PERFORM 2SCALE
IMPROVING HEALTH WORKFORCE PERFORMANCE

# Uganda research brief

## PERFORM2Scale in Uganda

Staff from Makerere University's School of Public Health, supported by commissioners from the Ministry of Health (MoH) and human resource personnel from the Health Services Commission (HSC), worked with District Health Management Teams (DHMTs) in three district groups in Uganda. In each they supported staff in identifying and tackling specific workforce and health services performance problems which were impacting on service delivery in their districts.

The management strengthening intervention (MSI) – a process of **planning, implementing, reflecting and refining** – allows staff to take ownership of their own problems and, using available resources, to address them.

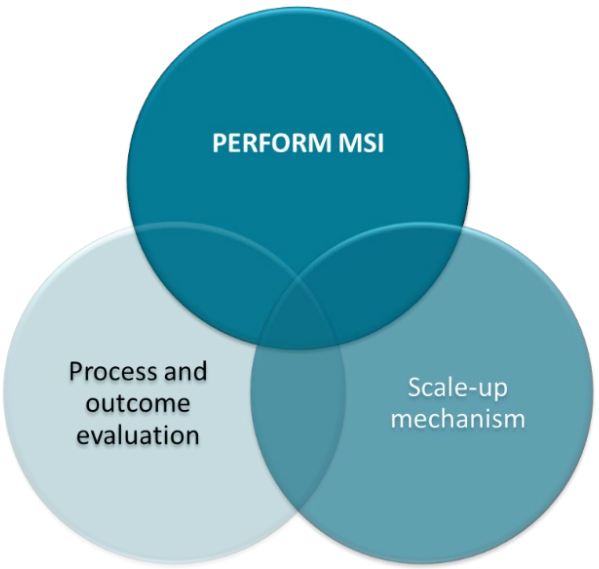
There have been many successes amongst the districts including **reduced absenteeism, improved TB cure rate, better team working and improved leadership**.

The team hopes that this evidence of effectiveness, and the enthusiasm and support of the participating DHMT members, will enable the intervention to be taken to other districts in Uganda and for its lessons to become embedded in national and district-level health planning.

## Our research

PERFORM2Scale aimed to develop and evaluate a sustainable approach to scaling-up a district-level management strengthening intervention in different and changing contexts.

This brief explains our research in Uganda, its findings, and hears from those involved in the work. We focus on the three core elements of PERFORM2Scale – **the management strengthening intervention, scale-up** and **the process and outcome evaluation.**




## Our research objectives

1. To develop a **framework and strategy for scaling-up** the management strengthening intervention
2. To **implement and validate the framework and strategy** for scaling-up the management strengthening intervention
3. To identify the **facilitators and barriers to scale-up** of the management strengthening intervention in different and changing contexts
4. To develop the **individual and institutional capacity** at regional and national levels to implement and sustain the use of the scaling-up framework and strategy
5. To ensure **engagement of stakeholders and institutions** needed to implement and sustain the scale-up of the intervention
6. To provide ongoing **communication for and about the scale-up process** and to disseminate the validated framework and strategy for scaling-up the management strengthening intervention.



The PERFORM2Scale project has received funding from the European Union's Horizon 2020 research and innovation programme, under grant agreement no. 733360.

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| Research | Method | Participants |
|---|---|---|
| 1. MSI process and outcome evaluation | Key informant interviews | • DHMTs<br>• Resource Team members from MoH, HSC & Ministry of Local Government<br>• National Scale-up Steering Group focal person at the MoH |
| 2. DHMT decision space analysis | Focus group discussions | E-DHMTs |
| 3. Assessment of DHT management and leadership competencies | Survey questionnaire | Core DHT |
| 4. Assessment of health workers' job satisfaction and management at facility and district level | Survey questionnaire | Health workers |

*Table 1. Research stages, methods and participants*

## Key findings from the process evaluation

**1. Human resource management is a major contributor to service delivery outputs**

During the implementation of the MSI cycle, the district management teams applied a human resource management (HRM) framework, and this enabled them to attain more traction for service delivery indicators, such as improved TB cure rates, malaria cases and immunisation coverage. For example, by tackling the problem of absenteeism among health workers within the TB cascade, the Luwero team improved the TB cure rate from 21% to 41 %. In the last MSI cycle, all districts expressed increased attention to human resource management by addressing a range of problems related to performance management, ie addressing sub-optimal appraisal, poor quality performance improvement plans and deficient management skills.

**2. Integration of MSI workplans into broader workplans**

The district management teams integrated MSI workplans into broader district workplans/budgets as an adaptation to working with minimal resources. Integration was easy because most of the planned activities were related to routine functions such as support supervision. Integration contributed to continuity and increased potential for securing more funds. For example, the Bunyangabu team used their workplan as a basis for lobbying their partners for support.

**3. Routine functions for DHMTs were strengthened**

The MSI strengthened routine management functions such as support supervision, rewards and sanctions, and attendance of DHT meetings which were reported to have been weak prior to implementation. These were enabled by teamwork.


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**4. Increased confidence in defining problems and designing feasible solutions**
The DHMTs' reported increased confidence in problem identification and prioritisation as the MSI stages progressed. This enabled them to increasingly develop feasible strategies for the next cycle.

**5. COVID-19 and related adaptations for continuity using skills acquired**
COVID-19 affected continuity of service and the progress of the implementation of Quality Improvement (MSI) cycles in all the study districts. PERFORM2Scale built DHMTs' skills in adaptive management, hence contributing to their ability to apply their new skills to COVID-19-related challenges within available resources. DHMTs' COVID-19-related adaptations included ensuring health worker availability (ie transportation, adjustment of duty rotas) and safety (ie provision of Personal Protective Equipment).

**6. Peer-to-peer learning enabled by platforms for shared learning**
Every quarter the three district groups were brought together in interdistrict meetings. During these engagements, the district teams shared activity plans, and updated on the progress of their implementation, successes and challenges. This enabled the districts to learn from each other and adapt according to their context. For example, in one interdistrict meeting, the districts in District Group 1 learnt from the Luwero team that the payment of health workers according to number of days worked can help address absenteeism.

**7. Improved teamwork among DHMTS**
DHMTs reported having observed improved teamwork during the MSI stages as well as during the planning and implementation of routine activities. This contrasted with their previous involvement in the MSI activities. Involvement in the MSI also led to improved relationships and coordination among the DHT and between health sub-district managers and the district health team.

> *"The MSI has strengthened team work which used to be lacking […] we now look at problems as a team, we look at the same vision, and we focus on the same objective as a team and support each other during implementation. […] our team is composed of two different works; people at the district level and at the health sub-district level, the MSI helped us interact better between the two levels."*
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# Management of human resources for health in districts in Uganda: a decision space analysis

**Increased awareness of decision space for DHMTs**
Findings from the decision space assessment showed DHMTs' awareness of their decision space increased due to their involvement in the MSI.

**Collaborative problem solving**
The implementation of the MSI program enabled 'relational capital' and created collaborative problem solving (joined-up governance/multi- sectoral approach) with other departments. For example, the Luwero team sacked laboratory staff found to be repeatedly absent from duty and were therefore contributing to the low TB cure rate in the district. This was enabled by engagement of the chief Administrative Officer's office.

**Increased confidence to perform HRM functions**
The implementation of the MSI helped strengthen HRM at the district level with DHMTs reporting increased confidence to take control and perform HRM functions such as supervision, appraisals, forecasting/analysis of HR gaps, and rewards and sanctions. Districts such as Ntoroko, Luuka and Buikwe reported improvements in conducting quality appraisals as well as in the number of health workers appraised. The Wakiso team reported improvements in their quality performance improvement plans.

Findings from the district groups in Rwenzori region showed that there was a slight variation in the use of decision space available to the DHMTs after the implementation of the MSI, with the three DHMTs reporting varying levels of control over HRM functions. Bunyangabu and Ntoroko DHMTs reported a wider decision space than their peers in Kabarole in both the baseline and endline studies.

Despite the existence of policies and regulations, a lack of resources, bureaucracy, local politics, and skills gaps remain major challenges to the use of available decision space by the DHMTs.

**NB** A paper of this subject - *Management of human resources for health in health districts in Uganda: A decision space analysis* – can be found on the PERFORM2Scale website.



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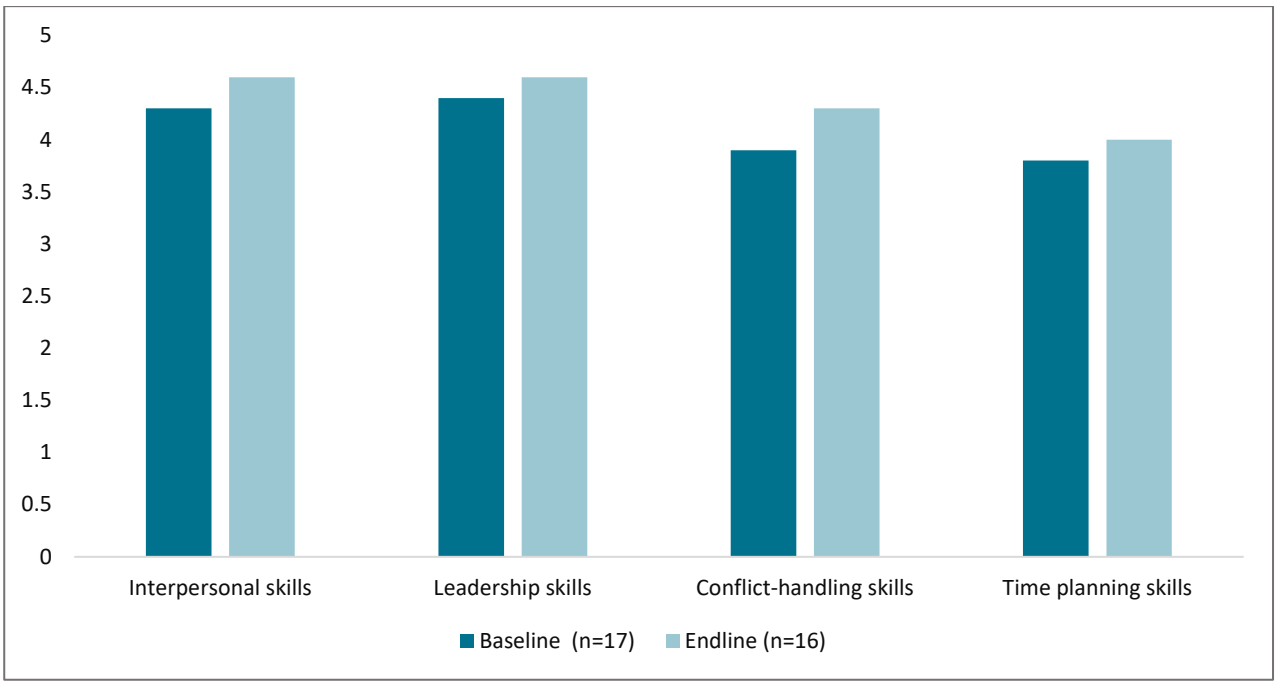
## Findings from the core DHT management competence survey

Baseline and endline management surveys were conducted among core DHT members in Nakaseke, Luwero and Wakiso (District Group 1) to understand changes in management competences. The results showed improvement, although not much, and the DHTs recognized that they needed to learn more. Areas that needed support included management and leadership as well as performance management stages such as schedules of duties and performance plans.

*Figure 1. Changes in core DHT management competences*




There is also evidence around some teams expressing agency by moving from awareness of the gaps to acting to improve performance management. For example, Luwero and Ntoroko teams respectively wrote concept notes and mobilized experts to train core DHT members and health workers from lower-level health facilities. Read our blog post on the work conducted to support this – *Observations during Performance Management training of district and facility health managers in Uganda: Who needs it more and why?* - for more details.



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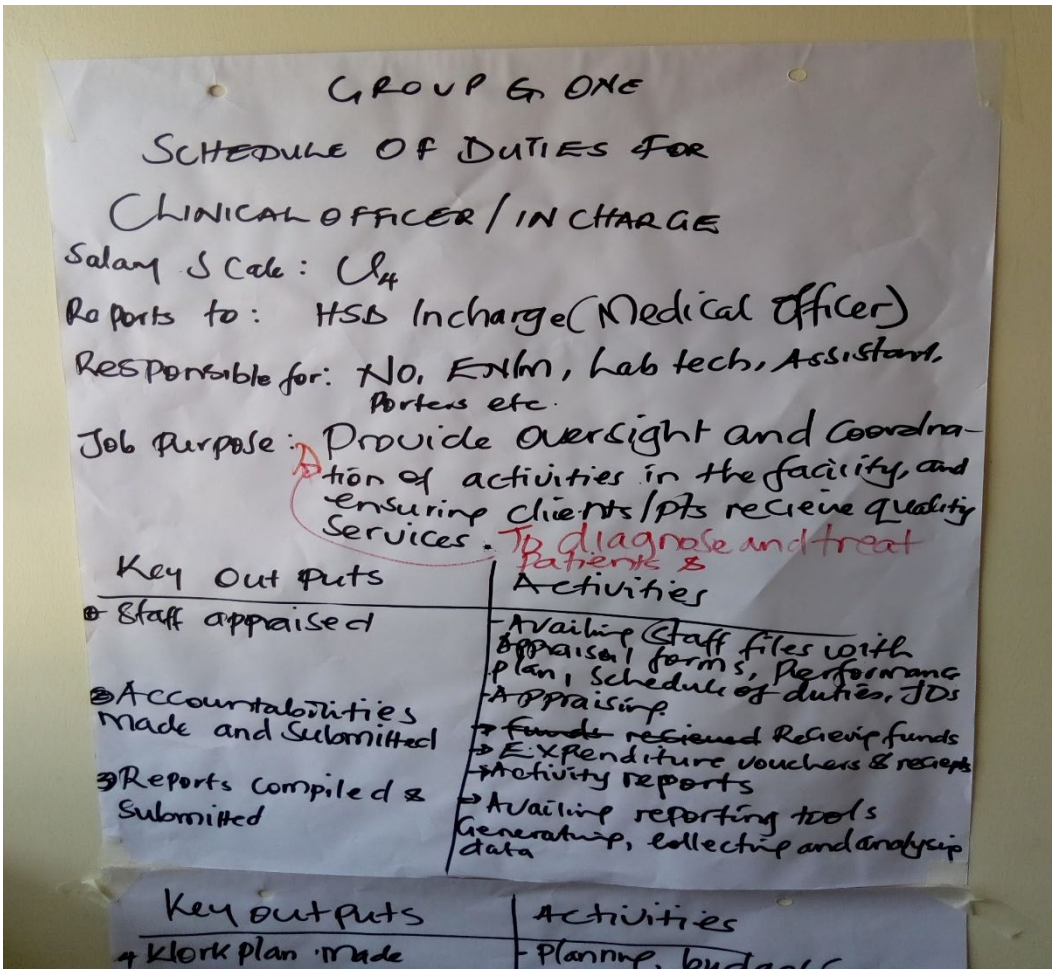
*Facilitator from Makerere School of Public Health leads a plenary discussion about leadership skills with district health managers. Part of a three-day Performance Management and Leadership training session for teams from Luwero, Nakaseke and Wakiso – December 2020*




*Example of a schedule of duties developed during the Performance Management and Leadership training session – December 2020*



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## Findings from the assessment of health workers' job satisfaction and management at facility and district level

A health workers survey was conducted at baseline and endline to measure perceptions of health workers about management and supervision at the district and health facility as well as in other areas, including organizational commitment, teamwork, safety climate, and job satisfaction. One of the assumptions in the PERFORM2Scale theory of change was that the effects of strengthening management would lead to improved health workforce performance of health workers at facilities who were not part of the core MSI/DHT implementation team.

Table 2 presents the results of the health workers' perception scores. Across all scales, the endline ratings were similar to the baseline ratings. Positive impacts or improvements (albeit small) in health workers' perceptions were seen in organizational commitment, teamwork climate, and supportive supervision and management at the district level at the endline compared to the baseline. However, management at the health facility and job satisfaction indicated negative scores (small declines) implying a negative effect on these constructs.

At the facility level, the trickledown effects were mixed, with both positive and negative effects noted. This suggests that either the effect is weak or that management should be improved to strengthen facility-level. However, these problems were much appreciated by the district level, and in the later cycles district managers changed to address performance management, e.g. improving the appraisal process and better enabling management at the facility level.

Furthermore, a survey was conducted to reveal any changes in the mood and satisfaction of health workers due to a spillover effect. It found that supervision had improved, however, there was a decline in workers' ratings of management at the facility level and in job satisfaction.

*Table 2: Perceptions of health workers survey findings*

| Outcome measure (composite scale scores) | Baseline | | Endline | | Diff ES (eta)/ Hedge's g |
|---|---|---|---|---|---|
| | N | Mean | N | Mean | |
| Organizational commitment | 528 | 3.52 | 572 | 3.71 | 0.269 |
| Teamwork climate | 527 | 3.80 | 568 | 3.88 | 0.133 |
| Supportive supervision | 526 | 3.86 | 568 | 3.92 | 0.078 |
| Safety climate | 524 | 3.71 | 571 | 3.80 | 0.142 |
| Management at facility | 484 | 3.80 | 480 | 3.76 | -0.038 |
| Management at district | 523 | 3.59 | 572 | 3.61 | 0.029 |
| Job satisfaction | 527 | 3.45 | 570 | 3.41 | -0.061 |

Notes: "Diff" is the average difference between baseline and endline groups, "ES" is the effect size of the estimated impact.
**Key:** Hedge's d value =0.2 (grey), 0.5 (yellow), and 0.8 (green) are considered to be small, medium, and large effect sizes.


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## Reflections about scale-up

**The need for flexibility**

Our original design for scale-up did not work out as expected. We had to modify both institutional arrangements and our approach. Reflexibility was made to work within the structures at both national and subnational levels, eg Technical Working Groups for Human Resources for Health (HRH) and Standard, Compliance, Accreditation and Patients Protection (SCAPP) - formerly SMEAR and now referred to as Governance Standards Policy and Regulation (GOSPOR).

**The need to be open to learning conversations**

Furthermore, the scale-up strategy could not be scripted ahead of time, and negotiation along the way was needed. Consequently, we learned that development of a scale-up strategy requires constant renegotiation about the most feasible way to achieve scale-up. The researchers/ implementers also need to be open to learning conversations and to adapt accordingly.

**For further information on any aspect of PERFORM2Scale please contact:**

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