The Life and Times of the Institutional Capacity Building Project in the Health Sector in Uganda

Lessons learned in leadership and management
The Life and Times of the Institutional Capacity-Building Project in the Health Sector in Uganda
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<td>AMREF</td>
<td>African Medical and Research Foundation</td>
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<tr>
<td>BTC</td>
<td>Belgian Technical Cooperation</td>
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<tr>
<td>DHO</td>
<td>District Health Officer</td>
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<td>DLG</td>
<td>District Local Government</td>
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<td>EA</td>
<td>Execution Agreement</td>
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<td>GLM</td>
<td>Governance, leadership and management</td>
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<td>HMDC</td>
<td>Health Manpower Development Centre</td>
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<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
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<tr>
<td>HSSIP</td>
<td>Health Sector Strategic and Investment Plan (2010/11–2014/15)</td>
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<td>ICB</td>
<td>Institutional Capacity-Building</td>
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<tr>
<td>IT</td>
<td>Information technology</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>MTR</td>
<td>Mid-Term Review</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
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<td>PCC</td>
<td>Patient-centred care</td>
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<tr>
<td>PNFP</td>
<td>Private not-for-profit</td>
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<tr>
<td>RHF</td>
<td>Regional Health Forum</td>
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<tr>
<td>RPMT</td>
<td>Regional Performance Monitoring Team</td>
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<tr>
<td>RRH</td>
<td>Regional Referral Hospital</td>
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<td>SDG</td>
<td>Sustainable Development Goal</td>
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Acknowledgements

In 2009, the Government of Uganda and the Kingdom of Belgium agreed on the formulation of the ‘Institutional Capacity Building project in Planning, Leadership and Management’ to be implemented by the Ministry of Health (MOH) in Uganda. Leadership and management weaknesses were identified as important bottlenecks hindering improvement of health sector performance. The project was intended to assist the MOH in closing the leadership and management gap in the sector and to initiate improved practices in District Local Government health services in the Rwenzori and West Nile regions.

During its time within the MOH, the project has undergone several adaptations to respond to the changing needs of the sector in general and the Ministry in particular. The flexibility experienced under the project has been a much-appreciated strength.

We have seen extensive technical and financial support to the Directorate of Planning and Development in the Ministry, with the development of new policies and strategic papers. Health services in the two project regions received much support through procurements of medical equipment and transport means, such as ambulances, utility vehicles and motorcycles. Direct funding to District Health Offices through Execution Agreements provided support in a performance-based modality. The support to the revitalization of the Health Manpower Development Centre under the project and the introduction of an e-learning system brought important changes to the opportunities for Continuous Professional Development for our health workforce.

On behalf of the MOH, I express our gratitude to the Belgian government for funding and supporting the project. We are very pleased with the continued support and especially the continuation of ‘Institutional Capacity Building’ with a second phase of the project.

My appreciation goes to the Project Steering Committee, the project management team, our staff members at the MOH and Regional Referral Hospitals and the stakeholders in the 15 supported District Local Governments, for their active participation and genuine interest in the success of the project.

Dr. Asuman Lukwago,
Permanent Secretary – Ministry of Health
ICB Project Director
Uganda and Belgium have been partners for many years. Over the past 5–10 years the focus of collaboration has been mostly on the health and education sectors. As one of the bilateral budget support donors, the Belgian government was concerned about the falling trend in health indicators over the period 2006–2009, which was attributed to challenges in sector leadership and management. The Health Development Partners were supportive towards investing in the health sector, but the identified leadership and management gap needed to be addressed. Under the Uganda–Belgium cooperation programme, an intervention on ‘Institutional Capacity Building in Planning Leadership and Management’ (ICB) was formulated and introduced in the Ministry of Health (MOH) in 2010.

The initial period of the project was difficult, as the Ministry was undergoing changes in its leadership. Also the concept of ‘Institutional Capacity Building’ as an institutional development approach was not yet well understood.

From 2011 onwards, the ICB project has been successfully implemented in the health sector at various levels. Support to the MOH headquarters targeted planning and quality assurance interventions, as well as policy development. The revitalization and transformation of the Health Manpower Development Centre, as the only health training institute under the MOH, was added to the original project objectives.

Covering two Regional Referral Hospitals and their surrounding districts provided the project with the opportunity to pilot a regional, rather than a district approach towards decentralized health services.

At the regional level the MOH and the District Local Governments developed several interventions, and a number of them are presented as case study in this publication. The case studies describe the process and results of the interventions, but also the challenges and lessons learned.

It is my hope that the seeds planted during the previous five years period will influence policy and will grow into mature and sustainable trees, providing fruits for the people of Uganda.

Dr. Isaac Alidria-Ezati,
Director Health Services – Ministry of Health
ICB Project Coordinator
Introduction

Dr. Hans Beks, Dr. Isaac Ezati

“We will live in a world where no child has to die from diseases we know how to cure and where proper health care is a lifelong right for us all.”

This quote relates to the third of the United Nations Global Goals for Sustainable Development (‘Sustainable Development Goals’, SDGs), officially launched in September 2015, and spells out the right to healthy lives with an absence of disease (“Ensure healthy lives and promote wellbeing for all at all ages”).

Other goals are relevant for the prevention of ill health: the eradication of hunger (Goal 2) and access to clean water (Goal 6). The 17 SDGs together are also relevant to the indirect attainment of global health.

Since 2000, the world has concentrated its development efforts on progress towards the Millennium Development Goals (MDGs), and enormous improvements have been made. At least three of the MDGs targeted health; however, despite the gains made, still too many people suffer from poor health and have limited access to care.

In Uganda, for example, the under-5 mortality rate stood at 180 per 1,000 live births in 1990, but has been reduced to 69 per 1,000 in 2015, nearly meeting the goal of a two-thirds reduction. However, it is unacceptable that 69 out of every 1,000 babies born are still dying before the age of 5.

Historical background of the Institutional Capacity-Building project

Before 2010, the health sector in Uganda passed through a difficult period, with deterioration in health-sector performance indicators. Although the sector was underfunded, with a per capita public health expenditure of only US$11, the lack of visionary sector leadership and weak management was considered a main bottleneck towards performance improvement.

The health development partners, together with the Government of

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2www.wethepeople.globalgoals.org.
5Targets for the reduction of infant mortality, maternal mortality, under-5 mortality, HIV prevalence and malnutrition were all missed (HSSIP 2010/11–2014/15).
7Technical and Financial File, Institutional Capacity-Building project.
Uganda, realized the need to increase financial support to the health sector as well as the need to strengthen its leadership and management. Within Belgian–Ugandan cooperation, a new intervention was developed in 2009, named ‘Institutional Capacity-Building in Planning, Leadership and Management’ (ICB project). Its objective was “to strengthen the planning, leadership and management capacities of the health staff at national level and local government levels”.

At the start of the project, important leadership positions at the Ministry of Health (MOH) headquarters were vacant. During the period 2010–2011, the MOH went through a process of ‘institutional change’ with new appointments in leadership positions and reengineering the relationships with some of the Global Health Initiatives. The ICB project supported the MOH during the change process and organizational development.

The context in which the project needed to operate within a central ministry was constantly changing, and over time several adaptations to the original project plan were necessary.

At the request of the MOH, the focus area of the project was shifted from supporting only four selected districts and four general hospitals in two regions in Uganda, to full regional support covering 15 health districts. This provided an opportunity to pilot a regional, rather than a district approach to the organization of the health care service. The support to a regional coordination mechanism in the Rwenzori and West Nile regions developed a model for the country and is described in detail in the first case study.

Over a period of five years, the support of the ICB project to the Ugandan health sector has targeted a variety of interventions, with varying degrees of success. To document the experiences and lessons learned, an end-of-project book, covering seven case studies, has been developed.

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8Permanent Secretary and Director of Health Services (October 2010) and the Minister of Health and Director General in July 2011.
9Technical Review in April 2011, shift of procurement modality to Belgian public system, Mid-Term Review in May 2013.
The choice of regions was made by the MOH in the context of ‘donor division of labour’ and the presence of other support to the health sector in the country. For historical reasons, Belgian cooperation mainly targets the west of the country — regions bordering DR Congo (see Annex B for country profile).

The Rwenzori region consists of seven districts surrounding the Regional Referral Hospital in Fort Portal. The population of the districts varies from 70,000 people (Ntoroko) to 700,000 (Kasese). The number of health facilities per district also varies from 15 to 120. Due to civil unrest in DR Congo, refugees are found in Kasese and Kyenjojo districts in varying numbers. The districts in the north of the region generally perform well according to the district league table. There are a large number of health partners and development agencies present in the region.

The Rwenzori region contains several national parks and the Rwenzori mountains; therefore, the tourism industry is an important economic sector in the region.

The West Nile region consists of eight districts surrounding the Regional Referral Hospital in Arua. Moyo district has the smallest population (137,000), while Arua has nearly 800,000 people. Yumbe has only 20 health facilities, while Arua has more than 100. The West Nile districts (Moyo, Yumbe and Adjumani) have seen an influx of varying numbers of refugees from South Sudan. After the end of the war with the Lord’s Resistance Army (LRA) in Northern Uganda in 2005, many international non-governmental organizations (NGOs) were active in the West Nile region. Most of them have now ended their programmes and have left the region.

The main economic activity in the West Nile region is trade, especially between Uganda and the neighbouring Congo and South Sudan. Agriculture is the main sector for formal and informal employment.

The theory and strategy of the Institutional Capacity-Building project

The focus of the ICB project (see Annex C) is on ‘institutional’ rather than on ‘individual’ capacity-building. It is using the framework of capacity strengthening at different levels in the health sector: central MOH headquarters, two Regional Referral Hospitals (RRHs), District Health Services, General Hospitals and the national Health Manpower Development Centre (HMDC).
Capacity-building interventions are perceived in a hierarchical pyramid, with all layers being important for performance strengthening: tools, skills, staff and infrastructure, structures and systems and the local context.\textsuperscript{10}

Between June 2010 and June 2015, the ICB project has been involved in a wide variety of interventions at different levels of the health pyramid.

The support at the national/sector level (output 1)\textsuperscript{11} has been targeted at the central MOH itself. Numerous interventions were supported in collaboration with various units and departments. The project assistance included financial and logistical support to ensure operational continuity of the MOH; strengthening of the national Health Management Information System (HMIS); support to regular performance reviews and planning; support to the development of national policies and programme strategies; and several studies to help the MOH make informed decisions.


\textsuperscript{11} Annex: ICB project description.
The support at the regional level (output 2) became the core of the project. Its aim was to show that improvements in leadership and management would lead to performance improvements in health care service delivery. It is already difficult to exactly define what ‘performance improvement’ means, but it is even more difficult to attribute proportions of noted improvements to various interventions in a complex context. A number of interventions initiated and supported under the ICB project are considered relevant and effective.\(^{12}\)

The transformation of the national training college in Mbale (output 3) was only added to the project scope after its first year. The MOH recognized the importance of leadership and management training for health workers, and targeted building the required capacity through the HMDC, the only training institute under its mandate.

As the start of the capitalization process (output 4), a list of project interventions under the various output areas was reviewed and discussed. Eventually seven interventions were selected to be developed into case studies, describing the aim, the process, challenges and achievements. The ‘lessons learned’ from each intervention were also described. This booklet bundles the seven case studies together; it is divided into three parts.

**Part 1: ‘Decentralized health systems’** includes two studies:

In Chapter 1, the authors (Damian Rutazaana, Charles Olaro, Ronald Miria Ocaatre, Bernard Odu, Martin Ssendyona, Jimmy Opigo, David Okia and Eric Kakoole) describe the project’s efforts to support the development of a regional-level health care service.

In Uganda public services are decentralized to District Local Governments (DLGs). The MOH provides stewardship of health care service delivery, with technical supervision, guidelines and policies, and resource mobilization. The delivery of services is under the mandate of the DLGs, and they employ all health workers in the district facilities. As more districts were created (from 38 to 112), the role of the technical ministry became more difficult and fragmented. In line with government policy, the MOH included the establishment of a ‘regional health level’ in its Health Sector Strategic and Investment Plan (HSSIP) for 2010/11–2014/15, but the expected national guidance on regional administrations did not materialize. The ICB project was targeted to support services in districts within the catchment areas of two RRHs (in Arua and Fort Portal), and a process of regional coordination and collaboration developed over the years. The intermediate outcome is that each region organizes a Regional Health Forum (RHF) every

\(^{12}\)Mid-Term Review 2013, Annual Project Result Reports 2013 and 2014.
quarter, which provides an opportunity for staff from District Health Offices (DHOs), hospitals and regional health partners to meet, share information and learn from each other.

In Chapter 2, the authors (Richard Obeti, Jimmy Opigo, Damian Rutazaana, Ronald Miria Ocaatre, David Okia and Charles Olaro) describe the introduction of Execution Agreements.

At mid-term of the project, the implementation of regional support interventions was centralized at the MOH. This was time-consuming but also obstructed local ownership. Execution Agreements were developed to support institutional capacity-building at the district level through delegated funding for selected activities. The introduction of Execution Agreements took place in phases and followed a performance- or results-based approach, whereby funding to districts was dependent on the execution of planned activities and the quality of accountability on previous funding. The Execution Agreements proved successful at increasing ownership of the project support. They also improved the effective and efficient use of resources with increased transparency. As a result, the MOH is exploring the possibility of using similar arrangements for the distribution of the government’s operational grants to districts.

Part 2: ‘Strengthening capacity for sustainability’ covers three case studies:

In Chapter 3, Eric Kakoole and James Ikabat describe the transformation process of the HMDC. The institution became dormant after donor support came to an end around 2005. The MOH made it clear that it wanted to maintain the HMDC as the only training institute under its mandate. It, therefore, proposed a process of revitalization and transformation into a national centre of excellence, with a focus on health management capacity. Under the ICB project, various activities to revitalize the centre were undertaken, such as upgrading the infrastructure, developing information technology (IT) and building staff capacity. To transform the centre, a roadmap for an organizational status change was proposed. Such an institutional change is a slow and time-consuming process, but a file with all the elements for a cabinet decision is now nearly completed.

Another key project intervention has been the training of health managers in governance, leadership and management (GLM), which is described in Chapter 4. Julius Balinda, Abassi Mansour, Jimmy Opigo, Richard Obeti and Damian Rutazaana describe how the course was developed, introduced, delivered and rolled out. After the initial two cohorts, an impact evaluation study was conducted, which showed
the course to be relevant and effective for health managers in the two project regions at all levels (DHOs, DLGs, hospitals and health facilities).

In Chapter 5, the development and introduction of a new method for training is described by James Ikabat, Florence Kebirungi, Resty Kamya and Jimmy Opigo. To increase access to training for health workers, a new system for delivery of training online (e-learning) was set up. Despite logistical and technological challenges, the option was received with great enthusiasm by health workers in the two project regions. A leadership and management training course for lower-level health facilities has been used to experiment with e-learning. The number of students has gradually expanded, and new courses like Anticorruption in health and Gender and Health Human Rights have been developed to be introduced through e-learning.

Part 3: ‘Making services more responsive to clients’ needs’ covers the last two case studies:

In Chapter 6, Jimmy Opigo, Julius Balinda and Abassi Mansour describe the development of a regional ambulance system and how communities are introducing creative measures for a sustainable referral system. The procurement of ambulances was accelerated in 2012 to increase project expenditure. The process was, however, targeted towards the development of a system of effective referrals for obstetric and other health emergencies. In addition to the procurement of ambulances and equipment, a package including maintenance, insurance and fuel subvention was added. Several training courses were also delivered (transport management, defensive driving and emergency and accident care), and services at the receiving facilities were strengthened. Two comprehensive assessments were undertaken to monitor the use and state of maintenance of the vehicles. Several districts mobilized community members to ensure the sustainability of the service after the project closed.

Chapter 7 describes the introduction of a patient-centred care (PCC) approach in the two RRHs as a way to improve the quality of services. David Okia, Charles Olaro, Bernard Odu and Damian Rutazaana elaborate on the process of understanding the approach, self-assessment at the facilities, identification of target areas and planning and implementing activities for quality improvement. Although the workload at the RRHs is high, some activities have contributed to increased awareness and improvements to services. Both hospitals were represented by a team at the 1st Global Conference on PCC in Nairobi in October 2015.
**Lessons learned**

Institutional development and capacity-building are long-term processes. The Belgian government is a long-term development partner in Uganda with a lot of experience in the health and education sectors. Its focus is on sustainability of its support.

Towards the end of the project period, the MOH and the Belgian government realized the many potential gains of interventions that were initiated under the ICB project. Therefore, a follow-up project was identified and devised in 2014–2015, to continue to support the strengthening of leadership and management in the health sector. This ‘ICB phase II project’ will build on the lessons learned from the various interventions, to support the MOH in its goal to reach universal health coverage.
In Uganda public services have been decentralized to District Local Governments. The MOH provides stewardship of health care service delivery, with technical supervision, guidelines and policies, and resource mobilization.

In this part of the book the regionalization process is described. Services within the catchment areas of two Regional Referral Hospitals (Arua and Fort Portal) were supported, and a process of regional coordination and collaboration developed over the years. Each region organizes a Regional Health Forum every quarter, which provides an opportunity for District Health Offices, hospitals and regional health partners to meet, share information and learn from each other.

In addition, so-called Execution Agreements were introduced, which accelerates the rate and quality of implementation of service delivery and fosters local ownership.

The two chapters show the strengths and challenges of introducing these innovative structures. Accountability, ownership and continuous dialogues at all levels contribute to improved quality of health care. Scaling up to the national level and the support of legal frameworks will enhance the sustainability of these approaches.
1. A COMPELLING CASE FOR A REGIONAL HEALTH CARE APPROACH IN UGANDA

Damian Rutazaana, Charles Olaro, Ronald Miria Ocaatre, Bernard Odu, Martin Ssendyona Jimmy Opigo, David Okia and Eric Kakoole

Key message
A health system structure at the regional level enhances coalition-building and the coordination of interventions implemented by the various stakeholders in the districts. It provides a platform for sharing information, planning, management, leadership and support supervision and offers district teams a way to discuss how to adapt national policies to a regional context.

Introduction

In Uganda the central government interacts with the districts directly, since there is no ‘intermediate administrative structure’ at regional/provincial level. Health care service delivery in Uganda is decentralized, with districts and health sub-districts playing a key role in delivery of health care services. Mindful of the fact that Uganda currently has 112 districts and 24 municipalities, with a possibility of more being created, it has become increasingly challenging for the Ministry of Health (MOH) to effectively perform its mandate of planning, coordination, support supervision, monitoring and quality assurance of implementation of the various health programmes in the numerous districts. Uganda has 14 Regional Referral Hospitals (RHHs), which provide health care services at a regional level.\(^1\) The National Health Policy\(^2\) and the National Hospital Policy mandate the RHHs to provide health care services at the regional level, but District Local Governments (DLGs) do not give them the responsibility to support these functions. In their current state they do not have the full range of human resources, as they are clinically oriented. A public health and management perspective and the necessary capacity to conduct support to the districts are lacking. In addition, they have no legal mandate over the districts.

The MOH has a number of regional health coordination and support structures which are currently operational in the country. These include the Uganda National Expanded Programme on Immunization services, Integrated Disease Surveillance and Response, Regional Malaria Response, Regional Blood Bank, Regional Performance Monitoring Teams (RPMTs) and Regional TB and Leprosy focal persons. However, there is little coordination of the activities of these bodies, and they have differing regional coverage. There are other government sectors that have regional structures such as Uganda Police, the Inspector General of Government, the Uganda Human Rights Commission and
Bank of Uganda. These primarily aim to ease the coordination and supervision of district-level services.

The MOH, in collaboration with the Belgian government under the Institutional Capacity-Building (ICB) project, has initiated a series of activities in the two regions of Rwenzori and West Nile to strengthen support and coordination of health care services at the regional level. Key among these interventions is the development of and support to the Regional Health Forum (RHF). A mapping study of existing regional structures and experiences in the health sector was recently conducted as a precursor for a feasibility study on establishing a regional administrative structure.

The key question of this case study is whether a regional-level health structure is relevant? What lessons can be learned and challenges addressed by the MOH as a result of the regional health approach supported by the ICB project in the two regions of Rwenzori and West Nile.

Sources of information

To develop this case study, the content was derived from the authors’ personal experiences and observations during participation in the RHF, as well as by reviewing documented experiences at the regional level in Uganda. Relevant documents in the following areas were reviewed: the regional level, regional planning meetings, inter-regional exchange visits, support supervision visits by RRHs to districts, a report on mapping of regional structures, RHF minutes (ICB/MOH), the Health Sector Strategic and Investment Plan (HSSIP) (2010/11–2014/15), the second National Health Policy, regional-level health development, and communication from the hospital directors of Fort Portal and Arua RRHs.

Case study

From June 2010 to November 2015, the ICB/MOH project supported the development of a regional health structure in the two regions of Rwenzori and West Nile through a number of initiatives: financial and administrative support to RHFs, support to RRHs to perform their regional role, and commissioning of a study mapping regional structures and experiences in the health sector.3, 4
Regional Health Forum

The RHF is a quarterly workshop that brings together health care leaders in each of the two regions of Rwenzori and West Nile to discuss and share experiences with the aim of improving health in the region. These meetings are coordinated and financed under the ICB/MOH project. The stakeholders participating in these forums include: District Health Officers, Assistant District Health Officers, District Biostatisticians, District Gender Focal Persons, RPMs, ICB and private not-for-profit (PNFP) staff, representatives of the PNFP health sub-sector, Chief Administrative Officers, district and regional health NGOs, MOH technical staff, the Director of the regional blood bank, RRH Directors and General Hospital Medical Superintendents. The forum is organized by a regional committee and is chaired by the Director of the RRH.3

Table 1.1. Stakeholders participating in Regional Health Forums for the two regions

<table>
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<tr>
<th>Title</th>
<th>Level</th>
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<tbody>
<tr>
<td>Hospital Director, Hospital Administrator, Senior Principle Nursing Officer – Regional Referral Hospital</td>
<td>Regional</td>
</tr>
<tr>
<td>District Health Offices (District Health Officer, Assistant DHO, bio-statistician)</td>
<td>District</td>
</tr>
<tr>
<td>Medical Superintendents – General Hospitals</td>
<td>District</td>
</tr>
<tr>
<td>Chief Administrative Officers</td>
<td>District</td>
</tr>
<tr>
<td>Ministry of Health – Planning and Quality Assurance department</td>
<td>National</td>
</tr>
<tr>
<td>Ministry of Health – Resource Centre (HMIS)</td>
<td>National</td>
</tr>
<tr>
<td>Technical Advisors and Regional Project Officers for ICB and PNFP projects</td>
<td>National</td>
</tr>
<tr>
<td>Regional blood transfusion service</td>
<td>Regional</td>
</tr>
<tr>
<td>Regional health development partners (e.g. Baylor Uganda; HRH Development/Intrahealth).</td>
<td>Regional</td>
</tr>
<tr>
<td>Regional Performance Monitoring Teams</td>
<td>Regional</td>
</tr>
<tr>
<td>Regional Medical Bureau representatives (Catholic, Protestant, Muslim)</td>
<td>Regional</td>
</tr>
</tbody>
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During its development the forum has gradually involved more stakeholders. As the workshops became more widely known, others also requested to be involved. However, there was a challenge that the meetings might become too big to have meaningful discussions.
The RHFs are hosted by districts on a rotating basis, so that members in each region can acquaint themselves with the settings of other districts. A total of 24 meetings were held in the two regions between November 2011 and June 2015. These provided a way to share experiences and adopt good practices. Some examples of these good practices are shown in Box 1.

**Box 1.1. Examples of shared good practices from Regional Health Forums**

- Yumbe District Health Office staff were able to perform a client satisfaction survey at Yumbe Hospital and Midigo Health Centre IV supported by the ICB project. The results of this survey were very informative for the hospital and the health centre staff, who were happy to learn that they were well appreciated by the community, despite previously believing that the opposite was true. This practice motivated staff and was shared at the RHF. This was well received by all districts, and consequently a client satisfaction study was also undertaken in other districts. The results of a similar study at the Fort Portal RRH motivated staff and pointed to specific areas of improvement, such as involving patients in the decision-making process.

- Moyo district had an innovative effective community ambulance system that it shared with other districts. The practice of involving community and political leaders in sourcing funds was well received, and Yumbe, Maracha and Bundibugyo have adopted the same approach.

- Kyenjojo District Health Office collected Health Management Information System (HMIS) data from private practitioners by supplying them with data collection tools and involving them in training and mentorships. Other districts (e.g. Kamwenge) took up this practice and improved their knowledge of the coverage and services delivered by private practitioners.

- Kyegegwa district actively involved the political leadership in implementation by informing the chairpersons and councillors about activities before they took place and also by giving them feedback after performing the activities. The chairpersons in turn were more committed to supporting district health activities in resource and community mobilization and advocacy. This information was shared at the RHF, and districts such as Kasese involved their political leaders more and reported that this made their work easier.
Support to Regional Referral Hospitals

The mandates of RRHs have been growing from merely a clinical role to include aspects of public health management, arising from the desire of the MOH to decentralize its stewardship functions. The MOH regional programmes based at the RRHs, such as the Expanded Programme on Immunization, assign more responsibility to them.

It is envisaged that the government will introduce a regional-level tier to the political system, and the RRHs will become the cornerstone for regional-level health care services.

In 2001, referral hospitals were made semi-autonomous. In keeping with this financial autonomy, the Parliament of Uganda allocated funds directly to them. Governance was then changed to Hospital Management Boards, appointed by the Minister of Health. While referral hospitals
were still headed by assigned Medical Superintendents, these schemes have been changed to (appoint) Hospital Directors in line with the MOH’s plan to prepare RRHs for further autonomy.²

a) **Traditional mandates of Regional Referral Hospitals**

RRHs are referral centres for advanced clinical care, the TB/leprosy control programme, medical equipment maintenance, specialist outreach services, advanced investigative services, teaching/coaching/mentorship and research.

b) **Regulatory mandates**

The Uganda Nurses and Midwives Council and indeed all professional health councils are mandated to oversee medical care, guarantee ethical behaviour, professionalism and employment standards. The Allied Health Professional and the Uganda Nurses and Midwives Councils have opened regional offices. The latter has piloted the use of regional hospitals to carry out some of the roles of the central office, such as renewal of registration certificates. This has cut down on the long distances the health workers from the regions have to travel to visit the MOH in Kampala.

c) **Project mandates**

The RRHs coordinate a number of projects implementing health interventions at the regional level, including the Expanded Programme on Immunization, Integrated Disease Surveillance and Response services, rehabilitative projects, the ICB project, regional laboratory coordination and RPMTs.⁴

The ICB project has supported regional structures to bridge the gap in coordination between the MOH at the central level and the districts.⁵ The RRH directors are the lead coordinators of the project in the regions. To better support regional structures and activities, regional project officers were introduced in Rwenzori and West Nile regions. This also sped up the implementation process and facilitated coordination of project activities.
Box 1.2. Support from the Institutional Capacity-Building project to enable Regional Referral Hospitals to carry out their regional mandate

The RRHs in Fort Portal and Arua have been supported to perform their role as a regional facility through a number of initiatives.

- The resource centres at the hospitals were refurbished. Books, equipment and internet services were provided. This provided a way for health workers in the region to access health information freely. The centres receive an average of 30 health workers per day. The hospitals have also provided over 50 health workers with basic computer skills. A local area network has been installed in the hospital to support e-health both at the RRH and in the two regions. It is envisaged that due to the limited number of specialists in the districts, facility health personnel in the districts can use these services to consult those at the RRH. Staff at the RRH can also consult the National Referral Hospital in Kampala using this equipment. Mulago National Referral Hospital has installed a local area network for this purpose as well.

- Fort Portal RRH has been able to recruit permanent staff at the resource centre and pays the costs of internet access. There has been increased utilization and appreciation of the resource centre by health providers from surrounding districts. The resource centre has also been used as a regional training centre for e-learning (over 60 health workers enrolled in various online courses), which has helped health workers in the region access training without having to travel long distances.

- The referral hospitals have also been provided with a vehicle under the ICB project, to carry out support supervision of lower-level health facilities. Technical support supervision for the districts is done by referral hospital staff, and these visits are a source of interaction and mentorship for health workers at the district and lower-level health centres with resource persons at the RRHs. However, there has been a limited number of support supervision visits, due to the low number of specialists (on average one for each discipline, with some disciplines lacking, such as no orthopaedic surgeon at Arua RRH) as well as expectations of financial compensation for the visits.

- The specialist services role has not been ignored. RRHs have been equipped with operating theatre tables and orthopaedic equipment. This has been very helpful, as the hospitals were facing challenges retaining specialists, partly due to the lack of equipment — for example, Fort Portal RRH has recruited a full-time and locally based orthopaedic surgeon, while Arua RRH will try to do the same.

- The Directors of both RRHs have been Chairperson of the RHF in their respective regions, strengthening their leadership and coordination role at the regional level. Districts have been able to easily share their concerns and have them addressed, as the RHF has helped to build relationships between the regional- and district-level stakeholders. For example, surgical training of medical officers was identified as a need in the districts. Based on the interaction at the RHF, medical officers from Bundibugyo and Kamenev districts were able to obtain mentorship and surgical skills training at the RRH.
Experiences from a mapping study on regional structures and experiences in the health sector

A study was undertaken to map regional structures and experiences in the country, to assist the MOH to make an informed decision on the best criteria for developing regional-level health care services. The study showed that there is a need for an agreed definition of a ‘region’ within the MOH (and beyond).4

Table 1.2. Summary of Ministry of Health initiatives and number of regions covered4

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Number of regions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of Health Area Teams</td>
<td>14</td>
</tr>
<tr>
<td>Malaria Coordination Teams</td>
<td>12</td>
</tr>
<tr>
<td>Geographic rationalization</td>
<td>10</td>
</tr>
<tr>
<td>TB/leprosy coordination</td>
<td>9</td>
</tr>
<tr>
<td>Integrated Disease Surveillance Response Teams</td>
<td>12</td>
</tr>
<tr>
<td>Regional Performance Monitoring Teams</td>
<td>12</td>
</tr>
<tr>
<td>Regional Referral Hospitals</td>
<td>14</td>
</tr>
</tbody>
</table>

The study also found that various initiatives have taken place in other sectors to decentralize services to the regional level (see Table 1.3), and all reported that it made coordination easier. However, they have no agreed definition of ‘region’ either. Thus regional support and the integration of services with other sectors is a challenge.

However, a common recommendation from respondents interviewed in the districts and regions and at the central level of the MOH was to form regions based on the catchment areas of the RRHs. The strengths of the RRHs include: strong relationships among RRHs, health centres and the local governments within the region; the management board of RRHs includes representatives from most districts in the region; and the existence of a Community Health Department which is supposed to run the public health domain of the RRH. Up until now, many of the MOH programmes at the regional level, such as RPMTs, were initiated and funded by donors, and many had little linkage with the RRH, thus when donor support dwindled, most of them became unsustainable.
On the other hand, the study found the following weaknesses of RRHs: they have no legal mandate over districts; the Community Health Departments are understaffed (only one public health nurse at Fort Portal RRH); and they do not have staff with relevant technical skills. There is also a conflict of interest between the MOH and DLGs over the ownership and supervision of General Hospitals and Health Centres.

**Regional planning meetings**

Another initiative by the ICB project supported the re-introduction of annual regional planning meetings in the two regions. These MOH meetings in the past provided guidance to the districts on national priorities, available budgets and planning templates, but they came to a stop due to a lack of resources and insufficient capacity at the national planning level. Their re-introduction through donor support was well received in the districts, but they were abandoned again, as the MOH did not provide the agreed counterpart funding and was unable to provide the required technical capacity. Due to the absence of these meetings, planning support from the central to the district level is still insufficient.  

**Discussion**

A regional-level health structure is urgently required. The HSSIP\(^1\) and the Health Sector Development Plan\(^7\) provided strategies towards the development of this structure; however, the MOH has little knowledge of good practices to guide it. The legal provision supporting regionalization is not well covered by the concept of a ‘regional tier’.\(^8\) A bill was passed by parliament in 2009 for the development of a regional system to operationalize Article 178 of the Ugandan Constitution,\(^10\) which states that two or more districts may cooperate in culture and development. Efforts are needed to revise the law and explicitly identify areas of collaboration and to create a political structure that can provide governance and oversight at the regional level. Several discussions have taken place on whether to have a separate political entity or to have regional-level health care services under the RRH as an agency of the MOH.

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**Table 1.2. Regional initiatives by other government sectors**

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Number of regions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electoral Commission</td>
<td>12</td>
</tr>
<tr>
<td>Inspectorate General of Government</td>
<td>16</td>
</tr>
<tr>
<td>Uganda Police Force</td>
<td>26</td>
</tr>
<tr>
<td>Uganda Prisons Service</td>
<td>14</td>
</tr>
</tbody>
</table>
With support from the ICB project, interventions such as the RHFs, support to RRHs and regional studies have generated important inputs, which will support the MOH to come to an informed decision on its regional approach (e.g. development of a regional identity, full stakeholder involvement, optimal size of regions etc.)

A regional-level health care structure in Uganda is necessary due to the increasing fragmentation of districts — from 34 in 1990 to over 112 in 2010\(^8\) — which makes effective administrative control difficult. As a result, central-level supervision and coordination by the MOH is unattainable and a very difficult task if continued in the current way. An earlier attempt by the MOH to constitute ‘area’ teams was found to be irregular, ineffective, costly and with infrequent visits and support to the districts.

Other regional health care initiatives such as regional disease programme focal persons had no structural or functional linkages to the RRH, making coordination and sustainability difficult. RPMTs were introduced in 2013 and linked to the RRHs, with support from the Global Fund to Fight AIDS, Tuberculosis and Malaria. However, their regional activities have so far been hampered by administrative and financial constraints.

In Kenya, Provincial Hospitals provide direct supervision and management of district hospital services.\(^9\) Uganda operates a decentralized administrative system, which gives autonomy to DLGs. However, districts cannot be left unsupported and require a framework for sharing knowledge and joint learning.

The RHFs in the Rwenzori and West Nile regions provide a platform for all health actors in the region to share ideas and improve health care performance at the regional level. This initiative highlights the benefits of a regional health care level and is well received. However, the major threats and challenges to this approach are the lack of a comprehensive national definition of a ‘region’ and its potential sustainability without a legal framework. A feasibility study is required to agree on the definition and roles of a regional health care level.

The development of a regional-level health care structure is possible, though challenging. It will require continued partner support and broad stakeholder involvement at the district level from RRHs, the MOH, the Ministry of Local Government and the national government. The support required is in the development of supportive policies and laws, followed by organizational capacity-building. If government commitment can be achieved, the strategy will be formally implemented and sustained.
Conclusion

The ICB project has contributed substantially to introducing a regional health concept and helping the districts in the two regions understand and benefit from it. It has also promoted the effectiveness of project implementation. This experience has shown that a regional structure is relevant. The need to develop a policy and legal framework for its backing is being supported by a planned feasibility study. It is hoped that the MOH will take on stewardship of the process and build the required organizational capacity to introduce and implement the concept. More studies and discussions need to be carried out and fast-tracked, as an evidence gap still exists on the merits and demerits of a regional health care structure in the Ugandan context. A feasibility study will go a long way to guiding the MOH and the Cabinet towards devising a policy for the development of a regional health care level.

Recommendations

In the short term, and in the absence of an explicit policy framework, the MOH should empower RRHs to support and supervise districts. They can increase the technical and operating capacity of the Community Health Departments of the RRHs to provide the much-needed support. In the long term, together with other sectors, the MOH should look at developing a regional administrative unit to coordinate and synergize activities of all sectors.

The RRHs should develop initiatives that not only bolster their clinical care but also public health and regional health system management, mentorship and supervision of districts.

Districts should continue advocating for an institutionalized RHF that is not project-dependent but, rather, part of the routine activities of the RRH, to continue having a platform to exchange knowledge (sharing), challenges and best practices (learning).
References


3. Institutional Capacity-Building project Regional Health Forum minutes for West Nile and Rwenzori from November 2011 to June 2015.


6. Institutional Capacity-Building project Regional Project Implementation Committee meeting minutes for West Nile and Rwenzori from January 2013 to June 2014.


The Life and Times of the Institutional Capacity-Building Project in the Health Sector in Uganda

Richard Obeti, Jimmy Opigo, Damian Rutazaana, Jakor Oryema, Ronald Miria Ocaatre, David Okia, and Charles Olaro

**Key message**

Execution Agreements provide a framework for stakeholder engagement, regulation and stewardship of the project between central-, regional- and district-level actors.

Execution Agreements improve the speed of project implementation and promote local ownership by regional and district teams and responsible and accountable project planning, implementation and compliance and thus contribute to improved overall performance of district health care systems.

**Introduction**

An Execution Agreement is a funding mechanism that aims to decentralize project activities such as planning and implementation. At the same time it intends to increase local ownership, including by embedding project activities in the district-level management of the health care sector. This is in line with Ugandan decentralization and health care policy, which designates districts as the operational-level structures for health care delivery.\(^1\), \(^2\)

It further aims to accelerate project implementation, by delegating operational project management responsibilities from the Ministry of Health (MOH) headquarters in Kampala to District Local Governments (DLGs).

Execution Agreements can also be considered a form of results-based financing, as replenishment disbursements are conditional on the attainment of pre-determined outputs.\(^7\)

The idea of Execution Agreements was born out of the findings and recommendations of the Mid-Term Review (MTR) of the Institutional Capacity-Building (ICB) project in April 2013, which revealed the low level of project execution, especially in enhancing capacity in planning, leadership and management in the local government health care sector.\(^3\)

The MTR identified the concentration of project execution at central government level as a key limitation to project implementation...
and effectiveness. The MTR recommended a system of delegated funding and responsibility to the district level, for implementation of selected activities of the district health work plans, which was deemed likely to improve project efficiency and implementation. To achieve the decentralization of the programme in the Rwenzori and West Nile regions, the MTR recommendation was adopted for project implementation.

It is in line with the MTR recommendation that a modality for safely decentralizing project implementation was developed in the form of Execution Agreements with the districts.

It is important to note that this approach supports the implementation of the Health Sector Strategic and Investment Plan (HSSIP) 2010/11–2014/15. This type of decentralized funding mechanism is also in line with MOH priorities and with the strategic vision as laid out in the second National Health Policy.

The key questions for this chapter are:

- Does an Execution Agreement provide a framework for stakeholder engagement, regulation and stewardship of the project between central- and district-level actors and promote a functional partnership?

- Does the mechanism of funding under the Execution Agreement translate into better financial accountability, increased local ownership of the projects and accelerated project implementation?

**Source of information**

The contents of this chapter are mainly based on observations and experiences of the authors, as active participants in the Execution Agreement process. It involves the authors’ understanding of best practices, lessons learned, challenges and recommendations arising out of their participation in the formulation, signing and implementation of Execution Agreements.

The contents were further informed by the study on ‘Organizational Assessments of 7 Districts in Rwenzori Region and 7 Districts in West Nile Region’, and other documents reviewed were: Execution Agreements for the implementation of the ICB project; the project MTR report; Execution Agreement implementation reports and feedback; presentations and discussions on experiences with Execution Agreements during Regional Health Forum (RHF) meetings; and the financial audit report of June 2015.
Case study

Selecting districts

To identify districts with capacity to engage through an Execution Agreement, a baseline assessment of all the districts in the West Nile and Rwenzori regions was conducted in the last quarter of 2013. This aimed at gaining insight into the existing capacities to manage Execution Agreements at district level, their need for support, and the role they were willing and able to play. Areas assessed were: the general nature of the contracting party; the institutional environment; technical capacities; control measures; financial management; audit; and procurement. The assessment was performed in two phases.

The first phase consisted of a pilot organizational assessment of two DLGs — Kabarole and Kasese — both in the Rwenzori region. Results were shared and validated during a regional meeting with representatives of the District Health Teams and District Finance Departments of all seven districts of the region. Recommendations on improving the assessment tool were made for studying districts in the second phase.

In the second phase, a ‘downsized’ and ‘tailor-made’ questionnaire was used to capture district-specific information for the remaining districts of Rwenzori and West Nile regions. A total of 12 out of 13 districts completed this questionnaire (Nebbi, Zombo, Maracha, Koboko, Yumbe, Moyo, Adjumani, Kyegega, Kamwenge, Ntoroko, Bundibugyo and Kyenjojo).

After the assessment, six districts (three from each region) were chosen (see Table 2.1), based on a favourable assessment outcome with a pass mark of over 70%, to sign Execution Agreements for implementation of the planned project activities. The initial districts were: Nebbi, Moyo and Yumbe (West Nile) and Kabarole, Kasese and Kyegega (Rwenzori).

This was then followed by the official signing ceremony of the agreements. Districts were represented by their respective Chief Administrative Officers, the MOH by the Permanent Secretary, and BTC Uganda by the Resident Representative.
### Table 2.1. Summary of district selection

<table>
<thead>
<tr>
<th>Category</th>
<th>Districts</th>
<th>Findings and comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Districts chosen to engage in the Execution Agreement</td>
<td>Kabarole, Kasese, Kyegegwa, Nebbi, Moyo and Yumbe</td>
<td>For districts in this category, the seven areas of assessment (general nature of the contracting party, institutional environment, technical capacities, control environment, financial management, audit and procurement) were found satisfying; therefore, the districts were given permission to engage in the Execution Agreement.</td>
</tr>
<tr>
<td>Districts where some improvements needed to be made before Execution Agreements could be signed</td>
<td>Maracha, Koboko, Zombo, Bundibugyo, Ntoroko and Arua</td>
<td>Districts in this category fulfilled some of the assessment criteria, but Execution Agreements were temporarily halted to allow the regional project officers to work with the District Health Team and conduct further on-site assessment of the capacity of the district.</td>
</tr>
<tr>
<td>Districts with serious capacity gaps to address before Execution Agreements could be signed</td>
<td>Adjumani, Kyenjojo and Kamwenge</td>
<td>Districts in this category did not fulfil most of the assessment criteria and, therefore, were not recommended for an Execution Agreement, to enable further capacity-building support of these districts by the central ICB project team and its regional project officers.</td>
</tr>
</tbody>
</table>

Initially only six out of 15 districts signed Execution Agreements in January 2014 (Moyo, Yumbe, Nebbi, Kyenjojo, Kasese and Kabarole). In a phased approach, support was provided through the project secretariat, and the nine remaining districts were able to sign Execution Agreements in May 2014 (Bundibugyo, Ntoroko, Kyenjojo, Kamwenge, Zombo, Arua, Maracha, Koboko and Adjumani).
Implementation process

The six District Health Teams were guided by the ICB project staff to develop work plans for project implementation, which were submitted to ICB headquarters for approval and funding. The capacity of the District Health Teams was built through mentorship by the central and regional project staff. Additional capacity-building of key personnel such as the Chief Finance Officers, Accountants and District Health Officers took place during the quarterly regional project implementation meetings where all the districts in the region were represented.

All the Execution Agreement activities had to be implemented based on approved work plans. The districts opened ICB accounts, and the funds were deposited into these accounts. Funds were replenished once the districts submitted accountability and activity reports to the ICB project. Every district could request new funding as soon as 50% of the initial funding was spent. The frequency of replenishments depended on the speed of implementation at district level.

The ICB project headquarters were able to monitor the progress of Execution Agreements in the different districts on a quarterly basis through quarterly reports submitted by the districts. These reports comprise a technical report, a financial report and a rolling output and outcome matrix.

Results

The Execution Agreement arrangements accelerated the flow of funds and implementation by regions and districts. In the initial phase of the project, funding for district activities was spent through the central project office. With the introduction of the Execution Agreements, it became possible to transfer funds to the districts and Regional Referral Hospitals (RRHs). Only 26% of the project budget had been spent by the end of February 2013 at the inception of the Execution Agreement, half of which on the procurement of vehicles and ambulances. By June 2015, 82% of the project budget had been spent, 45% of which through the Execution Agreements: out of the initial Execution Agreement budget of €1.2 million, €535,000 had been transferred to the districts.

Districts that were slow in executing the agreed work plan or did not comply fully with the administrative requirements (reporting and accountability) received less funding than those districts that executed according to plan and submitted accountability reports correctly and on time. Slow district implementation, therefore, compromised the service delivery in those districts.
The Execution Agreements contained built-in results-based-financing incentives (i.e. prompt replenishment of funds following good performance on previous funding). The external audit in March 2015 revealed generally good compliance with procedures and regulations by most of the districts. Two Execution Agreements were temporarily suspended to correct weaknesses in the administrative systems.

The Execution Agreements required districts to plan within the framework of the project objectives and set out responsive activity plans to meet their local priorities. This created local ownership and awareness of the opportunities.

“We understood the project when the project was ending,” one key informant was quoted during the formulation of ICB phase II. Alignment of project objectives with district priorities was and remains a challenge for many projects but improved after Execution Agreements were introduced.

**Health systems strengthening**

Funds were transferred to implement district-specific activities set out in the work plans. According to the quarterly reports and from personal communication with the District Health Officers and the district activity implementers, a lot of additional health systems strengthening activities were undertaken.
Box 2.1. Execution Agreements — examples of district activities

- In Kabarole district, 314 Health Unit Management Committee (HUMC) members were trained and equipped with knowledge and skills in basic management to perform their roles in accordance with the MOH HUMC guidelines. This helped to strengthen health facility management, as the HUMCs became vigilant in overseeing the day-to-day operations of the facilities. The District Health Office received reports from committee chairpersons demanding better supplies and human resources at their facilities. They also reported any underperformance by staff members.

- In Kyegegwa district the concept of the District Health Assembly, where all stakeholders meet to discuss the performance of the district health care sector and suggest practical solutions, was conceived during the Execution Agreement implementation. The same idea was copied by many other districts in the regions. It was found to be a good way to increase stakeholder involvement in strengthening the district health care systems, and the reports of the Health Assemblies were submitted to the MOH. The Minister of Health of Uganda, on a recent visit to Kabarole district, was quoted as saying “This financial year 2015/16, we are going to introduce Sub-district Health Assemblies to be chaired by the Resident District Commissioner and all the stakeholders to be involved to discuss performance of the health sector at the sub-district level...”

- Similarly, District Health Assemblies in Nebbi district, which were last held in 2006, were revived with the participation of many stakeholders, including technical, political, religious and cultural leaders, civil society and non-governmental organizations, members of the business community and implementing partners. Health Sub-district Assemblies were also held with the participation of stakeholders from lower-level local governments. This gave all stakeholders opportunities to provide inputs into health care service delivery.

- In Moyo and Yumbe districts, communities were mobilized through the Execution Agreement to support the district ambulance system, to improve the health outcomes of the districts. This not only improved the referral system in these districts but has also acted as a learning experience for other districts on sustainability planning.

- Supervision and monitoring of reproductive health increased under the Execution Agreement and was followed by quarterly review meetings. These have led to improved quality of antenatal care and increased outputs (e.g. testing for syphilis increased from 875 patients in 2013/14 to 2,473 by end of May 2015).
The use of Execution Agreements has shown the feasibility of introducing results-based-financing mechanisms, using regulatory and compliance tools.

In terms of governance, an important achievement of the Execution Agreements has been the introduction of a result-based-financing framework, which proved beneficial where districts complied with the regulations. For example, the project secretariat recovered funds that were not spent as planned, and two districts (Bundibugyo and Kasese) were temporarily suspended. Good performance (e.g. Kyegegwa district) was rewarded with supplementary funding after the initial funding was exhausted. Performance in terms of funding utilization is shown in Figure 2.1.

The Execution Agreements necessitated the introduction of regional project officers, to act as a link and support technical backstopping, and the development of guidance protocols, such as implementation manuals and a quarterly reporting format. The quarterly regional project meetings were transformed into RHF meetings, with expanded membership to share experiences, coordinate partner initiatives in the region and consolidate district activities and performance at a regional level.

*Figure 2.1. Execution Agreement funding utilization by region (EURO)*

Utilization of resources was seen to vary from district to district. It is notable that the districts identified as weaker at the initial assessment continued to perform relatively less well than their counterparts.
Kyegewa district performed very well, with 100% of the budget funds used, followed by Kabarole with 77% and Kasese with 61%. The other districts received less than 30% of the funds available to them. This was due either to delayed first funding (insufficient initial capacity as per the suitability assessment), slow execution of agreed activities or delayed submission of accountability reports.
Koboko performed best in the West Nile region, with 65% of the funds utilized, followed by Nebbi, Yumbe and Moyo districts at 61%, 60% and 55%, respectively. The other districts performed less than 30% of the planned activities. This is mostly related to a later start of Execution Agreement implementation.

**Financial management capacity**

Although the absorption capacity of the budgets was low (with 53% of the districts spending less than 30% of the planned budget), the financial management capacity of the districts improved over time. This was clearly demonstrated during the audit report (June 2015). The report concluded that the project funds provided by the Belgian Development Agency were, in all material respects, being used in conformity with the applicable contractual conditions. This translates to better financial accountability attributable to Execution Agreements. Only two of the 15 districts were identified as having challenges of compliance with good financial accountability (e.g. insufficient separation of duties, deviation from agreed activity budgets, failure to respect local government regulations).

**Discussion**

District Health Teams developed activity work plans, and this increased the local ownership of project support, as well as responsibility for results.

While districts are making progress in the implementation of the Execution Agreements, progress is uneven. In Rwenzori region, it was noted that Kyegegwa, Kabarole and Kasese had utilized over 60% of their budgets, whereas the other districts had utilized less than 30%. In West Nile, Koboko, Yumbe and Nebbi also utilized over 60% of their allocated budgets. Poor systems and weak leadership were cited as the factors behind the low absorption by some of the districts.

Technical challenges with the new electronic Financial Management Information System (FMIS) in some districts slowed implementation.

Execution Agreements proved effective tools for accelerating project implementation and improving local ownership of project support. Responsibility for results (and funds) was an important aspect in strengthening the local leadership and management capacity of the health care programmes. This has been noted through improved activity implementation and reporting, and interaction with various key informants in the districts.
Conclusions and way forward

As seen in the increased overall expenditure under the project, it is possible to accelerate project implementation by delegating operational project management responsibilities to the DLG level. However, support to strengthen the planning and financial management capacity at the district level is required.

Correlating the results at district level with the findings of the initial assessment reports, it is clear that issues of leadership, governance and management are very critical. Districts that are well organized provide strong leadership and respect management systems and procedures are among the best performers with the Execution Agreements (e.g. Kyegegwa and Kabarole), while districts with weak leadership and management practices are among the weakest performers (e.g. Arua and Kasese).

Execution Agreement arrangements can be replicated and used for implementation of other projects by DLGs within and beyond the health care sector, and similar contracts can be used to distribute government funds in a performance-based modality.

Recommendations

The good financial management system arising from the risk evaluation and the control measures established under the Execution Agreements can be adopted by the MOH to channel routine primary health care funding to the districts.

Execution Agreements can also be adopted by other health development partners for the implementation of projects by the DLGs, but they need to be accompanied by capacity-building in leadership and management.
References


7. Execution Agreement for the implementation of ICB District-Level Health Sector Capacity-Building Initiatives UGA 0901711, 2014.

The Life and Times of the Institutional Capacity-Building Project in the Health Sector in Uganda
The Life and Times of the Institutional Capacity-Building Project in the Health Sector in Uganda
Part 2: Strengthening capacity for sustainability

This part of the publication focuses on capacity development within health systems strengthening in Uganda. The process of revitalization and transformation of the Health Manpower Development Centre (HMDC) in Mbale is presented. Various activities to revitalize the centre were undertaken, such as upgrading the infrastructure, developing IT and building staff capacity.

The development and introduction of a course for governance, leadership and management training is presented. This training, originating from the African Medical Research and Education Foundation (AMREF) and the Ministry of Health of Kenya, was adjusted to the Ugandan context. It was successful in strengthening the capacities of health managers and thereby the local health system. Although a plea is made for implementation by an independent training centre, there is a need for national scaling up and policy support.

e-learning is an innovative activity being introduced in the health care sector. At the HMDC, a course management system was set up, and staff trained in its use. For training of busy (in-service) health workers, a blended approach of e-learning with other teaching methodologies is especially useful.

e-learning reduces time away from work stations and interruptions to health care service delivery at health care facilities. The initial stage of e-learning is costly, but it becomes cheaper in the long run.
3. THE REVITALIZATION AND TRANSFORMATION OF A NATIONAL TRAINING INSTITUTE: THE CASE OF THE HEALTH MANPOWER DEVELOPMENT CENTRE IN MBALE

Eric Kakoole and James Ikabat

Key message

To become an autonomous training institute to upgrade competencies and certify health workers, the Health Manpower Development Centre (HMDC) will need to change course by: a) acquiring a new legal status with an Act of Parliament; b) making strategic changes and investments; and c) mobilizing all possible support from key stakeholders.

An autonomous status is required to ensure accredited training programmes matched to the health needs of the country.

Background

The HMDC in Mbale, Uganda, is a national in-service training institution with a mandate of developing evidence-based training courses for the continuous professional development of all health workers. It started in 1982 when the Ministry of Health (MOH), the Canadian International Development Agency (CIDA) and the African Medical Research and Education Foundation (AMREF) signed a tripartite agreement to establish the Health Training Centre in Mbale for the purpose of providing in-service training/continuing professional development to various cadres of health workers in Uganda.

The HMDC is located in Mbale municipality in the Eastern region of Uganda, 230 kilometres from Kampala. Not long ago, Mbale was the cleanest of all urban areas in East Africa. Like many places in Uganda, relics of the aftermath of civil wars are evident in the gradual infrastructural decline. Mbale is now picking up again; a new wave of optimism among its residents is a pointer to the future.

Built within Mbale Regional Referral Hospital (RRH), the HMDC provides an attractive environment in which to live and study. Near the centre are the Mbale School of Nursing and Midwifery, the Mbale School of Clinical Officers (one of Uganda’s oldest) and Busitema University’s Faculty of Health Sciences; this is a future ‘health care training village’.

Currently the HMDC provides a wide range of in-service training courses on subjects including: leadership and management of health care facilities, gender and human rights, anti-corruption in health care, comprehensive management of HIV/AIDS, and reproductive health. In
2012, the centre introduced an e-learning infrastructure for health workers to access training across the country.

Currently the centre has three lecture rooms, a library, a conference room, two blocks of hostels, staff accommodation and adequate land for future expansion. There are four Senior Health Training Officers, with administrative and support staff.

The existing infrastructure has been upgraded over recent years, and the hostels still need to be rebuilt. The capacity of the existing staff has been increased through courses and technical support. The centre is in need of a reboot, however, with serious attention towards its leadership management.

The centre became instrumental in training mid-level health care facility managers and health care workers in clinical and management skills for the rapid launch and successful roll-out of programmes and interventions such as immunization, disease control, family planning and hospital management.\(^\text{13}\)

At its peak between 1990 and 2000, the HMDC was a hub for training health care workers in the East African region, with participants coming from as far as Kenya, Zambia, Malawi, Ethiopia and Tanzania. This attracted funding from the government, international funding agencies and the private sector.

However, poor governance and weak leadership and management led to poor-quality service delivery, low productivity and a loss of professional competences, which caused the centre’s eventual decline between 2005 and 2010. No other locally viable institution to train health care workers existed in Uganda,\(^\text{14}\) and alternatives measures, such as training abroad, were unsustainable.

In recognition of the vital role of training health manpower in-country, in 2010 the MOH decided to revitalize the centre in Mbale.

The revitalization process started with the development of a new Strategic and Investment Plan (2013–2018) outlining the mission and vision for the HMDC, its strategies and activities and required budgets. This provided the strategic direction for the revitalization of the centre.

One of the recommendations of the Strategic Investment Plan was the transformation of its governance and leadership. The existing institutional organization, with the HMDC as part of the Human Resource Development Division within the MOH, proved impractical.

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Instead, a new structure was envisaged, which would be accountable and responsible for the necessary reforms, to maximize the potential of the national training centre. This would require the centre to transform into a more autonomous and self-managed institution, with its own funding sources and capacity for resource mobilization. The process to request a status of autonomy needed to be accelerated.

The proposal was to transform the HMDC into a body corporate, established by an Act of Parliament, with a board of governors and its own management, assets and liabilities.

This case study chronicles the steps undertaken towards achieving an autonomous legal status for the training centre, with a specific focus on the process of consultation with strategic stakeholders.

The key question: What are the best practices and lessons learned for acquiring a legal status for a public institution?

**Case study: Stakeholders’ involvement in the transformation of the HMDC**

**The process**

Transforming the governance and leadership structure of an institution requires a set of actions. For the HMDC, acquiring the legal status of an autonomous institution was particularly crucial. Being instituted by an Act of Parliament means that you are able to make fairly independent decisions, have a Board of Governors to offer oversight, and are flexible enough to attract investments to grow.

However, changing the status quo requires a lot of ‘buy-ins’ from the interested stakeholders and takes tact, patience and excruciatingly long hours in negotiations to reach a consensus on the way forward. Many bills proposed in Uganda went nowhere, due to a lack of consensus from stakeholders.

To avoid failing, the HMDC needed an elaborate plan to identify and reach out to stakeholders for the purposes of coalescing them around a common purpose and minimizing resistance from influential parties that would have derailed the process.

To kick-start the process of achieving consensus from the key stakeholders, a concept note on the HMDC transformation roadmap was developed. This mapped out stakeholders and their level of involvement, budget and work plan. Figure 3.1 illustrates the various

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15 An autonomous institution in Uganda receives a direct financial vote from the Ministry of Finance appropriated by Parliament. It is a statutory body created by an Act of Parliament.

16 Body corporate is a governance structure with a board, assets and liability and can be sued or sue in its name.
levels of consultations needed to achieve optimal consensus from stakeholders.

**Figure 3.1. Levels of consultations with stakeholders**

**Consultations with stakeholders**

To kick-start the process, formal approval from the MOH was required. As a result, the concept note was presented to the Ministry’s Senior Management Committee and top management. The concept note was approved, and the HMDC was directed to carry out further consultation and fast-track the process.

Obtaining internal approval was one achievement, but the process of consulting external stakeholders was more exhausting in terms of time and financial resources than planned. For example, it took three years of consultations to achieve consensus from the stakeholders!

To reach stakeholders, different approaches were adopted. These included writing and emailing, visiting and presenting to various organizations, as well as conducting workshops and meetings. To be systematic, a stakeholder analysis was carried out by the Policy Analysis Unit of the MOH to establish levels of involvement and influence, as summarized in Table 3.1.
Table 3.1. HMDC stakeholders analysis

<table>
<thead>
<tr>
<th>1. High power, low interest</th>
<th>2. High power, high interest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Politicians, Members of Parliament, district leaders, Legal Advisory Committee, Health Service Committee</td>
<td>Ministry of Health officials, Health Service Commission, Public Service Commission, Cabinet Secretariat, Ministry of Education, Ministry of Finance, First Parliamentary Counsel, Law Reform Commission</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Low power, low interest</th>
<th>4. Low power, high interest</th>
</tr>
</thead>
<tbody>
<tr>
<td>General public, health workers, health work students</td>
<td>Development partners, NGOs, civil society organizations, media, religious organizations, advocacy organizations</td>
</tr>
</tbody>
</table>

From the stakeholders identified, it was clear that particular emphasis and effort would be put on those in Category 2 (high power, high interest). To reach out to and convince this category of stakeholders to support the proposed transformation, consultation meetings were organized with financial support from the Institutional Capacity-Building (ICB) project. The first meeting was organized in 2012 to collect views from the stakeholders on the viability of an autonomous institution.

At first, some stakeholders were sceptical of the HMDC’s capacity to stand alone and sustain itself. They were, however, informed that a nationally accredited in-service training institution would be capable of making independent and faster decisions. In addition, the institution could offer accredited courses, research and consultancy services, which could attract additional funding, and use cost-efficient strategies to limit its dependence on public funding. These were the essential ingredients of sustainability.

Stakeholder consultations are complicated and often frustrating, yet crucial and unavoidable. Some of the challenges faced included a lack of response or feedback, failure to attend meetings or representation by junior officers without decision-making capacity. In meetings themselves, a sense of priority for the core aspects to discuss is not always obvious, as this can differ for each stakeholder. For example, discussions on a new name for the institute were time-consuming because of the different perceptions of different stakeholders.

In some cases, meeting key people individually proved more effective than mass consultations. Additional inputs were also obtained from
other sources, such as impact studies (e.g. a regulatory impact assessment), and national and international benchmarking visits to other training institutions. These alternative methods must be seen as additional to consensus-building meetings, and all should be combined.

**Study tours: benchmarking**

To understand how an autonomous government training institution can run effectively, a study of existing similar institutions was necessary. In Uganda, the Civil Service College was chosen for being an in-service institution and being under a department in the Ministry of Public Service with similar structures of bureaucracy\(^{17}\).

Outside the country, two institutions in Tanzania were chosen for study: the Centre for Educational Development in Health, Arusha (CEDHA), and the Tanzanian Training Centre for International Health (TTCIH) in Ifakara. These two institutions were studied because of their similar history to the HMDC. Of interest was the fact that while they all started around the same time, their fortunes were different. While the HMDC went into near collapse, the Tanzanian institutions had flourished and progressed.

The two Tanzanian institutions had started as departments within the MOH but went on to acquire semi-autonomous status. Instead of enacting a Parliamentary Act establishing each of them, a government agency for regulating health training institutions was established\(^{18}\).

Back in Uganda, the Civil Service College had just been created in 2010. Its predecessor, the Uganda Management Institute (UMI), established to train public servants, had short-changed its founding rationale by becoming academic and commercial. It started admitting paying pre-service students, and its main focus shifted away from in-service training of civil servants. The government later turned it into a university, with a compromise of creating a new Civil Service College.

Lessons from Uganda and Tanzania were quite immense and compelling. First, diversified sources of funding are key to institutional survival, but balancing them is essential. Care should be taken to avoid a training college outgrowing its original purpose.

In the case of the UMI, an increased search for funds led to the introduction of multiple market-driven courses and a change of the client focus; thus it gradually moved away from its original purpose of providing continuous professional development to public servants.

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\(^{17}\)Report on benchmarking visit to Uganda Civil Service College.

\(^{18}\)As explained by the Director of CEDHA during a benchmarking visit to the Centre.
In the Tanzanian cases that were observed, the in-service training institutions are part of the ‘health care training village’. In this ‘village’, a hospital, a university, a community and places of worship are all working together with attention to synergies and cooperation. In such a complete centre for training, students (pre-service), health care practitioners (in-service) and the community benefit from each other, in an effective and efficient environment. Thus, for a health care training centre to thrive, cooperation and partnership with health institutions within and around should be emphasized.

**Drafting and documentation**

Without documentation, it is possible to learn and forget. Reports on benchmarking visits, stakeholder consultations, impact studies as well as minutes on various meetings have all been used for drafting a bill establishing a new ‘Uganda Health Services Management Institute’.

Rather than engaging consultants, the drafting of the bill was done within the MOH itself, by a select committee, which ensured that the primary stakeholders were involved, minimized back-and-forth consultations and secured local ownership and learning (capacity-building) from the process.

The committee involved members from the MOH (Principle Policy Analyst, Assistant Commissioner for Human Resource Development, training officers from the HMDC, representatives of District Local Governments and the District Health Officers Association). Together, they produced draft legislation and the principles to establish the Uganda Health Services Management Institute. While the method of using a select committee for drafting was productive and affordable, its drawback was the withdrawal of staff from various offices for a whole week.

Validation of the draft bill and its principles by stakeholders is required before the file can be submitted to the Cabinet Office for a final decision on the HMDC’s status change.

Alongside the benchmarking exercise, external consultants were engaged to conduct a regulatory impact assessment to understand the consequences of the proposed status change for government and other stakeholders. Its outcome, including a cost–benefit analysis, completes the requirements for submission of the draft bill.

**Consensus-building**

To build consensus, consultations and discussions with all stakeholders are required. Especially for new legislation, this process can be difficult
and time-consuming, as there will always be ‘winners’ and ‘losers’. For example, the loss of control over a more autonomous HMDC is a concern of the Ministry of Education. In October 2015, a national consensus-building workshop will be organized, where all relevant elements will be reviewed and discussed and a common recommendation on the establishment of the Uganda Health Services Management Institute will be made.

The process has been participatory, and lessons have been learned for future reference. The final phase of the actual Cabinet approval and adoption by Parliament is no longer under the control of the project or the MOH and needs to be awaited.

For the future, dreams are big, but there is a plan — the Strategic Investment Plan — which includes infrastructural expansion of the HMDC. Also planned is an overhaul of the leadership and governance structures, staff recruitment, accreditation of training courses, resource mobilization and health care systems research. With many health institutions (university, hospital, training centres) converging around the HMDC, future collaboration and partnerships will harness synergies and efficiencies for robust growth and development.

**Lessons learned**

Change, while desirable, is difficult to achieve and often painful. Even when there is overwhelming evidence that change is needed, it can bring on natural fear, resulting in resistance. This is because change affects stakeholders differently, creating winners and losers. Managing change is critically important. It is important to assure stakeholders that unavoidable negative impacts can be mitigated.

Legislation of whatever kind is expensive and time-consuming, without immediate outputs and results.

While achieving an autonomous status by an Act of Parliament is important, it is not a means to an end. The successful training institutions in Tanzania are still struggling to achieve autonomy by legislation. Revitalizing the HMDC and transforming it into an active and productive institution is at least as important as pursuing a status change, and this should remain the focus.

For any legislation, consultations are a must, and a mix of various methods should be employed. Building a personal rapport with key stakeholders is often essential to achieving results through mass consultations.
Documentation of the key steps taken in this process cannot be over-emphasized. The legislative journey is usually long, with a risk of people drifting away or dropping out, which affects institutional memory. With proper documentation the process can be continued at any time.

Lessons from the HMDC case study are that more time should have been spent on personal consultation with key stakeholders. Also, a market survey on the demand for services from the HMDC should have been conducted to provide a stronger background to the proposal. The benchmarking studies of training institutions were very informative and should have been made earlier in the process.

4. GOVERNANCE, LEADERSHIP AND MANAGEMENT TRAINING FOR HEALTH SYSTEMS STRENGTHENING IN UGANDA: THE INSTITUTIONAL CAPACITY-BUILDING PROJECT EXPERIENCE

Julius Balinda, Abassi Mansour, Jimmy Opigo, Richard Obeti and Damian Rutazaana

Key message

The training of health care managers in governance, leadership and management (GLM) is critical for health systems strengthening. The training produces competent officers who manage and lead health care services for results and apply the knowledge and skills acquired in their own situation.

When conducted in working teams, using trainers who are very familiar with the local health care system and its context, the training enables health care managers to acquire the right knowledge, skills and attitude to effectively manage health care services at different levels in Uganda.

Introduction

Health care systems in Africa are broken down and hardly responsive to the needs and demands of clients at community, national and regional levels. While there are many possible explanations for this state of affairs, key factors are inappropriate and weak leadership, management and governance structures and practices. This is clearly demonstrated by the piecemeal, rather than holistic, approaches to health systems strengthening. The African Union Health Strategy (2007) and the Africa Health Leadership and Management Network, through its constitution, acknowledge this; they have highlighted that most African countries are unlikely to achieve their national health targets and those espoused in Millennium Development Goals (MDGs)/health-related Sustainable Development Goals (SDGs), without
strengthening leadership, management and governance at all levels of the health care system.

The Ministry of Health (MOH) of Uganda identified challenges in health system governance, leadership and management; health financing; and the critical shortage and inadequate performance of human resources for health in its Annual Health Sector Performance Report, 2014/15.2

The maternal mortality rate for Uganda has stagnated since 2006 DHS at 438 deaths per 100,000 live births, as opposed to the set target of 131 by 2015.3 HIV prevalence increased from 6.8% to 7.2%.4

Globally, regionally and nationally health systems strengthening has been recognized as an essential ingredient for a dynamic and functional health care system. It ensures that health care systems respond to the health care needs of the communities and offer quality health care efficiently and effectively.5 Good governance and effective leadership and management enhance the attainment of national and global goals, including the MDGs and the health-related SDGs. This is mainly as a result of the effective and efficient use of resources to meet the organization’s objectives to realize improved health outcomes.

Following the above challenges, the MOH identified a need for GLM training in Uganda for practising senior health care managers and newly designated or aspiring managers at different levels in the health care sector. The intention was to effectively build their competencies to enable them to apply the newly acquired skills to strengthen the health care delivery system in the two regions of West Nile and Rwenzori. The MOH is still committed to supporting this initiative to enhance coordination, quality assurance and support for health care service delivery. One of the key components of the Institutional Capacity-Building (ICB) project is the training of health care managers at national, regional and district levels.

The overall goal of the training was to build participants’ capacity in terms of their knowledge, skills and attitudes and to enable them to plan, implement, supervise, monitor and evaluate health programmes and improve health care delivery in their institutions.

The training aimed to create a critical mass of professionals well equipped with state-of-the-art knowledge on issues pertinent to health systems strengthening in their health facilities, with the aim that they will further train their colleagues within their institutions.

This chapter presents the content and outcomes of the GLM training implemented in the Rwenzori and West Nile regions of Uganda. Reasons
why this training should be scaled up to more regions in the country will be presented.

**Source of information**

This chapter is based on the authors’ experiences of the GLM training implemented in the West Nile and Rwenzori regions of Uganda, a review of the training and evaluation reports, participants’ course evaluations, pre- and post-test results, a review of the adjustment of the African Medical Research and Education Foundation (AMREF) manual to Ugandan needs, and the impact assessment inception and evaluation reports. All served as sources of information for this case study.

Governance is defined as the “manner in which public officials and public institutions acquire and exercise the authority to provide public goods and services, infrastructure and a sound investment climate”.

Leadership is the process whereby an individual influences a group of individuals to achieve a common goal.

**Case study**

**Preparation of training in Uganda**

In 2013, the MOH ICB project contracted AMREF Kenya in Nairobi to conduct a 10-day Training-of-Trainers (TOT) course for 23 senior Ugandan health care managers. The participants were mainly drawn from the MOH, with only four from districts, including the District Health Officers (DHOs) of Kyegegwa, Moyo and Koboko and the Director of Fort Portal Regional Referral Hospital (RRH). It was deemed necessary to include district-based trainers from the two target regions for the purpose of coordinating the roll-out process in the regions.

The MOH selected a small task force of seven of the 23 officers (see Box 4.1), to review, adapt and develop the AMREF training manual for Uganda. A retreat was organized at the Health Manpower Development Centre in Mbale in 2013, in which the training manual was reviewed and adapted to the Ugandan health context and health training needs (e.g. use of Ugandan cases and examples).
Box 4.1. Members of the GLM task force

- Assistant Commissioner for Health Services (Human Resources Development)
- DHO, Kyegegwa
- DHO, Moyo
- Senior Medical Officer (Quality Assurance)
- Principal Policy Analyst MoH
- Acting Head of the Health Manpower Development Centre, Mbale
- Principal Bio-statistician (MOH Resource Centre)

At the same retreat, a concept note on the methodology and budget were developed for the roll-out of the training in the Rwenzori and West Nile regions. It was proposed to train 90 officers in two classes per region. The participants were all health care staff with management tasks and included members of District Health Teams (DHOs, Assistant DHOs in charge of maternal and child health, Assistant DHOs for environmental health, District Health Educators and Bio-statisticians), Assistant Chief Administrative Officer, Health Secretary, Principal Human Resource Officer, Hospital Supervisors, Administrators and Principal Nursing Officers. Four managers from RRHs were also included. These were from both public and private-not-for-profit health care sub-systems. It was planned that managers of primary health care facilities would be trained in the second round.

Course content and duration

The original course comprised 10 modules (see Box 4.2) and took 10 days. However, it was executed in two sessions of five days, with each session covering five modules. The period between the two training sessions was used for participants to work on a Community Health Improvement Project (CHIP, see below).

Performance assessment and certification

The participants were assessed through formal pre- and post-training tests. Additionally, an informal continuous assessment was applied through questions and answers after each module and active feedback from the participants. Attendance of at least 80% of the sessions was mandatory for successful completion of the course. A project for practical application in the field was developed and implemented by participants and also formed part of the assessment. Upon successful completion of the course, participants were awarded an MOH certificate of proficiency in GLM for health systems strengthening.
Box 4.2. Content of the GLM training course

Overview and context of the health system
Objectives of this module include: defining concepts of a health system; describing the components of a health system; explaining the importance of systems thinking for health systems strengthening; discussing the characteristics of a functioning health system; and describe the challenges and emerging health systems issues in Uganda.

Governance in health
Objectives of this module include: defining the concepts of good governance in health; outlining the principles and characteristics of good governance; describing the governance structures in health and their functions at various levels; discussing various health laws and health-related regulations impacting on good governance; and discussing factors that promote or hinder good practices on accountability and transparency.

Leadership in health
Objectives of this module include: defining the concepts and styles of leadership; describing characteristics of effective leadership; discussing the place of leadership in the health systems building blocks; and analysing approaches for effective leadership in health care.

Management for health
Objectives of this module include: defining the concepts and principles of management for health; describing the functions and roles of a manager in health systems strengthening; discussing strategic management approaches; and describing characteristics of effective teams.

Human resources for health
Objectives of this module include: defining the concepts of human resources for health in the context of health systems strengthening; discussing the relevant human resource policies and plans in human resource management; describing the process of human resource planning; discussing performance management in the context of human resources for health; and describing the various approaches that can be used in human resource development.
Health management information system (HMIS)
Objectives of this module include: defining the concepts of HMIS; describing the role and functions of HMIS in the context of health systems strengthening; discussing the contribution of HMIS policies and legal frameworks in systems strengthening; discussing the role of HMIS in knowledge management in the context of health systems strengthening; describing the process of evaluating and improving HMIS; and describing the role of ICT in HMIS strengthening.

Health financing
Objectives of this module include: describing health financing and related concepts; discussing mechanisms of financing health; describing processes of financial management; and discussing the use financial expenditure monitoring tools.

Health service delivery
Objectives of this module include: defining the concepts and models of service delivery; discussing the characteristics of effective service delivery; describing an effective referral system; and discussing the concepts and approaches in accreditation.

Supply chain management
Objectives of this module include: defining the concepts in supply chain management; discussing the contribution of existing policies, laws and regulations in strengthening supply chain management; describing procurement management practices in health; describing an effective distribution and stock control system for supply chain management; and discussing appropriate quality control measures to enhance health service delivery.

Monitoring and evaluation
Objectives of this module include: defining the concepts of monitoring and evaluation in the context of health systems strengthening; describing the frameworks for monitoring and evaluation systems; discussing tools and methods for monitoring and evaluation; and describing the role of evaluative research in health systems strengthening.

Training methodology
The training consisted of a mixture of adult learning methodologies, including short lectures, questions and answers, small group discussions, plenary presentations, video shows and role plays.
Participants from the same district developed their own CHIP together, which was presented to the class and discussed. The CHIP was meant to enable participants to analyse their district health care systems, prioritize certain problems for corrective interventions and redirect available resources to address these problems. Participants particularly reviewed and assessed the values, goals and objectives for relevance, critical problems to be addressed and the primary strategic options that might accomplish the objectives.

There was a constructive feedback session in which other participants and the facilitators gave their inputs on the CHIPS. This resulted in a refined CHIP project for each district. At the end of the course, each district team was required to implement their CHIP when they returned to work.

The participants assessed the cost of the project for appropriateness during the training course. Additional information was indicated, which included actions considered or to be taken, the time-frame, costs and staff responsible for implementation.

Finally, the participants were asked to develop the process milestones, monitoring and evaluation plans and the management structure for implementation of the CHIP. Examples of the CHIPS devised by the district teams are presented in Box 4.3.

Box 4.3. Selected examples from the Community Health Improvement Project

Kyegegwa district proposed strengthening support supervision and increasing coverage of maternal and child health indicators in Kyegegwa Health Sub-district. The District Health Team was given continuous medical education on support supervision and development and the use of a supervision checklist. Three health facilities started to provide antenatal care and maternity services, which led to an increase in the proportion of deliveries at health units from 34% in 2013 to 52% in 2014.
Yumbe district has a predominantly Muslim population, known for their polygamous communities, inadequate access to health care services and very fragile environment due to neighbouring South Sudan. The managers from Yumbe decided to focus on improving rates of health facility delivery in the district through community mobilization. This led to an increase in health facility delivery from 34% in 2013 to 48% in 2014.

Zombo district, located in a mountainous area, is known for its high volume of traffic to the Democratic Republic of Congo and a high prevalence of traffic-related injuries. The team, therefore, developed an injury control project. The results of the intervention are yet to be assessed.

Koboko district designed a project that focused on getting additional financial resources to address poor maternal health. This was done by re-directing the existing primary health care development grants for construction to maternity wards and to support the recruitment of midwives. The district built three maternity wards, and 20 midwives were recruited.

Achievements of the GLM training

Since 2013, two training courses have been carried out in the regions of Rwenzori and West Nile, and an additional course was also organized for the health care managers of Fort Portal and Arua RRHs.

In the first cohort, 60 health care managers from Rwenzori and 75 from West Nile were trained. In the second cohort, 80 health care managers from Rwenzori and 90 from West Nile were trained. In March 2015, 30 health care managers (15 from Fort Portal and 15 from Arua RRHs) underwent the first phase of this training in Hoima. The second phase was conducted in April 2015 in Mbale. Practical application skills were observed in the class.

There were immediate changes in the behaviour of the participants during the course of the training, as noticed in their team-building processes in group assignments and time management. Other intended competencies which are now being practised include systems thinking, stewardship, change management, performance management, service organization, support supervision and monitoring. This was ascertained through support supervision of the participants. Their increase in knowledge was demonstrated by their post-training test results, which all of the participants passed.
Proposal for roll-out to lower-level health care facilities

The national task force held a one-week retreat in Mbale to review and adapt the training to suit the needs of lower-level health care facilities after the first training course. At the same retreat, units on gender and anti-corruption in health, and health human rights were added to the governance module, and a unit on work climate was added to the human resources for health module. Also, a few errors that were identified in the manual were corrected. The training of health care managers in lower-level health care facilities by the district trainers under an Execution Agreement was recommended and agreed.

During the evaluation of the training, participants recommended that this kind of course be rolled out to lower-level health care managers due to its importance.

Discussion

The GLM training forms the backbone of the ICB project’s support to planning, leadership and management. The competences gained have contributed to systems strengthening at the skills and performance levels of the capacity pyramid, the framework established for the ICB project. The project has been able to train a team of 23 senior health care professionals at the MOH headquarters and at district level in the regions of Rwenzori and West Nile as national trainers. They can be called on at any time to train or act as facilitators in various different courses at national, regional and district levels. There was significant interruption during the training for the senior managers, as four of the managers dropped out of the training due to busy schedules. This affected the original number of trainers targeted at national level.

The roll-out of the GLM training in Rwenzori and West Nile was a success. The key senior health care managers in all seven districts in Rwenzori and eight districts in West Nile have been trained. They were from different disciplines, including health care professionals, bio-statisticians, administrators and politicians, and this facilitated team learning, with synergies anticipated in activity implementation after completion of the training. A critical mass of senior professionals equipped with state-of-the-art knowledge and skills on issues pertinent to health systems strengthening at their level of work has been created, as evidenced in formal and informal assessments. Similarly, the senior health care managers in Fort Portal and Arua RRHs have been trained. The participants are now expected to plan better, implement and monitor and evaluate health programmes in their areas for better health outcomes among the population they serve.
The training participants in both regions have been prepared to train other professionals in their institutions and lower-level health care facilities under their jurisdiction. A roll-out plan has been put in place to be financed under Execution Agreements.

The performance of the trained staff has been assessed through a formal evaluation. The preliminary findings of the evaluation report indicate improved health care management practices, and the trained staff at different levels have put in place management tools to monitor the performance of their workers (e.g. Kyegegwa Health Centre IV).

The course content was evaluated by all participants as being very useful to them; this suggests that the participants believe that the principles they learned will work and will, therefore, be implemented. Some training participants from the two regions have already participated in GLM training as facilitators. The districts and RRHs have been asked to plan for the roll-out of this course to lower-level health care professionals. By initiating and rolling out the GLM course, Uganda has added this particular course to the range of existing capacity-building training courses and complements and adds value to them.

The country now has a very important training manual adapted from the African context and tailored to Ugandan health care professionals’ needs. The manual has been adopted by other partners, including a short fellowship programme by Makerere University School of Public Health. Although the GLM training covered only two regions, there is a need to roll out the course to other regions not covered by the ICB project — either through specific efforts by the MOH or by development partners which consider this necessary.

The manual can be revised in future as the need arises. All participants were given the manual and also soft copies; therefore, continued training of other staff or even revision by the participants will be easy when necessary.

Depending on the need, various modules can be easily incorporated into the pre-service training curricula of doctors, nurses and other mid- and low-level health care providers. It is believed that if every health worker, regardless of their level of training, were equipped with some GLM competences, health care systems in Uganda would become more responsive, and the delivery of care would be more effective and efficient. There is, however, no plan yet to roll it out to other districts in the country under the ICB project — a limitation which cannot be addressed in the context of this project.
So far the training has covered district-level and RRH health care managers. While the key staff at district level were covered, two cohorts of 15 health care managers from Fort Portal and Arua RRH were trained, which is an adequate number to create a critical mass at RRH level as well. A challenge is that not all lower-level health care facility managers were trained, and this remains a gap to be addressed later.

This course could also be useful for other senior health care managers at national level. At this level the type of training could be tailored and shortened to suit the busy schedules of these officers. Consideration of appropriate venues for the training is also essential to avoid disruptions for the same reason.

There is a plan to deliver the GLM training through e-learning, to address the challenges of cost, time and work disruptions, and an e-learning format and content has already been developed to be delivered in future through the Health Manpower Development Centre’s e-learning platform.

Conclusion

According to an impact evaluation that has just been concluded, the GLM training for health care managers in Rwenzori and West Nile has been a success, given the over 90% completion rate and universal passing of the post-training test. A critical mass of professionals equipped with state-of-the-art knowledge of issues pertinent to health systems strengthening in their workplaces has been created.

Recommendations

To increase coverage of the number of health care managers trained in GLM, it is recommended that all the districts in the Rwenzori and West Nile regions should plan to roll out this training to lower-level health care managers. Health care managers in the 15 districts who did not take part in training at roll-out time should be trained with the lower cadres of staff at the roll-out to the lower-level health care facilities.

This course could also be useful for other senior health care managers at national level. At this level the type of training could be re-organized and shortened to suit the busy schedules of these officers. Consideration of appropriate venues for this training is essential to avoid disruptions for the same reason.
It was recommended that another 30 participants from Arua and Fort Portal RRHs should attend the course, to increase the coverage of senior managers from the two hospitals with GLM training. This was done after this case study was concluded.

It is recommended that the MOH and development partners should roll out the GLM training in the other regions in the country that are not supported by the ICB project.

In the selection of prospective trainers, their availability and commitment should be considered to avoid drop-out.

There will be a need to keep revising the training manual, as the health care systems change over time.

References


5. BLENDED ONLINE LEARNING AS AN ALTERNATIVE FOR DELIVERING LEADERSHIP AND MANAGEMENT SKILLS FOR HEALTH CARE WORKERS IN UGANDA

James Ikabat, Florence Kebirungi, Resty Kamya and Jimmy Opigo

Key message

Blended online training programmes for health care workers and managers reduce the time spent away from their work stations and improve their skills in health care management.

Introduction

The demand for health care services in Uganda has more than doubled in the recent past due to an increase in the population. The prevalence of infectious diseases such as hepatitis B and C, HIV/AIDS, malaria and tuberculosis is still high, and outbreaks of high-mortality infections (Marburg, Ebola) are increasing in the country. The prevalence of non-communicable diseases such as diabetes, hypertension and cancer is also increasing in the overall population. New technologies for patient care and management continue to emerge, requiring continuous adjustment of the roles and responsibilities of health care workers and managers.

In an attempt to address the changing knowledge requirements, the Ministry of Health (MOH) conducted a training needs assessment in 2010. The report highlighted the inadequate skills in leadership and management among health care workers and managers. It recommended a skills-building course to address the knowledge and skills gap. A lack of managerial and leadership skills among most health care workers and managers poses a major challenge to effective health care service delivery. Inadequate managerial skills would not only affect the quality of service delivery but would also reduce the utilization of services. In addition, the same report indicated that the existing training programmes for health care workers do not adequately address the managerial skills needed, and health care workers themselves expressed interest in acquiring the skills identified.

About the Health Manpower Development Centre

As we have seen in Chapter 3, responding to the increasing need for continuous professional development of health care workers and managers, the MOH established the Health Manpower Development Centre (HMDC) in 1984 as a national in-service training centre. The centre is mandated to develop evidence-based training courses for professional development and health services management. In the
past, paper-based distance teaching and learning was used to train health care workers and managers. Over the years, however, this approach proved costly and unsustainable following reduced donor support. The paper-based distance learning courses also included classroom sessions, for which participants were required to attend the HMDC. In addition to high costs, classroom sessions contributed to staff absenteeism.

To overcome these kinds of problems, the HMDC decided to develop a blended online training programme. The existing course on leadership and management for lower-level health care facilities (readily available and already used in face-to-face trainings) was transformed for delivery through e-learning. Other courses are currently still being developed (e.g. clinical instructors and mentors, gender and human rights, and anti-corruption in health care services). More online courses are planned for the future.

The aim of this case study is to describe how the blended online training course on leadership and management for health care workers was introduced in the two regions of West Nile and Rwenzori, thereby addressing the key questions: Can blended online learning improve the skills of health care workers? And what are the lessons learned from implementation of the blended online training course on leadership and management for health care workers? The chapter also discusses the challenges, experiences and outcomes of the online training.

In this case study, blended online training refers to online teaching and learning, supplemented by other methodologies such as CDs, face-to-face sessions and printed materials.

**Case study**

*Capacity-building for blended online training*

As a first step, a capacity assessment to facilitate online training by the HMDC was carried out, as well as an assessment of the IT infrastructure. According to the assessment report, the centre had no capacities to facilitate online training. There was no knowledge within the centre on how to organize and facilitate online learning and no equipment and materials to support online learning programmes.

Based on the assessment, the HMDC requested technical support to train its senior health training officers and to equip the centre with the necessary equipment and materials. An international expert was recruited for a period of two years under the Belgium Technical Cooperation’s Junior Assistance programme, to train senior health training officers on e-learning techniques and to develop the first modules.
The MOODLE (open source) platform was chosen for setting up a course management system.

The teaching staff at the HMDC took several online training courses at the Virtual University in Uganda, to learn more about facilitating online courses. Paper-based content was then converted into online content.

**Piloting e-learning in Moyo district**

As a first step, a sensitization meeting was organized for the introduction of an e-learning platform for all the District Health Officers (DHOs) in the two regions of Rwenzori and West Nile.

Moyo district was chosen for a pilot training course on leadership and management, and the District Health Office was assessed for the availability of space and infrastructure to start the e-learning programme. The DHO invited interested staff to take the programme. Using the available office space and one desktop computer at the District Health Office, the e-learning pilot started with a group of 16 participants. Among the participants, a coordinator was identified to assist his peers on minor IT challenges.

**Experiences of online learning and scaling up**

Of the 16 participants, 14 successfully completed the six-month course. The participants were very positive about the course, as mentioned in its evaluation. The evaluation recommended a scale-up of the pilot to cover all the districts in the West Nile and Rwenzori regions, using the resource centres at the Regional Referral Hospitals (RRHs) as hubs. In Uganda the RRHs are mandated as centres for in-service training and continuous professional development. To effectively manage the e-learning training programme in the two regions, mentors were identified among the successful graduates to provide guidance and support to the new participants.

Following the successful pilot, many health care workers expressed their interest in taking the course, and a total of 60 participants were enrolled in the second cohort. The mentorship strategy enabled the HMDC to increase the enrolment to 100 learners per region, making a total of 200 health care workers in each six-month cohort. The health care workers who enrolled in the course were mainly those in leadership and management positions at the health care facilities.

**Training set-up**

In both regions, the course support commences with a three-day face-to-face orientation session, later followed by a mid-term review
on learning progress and end-of-course performance assessments. During the orientation sessions, the participants are introduced to e-learning methods. Each participant is registered on the e-learning platform by creating an individual account.

Participants perform a pre-assessment test, which informs trainers on their level of knowledge and understanding of course concepts. It also identifies participants’ needs. A similar assessment is also conducted at mid-term and at the end of the course, to determine the progress and identify whether the skills acquired are being applied in the management of health care facilities.

The six-month leadership and management course for lower-level health care facilities at the HMDC has 15 modules. Each module contains a weekly online tutor-guided peer discussion, an online quiz and a tutor-marked assignment for the participants.

*Measuring learners’ performance*

Tutor-marked assignments account for 40% of the total course marks, the quiz 20%, participation in weekly discussions 20%, and the end-of-course assessment 20%.

At the end of the six months, graduation ceremonies are held at RRHs for the successful participants. During the ceremony, certificates are awarded, and the best performers receive an additional reward. During the ceremony, participants share their experiences with tutors and guests.

**Discussion**

- **Does blended e-learning training reduce health workers’ time away from their work station?**

For the HMDC e-learning scenario, the answer is yes. There was minimal interruption of health care service delivery during the course. Each course unit remained open on the learning platform for a period of 14 days, which allowed the learners to choose the best time to study when they were off duty. During the entire six-month course the participants spent only six days away from their work. This is less than the paper-based distance learning, where the face-to-face part took 13 days in total.

- **Does blended e-learning reduce the cost of conducting in-service training?**

The start-up costs for the e-learning programme were high. The subsequent costs include internet connectivity and tutors. The questions
on sustainability remain unanswered. A cost–benefit analysis is highly recommended to answer this question.

• **Does blended e-learning have advantages over traditional paper-based distance learning?**

A blended e-learning programme has a comparative advantage over traditional paper-based distance learning, since it provides learners with an opportunity to access extra course materials from different websites.

In addition, the e-learning approach allows participants to share their experiences through discussion forums. The tutors post questions online to stimulate discussions. Each student is required to contribute to the discussion, and their posted contributions are assessed and graded. During the course, tutors guide peer-learning discussions by probing more into the discussions to provide a detailed understanding of the course content.

• **How can blended e-learning ensure the acquisition of skills?**

At the beginning of the course, tutors visit the participants at their workplace to identify skills gaps and the likely support needed in relation to their work. Problem-based learning is applied during the course on these specific skills gaps.

The participants are visited again at their workplace in the middle of the course. During this follow-up visit the findings of the pre-course assessment are discussed, and the changes and challenges in performance are noted. Tutors have an opportunity to demonstrate some skills and ask for feedback.

After completing the course the participants reported being able to design the work plans and financial plans for their facilities, draw up and put in place arrival and departure record logbooks to better manage time and space, and improve customer care.

As some participants said:

“I *was not able to make a costed work plan, but now I am able to do it with ease!*” — learner from Moyo district

“I used to fear drawing up and using the arrival and departure book at my health facility... because I thought it was a tool for reporting my fellow health workers. I have found it a very useful tool for time management.” — health care worker from Moyo district
As mentioned above, the use of computers and the internet was a challenge, but many participants were able to overcome it. As one participant mentioned:

“At my age, ha! A computer was far from my work and learning expectations ...I used to hear about the internet in Kampala...now I am able to access it and read materials ...on my own!“ — member of staff at an RRH

The participants perceived the e-learning course as more interactive and more engaging than paper-based learning. They particularly appreciated sharing experiences. As one participant mentioned:

“I had done some paper-based distance learning in leadership and management... but it was not as engaging as this online learning by HMDC...the online peer discussions remove fears and help one to try out what others have shared...” — learner from an RRH

Participants’ immediate supervisors also appreciate the fact that the fear of handling computers is being reduced by the e-learning training programme. They also give feedback on the learners’ skills acquisition. Some of them had this to say:

“...compared to the past experience and those who have not done this course, I have now found it easy to get annual work plans from a health facility where in-charges have gone through this online course ... it makes a difference...” — supervisor from an RRH

“...even computers no longer gather dust here! ...the Nursing Officer can no longer sit at a desk without a computer... as soon as I leave the computer, I find her on it doing her assignments.” — administrator from an RRH

The activity reports from the DHOs and the Directors and Medical Superintendents of the hospitals also showed that health care workers who did the training course were better managers and leaders of the health care facilities than those who had not done the course. One of them said:

“...now my ward in-charges who did this course are able to communicate on email promptly and give prompt reports of their wards! They respond to emails easily and provide feedback, which was not the case before.” — officer from an RRH
The DHOs in the two sub-regions, the Medical Directors of the two RRHs and the Medical Superintendents at the hospitals are a major force behind the mobilization of resources for e-learning. They make considerable efforts to ensure the availability of computers and internet connectivity at their workplaces to enable health care workers access to the course. They also mobilize health care workers to undertake the HMDC leadership and management e-learning course and allow some time off duty during the face-to-face interactions.

- **Was blended e-learning acceptable to health care workers, given the fact that a majority of them were computer illiterate?**

The majority of participants, especially those in the pilot cohort, had no prior computer skills. In fact, 75% of the pilot group had no email address; these were created for them during the induction phase. With constant motivation, guidance and support from tutors at the HMDC and participants’ determination, the first 14 participants gained computer skills and successfully completed the course. One of them had this to say:

"...I now want all the health workers in this district to do this course...this is one in which we can improve the management of health services in this district... Many health workers can enrol without interfering with service delivery at their workplaces..." — officer from the Moyo District Health Office

The misconception that e-learning cannot be applicable to health care workers at remote health care facilities was also refuted by the HMDC’s experience, which demonstrated that they can learn through e-learning, provided they have internet access through a mobile telephone or a computer to download the course content. In the HMDC’s case, the e-learning course even had a multiplier effect, as participants who had no prior computer skills gained exposure to computers and learned computer skills and how to use the internet. Our learners are now able to use social networking and learn more from various e-learning sources.

- **Did the learning-by-doing approach used for building-capacity at the HMDC work?**

Capacity-building for trainers through hands-on training enhanced their skills for organizing online training programmes. During this hands-on training, the tutors at the HMDC appreciated the online delivery of content. They said the following:

"...at HMDC we did not know how paper-based content can be
transformed into online content...now we are able to do it...from one pilot course leadership and management of health facilities, we have now designed and introduced three more online courses.” — Senior Tutor and a Head of the HMDC

“...we were unable to attach source documents ...such as blogs, YouTube content for online teaching, but now we are able to.” — Senior Tutor from the HMDC

“...I did not know that it was necessary to first convert paper-based content to online content...” — Health Care Trainer at the MOH

“Through online teaching and learning, the tutors appreciated the importance of constant communication and providing prompt feedback...This is because learners pose questions any time they face challenges on internet access, the MOODLE platform and the content provided.” — Senior Health Care Trainer at the HMDC

**Challenges**

**Internet access**

During the pilot, the participants experienced internet problems and power cuts at their workplace. Such interruptions were frustrating, sometimes made it difficult for discussions to continue and could at times prevent the timely submission of assignments and provision of feedback by tutors. To overcome these problems, tutors were flexible and understanding of participants’ failure to meet deadlines.

“... I usually recall what I went through when doing my online course...and I fit myself in the learners’ shoes whenever they tell me about the challenges they face on accessing the online course...” — Senior Health Care Trainer at the HMDC

In addition, the tutors keep motivating learners to overcome online challenges and continue with the course to reduce drop-out rates. Given the work schedules and many factors competing for the learners’ time, a tutor remains flexible and positive towards the learners’ output expectations. Online tutors have to do more to motivate and encourage the learners to move on with their studies.

**Sustainability**

Sustaining the online training course at the HMDC remains a major challenge. The subscription for the MOODLE platform that hosts the programme and the internet connectivity for learners in Rwenzori and
West Nile have been funded by the ICB project. Currently, the HMDC is seeking a semi-autonomous status. If accorded, some costs can be shared with the participants.

**Conclusion**

With this pilot we have proved that blended online training for health care workers is possible in Uganda. It is the best strategy for providing the continuous professional development required by health care workers, who have busy schedules. e-learning is also the best approach for revitalizing regional continuous professional development centres, which exist at RRHs in Uganda. The approach reduces interruptions and time away from work and improves performance skills in health care services management. A strategy should be developed to address the current challenges so that the training can continue.

**Recommendations and way forward**

Online learning needs to be embraced by policymakers, planners and implementers at all level of the health care system. Institutional policy support to e-learning at the HMDC should be the next step taken by the Government of Uganda.

**References**

Part 3 covers the last two case studies, which show examples of how to make services more responsive to the needs of clients.

The development of a regional ambulance system started in 2012 and is an example of communities being challenged to introduce creative measures to make such a referral system sustainable. After the procurement of ambulances, the system was supported by training staff, strengthening referral systems and engaging the community. All these elements made the pilot successful.

The success factors of the approach were the response to the communities’ perceived needs, the presence of willing leaders, the involvement of a strong community organization and a functional emergency and ambulance system. The pilot shows that where these key success factors do not exist, a strong promotional and marketing plan should be part of the strategy.

A patient-centred care approach has just started to be rolled out in the two Regional Referral Hospitals. It is a first step towards improving the quality of services. The process started with better guidance for patients in the health care facility but also aims to strengthen referrals and provider–patient relations.

These two chapters show that for health care services to become more accountable to patients, extra efforts are needed. A guiding charter helps, specifying the roles and responsibilities of providers and patients. Client satisfaction surveys and suggestion boxes are only the beginning of a patient-centred approach. Health care planners and providers, communities and patients should all become allies and partners in health systems strengthening.
6. STRENGTHENING THE AMBULANCE REFERRAL SYSTEM THROUGH COMMUNITY PARTICIPATION IN THE WEST NILE REGION

Jimmy Opigo, Julius Balinda, Abassi Mansour and Damian Rutazaana

Key messages

A functional ambulance system is important for averting avoidable deaths and preventing secondary disability in obstetric, childhood and injury emergencies.

A functional and high-quality emergency care and ambulance system increases the community’s trust and willingness to participate in community ambulance financing schemes.

Community-initiated and -managed financing schemes successfully finance 50% of the variable recurrent operating costs of the ambulance system in Moyo and Yumbe districts of the West Nile region.

Introduction

The Uganda Health Facility Inventory of 2012 revealed that 140 of the 200 hospitals had ambulances but that only 30% of these were functional.\(^1\) The assessment also showed that a lack of financing mechanisms and poor fleet management practices were the major reasons for the low level of functionality of ambulances. A similar situation was also found in Rwenzori and West Nile regions in a transport assessment study conducted by the Institutional Capacity Building (ICB) project.\(^2\)

The annual Maternal and Perinatal Death Audit Report of the Ministry of Health (MOH) additionally attributed the high maternal and infant mortality not only to the general socio-economic conditions but also to structural, logistical and managerial health care systems issues, including a poor emergency transportation system.\(^3\) The World Health Organization (2009) also stressed the importance of communication and transport as crucial to eliminating delays in the delivery of emergency obstetric services.\(^4\)

The lack of a properly functioning ambulance system contributes greatly to poor health outcomes, especially in the areas of maternal, childhood and injury emergency care. The maternal mortality rate was 438 deaths per 100,000 births, and the under-5 mortality rate was 155 per 1,000 live births in Rwenzori and 125 per 1000 live births in West Nile in 2011.\(^5\)
The improvement of ambulance and referral systems is specifically advocated as a way to improve maternal and child health outcomes and reduce injury-related mortality.\(^8\) Proper management of emergencies by a functional ambulance system has been shown to reduce mortality in emergency situations from 30% to 5%.\(^6\) Studies by the Injury Control Centre in Uganda (2010) showed that functional ambulance systems can reduce mortality by 40%.\(^7\) In addition to appropriate, working technical equipment, referral protocols are also essential for an adequately functioning system.\(^9\)

Yet the ambulance system in Uganda is not well organized, except the planned intervention through the proposed Uganda National Ambulance Service (UNAS).\(^7\) The UNAS strategy indicates that existing ambulances are not equipped with life-supporting equipment and not staffed by paramedics. The ambulances cannot offer in-transit care and are just a ‘pick and run’ service. The ambulances are not linked to referring and receiving hospitals by a communications system, and the required pre-positioning at appropriate dispatch centres is not implemented. Most ambulances are reported as non-functional due to a lack of operating funds.\(^7\)

Given this situation, the ICB project focused on strengthening the operations of the ambulance service in two regions of Uganda: Rwenzori and West Nile. The West Nile region is located in the north-western part of Uganda. It is divided into eight districts and is served by Arua Regional Referral Hospital (RRH).

The intervention involved the provision and upgrade of fully equipped ambulances with short-term operational and management project support for beneficiary districts. In addition to vehicles, training for medical emergency staff was provided, as well as tools such as log books, vehicle use assessments and insurance. For the short term, recurrent inputs were provided, such as a fuel subvention and vehicle maintenance. The region was also encouraged to develop innovative financing mechanisms and management systems to support the ongoing costs of the ambulances in the longer term.

In this chapter we describe the community ambulance financing initiative in the West Nile region, which has succeeded in creating a financial mechanism to meet some of the operating costs of ambulances and keep them operational, thus improving the referral system and emergency health care outcomes. We also discuss some challenges and how these challenges were resolved.
The key question is: Can communities create a financial mechanism to meet some of the operating costs of ambulances and keep them operational? What were the lessons learned?

**Sources of information**

The chapter is based on the observations of the project personnel who participated in the implementation of the intervention. We also used the baseline transport assessment report and periodic fleet management and utilization reports of the two regions. Additional sources of information used were the Uganda National Ambulance Service strategy, selected World Health Organization resources, Uganda Injury Control Centre data and MOH reports.

**Case study**

*Implementation of the ambulance/referral project*

The project evolved through six phases:

**Phase 1**

Initially the ICB Project Steering Committee, comprising representatives of the MOH, BTC, SIDA and the Belgian Embassy, adopted the proposal to invest in regional ambulance and referral systems. It stressed the importance of a rational distribution of the ambulances and utility vehicles to be procured. A national expert was engaged to conduct an assessment of the existing emergency health care transport situation, focusing on availability, needs, use and management practices. Gaps were identified, and a number of suggestions for allocation of the vehicles were discussed. Procedures to limit misuse of the vehicles through strict fleet management guidelines and the use of log books were also included in the design of the system.

**Phase 2**

Based on the assessment, a regional ambulance system was developed and piloted in the two selected regions. Lessons learned from this pilot would later help the development of the Uganda National Ambulance Service.

**Phase 3**

The 12 new ambulances were allocated to districts that did not receive ambulances through other sources or did not have repairable ambulances. All districts were finally equipped with an ambulance (either new or upgraded) through different donor agreements. Eventually, a pool of 32 functional ambulances was available in the two regions.
Phase 4

Once the ambulances were distributed, drivers were trained in defensive driving. Additionally, ambulance crews (including drivers) were trained in providing accident and obstetric emergency care.

Phase 5

Each ambulance was provided with a temporary support package under the ICB project, including a 100-litre fuel subvention per month, standard routine vehicle servicing, regular tyre replacements and comprehensive insurance. Further ambulance management guidelines and referral system guidelines were also introduced to promote rational use of the vehicles.

In addition, the hospitals in the regions were supported with emergency equipment, such as operating theatre tables, medical equipment for obstetric surgery and mobile phones.

Phase 6

The districts and communities were encouraged to find additional financing for future operating costs. The districts developed different options, which included:

- allocating funds from existing budgets to ambulance operations;
- the introduction of an ambulance tax;
- the introduction of an ambulance scheme, managed by the sub-county authority; and
- the introduction of a community ambulance financing scheme.

The anticipated challenges of the first two options were immediately obvious, given that budgets were already overstretched and administration of an ear-marked tax could prove expensive and complex. The third option faced the risk of abuse by sub-county authorities, but Yumbe district chose to implement it. A control mechanism (a Memorandum of Understanding with punitive consequences) was included to regulate possible abuse. Arua and Nebbi districts adapted tax-based funding, while Maracha and Adjumani had no immediate needs for additional financing. UN support in Adjumani district was available for hosting large numbers of South Sudanese refugees, and this was used to fund the ambulance service for both host and refugee populations. Maracha District Local Government was able to allocate funds to ambulance services from its budget, because most of its population is settled along the trunk roads in the district. The fourth
option was chosen by Moyo and Yumbe districts and will be described in more detail.

**Community ambulance financing schemes: process**

Moyo and Yumbe conducted the following process for the development and introduction of the community financing scheme:

Technical teams conducted a problem and needs analysis and proposed intervention models. This included listing key political, administrative and community stakeholders for community ambulance financing. A strategy of sensitization, advocacy and marketing of the models to the stakeholders was implemented. Next, approval and support from the administrative and political structures was obtained.

As the start-up of a long-term intervention programme, the design focused on the feasibility and acceptability of the transformative and innovative designs, strategies and protocols.

Community structures in the form of committees of about nine people were decided on and formed by community members. The populations, led by their committees and guided by a district technical team, held discussions and brainstorming sessions to adapt their own design. The aim was to raise funds to cover the variable ongoing costs of the referral systems through community-based financing.

To avoid failure of the project, a well-crafted marketing plan to gain acceptance and build a sense of shared goals was promoted on the radio. Possible success factors for the specific context were explored and listed. The various stakeholders and actors were clearly identified, with a focus on their interest, influence, power and position. Beneficiary concerns and context issues were taken into consideration, and radical reforms were avoided. The outcomes of beneficiary and stakeholder consultations were used to update the strategy, which included:

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consensus on a governance and management system; community contribution based on solidarity; the pooling and purchasing mechanism; incentives; the call system, dispatch centres and routing; and how to manage the vouchers and minimize administrative costs. It was agreed that benefit packages would focus on obstetric, childhood, serious medical and life-threatening injury evacuations only. The household was defined as the enrolment unit, with an exemption for elderly people. It was agreed that contributions would be annual and that any unspent money would be kept in the scheme’s account at a sub-county savings and credit organization for Moyo and at the sub-county administration for Yumbe.

To ensure the success of the scheme, the first sub-counties to participate were carefully chosen using a number of critical success criteria. The literature had indicated that success depends on a number of factors, such as: perceived need; contextual factors; the availability of options; the presence of champions to lead the project; the presence of community structures to manage community insurance; and the level of solidarity and spirit of self-reliance.\textsuperscript{10–14}

The monitoring of the intervention focused on the number of sub-counties, community-based organizations and committees formed. It also checked for the presence of the factors known to influence success and failure. Households were documented for success factors and challenges. It also studied the amounts of funds collected and how they were used to provide emergency ambulance services. Other monitoring areas focused on reducing response and turn-around times and increasing the proportion of emergencies successfully handled by ambulance.

**Discussion**

The intervention of encouraging and supporting communities to form a community ambulance financing scheme has proved successful: three out of four sub-counties in Moyo district now have operational schemes.

Funds are available to cover the operational costs of the ambulance system, especially fuel. The structures that have brought stakeholders
together in the ambulance financing scheme are working well, and made sustainable by the community finance system.

The scheme has effectively removed the financial barriers to using ambulance services. Being a pre-payment system, it has also removed delays in accessing emergency care. The turnaround time for referral has significantly reduced from over six hours to two hours.

The strategies for exemption from payment and determination of need have addressed equity concerns by building a form of solidarity; wealthier people support poorer people, and healthy people support the sick, thus promoting equity in access to health care.

The purchasing and payment mechanism, use of vouchers and referral-needs-screening by referrers has limited the misuse of the funds collected.

The self-management of the scheme by communities, using existing village saving schemes and sub-county savings and credit organizations has minimized administrative costs and the misuse of funds.

The governance through village meetings and village leadership provides for good oversight, rate-setting, payment methods, exemptions, benefit packages and entitlements.

Good governance practices of participation and accountability are promoted through feedback mechanisms. The community is feeling empowered and responsible for its health.

Health-seeking for maternal and child health and levels of acceptance of the referral system have improved as the cost barrier has been reduced.

On the supply side, the functionality of hospital ambulances has increased from 30% to over 80%, as funds initially used for fuel have been freed up for use on maintenance. Additionally, community expectations and the promise of a functional ambulance service put pressure on hospitals to keep their ambulances running.

So far there has been no reported fraud, denial of referral services, conflict or refusal of scheme managers to participate.

**Challenges**

The scheme is facing the challenge of the village being a very small unit for pooling, making the risk pool less effective. This is being addressed by making the household the enrolment unit. It is expected that richer, younger, smaller and healthier households will subsidize poorer,
larger and less healthy households. The attempt to have communities form larger risk pools around the entire sub-county was rejected by communities. This is because there is no natural community grouping or organization at that level, since it is an administrative unit. The use of the sub-county or parish administration to manage funds was also rejected, as the community does not trust the government system. Earlier attempts at a government management scheme failed. The government administrative and political structures, therefore, only play an overall supervisory role.

Some members prefer to pay in kind (e.g. with farm products), so a mechanism to accept none-cash payments and convert them into cash needs to be developed.

There is no good alternative for serving non-members, which means that they face high financial barriers and poor emergency health outcomes. Promotion of ‘universal coverage’ is pursued, and a compulsory scheme is being debated. Community autopsy audits for maternal and childhood deaths are currently used to increase the community’s understanding of the importance of reducing delays in accessing emergency care to prevent avoidable and premature deaths.

The scheme still faces operational challenges of delays and poor-quality services from referrers and receiving emergency units in hospitals that tend to discourage communities. This is being addressed by quality improvement initiatives to strengthen the emergency and referral systems.

The benefits package of the scheme is limited to obstetric, childhood and severe medical conditions and accidents. Other emergency (and non-emergency) referrals are not covered. There is no agreement on expanding the benefits package, since this means raising each household’s contribution.

The screening for emergency need by referring facilities causes long delays, especially during weekends and at night. There are also limited on-site or community evacuations, due to poor physical addresses and access and the need to screen emergency needs.

The ambulance operations are challenged by having only three fuel stations in the district, with only one accepting a non-cash (voucher) arrangement. Another challenge is the bureaucracy of the savings and credit organizations in accessing funds (weekdays only, multiple signatures required), which slows down the referral system. These challenges mean that some groups prefer to carry out transactions in cash instead of vouchers.
It was difficult to market the scheme in some sub-counties for various reasons: the absence of strong local leaders and community development officers; the availability of alternative means of transport; the absence of recent triggers such as experiences of maternal death; no previous experience of a village savings and loan scheme; and a location that is easily accessible by other means.

Surprisingly, crafting the scheme around other community groupings — such as faith-based organizations, community associations such as women’s groups, community-based organizations, health care facilities and schools/employment organizations — failed in preference to village savings and loans associations. It appears that the promotion of the village savings and loans associations by various government and non-government actors and its use to address other community problems in solidarity (e.g. school fees and burial expenses) has raised their profile and improved their reliability. The governance of the associations, with open weekly or monthly meetings, strong internal controls, segregation of duties and banking practices, has made them more robust.

In Moyo and Yumbe, district authorities supported the collecting of funds. However, a more robust legal framework for this type of scheme is essential.

The scheme can only succeed if the ambulances and the emergency unit at the hospital are functional. Without quality emergency services and a functional ambulance system, communities are not easily convinced to contribute.

**Lessons learned**

Community-initiated and -managed financing schemes cover up to 50% of the variable ongoing ambulance operating costs in Moyo and Yumbe districts of the West Nile region.

The success of a community ambulance scheme depends on the intervention design, the strategy for its introduction, community and stakeholder involvement and supportive contextual factors.

The success factors are: a perceived need by communities, the presence of willing leaders, community organization and a functional emergency and ambulance system. Where these success factors do not exist, a strong promotional and marketing plan should be part of the strategy.

A strong community management and governance system is required to provide oversight, regulate enrolment criteria, define the benefits
package and the exemption system, promote solidarity, reduce abuse and provide incentives to joining.

Communities can only derive benefit and satisfaction from their contributions if the emergency and ambulance system is functional and of sufficient quality. It is, therefore, recommended that health systems strengthening for emergency care and the overall health system should accompany efforts to introduce community ambulance financing schemes.

The schemes should also include the promotion of early health-seeking behaviours (before serious complications occur).

The involvement of stakeholders, actors and beneficiary communities is very important in the problem and solution analysis and intervention design. They seem to know what they want, and it promotes shared understanding, acceptance, participation and ownership. A model of Inform-Consult-Involve-Seek Partnership (Vroom Yelton) was utilized to build stakeholder support.

A stakeholder analysis, with a clear understanding of their interest, influence and power, needs to be undertaken. The use of natural leaders, opinion leaders and community champions in introducing and promoting change is essential. The use of events such as unfortunate maternal deaths and community autopsy and audit promote understanding of the problems of emergency care, the role of pre-payment, solidarity and the importance of an operational ambulance system to reduce delays and improve emergency outcomes.

Proper context analysis for success and risk factors needs to be undertaken, and the strategy and scheme design performed accordingly. There is a higher level of acceptance of the scheme in very remote communities, where there is no alternative public transport. There is also greater acceptance where there has been a recent maternal death or major accident. The need in such cases is very clear.

The presence of a strong, functional and trusted village savings and credit scheme is also a success factor.

It is not advisable to attempt to form a scheme around government administrative units, since communities do not trust those structures and the risk of misuse of the scheme funds is high.
Recommendations

Given the high costs of ambulance operations and the inadequate government budget, it is recommended that the associated costs be shared between communities and government. It is recommended that the government takes a leading role in providing stewardship, concentrating on capacity-building and the provision of ambulances. The community could cover the operational costs. It is recommended that a feasibility and vulnerability study be done to explore supportive contextual factors and challenges, to guide an appropriate operational design for different communities.

A framework for good governance, regulation and leadership is recommended as a pre-requisite for the development of a community ambulance financing scheme. A structured evaluation of the intervention is recommended to generate more information on best practices for scale-up.

Where contextual factors are not very conducive to successful implementation, a stakeholder analysis followed by a well-designed marketing plan is required. Sensitization, advocacy and public education to promote solidarity and a ‘good Samaritan’ culture is essential for community participation.

References


7. Patient-Centred Care in Arua and Fort Portal Regional Referral Hospitals

David Okia, Charles Olaro, Bernard Odu and Damian Rutazaana

Key message

The introduction of patient-centred care (PCC) in Arua and Fort Portal Regional Referral Hospitals (RRHs) has led to improved communication between patients, their families and health staff and to improved client satisfaction with the hospitals’ service delivery.

Introduction

PCC is defined as “health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients wants, needs, and preferences and that patients have the education and support they require to make decisions and participate in their own care”.¹ It is being introduced globally to improve the quality of care.

Brief history of PCC in Uganda

The PCC approach was introduced in Uganda in October 2011 when the African Regional Consultative Workshop on Health Care Improvement (‘Catalysing and Institutionalizing Quality Improvement’) was held in Kampala. It was observed that “a patient-centred care culture and practice is a critical missing gap, both at health service delivery and in health service training across Africa”. A task force for an African Patient-Centred Care Initiative was formed, which included representatives of the Regional Centre of Quality Health Care in Kampala.²

The Quality Assurance and Clinical Services departments at the Ministry of Health (MOH), with support from the Institutional Capacity-Building (ICB) project, introduced the PCC approach in Fort Portal and Arua RRHs in February 2014. It started with the adaptation of international tools for self-assessment to the local context (PCC assessment checklist and patient- and family-centred care improvement guidelines).

Justification for introducing PCC in Arua and Fort Portal RRHs

Despite the long-standing aim of the Ugandan government to strengthen health systems, maternal mortality and morbidity rates and infant morbidity remained very high. The maternal mortality rate is 431 deaths per 100,000 live births, under-5 mortality is 66 deaths per 1,000 live births, and infant mortality is 44 deaths per 1,000 live births.³ Health sector reforms, including health financing reforms, are needed to improve performance of the sector.
Globally, PCC is recognized as the optimal form of care in all types of health care delivery, including primary, acute and long-term care settings.\textsuperscript{1,4} PCC will lead to improvements in health care quality and outcomes by increasing patient safety, cost-effectiveness and patient, family and staff satisfaction.\textsuperscript{1,4}

The key question in this chapter is: Has the introduction of the PCC approach in Arua and Fort Portal RRHs improved the quality of care and staff–client communication from the patient’s perspective?

This question will be addressed by sharing experiences, challenges and lessons learned in the implementation and monitoring of PCC activities in the two hospitals.

**Sources of information**

For this case study the following resources were used: reports of PCC training for national teams; reports of the sensitization of staff in the two RRHs; reports of baseline assessments at the RRHs; and PCC work plans developed by the RRH teams.\textsuperscript{5}

**Case study**

*Introduction*

Arua RRH is located in Arua district in the West Nile region of Uganda. Fort Portal RRH is located in Kabarole district in the Rwenzori region.

The aim of introducing PCC in both hospitals was to create partnerships among health care practitioners, patients and families that will lead to the best possible outcomes and enhance the quality and safety of health care.\textsuperscript{2}

The specific objectives of the PCC initiatives in both regional hospitals were: i) to institutionalize all PCC activities in the hospital care system and management; and ii) to improve the health care experience and outcomes for patients, families and health care professionals.\textsuperscript{2}

Activities to introduce PCC in the hospitals started with training of national teams. Three MOH staff participated in a five-day regional workshop in Kenya, where they learned and mastered the core concepts of PCC and strategies to introduce and adapt PCC to the Ugandan context. After a joint introduction workshop, each RRH organized a two-day sensitization workshop for its senior management and clinical staff, including a patient representative. Participants expressed worries about the high patient volumes at public facilities and the
limited availability of human resources. Expectations related to the improvement of quality of care were discussed. After the sensitization workshop the same group of participants was trained to equip them with the skills required to introduce PCC into service delivery.

Each hospital conducted a self-assessment using the (adapted) international tool for PCC, with the aim of assessing existing practices and the readiness to introduce the PCC approach. The tool is designed for use by an interdisciplinary team, including patients and relatives, and consists of 11 sections (see Table 7.1). Completion of the tool provided each hospital with scores on the quality of care and provided a baseline for priority setting and deciding on the actions needed to bring about quality improvements.

*Table 7.1. Summary of assessments checklist (MOH Patient- and Family-Centred Care Improvement Guidelines, July 2014)*

<table>
<thead>
<tr>
<th>Practice</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structures and functions necessary for change</td>
<td>Organization’s commitment to PCC is communicated to patients and families</td>
</tr>
<tr>
<td>in culture</td>
<td></td>
</tr>
<tr>
<td>Communicating effectively with patients</td>
<td>Patients are informed on how to raise concerns about care</td>
</tr>
<tr>
<td>Personalization of care</td>
<td>Patients are able to request when meals are served to accommodate their schedule</td>
</tr>
<tr>
<td>Continuity of care</td>
<td>Tools are provided to patients to enable them to manage their medications</td>
</tr>
<tr>
<td>Access to information</td>
<td>Patients have access to a consumer library</td>
</tr>
<tr>
<td>Family involvement</td>
<td>Family is defined by the patient</td>
</tr>
<tr>
<td>Environment of care</td>
<td>Space is available for communal worship</td>
</tr>
<tr>
<td>Spirituality and diversity</td>
<td>Comforting, healing and welcoming</td>
</tr>
<tr>
<td>Caring for the community</td>
<td>Space is available for community groups</td>
</tr>
<tr>
<td>Care for care-givers</td>
<td>Staff stress-reduction mechanisms available</td>
</tr>
<tr>
<td>Integrative medicine</td>
<td>Integrative therapies available depending on patient interest</td>
</tr>
</tbody>
</table>

Generally, the readiness of both hospitals to introduce PCC was average. For example, both scored well in family involvement and environment of care, but low in spirituality and diversity. PCC action plans were developed, based on the needs and priorities identified. Each hospital elected a PCC focal person, who joined the existing Quality Improvement Teams (QITs). Selected PCC activities were included in the hospital work plan for implementation under Execution Agreement funding through the ICB project (see Chapter 2).
Implementation of the PCC action plans in both hospitals is taking place slowly but steadily. The first impressions of staff and patients appear positive, although more in the private wards of the hospitals, where there are lower staff–patient ratios. In both hospitals patient communication has improved, with clear signposting in the hospital compounds, positioning of noticeboards and suggestion boxes, and the Patient Charter (including patient rights) clearly displayed (see Figure 7.1).

*Figure 7.1. Signposting at Fort Portal Regional Referral Hospital*

Review of the minutes of QIT meetings indicates improvements over time in a number of quality indicators. The QITs have collected data on the ‘5S’ principles of quality in various sections of the hospitals. The indicators include: patient volumes (number of admissions, attendance at health education activities, number of clients tested for HIV etc.); surgery-related morbidity and mortality; and the mortality rate of severe conditions (e.g. cerebral malaria, myocardial infarction, pneumonia). The data are collected monthly and discussed by the QITs.

Standard operating procedures (approved steps to be followed while carrying out medical procedures or operations) are clearly displayed and followed by all staff. Infection control has improved (all wards have waste segregation buckets, safety boxes and gloves), and most patients are managed by qualified staff members. The availability of essential drugs and supplies for emergencies has improved, and reference materials are available for health staff and patients in a functional resource centre.
A client satisfaction survey was carried out in 2015, one year after the introduction of PCC in Fort Portal RRH. An overall high satisfaction score (87.6%) was found for the services provided at the hospital.

**Lessons learned**

PCC implementation requires commitment from the hospital leadership. In both Arua and Fort Portal, the hospital directors actively participated in PCC introduction workshops and provided strategic direction for the PCC work plans and support for its implementation. This support from senior management has motivated health care staff in both hospitals to adopt PCC.

The PCC baseline assessment at the RRHs was conducted by teams consisting of hospital staff and managers. One patient representative was included, but no consumer organizations. The resulting assessment and work plans are, therefore, biased towards hospital rather than patients’ needs. In future, broader patient/consumer involvement is to be considered.

Implementation of PCC activities is easier if they are embedded in the hospital work plan. Dependency on donor funds makes PCC unsustainable and causes failure when funds are not available on time. Inclusion in hospitals’ work plans increases ownership and avoids PCC being perceived as an additional workload.

To achieve good results in the implementation of PCC in public RRHs with high patient numbers, the staff time needed for interaction with patients and their families increases. Understaffing undermines the willingness of staff to invest in quality improvements in general and in PCC specifically.

**Challenges**

The existing infrastructure at hospitals is not yet adequate for full PCC implementation (e.g. limited space for patients and staff, overcrowding in wards, few consultation rooms, no recreational facilities for patients etc.).

The low staffing levels at RRHs, especially among medical doctors, prevent adequate attention to PCC principles. Heavy workloads lead to demotivation and reduced quality of work.

**Conclusion**

The introduction of PCC in Arua and Fort Portal RRHs has led to improved communication between patients and health care staff. A client satisfaction survey carried out in Fort Portal RRH showed an
improvement in clients’ rating of the hospital’s service delivery, but more study is needed. The PCC approach is an international concept that has been adopted by the MOH. Roll-out to all regional and general hospitals is foreseen.²

**Recommendations**

To successfully implement the PCC approach in public hospitals, a well-motivated workforce is needed. In Arua and Fort Portal RRHs, increases in staff numbers and improvements in infrastructure are prerequisites for successful PCC implementation.

Both the baseline assessment of PCC readiness and the monitoring of results require the involvement of patient representatives (a minimum of 30% of the team is recommended).

All PCC activities should be embedded in the hospital work plan and not treated as separate activities.

Commitment from the hospital leadership is essential for successful implementation of PCC.

**References**


Annex A. Biographical information

**Dr. Julius Balinda** is a medical doctor (MB CHB) and public health specialist (MPH) and a graduate in a Fellowship in Health System Management (FPHSM), all from Makerere University, Uganda. He has 29 years of experience in clinical and health service management, especially at district level.

Julius worked as a Medical Intern in Jinja Regional Referral Hospital and as a Medical Officer in Rubaga Hospital, which is affiliated to the Uganda Catholic Medical Bureau. He started and ran Kibale District Medical Office (1991–1994) and Kyenjojo District Health Office (2001–2010). Currently, Julius is working as a District Health Officer in Kyegegwa district.

Julius was among the 23 senior officers who were trained as national trainers for Governance, Leadership and Management for Health Systems Strengthening. He has been coordinating the roll-out of training for the same course in the Rwenzori region of western Uganda. Julius has a particular interest in health care services management, with special interest in health systems strengthening in developing countries.

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**Dr. Hans Bek** has worked at the Ministry of Health in Uganda since 2010 as Technical Advisor on Institutional Capacity-Building. He started his career as a ‘tropical doctor’ in Zimbabwe in 1994 and has continued working in various countries in Africa since then. He holds a Master’s Degree in Health Systems Management (University of London) and a Diploma in Human Resource Management and Development (University of Manchester). His special interests are in health systems strengthening, human resource for health, health information systems and health planning.

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**Dr. Isaac Alidria-Ezati** is Director, Health Services (Planning and Development) at the Ministry of Health in Uganda and Project Coordinator of the ICB project.

Isaac has had a long career in the Ugandan health care sector. He has worked as a surgeon in various hospitals and as Deputy-Director at the National Referral Hospital, and in October 2010 he joined the Ministry of Health as Director, Health Services. His special interests are in clinical services (especially traumatology), health systems strengthening and quality improvement.

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**Marjolein Dieleman** (PhD) is a senior advisor Human Resources for Health (HRH) and health systems research of KIT Health and director of WHO collaborating center for Human Resources for Health. Key experiences include (action) research and reviews on among others governance and accountability, performance, retention and motivation of health workers. She has evaluated HRM interventions and has a particular interest in theory-based approaches to evaluations and research. Marjolein supports partners in Sub Saharan Africa in documenting and disseminating their experiences in health systems strengthening programs and research results. Additionally, Marjolein has extensive experience in strategic human resource for health management, policy and planning and training.

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**James Ikabat** is a Senior Health Training Officer specialized in health services management (MSc UMU). He has more than 15 years of experience in the training of health workers (nurses and clinical officers) in Uganda in the field of community health, health systems research, leadership and management.

James has worked with private not-for-profit hospitals, and was in charge of different nurses’ training schools for 12 years. He also worked for local government and for the health sub-district for four years and later at central government under the Ministry of Health for six years.
Currently James is the Acting Head of the Health Manpower Development Centre, a position he has held for over five years. He is actively involved in designing and developing health training programmes including online in-service training courses, classroom teaching and clinical practicum sites. He spearheaded the development of the HMDC’s five-year Strategic Investment Plan (FY 2013/14–2017/18) and the process of revitalization and transformation of the HMDC into an in-service training institute. He is also a member of the governing council of the Mbale School of Hygiene to provide an oversight role of governance and management.

His main areas of interest are capacity development, research, monitoring and evaluation of in-service training programmes for health workers, leadership and management of health services, gender and human rights mainstreaming.

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**Eric Kakoole** is a public policy specialist with over 12 year of extensive experience in development work, management and policy analysis. He holds a Master’s Degree in International Development Policy from Seoul University, South Korea, a Master’s Degree in Population and Reproductive Health and a Bachelor’s Degree in Development Studies from Makerere University, Uganda.

Eric worked with the Mangrove Support Group as an HIV/AIDS Technical Advisor in China between 2007 and 2009, where he helped set up and train support groups for people living with HIV/AIDS in Beijing, before which he was Programme Officer for community development at Action for Children in Uganda between 2004 and 2007.

Currently, Eric is the Head of the Policy Analysis Unit at the Ministry of Health and is the Project Coordinator for the Global Alliance Vaccines Initiative (GAVI) project. His main job is analysing government policies, laws and contracts as well as drafting policy recommendation for Cabinet and parliamentary decisions. As a GAVI Project Coordinator, he oversees the project implementation and liaises with development partners to improve immunization services in Uganda.

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Anke van der Kwaak is a senior advisor, researcher and PhD candidate at Kit Health. She trains and teaches in SRHR and is the coordinator of the Health Systems Research Module at KIT’s Masters of Public Health.

She has successfully led many research and advisory projects, and has a specific focus on adolescents and youth. Before joining KIT, she worked for ten years as a university lecturer at the Medical Faculty of the Vrije Universiteit in Amsterdam. Most of her work focusses on capacity-strengthening in mixed-methods research and evaluation and translating findings into knowledge products that will be used for informing, policy, programmes, new initiatives and action research.

She is a member of the Ethical Review Board of the Royal Tropical Institute and the Board of Studies of the Master in Internal Public Health. From December 2009 until May 2013 she was a member of the Scientific Advisory Board for Research on Islam to the Ministry of Foreign Affairs.

Resty Kamya is an Educational Technologist with 13 years’ experience in ICT for education. She has worked with the Ministry of Education in Uganda, where, as a consultant, she pioneered the introduction of science subjects at Advance level education in a rural school using virtual labs; as a United Nations Volunteer (UNV), bridging the digital divide in Nigeria; as an educational/ICT consultant with Tera Nuova in Somalia, designing ICT educational systems for a sustainable livestock industry; and with the Uganda Management Institute (UMI), setting up the e-learning programmes for a sustainable national management capacity.

Resty is currently working as Project Officer for Continuous Professional Development under the BTC Institutional Capacity-Building (ICB) project in partnership with the Ministry of Health at the Health Manpower Development Centre (HMDC) in Mbale, Uganda. She is working as a consultant on the transformation of the HMDC to semi-autonomous status and giving direction to the development of e-learning at the centre.

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Florence Kebirungi Bazirakye currently works as a Senior Health Training Officer at the Ministry of Health in Uganda. She is responsible for the policy development, supervision and guidance of in-service training for human resources in the health care sector. She also ensures provision of continuous professional development for the country’s health care workers. Before joining the MOH, she worked as a lecturer in the Department of Public Health.

Florence is an alumni fellow of the HIV/AIDS Leadership and Management Capacity-Building programme at Makerere University School of Public Health. As fellow, she supported capacity-building and strengthening initiatives with the Young Empowered and Health project. Florence is very interested in youth and women’s issues. She worked with the Uganda Women Entrepreneurs Association Limited and attracted funding to support women entrepreneurs in eight countries of Africa to trade and learn from their counterparts in East Africa. Within the Eastern Africa Sub-regional Support Initiative, Florence initiated programmes and activities to engage women’s organizations in advocacy work to promote gender equity and inclusion.

Florence worked with the Feed the Children Uganda Programme as Community Trainer and with the AIDS Information Centre as an HIV/AIDS, STD/STIs, TB and family planning counsellor, counselling and preparing clients for screening and offering post-test counselling.

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Abassi Mansour is a public health specialist (MSc) with more than 13 years of experience in the field of health promotion and education and the decentralized HIV/AIDS response at district level.

From 2004 Abassi led the coordination of various donor-related projects under UNICEF, UNFPA, Baylor HIV/AIDS Uganda, PACE, the AIDS Integrated Model programme and the Support Health Sector Strategic Plan Project (SHSSP) in Yumbe District Local Government. He oversees project implementation and provides monitoring and evaluation assistance to the local governmental and development partners.

Currently, Abassi is the District Health Officer for Yumbe district. He provides overall policy implementation for all stakeholders in health care delivery.
in the district, plays an important advocacy role in intersectoral action in health care delivery, and mobilizes and plans resources for all health care providers. Finally, he oversees the coordination and management of health care services, monitors and evaluates health care services in the district and coordinates activities of the agencies, health care providers and partners in the district health care system.

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**Dr. Richard Obeti** is a medical officer (MBChB) with more than three years of experience in health service management in Uganda.

Richard worked with Baylor Uganda in partnership with Kabarole District Local Government between 2012 and 2013, providing technical and managerial assistance at the health sub-district level until early 2014, when he was appointed to act as the District Health Officer of Kabarole.

As the District Health Officer, his mandate is to ensure the effective, efficient and affordable delivery of health care services for the well-being of the population of Kabarole district and Rwenzori region as a whole. He is also engaged in planning, directing, budgeting and coordinating all stakeholders in the district for the efficient delivery of health care services so as to effectively implement the national health policy.

Currently Richard is a student of Global Health and Development at the Graduate School of Hanyang University, Seoul, South Korea, and his main areas of interest are capacity development, research and evaluation, health financing, health system management, mobile health, and gender issues.

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**Ronald Miria Ocaatre** has been Acting District Health Officer of Maracha District Local Government since 2010. Before that he worked as Clinician-in-Charge at a level-three health centre (1994–1998) and as District Health Educator for the Arua District Local Government (2002-2009).

Ronald has been involved in public health activities for the last 19 years. He holds Bachelor of Social Work and
Social Administration, Master of Public Health Leadership and Master of Science in Health Promotion and Education degrees and a Diploma in Clinical Medicine and Community Health.

His fields of interest are public health generally, maternal and child health (sexual and reproductive health and rights) and HIV/AIDS training and awareness activities.

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**David Okia** is a medical doctor with a Master’s degree in Public Health from the Hebrew University, Israel. He worked as Medical Officer and later as Medical Superintendent of Ngora Church of Uganda Hospital (a rural, hard-to-reach hospital) for four years, providing clinical care and managing emergency obstetric operations and infectious diseases.

Currently he is working as a Regional Project Officer in the West Nile region. In this role he is responsible for the capacity-building of districts in West Nile; specifically, he supports the Regional Referral Hospital and all the districts in West Nile to develop, implement and monitor work plans.

His main fields of interest are in maternal health and health systems.

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**Dr. Bernard Odu** is currently working as Director and Senior Consultant at Arua Regional Referral Hospital. Previously he worked as Hospital Director at Soroti Regional Referral Hospital.

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**Dr. Charles Olaro** is a senior consultant surgeon who obtained his medical degree from Makerere University in 1994 and a Master’s degree in Surgery from the same university in 1999. He also possesses a Master’s degree in Health Services Management and a Master of Business Administration (MBA) degree from ESAMI.

Charles is currently working as Director and Senior Consultant Surgeon in Fort Portal Regional Referral
Hospital. Previously he worked as a Medical Superintendent at the same hospital and as a Medical Superintendent and Consultant Surgeon at Arua Regional Referral Hospital.

At various times between 1992 and 2006, Charles worked as a Medical Officer Special Grade, Senior House Officer and Medical Officer at Arua, Mulago and Lacor hospitals.

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Jimmy Opigo is a health systems expert with special interest in public and community health. At the moment he is working as a District Health Officer in the rural district of Moyo.

Originally trained as a medical doctor in Uganda, he specialized in public health at graduate level and has completed a Fellowship in Health Systems.

For the past 15 years Jimmy has been managing district-level health care services. His main fields of interest are health planning and financing, organizational development and management, programme management and monitoring, medicines and human resources management.

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Dr. Jakor Oryema is a medical doctor (MSc UMU) with over 20 years’ practical clinical experience in general surgery, obstetrics and gynaecology and specialized in health services management.

Jakor worked in both public and private not-for-profit hospitals before becoming a District Health Officer. Between 1985 and 2004 he worked as Medical Officer or Medical Superintendent at different hospitals (Arua, Kuluva and Nebbi hospitals). Jakor completed his Master’s in Health Services Management at Uganda Martyrs University Nkozi in 2004. He then moved to the District Health Office, where he has served as Caretaker, Acting and Substantive District Health Officer since 2004. Currently Jakor is District Health Officer at Nebbi district, a position he has held for the past 11 years. He is responsible for the overall planning, leadership and management of the district health care system. He is also the Health Board Chairman of the Nebbi Diocese Church of Uganda, where he has guided the upgrading of the largest and oldest health unit in the Diocese — Goli Health Centre — into a level-four health centre. Despite all human resources and funding challenges, he has maintained the district as the best performer in the West Nile region for the last five years.
His main areas of interest are research for guiding evidence-based decision-making and leadership and management of health services, with special interest in maternal and child health services.

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**Dr. Damian Amany Rutazaana** is a medical doctor (MBChB), epidemiologist and public health specialist (MSc CEB) with more than seven years’ experience working in the health care sector in Uganda.

Between 2012 and 2013 Damian worked as a national trainer for malaria case management under the Global Fund. He has extensive teaching experience as a lecturer at the Uganda Christian University Department of Health Sciences for the Master in Public Health programme and as a teaching assistant at the College of Health Sciences Department of Physiology. Damian has also worked as a medical officer at the International Hospital, Kampala.

Currently Damian is the Rwenzori Regional Project Officer for the Institutional Capacity-Building project under the Ministry of Health supported by Belgian Technical Cooperation. His main areas of interest are health systems strengthening, research, monitoring and evaluation.

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**Dr. Martin Ssendyona (MD, MPH, FHSM)** is a qualified Doctor of Medicine (MD) from the University of Dar-es-Salaam with a Master’s degree in Public Health (MPH) from Loma Linda University, USA. In 2015, he graduated as a Fellow in Health System Management from Makerere University School of Public Health in collaboration with Antwerp School of Public Health.

Martin was a Medical Officer in a private not-for-profit hospital from 1997 to 2001 and later joined Nkozi Hospital as Medical Superintendent from 2001 to 2007. In 2007 he was appointed as a Public Health Officer at the Ministry of Health. Martin has been involved in the coordination of quality improvement interventions, sector performance reviews and support supervision in the health care sector. He is also a national trainer in leadership and management.

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Annex B. Uganda country profile

Uganda is one of the countries in the East African Community (EAC). It is a Presidential Republic, with the President both Head of State and Head of the Government. The State was formed in 1962, following independence from the United Kingdom. The country practices a multi-party democratic parliamentary system with universal suffrage for all citizens over 18 years. The government is chosen by popular vote every five years, and exercises executive power through a nominated cabinet. Legislative power is held by the National Assembly, made up of elected Members of Parliament from across the country. Health care functions are managed by a Minister of Health.

Administratively, the country is divided into 111 districts and one city (the capital city of Kampala). The districts are sub-divided into 181 counties, 22 municipalities and 174 town councils, which are further sub-divided into 1,382 sub-counties, 7,138 parishes and 66,036 villages. Parallel with the administration are traditional kingdoms that enjoy some degree of mainly cultural autonomy.

Demographically, the country had a population of 34.9 million people in 2014, with an average annual growth rate of 3.03%, giving an estimated population of 42.4 million people by 2020. The average household size is 4.7 persons, with a sex ratio of 94.5 males per 100 females. An estimated 72% of the population lives in rural areas, compared to 28% in urban centres.

Of the total Ugandan population, 49% are under the age of 15, and 18.5% under five. Those aged 65 years and above represent 2.3% of the total population in 2015; this proportion should continue to increase as life expectancy improves.

Economically, the country’s Gross Domestic Product has been steadily increasing at a rate between 5% and 9% in the recent past (2010–2015). The percentage of Ugandans living below the poverty line decreased from 56.4% in 1992 to 19.7% in 2012. However, poverty remains deep-rooted in rural areas, where most of the population lives. The economy is transitioning from an agricultural one to an industrial, service-driven economy, with key drivers of the economic growth shifting towards

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21 Ibid.
more industrialized activities. Development aid has played a key role in stabilizing and improving the economy over the past 30 years. The per capita income, at 2002 constant prices, grew at an annual rate of 1.1%.23

The country has made significant improvements in social services, such as health, housing, education, water/sanitation and others. Most social services are provided free of charge at point of use, to reduce financial barriers to their utilization.

Health is a right, and thus it is increasingly becoming evident that everybody should have unhindered access to health care. Consequently, attention has been drawn to certain categories of the population with particular needs, such as pregnant women, elderly people, children and people with disabilities, among others. To this effect the country has developed a national strategic framework aimed at promoting a human rights approach to service delivery.

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The general objective of the Institutional Capacity-Building (ICB) project (or impact) was stated as: “To improve effective delivery of an integrated Uganda National Minimum Health Care Package”.

The specific objective (or outcome level) was: “Improved organizational and institutional performance of the Ministry of Health HQ and the health institutions in the two selected regions”.

The project worked along three key result areas (or outputs):

The Ministry of Health is strengthened in its organizational and institutional capacity.

Institutional capacity is developed in the health care sector in the Rwenzori and West Nile regions at all levels (i.e. regional coordination, regional referral hospitals, districts, general hospitals and health sub-districts).

The training needs in leadership and management of the health care sector are strengthened through the transformation of the Health Manpower Development Centre (HMDC) and the establishment of two regional training satellite centres.

The fourth output was targeted at ‘scientific support to the project’, which was later transformed into ‘capitalization’ of project achievements.

A first technical review in April 2011 resulted in formalizing the project structure with the (new) Director, Planning and Development taking up the responsibility of Project Coordinator. The project scope was expanded from targeting four selected districts, to full regional coverage (15 districts) and the inclusion of support to the national HMDC in Mbale. At the same time, two regional Project Project Implementation Committees (R-PICs) were introduced for the Rwenzori and West Nile regions.

Through delegated cooperation by the Swedish Embassy, €1.35 million was added to the project budget, and the project period was formally extended by one year to December 2015.

A Mid-Term Review took place in April 2013. The findings of the review resulted in adaptation of the project set-up, and a reformulation took place in July 2013 to: increase the focus on districts in two project regions through the development and introduction of Execution Agreements;

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24 Professor Omaswa and Dr. Eriki (ACHEST) and Dr. Paul Bossyns (BTC HQ)
reduce fragmentation in MOH/sector support with a concentrated focus on the Planning and Quality Assurance departments (Directorate of Planning and Development); and adapt the project staffing structure, with the introduction of two regional Project Officers and an international Contracting and Finance Coordinator. The new positions were filled in January 2014.

The above changes, approved by the project Steering Committee in September 2013, resulted in increased project ownership at district and regional levels. Also, the involvement and interest of MOH officials in project activities improved. As a result, the execution rate accelerated from 26% in July 2013 to 66% in December 2014.

Execution Agreements with 15 districts and two Regional Referral Hospitals proved a strong instrument to increase the ownership of project support. The expenditure of funds through the Execution Agreements gradually increased, and a number of important procurements to support the regional and district-level services were concluded, resulting in an execution rate of above 90% at the end of quarter 3 of 2015.

At the end of 2014, a new project (‘Institutional Support to the PNFP sub-sector’) became operational, and its activities would also target districts in the Rwenzori and West Nile regions, leading to synergy and joint opportunities. As a result of the successful implementation of the ICB project, and to improve collaboration between the public and private health sub-sectors, the Belgian government recommended the identification of a second phase of the ICB project. The formulation of ICB phase II was completed, and its start-up will gradually overlap with the closure of ICB phase I (November 2015).

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The support under the ICB project to the Ugandan health care sector has targeted a variety of interventions, with varying degrees of success. Strengthening referral systems, the implementation of Execution
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