.

Members of the DHMT had the resources needed to perform their routine duties in the three months preceding this situation analysis. PHC funds and several partners were available to assist the DHT to do planned activities. All members of the DHMT had job descriptions which describe their roles as members of the DHMT.

The DHMT and Performance Management

All existing staffs received job descriptions and there were some mentoring arrangements.

There is no functioning system for the allocation of financial incentives to staff based on performance. The reason is not known. However, the DHMT members know of the different ways that the best performing staff can be recognized.

The main methods of performance management are supportive supervision and performance appraisals and these are described in more detail below.

Supportive supervision

Supervisors in the district
Support supervision is one of the priority activities of the DHMT and supervisors are allocated to different levels of the district infrastructure (see Table 32 below). However, it is dependent on the availability of transport means (vehicles and fuel), tools and money for the logistical support. Internal support supervision is done by in-charges of health facilities while technical support supervision is done by program focal persons (based at either DHO’s office or HSD levels).

Table 32: Staffing levels at different levels

<table>
<thead>
<tr>
<th>Level</th>
<th>Current staffing</th>
<th>Existing number of supervisors</th>
<th>Support supervision competences</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHMT</td>
<td>9 DHT members (Normal establishment = 12)</td>
<td>6 others coopted from HSDs to do support supervision</td>
<td>DHMT members require training and mentorship esp. in case of new interventions e.g. Option B of the PMTCT.</td>
<td></td>
</tr>
<tr>
<td>HSD/HC IV</td>
<td>30 (normal establishment = 24)</td>
<td>Detail below 7 The DHMT mentors HC IVs and IIIIs to provide support supervision within and to lower level health facilities.</td>
<td>Lack of mentorship on new interventions due to inadequate PHC funds.</td>
<td></td>
</tr>
</tbody>
</table>

---

6 Health workers become supervisors based on length of service and potential to be good supervisors.

7 Some health workers were invited from HSD to join the DHT in Yellow Star programme. Yellow star is largely about quality improvement and is regularly done at all health facilities with financial support from the PHC funding. The integrated support supervision is supposed to be conducted quarterly and stops at HSD/HCIV but it is poorly funded and irregular. The DHMT is divided into five support supervision
HC III | 16 (normal establishment = 12) | 4 | Does not supervise HC IIs because of limited facilitation (transport, PHC funds,) and lack mentorship.

HCII | 4 (normal establishment = 3) | 3 | They are few. Lack transport and funds to supervise VHTs. They are supposed to supervise VHT.

The process of choosing supervisors is based on 3 attributes; qualification, commitment to do support supervision, and work experience and place of work. Health workers in high work volume sites have got more experience; area of training, workshops attended, management skills, attitudes, seniority are all taken into consideration when choosing a supervisor. The required competences of support supervisors were:

- Knowledgeable in the area because SS is an on-job training, it draws HW from community health and sanitation, nursing, clinical services, infection control.
- Must be occupying a senior position
- Must be respected.

There were no guidelines for development of supervisors and there is no plan in place to ensure continuous capacity building for the already existing supervisors or development of supervisors. Supervisors need training and mentoring in order to provide new supervision to the lower level health workers. Supervisors are given first priority whenever there is a training opportunity e.g. health workers will be undergoing training on PMTCT option B+.

**Supervisory visits**

The DHMT in Jinja district has a schedule for planned supervisory visits. However, no exact dates are given in the health plan but it is budgeted for. Supervisory visits made by the DHMT to regional referral hospital and district health centres during the six months prior to data collection is shown in Table 33.

**Table 33: Schedule of supervisory visits for Jinja district**

<table>
<thead>
<tr>
<th>Facility</th>
<th>Number of visits planned</th>
<th>Number of visits actually carried out</th>
</tr>
</thead>
<tbody>
<tr>
<td>The regional referral hospital can be visited whenever there is need for immunization data which is coordinated by the district</td>
<td>Depends on activity</td>
<td>Not known</td>
</tr>
<tr>
<td>Health centre from IVs _ IIs are all visited by the DHMT quarterly</td>
<td>Quarterly visits (4)</td>
<td>Quarterly visits (4)</td>
</tr>
</tbody>
</table>

The supervision schedule is produced every quarter and supervisees are informed through a telephone call, SMS or a letter. Supervision (internal, technical and integrated) and the mentoring and coaching are scheduled in the district and health facilities. They involve a meeting at DHMT level to discuss the teams (who is going where, the team leader and the secretary for each team) and resources (fuel, vehicles, allowances, drivers). All DHMT members’ supervision start on the same day but can finish on different days. Supervision usually takes 6 – 7 days for the yellow star.

groups. Each subgroup is assigned a zone (all the health facilities within a HSD). The exercise lasts a week and it draws resources like the HSD ambulances are all assembled for the exercise.
The DHMT uses a supervisory protocol/checklist during supervision. The yellow star programme has got a checklist that assesses a range of quality parameters in a health facility setting. Supervisory protocol/checklist covers all the district programmes/activities. The district has got a prominent yellow star programme which is basically a quality improvement intervention that relies on an assessment of key quality parameters. There is a comments section where we can add any other observation. The report left behind provides reference for the next support supervisor(s) whether from the centre or district and it is a basis for follow-up.

‘We follow the guidelines like for the yellow star, and we score according to the guidelines provided in the checklist’. (DHMT member).

Feedback and reporting supervision visits
Reporting and feedback mechanisms for the three types of supervision at different levels involve filling a checklist. The original copy of the checklist stays at the facility for their records and the carbon copies are carried by the supervisor to the DHO’s office. On return, the supervisors make a report and this is shared in the Monday meetings. The DHMT also chose a yellow star coordinator to whom the supportive supervision reports are submitted.

The reporting of supervision is documented in the facility reports and also in the accountability for the funds received. The output and budget tool is used to capture this. Supervision is also covered in the National Assessment for the Local Governments.

There is a regular follow up and feedback on action points to the in-charge and staffs. This is done immediately and is two-way. The technical persons in charge of specific programmes are also party because some of the action points require their input like if it is the cold chain, then the technician has got to come in. Some of the actions require political intervention, for example, if the HUMC are failing to work with health workers, the DHO has to take it up and so this requires the DHMT to report accordingly.

Facilitation of supervision
Facilitation of supervision at different levels in the health system is shown in Table 34.

**Table 34: Facilitation of supervision by health system level**

<table>
<thead>
<tr>
<th>Level</th>
<th>Type of transport</th>
<th>Allowances</th>
<th>Guidelines/checklist</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHMT</td>
<td>5 Vehicles from DHO and HSD</td>
<td>UGX 12000 a day (PHC fund)</td>
<td>Reproduce the checklist for yellow star.</td>
<td>Partners also facilitate technical support supervision like PMTCT,</td>
</tr>
<tr>
<td>HSD/HCIV</td>
<td>All the 5 HSD have vehicles</td>
<td>UGX 12000 a day (from PHC)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HC III</td>
<td>Only 4 HCIII have a motor cycle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCIi</td>
<td>&lt;20 HCIIIs have a bicycle</td>
<td>They don’t have a budget</td>
<td>They only go out for outreaches</td>
<td></td>
</tr>
</tbody>
</table>
Role of stakeholders in supportive supervision

There are two stakeholders involved in supportive supervision (Table 35). Their roles in supervision are varied, but most provide supervision for specific programmes such as HIV/AIDS or MCH.

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Roles</th>
</tr>
</thead>
<tbody>
<tr>
<td>TASO (took over from Baylor under the rationalization process)</td>
<td>TASO supports the district in HIV/AIDS only—although the support is systems strengthening like training of health workers or facilitating the outreaches, all the activities are in HIV/AIDS.</td>
</tr>
<tr>
<td>Save the Children</td>
<td>Helping babies to breathe at the time of birth (Reproductive health/saving newborns)</td>
</tr>
</tbody>
</table>

Factors facilitating supportive supervision

Mechanisms in place to ensure continuous support supervision and mentorship for supervisors included:

a. Incorporation of support supervision in the work plans
b. Inclusion of support supervision as an agenda item in meetings like the Monday DHT meetings and is discussed every time the DHMT meets
c. Creation of support supervision teams for the different supervision zones
d. Mentoring arrangements:
   • The DHMT is supposed to receive quarterly support supervisors from the Ministry of Health who mentor DHMT members
   • DHMT members attend workshops in specific areas
   • Meeting people who are technical like the CRTs
e. Mentoring arrangements for newly recruited, promoted, and those given new assignments were:
   • Orientation and induction of newly recruited staff
   • Workshops and mentoring programmes by which support supervision competences are enhanced

Challenges in providing supportive supervision

Actual adherence to the schedule and guidelines depends on logistics, availability of supervisors and the pace at which one is able to work. The major adherence-related issue at district and health facility levels is delay in requisition especially with the new financial management systems. The arrangement requires the DHMT to utilise the money in the stipulated time. There is a delay of PHC funds for example, it is now April, but the January – March quarter funds have just been released. There are issues like bureaucracy in getting the cheques for lower level facilities cleared.

Appraisal of health workers in the district

Working under probation or on a permanent appointment determines the frequency of staff appraisal. Health workers on probation are appraised twice a year and once they are confirmed as permanent,
they start undergoing one appraisal in each financial year, usually in June. It is a routine and usually a memo is circulated to all including the appraisees. The in-charges are supposed to appraise all the other health workers under them. The forms are available free of charge and the exercise is transparent except that it is a high workload especially in sections with so many staff like nurses. In-charges submit filled forms to the HSD in-charge who has to approve them before they are sent to the DHO’s office.

At the DHO’s office the completed appraisal forms are distributed to the different departments (clinical staff are handled by the DHO, health inspection staff by the Health Inspector, and the Principal Nursing Officer handles the nurses). By October of each year, the forms must have reached the CAO’s office. The DHO is also appraised based on the response rate (measured as a percentage of staff who have been appraised).

Health workers are oriented to conduct and to benefit from routine appraisals. In-charges of health centres are oriented when taking the forms. The forms also have got prompts/guidelines to follow during the appraisal. Although the forms are the same, questions are open ended to apply to all cadres of every rank. This is done in July which is a very busy month characterized by several workshops and meetings.

There are indirect rewards or sanctions as a result of appraisal. There is no way the best employee can be identified based on the appraisal. The appraisal has implications on promotions, pension, or permission to go for further studies and the disciplinary actions because people fear having no filled appraisal forms on their files. This is the time when personal files have to be vetted and there is usually scrutiny of the appraisal reports. Managers are charged by the CAO to appraise all staff working under their jurisdictions. If a health worker fails to go for appraisal, he/she still continues to work but risks missing some of the benefits that are awarded basing on one’s personal file.

Impact of existing appraisal system on staff performance is obscure. The exercise has no monetary value but the questions to a great extent link to the key performance indicators depending on one’s position. The exercise provides a moment of agreeing on performance areas that require personal and institutional improvement and it suggests mechanisms for improvement.

The process of developing appraisers of health workers involves several stages:

- Identification of potential appraisers and training needs. It depends on the position one holds but usually in-charges of health centres do the appraising. They receive the orientation first. The identification can take place during the appraisal (you get the chance to discover the best personnel and then you assign them responsibilities accordingly).
- The Principal Personnel Officer trains the senior managers in the DHMT who later train others.
- Appraisers seek help from their own line managers when they have difficulties with certain appraisals. They can travel long distances to come and ask for clarifications.

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Conflict resolution

The DHMT plays a role in managing conflicts between staff in the district. There is a conflict resolution committee – one for health and another for the entire district service. The one in health deals with only health workers. Complicated issues are referred to the district one which is chaired by the CAO.

The disciplinary actions taken by the DHMT and their frequency depend on the occurrences and gravity of the offence. Below are the two scenarios of conflict resolution within a district:

- Health conflict committee; for cases like absenteeism from duty and conflict, the affected health workers are invited to defend themselves and then after, the DHMT monitors them closely to ensure that there is compliance with the agreed behaviour changes.

- District disciplinary committee which handles individuals who have failed to comply with recommendations of the health conflict committee. This may lead into stopping the salary or dismissal, interdiction, suspension as the situation demands.

The DHT members appraised the staff in the DHO’s office and health sub-districts. However, there was little linkage between appraisal and promotion of staff. The district budgetary constraints did not support staff promotion.

Health Systems Building Blocks and their Relationship to HRH

HMIS

The district has satisfactory HMIS with 83% timeliness and 86% completeness according to annual MOH league table 2012. The health management information system (HMIS) reports for the 12 months prior to this situation analysis were available except for the months of May and June 2012 which were not entered because two facilities had just submitted their data (hard copies were seen). New innovations like M-TRAC (a mobile tracking system using mobile telephone SMS which involves a relay of information from one central place (e.g. HMIS and usually by the biostatistician) to network of concerned parties such as the DHO, Ministry of Health, disease surveillance focal person) have come up to add community level information and monitoring to the traditional HMIS. Information about internal staff movement and transfers was not available. District health plans were prepared using the data from the HMIS. Last year’s output was being used to project the targets for the next year’s health plan.

There is a system for recording human resources data in the district. Through the support of Uganda Capacity Project, a human resource information system (HRIS) was established in the office of the District Personnel Officer. Information on health workers was available.

Service Delivery

The delivery of health services in Jinja district follows a decentralised structure. The district was targeting to increase facility based deliveries by equipping and staffing health centre IIIs with midwives. It was revealed that HC IIs were delivering more mothers than the HC IIIs partly because of the low
functionality of health centre IIIIs. Utilisation of health services as shown by the number of bed days, normal deliveries and outpatients at different HCIVs in Jinja district during the 12 months prior to this situation analysis is shown in Table 36.

Table 36: Number of occupied bed days, normal deliveries and outpatients at HCIVs in Jinja district (2012)

<table>
<thead>
<tr>
<th>Facility</th>
<th>Bed days</th>
<th>Normal deliveries</th>
<th>Number of outpatients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budondo HCIV</td>
<td>291</td>
<td>324</td>
<td>14,034</td>
</tr>
<tr>
<td>Mpumudde HCIV</td>
<td>244</td>
<td>486</td>
<td>25,948</td>
</tr>
<tr>
<td>Buwenge HCIV</td>
<td>1318</td>
<td>684</td>
<td>21,554 (June 2012 data missing)</td>
</tr>
<tr>
<td>Bugembe HCIV</td>
<td>No report</td>
<td>1242</td>
<td>17,939 (June 2012 data missing)</td>
</tr>
</tbody>
</table>

DTP3 vaccinations in Jinja district in the 12 months preceding this situation analysis was 14,869.

**Supplies and Technology**

Medicines, supplies and technologies depend on the National Medical Stores (NMS). NMS has 6 distribution cycles and each of these is meant to cover 2 months. The orders raised at HC IV however is supposed to cover 5 months in order to cater of the lead time in ordering and also the lag period whenever there are delays.

The pharmacy technicians initiate the order which is approved by the DHO before it is submitted to NMS. NMS has got 5 clusters (regions) and Jinja with other central east and eastern districts are in cluster 1. On the distribution schedule, the first cycle is 14th of June and for timely ordering deadlines are that: health centre IVs submit orders to DHO by 5th of a month, the DHO compiles the orders by 10th and by 14th of a month, orders should have reached the NMS. Previously NMS used to bring the supplies up to the DHO’s office but now they distribute up to the health centre level. The NMS trucks deliver medicines and other supplies to districts and locally contracted NMS transporters do the distribution within the district. At the health centre level, the supplies are received by the HC staff and witnessed by the member of the health unit management committee who then informs the community about the availability of drugs.

The most frequently used drugs and frequency of being out of stock are shown in Table 37.

Table 37: commonly used drugs and drug stock outs in 2012

<table>
<thead>
<tr>
<th>Most frequently used drugs in the district</th>
<th>Number of days in the previous year when drug was out of stock</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Coartem</td>
<td>This year, no stock out has been registered and last year, it was only 2 months of no coartem.</td>
</tr>
<tr>
<td>2. Paracetamol</td>
<td>3 times a year. This is because lower level HCs tend to run out of paracetamol before HC IVs. This results in most people coming to health centre IVs.</td>
</tr>
<tr>
<td>3. Amoxyl</td>
<td>3 times a year and it happens because may be there is a missed cycle or the lower health centre(s) has suffered a stock out.</td>
</tr>
<tr>
<td>4. Cotrimoxazole</td>
<td>Stable supply in all units at all times. Partners also supply</td>
</tr>
<tr>
<td>5. Ciprofloxacin/ Erythromycin</td>
<td>Every cycle, we have a shortage going for 15 days</td>
</tr>
</tbody>
</table>
Management of medicines in health facilities has been improved by the collaboration with one of the development partners. Prescription guidelines, use of stock cards and community behaviour have been tackled in this partnership. Using Medicines Management Supervisors, drugs can be redistributed within a district to avoid expiry and to ensure equity in access to medicines. “We encourage health workers to minimize use of drugs and we encourage redistribution in case of redundant stock” (DHMT member).

Stock outs emerge because of changing seasons especially for the case of tropical diseases. Although NMS encourages DHMT to make emergency orders, the procedure in place would work well for drugs like ARVs where the ordering is based on data (patients already recruited + patient targeted for initiation). For drugs like amoxicillin, it is very difficult to estimate because the number of people in need keep changing, for example, in the rainy season, the consumption of coartem and paracetamol is on the rise.

Only one private hospital (Alshafa) in the district had a functioning (working) oxygen tank and supporting equipment for resuscitation (for both adults and children). The rest of the health facilities are health centre IVs and they do not have such facilities.

**Governance and Leadership**

Meetings between the DHMT and relevant facility and community representatives are detailed in the Table 38.

<table>
<thead>
<tr>
<th>Name of group</th>
<th>Number of meetings held in the past 12 months</th>
<th>Frequency</th>
<th>Records/Minutes of meetings available</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>HUMC</td>
<td>4</td>
<td>Quarterly</td>
<td>Yes</td>
<td>This usually stays at facility level</td>
</tr>
<tr>
<td>S/county AIDS committees</td>
<td>4</td>
<td>Quarterly</td>
<td>Yes</td>
<td>Addresses HIV/AIDS issues in the sub-county</td>
</tr>
<tr>
<td>VHTs</td>
<td>4</td>
<td>Quarterly</td>
<td>Yes</td>
<td>This was VHT training in the municipality</td>
</tr>
</tbody>
</table>

There is a district health plan. It has a vision, mission and goal that are the same as the national HSSIP for MOH. There was a good use of data from HMIS of the district in the plan document. The first priority for the financial year 2010/11 was human resource with the following issues:

- recruitment to fill 63 critical vacant posts – medical officers, health information officers, enrolled nurses, laboratory technicians, public health nurse, ophthalmic clinical officers and a driver;
- capacity building for health workers and health unit management committees and VHT through workshops and seminars;
- procurement of staff uniforms and personal protective equipment/supplies.

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*Jinja Regional Referral Hospital also had a functioning (working) oxygen tank and supporting equipment for resuscitation (for both adults and children).*
Health sector partners working in the district were 29 most of them for HIV family planning and other health projects such as Sight Savers.

Each health facility is managed by a health unit management committee (HUMC) which provides an interface between health workers and the community. In most health facilities, these committees hardly meet because of lack of funding. The HUMC is composed of community members endorsed by the local councils. For Health centre IV, the committee is endorsed by the District Council while for the HCs III and II, the endorsement is done by Sub County, division or Town council in which the health facility is located. The term of office for the committees in the district expired although the members have continued to work. The district health management team identifies lack of funds as the reason why these committees have not been replaced. The other avenues that community members interface with health workers is during the Barazas (community dialogue) or when there are mobilisation campaigns like the child days plus (immunisation days).

There are no local policies on health workforce performance. There are no district policies on health workforce performance. The local factors that adversely affect the performance of the health workforce in the district include;

a. Political interference. The politicians usually want to jump the queue; they want to carry medicines even when they are not sick. So they end up conflicting with health workers.

b. Sometimes in the event of stock out of drugs health workers are labelled as thieves even when they are innocent.

There are national policies on health workforce performance. There is a national policy on human resource. National factors that affect the performance of the health workforce in the district include;

a. limited incentives like lack of accommodation (some houses were sold off to private individuals like in Jinja town)

b. Recruitment which is heavily depended on the restricted wage bill.

Finance

Jinja district has a district health budget. Sources of funding for the district health budget were; national transfers/grants, development partners (e.g. Baylor College of Medicine), and the district council. Preparation of the district health budget involves all health unit heads who come up with a list of their wishes and present it to the DHT meeting for consideration. Their needs are adjusted according to indicative budget figures provided to the district by the centre (Ministry of Finance, Planning and Economic Development). The District Council then approves the district health budget. Once the budget is approved, the DHMT can only re-allocate a small proportion of the budget to other activities with approval from the centre. The DHMT has a limited role in the allocation of funds to activities because most of the funding comes as conditional grants. The level of authority the district has to use its budget for some specific area is shown in Table 39.
Table 39: Level of authority the district has to use its budget for each specified area.

<table>
<thead>
<tr>
<th>Area</th>
<th>Level of authority</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full</td>
</tr>
<tr>
<td>Paying staff salaries</td>
<td></td>
</tr>
<tr>
<td>Paying staff allowances</td>
<td></td>
</tr>
<tr>
<td>Hire additional staff on contract (70 Staff by Baylor for HIV and records)</td>
<td>☒</td>
</tr>
<tr>
<td>Purchasing drugs</td>
<td></td>
</tr>
<tr>
<td>Purchasing other supplies such as linen, stationery, cleaning materials (uniforms etc)</td>
<td>☒</td>
</tr>
<tr>
<td>Purchasing equipment (Some are donated)</td>
<td></td>
</tr>
<tr>
<td>Repairing equipment(^1)</td>
<td></td>
</tr>
<tr>
<td>Maintaining buildings</td>
<td></td>
</tr>
<tr>
<td>Maintenance vehicles and motorcycles</td>
<td>☒</td>
</tr>
</tbody>
</table>

\(^1\) It depends on the type of equipment. Some equipment is repaired by the centre.

The health facilities are required to develop annual work plans based on the indicative budget. The money is then received as a conditional grant. The biggest part of the budget is retained at the centre to take care of the wages (salaries) and the purchase of drugs. The district then receives the primary health care non-wage and the primary health care capital development. These moneys are then passed on to health facilities as earlier planned.

An integrated financial management system (IFMS) is used to manage the finances sent to the district. The financial allocation is based on district population and two issues arose for districts.

The central government funding has been reducing and no longer matches the volume of activities. This has affected key service areas like supportive supervision and facilitation of the health unit management committee activities.

There is a number of donor driven programs in the district but these are targeted to specific programmes. One of the partners in HIV/AIDS provided support to the district to recruit some key staff like the laboratory staff and midwives to fill the existing manpower gaps. The partner also supported the recruitment of HIV/AIDS counsellors, a cadre that does not exist on the government structure.

A breakdown of health expenditure of the district for the past financial year was not available as salaries are paid directly from the centre to individual bank accounts, money for drugs and supplies goes to National Medical Stores directly from the centre and for other supplies, the district may simply be called upon to go and pick without knowledge of the cost details.

There was a budget allocation for staff salaries and allowances. This does not come from the district but PHC funds centrally managed. Salaries are wired on to personal bank accounts of individual health workers. In general, central government through a payroll system (initiated by the district) pays all government workers and the money is wired through the electronic funds transfer to the...
workers’ bank accounts as salary. Salaries are generally paid on time; by the 30th day of a month the salary is on individual workers’ account.

There is no input by the DHMT in the planning of the salary budget for district health staff. The DHMT simply goes by what the centre gives and no addition from the district. There is no budget for financial incentives for staff except from partner supported programmes.

The financial monitoring systems in use for monitoring execution of the district health budget are shown in Table 40.

**Table 40: Financial monitoring systems**

<table>
<thead>
<tr>
<th>Structures</th>
<th>Existence</th>
<th>Actual use</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Financial records</td>
<td>☒</td>
<td>☐</td>
</tr>
<tr>
<td>Accounting procedures</td>
<td>☒</td>
<td>☐</td>
</tr>
<tr>
<td>Financial reports</td>
<td>☒</td>
<td>☐</td>
</tr>
<tr>
<td>Periodic auditing visits (quarterly)</td>
<td>☒</td>
<td>☐</td>
</tr>
<tr>
<td>Others (specify): Electronic Funds Transfers, Rapid financial management system</td>
<td>☒</td>
<td>☐</td>
</tr>
</tbody>
</table>

**Key Challenges on HRH within the District**

In a series of meetings with the CRTs, DHMT members brainstormed and prioritised key assets and challenges listed below:

1. The district is not able to employ health workers according to their level of training. Health workers have been upgrading but have not been considered for promotion even when there are vacant positions. For example, one medical doctor is serving as a clinical officer at a health centre IV and the district has not considered appointing him as a doctor despite having no other doctor at the facility. Many nurses and midwives have acquired advanced training but have not been promoted in accordance to their new academic qualifications.

2. Health workers are given additional assignments and are expected to continue serving the way they have been without additional remuneration. The position of in-charge is acting one and usually there is no written appointment letter to it no a salary increment.

3. Late coming and absenteeism at health facilities and offices. This results into a situation where the few health workers present get overloaded with work.

4. Uncoordinated training –many health workers have gone away and this burdens the few who remain.

5. Lack of motivation which makes people prefer to go away for further studies because they are sure of continued salary. District jobs have limited allowances or anything motivating for people to stay.

6. Working fewer hours than what is prescribed. Health workers are supposed to work for 8 hours a day but most times, they report late and leave the work stations early.

7. Nurses are doing more work than the clinicians themselves. This is partly due to task shifting and over delegation.

8. Uncoordinated task shifting where the clinicians tasks have been shifted to the nurse
Findings from the evaluation

Management strengthening: processes

Support given to the DHMT

The DHMT reported that they received support from the CRT during the processes of situation analysis, problem analysis, bundle formulation, modification and implementation. The CRT facilitated the brainstorming meetings in which the DHMTs listed and prioritised the performance problems within the district, and developed bundles. The DHMT explained that the meetings or workshops were participatory and the CRT helped them to think through their issues more fully so that they could focus on what they really wanted to address. Through regular visits and the provision of the diary, the district was supported to document the whole process of bundle implementation.

“This was a participatory activity that we were guided by the research team on how to identify the gaps of which - were not obvious to us at the time” (JDHM FGD UG)

“With the assistance of PERFORM, we managed to come to identify those gaps and problems where we came up with the bundles” (JDHM FGD UG)

“What went well in the area of support that as the DHMT we were ably supported technically, the research team when it came to like the situational analysis at the beginning this is what to me was ably handled with a lot of knowledge and skills being imparted into us and also along the way the visits that you have been making we have learnt a lot” (JDHM FGD UG)

“The interaction we had was inviting us to think more because there were some questions that we thought that we had sorted and when the facilitators kept asking us, ..... the probing and discussions we had were useful in helping us focus our thinking it helps us crystallize the issue that we wanted to actually address and this wouldn’t have been so without the guidance” (JDHM FGD UG)

PERFORM provided communication mechanisms for districts to share and learn from one another. The three PERFORM districts convened in both the national workshops and the inter-district meetings to share experiences and review progress which enabled DHMTs to learn from one another. The DHMTs reported that the inter-district meetings were the most valuable as they provided for more sharing of experiences and learning. The reports of these workshops and meetings describe how the DHMTs appeared to appreciate the support that they received for developing the problems trees and bundles of strategies and were enthusiastic about the next workshop and other interactions with the CRT. The documents described how the CRT visited Jinja DHMT to discuss progress with implementation of the project. They report that the DHMT receives advice from the CRT and then follow up on action points from the meetings. However, they also report that the DHMT would like feedback from the CRT after the visits. The documents recorded that the diaries are useful for monitoring DHT activities, but the DHMT would like more support to capture reflection, and for the diaries to be introduced in the six sub-districts.
“I can maybe cite how we have worked with a research team is through the workshops where all the PERFORM - all the districts that are in PERFORM have gathered and then share on the progress and shared progress reports with the guidance of the PERFORM team or the research team and in this for example what I can cite is you have guided us on how to do the presentations, the thematic areas to capture the presentations and then you have guided us in action planning during those workshops” (JDHM FGD UG)

“They seem happy to get some interim support on refining the problem analysis and finishing the district reports and are very enthusiastic about coming to the next workshop.” (National workshop 1 Report).

“There were three specific objectives in meeting with the DHMTs: (1) to help the DHMT members and visitors to jointly explore the opportunities and challenges in implementing the planned bundles of HR/HS strategies; (2) to explore together the opportunities and challenges in recording the process and reflections of implementing the project; and (3) to help the overseas PERFORM team members gain a better understanding of the health care system in Uganda and the context in which it operates.” (Jinja District Visit report November 2013).

“The chair (DHO) also noted that, although it was a long time since the CRT last visited, PERFORM was still on the DHMT’s minds: “we can be slow but for sure we are taking steps to be somewhere”” (Report of CRT visit to Jinja DHMT March 2014).

“The headings of the table in the diary are specific and direct (i.e. activity, date, officer responsible, results and next steps). This makes the diary’s recordings restrictive and devoid of room for capturing other information relevant to the PERFORM AR cycle. The DHMT members acknowledged the need for the CRT to support them in improving the scope of information gathering. They want CRT guidance to capture information on reflection of AR processes and activities. The team emphasised the need to introduce diaries in the 6 sub-districts. They believe this will simplify documentation.” (Jinja District visit report November 2013)

“The DHMTs felt that there were still a number of challenges in implementing the HR bundles of strategies: high office workloads; logistical constraints interrupting monitoring activities; some new staff members were not being orientated due to financial constraints; appraisal forms had not been customised to reflect different cadres; communication gaps persisted between the CRT and DHMT members, as well as between DHMT members. The DHMT would like the CRT to provide feedback after monitoring visits.” (Jinja District visit report November 2013)

The other mechanisms reported included the project newsletter, emails, telephone calls and the use of Facebook. Some DHMTs requested that the newsletter be more frequent – monthly or quarterly so that they could learn more frequently from other districts instead of waiting for the inter-district meetings. Some DHMTs were not used to using Facebook, and therefore did not access the PERFORM Facebook site.

“We were using multiple ways of passing on communication where emails and phone calls contributed much of the communication and where even an email was sent and there was no response always a follow up telephone call was made and this to me was a good thing because sometimes we got buried into our day to day activities and sometimes you forget some commitments that you had made to me that was an issue that went well” (JDHM FGD UG)
“I have some issue with the communication, I do not know may be because I never used to use the platform, the face book and..... but I thought we would get like quarterly or monthly newsletters to get experiences from these other districts where PERFORM project is based and we see how to improve our way of doing things instead of waiting for the inter district meetings. We would like to get documentation like a newsletter or something that captures some of those things” (JDHM IDI 04 UG)

“What did not go well as far as communication is concerned is that we had agreed on using the recent, this face book was one of them but some of the teams as you realize they were not very friendly with using this interface so in a way they politely did not object to the choice of the media exchange they had chosen but they also did not give us the feedback whether they are accessing the communication or not” (JDHM FGD UG).

Two DHMT members reported that they had expected some financial support from the CRT to implement the interventions.

“But what didn’t go well is some areas which required some little financial support, some what we did access some finance form the research team so I think that is partly what didn’t go well” (JDHM FGD UG).

“Officers came in this place this is what I remember and they said we are not here on the purpose of bringing money, we are only here to help you improve quality of care and I held of course these days our interest is money but I changed my attitude. I said even care to patients can be turned into a resource and to me I counted it as a resource offered to us to improve our skills and quality of care” (JSDman IDI 03 UG).

DHMTs reported that they agreed with the CRTs on the next meeting dates and reminders were always sent around. The CRT developed a detailed plan for visits to the districts in discussion with the EP.

“It was agreed that the next review should be through individual visits and the following review could be a joint meeting. In between support would be provided by e-mail and phone. Action 7.1: SB to make calls to districts as soon as possible. In particular to follow up with ... Jinja about their plans for strengthening the appraisal system and their discussion with DHO about including HSD in using the DHMT diary. Action 7.2: Sebastian to plan next individual district meetings for the second half of June. Action 7.3: plan joint meeting on progress in August; LSTM may be able to support this, subject to availability. SB to communicate this joint review meeting to the DHMTs quite soon so that they start to think about what progress they would present at this meeting.” (Report of Uganda visit May 2013).
Analyses of problems that DHMT face

Sources of information about the problems

The DHMT began by identifying the problems which they verify by engaging the concerned parties. Information often comes from the analysis of periodic reports. Going to the field and meeting teams or individuals concerned with the problem identified are the methods used to initiate the problem analysis. Field verifications often take place during supervision visits. Reports from such meetings are then discussed by the DHMT with the aim of finding the exact root causes and recommend solutions. However providers are also requested to verify the problem and propose solutions.

“After getting reports and going down identifying the problem we try to investigate by interviewing individuals and then a group and then of course with our findings we can tell, meet the people who are concerned tell them our” (JDHM IDI 02 UG)

“The problem we identified was based on declining trends of the data that is coming from these facilities. And when we visited and discussed with the health workers during the support supervision... when we identify problems, assuming it’s at a health facility, we engage the health service providers at these facilities and find out whether what we are perceiving as a problem is also considered as a problem at their facility” (JDHM IDI 03 UG).

Sometimes problems are reported by community representatives who then get involved by the DHMT for analysing it and finding possible solutions.

“...the community could come up with an issue that they want addressed and they pass this information to through the local leaders and these local leaders present this during the budget conferences. And from this budget conference we are gathering ideas from the population then the district technical planning committee picks priorities because some of the issues to be addressed may be beyond the available resources for us to handle.” (JDHM IDI 03 UG).

Other sources of information about problems are data produced by different monitoring tools for specific programmes.

“...we have Reach Every Child (RED) so we have a template, an excel template that helps us to see how immunization accessibility is, how immunization is and this ranks sub counties. Those that have performed well are ranked in category 1 and it goes from category 1 to 4. So we look at this on a monthly basis for example on the line of immunization.” (JDHM IDI 03 UG)

The DHMT involves the community in their decisions about how to address specific problems as suggested by example given by a DHMT member:

“...we have the popular jigger infestation so we have gone to sub counties especially here in XXXXX and we have identified some villages of course we worked with the village leaders so we identified which areas are more affected than the others, so we had some external support from a program called... they call themselves Soul Hope. So now when we identified these villages we communicated to Soul Hope the villages so we went there and made a kind of a survey to justify our position so when we went there we really met so many people of those people affected with the disease jiggers. So now we have developed out a method of how to combat them one ours was our interest was to
improve the sanitation of the area theirs was to extract jiggers and treatment and then spraying. So these areas have been worked on.” (JDHM IDI 05 UG)

Feedback from patients is also used as a means to verify the quality of health services and identify problems that affect service access and utilization as suggested by this health facility manager:

“...at one time we had so many HIV patients who could ask for transfer out. Then we sat and we said why are people losing interest in our clinic? Then we realized that the major important thing was on timing; starting the ART clinic at midday or 11, and even staying as late as 4.00pm. So we said before we blame them can we realize something and blame ourselves. These days I am happy to mention transfer outs have reduced. By 8.00am a clinician has already started seeing ART patients and by 2.00pm that clinic is almost closed.” (JSDman IDI 03 UG)

Health services’ users sometimes bypass the DHMT with their complaints and go to the highest decision-making bodies within the district as this stakeholder mentioned during his interview:

“They have that power, they tell the DHO, now they don’t tell him because they tell the LC5 [LC5 is the Local Council in charge of the whole District] if they don’t know their sector minister, they go to the LC5 because everyone here in the district knows the LC5. We have such and such a problem, we don’t want the in-charge of this such and such a health centre...” (JDstake IDI 04 UG)

Prioritisation of problems

The DHMT prioritize these problems for which solutions are financially feasible.

“So the district team normally prioritizes what could be handled in a specified period based on the available resources. That is one way of identifying priorities.” (JDHM IDI 03 UG)

Analysis of the problems

The process of initial problem analysis started with a situation analysis and was followed by the root cause analysis undertaken during national workshops. DHMT members and in-charges of HC IVs participated in these processes that were facilitated by the CRTs. DHMT members brainstormed the priority problems and went ahead to identify the root causes. There was consensus building to arrive at priority problems and their actual root causes.

“We started with meetings at the district level here and we started identifying the problems that we had” (JDHM FGD UG)

“What I noted was that there are certain things that some of us were not paying attention to but during the problem statement or problem statement or problem tree identification we realized that actually, however small something is, it could be the barrier between us achieving what we wanted to achieve” (JDHM FGD UG)

The process was considered as being participatory and well supported by the CRT. The managers appreciated working in a group to analyse the problems because the consensus generated agreement about the actual root causes.
“This was a participatory activity that we were guided by the research team on how to identify the gaps of which were not obvious to us at the time, but the process we went through of coming up with a problem tree guided us on getting the root cause of some of these gaps” (JDHM FGD UG).

“The health officers under the District Health Office and then the leaders of the health sub-district systems are the ones who were involved in identifying these problems because actually the effect was being felt in those levels - the District Health Office, DHT.” (JDHM FGD UG)

Building consensus about problems identified and solutions proposed helped in aligning priorities and promoting ownership of decisions made on how to address issues.

“The process was good in building consensus around what is being discussed because by the time we arrive at saying this is what fits at this level of the tree you have built consensus around it and at the end of the day it wasn’t viewed as one man’s idea, it was now what was a reflection of what was happening in the district as opposed to maybe one person saying that for me as I am concerned these are the issues that we want to address” (JDHM FGD UG)

Three of the problems identified in Jinja as per information gathered during IDIs and FGDs were 1) inadequate support supervision and 2) performance management and 3) low staff motivation.

“...the problem identified that the DHMT of Jinja decided to focus on was the area of support supervision we identified that support supervision was weak in that few supervisors had the capacity to do quality support supervision and that the visits made to the facilities were not adequate so we choose to strengthen the support supervision to the facilities; then another thing that we identified at that time was performance management which encompassed performance planning, performance monitoring and the appraisal.” (JDHM FGD UG)

“The other area that we identified in DHMT is the low motivation of staff and we thought that for us to be able to motivate staff we need to recognize those that are performing well and also make sure that we discuss and expose those that are not performing well.” (JDHM IDI 03 UG)

The findings of the initial problem identification process were further fine-tuned during district meetings and the National Workshop 1 (held in Jinja and attended by 9 members of the Jinja DHMT). The key problems identified were:

1. Ineffective use of the traditional control mechanisms
2. Low staff motivation
3. Inadequate supportive supervision
4. Staff training that is not guided by available opportunities in the district (National Workshop 1 Report)

However the records from this workshop do not match exactly with what was mentioned later during IDIs and FGDs which suggests further analysis and prioritisation by the DHMTs in their workplace, or the individual perspective of interviewees was slightly different from what was identified through the consensus building process. The lapse of time between NW1 and interviews may also have had an impact on the priorities identified at each time.
Problems identified were grouped depending on whether they were health system problems or specific human resources issues.

“...how we bundled up the issues and then they were categorized about the categorized as health system strengthening, support supervision, and human resource.” (JDHM FGD UG).

Problems were later presented during National Workshop 2 (attended by 8 DHMT members) and discussed in plenary. Some comments on the presentation of problems by Jinja DHMT included:

- “The DHMT chose to take on the arm/branch that reinforces management supervision
- Disentangle the lack of enough supervisors
- Separate the heavy workload from understaffing
- Commitment and motivation – are the causes too similar? What is the difference between commitment and motivation? (National Workshop 2 Report)”

Figure 6: section of Jinja DHMT’s problem analysis in National Workshop 2

(Figure 6: A visual representation of the problem analysis discussed in National Workshop 2. The diagram illustrates various issues such as lack of supervisors, workload, and motivation, indicating how these problems were categorized and addressed.)

Further problem analysis

The practice of using problem analysis has been adopted in Jinja district and is currently being used to identify and analyse problems that are not necessarily related to HR. Problems are identified during supervision and also through the analysis of data such as whenever there is a report indicating some
performance gaps. The problems identified are verified through visits to effected sites or meetings where the concerned officers are asked to provide details.

“...and that in a way was not only helped us to only consider the bundles that we selected at the time but it has become part and parcel of the day to day running of this office that sometimes when we are in our meetings we tend to brainstorm on issues and we build consensus around what we have agreed upon not one person dictating the pace or the direction that we should take.” (JDHM FGD UG)

Periodic activity reports, epidemiological data and findings during supervision visits are the main sources of information for routine problem identification by the DHMT.

“We have weekly reports. Some reports are given quarterly, some reports are given just like that so in these reports of course we compare the output with the target that we had.” (JDHM IDI 05 UG) “...But the other way in which we usually do this is through the HMIS, because every I think monthly the data that comes in is analysed.” (JDHM IDI 05 UG)

“...when we go for support supervision, or when there is a problem we go and visit the site not all but some DHT members go to the site and we try to investigate. We interview the people concerned, we carry out our investigations when we find out anything of course we convene a meeting with the people concerned, we tell them our findings.” (JDHM IDI 02 UG)

Selection of bundles

Selection of initial bundles of interventions

The DHMT reported that the initial bundles of interventions were composed in the first national workshop meetings and they included supportive supervision and staff appraisal (see below). In the workshops they had presentations about possible strategies and these helped them to select ones that would address their problems. They explained that as the research team facilitated the DHMT to identify solutions to their problems, this helped them “own” their interventions.

“At the national workshop we had presentations on the strategies to be used on the problems identified” (JDHM FGD UG)

“There is support supervision, monitoring the appraisal system at the lower levels, and the other one is entailed in supervision. Supervising the lower level facilities on how they manage their finances” (JDHM IDI 04 UG)

“We included them because they were relevant to helping us achieve our results, the results of the sector” (JDHM IDI 04 UG)

“My lessons learnt is that the best answers are the people where the problem is because during our interactions with the research team, they were more of facilitators of the discussion and actually we came up with what we thought was the best solutions to address these challenges and that in itself have made the interventions our own” (JDHM FGD UG)

Bundles of HR strategies were selected basing on the mandate of the DHMT and the resource/cost requirements. Strategies that did not require additional funding were included.
“We identified issues that we could not require a lot of input and additional resources so we considered the challenges that we could tackle without necessarily requiring more additional resources yet they could translate into the improvement of service delivery” (JDHM FGD UG).

“The choice of the problems we chose to tackle we were guided by the mandate of the DHMT, our roles have been defined on what we cannot do so we chose areas that are within our scope of work because we thought that these are the interventions for which we had control” (JDHM FGD UG).

The DHMT referred to other districts’ strategies during the second national workshop and this enabled them to refine their earlier composed bundles.

“we had our own ways of looking at things but during these meetings, when you get to see other districts are doing what we did, you pick what you feel was done better - helps us to refer in the other districts and it becomes part of the strategy” (JDHM FGD UG).

The bundle of interventions was developed alongside the problem analysis (see Figure 7 below) then written up into a table before incorporating it into the district annual plan.

**Figure 7: Jinja DHMT developing the bundle of interventions**

(National Workshop Report 2)

Based on the problems identified during the situation analysis Jinja DHMT followed the steps proposed to develop bundles of interventions (see section on Methods) as indicated in the report of National Workshop 2 (NW2):

**“Key Steps for Developing Bundles of HR/HS Strategies**

This was demonstrated by Tim taking the DHMTs through a table with sample strategies.

1. Identify problems to be addressed
2. Review options of strategies by performance area (in the manual). Explore all possibilities; have a good think about this.
3. Put selected strategies in planning table and complete all columns.” (National Workshop 2 Report)

The main strategies of the plan are given in Table 41 below and the full plan using the template provided in the workshop which includes supporting activities, indicators linkages to other relevant HR or health systems strategies is given in Annex 4.
Table 41: Main bundles of strategies to strengthen supervision and appraisal mechanisms developed at National Workshop 2

<table>
<thead>
<tr>
<th>A. Performance area/broad objective</th>
<th>B. Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengthen support supervision</td>
<td>To ensure monthly support supervision</td>
</tr>
<tr>
<td></td>
<td>Building competences of supervisors</td>
</tr>
<tr>
<td></td>
<td>Ensure regular follow up and feedback on action points</td>
</tr>
<tr>
<td>Strengthen appraisal mechanism</td>
<td>Regular appraisals of all health workers</td>
</tr>
<tr>
<td></td>
<td>Build competences of managers on appraising staff</td>
</tr>
<tr>
<td></td>
<td>Ensure transparency and honest for all staff</td>
</tr>
</tbody>
</table>

(National Workshop Report 2)

Selection and modification of follow up interventions

The DHMTs reported that they modified the interventions following the discussions on implementation progress in the inter-district workshops. They recognized that by changing or adding more activities, they would achieve what they set out to do i.e. improve human resource performance. They gave examples of including recognition of best performing facilities and staff as a way of motivating all staff to work well, and introducing an attendance book to help monitor absenteeism.

“So this was not really part of our initial work plan but when we discovered that during the sharing that indeed rewarding and recognizing would help to improve performance of human resource we adjusted and captured that in our work plan which was not really captured in the beginning and for example in the previous just concluded financial year we were able to recognize the best performing centres by level and also the health workers best performing health workers and quality improvement team”. (JDHM FGD UG)

“During the sharing, when we, that we have been doing we have been identifying what works and what doesn’t work and somewhat it has trickled us to like adjust the work plan for example as we are implementing these activities we noted that at the end of all of it if we don’t like recognize and reward the best performers somewhat the work force would not be motivated” (JDHM FGD UG)

“First of all, it was last or the other year when we introduced the attendance books. They were produced by the district and given to each heath unit and in a way this one helps us to identify to control certain or ascertain extents of absenteeism at health centers because one has to sign in the time you have arrived and what time you have gone away” (JDHM FGD UG)

The DHMT also reported that they continue to observe how the activities are being implemented and their results, and then modify the bundles so that they are more effective.

“The danger we still have is that the appraisals at different levels I think are not able to exactly bring out what we want at different health centers. It is now being done; the majority are really being appraised. But I think the standard of appraisals is still wanting. We still need to improve on the ability to handle those appraisal forms so that they really bring out exactly what we want” (JDHM IDI 05 UG).
Integration of bundles into the work plan

The two bundles of interventions – supportive supervision and appraisal of staff - were already part of the district work plan and therefore had some budget allocation. However, some of the activities were not funded and were therefore either conducted without funding which was challenging for the DHMT, or were delayed until funding was available. Over time, resources were mobilized and more bundle activities were integrated into the district work plan.

“Some of the activities like support supervision because it was running from the original work plan of the district across to the PERFORM work plan, at least it had some budget attached and with some cost funding but some activities were gradual we needed to do them but minus any money so the challenge was that we had to do them though hardship because we needed to improve our work plan” (JDHM FGD UG)

“Externally if there are some external funds allocated to my department that one I think I have to sit with my departmental staff and see what else we can include in what we never included last time” (JDHM IDI 05 UG).

“Another challenge that has already come up in this discussion was the financial implication; we lacked finances, some activities we thought that maybe could be done without finances. For example, training the managers that do the appraisal this is one activity that we discovered along the way that would require funding and we have had funding challenges and some of the activities have not been implemented because of that” (JDHM FGD UG).

“We needed to address issues that didn’t require additional resources. In the work plan, we had to put a budget definitely you cannot have a work plan drawn without a budget line and you call it a work plan because it will look like it is something that is put there to decorate the room but under that line, the budget line, we found that actually the activities were being budgeted” (JDHM FGD UG)

Management strengthening: Effects

Effects on DHMT

DHMT decision making practices

Jinja DHMT holds weekly meetings to review the previous week’s performance and make plans for the week. They receive and discuss HR issues. Usually the meetings are chaired by the DHO and the agenda is usually developed from the meeting.

“We know that every meeting the time when it happens it is between 9.00 and 11.00 in the morning and always on Mondays, so the meetings are always chaired by the District Health Officer and what happens is that each individual person depending on his/her kind of responsibility that he/she is supposed to implement in the district gives a report of what happened during the course of the previous week, for example, what you had planned to do in the week on top of what you have achieved” (JDHM IDI 01 UG)
The decision making processes seem to be very participatory.

“Members are given the opportunity to give feedback or to discuss or ask clarifications and the team gives either responses or possible solutions to the issues that are raised as a team and they are “minuted” and they are binding at that time” (JDHM IDI 01 UG)

They supervise and appraise health workers and health programmes within the district. They plan and budget for the sector.

“If I go out for supervision and I identify some gaps that I really need to put to the attention of the DHMT, I conceptualize my findings, I write them down, I write a report and then I present it to the members. I make sure everyone has a copy of the report and with my proposals, so when they read my report they have also there suggestions to add onto mine, then I capture their inputs and my views maybe accepted or not” (JDHM IDI 04 UG)

“For instance someone is deteriorating you can even request for forms of 3 years, 2012 this was your output 2013 you declined 2014 am seeing you declined” (JDHM FGD UG).

“When you also move out during the mentorships and coaching, there are things that we identify that these facilities require and when you look at their budget and they did not factor it in, then we include it and tell them we have put this because we want it in place and we are sending money for it. So it is not really that the facilities will sit and make a smaller budget but if you made a smaller one we can end up making it bigger depending on the need identified as we move around because if we came to your filing room, your recording room, and we expect you have the shelves and they are not there and you have been keeping the files in the boxes and you do not factor it in your project we would have to include it because I know you are not just keen to identify that you need this” (JDStake IDI 03 UG).

Decisions are normally made during scheduled meetings. However regularity depends of some factors out of the hands of the DHMT members such as lack of resources.

“The DHT meets regularly; once every month, for example, we have scheduled a meeting for 07/04/2014. DHMT meetings are supposed to be held quarterly which is not always the case. Certainly we need resources to run such meetings.” (CRT Visit to Jinja DHMT March 20 2014 Report)

**DHMT composition**

Jinja DHMT is mainly composed of officers in the DHO’s office.

“Most of the members who are on DHT are within this block and mainly these are heads of departments or projects in the district so what I can mention is that the DHO has to be there, the assistant DHO has to be there because the assistant DHO is in charge of MCH and in charge of health maternal and child health services. However, we have other two nursing officers; one of them implements surveillance and immunization, and the other one PMCT and quality improvement so those ones come on board. We have health inspection department also the head attends, we have like in data HMIS and the bio-statistician attends and health educator attends, the drug
inspector, the TB leprosy focal person, I myself and the accountant. On average there are 10-12 members” (JDHM IDI 01 UG)

DHMT can be expanded to include stakeholders and in-charges of health facilities.

“If we are unable to solve the problem as the DHT we can involve other people like maybe the in-charges of Health sub districts, if it is beyond that and maybe it requires the human resource of course as this concerns mostly indiscipline of the workers” (JDHM IDI 02 UG)

“The one from TASO our implementing partners he has also actually joined the DHT, he is the district Health strengthening focal person” (JDHM IDI 02 UG).

There is no seniority criteria in selecting DHMT members. The composition is meant to include heads of sections/programme but sometimes the DHMT member is not the most senior person in the specific programme or section.

“For example in the office of the principal health inspector there is a health... a senior health inspector but the principal health inspector is the member of the DHMT” (JDHM IDI 02 UG)

The team has expanded during the implementation phase as suggested by this fragment of a field visit report in March 2014:

“There are new people on the team; the Biostatistician, the Assistant DHO (Maternal and Child Health) and the CDC/MakSPH Fellow.” (CRT Visit to Jinja DHMT March 20 2014 Report)

DHMT learning from other districts

In the PERFORM project, Jinja DHMT shared best practices with the other partner districts. The national and the inter-district workshops provided a platform for sharing.

“Regarding sharing expertise, like we had in the meeting (inter district meeting) they wanted us to go and show them how we came up with this concept of the league table and how we rank the facilities” (JDHM IDI 04 UG)

“It motivated me we moved on ground we shared with the DHO of that district we saw what they were doing, they were telling us how they have managed to improve on their workforce performances and really you could see that things are moving on well so when we picked on the strategies to apply here in Jinja especially on the human resource problems we at least had seen something in Kabalore that could also trickle our performances here and actually we tried much to at least copy from there and we used some of those skills even the infrastructures’ we really saw that there was some differences between Kabalore and Jinja that time but as per now I think we are also almost over running them because when we went for the previous meeting when we were sharing they were also appreciating that at least now you are almost ahead of us” (JDHM IDI 05 UG)

“...basing on the national workshop we attended in Fort Portal it helped us, this is an advantage through those, that workshop we were able to share as districts to share the problems and experiences within our district and then we compare and you see how you can really adjust to suit
in your own district because there was a lot of sharing and discussions within the workshop” (JDHM IDI 05 UG)

“...it also provided us with an opportunity to pick best practices from elsewhere other than what we are doing as district, you know in one of our dialects they say whoever who has not travelled will always consider the mothers the best cook, but when you get the opportunity to travel you get to know that the others that are doing it sometimes even a little bit better than their mother so when we went for this workshops it provided us an opportunity to compare notice what is it that we are doing well and what is it that probably we could have done better especially if we had opted some of the approaches that other districts were using” (JDHM FGD UG)

Jinja DHMT has been used as a model for other districts to learn from. The ministry of Health is piloting the new quality improvement frame work in the district and already, Jinja district has resource persons who provide mentorship to teams outside the district.

“As far as what we do is concerned, yes we do receive requests to share expertise outside the district” (JDHM IDI 03 UG)

DHMT Human Resource Practices

The DHMT supervises the lower level health facilities. They receive and analyse reports from the lower level health facilities. They plan for the health sector including the health workers in the district. They provide opportunities for mentoring, coaching where individual health workers and the teams working in health facilities are helped to improve performance. The DHMT rewards the health workers for good performance as one way of bringing about motivation. They can also take disciplinary measures to address poor performance and absenteeism.

“What I know of is that now the district has gone ahead to reward the best performers. So it has become a reward kind of performance management of recent. I think 2 months ago; there was a party here at the district where best performing facilities and best performing personalities were being awarded” (JDstake IDI 03 UG).

“We have a disciplinary committee here which sits monthly, if maybe we fail to resolve the problem the DHO can go and either write or engage the other people in the meeting and then they decide what to do” (JDHM IDI 02 UG)

“The ones who fail to PERFORM to expectation, we call them and we try to ask why they had to PERFORM that way. We also make them interact with the ones who perform well to share best practices on how they do things so that they can improve” (JDHM IDI 04 UG).

“If the person has been maybe been warned for example if it is absenteeism from duty, of course they will ask the person to explain and of course after may be the in-charge has told that person several times or has warned him or her several times and the person doesn’t change, that person will be called here to face the disciplinary committee” (JDHM IDI 02 UG).

Health facility managers seems to be central for bundle implementation as suggested by these fragments of the minutes of a DHMT meeting where staff attendance was being discussed:
“In-charges were urged to monitor when staffs should go for leave and should agree with the staff member on the appropriate time of going for leave.”

“In-charge should utilize field staff and utilize them as much as possible.”

“Some staff go for training without informing in-charges.” (Minutes of DHMT Meeting 2 January 2012).

DHMT use of action research in management

Links between action research steps

The DHMT reported how they followed the action research cycle to analyse problems, plan interventions to solve the problems, implement the interventions, observe their effects, and modify the interventions.

They reported that they discuss as a team how the activity has been conducted, what worked and what didn’t work well, if the activity has had its intended effects, and if necessary adjust the plan so that it may work better.

“We gave our ideas of what we wanted to track and this person developed the tools and it came back to discussing if that is what all of us had envisaged the tools to use, so it was not a straight line but you implement, come back and discuss - is this what you intended us to do? If not, how best could it have been done differently? If it is what we wanted, is it working? If it is not working, again we brainstorm - what could be the gaps that we never saw at the time of developing this plan?” (JDHM FGD UG)

They gave some examples of reflecting on the effects of the bundles, and adjusting the work plans (adding or modifying the strategies) so that the effects would be greater.

“During the sharing, when we, that we have been doing we have been identifying what works and what doesn’t work and somewhat it has trickled us to like adjust the work plan for example as we are implementing these activities we noted that at the end of all of it all if we don’t like recognize and reward the best performers somewhat the work force would not be motivated so this was not really part of our initial work plan but when we discovered that during the sharing that indeed rewarding and recognizing would help to improve performance of human resource we adjusted and captured that in our work plan” (JDHM FGD UG)

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Activity</th>
<th>Root cause</th>
<th>Effects of strategy</th>
<th>Learning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support supervision and</td>
<td>Training of staff in stores management and</td>
<td>Rational prescribing poor. No supervision of prescriber and mentorships</td>
<td>Provided detailed report on the</td>
<td>Involvement of unit in-charge is crucial. Mentorships for prescribers</td>
</tr>
<tr>
<td>monitoring of medicines and</td>
<td>rational prescribing</td>
<td>limited</td>
<td>findings to concerned staff</td>
<td>targeting medical officers</td>
</tr>
<tr>
<td>supplies management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Diary, 4/11/13)

The reported that they have developed the skills of identifying problems, prioritising them, developing plans to address the problems, implementing and continuously monitoring them.
“I just want to say that this team has worked with us very well we have got the skills of even monitoring the levels at which we have reached and we can also do a circle planning into these activities that we have identified as priorities activities and if we do well then we are able to look through the rest that we left out and prioritize others and continue improving on our services” (JDHM FGD UG).

“with the PERFORM project the lesson is that we went through told us or made us learn that at every point, there is at least a problem that creates barriers for good performance or for achievement in work and the lesson is that the PERFORM project has done well with us, teaching us how to identify problems, prioritize them, implement them, continue monitoring them” (JDHM FGD UG).

The paired partners reported that the DHMT found reflecting on the implementation and effects of the bundles as the most challenging step in the AR cycle. They thought that more support was needed.

“I wonder whether having more sort of more presence within the district to facilitate the action research cycles a little bit more and especially on the reflection part of those cycles and whether having somebody more present in the district might help that. Although that brings challenges in terms of sort of disturbing the kind of working environment of a DHMT” (Interview with LSTM team).

Lessons learned from action research cycle

The DHMT identified several lessons learned from implementing the action research cycle. First, a limitation of the project was to only include the DHMT. They felt that the facility managers and health workers would benefit from the PERFORM approach and this would help achieve better workforce performance.

“In my view all the health workers and the program managers at various levels would benefit from this approach. We would have realized even more results if we had involved for example the managers at health district and below” (JDHM IDI 03 UG).

Second, staff need to be fully oriented to use the diary so that it is a useful tool to help identify health system problems.

“One of the approaches used in this PERFORM project is the documentation journal so I see a challenge in that in the future if members are not oriented on how to use it they may not be able to document properly so we might miss out on the gaps that are existing in the system” (JDHM FGD UG).

Third, small problems that require few resources to solve may have a lot of impact on performance.

“Before PERFORM people would not pay attention to these problems even the small ones, they would just look at... ok if there is may be. Ok they would look for the big problems that require a lot of resources and; yet, the small problems also impact on our performance” (JDHM IDI 04 UG).

Fourth, it is important to address the root causes of problems if you want to address performance.
“If you want to improve on the performance of anything it is key that you address the root causes previously, when you look at the areas of human resource performance I think we were not really addressing the root causes” (JDHM FGD UG).

Application of action research lessons

There were a few examples of where the DHMTs have used the action research cycles in other aspects of their work. One DHMT member reported that in the DHMT meetings they now reflect on their activities and discuss as a team. Another DHMT member suggested that the PERFORM approach should be rolled out to other districts. During a visit to the district, the CRT reported that the DHMT had shared their experience of working with PERFORM with another district.

“We could come back again and say, how best could have this been differently and that in away was not only helped us to only consider the bundles that we selected at the time but it has become part and parcel of the day to day running of this office that sometimes when we are in our meetings we tend to brain storm on issues and we build consensus around what we have agreed upon not one person dictating the pace or the direction that we should take.” (JDHM FGD UG)

“I for one I have observed that really the PERFORM project has been an eye opener and it came in on time to kick start or to re-enforce us to be able to identify the problem and find ways in means of solving these problems because they have been with us and it was a matter of re-enforce... I feel that we being the pilot, this project should be extend to other districts also so that they can be able to be where we are.” (JDHM FGD UG)

“I would love to see PERFORM continue or even widen its mandate. I like PERFORM especially when it comes to performance appraisal. We have had challenges of translating this appraisal into the typical Result Oriented and Management, so if PERFORM came to assist the district to improve on this area definitely I have no problem and why does it not even spread to other critical areas? What limited PERFORM to only health workers?” (JDStake IDI 01 UG)

Workforce performance: process

Implementation of the bundles

DHMT members were involved in most of the bundles’ implementation and follow-up. They had successes and also met some challenges during the implementation. The health facilities where the bundles were implemented had to pick up from where the DHMT stopped and this did not happen especially in lower level health facilities. The PERFORM focal person coordinated the activities and the diary was used to document the activities. The Coordinator composed teams and provided schedules of PERFORM activities. The diary was used to review the implementation of bundles in the DHT meetings.

“what did not work well was the assumption that only the intervention that we needed to improve could happen without the need of any additional inputs, for example of performance appraisals, we knew that these performance appraisals are provided but we don’t dictate the time at which these forms will be available for us to be able to fill them and even where we have filled them, what did
not work well is that not everyone in the system from all the facilities appreciated these problems the way the DHMT had come up with the list of priorities” (JDHM FGD UG)

In order to ensure implementation and to stimulate health service performance DHMT used rewards and sanctions.

“Another activity that we have been implementing is rewards and sanctioning where we have systematically worked through to identify the best performing facilities and individuals and have been able to reward them” (JDHM FGD UG)

DHMT members monitor implementation during supervision visits during which district managers provide direct feedback to facility workers about their findings.

“We have been mentioning that when we go for support supervision and we have much interest around our bundles, the bundle of human resource and bundle of infrastructure, we look at the human resource how they are producing at the work place, the productivity of course productivity we are looking at their availability and looking at the availability’s results” (JDHM FGD UG)

“…when we go for support supervision, we don’t leave any facility that has been supervised minus giving feedback and in giving feedback at that level all these issues are reflected on like the issues of absenteeism” (JDHM FGD UG)

Most activity recorded in the diary shows emphasis on implementation of strategies dealing with supervision with a focus on the different programmes as this extract in Table 42 shows.

Table 42: DHMT diary extract

<table>
<thead>
<tr>
<th>Date and place</th>
<th>Bundle of strategy</th>
<th>Activity</th>
<th>Root causes</th>
<th>Effects</th>
<th>Way forward</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-21/02/2013</td>
<td>Health system</td>
<td>Support supervision of eye care services</td>
<td>Infrastructure well equipped</td>
<td>Discuss about missing supplies</td>
<td>Liaise with HSD manager for replacement and supply of equipment</td>
</tr>
<tr>
<td>5/03/2013</td>
<td>Medical supplies and equipment</td>
<td>Support supervision on stock management</td>
<td>Stock management and prescribing</td>
<td>Training store staff on store management</td>
<td>Hospital to organize a meeting with prescribers to improve prescription habits</td>
</tr>
<tr>
<td>4/10/2013</td>
<td>Health system</td>
<td>EPI support supervision</td>
<td>Management of vaccine stock-outs</td>
<td>Find out how we can manage vaccines to minimise wastage</td>
<td>Develop system to ensure vaccines availability</td>
</tr>
</tbody>
</table>

(Jinja Diary)

The DHMT has adopted some supporting measures to facilitate bundle implementation. For instance they have included HUMC in supportive supervision, they have budgeted USh 12,000 fee for support
supervision field visits and they have decentralized the use of the reflective diary to sub-district facilities.

“HUMCs have participated in integrated support supervision at health sub district (HSD) because it has technical officers namely; the representative of nurses, a clinician and a representative of staff who are very competent in supervising health workers. HUMCs have been able to raise critical issues regarding the performance of the in-charges at facility level.”

(Inter-District Workshop 2 Report)

“The district health office has mobilized and provides a daily rate of Uganda shillings 12,000 as a standard allowance or fee for support supervision.” (Inter-District Workshop 2 Report)

“The PERFORM diary was supposed to be stationed at the DHO’s office. We decided to proactively make copies of it and send them out to each HSD to document their activities…” (Inter-District Workshop 2 Report).

But supportive supervision is not the only strategy the DHMT uses to ensure appropriate service delivery. The DHMT also monitors that activities being reported by health facilities are really implemented.

“So before money is paid we are now going do spot checks, we go for support supervision but then after that we shall be going to where these people will have claimed to have done the work and we do cross checks to make sure the work has been done before paying. That is one of our strategies [ummmh aah] we also intend actually to go and interview the community members where these outreaches will be done or according to their schedules we have that, that plan of going to interview the community as... as a form of spot checks, so they tell us whether the immunization really was conducted” (JDHM IDI 02 UG).

By monitoring bundle implementation DHMT is able to modify and adjust the strategies, for example in improving performance.

“As we are implementing these activities we noted that at the end of all of it all if we don’t like recognize and reward the best performers somewhat the work force would not be motivated so this was not really part of our initial work plan but when we discovered that during the sharing that indeed rewarding and recognizing would help to improve performance of human resource, we adjusted and captured that in our work plan” (JDHM FGD UG)

The fact that PERFORM has no funding attached to the bundles was initially surprising for local administrators.

“when we mentioned that we are having PERFORM to guide us on performance and we shared with our local leaders, some of them were initially asking how did you start working with these ones when we have not approved the budget because they know that whenever you talk of a project, it has a budget and if it was not in the work plan, they have to approve so those are the issues that came up when we are trying to share with the leadership of the district” (JDHM FGD UG).

DHMTs followed up the implementation of bundle strategies even when they were already included in the original district work plan. Through communication among stakeholders, teams were composed
to implement the strategies. Stakeholders committed to support the interventions. Strategies like the attendance registers have not been fully adopted in all health facilities.

“Actually the factors which were important in implementing the activities in the PERFORM project with linkage to the district plan was actually communication which helped the harmonizing of activities that were originally in the district work plan which crossed to the PERFORM work plan. We have not duplicated any activity but we have implemented them at the right time and the right way we wanted to implement them” (JDHM FGD UG)

“I realized that for the success of these activities to happen it required a collective effort and each of us to be required because it is not all of us that were always familiar with or remembering what we had committed ourselves to do, so the issue of being reminded was one of the issues that were happening all the time” (JDHM FGD UG)

Problems with implementation of bundles

There are some factors that affected bundle implementation and that were not considered during the bundle development phase, such as the shortages of staff and consequent high workload hindering the implementation of some performance management strategies.

“Are there cases where understaffing seriously affects support supervision such that the supervisor is not able to do their work? Yes, you find one person doing everything at the health facility and they simply don’t have time for support supervisors (the supervisor has a lot of things to look at/ focus on so they end up not doing them).” (National Workshop 2 Report).

Stakeholders’ participation in bundle implementation

There are several stakeholders in the district, as reported in earlier sections. They provide technical guidance, funding, oversight, logistics support and supervision to the health sector. Some partners supported the bundle implementation as one way of strengthening the health system. DHMT lobbies the stakeholders for support depending on their mandate.

Among the stakeholders there are local senior civil servants in charge of key areas of the administration with strong influence on the overall health sector’s performance.

“…we have the political leadership, we have the administrators here under this we have the CAO, the sub county chiefs and also the service consumers of the health service delivery in the district. The Chief Administrative Officer and all these others under her are responsible for sanctioning our requisitions if we’ve asked for money. So if they are not part of the system and they don’t understand what you plan to do, chances are that they will not approve certain expenditures.” (JDHM IDI 03 UG)

There are also politicians who play a dual role: first, they are senior managers dealing with all sectors including health and second, they represent the community.
“The political leadership is important because they one, approve our budgets and work plans, two, they represent the community that we serve. They are the political supervisors of all the civil servants in the district so we need them on board” (JDHM IDI 03 UG)

There are NGOs and development organizations working in the district that support bundle implementation. Specifically their support consists mainly providing extra staff to cover gaps, facilitate transport, technical support during supervision visits and directly funding some of the activities that are beyond the district budget.

“Sometimes because TASO goes out most of the days to the Health facilities, if it happens that where they are going is where we want to go, we can use the TASO vehicle or the DHO can give us fuel for our activities that we want to do that we have reported to the DHMT meeting” (JDHM IDI 02 UG)

“The SURE project which used to facilitate the supervision and management of medicines in the district ended but there was still some facilitation in form of fuel to go out for support supervision...” (CRT Visit to Jinja DHMT March 20 2014 Report)

“...the partners have played quite a number of roles; one is where we had challenges of human resource in terms of numbers at HC II they recruited enrolled nurses for us they were twenty three for the health centre II...the other issue where development partners have been of help is that now our visits to the facilities have increased because they also pass here to at least involve one or two of us to be part of the team when they are going to do activities at the facility... ...they have also helped us by directly funding some of the activities in the district especially at health centre IIs and IVs... ... they provided us with technical people if we needed improvement in a given area” (JDHM FGD UG).

Workforce performance: effects
Perceptions of bundle design

There were no negative comments about the bundles designed, so it is assumed that the respondents were satisfied with them.

Perceptions of effects of bundles

When discussing the effects of the bundles, the respondents focused on four areas: supervision, appraisal, rewards systems and attendance monitoring.

Supportive supervision

The DHMT reported that there have been improvements in supervision. They have modified supervision tools so that they work better in their context. They found it useful to conduct regular quarterly supervision visits to facilities so that they can identify issues. They compared themselves with another district where quarterly visits do not happen. Jinja was selected by the MoH as a district to pre-test supervision tools because they were good at supervision.

“The original guideline, for example, for monitoring support supervision has been developed by Ministry of Health, but we’ve added our addendum” (JDHM IDI 03 UG)
“To give one positive story about the support supervision, strengthening support supervision in Jinja it happened that recently Jinja was looked at as a district, a single district in the country that has mentioned strengthening support supervision and even the ministry they were also updating some of their support supervision tools and they used Jinja for pretesting” (JDHM FGD UG).

“The other one is the follow ups during support supervision- what I have seen because of recent this survey we had, we first practiced it in Iganga. But if you went to Iganga and looked at what they do compared to what is done here in Jinja, is completely very different because for us we go quarterly for these support supervisions and going quarterly identified issues per unit is very useful to us” (JDHM IDI 05 UG).

Health facility managers also reported that supervision had improved: now both the supervisor and staff member identify and solve problems together. One manager reported that the visits had motivated the staff to keep the facility clean.

“The strength that the support supervision team for example identified in here was keeping our health centre clean” (JSDman IDI 01 UG).

“I think making support supervision to be more participative than facilitative and has really helped. If a staff has a problem, you work with her or him, find out what the problem is and how best you can solve that problem. It is no longer fault finding like it used to be. That you get somebody and you’re like no why is this like this, they look at it like policing. But now you make it friendly somebody may even think that you have gone for a friendly visit when actually you have gone for support supervision. And you are able to freely discuss and get the actual causes of problems which may be existing.” (JSDman IDI 04 UG).

The documents also revealed improvements in supervision: developing supervision schedules with partners so that there is no duplication in visits; spending longer at facilities to help solve problems; leaving a copy of the action points at the facility so that staff act upon them; improved data management and reduction in stock-outs.

“A number of things have changed in support supervision. For example, every planning and budgeting now has to include support supervision by both the DHMT and the partners. We pool resources, e.g. fuel from local and partner funding so that all can conduct support supervision in a team perspective. This arrangement ensures that each one can get at least fuel to go out for support supervision unlike when programmes were running parallel. The kind of support supervision happening now is in form of mentorship and we take more time at the facility and we are more practical now. For example, we constructed a washing facility at one of the health centres. The support supervision tools have been changed. We go conduct support supervision, come back and write a report with action points. We thought what we agreed would be implemented but they were not. Now the action points are recorded on carbonated paper and a copy left at the facility so that next time we can begin from there” (Report of CRT visit to Jinja DHMT March 2014).

“Supportive Supervision to improve quality of the delivery of health services within XXX HSD. Health workers are doing their best with limited resources available in the health facilities. Some gaps identified have been catered for especially in the area of immunisation. Data quality and storage has improved greatly. Gas and vaccine stock-outs are minimal.” (Diary, 3-5th April, 2013)
Appraisal

The DHMT members and managers reported that improvements in appraisal have been made: setting targets with appraisees, making forms available, ensuring that forms are completed on time, and as a result the proportion of people receiving appraisals has increased.

“And also appraisals now we are to ensure that these forms are in place and they are worked on in time” (JDHM IDI 05 UG).

“But in our achievement would be, we are able to appraise almost it is coming ninety something percent (90%) there.” (JDHM IDI 05 UG).

“Changes to work? The other thing is setting performance targets for the health workers such that they get to know what is expected of them at the end of the appraisal season. When you appraise them, they may not think that whether you are biased or what, but they’ll know that ok I didn’t achieve my target and what could be the reasons so that you support them to improve.” (JSDman IDI 04 UG).

However one DHMT explained that although the number of appraisals has increased, there are still problems with the quality of the appraisal.

“I think we have really gone a long way in those areas because now like in the area of appraisals but still the danger we still have is that the appraisals at different levels I think are not able to exactly bring out what we want at different health centres. It is now being done, the majority are really being appraised. But I think the standard of appraisals is still wanting. We still need to improve on the ability to handle those appraisal forms so that they really bring out exactly what we want”. (JDHM IDI 05 UG).

Reward systems

The DHMT members reported that the introduction of a rewarding system has helped motivate staff to work well. One DHMT member described how a manager of a health facility was rewarded for good performance and this has further motivated her and her staff to work as a team to provide services.

“…like the recent one that took place there is a certain health facility where there is an in-charge, she has been receiving rewards most of the time … When you go on the ground you cannot tell that that is the in-charge because you will find her sweeping, she will be involved in scrubbing, scrubbing she is everywhere; she is hard working. She has even encouraged others they actually work as a team; there is actually team work at her facility.” (JDHM IDI 02 UG).

“Because of the reward system that we came up with; to recognize the best performing, yeah, so that has motivated them to do their best knowing that at the end of it all, there is some recognition attached to it, however small it is” (JDHM IDI 04 UG).
Attendance monitoring

DHMT members and the majority of managers reported that introduction of the attendance register to health facilities has helped to monitor and reduce absenteeism. DHMT members explained that staff who are frequently absent are called to a disciplinary committee.

“Previously we were not tracking staff absenteeism because we did not have the tools. Now we’ve developed them and it has become part of the indicators that we report on” (JDHM IDI 03 UG).

“What I can say is that absenteeism rates have dropped, and these days people value their work” (JDHM IDI 04 UG).

“there is now reduced absenteeism because that time when it was much we were even forced to... with the PERFORM guidance (general support, workshops etc in PERFORM), we had to form a disciplinary committee under this department and it started off with its work disciplinary the people that were being identified as, who are practising absenteeism are now a normal behaviour in their work days so at least looking at how the rates were at that time and how, we see there is some reduction though I can’t mention the percentages I have not put them at percentages level but at least there is a reduction because the cases that we are disciplining now have reduced to one per quarter” (JDHM FGD UG).

Most facility managers explained that staff understand the importance of completing the attendance register. They must now give a reason for being absent and this has encouraged them to attend the facility. They also described how they identify staff who are absent and discuss the reasons for their absence. One manager explained the positive impact of staff arriving on time at the facility on the flow of patients through the outpatient department.

“Registering in attendance book has changed health workers’ presence at the health unit because there were some staffs missing without a reason. They have stopped missing since that book was brought. You have to miss with a reason...Because of the attendance register the in-charge is able to identify people who are absent and then discuss it with them. It all changed since the introduction of the attendance register” (JSDman IDI 01 UG).

“Like people’s perception towards something, For example what they say towards it makes you begin to know that may be people like it. For example, the attendance register, you find people coming to look for the register wanting to sign. Me I feel that is a positive sign and they are beginning to attach meanings to it. Things like, oh you know when people from the ministry come, they are going to ask for this attendance register, and those people who have not been attending may find it very difficult to prove that you have been working. So they are beginning to attach meaning/value to some of these things which is quite good.” (JSDman IDI 04 UG).

“There are changes in the methods of work. Well, for instance, I can cite one issue we had 'late coming' as a point, especially we have entry points like the OPD. This is where patients come in and until a clinician is around a patient may not go to the laboratory, and the clinician may be as late as 11:00 am; patients may report by 8.00 am. If the clinicians are see the first patients early enough at least by 9:00 the laboratory is functional. Then around 10.00 am our dispensing window is open such that if a patient came in by 7:00 or 8:00 at least minimum by 10.00 am he/she is attended to and if not for admission that patient can walk off with the drugs. We could start dispensing at
However, one manager had another view of the attendance book. He reported that not all staff want to use the book and be followed up about their attendance.

“Some people do not want to use the attendance book. They do not want maybe to be followed up. They say if they come and check when I was not here that day, what will they complain, what will they say, so I see as if when I introduce it, I will be the only one writing in it.” (JSDman IDI 02 UG).

Overall effects

Several DHMTs reported that the bundles collectively have had positive effects: ownership of what we do; and increased numbers of outpatients.

“We wanted to strengthen appraisal mechanisms that has improved, we wanted to reduce on staff absenteeism, that has improved, we also wanted to have ownership on whatever we do, and we think we are getting there”. (JDHM IDI 03 UG)

“OPD attendance has improved because of support supervision, appraisal and the attendance book”. (JSDman IDI 01 UG).

Context

Health system

Disruption in drug supply to health facilities was reported by some managers which affects not only the patient who does not receive the treatment required but also it affects worker’s motivation and consequently staff retention.

“Naturally I think they are demotivated. I could have a target but this quarter delivery of drugs delayed for over a month and what they brought was little and even right now as I am talking I have not gone for a second month without drugs and most drugs are little.” (JSDman IDI 03 UG)

Release of funds for salaries from central government is key for some essential areas of HRH which is beyond the control of the DHMT. No matter what the DHMT does to improve motivation and/or retention if salaries are not reaching Jinja that affects health workers’ productivity. This also affects the other DHMT activities such as training or promotions.

“…retention and sustainability – this is more of a government’s commitment by ensuring that it sends enough money to pay salaries, encourage capacity building, upgrading.” (JDStake IDI 01 UG)

“Like this year we had some delays in salary, and as human beings we can change according to the environment. If the salary is not coming and the guy comes from almost 15km and says I can’t make the 4 days transport up to this place without salary. How are you going to manage? Probably you squeeze and work two days a week.” (JSDman IDI 03 UG)
Other projects

As reported earlier, Jinja district has several projects supporting the district health plan. Some are supporting the HR/HS bundles or interventions that are aimed at performance improvement. Others are scaling up service delivery which requires health system strengthening at the onset. They support different parts of the district work plan and others operate an off-budget support to the DHMT or to the health facilities within the district.

“14. Partners- TASO, Evision, SURE, MSH, Family Hope, AFENET. Assist, Sight Savers, Save the Children” (Section of attendance sheet, DHMT meeting Minutes, 30th June 2014)

TASO is the most recognized partner supporting systems strengthening interventions. The DHMT directs the project support using the gaps identified during support supervision. As part of systems strengthening, TASO is supporting 22 additional staff in Jinja by paying their salaries.

“I came on a contract with TASO. TASO is the one supporting us, paying our salaries but it is working together with Jinja district.” (JSDman IDI 01 UG)

“...yeah it is actually included even now as we talk some supervision is taking place and even in the like Implementing Partner budget it for example here we have separate I don't want to call it donation it is support from TASO through CDC we budgeted for support supervision it is included.” (JDHM IDI 01 UG)

“...TASO has been able to recruit 22 enrolled nurses and these were placed in the identified gap areas in the different health facilities in the district.” (JDHM IDI 03 UG)

Other issues

Some activities are beyond the DHMT mandate. Recruitment in Uganda is done at central level. DHO’s power on staff deployment is limited to transfers within the District. Jinja is reported to have a 42% vacancy rate including some senior positions such as the District Assistant Drug Inspector. Staff ceilings and recruitment ban at District level together with low responsiveness from Ministry of Public Service to replace workers who left the district have caused some key positions to remain vacant for long periods of time.

“The position of District Assistant Drug Inspector (DADI) was vacant in the 12 months prior to this situation analysis.”, “...due to staff ceilings and the ban on recruitment, the vacant positions stay on for a long time even when they are critical.” (Description and Analysis of Human Resources for Health (HRH) within the District (Jinja), Situation Analysis Report).

However Jinja’s workforce has been scaled-up substantially in 2013 which could have represented a challenge in terms of HRM for the existing DHMT. However it seems that they feel they are able to cope with this extra burden thanks to the improvements achieved through implementation of bundles.

“Jinja has added on about 60 health workers in the recent (2013) recruitment drive. It is through appraisals that we were able to confirm all our staff within 6 months. Dialogues and reports on staff performance during appraisal helped us to collaborate with the district HR office to enable them understand the capacity and challenges of the DHMT.” (Inter-District Workshop 2 Report).
In fact comparatively Jinja is perceived as a privileged district in terms of staffing levels and recruitment and all is attributed to the persistence and leadership of the DHO and his team.

“It has been doing well now but also recruitment compared to other districts I think Jinja is far ahead in the staffing levels of course this is because the DHO and the staffs have to push and see to ensure these things are prioritized.” (JDHM IDI 05 UG)

Unintended effects

There is a perception of empowerment among DHMT members as suggested in this fragment of a field visit report:

“The DHMT were very positive about the effects of PERFORM, with one senior member saying: “PERFORM has empowered us”. As a result, the DHMT described how they had shared their experience of PERFORM with another district.” (Jinja District Visit Report November 2013)

The Ministry of Health and its partners have piloted new Supportive Supervision guidelines in Jinja district.

Conclusion and Recommendations for Jinja

Summary of findings for Jinja

• The DHMT was able to develop plausible plans for improving workforce performance based on more thorough problem analysis than would usually be done.

• These plans are being implemented and are showing some positive results in improving supervision. The plans have been modified and added to as more or different needs became apparent and should lead to wider improvements in performance management.

• DHMT members like the approach used to identify and analyse problems and develop relevant strategies. They are adapting some of the approach to their routine work, but some would like more continued support with this approach and more communication between participating districts.

• In spite of external constraints on the DHMT, they do have sufficient room for manoeuvre to address many problems they face at district level. There is now a critical mass in the management team with improved problem solving and planning skills.

Key recommendations for policy makers or Jinja DHMT

• Ongoing support should be provided to the critical mass of DHMT members to continue using the action research approach.

• Continue sharing experiences across districts – this appears to be beneficial and highly appreciated.
3.3 Luwero District

Findings from the situation analysis

Geography and demography of Luwero District

Luwero district is located in central Uganda region (see figure 1). It is bordered by Nakaseke district in the West, Mityana district in the southwest, Wakiso in the south, Nakasongola district in the North and Kayunga in the East. It has a total population of 440,311 people with an annual population growth rate of 2.6% and the main economic activity is subsistence farming.

Health Infrastructure

The district has got 4 health centre IVs, 23 health centre IIIls and 34 health centre IIs as shown in Table 43. Luwero district neither has a regional referral hospital nor a district hospital. It hosts a military hospital which can also be accessed and utilized by civilians.

Table 43: Number and type of facilities in the district by provider

<table>
<thead>
<tr>
<th>Type of facility</th>
<th>Government</th>
<th>Other/NGO</th>
</tr>
</thead>
<tbody>
<tr>
<td>District hospital</td>
<td>0</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Other hospital</td>
<td>1 military hospital</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Health centre IVs</td>
<td>3</td>
<td>1 (NGO)</td>
</tr>
<tr>
<td>Health centre IIIls</td>
<td>16</td>
<td>7 (NGOs)</td>
</tr>
<tr>
<td>Health centre IIs</td>
<td>20</td>
<td>14 NGOs</td>
</tr>
</tbody>
</table>

Health services provided depend on the level of health facility in the health service system. Services provided by different health centres levels are shown in Table 44.

Table 44: Services provided by health centres by level

<table>
<thead>
<tr>
<th>Health facility level</th>
<th>Health services provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>HC IV</td>
<td>General consultations, Mother and child health, Vaccinations, Theatre, Deliveries, Family Planning, Information and Education for health and laboratory services.</td>
</tr>
<tr>
<td>HC III</td>
<td>General consultations, Mother and child health, Vaccinations, Deliveries, Family Planning, Information and Education for health and laboratory services.</td>
</tr>
<tr>
<td>HC II</td>
<td>Preventive and a few curative services in OPD. Some do deliver mothers but the health workers there although they are qualified midwives are not supposed to deliver mothers.</td>
</tr>
</tbody>
</table>

Most Common Diseases

The five commonest diseases in a descending order in the district disaggregated by age group are shown in Table 45.
Table 45: commonest diseases by age group

<table>
<thead>
<tr>
<th>Disease priorities</th>
<th>Adults</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Malaria</td>
<td></td>
<td>1. Malaria</td>
</tr>
<tr>
<td>2. Diarrhoea</td>
<td></td>
<td>2. Diarrhoea</td>
</tr>
<tr>
<td>3. Injuries (especially accidents)</td>
<td></td>
<td>3. Severe acute respiratory infections</td>
</tr>
<tr>
<td>4. Pneumonia</td>
<td></td>
<td>4. Pneumonia</td>
</tr>
<tr>
<td>5. Skin diseases</td>
<td></td>
<td>5. Skin diseases</td>
</tr>
</tbody>
</table>

Human resources

Staffing: numbers, distribution, recruitment and transfers

Luwero district has 68% of the approved staffing positions filled but some of the health workers were on study-leave (not in actual service delivery). The 32% posts that were vacant include one doctor and 41 for nurses. The ratio of professional groups to people at the district level varied with the cadre of health worker: doctors – 1: 55,039; nurses – 1: 3,967; and midwives – 1: 8,634 people.

The district maintains records of the total number of government health staff (by type and number) employed in the district. Disaggregation of the existing professional staff at different health centre levels by gender shows that overall there are more females than males (see Table 46). Medical officers and Clinical officers were mainly males while the nurses and laboratory assistants are mainly females as shown.

Table 46: Number of professional staff by type of health facility and gender

<table>
<thead>
<tr>
<th>Health facility</th>
<th>Professional staff</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
<td>Total</td>
</tr>
<tr>
<td>DHO</td>
<td>6</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>Health centre IV</td>
<td>31</td>
<td>59</td>
<td>90</td>
</tr>
<tr>
<td>Health centre III</td>
<td>28</td>
<td>100</td>
<td>128</td>
</tr>
<tr>
<td>Health centre II</td>
<td>2</td>
<td>33</td>
<td>35</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>67</strong></td>
<td><strong>197</strong></td>
<td><strong>264</strong></td>
</tr>
</tbody>
</table>

The numbers of professional staff recruited and those who left are shown in Table 47.

Table 47: Staffs recruited and those that left their jobs within the last 12 months

<table>
<thead>
<tr>
<th>Professional group</th>
<th>Number of new employees</th>
<th>Number of staff who left(^9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Nurses</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Midwives</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Bio-statistician</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Clinical Officers</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

\(^9\) Staff that resigned or left for other reasons apart from transfers, illness or job termination.
No doctors, nurses and midwives employed by the government were transferred into or out of the district in the 12 months preceding this situation analysis. Normally staff have to apply and compete for vacant positions if they want to move to a different district. Government employed staff who were transferred within the district (e.g. from one health facility to another health facility within the same district) within the 12 months preceding this situation analysis are shown in Table 48.

Table 48: Staff transfer within Luwero district

<table>
<thead>
<tr>
<th>Professional group</th>
<th>No. staff transferred within the district</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
</tr>
<tr>
<td>Doctors</td>
<td>0</td>
</tr>
<tr>
<td>Nurses</td>
<td>0</td>
</tr>
<tr>
<td>Midwives</td>
<td>0</td>
</tr>
<tr>
<td>Health information Assistants (records)</td>
<td>1</td>
</tr>
<tr>
<td>Clinical Officers</td>
<td>5</td>
</tr>
<tr>
<td>Laboratory assistants</td>
<td>2</td>
</tr>
<tr>
<td>Health inspectors</td>
<td>0</td>
</tr>
<tr>
<td>Health Assistants</td>
<td>0</td>
</tr>
</tbody>
</table>

District Management Structure

**District Development Committee**

There is a District Development Committee. It has guidelines on its function and responsibilities. The District Development Committee held quarterly meetings in the past 12 months. There were records (i.e. minutes) of these meetings. The structure has authority to make decisions on:

- District health plans
- District health budget
- Personnel e.g. recruitment, posting or transfers
- Purchase of drugs and other medical supplies

**District Executive Committee**

There is a District Executive Committee. It has guidelines on its function and responsibilities. The District Executive Committee held monthly meetings in the past 12 months. There were records (i.e. minutes) of these meetings. The structure has authority to make decisions on:

- District health plans
- District health budget
- Personnel e.g. recruitment, posting or transfers
- Purchase of drugs and other medical supplies
**District Health Management Team**

There is a District Health Management Team. It has guidelines on its function and responsibilities. DHT held monthly meetings in the past 12 months. There were records (i.e. minutes) of these meetings. The structure has authority to make decisions on:

- District health plans
- District health budget
- Request, post or transfer personnel and inform the Chief Administrative Officer (CAO)
- Purchase of drugs and other medical supplies

**District Health Management Team**

**Composition**

The District Health Management Team prescribed by policy should be made up of the District Health Team (DHT), in-charges of health sub-districts, health development partners (e.g. NGOs and other stakeholders). The DHT is composed of the DHO, Assistant DHO (Maternal and Child Health), assistant DHO (Environmental Health), District Nursing Officer, District Health Inspector, District health Educator, Biostatistician and District Assistant Drug Inspector. The list of existing members of the Luwero District Health Management Team, their roles and gender in the district is shown in Table 49.

**Table 49: District Health Management Team, their roles and gender in the district**

<table>
<thead>
<tr>
<th>DHMT Post</th>
<th>Role(s)</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHO</td>
<td>Overall in-charge of overseer of Service delivery</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Acting ADHO/MCH</td>
<td>In-charge of overseeing Maternal Child Health activities and supervision of all the Nurses and Midwives</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Acting ADHO/EH</td>
<td>In-charge of overseeing Environmental Health activities and supervision of the staff that fall under this department</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>DHE</td>
<td>In-charge of the Health Department and the staff there under</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>HMISFP</td>
<td>In-charge of the district data and the staff there under</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>DADI</td>
<td>Responsible for ordering and distribution of all the medicines and medical supplies in the district</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Biostatistician</td>
<td>In-charge of the district data and the staff there under</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>DSFP</td>
<td>Responsible for all Epidemics and emerging diseases (Disease surveillance manager)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Secretary for Health</td>
<td>Political leader</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>HSD Heads</td>
<td>Supervisory roles in their respective HSDs (DHOs of their respective HSDs)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Accountant</td>
<td>In-charge of the finance and financial transactions of the department</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
One DHMT member was changed in the previous 12 months to this situation analysis; he went to Kalagala health centre IV that had leadership problems which had caused performance to deteriorate.

There were three (3) vacancies unfilled on the DHMT over the past 12 months; two Assistant District Health Officers and one Cold Chain Technician.

**Functions of the DHMT**

Functions of the District Health Management Team include: leadership and governance; planning and budgeting; supervision, monitoring and evaluation of health service delivery; implementation of national health policy, health sector strategic and investment plan.

The sorts of issues discussed at DHMT meetings include:

1. Issues related to performance of health facilities and their respective staff as well.
2. Issues of Human Resources for Health (HRH)
3. Planning for different health programmes
4. Performance review of quarter, bi-annual and financial year periods
5. Discipline of staff such as absenteeism of staff

**Decision making processes within the DHMT**

Decision making by the DHMT is guided by gathered documented evidence, observations, existing policy and Standing Orders. Higher levels (national) do not influence how and which decisions are made by the DHMT.

Written evidence on how the DHO spends his 5 working day of the week was not documented. However, a recall on how he spends this time is shown in Table 50.

**Table 50: Average percentage of a 5-day working week the DHO spends undertaking management tasks**

<table>
<thead>
<tr>
<th>Management task</th>
<th>Percentage of time spent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending meetings within the district</td>
<td>20%</td>
</tr>
<tr>
<td>Attending meetings outside the district</td>
<td>10%</td>
</tr>
<tr>
<td>Visiting health facilities</td>
<td>20%</td>
</tr>
<tr>
<td>Supervision/mentoring</td>
<td>30%</td>
</tr>
<tr>
<td>Receiving visitors</td>
<td>10%</td>
</tr>
<tr>
<td>Others (please specify)</td>
<td>10%</td>
</tr>
</tbody>
</table>

Members of the DHMT had the resources they needed to perform their routine duties in the past three months as planned.

**The DHMT and Performance Management**

The main methods of performance management are job descriptions, mentoring, supervision, performance appraisals and the management of conflicts and discipline. These are described in more
detail below. There is no functioning system for allocation of financial incentives to staff based on performance. There is no incentive related to performance in terms of money.

**Job descriptions**

Some staffs received job descriptions. Job descriptions are given only in the job advert which comes out in the newspapers and tend to remain there. DHMTs reported that recruits should be given hard copies of written job description on recruitment. In-charges are given letters spelling out the duties and responsibilities. It was reported that there is a plan to give written job descriptions to all health workers.

**Mentoring arrangements**

Mentoring arrangements exist for some staffs. There are no district funds earmarked for mentoring staffs. It all depends on individual programmes. When done it takes place every 5 months according to need.

**Supervision**

Supervision exists for all staffs. It has the following characteristics:

1. Mix of technical and political supervision
2. Integrated technical but mixed team – checks on the internal support supervision
3. Program specific support supervision
4. Internal support supervision – done by in-charges of health facilities for their staff.

Supervisory visits were made by the district health management team to district hospitals and district health centres during the last six months. They are planned to be quarterly support supervision visits and all the planned support supervision visits were actually done. There are records on these visits available for review. There was a schedule for planned supervisory visits by the DHMT and a supervisory protocol/checklist which covered all district programmes/activities.

There were also impromptu support supervision exercises by partner programmes like there was an Ebola epidemic in the area in 2012; one by Mild-May (joint support supervision), one with Strengthening Decentralization Services (SDS) project, and another one supported by Protecting Families Against AIDS (PREFA). The latter involved all the big health sector players. These were not initially planned. Records on these visits are available.

**Performance appraisal**

Performance appraisal exists for all staffs. It has the following characteristics:

1. Staff on probation are appraised at 3 months and 6 months of service
2. Confirmed staff are appraised annually
3. DHO writes circulars/memos to all health facilities …. “please appraise health staff” and the DHO signs for the lower level health facilities.
4. At the DHO level, heads of sections appraise their subordinates and the DHO countersigns
5. Performance appraisal has not been used to monitor staff productivity.

The DHO asks for health facility meeting minutes and attendance list. The message is given to health facilities and is followed up to HSD in-charges.

Managing conflicts and discipline

The DHMT plays role in managing conflicts between staff in the district. The DHT has a management disciplinary committee. Health facilities do not have such committees but the DHT handles these issues. This has not been working because the chairperson died. It reports to the CAO. Its mandates are:

1. Handling conflicts
2. Handling issues of discipline
3. Resolving complicated issues. “we had two disciplinary issues last year which were resolved by this committee” (DHMT member).

The disciplinary actions available to the DHMT depend on the gravity and frequency of the offence. The actions taken include:

1. Caution: audience with the affected person is sought and he/she is given a caution if proved that the offence was committed
2. Ask the CAO to withhold the salary if need be
3. Refer to the affected person to the district disciplinary committee where the suspected culprit is presented for consideration
4. The accused can write to protest the accusations against him/her

Health Systems Building Blocks and their Relationship to HRH

HMIS

HMIS reports for the previous 12 months were available. All health facilities do report. Level of completeness of the reports is at 100% but reports are received from 98% of the health facilities due to some NGO facilities which do not submit reports. There are administrative issues in NGO facilities that are failing to report but majorly understaffing is a problem followed by lack of transparency on the financial releases.

The district health plan is prepared using the data from the HMIS. ‘Like in resource allocation, we use output. Those with less receive less (less in terms of staff and funds) like Kasana HC IV is a highway facility and has a higher OPD attendance than any other HC IV. It receives 10 millions annually while the rest get 8 millions each’ (DHMT member).

There are two systems for recording human resources data in the district: an Excel-based programme, and the human recourses information system (HRIS), both supported by the Uganda Capacity Programme. This programme trained the district HMIS focal person and Secretary to the DHO in HRIS. One desktop computer to manage the HR data was also received.
Service Delivery

Health care services in Luwero district are offered by the different levels of health care are shown in Table 51.

Table 51. Health care services offered by the different health centres

<table>
<thead>
<tr>
<th>Type of facility</th>
<th>Services provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 HC IVs</td>
<td>General consultations, Mother and child health, Vaccinations, Theatre, Deliveries, Family Planning, Information and Education for health and laboratory services.</td>
</tr>
<tr>
<td>24 HC IIIs</td>
<td>General consultations, Mother and child health, Vaccinations, Deliveries, Family Planning, Information and Education for health and laboratory services.</td>
</tr>
<tr>
<td>40 HC IIs</td>
<td>Preventive and a few curative services in OPD. Some deliver mothers but the health workers there although they are qualified midwives are not supposed to deliver mothers. The Midwives are for ANC and PNC. Their performance is not measured on the deliveries conducted. Very remote areas are considered high alert facilities for the ambulance to carry the women in labour.</td>
</tr>
</tbody>
</table>

Information on the number of occupied bed days in the previous 12 months per health facility was not available. It was reported that some development partners bought and distributed beds. Some facilities have more patients than their bed capacity and have patients sleeping on the floor. Districtwide, there is 97% bed occupancy. Kasana HC IV has 16 beds in maternity instead of 8.

Supplies and Technology

The delivery of supplies is on a monthly basis for all the government facilities in the district. The HC IIIs and IIs receive drugs through the push system while the HC IVs make their own requisitions (pull system).

Information on the stock out of the five most frequently used medicines in the district is provided in Table 52.

Table 52: stock out days on five most frequently used drugs / supplies

<table>
<thead>
<tr>
<th>Five most frequently used drugs / supplies in the district</th>
<th>Number of days in the previous year when drug/supply was out of stock</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Artmether/Lumefentrine 120/20mg</td>
<td>154</td>
<td>HC IVs are always the first ones to register stock outs because of referrals. Patients prefer HC IVs because there are doctors, theatres, scan and lab services</td>
</tr>
<tr>
<td>Cotrimoxazole 480mg</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Dextrose 5%</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td>Disposable gloves</td>
<td>227</td>
<td></td>
</tr>
<tr>
<td>Tabs. Quinine Sulphate 300mg</td>
<td>263</td>
<td></td>
</tr>
</tbody>
</table>
Luwero HC IV has got a functioning oxygen tank and supporting equipment for resuscitation (for both adults and children). There is a need for a second oxygen tank and supporting equipment for the theatre. Currently they have an oxygen concentrator. The health centre experiences Oxygen shortage and the repair of the machine is by Ministry of Health engineering division.

**Governance and Leadership**

There is a district health plan that runs over 12 months (i.e. financial year). There is a district human resource (HR) plan. It is integrated into the district general plan.

The District Service Commission recruits health workers, and the DHO on behalf of the CAO posts and transfers staff within the districts.

The DHMT held meetings with the health facility and community representatives. The existing VHTs are not fully active. They were trained by AMREF. In January 2012, the DHMT held a meeting with the VHTs. Lack of a budget for the VHT members is the sole reason for not working. There is no budget line and VHTs’ reporting tools are too expensive to reproduce. They are mainly used in health campaigns e.g. Family Health International uses them to promote family planning while STRIDES uses them in Nutrition programmes in 3 sub counties.

There are national policies on health workforce performance but there is no key interest in implementing the policies.

**Finance**

The district has an annual health budget. Sources of funding for the district health budget were the central government and developmental partners. The DHMT, together with all the health facility incharges, prepares the district health budget. Luwero District Council approves the district health budget. The DHMT has a limited role in the allocation of funds to activities for the current financial year as shown in Table 53.

<table>
<thead>
<tr>
<th>Area</th>
<th>Level of authority</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full</td>
</tr>
<tr>
<td>Paying staff salaries</td>
<td></td>
</tr>
<tr>
<td>Paying staff allowances</td>
<td>☒</td>
</tr>
<tr>
<td>Hire additional staff on contract</td>
<td>☒</td>
</tr>
<tr>
<td>Purchasing drugs</td>
<td>☒</td>
</tr>
<tr>
<td>Purchasing other supplies such as linen, stationery, cleaning materials</td>
<td>☒</td>
</tr>
<tr>
<td>Purchasing equipment</td>
<td>☒</td>
</tr>
<tr>
<td>Repairing equipment</td>
<td>☒</td>
</tr>
<tr>
<td>Maintaining buildings</td>
<td>☒</td>
</tr>
<tr>
<td>Maintenance vehicles and motorcycles</td>
<td>☒</td>
</tr>
</tbody>
</table>

Table 53: Luwero DHMT's level of authority to use its budget

Luwero district has financial monitoring systems that are used for monitoring execution of the district health budget as shown in Table 54.
NGOs send their external auditors to conduct both programmatic and financial accountability.

<table>
<thead>
<tr>
<th>Structures</th>
<th>Existence</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial records</td>
<td>☒</td>
<td>☐</td>
</tr>
<tr>
<td>Accounting procedures</td>
<td>☒</td>
<td>☐</td>
</tr>
<tr>
<td>Financial reports</td>
<td>☐</td>
<td>☒</td>
</tr>
<tr>
<td>Periodic auditing visits</td>
<td>☒</td>
<td>☐</td>
</tr>
<tr>
<td>External audits</td>
<td>☒</td>
<td>☐</td>
</tr>
<tr>
<td>Medicines and Health services</td>
<td>☒</td>
<td>☐</td>
</tr>
<tr>
<td>delivery monitoring unit</td>
<td></td>
<td>☒</td>
</tr>
</tbody>
</table>

NGOs send their external auditors to conduct both programmatic and financial accountability.

A breakdown of the health expenditure of the district for the past financial year (excluding salaries for health workers) was: recurrent costs of the Uganda National Minimum Health Care Package or UNMHCP (2.3 Billion); PHC Development grant (139 million), and PHC NGO conditional Grant (181 million).

There was a budget allocation for staff salaries and allowances. Salaries are paid by the Central Government with approval from the district Chief Administration Offices, and money is wired through the electronic fund transfer system to individual staff bank accounts. The input of the DHMT in the planning of the salary budget for district health staff is “we normally do payroll cleaning, make changes and also advise central government on staff in post on a monthly basis.”

There is no separate budget for financial incentives for staff. All incentives are incorporated in the salary (i.e. lunch, transport, housing allowances, etc). Central government pays the district staff salaries directly to their bank accounts. Salaries are generally paid on time.

**Key Challenges on HRH within the District**

The DHMT facilitated by the CRT revealed the following challenges faced by the district.

1. Inadequate human resource
2. Demoralised health workforce due to low pay and poor working conditions
3. Inadequate/dilapidated infrastructure including staff houses
4. Inadequate medicines and health supplies
5. Increasing emergencies such as epidemics, disease outbreak and road traffic accidents
6. Gaps in leadership and management positions at different levels of health service delivery; some managers are health professionals who do not have any management or leadership training and therefore require some capacity building
7. High levels of staff absenteeism and late coming in health facilities
8. Over decentralization of health services
9. Lengthy procurement procedures hindering timely implementation
10. Restrictive demands of the new financial system has slowed down programme implementation
11. Lack of uniforms for health workers
12. Limiting budget for wages
13. Limiting promotion slots in the staff structure
14. Most health centres were not able to pay their utilities (water/electricity) throughout the year
15. All department vehicles are very old (maintenance costs are too high)
16. Ministry of Finance, Planning and Economic Development sometimes do not follow our HR requirements submitted to the Ministry of Public Service leading to short falls in wage.

Findings from the evaluation

Management strengthening: processes

Support given to the DHMT

The DHMT members reported that the PERFORM project supported the DHMT in a variety of ways.

National workshops and inter-district meetings

The DHMTs reported that the workshops helped them conduct in-depth problem analysis, identify the root causes of the problems and develop possible solutions to the problems. Through these interactive workshops and meetings the PERFORM team provided technical support to the DHMT. The DHMT explained that the workshop setting away from the office provided a conducive environment for discussion. The workshops and meetings also allowed for sharing of experiences, learning and benchmarking with other districts.

“The workshop approach was very good because it was bringing people from different districts and different problem together, and they would share their experiences and reflections. Then we also could see what the other districts were doing and copy some of the things we felt they were positive and took them on board. There were synergies where those people strengthened where you have a weakness. You come back with renewed energy to work.” (LD FGD UG)

“From the meeting we had in Fort Portal (Kabarole district) we narrowed down to (i.e. we agreed to focus on) professionalism as our problem. We developed HR/HS bundles to address the problem. We drew a work plan in consultation with the district work plan and started implementation.” (LD FGD UG)

“The workshop based approach model was advantageous in the sense that we were three districts. This made more than one eye to look at the problem analysis, the problem tree, the strategies, the objectives and then get a consensus beyond one district DHMT. This was very advantageous in terms of making people to concentrate while away from their district offices i.e. the workshop environment facilitated concentration and productivity.” (LD FGD UG)

“The whole process has been interactive with the district and we got technical support from the PERFORM team.” (LD FGD UG)

“Problem analysis as a process is very useful and critical. For example, you have a problem of under immunization of in the district; instead of the having 90% or 85% and you are at 80%. Then
you use the problem analysis methodology to identify the gaps and possible causes and solutions. That is also a contribution by PERFORM project. The PERFORM project has helped us in our work, it has helped the district.” (LDHM IDI 04 UG)

“I think we have worked together with the country research team using quite a wide range of approaches, one of it has been conducting meetings and they would work really as facilitators or guides, for that matter we have been engaging each other on emails this was also a means of guiding us to do the right thing and the other aspect has been bringing the three districts together or the three teams together as means of solving and these meetings the research team has been there as in over see a team to guide the districts to take the right course of action.” (LD FGD UG).

“Sharing performance in inter-district meetings helps to identify strengths and gaps in the district and create a way forward.” (Luwero presentation at inter-district meeting, July 2014)

National workshop 1 report described that DHMTs were facilitated by the CRT and the European paired partner to refine their problem statements and to identify additional data requirements for their situational analysis reports. DHMTs appeared to value the support given to refine the problem analysis, finish their reports, and looked forward to the next workshop.

In National Workshop 2 report, a plan for communication between the DHMT and CRT was developed as it was recognised that communication was important during the implementation phase of the project. This included: visit by CRT 6 weeks after the workshop, 6 monthly inter-district meetings, weekly telephone communication by CRT, creation of a Facebook page and e-mail newsletter to enhance sharing of experiences and lessons learnt amongst the DHMTs.

Inter district reports described the objectives of the workshop as enabling DHMTs to share progress and experience with implementation of the bundles, sharing lessons learnt about problem solving and improving HR performance, developing an action plan to improve the implementation of the bundles.

The CRT and EP reported that the DHMTs, despite being very busy, managed to get together and communicate effectively face to face during inter-district meetings which were organized by the CRT. The good relationship and fluid communication that the CRT had with the three DHMTs helped in achieving good attendance to these meetings.

“one of the CRT talked about was that these inter district meetings when the DHMTs came together, 3 of them the 3 teams came together and a lot of them came to those meetings and I know that one of the other development partners had commented that ‘how on earth do you get those DHMTs to come to these meetings because we haven’t been able to do that’. So somehow you know the [good] relationship between the CRT and the DHMTs has enable these meetings to happen and I think that is probably due, well maybe partially due to good communication with them, good relationships with them and I think also the way that those meetings happened and the way that the DHMTs communicated with each other in that meeting and the way that CRTs were facilitating that process was very useful and very effective I think.” (Interview with LSTM team)
Use of the diary

The DHMT also reported that the PERFORM team helped them to document their activities and learning through the use of the diary. Over the course of the project, they adapted how they used the diary.

“Over time there is a lot that we have learnt that documentation is very critical. We started with one book (‘PERFORM Diary’) which was rotated between the DHT and health sub districts. Now we have a book (‘PERFORM Diary’) at each health sub district level.” (LD FGD UG)

CRT visits to the districts

The CRT made a number of visits to Luwero district to discuss progress with the PERFORM project with the DHMT: the implementation of the bundles, any challenges encountered, reflections on the implementation and effects, and the use of the diary to document any learning. For example, a visit report mapped out the agenda for the meeting:

“Agenda
1. Update on the implementation of the bundle
1. Look at the diary and discuss its use
2. Strengthening communication
3. Test the new tool
4. AOB” (CRT meeting Luwero DHMT 17 March 2014)

Analyses of problems that DHMT face

Main problems identified (initial problem analysis)

Records from DHMT meetings held in April 2012 suggest that the two main problems in the district were absenteeism and staff shortages which subsequently leads to work overload.

“An abrupt supervision was conducted by the ADHO/EH and the findings established the following:

• Some (6 out of 10 facilities) visited did not have their in-charges present on duty
• Xxx Health Centre was found open with patients waiting but no staff to attend them

It has been noted that some health workers sub-contract other people to do their work the chairperson informed members”. (DHT meeting minutes 16/04/2012)

This problem was later confirmed by a DHMT member during his interview.

“The problem was some facilities were understaffed and there was work overload.” (LDHM IDI 02 UG).

During National Workshop 1 in October 2012 problems identified during the situation analysis were discussed and consensus was reached on the following:
Problems were discussed and further analysed during National Workshop 2 in February 2013. Figure 8 shows how the DHMTs discussed and displayed the problem tree analysis.

Figure 8: Luwero team discussions during National Workshop 2

The four main problems leading to the poor performance of the health sector in Luwero agreed during this second workshop and included in the problem tree were 1) Poor recognition systems, 2) lack of effective communication within the team, 3) lack of shared vision, and 4) absenteeism (Figure 9)

Figure 9: Luwero team discussions during National Workshop 2

<table>
<thead>
<tr>
<th>Luwero</th>
<th>1. Lack of Professionalism</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Poor Communication</td>
</tr>
<tr>
<td></td>
<td>3. Inadequate Capacity building</td>
</tr>
<tr>
<td></td>
<td>4. Inadequate medicines/equipment/supplies</td>
</tr>
<tr>
<td></td>
<td>5. Inadequate Support Supervision</td>
</tr>
</tbody>
</table>

(National Workshop 1 Report)
The reactions of the NW2 participants to the presentation of the problem tree by Luwero District were focussed on 1) low professionalism and 2) weak management and leadership capacity.

“Low professionalism was considered their main problem. The discussion, however, whether questioned this was a main problem with some participants suggesting the problem may be lack of ethics.” (National Workshop 2 Report)

The induction of health workers that goes on in the district is lacking; there is no training and no induction in the area of management and leadership. Medical officers from university hardly have any training and skills in human resource and financial management.

“Is there a way mentorship can be done in these districts/teams?” (Main points of discussion after presentation of problem tree by Luwero District, National Workshop 2 Report)

Sources of information about problems

The main sources of information cited for problem identification were supervision visits and periodic reports. Problems identified through interaction with health staff working in facilities are then shared with the rest of the team during DHMT meetings where discussions on how to address them are held.

“Problems are identified in very many approaches. At times we identify problems through support supervision, then one on one interaction of the lower level staffs and at times of review of data and when you look at performance and you see that reports are talking about stock out of vaccines stock out of medicines, then those are the issues we have to look at in the meeting and devise means of addressing them.” (LDHM IDI 02 UG).

Prioritization and analysis of problems

Problem analysis was perceived as being useful not only for problem identification but also to prioritize which problems can the DHMT address and which ones they cannot depending on resource availability.

“It is very useful because you can’t, there are so many problems; you have to make a priority and try and sort them out and see which one you can handle.” (LDHM IDI 01 UG).

In analysing the problems the DHMT considers potential barriers such as the influence of external agendas, political interferences or complex bureaucratic processes.

“…if an external force is needed it can also hamper you because they will come in their own time and may be you wanted to do it fast, but then you are hindered. And then if it is political you find it has so many issues to deal with it, it may hinder you. And then also if it is to go through the tendering process and those processes may be cumbersome.” (LDHM IDI 01 UG).

On the other hand factors that are perceived as facilitating the analysis are more related to the inclusiveness of the process. The role of the CRT in supporting the DHMT and sharing findings of the problem analysis with other districts was mentioned as a driving factors.
“...the second aspect is the continuous dialogue between the research team [CRT] and the DHMT and sharing with the other districts involved, I think this itself was a driving force that led us to achieving the results.” (LD FGD UG)

Also related to the inclusiveness of the process, involvement of lower levels of the system was found to be essential to ensure feasibility and sustainability of the interventions proposed.

“...the third aspect is people understanding the problems they were addressing because you appreciate that this is like bottom up approach, they raised the problems, they analysed the problems and the problems became part and partial of them and this meant that even the activities would follow shortly, so personally I think these factors led to the success we are talking about.” (LD FGD UG)

Issues faced by DHMT in gathering information about problems

Some members of the DHMT interviewed suggested that despite the whole process of problem refinement having helped in defining the problems further there was still need to assess the scope and definition of the problems identified.

“Initially our ideas were big, we were thinking too big and I think that was a challenge. Even in our meeting in Fort Portal (NW2), where all the districts were together, we were still finding it difficult to define certain concepts.” (LD FGD UG).

The team finally agreed to narrow the problems down to “professionalism” for which a bundle of interventions was later defined.

“From the meeting which we had in Fort Portal we narrowed down to professionalism, we worked on it, and we put it into bundles.” (LD FGD UG)

Further problem analysis

There is no data from the interviews, FGD and reports about further problem analysis.

Selection of bundles

Selection of initial bundles of interventions

The DHMT members described the way that they selected the initial bundles of interventions. They linked it to the problem analysis. At the beginning the DHMT identified many problems but then went on to prioritise and classify them into those that can be addressed immediately by the district using available resources and those that cannot be done at district level or that can be done at national level. They focused on the issue of low professionalism.

“We came up with a number of areas; ethics and professionalism, human resource, drugs, supervision but eventually we started narrowing down because we were required to prioritize things to do without extra cost. They were also system problems which can be addressed by the DHMT
without an extra cost. Then we developed workable solutions within our reach to address.” (LD FGD UG)

“We focus on the root causes. Mainly we focus on the root causes. We look at those causes because each cause is a problem. So we look at the causes, we list them down. We see which we can solve immediately, which can take long to be solved, so we start with those that can be solved immediately. Then we draw an action plan and then move forward.” (LDHM IDI 03 UG)

“...the strategies which we had to make sure that have to improve the staff understanding and general work plan, feedback on performance and this included the updating of that staff job description, induction and orientation of staff then and also regular open appraisals. Then we also we had another strategy on improving the daily and weekly feedback on performance whereby we had to see that the facilities are able to use their work plan and also to develop and use their work plans and we had to share the annual work plans, targets and performance during the team meetings. And also another strategy was to increase the number of staff present at work place where we had to do attendance monitoring and we had to introduce monitor attendance registers this is where we introduced the arrival books and also we improved on the way of making the duty rosters because before some facilities were giving themselves a week off and then a week on duty then we revised those duty rosters. And also under that strategy we had to train the health unit management committees on supervision and monitoring the. Another strategy was on reward and sanction whereby we had to introduce team incentives and also we had to give staff additional responsibilities and to give to issue verbal and written warnings to those ones who are not performing well and also under that rewards and sanction we had planned to dismiss whoever is not performing well in the district. Then we had another strategy on health system whereby we had to monitor staff productivity re-arrange delivery of the service to make best use of it and also to involve staff in problem solving.” (LD FGD UG)

The DHMT reported that as a team they looked at the entire health system (the six blocks) and identified areas in each block that could be paired with the human resource issues to address the problem of low professionalism. They selected strategies taking into consideration the DHMT manual, relevant policies, the district work plan and the resources available.

“We looked at many parameters; the DHMT manual, the existing laws and policies, the work plan that we had already made and the resources available both in terms of skills and man power. This helped us to zero down on activities and we prioritized those that we could do immediately done especially those that were at the district level and then those we would do later. We also prioritized those that we could be done at the district level and those that required national level intervention.” (LD FGD UG)

“I think when we were analysing our problems we made bundles and after making bundles we looked at the big area in which we looked at the objectives, we looked at the activities and eventually made a work plan, this was done as in district specific though discussions with guidance from the team from school of public health and Liverpool I think that is partly what we did.” (LD FGD UG).

“There was no major challenges, it was developed by a team and the background of PERFORM is to build a team and systems, so we worked out the plan as a team as looking at implementing these
activities versus the other routine activities on the general plan of the department and most activities were agreed upon by the team” (LD FGD UG).

However, one DHMT member reported that the CRT taught them how to develop the bundles in the workshop, but as there were so many issues to discuss, they randomly selected interventions.

“The strategies to choose, actually as we were with the research country team they taught us the bundles, how to make bundles. However when we are seated there because of the many issues to discuss you may fail to make bundles and you just choose randomly” (LDHM IDI 03 UG).

In National Workshop 2, the bundles were developed next to the problem tree and then written up into a table. Most DHMT member felt that the workshop helped them to develop the bundles, however a few reported that the concept of bundles was challenging, and more time need to be spent on bundles, particularly HR and HS bundles. The support provided by the CRT in developing the bundles was appreciated by managers.

“The strategies to choose, actually as we were with the research country team they taught us the bundles, how to make bundles.” (LDHM IDI 03 UG)

Figure 10: Luwero DHMT using the refined problem tree to generate bundles of strategies

The main strategies of the plan are given in Table 55 below and the full plan using the template provided in the workshop which includes supporting activities, indicators linkages to other relevant HR or health systems strategies is given in Annex 5.

<table>
<thead>
<tr>
<th>A. Performance area/broad objective</th>
<th>B. Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve understanding of daily/weekly + feedback on performance</td>
<td>Use of work plans</td>
</tr>
<tr>
<td></td>
<td>Team meetings</td>
</tr>
<tr>
<td>Improve staff understanding of general work + feedback on performance</td>
<td>Ensure that staff have updated job descriptions</td>
</tr>
<tr>
<td></td>
<td>Induction/orientation of new staff</td>
</tr>
<tr>
<td></td>
<td>Regular open appraisal</td>
</tr>
<tr>
<td></td>
<td>Regular supportive supervision</td>
</tr>
</tbody>
</table>
### Selection and modification of follow up interventions

The DHMT members reported that they made some changes to the bundles work plan. When they encountered challenges in implementing the bundles, they then found solutions to these challenges. They also focused on one part of the work plan, and then reviewed their achievements, and then moved on to another part of the work plan. The DHMT members also said that some activities were delayed for two main reasons: delay in funding and having to manage other priorities.

“After prioritizing which one to be the first activity to be done then after carrying out those activities we could sit again and give feedback and see how far we have gone then we review our work plan and see which one is next and which one has not been done then we prioritize again we look at the strength and the challenges and also we make solutions for the challenges we continue like that.” (LD FGD UG)

“The other issues were competing activities you find you have planned an activity, another activity come on and you find there is conflict of interest an you find that the activity is not implement as earlier scheduled.” (LD FGD UG).

“Then the other areas like support supervision were lying within our PHC funds and the delay in release affects our time schedule for some of the activities”. (LD FGD UG).

“Number one so after prioritizing which one to be the first activity to be done then after carrying out those activities we could sit again and give feedback and see how far we have gone then we review our work plan and see which one is next and which one has not been done then we prioritize again we look at the strength and the challenges and also we make solutions for the challenges we continue like that, we continue with, that is how we have been contributing with our work plan until now.” (LD FGD UG).

“Through the discussions there are some changes which we have made from the big work plan which we had we have been narrowing down to look at, we have been looking at what we have achieved and on what we have not achieved then we draw another mini work plan, which we have been presenting whenever we meet and then that mini work plan you look at it and see what you
have achieved still what you are able to implement whatever you planned before in the big work plan.” (LD FGD UG).

“We devised a strategy to avoid staffs working a week off and a week on duty. We got 2 arrival books, one for day duty and the other for evening duty. With this, all staff have availed themselves at the facility at least every time they are no duty” (Diary, no date).

Integration of bundles into the work plan

The DHMT members reported that the annual district health plan is developed according to the Ministry of Health guidelines and template. All the facilities in the district make their work plans and these are discussed and integrated into the overall district plan. The PERFORM work plan focused on areas that were already in the district plan but aimed to strengthen these activities so that they achieved their targets. One DHMT reported that as the DHMT managed both the PEFORM work plan and the district plan, this helped make sure that the activities were funded.

“When we are making this district work plan, first all the facilities they make their work plan, and then the DHO’s office also makes its work plan we sit as a team, we integrate those work plans. But since the DHT meetings composed of the core DHT and the extended DHT so we all know the steps to take when we are making the work plans so you find that from our meetings we discuss these steps which the health sub district in charges take down to the in charges in the facilities and then we follow the same steps.” (LDHM IDI 03 UG)

“You know the district work plan actually is always made according to the guidelines from the ministry which we have to follow. The ministry provides a template from there you customize into strategies. Strategy development was useful in developing the annual work plan. In fact was a good approach to move forward to achieve the goals and missions or whatever. Once you have the targets you will be able to develop indicators and then look at the indicators after a certain period to see if you have achieved what you wanted. That is why strategic planning and management are very important.” (LDHM IDI 04 UG)

“When you look at some of the identified problems like improving understanding of the general work and feedback on performance and we expect normally to do this in our routine integrate technical support supervision, so that area is linked to our general work plan on supporting lower level health facilities where you are expected to go to work with the staff in facility to assess their performance and help them to improve in areas where they are not performing well. So that block is entirely linking into our general work plan on our giving support to the lower level health facilities. So when you look at appraisals, it’s a routine. It has always been there but weak so our perform work plan was looking at strengthening staff appraisal which has been there. So we are looked at existing areas which are weak to make sure that we support them using the PERFORM work plan.” (LD FGD UG)

“There was no much challenge in the source of funding because the plan was developed by the DHMT which implements both work plans; the PERFORM work plan, and then the PHC general work plan so there was no conflict.” (LD FGD UG)
One of the objectives of National Workshop 2 was to integrate the bundles of strategies into the district work plan. In the workshop evaluation, the participants perceived that this had been achieved, and that the workshop was timely as the districts were in the process of developing work plans 2013/14.

However, the CRT felt that as the bundle selection started in the middle of the financial year, it was difficult for the district to incorporate the bundles into the district plans. Nevertheless one participant of the workshop said in the evaluation; “The workshop was timely in a sense that the districts are in the process of developing work plans 2013/14”.

Management strengthening: Effects

Effects on DHMT

DHMT decision making practices

Decision making in Luwero health district is perceived as being participatory and democratic, giving equal opportunity to all involved.

“It’s an open discussion where everybody is free to contribute and deliberate on issues as the proceedings may be. (LDHM IDI 02 UG)

“Whoever brings the view is respected. It is respected and then when it needs to polish it is polished up but they respect each one’s views.” (LDHM IDI 03 UG)

“Everybody is given equal opportunity to participate and air out his or her views according to what is on the ground. So it’s active participation and nobody is isolated.” (LDHM IDI 04 UG)

“All views are taken equally and normally where there is contention issue we normally at times go in for voting to take democracy over it.” (LDHM IDI 02 UG)

Issues brought up by the different DHMT or DHT members are discussed during meetings and decisions are made by consensus.

“Definitely if a member of the DHMT has brought his issue, we discuss along that issue and agree on the next action, so we cannot either marginalize somebody or but it is generally a decision of everybody agreeing on how we can handle it... We normally take consensus we present issues, we discuss them and agree as a team and normally assign responsibilities if it requires for someone to follow up.” (LDHM IDI 02 UG)

Decisions about budget allocation to different programmes or activities are made based on guidelines from the central level which define the proportion that can be earmarked to each budget line. The DHMT prioritize activities and allocate funding following criteria established in these guidelines.

“We list the priorities and then there are guidelines on expenditure; percentages per different item. So we just agree on which items and then we look at which guidelines are talking about the percentages and then we allocate as per the guidelines.” (LDHM IDI 02 UG)

Performance is considered as the main criteria on which the DHMT makes operational decisions. In this regard the HMIS focal person is a key actor in decision making. He receives activity data from the
different health facilities (e.g. number of OPD consultations, number of institutional deliveries, etc.), analyses it and present findings during DHMT meetings. If problems of underperformance are detected in any health facility the team decides on possible lines of action to address it.

“...because all our performance is tied to outputs so what shows how we are working is what is collected through HMIS reporting. So for him [HMIS focal person], with us also, but him as the key person, he gets all the information from the health facilities, he analyses the data, he makes his own, he makes the graphs... the others... and then during the meetings he can show us how we are performing.” (LDHM IDI 01 UG)

The DHMT meets on monthly basis involving managers from the sub-districts and programme managers. DHT meets on weekly basis (normally on Mondays). Both meetings normally take place at the district health office and are chaired by the DHO.

“DHMT meetings, this is the district health team at the district health office here and members of the Health sub District who are mostly medical officers. We have three Health sub Districts each led by a medical officer. We hold monthly meetings.” (LD FGD UG)

“So we sit mostly I would say monthly, but also sometimes for the not DHMT for the DHMT meeting, but for the DHT we seat every Monday.” (LDHM IDI 01 UG)

The agenda for the meeting is defined based on issues identified during supervision visits, issues brought up by sub-district managers and also by programme managers. Discussions and decisions agreed are recorded in meeting minutes.

“The DHMT draws the agenda on the issues to be discussed after identifying the gap. Actually the meeting is chaired by the DHO. The issues we discuss about are human resource issues, health system issues, and issues in the health facilities and human resource. We identify the gaps in the facilities when we carry out support supervision and sit and discuss those issues and then plan how to improve our services in those facilities.” (LDHM IDI 03 UG)

“At the meetings we look at programs we have been implementing, program heads present reports, we discuss them, we make recommendations and action points for follow up. And responsibilities attached to officers who are going to follow up on the recommendations and normally they are minuted.” (LDHM IDI 02 UG)

Decisions about annual plans are made in “special” meetings which normally take place once per year and run for two days. Decisions in these meetings are made based on previous year’s performance trying to coordinate with existing work plans.

“Normally we normally we get two day’s meeting. One day is looking at the strategies versus our previous performance then the second day is looking at marrying it with the work plans. It is normally done every financial year once.” (LDHM IDI 02 UG)

At sub-district level health facility managers can bring up issues to the DHMT. There is a Health Unit Management Committee (HUMC) formed by health staff, representatives of the main community groups including traditional, religious or opinion leaders and politicians. The HUMC oversees the activity at the health facility and can bring issues up to the DHMT for discussion. Complaints can also
be referred to the DHMT or DHT directly by individuals affected by any problem while receiving healthcare services.

“At the health facility we definitely have the in-charge plus his staff but also have the Health Management Committee. So some of the issues can be brought by the In-charge to us, some of the issues can be through the management committee, some of the issues we go through support supervision, we find out their problems and the community members like LCs. Somebody can complain about something and you get that information. Then we also have sub county administrations so they also look into issues especially of health and they make the reports when they sit in their meetings, political meetings and other meetings and dialogues. They can bring those issues. And then we have the… the CBOs, we have these bodies, they are like, they go to the community advocating.” (LDHM IDI 02 UG)

Sometimes members of the DHMT provide support to health facility managers on how to plan their activities within the budget constraints.

“So agreeing to what we need is actually, may be like if on my side, as MCH I know HCIII, I know their budget and may be they come up with activities because they are also part of the budget, so I can guide them according to how we are performing actually in the district.” (LDHM IDI 01 UG)

**DHMT composition**

The DHMT is headed by the DHO and formed by the DHT, sub-district managers and development partners. The DHT is composed of the DHO and several senior officers in charge of different areas.

“The DHT meeting comprises of the DHO, there is MCH focal person at the district that is the Principal Nursing Officer, there is District Health Educator, there is District Environment officer, we have the accountants who are helping us with the work plans and the budgets, then we have also the biostatistician and the extended DHT members.” (LDHM IDI 03 UG)

Since the beginning of PERFORM the composition of the DHMT has not changed but the DHT has integrated new members, mainly senior officers from sub-districts as mentioned by one of the CRT members.

“Male Respondent: the DHT has had adopted many more members Interviewer: ah ah that is a, that is an impact yeah?
Male Respondent: especially senior people from health sub district Interviewer: Hmm hmm so, the project influenced that?
Male Respondent: yeah partly” (Interview with Uganda team)

**DHMT learning from other districts**

The DHMT considers inter-district meetings as very useful opportunity to learn from other districts. Luwero was able to compare their performance with other districts during the inter-district meetings.
“I think in terms of performance when we were in Fort Portal regional meeting the performance of the overall performance of Kabarole district and Jinja was too far ahead of us in the national league table but for the following year I think there was a dramatic change for Luwero and I think partly this was as a result of people understanding the gaps in performance and trying to address them.” (LD FGD UG)

“...the inter district meetings which has been held actually we have learnt a lot, because the performance we have been sharing with those people has helped us to improve so much... the sharing which we have been with in other district have helped us like in the last meeting which we had when they introduced the district league table the Jinja DHMT introduced the district league table which was so good to us and we coped that and we are expecting that by December we are going to start that district league table which I think that it will help to improve on our performance in the facilities and also will force us to reward the best health facilities.” (LD FGD UG)

“I think the workshop approach was very good because it was bringing people from different districts and different problem together and they would share their experiences and reflections and then we also could see what they are doing in their different districts and some of the things if we felt it was positive we could copy not copying as copying but we could take it on board...” (LD FGD UG)

Getting feedback from other districts about their problem analysis was perceived as strengthening the process and improving the outputs.

“...the workshop based approach model I think was advantageous in the sense that we were three districts, this made more than one eye to look at the problem analysis the problem tree, the strategies the objectives and then you get a consensus beyond one district DHMT...” (LD FGD UG)

Inter-district meetings, besides an opportunity to learn from other district was considered a good strategy to make teams concentrate and don’t get disturbed by other issues. Going out of their district for these meetings was considered as a relief from their daily routine.

“...and also like the Kabarole trip if the Luwero people went there it is out of Luwero it is in different environment all together and it refreshes you when you go there you feel relaxed and when you comeback you have a renewed energy to work and continue, the same with trips in Jinja because when you are in your district you have so many things you have to do at the same time, that is what I feel, also the sharing, there are synergies where those people have strengthened you have a weakness you tell them to get synergized by those districts.” (LD FGD UG)

Learning from better performing districts was appreciated as an incentive to improve their own performance.

“...and what I think was again good is that we could sit with those people who were just performing to the best level, we could get chance to sit together and discuss directly with those people who are performing to the best level so that at least we can discuss without limit of the information and then we could just learn directly from them and of course we made friends we looked at the new environment and we learnt quite a lot and to me I recommend that the workshop model approach could continue it was really good.” (LD FGD UG)
Not all members of the DHT were able to attend the inter-district meetings but those who went shared their experiences with the others during their weekly meeting after their return to Luwero.

“...not all the members of the DHT were in the workshops and were all involved in the development of the work plan, the first activity was on coming back to have our DHT meeting which normally occurs on Monday and share the outputs of the workshop and see who is responsible for what and how can all of us be involved...” (LD FGD UG)

Sharing problems with other districts helped the Luwero team to find solutions.

“...the inter district meetings, we know that we have been with our strength and we have weaknesses but when you continue sharing you find that some of the problem which we have they are cross cutting but can be helped, the solutions can be got from your friends as you share your performance but when your sit alone you can die with your problems without knowing how to solve them actually the inter district meetings have helped us also much.” (LD FGD UG)

DHMT HR practices

PERFORM has contributed to develop and adopt new practices in the area of HRH. For instance for the specific problem of absenteeism the Luwero team introduced an attendance book in health facilities which seems to have contributed to identify problems in this regard.

“We called a staff meeting to hear for ourselves whether what was reported in the meeting was the truth to to hear their side. So it is true we called for the book because one of the things was that they were absenting themselves and they were coming late. So we had to use that book to check whether what was reported was true or not and surely we found that those were the gaps that I told you about.” (LDHM IDI 01 UG)

Other practices were already in place for the district level but Luwero management team decided to expand it to lower levels.

“We, through the district service commission, we got the updated, I think there is a book, where the roles and descriptions are so they are photocopied and given to health units to give to their staff...” (LDHM IDI 01 UG)

Some practices were in place but they have been modified since PERFORM started. For instances the Disciplinary Committee was replaced by the Rewards and Sanctions Committee.

“...we changed from the disciplinary committee and went to reward and sanction committee, and we hoped to introduce it when we came back from the Jinja meeting.” (LDHM IDI 01 UG)

DHMT use of action research in management

Links between action research steps

Some DHMT members described how they used the action research steps in identifying problems that they could tackle, planning and implementing the strategies, observing the effects, and then re-planning further strategies.
“the process was not easy because the health system had a lot of gaps covering almost all the blocks and narrowing down to get the core problems that we thought we would tackle and have a difference I think it took us over a month, that is why we eventually had to come on a level of making bundles so that we could marry one problem to the other and see what best way we can apply to solve more than one problem but using models like the same means but eventually, I think it became also a learning process and we narrowed down to what we thought was within our reach and we required very minimal or no resources beyond what we have in order to address it.” (LD FGD UG)

“Through the discussions there are some changes which we have made from the big work plan which we had we have been narrowing down. We have been looking at what we have achieved and what we have not achieved. Then we draw another mini work plan (action points) and you look at it and see what you have achieved and still what you are able to implement whatever you planned before in the big work plan.” (LD FGD UG)

“We are doing that when we review the work plans and see what we have not achieved you have to ask yourself then you go down to the ground if the issue is to go in the facilities then you go in the facilities to confirm from the facilities. If it is to go to the community then you go to the community and do what? And confirm from the community and then you get a way forward.” (LDHM IDI 03 UG)

“So after prioritizing which one to be the first activity to be done then after carrying out those activities we could sit again and give feedback and see how far we have gone then we review our work plan and see which one is next and which one has not been done then we prioritize again we look at the strength and the challenges and also we make solutions for the challenges we continue like that, we continue with, that is how we have been contributing with our work plan until now.” (LD FGD UG)

The DHMT reported that the diary helped them to reflect on their activities and compare with the targets set in their work plans.

“We had issues with the PERFORM diary, some colleague could go implement and then updating the PERFORM diary was another challenge but when we started scheduling and sharing PERFORM activities in our plans, then we would reflect with the PERFORM diary, what are the activities implemented in this week versus the target in our PERFORM plan so we frequently reflected in the PERFORM diary and that motivated colleagues to update the PERFORM more frequent, so it changed our attitude.” (LD FGD UG)

Lessons learned from action research cycle

The DHMT reported some lessons learned from the action research cycle. First, it is important to develop a plan and then discuss as a team when plans are not successfully implemented.

“The lesson I have learnt is that before you implement any activity you must have a plan and then assess whether the way it is implemented is how you planned it and if not then you go back to find what brought about the failure by so doing still you again re-plan. Whenever there is a failure of something, it is better you discuss it as a team and then agree on action points. Try it again and see whether you will be able implement or not.” (LD FGD UG)
Second, inter-district workshops allowed for open discussions across the different districts and sharing of good practices.

“The workshop model was the best approach because you discuss directly with other colleagues from different districts. We learnt quite a lot and we could just measure ourselves how far we are performing compared to other districts level of their performance. It was good in that we could sit with those performing to the best level and discuss directly without limit of the information and learn directly from them.” (LD FGD UG)

“The workshop approach was very good because it was bringing people from different districts and different problem together and they would share their experiences and reflections. If we felt it was positive we could copy and take it on board.” (LD FGD UG)

Third, working as a team, good communication and clear understanding of problems are key to making positive changes.

“I appreciated team work in the PERFORM project. When people work as a team has additive (synergy) effect of each individual’s effort leads to better results. The other one was when the communication is effective you realize that you get positive changes. The third is people understanding the problem they want to tackle very clearly; if people understand the problems they want to address clearly they will always work towards getting a solution and I think this is one of the thing we have witnessed.” (LD FGD UG)

“The reasons for achievement it is the teamwork which we put in. Actually we have team work as the DHT to see that whatever we identify we work on it. It is mainly the team work which we has been introduced.” (LDHM IDI 03 UG)

Fourth, DHMT member identified that it was important to identify issues which can be resolved within the district and then adjust the solutions as you implement.

“I have also learnt that there are so many issues but perform they made us to try and work out the issues which can be worked, tackle those ones you can and maybe plan and re-plan adjust the changes, team work and you keep on persisting.” (LD FGD UG)

During the district visits, the CRT and DHMT discussed how the action research cycle had affected how they managed the district.

“The DHMT agreed that the PERFORM cycle had helped to promote teamwork and they could identify clearly what had helped them to improve their management. The DHMT were clear about the challenges ahead, but were optimistic about continuing to implement the bundles, especially given the low-cost of implementation. They expressed a desire to implement the approach at the lower levels. The visitors felt that it would be beneficial for the DHMT to reflect more on the situation analysis and to link this to their strategy development in order to enhance the outcomes of PERFORM.” (Luwero District Visit Report November 2013)

In the second inter-district meeting, the Luwero DHMT reflected on how they implemented the bundles of strategies and their effects on health workforce performance. This helped them to identify key learning points. Table 56 is extracted from the Luwero presentation from inter district meeting in July 2014.
Table 56: Reflection and learning by DMHT (July 2014)

<table>
<thead>
<tr>
<th>Reflection</th>
<th>Learning</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction of arrival books has improved on reporting time and reduced on absenteeism</td>
<td>1. Sharing performance in inter district meetings, helps to identify strength and gaps in the district and create a way forward.</td>
</tr>
<tr>
<td>2. Appraisal system is now being appreciated by staff as one of the measures of individual performance annually</td>
<td></td>
</tr>
<tr>
<td>3. Re-activation of QI teams and QI meetings has made health workers to identify their problems and be able to manage them.</td>
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(Inter-district workshop 2 report)

The CRT members and paired partners reported some other lessons learned. They identified a need to provide more support to the DHMT in implementing the action research cycles. The researchers learned a lot during the PERFORM project and would apply this to other areas of work. Encouraging the DHMTs to identify their own problems within the district, increased their ownership of the project, which was crucial to the success of PERFORM. Continued support from the CRT over a long period of time through the workshops, visits, telephone calls and e-mails helped build relationships and understanding of how the DHMT works. The CRT were then able to help the DHMT reflect on the process of implementing and monitoring the strategies and learn from these experiences.

“I wonder whether having more sort of more presence within the district to facilitate the action research cycles a little bit more and especially on the reflection part of those cycles and whether having somebody more present in the district might help that. Although that brings challenges in terms of sort of disturbing the kind of working environment of a DHMT”. (Interview with LSTM team).

“And then now the partners came in to refine how are the programmes development of the bundles and I believe also building capacity for the CRTs in addition to the DHMTs, me personally wasn’t really action research, I came across it when I came into PERFORM and I found it interesting, I think I can now apply it in other areas.” (Interview with Uganda team).

“I think that I think also another strength is the continued support from the country research team. You know it’s not just a one off workshop, get on with it sort of thing its more this sustained kind of support and facilitation by the CRT that is quite, it’s difficult to do and it wasn’t perfect by any way I don’t think but I think it did help and was this sort of relationship building, talking with the DHMTs, understanding how they work, understanding what the challenges are within their districts and kind of learning from that and getting them to reflect on that process.” (Interview with LSTM team).
Application of action research lessons

Several DHMTs reported that they plan to use the Action Research cycles in their work. However they also identified several challenges such as their decision making space and availability of resources.

“I think when you learn a skill, the skill becomes part and parcel of you because you remember when we were learning a problem analysis it was like as if we were in school, in class, and that translated into strategies, activities and eventually work plans, so knowingly or unknowingly I think people will continue to use the skills that they have so far acquire, so there is no doubt about that.” (LD FGD UG).

“We will use the PERFORM approaches, the challenge which I see is indirect to what happening say at the work place there may be other issues which make it difficult to really do the planning activities at it is and may be some times also the time and resources as we have said earlier on but we will try to use the approach.” (LD FGD UG).

One DHMT member suggested that the lessons learned from the PERFORM project should be shared with the government.

“I wish the result of the project after publication you could share the results for example with bodies like the parliament might be able to cause a change.” (LDHM IDI 01 UG).

Another DHMT requested that the CRT continue to visit the district to assess how they are progressing.

“I would like to thank PERFORM project. They have shown us the way. And we hope that we shall use the strategies they have helped us to lay. But it would be good at the end of the project also for them to come up with a report and we still share the final journey and not to leave us completely but once in a while you come back and see whether we are still there or we are relaxed or we have become more much better than we were before. And definitely we looked at those bundles but they were bundles which could work within but is there any way PERFORM may mobilize some more funding to tackle those other issues?” (LDHM IDI 01 UG).

Workforce performance: process

Implementation of the bundles

Bundle implementation is monitored through different mechanisms. The reflective diary was introduced with this purpose. However the use of the diary (sometimes called “journal”) has not been consistent, particularly at the beginning when staff was not used to register their activities. However the situation improved when they started to use the diary as a guide to discuss their weekly activities during meetings.

“... what I can say, this is number two, that from the word go as number three said and five we had issues with the journal, some colleagues could go implement and then updating the journal was another challenge but when we started scheduling and sharing perform activities in our plans, then we would reflect with the journal, what are the activities implemented in this week vis a vis the target in our perform plan so we frequently reflected in the journal and that motivated colleagues to update the journal more frequent so it changed our attitude, before we had we were just lazy.
“Each team we would go you have support supervision handle issues of human resource you can come and put it in the general report but not updating the journal, but when we started sharing the journal in our meetings so we would reflect on what activities have we done are they causing any impact versus the plan versus the program tree our strategies, then we had no issues on reflecting the journal frequently when we have meetings we would reflect on the journal frequently after the implementation as an activity you would go and update the journal.” (LD FGD UG)

Looking at the dates of entries in the diary, recording of activities seems to have stopped during the second half of 2013 and first of 2014. Then recording is more consistent having included entries every month from May 2014 onwards. Activities recorded include mainly supervision and meetings.

The DHMT and the health sub-districts provide supportive supervision to health units and immediately give them feedback.

“During the time, the DHMT or the health sub-district has conducted support supervision to health units, there has been a lot of giving constructive feedback immediately after because we hold a meeting with them when we know their problems so that they can improve. We are really have hands on now; we understand more of the appraisal and how to appraise because we know what period and how somebody has been performing. You as the supervisor of the other person you can also see how you can help that person.” (LD FGD UG)

Problems with implementation of bundles

Lack of funding was sometimes hindering implementation of some of the strategies.

“Yes, we do, we would like really to do regular support supervision but regular support supervision goes on with the funding so we plan but sometimes we may not go according to our plan.” (LDHM IDI 01 UG)

“...of course things like support supervision is being done quarterly though these days we have challenges of funding.” (LSDman IDI 06 UG)

“Now like training of health management committee we do not have that budget. Then we have training of departmental in charges in leadership and management. We don’t have that budget.” (LDHM IDI 01 UG)

Interventions aiming at improving motivation through economic rewards are often not included in district plans due also to lack of funding.

“Mainly that of motivation was, is there but it had no funding. So mainly staff motivation in terms of rewards, get together parties, those ones have not been budgeted for.” (LDHM IDI 01 UG)

In trying to expand the scope of some posts some cadres were sent for training. However upon completion of studies health workers demand an economic reward linked to additional responsibility which sometimes is not possible causing demotivation which in turn may hinder implementation of the bundles.
“...we have different cadres of nurses and midwives and others had gone for further studies and when they come back you would like to use them because they have acquired knowledge and skills. Some of them say yes, please use us but others say that -but sister don’t you see I am getting more responsibility and there is no responsibility allowance-. So what will motivate that person is if you put there a small token of some amount of money so that she can maybe do an extra work. But otherwise they are saying that our salary has remained the same and activities are becoming more and more by the day.” (LDHM IDI 01 UG)

However lack of funding has pushed DHMT to be more realistic in prioritizing interventions.

“It has helped us because at the beginning when we identified those gaps actually we did not know that we will be able to fill those gaps without any funding. But as we were using that situational analysis, looking into our problems how to solve them, how to prioritize them so we started with those ones now like the duty rosters, it didn’t need money to solve that, the introduction of arrival books that was a little thing which you can use even just little money to buy those books so that’s how it helped us in that way in those small small things we have achieved them even without even funds.” (LDHM IDI 01 UG)

Stakeholders’ participation in bundle implementation

There are many stakeholders engaged in the district health sector e.g. politicians, secretary for health, CAO, human resource officer, implementing partners, departmental in charges, health facility in charges, porters, SDS, PLAN, PREFA, STRIDES, SURE, Ministry of Health.

“The relevant stakeholders in the district are; the human resource officer, CAO, the head of the section. They are important at the supervisory level. They are the technical persons in that area. Those are the technical personnel in looking at human resource performance.” (LDHM IDI 02 UG)

“We have politicians, implementing partners, departmental in charges, and health facility in charges are also relevant stakeholders.” (LDHM IDI 03 UG)

Stakeholders are playing an important role in monitoring the implementation of bundles.

“We have involved them in the monitoring the implementation of the bundles. Yes we have been moving together with them to monitor the implementation of the activities.” (LDHM IDI 03 UG)

Funding of activities included in the bundles is provided by stakeholders which may compromise its sustainability.

“I also appreciate the support from the implementing partners because some of these activities have been funded by the implementing partners.” (LD FGD UG)

Some donors deliver support based on performance which may have contributed to strengthen this important area identified during the problem analysis and for which a bundle of interventions was developed.
“In some of these activities we rely on our implementing partners. Some implementing partners have a performance score board, targets, and if you don’t meet the target either they reduce on the funds they are giving you or they don’t give you at.” (LD FGD UG)

The relevant stakeholders play different roles in the district health sector such as capacity building, planning, supportive supervision, funding and service delivery.

“For the laboratory, partners were identified and approached for equipment. More facilities now have been equipped. I think that is also a contribution as far as PERFORM is concerned. I'm telling you strongly that everybody is relevant. Let it be an in charge of the facility, CAO, a porter at a facility is very relevant.” (LDHM IDI 04 UG)

“Even we involve the security agencies like the prisons, the police, the teaching, sub county councils, district councillors. We need different stakeholders to get involved and to share with us. And I think, PERFORM also has done a lot. You see sometimes we have a challenge with partners, development partners, they think support is in terms of giving money but the PERFORM is handling I have liked it because it help us.” (LDstake IDI 02 UG)

Politicians were also involved in supervising and monitoring bundle implementation

“We join hands with political leaders and we go and supervise and monitor the services down there.” (LDstake IDI 01 UG)

Stakeholders appreciated the close collaboration they had with the PERFORM team and they feel motivated by what they consider a very important role in improving health service delivery in their districts. They consider that the experience should be extended.

“We interact with PERFORM research team, share experiences and they are appreciated. And this one has caused some impact through your research study you are carrying out here. Even me myself I have seen that we have to do something and I am also motivated. So, for the impact you have caused, for sustainability, we need you not just to leave just like that also try to guide the so that we include guide the top management at the district level. I think we still have a lot to learn from you and to share with you.” (LDstake IDI 02 UG)

Some of the stakeholders support the organizations of meetings to discuss issues related to the bundles

“PLAN normally organizes for us some quarterly meetings. Normally they involve the Secretary for Health. They invite the chair person, the district chair person, at time they even involve the chairperson for that sector, we have sectoral committee chairpersons.” (LDstake IDI 01 UG)
Workforce performance: effects

Perceptions of bundle design

Strategies selected were perceived as being relevant to the problems identified as mentioned by this DHMT member during a visit of the CRT to Luwero in March 2014:

“I think the strategies against the identified problems were very relevant. The last time we had a meeting here, we agreed they were relevant.” (CRT Visit Report 17th March 2014)

Bundle design was perceived as being useful for the development of annual plans as this DHMT member says:

“(Strategy development) it’s very useful because it makes us to know which areas to tackle on and which ones not to tackle on.” (LDHM IDI 03 UG)

However they also acknowledge the fact that the process was not straightforward as there were many problems in the health sector and some of the problems identified were interlinked. But in general they perceived it as a good learning experience and a good way of making good use of scarce resources.

“I want to say that the process was not easy because the health system had a lot of gaps covering almost all the blocks and narrowing down to get the core problems that we thought we would tackle and have a difference I think it took us over a month, that is why we eventually had to come on a level of making bundles so that we could marry one problem to the other and see what best way we can apply to solve more than one problem but using models like the same means but eventually, I think it became also a learning process and we narrowed down to what we thought was within our reach and we required very minimal or no resources beyond what we have in order to address it.” (LD FGD UG)

Designing the bundles was perceived as an easier task than implementing them.

“these work plans are easy to make but the only problems comes in the implementation; now take an example here in Luwero, we have a problem of transport so the work plan is ok but when it comes to implement that is where the problem comes in then we carry out what we call integration but also integration has a limit.” (LD FGD UG)

Perceptions of effects of bundles

When discussing the effects of the bundles, the respondents focused on three areas: induction, appraisal, supervision, attendance monitoring and rewards.

Induction

DHMT members reported that they now do inductions for all newly appointed staff, and that they are better delivered.

“To me as an individual, we have achieved. We have achieved because when I look at the staff induction now we are doing it very well than we used to be. Doing Appraisals now it has improved tremendously.” (LDHM IDI 02 UG)

“We have now done inductions for new health workers.” (LD FGD UG).
**Appraisal**

The DHMT members reported that staff appraisals are now done routinely and on time. They felt that appraisals were conducted in a much better way. Facility managers also reported that the appraisals are being done routinely and that staff find them to be positive. They explained that staff are much more serious about their work after the appraisals.

“Before you find a staff can take like three years without being appraised but now it is routine. At the end of each financial year we normally send them a memo to prepare for assessment.” (LDHM IDI 02 UG)

“We have tremendously started doing appraisal than it used to be and it is normally now done on time so even on communication our information sharing has now improved so at least there is communication to lower level facilities than it used to be before so I think we have achieved” (LD FGD UG).

“Interviewer: how about like for appraisal how has it helped them to improve performance? Respondent: ooh yea the appraisal. Now they are a bit serious after this one, the one we have done. At least some have tried to change their performance like, like, they work. They work, oppose d to the way they were before.” (LSDman IDI 05 UG).

During an inter-district workshop, the DHMTs discussed with the CRT how appraisals have changed so that they are done regularly and really identify where staff are finding challenges so that plans for improvement can be made.

“The DHMT was able to change the norm of appraisal – “health workers filled appraisal forms only when one needed to be promoted”. Majority of the appraisals happen a little lower than where members of the DHMT members sit. Previously appraisals were a ritual and there was a tendency to award good marks – which was quite challenging because it was hard to discover those who needed assistance. Today appraisal provides an opportunity for the supervisee to share her/his work challenges with the supervisor and they both agree on improvement plans.” (Inter-district Workshop 2 Report, July 2014).

**Supervision**

The DHMT members reported that there are now schedules for supervision, visits are made regularly, action points are made during the visit with allocation of staff responsible for implementing these actions, and the actions are followed up after the visit or in the next supervisory visit. They explained that they interact with the staff in a friendlier manner, build positive relationships and this encourages the staff to discuss their issues more openly and find joint solutions. A stakeholder also reported that supervisors now spend time with the staff to help resolve problems. As a result they found that there have been improvements in the reporting systems, better documentation in the facilities especially the completion of the registers such as delivery and antenatal care registers.
“The improvement process or part of it was because as we went to the health units and interacted with colleagues in more friendly manner they also opened up and we started, it raised a motivation for them so with the reporting they also started reporting and they have been consistently reporting.” (LD FGD UG).

“How this time round you would see supervision reports picking out key action points, reports picking out who is responsible and then a feedback done to address the identified problem than it used to be, so it helps us to measure the improvements, feedback to the facilities then us taking actions to the identified areas; then that improved the working relationship bonding the teams between the gap between the facilities and the district.” (LD FGD UG).

“You know, initially there are some teams which came here but it was like coming to give orders but now we see we sit with them and we see really how best we can do any activity. We address our problems.” (LDstake IDI 03 UG).

“Before I found that the reporting system was weak. And as we kept on monitoring, supportive supervision and evaluating our selves then there was improvement on the reporting system.... Then another achievement it is documentation, documentation especially in the registers. You find that documentation was poor but with frequent support supervision it has improved.” (LDHM IDI 03 UG).

The managers also reported that their skills in providing supportive supervision had improved. They also described that as a result of the supervision, record keeping in their facilities had improved.

“Of course there are some things which we, ok in which the skills we are not so good, but at least we get that support supervision the skills have changed a bit.” (LSDman IDI 02 UG).

“One doing internal supervisions personally and also being able to face the staff and tell them exactly they are supposed to do, after such identifications have been made, yea because basically I didn’t have such.” (LSDman IDI 05 UG).

“I have had challenges with reporting. The reports were incomplete, sometimes they are the quality is not okay and whenever the biostatisticians comes around with a team to do the validation it helps, secondly I had issues with registers, people were not really updating registers as required and at least now they have improved. Because I also took it up seriously, after it had been noted, I had to go physically to the registers and find out are these areas worked on well, at least they have helped.” (LSDman IDI 05 UG).

The diary includes many entries about supervision visits to the health facilities. The DHMT recorded some improvements, for example in record keeping and stocking of drugs.

“Support supervision of lower units emphasised in the last quester and 21 units out of 24 were visited. Emphasis was put on following up records and lab personnel for better output. Performance improved since only two labs and one records personnel are lagging behind and they are being followed.” (Diary, June 2013).

However one manager was not so positive about the effects of supervision on staff performance. He thought that it had little effect as supervisors tended to focus on weaknesses in the facilities and with staff and this resulted in staff being less motivated.
“The support supervision, basically they are negative, reason being that its majorly you know like they emphasize more on areas of weakness and you know as employees sometimes they don’t like it that they are tough and you know such issues... So supervision it has helped to some extent, but because the negativity attached to it people don’t really feel so positive.” (LSDman IDI 05 UG).

Attendance monitoring

DHMT members and several health facility managers reported that the use of duty rosters and attendance books had increased staff presence and reduced late coming at facilities. Managers went on to describe that because staff were at the facilities, community members were more likely to attend the facility, more services were provided and more patients were admitted.

“The late coming of staff on duties with the introduction of the arrival books it improved. The duty rosters you find that they were abusing the duty rosters – the health workers, you could reach there in the health facility and find someone is already there on duty but she is not what? Appearing on the duty roster. However the duty roster shows that she is supposed to be there. And also you found out that they were giving long offs. And that one also we achieved in most of these facilities.” (LDHM IDI 03 UG).

“What I am saying is that there is also presence of health workers at the health facility and how have we achieved by this aaa, aaa, arrival books have been put in place and these every health worker who is supposed to be on duty is at least registering in that book as an evidence that at least health workers are at work.” (LDHM FGD UG).

“As a district we have a problem of absenteeism and we really wanted to reduce on absenteeism, and I think personally as an HSD we are hitting our target, we have more staff on ground than we used to because I remember in my first few months I was even wondering what I was doing in a facility without staffs. You would have more patients than staffs at the facility but now you can go to a facility and because those days to call a meeting you would expect like 3 staffs but these days even if it’s an abrupt meeting and you say how many staffs are available you can get a good number, a respectable number on the ground. So I think we achieved our desired outcome” (LSDman IDI 01 UG).

“Staff attendance there are changes, then also the services, the patients are getting their services daily, then admissions they are being done.” (LSDman 03 UG).

An entry in the diary showed that spot checks by the DHMT had improved staff attendance at the facility and this had helped reduce community complaints (see Table 57 below):

Table 57: diary entry on supervision

<table>
<thead>
<tr>
<th>Activity</th>
<th>Root cause / issues to be discussed</th>
<th>Effects of activity</th>
<th>Reflections on activities and effects</th>
<th>Way forward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spot checks by HSD team to facilities</td>
<td>Staff absence from facilities</td>
<td>Reduced complaints from communities served improved staff presence</td>
<td>The on spot checks have to be strengthened</td>
<td>Increase HSD budget for better monitoring</td>
</tr>
</tbody>
</table>

(Diary, 2/8/14)
However some managers and stakeholders identified problems with the attendance book: if the manager is away, staff will sign for another member of staff who is absent; some staff sign for others or sign in for the following days. They suggested that attendance registers should not be relied upon to track attendance.

“Now one, the attendance register is one thing that I feel it is good, but it also has challenges because like human beings, if I know for example now, on Monday I was at the facility, Tuesday I had a meeting, yesterday I was in Kasana doing something and I was not there, so if they know that the in-charge is not there, someone will want to sign for the other. Some people were like why should I sign in that book, after all I have come for work. But their challenges up there, there are incidences whereby someone was accused of not being at the facility yet he was there, but the only thing that could rescue is the attendance register, so the DHO had to ask for a register to prove that you’re there. So people are realizing that may be this book can be helpful but really it’s not something very easy ok in some facilities you find that some people don’t even appreciate it.” (LSDman IDI 06 UG).

“We also realized that there are some who sign in advance. That today tomorrow I won’t be there. So we have realized that the more you introduce certain measures or mechanism people become also more creative in the way of adding things. You find now they have become again more creative. So when you depend on the attendance alone you will find that almost everybody is attending.” (LDstake IDI 02 UG).

During visit by the CRT to the district and the inter-district workshops, the issue of absenteeism and how this is being addressed was discussed. Here are two extracts from the reports:

“There appeared to be more emphasis on sanctions rather than rewards. However, the number of days of absence at the health facilities had reduced. Meanwhile, whereas the number of days of absence had reduced at the sub-district level, the numbers of hours staff work had not changed. Since staff are present, health units can submit their weekly reports” (Luwer district visit report Nov 2013).

“The attendance book is actually a resource that everybody associates easily with and signs voluntarily. The attendance book has served as an incentive for health workers to attend duty because they at least can find evidence to counter false political accusations alleging absence from duty without reason. Close reference is made to the duty roster to allow supervisors to establish the proportion of staff who have been able to report to their duty stations, and if not, why? This innovation served as an incentive for all health workers to sign up the attendance book with a change in attitude that the book was not introduced to monitor them but rather to recognize their effort and service. Use of initials is discouraged in the attendance book so everyone is compelled to register in full names and a personal signature must be inserted.” (Inter-district workshop 2 report, July 2014).
Provision of rewards

The DHMT members reported that they have not been able to provide any incentives to staff as a way of rewarding them for good performance as there has been no funding for this activity.

League Table

DHMT members also reported that the PERFORM project had helped the DHMT and staff to identify the gaps in health workforce performance and address. This contributed to their climb in the National League Table.

“I think in terms of performance when we were in Fort Portal regional meeting the overall performance of Kabarole district and Jinja was too far ahead of us in the national league table but for the following year I think there was a dramatic change for Luwero and I think partly this was as a result of people understanding the gaps in performance and trying to address them.” (LD FGD UG).

Context

Health system

Respondents identified several contextual issues related to the health system that are relevant to the PERFORM project. First, there are roles which are played by the central government and the district does not have the mandate to do them, for example, the PHC funds are determined by the central government, the Ministry of Public Services is responsible for recruitment of staff, introduction of a new payroll system.

“Primary health care (PHC) funds are determined by the central government.” (LDHM IDI 03 UG)

“We had a lot of interruptions. Quite a number (over sixty) of our health workers especially the nursing officers were off the pay role were deleted from the payroll for about three to five months even as we talk now not all of them have accessed their salaries. This affected their morale and affected our performance and yet this was a problem beyond us.” (LD FGD UG)

“Recruitment of human resource is a sole mandate of the Ministry of Public Service and may not quickly respond to the demand of district to increase the number of inadequate staffs.” (LSDman IDI 01 UG)

“Introduction of a staff payroll system where staffs are required to sign on a staff payroll list before they are paid at the end of the month. So basically for a staff to get salary they should have signed that staff payroll list. This has really improved presence at work stations. It has it has pushed staff to come to the facilities to work because once they don’t appear, they will even be ashamed of coming to sign on the staff payroll, so I think it is working wonders.” (LSDman IDI 01 UG)

Second, at times the DHMT faces challenges caused by competing demands for the available resources and compelled to make choices of what to do in the available time.
“There are some competing activities which would come in and really they require priority. You find you have planned an activity, another activity comes on and you find there is conflict of interest and you find that the activity is not implemented as earlier scheduled.” (LD FGD UG)

“Some of the activities needed some extra resources than what we had and yet there were no sources of extra resource. This affects our work plan. Some of the tools that we need to do work, for example, support supervision book has not changed since 2001; yet, a number of things have changed such as the national health policy and the health sector investment and strategic plan.” (LD FGD UG)

“We stated earlier that we were trying to link the strategies into our district health plan and some strategies need financial support. So delays in the release of funds automatically affects the implementation time of the PERFORM plan.” (LD FGD UG)

Third, it is a requirement of the Ministry of Public Service to appraise all confirmed public servants annually and those on probation every six months or bi-annually.

“Staffs confirmed in service are appraised once a year and the new staffs every after six months. The issues usually discussed in appraisals are; improvement in performance, reduction in absenteeism and late coming, and communication with our patients. Performance indicators are developed and agreed upon between the appraiser and appraise at the beginning and reviewed during the appraisal process to give a score to the appraisee.” (LSDman IDI 03 UG)

Fourth, the work environment is not always favourable for health workers to perform their duties as planned or expected such as poor infrastructure, lack of drugs and lack of funds.

“The work environment may be difficult and when you go very far there is no road, there is no water, there is no fence, some of those things make the staff not really very motivated; yet, you can’t deal with them straight away because they have a barring in the performance of staff.” (LD FGD UG)

“Some of the work environments are difficult; very far from district headquarters with no road, no water, no fence, and some of these things make the staff not really very motivated to be there and affect performance.” (LD FGD UG)

“Delays in the release of funds. We have a system that is used in the processing of funds which breaks down quite often and we can’t implement planned activities without funds.” (LD FGD UG)

“Drug stock outs occur, for example, antibiotics may run out stock. Clinicians continue to attend to patients, refer them to the laboratory for investigations and give them drugs if available or explain to the patient when the drug is out of stock.” (LSDman IDI 01 UG)

Other projects

Several other projects are operating in the district, such as PREFA, MildMay and Sure. They have an effect on the activities of the district and have implications for human resource performance.

“PREFA does on job training like for HIV and support supervision. They also do provide family planning services.” (LSDman IDI 05 UG)
“PREFA is facilitating quality improvement (QI). PREFA has just started mentorship following up on the people we trained. It is the same way they do for the support supervision: airtime, transport, facilitation and daily allowances.” (LDstake IDI 04 UG)

“SURE project targets at improving medicines’ management such as arrangement of drugs in the stores. Now, the store’s lady has improved. The arrangement of drugs originally we didn’t have book which we are supposed to fill to date to show the flow of drugs. Now the flow of the drug is clearly shown. Secondly, now they fill the dispensing log properly.” (LSDman IDI 05 UG)

“Mild May is facilitating quality improvement. There is a team that is facilitated by Mildmay that goes around on a quarterly basis following up on the QI projects being done. It’s the same thing the way you do for the support supervision: airtime, transport, facilitation and daily allowances.” (LDstake IDI 04 UG)

In the District report (2012-2013), there are a number of projects being implemented in the district (see Table 58). However it is not clear from the report which projects include HR performance activities.

**Table 58: NGO projects implemented in Luwero district (2012-2013)**

<table>
<thead>
<tr>
<th>No</th>
<th>Partner</th>
<th>Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>World Health Organization (WHO)</td>
<td>Supports Surveillance system in districts</td>
</tr>
<tr>
<td>2</td>
<td>UNICEF</td>
<td>RED Strategy (Supporting district in improving immunization coverage) with financial and technical support</td>
</tr>
<tr>
<td>3</td>
<td>PLAN International</td>
<td>Child development protection (child development and protection)</td>
</tr>
<tr>
<td>4</td>
<td>AMREF</td>
<td>SMC ( supporting district in HIV prevention through safe male circumcision)</td>
</tr>
<tr>
<td>5</td>
<td>Protecting Families against HIV (PREFA)</td>
<td>PMTCT (Supporting district in HIV prevention through Elimination of mother to child transmission of HIV) with financial, material and technical resources</td>
</tr>
<tr>
<td>6</td>
<td>Reproductive Health Uganda (RHU)</td>
<td>RH services (supporting district through provision of maternal and child health services with a bias on family planning)</td>
</tr>
<tr>
<td>7</td>
<td>Luwero Diocese (Church of Uganda)</td>
<td>PHC (offers full package of the national minimum Health care through church owned health units)</td>
</tr>
<tr>
<td>8</td>
<td>Kasana Luwero Catholic Diocese</td>
<td>PHC (offers full package of the national minimum Health care through church owned health units)</td>
</tr>
<tr>
<td>9</td>
<td>Strengthening decentralization for sustainability (SDS)</td>
<td>Systems strengthening (supports district in system strengthening and sustainability)</td>
</tr>
<tr>
<td>No</td>
<td>Partner</td>
<td>Project</td>
</tr>
<tr>
<td>----</td>
<td>-------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>10</td>
<td>Programme for accessible health communication education (PACE)</td>
<td>Nutrition in HIV care (Child protection with a bias in feeding and nutrition)</td>
</tr>
<tr>
<td>11</td>
<td>Strides for Family Health</td>
<td>Family Planning</td>
</tr>
<tr>
<td>12</td>
<td>Red Cross</td>
<td>Lifesaving (Supports the district in community mobilization and sensitization) on health programmes</td>
</tr>
<tr>
<td>13</td>
<td>Mild May Uganda</td>
<td>HIV Care services and System strengthening through ART treatment, care, financial and technical assistance</td>
</tr>
<tr>
<td>14</td>
<td>Marie stopes (Blue Star)</td>
<td>Family Planning</td>
</tr>
<tr>
<td>15</td>
<td>Healthy Vine – Sekamuli</td>
<td>PHC-Sekamuli Parish</td>
</tr>
</tbody>
</table>

Unintended effects

There were no unintended effects identified in the documents, transcripts of the interviews and FGD.

Conclusion and Recommendations for Luwero

Summary of findings for Luwero

- The DHMT was able to develop plausible plans for improving workforce performance based on more thorough problem analysis than would usually be done.
- These plans are being implemented and are showing some positive results in improving supervision, appraisal and induction. The plans have been modified and added to as more or different needs became apparent (e.g. attendance) and should lead to wider improvements in performance management.
- DHMT members like the approach used to identify and analyse problems and develop relevant strategies. They are adapting some of the approach to their routine work, but some would like more continued support with this approach and more communication between participating districts.
- In spite of external constraints on the DHMT, they do have sufficient room for manoeuvre to address many problems they face at district level. There is now a critical mass in the management team with improved problem solving and planning skills.

Key recommendations for policy makers or DHMT for Luwero

- Ongoing support should be provided to the critical mass of DHMT members to continue using the action research approach.
- Continue sharing experiences across districts – this appears to be beneficial and highly appreciated.
3.4 Comparison of findings across the three districts

In this section we compare the findings from the three districts under three main areas: changes in management, changes in workforce performance and unintended effects (Tables 59, 60 and 61). Within these tables we have compared the findings across the three districts under key themes generated from the data.
<table>
<thead>
<tr>
<th></th>
<th>Kabarole</th>
<th>Jinja</th>
<th>Luwero</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DHMT composition</strong></td>
<td>• DHO left for studies and replaced</td>
<td>• DHMT has expanded with posts filled biostatistician, assistant DHO, CDC/ Makerere School of Public Health Fellow</td>
<td>• DHMT now includes more senior officers from health sub-districts</td>
</tr>
<tr>
<td></td>
<td>• Filled vacant post: new posts : biostatistician (funded by USAID)</td>
<td>• New posts: HMIS records officer (coopted from HSD); Performance management focal person</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• New posts: HMIS records officer (coopted from HSD); Performance management focal person</td>
<td>• Include representatives from implementing partners, PNFP and CBO</td>
<td></td>
</tr>
<tr>
<td>Judgement</td>
<td>• Include representatives from implementing partners, PNFP and CBO</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• DHMT has expanded with posts filled biostatistician, assistant DHO, CDC/ Makerere School of Public Health Fellow</td>
<td>• Can include health facility managers and other stakeholders when needed</td>
<td></td>
</tr>
<tr>
<td>Decision space</td>
<td>□ Involvement of CAO and LC HR person in meetings to expand decision space</td>
<td>No evidence</td>
<td>• Has some decision space to implement some plans</td>
</tr>
<tr>
<td>Problem solving / team work / ownership</td>
<td>• Root cause analysis helped to identify possible solutions</td>
<td>• Valued working as a team to find the root causes of problems</td>
<td>• Worked as a team and involved managers and staff from facilities in problem solving to ensure feasibility and sustainability of strategies</td>
</tr>
<tr>
<td></td>
<td>• Analysed problems and found solutions as a team; valued that members have different backgrounds and work in different programmes; democratic process</td>
<td>• Worked as a team and built consensus on priority problems – encouraged ownership of problems and solutions</td>
<td>• Recognised need to understand problem clearly in order to address it</td>
</tr>
<tr>
<td></td>
<td>• Modified activities so that they would be more effective in solving problems</td>
<td>• Modified activities after team discussion</td>
<td>• Identified many problems and so had to prioritise them</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Modified activities so that they would be more effective in solving problems</td>
</tr>
</tbody>
</table>
### Attitude to use of resources to support plans

- Can find solutions using existing resources
- Identify own strengths within district and where support is needed

- Funding challenges delayed implementation of strategies
- Small problems requiring few resources to solve may impact performance

- Linked strategies to existing funded activities so that they would be funded
- No funding for some strategies, therefore could not implement

### Learning from other PERFORM districts

- Learned leadership and management from other districts; how to solve problems
- Learned how other districts solve problems and adapt to Jinja situation

- Sharing of experiences, learning and benchmarking with other districts
- Learning from other districts helps them to improve performance so that they will have better position in District League Table.

---

### Table 60: Changes in workforce performance

<table>
<thead>
<tr>
<th>Problems identified</th>
<th>Kabarole</th>
<th>Jinja</th>
<th>Luwero</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership and management of team leaders</td>
<td>• Ineffective use of the traditional control mechanisms</td>
<td>• Poor communication</td>
<td></td>
</tr>
<tr>
<td>Strengthening of support supervision</td>
<td>• Low staff motivation</td>
<td>• Inadequate capacity building</td>
<td></td>
</tr>
<tr>
<td>Enhancing health workers’ commitment</td>
<td>• Inadequate supportive supervision</td>
<td>• Inadequate medicines/equipment /supplies</td>
<td></td>
</tr>
<tr>
<td>Improving working environment</td>
<td>• Staff training that is not guided by available opportunities in the district</td>
<td>• Inadequate supportive supervision</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Performance areas</th>
<th>Kabarole</th>
<th>Jinja</th>
<th>Luwero</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervision</td>
<td>• Number of supervisors has increased: new supervisors identified, trained and mentored</td>
<td>• Modified supervision tools to Jinja context</td>
<td>• Process of supervision improved: schedules for supervision, visits are made regularly, action points made and followed up; spend longer at facilities; work with staff to identify challenges – friendlier approach</td>
</tr>
<tr>
<td></td>
<td>• Number of visits has increased</td>
<td>• No longer fault finding; supervisor and staff work together to find solutions</td>
<td>• Resulted in improved record keeping</td>
</tr>
<tr>
<td></td>
<td>• Perceived positive impact: improved staff attendance; more clients using facilities; better record keeping</td>
<td>• Leave copy of action points at facility so that staff act and for follow up</td>
<td>• Pool resources to improve efficiency of supervision</td>
</tr>
<tr>
<td></td>
<td>Kabarole</td>
<td>Jinja</td>
<td>Luwero</td>
</tr>
<tr>
<td>----------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| **Appraisal**        | • Perception that proportion of staff receiving appraisals had increased; done routinely not just for promotion purposes | • Appraisal process improved: setting targets with appraises; forms are available  
• Quality of appraisal still require improvement  
• Proportion of staff receiving appraisals has increased | • Done routinely and on time  
• Identify challenges and develop plans to address the challenges  
• Staff take appraisal seriously now – perform better after appraisal |
| **Attendance monitoring** | • Attendance registers introduced; supervision team review attendance  
• Staff attendance has improved | • Attendance register introduced to facilities has helped to monitor and reduce absenteeism | • Use of duty rosters and attendance books had increased staff presence and reduced late coming at facilities  
• Supervisors assess roster and attendance book against staff at facility  
• MTRAC has helped identify problems with attendance and other misconduct  
• Staff can abuse attendance registers, therefor need to include other methods of monitoring such as spot checks  
• Perceptions that this resulted in more clients using facilities, more outpatient and inpatient services provided |
| **Induction**        | □ Induction for new staff funded by local Bank | N/A | □ All new staff have induction; induction is better delivered |
| **Rewards and sanctions** | • Committee established  
• Improved performance of staff called to committee | □ Introduction of a rewarding system has helped motivate staff to work well | □ Some facilities reward good performers with prioritisation for training / workshops; in end of year party good performers are recognised in front of key stakeholder; other rewards not given as no funding |
| Training HUMC | 70HUMC members trained | Take active role in supporting the facility, and helping the manager and staff to find solutions to problems | N/A | N/A |

| Table 61: Unintended effects |
|---|---|---|---|
| **Unintended effects** | Kabarole | Jinja | Luwero |
| Proposal writing | Improved proposal writing skills: successfully obtained funding for implementing strategies | No evidence | No evidence |
| Entrepreneurial approach | Lobbying local businesses and partners to support strategies | No evidence | No evidence |
| Sharing experiences with DHMTs outside of PERFORM | Visited other districts or districts visited them to learn about the problem analysis and selection of bundles approach | • MoH is piloting the new quality improvement framework in Jinja • Provide mentorship to teams outside the district | No evidence |
| Routine reporting improved as need data for monitoring | Identified need for good quality data for monitoring effectiveness of interventions | No evidence | No evidence |
4. Discussion
This research project was designed to enhance our understanding of how, and under what conditions, a management strengthening intervention can improve health workforce performance in decentralised districts. This section discusses the management development intervention using action research including the process of facilitation, the process of developing bundles of HR and health systems strategies to improve health workforce performance and the limitations of the overall study in Uganda.

Management development through action research
The DHMTs went through the main steps of the action research process while implementing the project. The plan phase took participants through an interactive process of problem analysis related to health workforce performance problems first in the situation analysis, then National Workshop 1 and finally on Day 1 of National Workshop 2. In designing the problem analysis process, the researchers were concerned that it would be seen as repetitive, but each iteration produced a more specific and detailed problem analysis. The Luwero team started with a vague idea of lack of professionalism but with further analysis identified the root causes of the problems being absenteeism, poor communication, inadequate support supervision and poor recognition systems before focusing on four key objectives for their workplan. The Jinja DHMT were able to connect the problems they identified with the wider objectives of the district, linking lateness of clinical staff with its consequences for service users. In the process of analysis they recognised that it is often the small things that need to be addressed to remove barriers and where best to target available resources. DHMTs found they could find solutions to problems from within the team and that gaining consensus was important to tackling problems effectively.

As the plans were implemented (the act phase) the DHMT members observed both the process (e.g. delays in implementation due to lack of resources in Kabarole; improvements in the quality of supervision, appraisals being carried out more regularly in Luwero) and the effects (e.g. the number of HUMC members trained and the effect of the training on the ability of HUMC members to support supervision in Kabarole). Most of the information on observation came from the interviews. Evidence of the reflection phase was hard to get, though one example from Jinja illustrated that though the frequency of appraisals was increasing, the quality still needed improvement. The diaries were designed to help with reflection, but DHMTs had difficulty with this function and it was challenging for facilitators to help them. However, the fact that plans were changed based on observations and reflections implies that some did take place. For instance after their experience implementing the bundles Luwero decided to reactivate the QI teams; Jinja started to recognise best performing staff and facilities and introduced the attendance book; and Kabarole decided to introduce spot check supervision visits but also to put more emphasis on rewarding the best performing staff rather than using sanctions against bad performers.

The evidence is quite strong that management behaviours changed as a result of the action research cycle based on real world problems. Specific areas include, working as a team, problem analysis based on root causes, integrated planning, resourcing and monitoring both processes and effects of the plans. This supports our ‘theory of change’. However, evidence to support the assumption that there would be sufficient ‘decision space’ or room for manoeuvre for the DHMT to sufficiently address the problems identified is not robust. Our selection criteria for PERFORM countries was their degree of
decentralisation at district level. In Uganda the ‘decentralisation’ is operationalised through the
developed local government structures. The powers of the DHMT are limited by decisions made by the
District Council (e.g. budget content and structure or staff posting and transfer) and some decisions –
particularly related to HR are made centrally (e.g. salaries and staffing levels). Because of these
limitations, Kabarole decided to invite the CAO to their meetings to involve him in the decisions made
by the DHMT and also to advocate for their requests to the district council. On the other hand, there
was clear evidence of entrepreneurial approaches taken by the DHMTs (e.g. Kabarole induction funded
through the bank; and collaboration with DP for funding and flexible use of the existing budget –
possible because the budget headings are quite broad). This raises the question of what degree of
decentralisation is needed for DHMTs to implement customised strategies based on identification of
root causes of problems identified and prioritised.

The fact that PERFORM was not coming with additional financial resources was initially surprising for
the DHMTs. However despite problems of funding affecting implementation of some of the
interventions, the DHMTs found that some of the problems could be addressed within existing
resources which overall strengthened their capacity for planning within budget limitations which is an
important asset for district managers working in resource constrained settings.

DHMTs were stable in terms of composition with a relatively low turnover which has enabled the
formation of a critical mass of health managers with experience in applying action research to their
practice. Retaining this critical mass in the districts would be important in terms of sustainability
although these are skills that once acquired can be used in any other position in case they decide to
move somewhere else.

Facilitation
The design of the intervention was based on a recognition that the DHMT members would have limited
time in general and specific time constraints as they could be called away at short notice. The events
to engage the DHMT were therefore relatively short (the longest workshop being 2.5 days) and quite
spread out. The reaction from participants was mostly a request for more inputs with greater
frequency; there were no complaints that PERFORM took up too much of their time. Nevertheless,
the reflection phase of the cycle was probably the weakest and maybe needed more time working
with DHMT’s in the early stages of the implementation phase of the project.

The facilitators were researchers rather than management development consultants. Their role was
assisted by the provision of tools to support the action research cycle, including a problem analysis
approach, planning frameworks and guidelines for all workshops and meetings, as well as the DHMT
manual that both facilitators and DHMTs used. The intention is to review these tools based on the
PERFORM’s experience in Uganda and other participating countries (Ghana and Tanzania), and make
them available more widely.

The design of the intervention was also based on the recognition that most knowledge needed to
address their problems could be found within the DHMT. This concept was expanded by bringing
together three districts from different parts of the country. Bringing all three districts together for the
National workshop was partly driven by economies of scale, but inter-district meetings were
deliberately designed to promote sharing of experience which was repeatedly perceived as a strength
of the project. Complementary mechanisms were also introduced such as the popular newsletter and the less successful Facebook page. All districts reported benefiting from the experience of other districts.

There is a clear demand from the participating DHMTs to continue the action research approach after the PERFORM project, and a number of DHMT members suggested extending it to other districts. Some of the participants appeared to be familiar with similar approaches to problem analysis and strategy development but expressed appreciation of the freedom to select their own problems to address.

**Workforce Performance**

**Types of problems identified**

The focus of PERFORM was on improving workforce performance, so this was the only limitation imposed in the DHMTs for the selection of problems to address for the DHMTs. They could have selected a service delivery problem of which an aspect to workforce performance was a significant cause. However, all DHMTs in Uganda selected problems that were entirely workforce performance related.

Looking at the final set of workforce performance problems each DHMT identified, they do not seem unusual. However, this masks the sometimes lengthy iterative process that the some of the teams went through to arrive at the list. Time was not wasted, as this actually provided an opportunity for facilitators to help the DHMTs learn more about workforce performance by clarifying causality of HR problems using the performance model in the methods manual and presentations. This contributed further to the management strengthening objectives of the project.

**The HR/HS strategies used**

Though the DHMT manual provided a table with a wide selection of HR and health systems strategies for addressing workforce problems, the teams mainly chose to resurrect or improve existing performance management systems such as supervision, appraisal and attendance monitoring which would make more efficient use of the existing workforce. The focus on existing systems probably makes the changes more sustainable. While they all considered the use of financial bonuses for rewarding good performance, they recognised their budgetary limitations. The only strategy that went beyond the normal performance management tools was use of the Health Unit Management Committee, which includes community representatives, to support supervision. However, other considerations of the wider health system were evident at activity level, for example with the pooling of resources from different programmes to improve the efficiency of supervision.

Though the workshop participants struggled a bit with the concept of integrating strategies to develop coherent bundles, the resulting plans produced by the end of National Workshop 2 were quite coherent bundles (e.g Kabarole’s plan to increase the number of supervisors by training up existing staff with potential, using incentives to retain them, developing existing partnerships to provide additional financial support for supervision and to engage the HUMCs to support supervision processes at facility level). During the implementation period DHMTs identified strategies that would enhance
the coherence of the bundles – for example Kabarole added attendance monitoring to increase the effectiveness of supervision.

The primary purpose of the intervention was to strengthen management by going through the action research cycle. Health workforce performance was the chosen area for applying the cycle. The effects on workforce performance was of secondary importance and of course dependent on the appropriate design and implementation of the bundles of HR and health systems strategies. Measuring the effects of the bundles would require robust before and after data. Although the development of indicators was included in the planning process in National Workshop 2, the collection of baseline data had to be done at a later stage. The implementation of the bundles was a higher priority on DHMTs’ return to districts in the face of competition of routine activities, so collecting baseline data for the bundles tended to be neglected. However, DHMTs began to recognise the importance of data for monitoring progress and effects later during the implementation phase – an important management lesson learnt.

The effects were largely established using a retrospective perception of the situation at baseline. An example of effects comes from Kabarole where as a result of the bundle of strategies implemented, the number of supervisors increased over the 18-month implementation period at district level by 250% and at sub-district level by 350%. A tool – the supervision book – was developed for supervisors to use and processes developed (e.g. the involvement of staff at lower levels) to support supervision. There is no clear evidence at the moment of whether the changes in supervision have led to better staff performance. This level of effects will need to be addressed by the DHMTs for all strategies.

Limitations
The strengths of this study lies in its use of mixed methods and data from multiple sources. However, there is limited quantitative data that illustrates the effects of the bundles on health workforce and service performance.

This study takes place in the real life context of three districts in Uganda. Over the course of the study, other projects such as Baylor, Capacity Project, BTC and government initiatives targeting workforce issues have been operating. Although these provide opportunities for the DHMTs to strengthen HRH in the district, it raises challenges in attributing any changes in workforce performance to PERFORM. However, qualitative findings have helped in teasing out this attribution.

There were several challenges in facilitating and documenting the process of the action research cycle (planning the bundles, implementing, observing the effects and reflecting on the process). Facilitation skills are key to successful action research, and the research team had varying degrees of experience of facilitation. They therefore developed these skills through the lifetime of the project. The DHMT generally used the diary to record activities rather than as a tool to document how the activities were implemented, their effects and any reflections. All researchers (including the DHMT) found that the most challenging step of the action research cycle is the reflection stage, and although this was introduced early on in the project, and discussed at all subsequent meetings, workshops and visits, more time could have been spent on this important step.

The data collection for the final situation analysis was conducted by the Ugandan CRT, with support from the LSTM team. This may lead to some bias in the interpretation of the data. However, several ways to minimise this bias were used: using tools to guide the interviews, FGDs and quantitative data
collection; using multiple sources of data such as the diaries and visit reports; all researchers being involved in the analysis process; and discussing the findings with the DHMTs in a workshop.

Conclusions
The management strengthening intervention of facilitated action research based on real workforce performance identified by the DHMTs has enabled them to develop plausible plans for improving workforce performance based on more thorough problem analysis than would usually be done. These plans are being implemented and are showing some positive results in a range of areas of performance management. Most plans include the strengthening of existing performance management systems that will improve the efficiency of the existing workforce, thus helping to mitigate the impact of staff vacancies. During the implementation period the plans have been modified and added to as more or different needs became apparent and should lead to wider improvements in performance management.

DHMT members were engaged in and liked the management strengthening approach used to identify and analyse problems and develop relevant strategies. The DHMTs were already familiar with some of the elements of the approach, but generally not the freedom to apply them to their priority problems. The fact that some DHMTs are adapting the approach, or elements of it, to their routine work indicates that they find it appropriate for their situation. Some DHMT member would like more continued support with this approach and more facilitated communication between participating districts.

Because the DHMTs are in control of the problem selection and analysis process and plans they develop, they have learnt to work within their ‘decision space’ and resource limitations and even found this discipline beneficial for other areas of management.

The study has been able to document the process of developing and implementation of the bundles of HR and health systems strategies. It is too early to comment on the effects of the strategies on health workforce performance, and little base line data was collected. However, through the process of reflection, DHMTs have now recognised the importance of monitoring the effects and are likely to do so.

So the management strengthening approach appears to be acceptable, effective and viable at district level in Uganda. There is now a critical mass in the management team with improved problem solving and planning skills and a better understanding of workforce performance problems and appropriate strategies. The recommendations below describe how the Ministry of Health and local councils could build on the substantial gains made by this project.
Recommendations
The followings suggestions are presented for consideration by the Ministry of Health, the Ministry of Local Government and development partners:

1. Ways of providing at least some ongoing support for the next annual budget cycle to the three participating DHMTs should be investigated, so the teams can consolidate their skills for improving the management of workforce performance. Particular support should be provided for monitoring the effects of the strategies and continued information exchange between districts.

2. The potential and benefits for using this approach in other districts should be explored. Clustering of districts could be considered to make external facilitation and interdistrict exchange more efficient. PERFORM facilitation materials, which will be made available, could be used with modifications if necessary.

3. The critical mass of DHMT members who have participated in the PERFORM approach could be drawn on to develop a pool of facilitators to support new districts wishing to use this approach for management strengthening. The participating districts could also host orientation visits for DHMTs from other districts wishing to learn more about the approach.

4. Effective methods of improving workforce performance within the financial and decision-making constraints of the DHMT could be reviewed with the intention of further dissemination by the relevant departments of the Ministry of Health and the Ministry of Local Government and other partners involved in supporting workforce performance improvement.
Annex 1: Data collection tools used for the evaluation

A. Topic Guide for Focus Group Discussion with District Health Management Team

Introduction

We would be grateful if you could share with us your experiences and views on four topics related to the PERFORM process:

• Topic 1: Reflections on the PERFORM process and journey
• Topic 2: Reflections on changes made along the way
• Topic 3: Reflections on working with the PERFORM research team
• Topic 4: Reflections on the usefulness of PERFORM

Topic 1: Reflections on the PERFORM process and journey

As you know, PERFORM is about working together to improve workforce performance by addressing human resource problems.

Please start by telling me about the time in the PERFORM process when you first identified workforce problems to address.

• What was the process used to identify the problems?
• Who was involved?
• What problems did you choose to focus on?
• Why did you choose these problems and not different ones?

How did you feel about this process of problem identification?

• What worked well?
• What worked less well and could have been improved?
• [Can probe specifically about problem analysis approach, problem trees, workshop facilitation by research team, learning from this process]

What did you do after you selected the problem?

• You came up with quite a few strategies: so, how did you select strategies to address these problems? What were your thought processes or criteria? What guidance did you have on selecting the strategies? [Did the DHMT use the DHMT manual and the big table within it?]
• Was there a plan? [If yes, then ask:]
• Who was involved?
• What specifically did the plan consist of? Can you tell me a bit more about this?
• What were the challenges in developing the plan? Did everyone agree to the plan?
• Was the plan linked to the problem you chose? How is this so? Could you give me some examples of how the problem and plan were linked? OR If not, why do you think there wasn’t a link?
• Thinking back about the workshop as a whole: what do you think were the advantages and disadvantages of using the workshop for the process of problem identification and developing the plan?

What were the next steps after you developed the plan?

• How did you start to put the plan into action? What did you do? Can you give me some examples?
• Who was involved? Why? What were their roles?
• What were the challenges in the process of implementing the plan? What do you think caused these challenges?
• Did the implementation clearly follow the plan? If not, why not?
• What factors do you think were important in ensuring that implementation was linked to the plan? (E.g. Good communication between DHMT? Team work? Support from CRT? Understanding of the PERFORM action cycle? Knowledge of problem analysis techniques?)
• What were the challenges for linking implementation tightly to the plan? (E.g. disagreements about causes of problems? Gaining support and enthusiasm for implementation? Funding?)

**What were the first things you noticed when you started to implement the plan?**
• What specifically did you notice? [You could talk about effects on the DHMT or on health workers]
• Did you notice anything else as time went on?
• What tools or processes did you use to monitor your plans? How useful have these been?
• Did you discuss what you noticed with other DHMT members – either informally or during meetings? Can you give me examples of some of these discussions? What worked well and what didn’t work so well [can be about bundles themselves or implementation]?
• What actions did you take as a result of these discussions? Did you make changes to the plan or implementation?

Thank you for sharing your experiences so far. Now that we’ve started to talk about what hasn’t worked so well, let’s move on to topic 2 and reflect more about any changes you may have made.

**Topic 2: Reflections on changes made along the way**

Please tell me: did you make any changes to your initial plan as result of what you saw happening?
• What did you change? Why?
• What process did you use to make this change? Why did you do it like this?
• Who was involved and who made the decision to change?
• How easy or difficult was it to make this change? Why?

Did the change you made now address the problem more effectively?
• How did it improve it? [refer back to problem discussed]
• How do you know it improved it – can you give me some examples?

Thank you again for sharing your experiences. I would like to move onto topic 3 and reflect on your experiences of working with the PERFORM research team.

**Topic 3: Reflections on working with the PERFORM research team**

Can you describe how the CRT works with you?
• In what areas? (e.g. Problem solving? Technical (and at the workshops)? Facilitating planning and implementation?)

How is the support organised?
• Is this planned? Is it a written plan or verbal agreement or is support provided on ad hoc basis?
• [If a written or verbal plan exists, ask the following questions:]

How was this plan developed?
• Who was involved?
• What was discussed?
What does the plan include?
• What areas does it cover?
• Does the plan also include X, Y and Z (e.g. phone calls, emails, visits, review meetings)?

Did you and the research team both agree on and understand the plan’s content?
• If not, where were the disagreements or misunderstandings?
• Did you change the plan?

Was the support provided as planned?
• If not, why not?

What has gone well in terms of communication and support?
• Why?

What has not gone so well in terms of communication and support?
• Why?

Thank you again for sharing your opinions. Finally, I would like to move onto topic 4 and reflect in more detail on how useful you feel the PERFORM approach has been, and how useful it might be in the future.

Topic 4: Reflections on the usefulness of PERFORM

After you started to implement the plan, have you had much chance to reflect on the journey – from identifying the problem to implementing and monitoring the plan?
• Can you share some of your thoughts and reflections – either personally or thoughts generally among the team – about the journey?
• What lessons have you learned from your experience with PERFORM?
• Are these views shared across the DHTM?

In the future, will you continue to use the PERFORM approach to address problems (planning, implementing, monitoring, reflecting, replanning?)
• Will you use it to address more HR problems? Have you already started to do this? If yes, what was your experience?
• Will you use it to address non-HR problems? Why?
• If you plan to use the PERFORM approach, what might the challenges be?
**B. Topic guide for interviewing DHMT members**

<table>
<thead>
<tr>
<th>Introduction: key components</th>
<th>I want to thank you for taking the time to meet with me today. My name is .............................. and I would like to talk with you about the health workforce in .................... district. Specifically, as part of the PERFORM project, we are trying to understand the factors affecting workforce performance in order to find ways to improve the performance of the health workforce in .................... district. The interview should take about one hour. I will be taping the session because I don’t want to miss any of your comments. I explained these procedures to you when we set up this meeting. Although I will be taking some notes during the session, I can’t possibly write fast enough to get it all down. Because we are on tape, please be sure to speak up so that we don’t miss your comments. All responses will be kept confidential. This means that your interview responses will only be shared with research team members and we will ensure that any information we include in our report does not identify you as the respondent. Remember, we don’t have to talk about anything you don’t want to and you may ask for the recorder to be switched off at any time or end the interview if you wish. Do you have any questions about the PERFORM project or about what I have just explained? Are you willing to participate in this interview? Are you happy for me to record our conversation?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Thank you</td>
<td>Q1. Please introduce yourself. What is your role within the DHMT? Please describe what you do.</td>
</tr>
<tr>
<td>• Introduce yourself</td>
<td>Q2. How does the DHMT discuss and/or agree before decisions are taken (for example, key decisions to with budget, or planning new programmes)?</td>
</tr>
<tr>
<td>• Explain purpose of interview</td>
<td>Q3. Can you describe a typical DHMT meeting (who comes, is there an agenda, who sets the agenda, what happens)?</td>
</tr>
<tr>
<td>• Confidentiality &amp; anonymity</td>
<td>Q4. How do you perceive the participation of each member of the DHMT during a meeting?</td>
</tr>
<tr>
<td>• Duration</td>
<td>Q5. In your opinion how are the views of each member of the DHMT taken into consideration when decisions are made? Can you give specific examples?</td>
</tr>
<tr>
<td>• Explain how the interview will be conducted</td>
<td>Q6. How often does the DHMT meet as a group? Do all members attend these meetings? If not, why? Are there minutes of these meetings? What happens with these minutes?</td>
</tr>
<tr>
<td>• Opportunity for questions</td>
<td>Q7. How do you identify problems? [NB not how DHMTs did this initially, but focus on how they do it now]. Can you give us some examples of recent problems identified by DHMT? How did you identify them?</td>
</tr>
<tr>
<td>Questions</td>
<td>Q8. Since the beginning of the project, does your team undertake analysis of problems that arise in the district? If yes, please give a specific example. How often do you do this? When?</td>
</tr>
<tr>
<td>• Chose quiet place where can talk freely</td>
<td>Q9. How does the process of problem analysis inform prioritization and planning? (Which causes do you focus on?)</td>
</tr>
<tr>
<td>• Ask factual questions before opinion.</td>
<td>Q10. In your opinion, is the problem analysis process useful? What factors have helped and/or hindered this process?</td>
</tr>
<tr>
<td>• Use probes as needed.</td>
<td>Q11. How do you, as a team, usually decide which strategies to use to address workforce problems? How often? When?</td>
</tr>
<tr>
<td>• Include note taker</td>
<td></td>
</tr>
</tbody>
</table>
Q12. How do you include these strategies in the overall district work plan?

Q13. In your opinion, is the strategy development useful as part of developing your annual work plan?

Q14. What workforce strategies are included in your district work plan for this year? Why did you include them?

Q15. Are there some workforce strategies that you did not include in the district work plan? Why did you leave them out?

Q16. Has sufficient money been set aside in your budget for the implementation of each workforce strategy included in your work plan?

Q17. In your view, has the PERFORM project had any impact on the composition of DHMT (attraction and attrition)? If yes, please explain. Why has this happened? How was it managed?

Q18. In your opinion, has the PERFORM project had an impact on the practices of DHMT? For example, do you now spend more time on the management strengthening intervention (explain problem solving and strategy development approach) and so have less time for other tasks? Do you now receive more resources or attract projects? Do you receive requests to share expertise outside the district?

Q19. How do you track (monitor) the activities in the district workplan? How do you keep a record of this (e.g. quarterly/annual report)? Have you made any changes to the way you track these? Do you have a record of these monitoring activities? (E.g. quarterly or annual report). If yes, can I have a copy of this document please? Have you made any changes to these monitoring activities recorded here? If yes, please explain why these changes were needed.

Q20. In your view, who are the relevant stakeholders in the district? Why are they important? Have you identified and involved relevant stakeholders in the planning of the bundles? How and why?

Q21. Have these stakeholders been involved in monitoring the implementation of the bundles? How? If you haven’t involved stakeholders in monitoring, why not?

Q22. In your opinion, have the bundles achieved the desired outcomes which you set out at the beginning of the project? Please explain why or why not.

Q23. In your opinion, has the PERFORM project helped your work in the district? If so, how? If not why not? What about staff performance? Please explain why or why not. What do you believe are the reasons for this?

Q24. Is there anything more you would like to add or do you have any comments about the PERFORM project which we have not already discussed?
C. Topic guide for interviewing sub-district managers

<table>
<thead>
<tr>
<th>Introduction: key components</th>
<th>I want to thank you for taking the time to meet with me today. My name is ............................. and I would like to talk with you about the PERFORM project. Specifically, we are trying to find out your views on the activities implemented as part of the PERFORM project in ............... district. The interview should take about ........ hour. I will be taping the session because I don’t want to miss any of your comments. I explained these procedures to you when we set up this meeting. Although I will be taking some notes during the session, I can’t possibly write fast enough to get it all down. Because we are on tape, please be sure to speak up so that we don’t miss your comments. All responses will be kept confidential. This means that your interview responses will only be shared with research team members and we will ensure that any information we include in our report does not identify you as the respondent. Remember, we don’t have to talk about anything you don’t want to and you may ask for the recorder to be switched off at any time or end the interview if you wish. Do you have any questions about the PERFORM project or about what I have just explained? Are you willing to participate in this interview? Are you happy for me to record our conversation?</th>
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<tr>
<td>I will be analyzing the information you and others have given me and preparing the next version of this tool. Thank you for your time.</td>
<td></td>
</tr>
<tr>
<td>Closing: key components</td>
<td>I want to thank you for taking the time to meet with me today. My name is ............................. and I would like to talk with you about the PERFORM project. Specifically, we are trying to find out your views on the activities implemented as part of the PERFORM project in ............... district. The interview should take about ........ hour. I will be taping the session because I don’t want to miss any of your comments. I explained these procedures to you when we set up this meeting. Although I will be taking some notes during the session, I can’t possibly write fast enough to get it all down. Because we are on tape, please be sure to speak up so that we don’t miss your comments. All responses will be kept confidential. This means that your interview responses will only be shared with research team members and we will ensure that any information we include in our report does not identify you as the respondent. Remember, we don’t have to talk about anything you don’t want to and you may ask for the recorder to be switched off at any time or end the interview if you wish. Do you have any questions about the PERFORM project or about what I have just explained? Are you willing to participate in this interview? Are you happy for me to record our conversation?</td>
</tr>
<tr>
<td>• Describe next steps</td>
<td>I will be analyzing the information you and others have given me and preparing the next version of this tool. Thank you for your time.</td>
</tr>
<tr>
<td>• Thank you</td>
<td>I will be analyzing the information you and others have given me and preparing the next version of this tool. Thank you for your time.</td>
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C. Topic guide for interviewing sub-district managers

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<tr>
<th>Introduction: key components</th>
<th>I want to thank you for taking the time to meet with me today. My name is ............................. and I would like to talk with you about the PERFORM project. Specifically, we are trying to find out your views on the activities implemented as part of the PERFORM project in ............... district. The interview should take about ........ hour. I will be taping the session because I don’t want to miss any of your comments. I explained these procedures to you when we set up this meeting. Although I will be taking some notes during the session, I can’t possibly write fast enough to get it all down. Because we are on tape, please be sure to speak up so that we don’t miss your comments. All responses will be kept confidential. This means that your interview responses will only be shared with research team members and we will ensure that any information we include in our report does not identify you as the respondent. Remember, we don’t have to talk about anything you don’t want to and you may ask for the recorder to be switched off at any time or end the interview if you wish. Do you have any questions about the PERFORM project or about what I have just explained? Are you willing to participate in this interview? Are you happy for me to record our conversation?</th>
</tr>
</thead>
<tbody>
<tr>
<td>I will be analyzing the information you and others have given me and preparing the next version of this tool. Thank you for your time.</td>
<td></td>
</tr>
<tr>
<td>Questions</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>• Choose quiet place where you can talk freely</td>
<td>Q1. Please introduce yourself. What is your job/title? Please describe what you</td>
</tr>
<tr>
<td>• Ask factual questions before opinion.</td>
<td>do. How long have you been in this job?</td>
</tr>
<tr>
<td>• Use probes as needed.</td>
<td>Q2. Have you heard of the PERFORM project before? If yes, what do you think is</td>
</tr>
<tr>
<td></td>
<td>the aim of the PERFORM project? If no, please refer the respondent an information</td>
</tr>
<tr>
<td></td>
<td>sheet and/or briefing note so they can read about the project later.</td>
</tr>
<tr>
<td></td>
<td>Q3. Are you aware of any changes to work or activities related to workforce</td>
</tr>
<tr>
<td></td>
<td>improvement that are currently being implemented or planned in the district?</td>
</tr>
<tr>
<td></td>
<td>Q4. If yes, can you please describe them? How is this activity/ activities being</td>
</tr>
<tr>
<td></td>
<td>implemented in your facility?</td>
</tr>
<tr>
<td></td>
<td>If no, prompt with some examples from the bundle work plan.</td>
</tr>
<tr>
<td></td>
<td>If still no, skip to question 8.</td>
</tr>
<tr>
<td></td>
<td>Q5. How do you monitor progress in the implementation? Do you have a record of</td>
</tr>
<tr>
<td></td>
<td>these monitoring activities? (E.g. quarterly or annual report). If yes, can I</td>
</tr>
<tr>
<td></td>
<td>have a copy of this document please? Have you made any changes to these monitoring</td>
</tr>
<tr>
<td></td>
<td>activities recorded here? If yes, please explain why these changes were needed.</td>
</tr>
<tr>
<td></td>
<td>Q6. In your opinion, have the activities achieved the desired outcomes which were</td>
</tr>
<tr>
<td></td>
<td>set out at the beginning of the implementation? Please explain why or why not.</td>
</tr>
<tr>
<td></td>
<td>Q7. In your opinion, have these activities or changes helped you and your</td>
</tr>
<tr>
<td></td>
<td>colleagues perform better and to achieve your targets? If so, how? What do you</td>
</tr>
<tr>
<td></td>
<td>believe are the reasons for this? If not, why is this?</td>
</tr>
<tr>
<td></td>
<td>Q8. Have you heard of the PERFORM project? If yes, do you have any comments?</td>
</tr>
<tr>
<td></td>
<td>If no, please refer the respondent to the information sheet and/or project</td>
</tr>
<tr>
<td></td>
<td>briefing note so they can read about the project later.</td>
</tr>
<tr>
<td>Closing: key components</td>
<td>I will be analyzing the information you and others have given me and preparing</td>
</tr>
<tr>
<td>□ Describe next steps</td>
<td>the next version of this tool.</td>
</tr>
<tr>
<td></td>
<td>Thank you for your time.</td>
</tr>
</tbody>
</table>
D. Topic guide for interviewing Sub-district staff

| Introduction: key components | I want to thank you for taking the time to meet with me today. My name is ___________________________ and I would like to talk with you about the PERFORM project. Specifically, we are trying to find out your views on the activities implemented as part of the PERFORM project in ____________ district.

The interview should take about ______hour. I will be taping the session because I don’t want to miss any of your comments. I explained these procedures to you when we set up this meeting. Although I will be taking some notes during the session, I can’t possibly write fast enough to get it all down. Because we are on tape, please be sure to speak up so that we don’t miss your comments.

All responses will be kept confidential. This means that your interview responses will only be shared with research team members and we will ensure that any information we include in our report does not identify you as the respondent. Remember, we don’t have to talk about anything you don’t want to and you may ask for the recorder to be switched off at any time or end the interview if you wish. Do you have any questions about the PERFORM project or about what I have just explained?

Are you willing to participate in this interview?
Are you happy for me to record our conversation?

| Questions | Q1. Please introduce yourself. What is your job/title? Please describe what you do. How long have you been in this job in this facility?

Q2. In your view, who are the relevant stakeholders with regard to human resources in the district? Why are they important? Would you say you are an important stakeholder in the district? (The interviewer may have to explain the concept of stakeholder to respondent)

Q3. Are you aware of any changes to work or activities related to workforce improvement that are currently being implemented or planned in the district?

Q4. If yes, can you please describe them? How is this activity/activities being implemented in your facility?

If no, prompt with some examples from the bundle work plan.

If still no, skip to question 8.

Q5. Were you involved in the planning of these activities? If yes, How and why? If no, why not?

Q6. Were you involved in monitoring the implementation of the activities? How?

If you haven’t been involved in monitoring, why not?

Q7. In your opinion, have these activities achieved the desired outcomes which were set out at the beginning of the implementation? Please explain why or why not.

Q8. In your opinion, have these activities or changes helped you and your colleagues perform better and to achieve your targets? If so, how? What do you believe are the reasons for this? If not, why is this?

Q9. Would you like to see this activity continue? Why/Why not?

Q10. Have you heard of the PERFORM project? If yes, do you have any comments? If no, please refer the respondent to the information sheet and/or project briefing note so they can read about the project later.

| Questions | Q1. Please introduce yourself. What is your job/title? Please describe what you do. How long have you been in this job in this facility?

Q2. In your view, who are the relevant stakeholders with regard to human resources in the district? Why are they important? Would you say you are an important stakeholder in the district? (The interviewer may have to explain the concept of stakeholder to respondent)

Q3. Are you aware of any changes to work or activities related to workforce improvement that are currently being implemented or planned in the district?

Q4. If yes, can you please describe them? How is this activity/activities being implemented in your facility?

If no, prompt with some examples from the bundle work plan.

If still no, skip to question 8.

Q5. Were you involved in the planning of these activities? If yes, How and why? If no, why not?

Q6. Were you involved in monitoring the implementation of the activities? How?

If you haven’t been involved in monitoring, why not?

Q7. In your opinion, have these activities achieved the desired outcomes which were set out at the beginning of the implementation? Please explain why or why not.

Q8. In your opinion, have these activities or changes helped you and your colleagues perform better and to achieve your targets? If so, how? What do you believe are the reasons for this? If not, why is this?

Q9. Would you like to see this activity continue? Why/Why not?

Q10. Have you heard of the PERFORM project? If yes, do you have any comments? If no, please refer the respondent to the information sheet and/or project briefing note so they can read about the project later.

| Questions | Q1. Please introduce yourself. What is your job/title? Please describe what you do. How long have you been in this job in this facility?

Q2. In your view, who are the relevant stakeholders with regard to human resources in the district? Why are they important? Would you say you are an important stakeholder in the district? (The interviewer may have to explain the concept of stakeholder to respondent)

Q3. Are you aware of any changes to work or activities related to workforce improvement that are currently being implemented or planned in the district?

Q4. If yes, can you please describe them? How is this activity/activities being implemented in your facility?

If no, prompt with some examples from the bundle work plan.

If still no, skip to question 8.

Q5. Were you involved in the planning of these activities? If yes, How and why? If no, why not?

Q6. Were you involved in monitoring the implementation of the activities? How?

If you haven’t been involved in monitoring, why not?

Q7. In your opinion, have these activities achieved the desired outcomes which were set out at the beginning of the implementation? Please explain why or why not.

Q8. In your opinion, have these activities or changes helped you and your colleagues perform better and to achieve your targets? If so, how? What do you believe are the reasons for this? If not, why is this?

Q9. Would you like to see this activity continue? Why/Why not?

Q10. Have you heard of the PERFORM project? If yes, do you have any comments? If no, please refer the respondent to the information sheet and/or project briefing note so they can read about the project later.
I will be analyzing the information you and others have given me and preparing the next version of this tool. Thank you for your time.

E. Topic guide for interviewing Stakeholders

Introduction: key components
- Thank you
- Introduce yourself
- Explain purpose of interview
- Confidentiality & anonymity
- Duration
- Explain how the interview will be conducted
- Ask them to sign consent form if not already done.

I want to thank you for taking the time to meet with me today. My name is ________________ and I would like to talk with you about ________________.

The interview should take about ________________ I will be recording the session because I don’t want to miss any of your comments. All responses will be kept confidential. This means that your interview responses will only be shared with research team members and we will ensure that any information we include in our report does not identify you as the respondent.

Remember, we don’t have to talk about anything you don’t want to and you may ask for the recorder to be switched off at any time or end the interview if you wish.

Are you willing to participate in this interview? Are you happy for me to record our conversation? Please sign the consent form I gave you earlier. Can you please give the consent form to me.

Questions
- Chose quiet place where can talk freely
- Ask factual questions before opinion.
- Use probes as needed.

Q1. Please introduce yourself. What is your job/title? Please describe what you do. How long have you been in this job?
I will like to ask you a few questions about the activities which the DHMTs have been implementing in the district as part of the PERFORM project. Q2. Are you aware of the PERFOMR project? If yes, proceed to Q2. If no, please refer the respondent to the information sheet and/or project briefing note so they can read about the project later.
Q3. Are you aware of any changes to work or activities related to workforce improvement that are currently being implemented or planned in the district? If yes, please describe these activities to me.
Q4. Have you (or your organization) been involved in the implementation and/or monitoring of these activities? If yes, please explain which activities you are involved in and how you are involved.
Q5. In your opinion, have these activities solved the problems or addressed the issues which they were intended to solve? Please explain why or why not citing outcomes from the activities.
Q6. Do you think that these activities are enough to address the issues/problems they are focused on? If not, how can they be improved?
Q7. Do you think the outcomes of these activities are sustainable? Do you think the problems are likely to reoccur? Why or why not?
Q8. Have you heard of the PERFORM project? If yes, do you have any comments? If no, please refer the respondent to the an information sheet and/or briefing note so they can read about the project later.
I will be analyzing the information you and others have given me and preparing a report based on your responses. Thank you for your time.

F. Tool for facility data collection

<table>
<thead>
<tr>
<th>G. Protocol</th>
<th>Table 1 reference</th>
<th>Version</th>
<th>Print</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[8.5 to 6]</td>
<td>28/08/14</td>
<td></td>
</tr>
</tbody>
</table>

Subject: Health Facilities  
Questions: 1 - 49  
Page: 203/14

Identification information

1. Questionnaire serial number ............................................ | _ | _ |
2. Today's date ......................................................................................... | _ | _ | / _ _ _ / _ _ _ _ _
   day / month / year
3. Starting time ......................................................................................... | _ | _ | : _ _ _ _
   hour : minutes
4. Name of the person filling this form ........................................... | ____________________________ | Capital letters
5. Position of the person filling this form ........................................... | ____________________________ | Capital letters
6. Country name ................................................................. | ____________________________ | Capital letters
7. District name ................................................................. | ____________________________ | Capital letters
8. Health Facility name ............................................................. | ____________________________ |
9. Health Facility official code (if available) ...........
   | ___ | ___ | ___ | ___ |
   Write | 9 | 9 | 9 | 9 | if not available

10. Type of health facility ...........................................
    | ___ |
     Hospital with specialties | 1 |
     Hospital without specialties | 2 |
     PHC with beds and deliveries | 3 |
     PHC without beds | 4 |
     Health post | 5 |

11. Calendar year for the data reported here ..........
    | ___ | ___ | ___ | ___ |

12. Population in the catchment area of the health
    facility .............................................. | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ |

13. Population: women in child bearing age ..
    | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ |
14. Population: under-fives
    ............................................ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ |

Human resources in the previous calendar year
Check the payroll or list of staff towards the middle of the calendar year reported here.

15. TOTAL number of staff in the payroll .................. | ___ | ___ | ___ |

16. Number of staff with ONLY management or administrative
    activities (e.g. accountant) ................................. | ___ | ___ |

17. Number of staff with in laboratory, imaging, pharmacy and other
    technical supporting services (e.g. pharmacists) .......... | ___ |

18. Number of staff other technical staff (e.g. clinicians, nurses,
    health promotion, education, public health staff) .......... | ___ |

19. Number of staff orderlies, cleaning, non-qualified staff ...
    | ___ | ___ |

   q15 = q16 + 20. Check that ...

   q16 = q19 + 20. Check that ...

20. Check that ...

21. Source document for issues under heading 0 ............... | ___ |
    Health facility report | 1 |
    District report | 2 |
    Other | 3 |

Activities in the previous complete calendar year

22. Total number of curative total outpatient consultations (OPD),
    including adults and children ......................... | ___ | ___ | ___ | ___ |

23. Number of curative new consultations (or new cases), including
    adults and children .................................... | ___ | ___ | ___ | ___ |

24. Number of curative total outpatient consultations, only
    children ....................................................... | ___ | ___ | ___ | ___ |

25. Number of curative new consultations (or new cases), only
    children ....................................................... | ___ | ___ | ___ | ___ |

26. Total number of beds available ............................ | ___ | ___ | ___ |

27. Total number of inpatients discharged .................. | ___ | ___ | ___ |

28. Total number of occupied bed-days ............ | ___ | ___ | ___ |

203
29. Total number of major surgical operations .......
   |__|,|__|__|__|
30. Total number of minor surgical procedures .... |__|__|,|__|__|__|
31. Total number of new ANC consultations .......
   |__|__|,|__|__|__|
32. Number of ANC contacts ................................ |__|__|,|__|__|__|
33. Total number of deliveries ........................ |__|__,|__|__|__|
34. Number of vaginal deliveries ..................... |__|__|,|__|__|__|
35. Number of caesarean sections ...................... |__|__|,|__|__|
36. Number of still births ................................ |__|__|__|
37. Number of DTP1 doses administered to under-1s ........................................ |__|__|,|__|__|__|
38. Number of DTP3 doses administered to under-1s .................................................. |__|__|,|__|__|__|
39. Do you have specific resources (human, infrastructures) uniquely dedicated to TB patients (e.g. TB clinic) ................. |__| |
   Yes | 1 |
   No  | 2 |
40. Do you have specific resources (human, infrastructures) uniquely dedicated to HIV suspected or AIDS patients (e.g. VCT) .... |__| |
   Yes | 1 |
   No  | 2 |
41. Source document for issues under heading 0 ........................................ |__| |
   Health facility report | 1 |
   District report  | 2 |
   Other  | 3 |

Budget and accounts
42. What was the total income budgeted for the last fiscal year? ........................................... |__|__|,|__|__|__|,|__|__|__|
43. What was the total expense budgeted for the last fiscal year? ............................................ |__|__|,|__|__|__|,|__|__|__|
44. What was the amount budgeted for salaries? ................................................................. |__|__|,|__|__|__|,|__|__|__|
45. What was the real income in the last fiscal year? ............................................................ |__|__|,|__|__|__|,|__|__|__|
46. What was the real expenditure in the last fiscal year? ....................................................... |__|__|,|__|__|__|,|__|__|__|
47. What was the real expenditure for salaries? ................................................................. |__|__|,|__|__|__|,|__|__|__|
48. Source document for issues under heading 0 ........................................ |__| |
   Health facility report | 1 |
   District report  | 2 |
   Other  | 3 |
49. Ending time .......................................................................................................................... |__|__| : |_ |__|
   |__|__|__|__|
H. Tool for district data collection

DISTRIBUTION LEVEL

A. DISTRICT HEALTH MANAGEMENT TEAM

1. Population in the district

2. List the 5 most common diseases in the district

<table>
<thead>
<tr>
<th>Adults</th>
<th>Under 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

3. Number of DHMT in post

4. Number of DHMT posts that have been changed over the previous 12 months

5. Number of DHMT posts that have been unfilled for at least 3 months over the past 12 months

B. INFORMATION SYSTEMS

6. How many district HMIS reports should be prepared each year?

7. How many HMIS reports are available and complete for the previous 12 months?

8. Is there a system for recording human resources data in the district?

   Yes [ ] No [ ]

9. Is the system for recording human resources data in the district up to date and used by management?

   Yes [ ] No [ ]

C. SUPPLIES AND TECHNOLOGY

10. How often are supplies (medicines and consumables) delivered to the district?

    Weekly [ ] Monthly [ ] Quarterly [ ] Other [ ]

11. Provide information on stock-out of the 5 most frequently used medicines in the district

<table>
<thead>
<tr>
<th>5 most frequently used medicines</th>
<th>Stock-out frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[Days not available/365 days x 100%]</td>
</tr>
<tr>
<td></td>
<td>(If no exact data available provide estimate e.g. 20% (est))</td>
</tr>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>
### D. LOCAL, REGIONAL AND NATIONAL CONTEXT

12. Please give details of any ongoing or completed local, national or regional projects on issues related to health workforce in the table below.

<table>
<thead>
<tr>
<th>Project Title</th>
<th>Level (Local, Regional, National)</th>
<th>Status (Completed, Ongoing)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13. Are there any policies on health workforce? ................................................................. [ ]
   Yes [ ]    No [ ]

14. If yes to above, are the policies ................................................................. [ ]

<table>
<thead>
<tr>
<th>National [ ]</th>
<th>Regional [ ]</th>
<th>Local [ ]</th>
<th>Other [ ]</th>
</tr>
</thead>
</table>
Annex 2: Coding framework used in the analysis of qualitative data in the evaluation

1. EU partners facilitation and technical support to CRTs
   1.1. Communication between CRT and EU
   1.2. Capacity building
2. Support to DHMT
   2.1. Development of support plan (CRT and DHMT)
   2.2. Implementation of support plan (CRT and DHMT)
3. Analyses of problems that DHMT face
   3.1. Initial problem analysis
   3.2. Further problem analysis
4. Bundle selection
   4.1. Selection of initial bundles of interventions
   4.2. Selection and modification of follow-up of interventions
5. Bundles implementation
   5.1. Content of bundles
   5.2. Stakeholder involvement in bundles
6. Perception of effects of bundles
7. Perceptions of bundle design
8. Integration of bundles into the district plan and budget
9. DHMT
   9.1. DHMT decision making practices
   9.2. DHMT composition
   9.3. Learning from other districts
   9.4. DHMT HR practices
10. Action research cycle
    10.1. Links between AR steps
    10.2. Lessons learnt from AR cycle
    10.3. Application of AR lessons
11. Blank or not used in Uganda
12. Context
    12.1. Health system
    12.2. Other projects
    12.3. Other issues
13. Good quotations
## Annex 3: Kabarole District: Strategies for Improving Health Workforce Performance (Activities for FY 2012/2013 are highlighted)

<table>
<thead>
<tr>
<th>A. Performance area/broad objective</th>
<th>B. Strategy</th>
<th>C. Sample activities</th>
<th>D. Expected Change</th>
<th>E. Possible indicators for M&amp;E</th>
<th>F. Link to other HR/HS strategies</th>
<th>G. Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase number of supervisors</td>
<td>Select &amp; develop a team of supervisors</td>
<td>Selection of supervisors</td>
<td>-Update HRH invention - Develop selection criteria for good supervisors</td>
<td>Identify potential supervisors</td>
<td>Increase number of supervisors</td>
<td>% increase in number of supervisors</td>
</tr>
<tr>
<td></td>
<td>Train HW in Supervision and Mentorship</td>
<td>Identify resource for training in SS</td>
<td>-Develop a training scheme &amp; implement -Train supervisors &amp; mentors</td>
<td>Available HWs to become supervisors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Performance area/broad objective</td>
<td>B. Strategy</td>
<td>C. Sample activities</td>
<td>D. Expected Change</td>
<td>E. Possible indicators for M&amp;E</td>
<td>F. Link to other HR/HS strategies</td>
<td>G. Comments</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>-------------</td>
<td>---------------------</td>
<td>-------------------</td>
<td>--------------------------------</td>
<td>-----------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Continuous supervision &amp; mentorship</td>
<td>Develop SS plan and schedule</td>
<td>Mobilize and allocate resources</td>
<td>Increased number of supervisory visits</td>
<td>Number of SS reports produced</td>
<td>Supervision Plan</td>
<td>Induction of HWs should be reflected in the District work plan</td>
</tr>
<tr>
<td>Retention and incentives</td>
<td>Appraisal of supervisors</td>
<td>Develop mgmt performance plan</td>
<td>Increased number of supervisors appraised</td>
<td>No. of supervisors appraised</td>
<td>Available in service training program</td>
<td></td>
</tr>
<tr>
<td>Recognize and reward good performers</td>
<td>Develop a criteria for reward &amp; sanction</td>
<td>Mobilize &amp; allocate resource for rewards</td>
<td>Reduced number of supervisors leaving</td>
<td>% reduction of supervisors leaving</td>
<td></td>
<td>-Lack of facilitation e.g. stationery and fuel</td>
</tr>
<tr>
<td>- Availability of mentors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Availability of HRIS system</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formally assign roles to supervisors</td>
<td>Follow up on assigned roles</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop partnership with existing partners</td>
<td>Identify partners to Support SS activities</td>
<td>Develop a joint SS plan with the partners</td>
<td>Mobilize resource and implement Joint plan</td>
<td>Increased regular SS visits</td>
<td>No. of joint SS visits done/reports</td>
<td>Availability of partners interested in mentorship and SS</td>
</tr>
<tr>
<td>Engagement of HUMC in Supervision</td>
<td>Induct HUMC members on their roles</td>
<td>Provide HUMC member with guidelines on their roles</td>
<td>Increased supervision visits of HUMC members</td>
<td>No. of visits made by HUMC members</td>
<td>Availability of HUMC Teams in place</td>
<td></td>
</tr>
</tbody>
</table>
## Annex 4: Jinja District: strategies for improving health workforce performance

<table>
<thead>
<tr>
<th>A. Broad objective</th>
<th>B. Strategy</th>
<th>C. Sample activities</th>
<th>D. Expected change (and how problem is addressed)</th>
<th>E. Possible indicators for M&amp;E</th>
<th>F. Link to/conflict with other HR/HS strategies</th>
<th>G. Comments</th>
</tr>
</thead>
</table>
| Strengthen support supervision | To ensure monthly support supervision | 1. Ensure availability of supervision schedule  
- developing support supervision schedule  
- incorporate it in the DHMT calendar  
2. Ensure logistical support  
- Budgeting for fuel,  
- Budget for vehicle maintenance  
- Budget for allowances | Monthly support supervisions (routine) | Percentage of releases for support supervision  
Percentage of facilities supervised monthly | Annual support supervision work plan. |                  |
| Building competences of supervisors |                                  | 1. Training, mentoring, coaching and orientation.  
- reproducing training materials  
- budgeting for training  
- request for training support  
- identifying/selecting trainers from the DHMT  
- Identifying trainees  
2. Disseminating support supervision guidelines and tools.  
- Source guidelines from MOH and other agencies  
- reproducing guidelines and tools  
- distribution of guidelines and tools  
3. Compose support supervision teams.  
- co-opt special skills on support supervision teams  
- allocate support supervision teams to catchment areas | More competent staff in support supervision  
Support supervision is guided by right tools/guides  
Support supervision teams for integrated support supervision | Proportion of DHMT members trained  
Proportion of managers mentored in support supervision  
Number of staff involved in support supervision teams  
Number of HUMC members trained in support supervision | Capacity development plan  
Partners supporting human resource and development |
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Ensure regular follow up and feedback on action points</td>
<td>Regular appraisals of all health workers</td>
<td>Perform periodic appraisal of staff Submit appraisals reports to the rewards and sanction committee</td>
<td>Action points implemented</td>
<td>Number of reports on follow up activities Percentage opt health facilities with support supervision registers Number of review meetings held Percentage of health showing improvement</td>
<td>Weekly DHT meeting</td>
<td></td>
</tr>
<tr>
<td>Strengthen appraisal mechanism</td>
<td>Build competences of managers on appraising staff</td>
<td>Training, mentoring and coaching Orient in charges on appraisal system Sensitize staff on appraisal</td>
<td>Staff get feedback on performance Suctions and rewards based on performance</td>
<td>Percentage of staff appraised on time Number of appraisal reports submitted to reward and sanction committee</td>
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<tr>
<td></td>
<td>Ensure transparency and honest for all staff</td>
<td>Follow up on action points Set baseline measureable out puts Set up a tribunal for complaints</td>
<td>Appraisal reports that reflect the true picture of performance of the staff</td>
<td>Number of staff with followed up action points Number of staff with measurable out puts A complaint tribunal set up</td>
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</tbody>
</table>
### Annex 5: Luwero District: strategies for improving health workforce performance

<table>
<thead>
<tr>
<th>A. Broad objective</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Improve understanding of daily/weekly + feedback on performance</td>
<td>Use of Work plans</td>
<td>Development of departmental work plans</td>
<td>Staff prioritizing work plans</td>
<td>% of departments following work plans</td>
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<tr>
<td></td>
<td></td>
<td>Sharing annual work plans, targets + performance during team meetings</td>
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<tr>
<td></td>
<td>Team meetings</td>
<td>Managerial meetings at HF,HSD + Dist</td>
<td>Team leaders will understand problems</td>
<td>% of planned meetings conducted</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Make annual timetable for all meetings (with time &amp; dates)</td>
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<tr>
<td></td>
<td></td>
<td>Submission of minutes + attendance lists to DHO on monthly basis.</td>
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<td></td>
<td></td>
<td>Review the methods of invitation to meetings</td>
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<td></td>
<td></td>
<td>Monitoring attendance at meetings as one output of performance appraisal.</td>
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<td></td>
<td></td>
<td>Develop a district and HF QI team to monitor outputs at meeting.</td>
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<tr>
<td>Improve staff understanding of general work + feedback on performance</td>
<td>Ensure that staff have updated job descriptions</td>
<td>Orient managers at all levels on job descriptions.</td>
<td>Staff know tasks they should perform</td>
<td>% of staff updated on job descriptions.</td>
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<tr>
<td></td>
<td></td>
<td>Managers update job descriptions.</td>
<td></td>
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<td></td>
<td>Induction/ orientation of new staff</td>
<td>Develop a checklist for induction</td>
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<td></td>
<td></td>
<td>Assign mentors new managers</td>
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<tr>
<td></td>
<td>Regular open appraisal</td>
<td>Managers conduct proper inductions</td>
<td>Staff know the tasks they should perform</td>
<td>% staff employed who received basic induction</td>
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<tr>
<td></td>
<td></td>
<td>Reinstate existing lapsed appraisal system</td>
<td>Staff get feedback on performance + support</td>
<td>% of staff appraised</td>
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<td></td>
<td>Brief managers + staff on procedures + advocate benefits</td>
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<td></td>
<td></td>
<td>Training of managers on appraisal process</td>
<td>Staff get feedback on performance</td>
<td>% of staff supervised</td>
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<tr>
<td></td>
<td></td>
<td>Regular supportive supervision</td>
<td>Training supervisors in effective Supervision</td>
<td>Staff get feedback on performance + support</td>
<td>% of staff Trained</td>
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<tr>
<td></td>
<td></td>
<td>Supervisors conducting effective supervision</td>
<td>Staff get support and feedback</td>
<td>% of staff supervised</td>
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<tr>
<td></td>
<td></td>
<td>Develop a regular support supervision schedule.</td>
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<td></td>
<td></td>
<td>Develop tools</td>
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<tr>
<td>Increase number of staff present at work place</td>
<td>Attendance monitoring</td>
<td>Monitor attendance + service delivery registers</td>
<td>Improved staff attendance</td>
<td>Number of working days lost by staff</td>
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<td></td>
<td></td>
<td>Conduct spot checks by both DHT &amp; HSD</td>
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<td></td>
<td></td>
<td>Training of HUMC on monitoring of staff attendance</td>
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<td></td>
<td>Rewarding good attendance</td>
<td>Refer to rewards</td>
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<tr>
<td>Rewards &amp; Sanctions</td>
<td>Introduce team incentives</td>
<td>Establish a reward system</td>
<td>Improve staff performance</td>
<td>Incentive system introduced</td>
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<td></td>
<td>Disseminate reward system to all managers</td>
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<td>Identify the types of rewards</td>
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<td>Identify who are to reward</td>
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<td></td>
<td>Give staff additional responsibility</td>
<td>Expand job description</td>
<td>Improved job satisfaction</td>
<td>Level of satisfaction</td>
<td></td>
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<td></td>
<td>Issue verbal + written warnings</td>
<td>Disseminate existing policies + guidelines</td>
<td>More staff follow rules + regulations</td>
<td>No. warnings given</td>
<td></td>
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<tr>
<td>Implement the existing policies + guidelines</td>
<td>Disseminate existing policies + guidelines</td>
<td>Improve staff behaviours including attendance</td>
<td>No. of times staff pay withheld</td>
<td></td>
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<tr>
<td>With hold pay</td>
<td>Disseminate existing policies + guidelines</td>
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<td>Dismiss or recommend for dismissal</td>
<td>Disseminate existing policies + guidelines</td>
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<tr>
<td>Implement the existing policies + guidelines</td>
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</tbody>
</table>

| Health system | Information system | Monitor staff productivity | Use service delivery data to monitor performance | % of HFs using data to monitor performance | | |
| Service delivery | Rearrange delivery of services to make best use of staff | More efficient use of existing staff | Improved performance and good district ranking in league table | | | |
| Governance | Involve staff in planning + problem solving | Increased ownership of plans | % of staff involved in planning + problem solving | | | |
| Ensure equipment, drugs & supplies available | Ensure requisition/ordering system are functioning | | | | | |
| Ensure regular maintenance of equipment | Staff have equipment, drugs and supplies to perform carry out jobs correctly | | % of HFs without stocks of tracer medicines in the last quarter. | | | |