

Public service reforms and their impact on health sector personnel in Uganda

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Preface

Over the past decade many countries have undergone public service reforms of some kind, however the consequences for employment and working conditions in the health sector have hardly been documented. This gap in information needs to be addressed, as any public service reform should be judged in terms of its influence on various sectors. The health sector is in most countries predominantly a public sector and therefore influenced by public service reforms. Achievement and improvement in the health sector are crucially dependent on the performance of staff at all levels which, in turn, is intimately related to their general employment and working conditions.

In 1998 the International Labour Office (ILO) and the World Health Organization (WHO) therefore launched a joint research programme to document selected reform processes and detail their impact on health care personnel. The lessons drawn from the individual cases are designed to assist international advisers, governments and organizations of civil society to implement more effective health sector reforms. Six countries from different regions of the world were selected as the focus for this international research (Cameroon, Colombia, Jordan, the Philippines, Poland, Uganda) and studies on public service reforms and their impact on health sector personnel in these countries were carried out in 1998 and 1999. Colombia and Uganda served as pilot country studies in 1998 and the other country studies followed in 1999. They all were discussed at an international round table. The Public Administration Promotion Centre of the German Foundation for International Development (DSE), Public Services International (PSI) and the International Council of Nurses (ICN) together with their affiliates assisted this joint effort of WHO and ILO throughout the whole process by providing technical advice and information at national, regional and interregional levels. The reasons for ILO and WHO launching this programme had different origins, but led to the same interest in the theme for the joint programme.

The 1998 sectoral meeting on health services requested the ILO to facilitate the exchange of experiences among countries through regional meetings and network arrangements of representatives of employers, workers and governments and to facilitate research activities on the impact of reform processes on the workforce. The joint programme with the WHO and the round table were a first response to these requests. For the ILO, this programme contributes to the follow-up of a series of sectoral meetings on reforms in both the health services and the public service sectors which concluded that “reforms are most likely to achieve their objectives of delivering efficient, effective and high-quality services when planned and implemented with the full participation of the public sector workers and their unions and consumers of public services at all stages of the decision-making process. Continuing dialogue between governments and the citizenry as a whole, including public sector workers, should be ensured” (1995) and that successful “health care reforms cannot be imposed from above and from outside” (1998).

For the WHO, the study of the impact of public sector reforms on health human resources is part of a programme to better understand the environment, factors and conditions that have an impact on health workers. With these data and information, discussion papers have been developed and disseminated to enable and increase debate on the key issues. These issues include: education and training, motivation of health care providers, policy development, planning, recruitment, retention and deployment. The research is intended to provide the basis from which policy options can be developed for use by decision-makers in different countries. The WHO’s workplan in the area of health workforce, education, performance and policy includes:

- a review of the changing roles of health professionals in many countries, through a reprofiling of different methods of health provider mix under different institutional arrangements;
- strengthening national capacity to use existing computer-based tools for health workforce planning and management;
- development of a set of standards for quality in the education of health workers;
- development of a set of policy options for improving provider performance;
- direct country support in overall human resource policy development and more specifically in nursing educational issues.

The WHO is working with countries as well as bilateral and multilateral partners in forwarding this agenda.

At an international round table of experts hosted by the DSE in October 1999 in Berlin, the experiences documented in the country studies were analysed and complemented. This round table was attended by the authors of the country studies, representatives of governments, private employers' and workers' organizations from the countries, as well as by officials from the organizations cooperating in this programme. The result of the discussions was the formulation of critical questions which were meant to facilitate the design, implementation and evaluation of human resource policies in public service and in particular health sector reform. This set of "Critical questions for initiating and reviewing public service reforms" is published in the report of the round table in Berlin in October 1999 and can be obtained from the organizers. With the present working paper the ILO and the WHO make also available the full text of the country studies which were revised by the authors in the light of discussion at the round table in Berlin. The opinions expressed in the studies are those of the authors and not necessarily those of the ILO and the WHO. Working papers are preliminary documents circulated to stimulate discussion and obtain comments.

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Executive summary

Origin and context of reform efforts

In the years after independence, the public service of Uganda, including the health service, was regarded as one of the most effective in sub-Saharan Africa. The population of the country was put at just over 8 million (8,135,000) in 1968. The annual economic rate of growth was 2.5 per cent. GDP was reasonable at Ush4,922 million. At that time, the Ministry of Health (MOH) budget was 14 per cent of total budget.

But, the 1970s and first half of the 1980s saw a dramatic deterioration in the economic health of the country. GDP declined by 6.6 per cent per year from 1978 to 1980. Inflation reached unsustainable levels. The declining standard of living and the increasing insecurity in the country led to an exodus of skilled manpower from the country. All services declined.

When the Government headed by President Yoweri Kagatu Museveni came to power in 1986, it found a civil service that was ineffective, lacked accountability and was demoralized. Corruption and abuse of office as a way of survival were widespread. The Government recognized that if the economy were to recover it was necessary to have an efficient and effective administration to guide and direct it.

In 1989, it set up the Public Service Review and Reorganization Commission (PSRRC). The Commission was to address itself to four key areas:

- personnel management issues;
- organization structure;
- accountability/financial management; and
- conditions of service.

It found that the Uganda civil service had not only been bloated but also suffered from inefficiency and poor performance. It identified inadequate pay and benefits, poor management skills, dysfunctional organization and inadequate personnel management and training as major issues. The 225 recommendations made by PSRRC were accepted by the Government in 1991 and formed the basis of the Public Service Review Programme (PSRP).

Over the last ten years, the economy has been growing at a rate of 6.5 per cent per annum. This remarkable rate of growth has been achieved with a low rate of inflation, a

reduced budget deficit and a relatively stable exchange rate. The current figure for population given in a recent country profile in *The Courier* is 20.4 million.

While the country still faces major problems (there are signs that the rate of growth may be slowing somewhat), the international community is upbeat about the management of the economy. This was acknowledged by the World Bank and the International Monetary Fund when Uganda was made the first beneficiary of the highly indebted poor countries (HIPC) initiative. The initial disbursement from this fund will go mainly to improve health and education.

Reform of the health service

Health service reform takes place within the broader framework of the Public Service Reform Programme (PSRP) and reflect its mission. This mission is to develop a public service which delivers timely, high quality and appropriate services at the least cost to the nation, supports national development, and facilitates the growth of a wealth-creating private sector. Major reform components include decentralization of powers, introduction of results-oriented management (ROM) and capacity-building. The main focus of the first phase of the reform programme was the creation of a competent, accountable and affordable civil service. The second five-year period of the reform programme focuses on macroeconomic stabilization, encouraging growth of a vibrant private sector, improving service delivery and poverty eradication. All of these impact on the health services and their personnel.

Decentralization has brought fundamental change in the allocation of roles, responsibilities and relationships between central and local governments. Both the Ministry of Health (MOH) and the district administration are being restructured. In the new structure, the core functions of the central and district administrations have been articulated to reflect the division between policy direction and policy execution. All hospitals (except referral and training hospitals) become the responsibility of the district local councils. These councils are also charged with provision of facilities for primary health care (PHC). Staff of these facilities are employed by the councils. Decentralization also emphasizes empowerment of civil society and local populations. In the health service context, this empowerment expresses itself in greater involvement of local communities in service provision as well as in management of publicly provided services through user membership of hospital boards and health unit management committees. The introduction of results-oriented management on a pilot basis in the Ministry of Health (together with four other ministries) and five districts has started to address the challenging task of changing the management culture of the civil service away from the traditional bureaucratic administrative approach to one of policy formulation and direction with a greater involvement of civil society in the process.

Impact on health sector personnel

The reform programme significantly affects the conditions of employment of staff. Local administrations have replaced the central Government as the employer for staffs of local facilities. The level of responsibility which staff at subnational levels have to assume has greatly increased. Yet, there is a general lack of adequately trained manpower to take

on the administrative and financial responsibilities of decentralization. To help overcome some of the immediate problems of financial management training is now being provided in management skills. There is, however, still no comprehensive programme of staff development (though one is in preparation as part of the PSRP).

With regard to health service professionals, as councils are now the employers, staff cannot be moved to districts by a central authority. It is anticipated that this may lead to some difficulty in ensuring adequate staffing in the more remote areas. Also, stringent controls on levels of staffing in all sectors, instituted as part of the PSRP, has made it difficult to employ newly qualified health personnel, despite serious shortfalls in the staffing levels for most of the cadres, particularly in the rural health facilities.

Retrenchment and contracting out of service provision are two elements of the policy of reducing the salary and wages bill in Uganda as elsewhere. The terms for retrenchment appear to be less favourable for lower paid workers and (re)training for work in the private sector appears to be inadequate. These workers are not very strongly organized in Uganda where unionization is relatively weak.

On the organizational side, communications and coordination systems and structures in place are not adequate to give efficient effect to some of the organizational elements envisaged in the reform programme. The ROM calls for monitoring of performance and standards of service delivery on an ongoing basis. This requires performance indicators and the effectiveness of these, in turn, is dependent on the quality of the information provided. There is reason to be concerned about the reliability of available data. In addition, the unfamiliarity of managers with use of available information hinders the effective operation of performance appraisal.

The reform programme has very large implications for the staff of the health services at all levels. It brings with it changes in relation to responsibility for recruitment, remuneration, organization of work and range of responsibility. It is envisaged that personnel management, including promotion criteria and basis for salary, will, therefore, change significantly.

Lessons to be drawn and their transferability

One of the clearest and most general lessons to come out of review of public service reform programmes right across the economic and cultural spectrum is that experiences elsewhere have to be interpreted in the particular environment – political, economic, social and cultural – in which they are to be used. As James Katorobo, a Ugandan professor and consultant, put it “rebuilding Uganda involves remaking all aspects of Ugandan society – from physical infrastructure to the soul and spirit of the nation”. Lasting and sustainable reform calls for a programme adapted to the local conditions. With that caveat, however, lessons drawn from experience in one country can be of use to those dealing with reforms in another.

The following lessons are among the most important which can be drawn from the Ugandan experience with health service reforms.

1. *Reform of the health sector is political as well as technical.* Because of this it is important to secure and maintain political support at high level.
2. *Health service provision is complex, so is its reform.* The service interacts with several other policy areas and programmes in these have an impact on the programmes in the health sector.
3. *Reform programmes must be given adequate financial and human resources.*
4. *Management capacity is essential.* Reform programmes do not just happen. They address sensitive issues, affect individual and group interests and to ensure that they stay on course they must be well managed on a continuing basis.
5. *The pace of reform must be adapted to the available capacity of the service being reformed.* Keeping up momentum is important but if the reform is to be sustainable it must be kept within the bounds of available capacity.
6. *Reform proposals must have credibility.* People must have confidence in them.
7. *Communications are crucial and must be given continuing attention.* Every aspect of reform from development of the programme to securing and retaining support for it require excellent systems for the reception and dissemination of information.
8. *Good decisions need good information.* Information needs to be accurate, complete and timely.
9. *Reform has to manage tensions.* Tension is inherent to change processes. Its recognition and development of approaches to deal with it are particularly in the context of consideration of the impact of reforms on personnel.

Acronyms

AIDS	Auto Immune Deficiency Syndrome
DPMF	Development Policy Management Forum
DSE	Deutsche Stiftung für Internationale Entwicklung (German Foundation for International Development)
ECDPM	European Centre for Development Policy Management
EU	European Union
GDP	Gross domestic product
HSD	Health subdistrict
IIAS	International Institute of Administrative Sciences
ILO	International Labour Office
KIT	Koninnglijk Institut voor de Tropen (Royal Tropical Institute)
MOH	Ministry of Health
MPS	Ministry of the Public Service
NGO	Non-governmental organization
NMS	National Medical Stores
PHC	Primary health care
PSI	Public Services International
PSRP	Public Service Review Programme
PSRRC	Public Service Review and Reorganization Commission
ROM	Results-oriented management
TQM	Total quality management
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
Ush	Ugandan shilling
US\$	United States dollar
WHO	World Health Organization

1. Synthesis of public service reform in Uganda (with special regard to health sector relevance)¹

1.1. Origin and context of reform efforts

In the years after independence, the public service of Uganda, including the health service, was regarded as one of the most effective in sub-Saharan Africa. The population of the country was put at just over 8 million (8,135,000) in 1968. The annual economic rate of growth was 2.5 per cent. GDP was reasonable at Ush4,922 million. At that time, the Ministry of Health (MOH) budget was 14 per cent of total budget.

But the 1970s and first half of the 1980s saw a dramatic deterioration in the economic health of the country. GDP declined by 6.6 per cent per year from 1978 to 1980. Inflation reached unsustainable levels. The declining standard of living and the increasing insecurity in the country led to an exodus of skilled manpower from the country. All services declined.

When the Government headed by President Yoweri Kagatu Museveni came to power in 1986, it found a civil service that was ineffective, lacked accountability and was demoralized. Corruption and abuse of office as a way of survival were widespread.

The impact of an inefficient civil service complemented the decline in economic growth of the country through undermining the proper implementation of public investment programmes ... Those who had access to public investment funds used the money to directly supplement their salaries and wages while those who did not have access to such money lost morale and never cared whether or not public investment stalled.² (Orech, 1995.)

The Government recognized that, if the economy were to recover, it was necessary to have an efficient and effective administration to guide and direct it. To address the management aspects of economic recovery, in 1989, it set up the Public Service Review

¹ This study is based on: material identified by ILO, WHO, DSE and PSI on health sector reforms in Uganda; documents relevant to public service and health service reforms in Uganda made available to the author; supplementary information supplied by Dr. Sam Lymoki, General Secretary, Uganda Medical Workers' Union at the Roundtable on Public Service Reforms and their Impact on Health Sector Personnel jointly organized by WHO, ILO and the German Foundation for International Cooperation (DSE) in Berlin from 13 to 15 Oct. 1999. A brief introductory note on the country is attached as an appendix.

² Country paper prepared by Mr. Martin Orech, then Head of the Civil Service of Uganda, for a workshop on "Civil service reform in the context of structural adjustment" at ECDPM, Maastricht, July 1995.

and Reorganization Commission (PSRRC). The Commission was to address itself to four key areas:

- personnel management issues;
- organization structure;
- accountability/financial management; and
- conditions of service.

The Commission found that the Uganda civil service had not only been bloated but also suffered from inefficiency and poor performance. It identified inadequate pay and benefits, poor management skills, dysfunctional organization and inadequate personnel management and training as major issues. The 225 recommendations made by PSRRC were accepted by the Government in 1991 and formed the basis of the Public Service Review Programme (PSRP).

Over the last ten years, the economy has been growing at a rate of 6.5 per cent per annum. This remarkable rate of growth has been achieved with a low rate of inflation, a reduced budget deficit and a relatively stable exchange rate. Health expenditure is back up to around 14 per cent. But the population is also growing. It was 18,659,000 in 1995 – with almost 75 per cent under 30 years of age. Projections for 2000 and 2010 were just over 21 and 27 million respectively. However, a figure given in a country profile in a 1998 issue of *The Courier*³ was already 20.4 million.

While the country still faces major problems and there are signs that the rate of growth may be slowing somewhat, the international community is upbeat about the management of the economy. This was acknowledged by the World Bank and the International Monetary Fund when Uganda was made the first beneficiary of the highly indebted poor countries (HIPC) initiative. The initial disbursement from this fund will go mainly to improve health and education. The programmes of the European Union and other bilateral funding agencies also attest to the progress being achieved in Uganda.

1.2. Reform objectives and strategies

The mission of the Public Service Review Programme is stated as follows:⁴ “to develop a public service which delivers timely, high quality and appropriate services at the

³ “Uganda country profile”, *The Courier*, July-Aug. 1998, No. 170.

⁴ Public Service 2002: *Public Service Reform Programme 1997-2002*, issued by the Administrative Reform Secretariat, Ministry of the Public Service, Uganda.

least cost to the nation, supports national development, and facilitates the growth of a wealth-creating private sector”.

To achieve this mission, the programme includes:

- rationalization of public service structure and functions to improve efficiency and to reflect decentralization and the emphasis on service delivery;
- increased devolvement of responsibility to district administrations in the area of financial and economic management;
- provision of focused support to district and sectoral programmes that will have the greatest impact on service delivery and development;
- increased accountability, transparency and improved service delivery through the introduction of results-oriented management and the establishment of clear objectives, service standards and greater citizen and private sector participation;
- improvements in resource management and expenditure control through improved procedures, the greater use of information technology (e.g. personnel, payroll, budgetary and financial systems) and improvements in asset management and audit/inspection;
- removal of bureaucratic hindrances to economic development, whilst maintaining the necessary regulatory role of the State;
- development of a professional, capable, motivated public service through improvements in training, remuneration, performance management, communication and recruitment/selection/promotion processes;
- development of the necessary legal and regulatory framework to support the reform programme.

1.3. Reform processes and actors

In the first five-year PSRP, the Government identified seven major reform components for implementation. They were:

- rationalization of government structures and functions including decentralization of powers to the districts;
- rightsizing the public service;

- pay reform including a salary enhancement programme and monetization of non-cash benefits;
- personnel and establishment control;
- improvement of records management;
- introduction of results-oriented management (ROM); and
- capacity-building.

The reform programme is designed in such a way that it avoids a piecemeal approach which would risk losing sight of the interlinkages between different elements of the programme, but at the same time it tries to avoid an overly comprehensive approach. The agenda recognizes the need to balance the content of the programme with the capacity available to implement and sustain it.

1.3.1. Actors – Management at central government level

Recognizing the interministerial character of many of the programmes, institutional provisions for the management of the reform have been carefully designed. The management overview for the public service reform programme is headed by a Cabinet subcommittee chaired by the Vice-President. The Permanent Secretaries of the Ministries of the Public Service, Finance, Planning and Economic Development and Local Government, the Attorney-General and the Head of the Civil Service (who is also Permanent Secretary in the President's Office) constitute the membership. A steering committee under the lead of the Head of the Civil Service as Programme Director includes the other permanent secretaries from the Cabinet subcommittee and also has in its membership the Solicitor-General, a district representative, the head of the reform secretariat and, by invitation, permanent secretaries of line ministries. Service commissions and donors relate to the management process at the level of the steering committee. Reporting to the steering committee are four project teams – 2002. Each team is headed by a project manager and has technical committees or consultative groups in relevant functional areas.

The project teams are:

1. *Enhancing restructuring and rationalization*: restructuring and rationalization; divestiture; rightsizing; retooling; and efficiency studies.
2. *Management information and control systems*: budgeting and financial systems; personnel and payroll systems; assets management; records management; audit and inspection.

3. *Developing human resources*: pay and conditions; performance management; training and development; employee relations; and recruitment, selection and promotion.
4. *Good governance and private sector development*: policy process; legal framework; service delivery; standards; private sector liaison; and networking and best practice.

3.1.2. Actors – Staff and staff representatives

Staff of the health service are clearly core actors in the reform implementation process. Because several elements of the reforms affect the terms and conditions of service of these staff, their representative organizations are (or should be) actively involved. However, trade unions, as “the vehicles of political expression of labour” have only to a limited extent participated in the decision-making process in the public service. With regard to the health service unions, the labour unrest in the second half of 1995 led to the establishment of the Cabinet Committee on Health Workers’ Grievances. “The recommendations of this committee were widely discussed between public service unions and the Government (including the newly established Interim Public Service Negotiating and Consultative Council). It is now agreed that the public service unions should be involved and consulted in matters concerning the wage bill distribution and other matters concerning the terms and conditions of service.”

3.1.3. Other actors

Given the participatory philosophy inherent in the decentralization policy, there are numerous other actors at the several levels of service delivery. The line ministries are actors; the district administrations are actors; the citizens who are being given more voice in policy formulation and execution are actors. Although the reform programme is nationally managed and directed, the external funding agencies are also actors.

1.4. Focus and scope of reform implementation (relative emphasis on sector policies, structures/ institutions, financing, management processes, workforce issues)

The scope of the public service reform programme spans the whole public sector. The Commissioner for Human Resource Management in the Ministry of the Public Service, Ms. B.M. Sezi, describes the programme as “a bold policy measure designed to revamp the civil service and to re-establish its professionalism”⁵ (Sezi, 1997) with structures, systems and staffing – in effect with the whole institutional infrastructure required by the State to direct the national affairs. The policy of decentralization makes it necessary to include the subnational levels of administration as well as the central administration. The policy of

⁵ Prisca B.M. Sezi: “Reaffirming the values of professionalism in public administration: The Uganda experience”, *International Review of Administrative Sciences*, Vol. 63 (1997).

privatization calls for reform of the parastatal and public enterprise sectors as well as requiring changes in functions and development of new regulatory systems to cover private sector development in the central administration.

The main focus of the first phase of the reform programme was the creation of a competent, accountable and affordable civil service. Much of the emphasis was on rationalization of structures and functions, rightsizing the public service and creating a working environment which would make it possible to attract and retain the necessary staff.

The second five-year period of the reform programme focuses on macroeconomic stabilization, encouraging growth of a vibrant private sector, improving service delivery, and poverty eradication. The Government is the provider of most essential services in areas such as education, health, roads, water and sanitation so is responsible for the management of major investments in both social and physical infrastructure. Public Service 2002 avers that the effectiveness of these investments “will be undermined and even negated if the system of public administration is ineffective, inefficient or corrupt”. Thus, the importance of an efficient and effective public service for the realization of these goals continues to be emphasized.

The Government of Uganda is committed to a policy of decentralization. This is enshrined in the 1995 Constitution.⁶ The emphasis on improvement of standard of delivery of service in the Public Service Reform Programme (PSRP) has made decentralization one of the pillars of the PSRP in Uganda. Decentralization has brought fundamental change in the roles, responsibilities and relationships of political leaders and civil servants in the central ministries and the local governments. Decision-making powers are based at the district level on such matters as human, financial and physical resources. The districts have become focal units for managing a complex range of activities formerly directed by central ministries. This change brings with it the need to develop a culture which sees service provision as being responsive to the needs and demands of the population to be served. All institutions of the Government – both central and local – must be committed to this value of responsiveness.

Effective performance in the new environment calls for major developments in the communication and coordination mechanisms between ministries and districts and also between ministries at the centre. As Sezi puts it: “The challenge is getting commitment to shared values across the Government, both in the central ministries and the districts.”⁷ This has necessarily put considerable emphasis on such sector policies as health and education. These policy sectors touch immediately the lives of virtually all citizens. They are present

⁶ It is of interest to note that not all politicians were in favour of the form of decentralization being introduced at that juncture. Some advocated a form of federalism which they believed would “countervail and enrich the centre and thus prevent the growth of autocratic governments”. There was concern that if “political robbers capture power at the region or district, they make a mockery of the process of empowering people”. Those expressing this point of view considered that it would be essential to democratize the centre, the region, the district and the parish before power was distributed to all levels. Among those supporting this view was a professor from Makerere University who at the time was Minister for the Public Service in Uganda.

⁷ Sezi, *op. cit.*

at district and subdistrict levels and must form a significant segment of any decentralization programme. Since in Uganda the responsibility for the decentralization at central level lies with the Ministry of Local Government, any delegation of responsibility for health services requires new institutional linkages between the Ministries of Health and Local Government at the centre as well as between these ministries and the subnational levels of the Government.

The organizational and procedural measures in the second phase agenda reflect decentralization and the emphasis on improved service delivery. The phase envisages increased devolvement of responsibility for financial and economic management to district administrations and removal of bureaucratic hindrances to economic development while maintaining the necessary regulatory role of the State. To ensure the capacity necessary to realize the objectives of decentralization, there will be more focused support to district and sectoral programmes that will have the greatest impact on service delivery and development. Systems and procedures in resource management will be enhanced through greater and more effective use of information technology (e.g. personnel, payroll, budgetary and financial systems) and improvements in asset management and audit/inspection. Improvements in training, remuneration, performance management, communications, recruitment/selection/promotion will help the further development of a professional, capable, motivated public service. The continued development of the results-oriented management approach introduced during the first phase should lead to increased transparency and accountability.

1.5. Overall achievements, constraints and failures

Public Service 2002 states that Uganda made considerable progress towards a more efficient and effective public service in the five years of the first phase of PSRP. International opinion concurs.

As might be expected, there are some areas where progress was less rapid than others and some unanticipated institutional issues arose. Also, the programme appears to have lost some of its momentum in the last one-and-a-half years. The new five-year programme aims to revive commitment and re-energize the programme.

Achievements include a fundamental review of the mission, strategic objectives, structure and staffing levels of all ministries and departments of the central Government as well as district administrations. This resulted in the reduction of the number of ministries from 38 in 1992 to 22 in 1997. The staff complement in the central Government was cut from over 320,000 in 1990 to less than 130,000 by 1997. Improved payroll control resulted in the deletion of over 20,000 invalid payroll records from the teaching service, police and the central Government.

This reduction in staff numbers coupled with donor financing for the retrenchment programme allowed for fundamental pay reforms. In addition to increases in pay levels, the pay structure was simplified with many non-cash benefits being consolidated into pay though the impact of the latter was not seen as being equally advantageous at all staff levels (see 2.2.6).

The introduction of the ROM on a pilot basis in five ministries (including the MOH) and five districts has started to address the challenging task of changing the management culture of the civil service away from the traditional bureaucratic administrative approach to one of policy formulation and direction.

A staff training programme was designed and launched to provide personnel with the necessary skills to respond to and implement the reforms. A service-wide training needs assessment to further strengthen training capacity was being carried out at the time of publication of Public Service 2002.

There has been progress on decentralization. New structures have been developed for all local governments. Staff have been transferred from the centre to the districts. But the full implications of the proposed decentralization in terms of requirements for institutional infrastructure, personnel and finance have turned out to be greater than anticipated in the beginning. The experience with the Ministry of Health clearly identifies the problems that have to be faced in this context.

2. Assessment of the impact of public service reforms on health sector employment and working conditions

2.1. Implications for human resources policies in the health sector

2.1.1. Institutional changes (organization of the health sector, hospital and outpatient treatment) – Capacity-building

As was the case in relation to the public service more generally, the health services in Uganda in the years after independence were rated as among the best in Africa. Also in common with the more general pattern they suffered a serious decline in the 1970s and first half of the 1980s. Health indicators like infant mortality rate (97 per 1,000 live births) and maternal mortality rate (506 per 100,000 live births) given in the May 1998 profile are among the poorest for low-income countries. This is a serious deterioration from 1972 when the estimated figures for these rates were 78 and 380 respectively.⁸ The Government of President Museveni acted quickly in relation to the health services when it took office in 1986. The following year it set up the Health Services Review Commission. The output of this and of the Public Service Review and Reorganization Commission which followed are the basis for the reforms currently being implemented.

⁸ Pilot project for comprehensive district health care in Jinja, Republic of Uganda – Project proposal, March 1998, Koninklijk Instituut voor de Tropen (Royan Tropical Institute, Netherlands).

The Government health policy now is to ensure:

- equity of access to health services by all citizens;
- appropriate and good quality health care;
- efficiency and accountability in health care delivery and management; and
- community empowerment to enable citizens to be responsible for their own health and well-being.

The policy strategies to implement this are to:

- decentralize the management of health services to the district and lower levels;
- strengthen human resource management to ensure adequate supply and productivity;
- build capacity for resource mobilization and efficient utilization;
- strengthen partnerships with the NGOs and for-profit private sector in a move towards achieving a sector-wide approach to health development; and
- improve health infrastructure for effective health care delivery based on primary health care.⁹

Health service organization pre-PSRRC

Health service policies and their delivery were substantially the responsibility of the Ministry of Health until 1994. The MOH was responsible for policy, planning, resource mobilization and allocation, provision of health services and monitoring. It was directly responsible for government hospitals and provided services through them. Finance and personnel came from the centre. The Ministry was the employer of qualified staff in the hospitals. Below hospital level, health services were, in principle, the responsibility of the local administration under the overall supervision of the Ministry of Local Government but necessary personnel, equipment and supplies were still provided and supervised by the MOH.

⁹ Health systems development: Country health system profile, Uganda, May 1998.

Changes envisaged with decentralization

The Local Government Statutes (1993) provided for decentralization to district level. The 1995 Constitution and the Local Government Act, 1997, clearly define the responsibilities for management of health services at the central and district levels. All functions, powers, responsibilities and services are to be decentralized to the several levels of local government to ensure people's participation and democratic control in decision making.

To achieve effective implementation of the decentralization policy, both the MOH and the district administration have been restructured. The restructuring of the MOH has been done to improve clarity of roles and responsibilities, eliminate overlap within the Ministry, improve the spans of control and ensure clear lines of accountability. The Ministry is one of the pilots involved in the introduction of the results-oriented management (ROM) programme which is part of the broader public service reform. (It can be presumed that the MOH suffered from the same capacity lacks as the other parts of the central administration in the latter half of the 1980s. The move to a policy of decentralization would, on the basis of experience elsewhere, greatly increase the number and severity of institutional issues to be addressed.)

It is necessary to reorganize the district health system to enhance its capacity to cope with the increase in responsibilities arising from decentralization. District level health management is being upgraded and strengthened and management of health service operations is being further decentralized to health subdistricts based on electoral areas with an average population of about 75,000. The management of the health subdistrict (health zones) will be based at an existing hospital within the health subdistrict. Where there is no hospital in the subdistrict, a health centre will be up-graded to take the leadership role. The planning, budgeting, distribution of resources, routine technical supervision and monitoring will now take place at the health subdistrict (HSD) level. The District Medical Office, now being elevated to the Directorate of District Health Services, will provide overall leadership in planning, resource mobilization and allocation, coordination, health information management and evaluation.

In the new structure, the core functions of the central and district administrations have been articulated to reflect the division between policy direction and policy execution.

The core functions of the MOH are as follows:

- formulation of national health policy and plan, and ensuring that health issues are adequately addressed in the policies and plans of other ministries;
- setting and dissemination of minimum national standards for the delivery of health services including access to health facilities, basic health package for the various types and levels of health facility, standard of accommodation and equipment of health units, and standard on training of health professionals;
- ensuring adherence to national policy and to minimum standards for health care;

- supporting districts and referral hospitals in developing capacity for planning and management to discharge their functions of coordination of epidemic and disaster management.

The following are the core functions of the district health office:

- formulation and implementation of district health plans in line with the national health policies and plans;
- resource allocation, use and accountability;
- coordination of health services within the district and with the national level;
- disease surveillance and epidemic control;
- health information management;
- in-service training and supervision of health service providers;
- procurement, distribution and ensuring proper utilization of supplies and equipment;
- deployment and management of human resources;
- monitoring and evaluation of health interventions.

Citizen participation

Apart from the changes in allocation of responsibility between central and local institutions, decentralization also emphasizes empowerment of civil society and local populations. At the institutional level, citizen participation in planning is provided for through the local governing councils and health management structures at all levels of the administrative hierarchy – district, subdistrict, parish and village. Citizens participate in management through membership of hospital boards and health unit management committees.

The decentralization programme also offers opportunity for other types of citizen/community involvement in the development of health services. An example from the July-August issue of *The Courier* will serve as an illustration. As part of its micro-projects schemes, the European Union makes a typical grant of, say, Ush35.

The accent is on “participatory development” with the local workforce providing the labour and some of the building materials. The beneficiary

community typically meets around 25 per cent of the project's costs ... once a decision is taken to proceed with a project, a Memorandum of Understanding is drawn up with the local community to decide who does what. Among the challenges are to ensure that local authorities can equip and supply the buildings, and that teaching and medical staff are available.¹⁰

Hospital management

Under the decentralization proposals, all hospitals with the exception of those providing referral and training, which depend directly on the Ministry of Health, are to be the responsibility of district local councils. These councils are also responsible for such health-related services as environmental sanitation, health education, vector control, primary health care, communicable disease control, maternal and child welfare. Even in relation to referral and training hospitals, administration of the facilities is to be delegated to the local level.

The MOH proposes to phase the handover of hospitals over a three to five-year period. This will allow for development of the necessary capacity at district level and below, the development and testing of monitoring procedures including enhanced management information systems, the identification of further areas where there is need for institutional adaptation, as well as the necessary acculturation of the personnel to the new structures and system. A consultant's report prepared for the World Bank in January 1997¹¹ indicates that such a phased handover is desirable in the light of the gap between institutional (and indeed physical) requirements to meet the standards of the policy and the available resources. It will also allow for a review of what needs to be done in relation to improvement of the existing physical infrastructure and such expansion of facilities as may be necessary to realize the policy of the Government for health service provision.

In the light of the recent decision to designate NGO hospitals as district hospitals where there is no government hospital in a given district, there will be a further need to reorganize the nature of the relationship between the hospital management, the NGOs involved and the district administration. There will also be a need to develop administrative systems and procedures to make the new relationship work. For example, there is some uncertainty (among NGOs at any rate) about the exact nature of the management relationship between facilities financed by them and the ministry/district. These relationships have a direct bearing on the reporting relationships of staff, appeals procedures, industrial relations processes as well as access to and control of resources. They need to be clarified. Given the amount of NGO involvement in delivery of health services, this is a major need.

¹⁰ *The Courier*, op. cit.

¹¹ Government of Uganda: "Introduction of results-oriented management", Ministry of Health, 27 Jan., 1997 KPMG report.

Primary health care

At district level, primary health care, which is the keystone of the health policy in Uganda, is provided through health centres. These constitute the second level of care – the first being at community level. It is government policy to establish at least one health centre in each subdistrict serving on average a population of 20,000. (At community level the population to be served is about 5,000.) There is a total of 1,030 government health centres in Uganda as well as 344 run by NGOs and 33 private facilities. There are four levels of centre classified according to services provided and bed capacity. They range from level 1 which are basically aid posts largely initiated by the community to level 4 which is in effect a small hospital with general as well as maternity beds, facilities for simple emergency surgery which also provides some outreach services. This latter level serves a population of around 100,000.

2.1.2. Overall costs, fiscal restraints and availability of resources (human and financial)

Decentralization comes with a price tag. It calls for new institutions, greater personnel resources at subnational level and new consultative and decision-making modes. In Uganda, the organizational structure has been well set out and, despite the reservations of some on the nature of the decentralization process, there is general political agreement on the desirability of decentralized government. But the operational management systems, financial means and personnel capacity to underpin it are still short of what is required.¹²

The average spending on health per head of population in sub-Saharan Africa is about US\$10. The WHO estimates that low income developing countries need health expenditure of US\$12 per head of population to provide a basic, essential health package to the population. As can be seen from the table below, the situation has been improving in Uganda during the 1990s. However, the figure for 1995-96 is still below US\$10.

¹² The KPMG report noted that “Neither the Planning Department [of the MOH], the Finance Department, the Ministry of Local Government nor the decentralization secretariat could give us the budget or actual expenditure figures for the costs of delivery of health services in the districts.”

Health care expenditure in Uganda

Source	1992-93	1993-94	1995-96
Government (Ush billion)	19.5	33.4	44.7
Donors (Ush billion)	25.2	24.0	40.8
Private (Ush billion)	104.6	94.6	104.3
Total expenditure (Ush billion)	149.6	152.1	189.8
Per capita expenditure (US\$)	7.12	7.26	9.88
Public per capita expenditure (US\$)	2.14	2.74	4.50
Private per capita expenditure(US\$)	5.07	4.52	5.38

Source: Pilot Project for Comprehensive District Health Care in Jinja, Republic of Uganda, KIT – Royal Tropical Institute, Amsterdam.

The trend is positive and an analysis of 1998-99 estimates indicates that the figure for 1997-98 may come to 12.24 per cent.¹³

Total recurrent expenditure on health as a percentage of GDP is estimated to increase from 4.25 per cent in 1997-98 to 4.50 per cent in 2000-01. It is pointed out that these estimates may need to be revised when more reliable figures come available.¹⁴

Decentralization has complicated the task of estimating the share of government resources allocated to health. Much health expenditure – especially salaries – is now funded from the unconditional grant to local authorities. Unlike the situation in relation to education and agriculture, the salaries for health personnel are not earmarked.

Finance

The main sources of finance are the Government, donors and the private sector. Current policy includes the introduction of user charges.

Almost 23 per cent of all donor funds goes to health in Uganda; 60 per cent of this is committed to the districts. While all donor funding is shown within the development budget, in the health sector a major amount of it (almost two-thirds if the contribution to the rehabilitation of the Mulago hospital complex is excluded) may be regarded as recurrent. The analysis of estimates for 1998-99 projects that resources will be increasingly shifted away from the centre and hospitals to district health services. The allocation to the centre and to Mulago is expected to decline in real terms. There will be a modest increase in the allocation to hospitals and a more than doubled allocation of resources to district

¹³ Supplied by Anitta Underlin, Financial Management Adviser, Uganda, MOH/Danida.

¹⁴ Estimates of staff costs in the “Analysis of budget 1998-99” are based on the numbers of staff currently working within the health system. It uses an average of salary rate of Ush130,000 per month (referral hospitals and training school: Ush100,000 per month in district hospitals and Ush105,000 per month in district health services). It is intended to refine this approach shortly.

health services. This latter is being underwritten in part by donors through the Poverty Action Fund.

Local governments receive block grants, conditional grants, such as those for primary health care, and equalization grants from the central Government. It is estimated that in 1998-99 health will receive 10.6 per cent (Ush31 m) of the total district vote.

Local authorities also have their own locally generated resources. There is found to be a difference of interpretation between the subdistricts and the districts as to the allocation of resources. Sixty-five per cent of revenue is left at subdistrict level although the district is responsible for delivery of the bulk of the services throughout the district.

The high cost of the public health service and donor interest in supporting this segment of the health service has led to some donor dependency. The narrow revenue base in the country and the unlikelihood of a significant expansion of taxation means that no major real increase in allocation of resources to the health sector can be expected in the coming three years. This will affect the rate of takeover of responsibility for public health services from external funding agencies by the Government.

Improvement of the health service infrastructure is one of the main targets of the money being provided under the funds of the HIPC initiative. Other funding agencies are also active in this sector either as part of their support of decentralization or directly in support of health. For example, the micro-projects scheme of the European Union aims to reach some of the most disadvantaged sections of the population by building infrastructure in rural communities where development was hampered by the protracted civil war. One prong of the scheme is to build schools and hospitals in these areas. The EU has another scheme for rural health services geared towards building capacity to improve management, ensure supplies and provide training. The WHO, UNDP, UNICEF, World Bank and ADF are other multilateral agencies involved supporting the health service in Uganda. Bilateral agencies include those of Austria, Canada, Denmark, Germany, Italy, Netherlands, Nigeria, Spain, Sweden, United Kingdom and United States.

Personnel

Overall, there is a lack of adequately trained manpower to take on the administrative and financial responsibilities of decentralization. To help overcome some of the problems of financial management, training is now being provided in such skill areas as management of revenue, accounting procedures, setting revenue targets, setting the fee for service (the Government is currently trying to reintroduce fees on a standardized basis), supervision and audit for those in charge of health units, cash handlers and health unit management committees.

It is envisaged under the provision of the decentralization policy that all personnel working in the districts are recruited and employed by the districts. However, remote and disadvantaged districts have been unable to attract sufficient personnel. The Ministry of Health can no longer legally transfer or appoint staff to districts as a means of equalizing the provision of services throughout the country. But the degree of adherence to these provisions throughout the whole system is not clear. One officer has gone so far as to bring

the Ministry to court to contest its right to transfer him under the new dispensation. This would appear to indicate that transfers have not yet completely stopped. In respect of doctors, a provision has been introduced to require newly qualified medical personnel to serve for two years in rural areas before they are considered eligible for senior appointments.

Organization

Communications and coordination systems and structures in place are not adequate to give efficient effect to some of the organizational elements envisaged in the decentralization programme. For example, the Uganda Health Services Profile of May 1998 sees the main problem that has emerged as a result of the introduction of changes in the health care system as how to ensure that the districts comply with national standards, policies and priorities in the allocation of resources at the local levels in the decentralized system. It states that while the MOH is “responsible for the formulation of national health policy and setting guidelines and standards, these have not been adequately disseminated to the district level and to relevant district authorities such as the district council. There are differences in perceptions and setting of priorities, so that districts sometimes overlook national priorities”.

Another organizational issue arises at the level of the central administration – lack of coordination of vertical programmes. This issue arises both intraministerially and interministerially in the context of introducing programmes of decentralization. (See earlier comments on need for coordination with the Ministry of Local Government.)

There is, too, lack of coordination by the centre of donor contributions. This leads to duplication of provision in some areas while other districts are left out completely, thus failing to utilize optimally the resources that are available.

Sezi believes that:¹⁵

Efficiency is threatened in the short run by the shortage of personnel to perform necessary tasks ... [and that] increased workload was a constraint on performance. [Nevertheless], the central agency responsible for the reform continues to resist the constant pressure from the ministries to fill vacant positions in the rationalized structures.

2.1.3. Reduction and migration of staff (internal and external)

There is an imbalance in the distribution of health facilities in Uganda with most hospitals and specialized health facilities being located in the urban areas. Accessibility to facilities providing both curative and preventive services is as low as 8.9 per cent in some

¹⁵ Sezi, op. cit.

remote rural areas and as high as 99.3 per cent in Kampala (May 1998 profile). While the urban areas are often overstaffed, remote rural facilities are, in fact, run by nurse aides who have been trained on the job.

A major problem that has emerged is that, as a result of the public service reforms in Uganda which have instituted stringent controls on levels of staffing in all sectors, it has been difficult to employ newly qualified health personnel, despite serious shortages of most of the cadres, particularly in the rural health facilities. There is also a problem in ensuring optimal skill mix for the provision of the essential health package at district level. The decentralization has made it difficult to help districts to improve the staffing in rural health facilities. Districts no longer accept staff posted directly to them from the centre. On the other hand, the numbers that they can recruit depend on their ability to pay the wages.

Part of the difficulty of attracting and/or retaining staff in rural areas may be related to the poor state of equipment and buildings. Great efforts over the last ten years on the part of the Government has somewhat improved the situation. Decentralized management has improved the availability of drugs and supplies. In addition, it is anticipated that the future plans to link larger health care facilities to primary health care is likely to improve the utilization of the resources of the larger facilities.

The lack of a developed social infrastructure including educational facilities is likely to be another factor. It certainly has been in many countries not only in Africa.

2.1.4. Educational systems (pre-service training, registration)

The human resource development policy has been drafted with the main objectives to ensure adequate supply of skilled human resources, increase productivity and improve deployment and retention of trained health personnel. The policy puts emphasis on producing polyvalent health workers.

The basic training of medical doctors is well developed. The curriculum exists and is community oriented, with strong emphasis on primary health care. However, the in-service medical education for doctors is not well organized. There is no curriculum, and the training provided is very much dependent on what is perceived by the senior management in the health sector as the needed training. For doctors working in the primary health care area in the districts, management training is emphasized. They receive better organized training and receive it more often than their counterparts in the hospitals.

The MOH and the Nursing Council organize the basic training for nurses very well. There are curricula for the various nursing disciplines, which have recently been revised and reoriented to primary health care. Like with the doctors, the in-service training is not standardized. The training is based on needs identified. The nurses working in the primary health care areas in the districts receive a lot more in-service training than their counterparts in the hospitals.

One reason for the greater attention to in-service training at primary health care level may be that PHC provision often involves donor-funded projects and programmes.

Management training is not well integrated in the basic training curricula for nurses and doctors, although some management aspects have been recently included in the new or revised curricula. There is a one-year postgraduate diploma course in health services management for all cadres of health personnel, jointly implemented between the MOH and Makerere University.

Training for administrative personnel has been referred to earlier. It is provided for within the overall reform programme but it is not easy to get a breakdown of figures on the training expenditure. Given the overall tight staffing situation, it may be expected that release for training presents difficulties. A figure in the KPMG report referred to earlier on introduction of ROM lends credence to this. The annual total recurrent budget for training is Ush5,229,574,276. The actual expenditure in the fiscal year 1996 was Ush947,228,006. It is not clear whether this was the result of a shortfall in release of potential trainees or in the actual amount of finance available.

2.1.5. Professional standards, rule of practice

Following on the introduction of the Uganda Medical and Dental Practitioners Statute, 1996, the Nurses and Midwives Statute, 1996, and the Allied Health Professionals Statute, 1996, new bodies have been formed to regulate these three staff groupings.

The Uganda Medical and Dental Practitioners' Council supervises, controls and maintains professional medical and dental training and practices, including registration and licensing of private practice.

The Nurses' and Midwives' Council regulates the standard of nurse training and practice in the country including registration and enrolment of nurses and midwives, registration and regulation of private nursing and midwifery practice.

The Allied Health Professionals' Council is responsible for regulating the standard of training and practice of the professionals within its mandate.

Legislation directed towards ensuring improved procurement and management of drugs includes:

1. Uganda National Drug Policy and Authority Statute, 1993, which aims at ensuring availability and rational use of good quality essential drugs, including regulating the manufacture, importation, exportation and marketing of drugs;
2. Pharmacy and Drugs Act, 1997, which aims at amending and consolidating the law related to the control of pharmacy practice and trade in drugs and poisons. It provides for the establishment of the Pharmacy Board, Pharmaceutical Society of Uganda and

the regulation of manufacture, importation, storage and transportation of drugs including narcotics;

3. National Medical Stores Statute, 1993, which provides for the establishment of the National Medical Stores, its composition, powers, objectives, functions, financing and management. It establishes the NMS as a corporation, which procures medical supplies for the public health service and selected private services.

Despite the existence of this body of legislation, there is some concern that liberalization of terms of trade has brought about problems of control of the quality of drugs in practice. There are instances of the import of low efficacy drugs or drugs with a short or even expired shelf life. Putting the existing legal controls into effect has not proved simple.

On the organizational side, the ROM calls for monitoring of performance and standards of service delivery on an ongoing basis. Therefore, at all levels of management, there is need for performance indicators and processes by which work is assessed on the basis of these. Districts will only take over responsibility for district hospital effectiveness and efficiency when the hospitals are handed over. During the transition period for decentralization of services, the MOH will need indicators not only for itself but also for the decentralized parts of the service. At the beginning of 1997, a profile of performance indicators with 36 indicators in nine clusters was drawn up. The clusters related to the nine key output areas of the Ministry.

In the context of a programme of total quality management (TQM), the Quality Assurance Department of the MOH arranges quarterly visits to all districts to discuss and agree quality improvements. This has been useful and it is expected that the clearer performance measures, indicators and targets which characterize the ROM will enhance its utility.

Performance indicators are, of course, dependent on the quality of the information provided from the various work centres. There is reason to be concerned about the reliability of such data. District medical officers have not themselves established effective means of collecting much of the information required. Their returns are infrequently checked for accuracy and, where they are and information is found wanting, follow-up action is rarely taken (KPMG consultant's report, page 15). A project to improve health management information had been successfully piloted in two districts at the end of 1996 and is to be expanded to the whole country.

Information on performance in the Ministry itself is not easy to collect. Apart from intrinsic problems common to all parts of the service (availability, accuracy and completeness of the information, capacity of personnel to process data, etc.), there is also the issue of programmes funded by donors. These are regularly assessed against their own terms of reference and overall objectives. These assessments do not necessarily give useful information about the performance of the Ministry against its key output targets.

The task of reviewing standards of performance will be helped by the activities of the Inspection Department of the Ministry of the Public Service (MPS) which conducts

efficiency audits and reviews of central ministries. Also, MPS plans to commission annual service delivery surveys (January 1997 consultants' report already cited).

2.1.6. Labour relations (unionization, collective bargaining, conflicts, settlements of conflicts)

Official figures bear witness to lack of strong union movement in Uganda (see page 12 of paper by Dr. S Lyomoki referred to earlier). Trade union membership in the country is among the lowest in sub-Saharan Africa. In 1995, total trade union membership in the country was 63,000 representing 3.9 per cent of the non-agricultural workforce, 6.8 per cent of the formal sector wage earners. Only Gabon and Guinea were lower. The situation is in marked contrast with the neighbouring country of Zambia. There, while there was also a reduction in membership in the period covered, the relevant percentages were 12.5 per cent and 54.5 per cent respectively. One NGO official told me that she had rarely encountered union negotiations in Uganda. The question did not arise for the most part in relation to any changes in the work situation. Her experience in Zambia was very different. This appears to support Barya's thesis.

“Under the present (1997) system, the Government (employer) determines the conditions of pay and employment. To accommodate the unions' demands for collective bargaining, the Government will have to make certain information available to them that has traditionally been closely guarded.” (Sezi)¹⁶ Another author (J.-J. Barya) points out that, in relation to the reduction in staff numbers in the public service in Uganda, most of the retrenchees were group workers who had very little legal protection in terms of job security. Only a small fraction of them belonged to the union – Uganda Public Employees' Union – which, he averred, was the weakest in the Ugandan trade union movement. There is also a Ugandan Medical Workers' Union. This union is affiliated to Public Services International which is headquartered in France. Barya believes that the success of the reforms has been contributed to by lack of a strong opposition or trade union movement in Uganda.

Privatization has led to a policy of contracting out some support services. In many cases, the workers involved are not unionized. They work under very poor conditions and temporary terms of service.

¹⁶ Sezi, op. cit.

2.2. Impact on the health workforce in general (specified for public and private sector)

2.2.1. Development of employment (structures and levels) including gender implications

According to the Under-Secretary for Personnel in the MOH, directives for staffing levels and structures are in place. Gender issues are also a point of the Ministry policy. It was not possible to get concrete data on the present position. The issue is very sensitive with a number of different views and requires a lot of discussion to reach agreement.

The economic measures to reduce public expenditure apply equally to the health services as to other parts of the economy. Thus, there is a freeze on recruitment¹⁷ which means that an already heavy workload is increased and patient/health worker ratios deteriorate. Monetization of benefits and non-payment of annual increments are said to have a negative impact on morale and worker input. The decrease (up to 30 per cent in some cases was mentioned) in money released to the sector by the Government has a negative impact on the implementation of programmes. One union official expressed the view that there is more emphasis on infrastructure than on personnel.¹⁸

In Uganda, gender policy mainstreams gender concerns in the national development process in order to improve the social, legal, political, economic and cultural conditions of the people especially women. Since women tend to be a majority of the health workforce it may be expected that general gender issues are relevant to them. (Incidentally, "gender" seems to connote "women" in its usage in documents relating to Uganda.) The health plan makes specific reference to the problems for the health service posed by the position of women in the society. They tend to be poor, badly nourished and overworked all of which make for heavy demands on the health service.

However, there is also evidence of women very successfully developing community-based services. One such is TASO, an AIDS support organization and the most successful of a number of indigenous organizations established by Ugandan women. It is cited as an example of best practice in the World Bank publication, *Africa's management in the 1990s and beyond*.¹⁹ TASO aimed to develop a constructive cooperative relationship with the Government. It clearly defined its relationship with the Government from the beginning. Its structure makes it a model for empowerment of local communities. Its development

¹⁷ The January 1997 KPMG report notes that there are some 800 health workers unemployed. This suggests that there is oversupply from the training organizations in relation to the vacancies though the report does point out that some trained medical personnel may be otherwise employed at their own choice. Yet, the fact that the same source found that only 16.7 per cent of the projected posts at district level were filled at the time of their report suggests that the recruitment freeze is a factor.

¹⁸ Lymoki Kamondi, Margaret: Paper on [Ugandan] trade union views prepared for an ILO Meeting on Terms of Employment and Working Conditions in Health Sector Reforms, Geneva, 21-25 Sep. 1998.

¹⁹ Dia, Mamadou: *Africa's Management in the 90s and beyond*, World Bank.

into an organization which helps local communities to develop economic activities to generate the revenue to improve the welfare of its clients and their families shows how an organization founded with a support focus for a specific group can expand into a real development agency.

2.2.2. Legal status of staff and contract flexibility

The Standing Orders of 1991 are relevant in this context. These are currently under revision.

All staff in the district health service (with the exception of those in the referral and training hospitals) are employed by the local governments. In each district, a district service commission has been established to appoint, confirm appointments, exercise disciplinary measures and to remove persons from office.

The exact position in relation to staff in NGO hospitals which are designated district hospitals is not known at the present time. The decision on such designation has only very recently been promulgated.

There appears to be no intention to address the issue of flexibility at least for the present.

2.2.3. Training and retraining, career opportunities, mobility

There is no agreed long-term human resource development plan though the MPS is in the process of developing a training policy for the public service. However, in the document from the Ministry of Health – Health Policies for Uganda 1997-2001 – the following capacity-building components are included:

- to develop professional enhancement programmes for leaders at the Ministry to enable them to fulfil the expanding role of the restructured Ministry;
- to develop training programmes for the directors of district health services to enable them to fulfil their function as leaders of planning in their district;
- to build the capacity of the members of the district health team to enable it to give administrative and technical support to the director;
- to develop training for medical superintendents of hospitals to enable them to fulfil their management and planning functions;

- to develop programmes for continuing medical education for all levels of health professionals;
- to develop training for leaders of community health programmes to enable the community to take its proper place in health enhancement.²⁰

Activities which are envisaged to build up necessary capacity include enhancing technical skills through training. Training at the basic, post-basic and in-service levels will be reviewed to bring them into line with the needs at both central and district levels. Leadership training to operate effectively in the ROM and TQM environments will be provided for the senior personnel in the Ministry and in the districts. As already mentioned, extensive training in financial administration and management is called for by the delegation of responsibility for budgets. A strong programme of continuing medical education will be developed to cope with rapid expansion of technical knowledge that is necessary for skills updating. In pursuing community and household empowerment, support for the community capacity-building programme will be continued. This programme is currently training community health facilitators at LC3 level and will be encouraged to train community health workers in LC4 and LC5 units.

It is also relevant under this heading to advert to the practice already mentioned of requiring newly qualified medical personnel to spend two years up country before becoming eligible for postgraduate study grants. This is at once a contribution to staffing facilities in remote regions and give good experiential training to new doctors which can serve as a sound base for their further development.

2.2.4. Work organization, responsibility/accountability, supervision/management, participation of workforce and users

Aspects of this subsection have been dealt with at other points in this report. A point may be emphasized here in respect of responsibility and accountability. The whole thrust of decentralization is towards greater transparency (more accountability). The ROM specifically focuses on accountability and personal responsibility for results. This is a relatively new approach in public services everywhere. Indeed, public services in the industrialized world are still struggling with development of a new breed of public official to operate in this changed environment. It is a material change in the work environment and organization. It also has implications for the interface between politicians and management.

The involvement of users in the planning and management for services adds another dimension to the delivery of these services. Officials who were used to being able to control what they gave, when and to whom, now find themselves in a far less powerful position.

²⁰ Barya, John Jean: "The civil service and policy management in Uganda – 1980-1995: An appraisal"; DPMF Working Paper No. 8, July 1996, Addis Ababa.

2.2.5. Working time (part-time work and flexibility, shift and night work, rest periods)

The 1997 KPMG report already mentioned refers to a 37.5-hour contractual working week. Survey results – internal to the MOH and external – indicate that health personnel at the district level attended for work between two and 25 hours per week.

As mentioned in 2.2.2 above, the Standing Orders of 1991 are under revision. However, the issue of introduction of part-time work arrangements does not appear to be under consideration.

2.2.6. Staff performance, remuneration, incentives and other entitlements (special issue: delinking health sector staff benefits)

Key performance indicators were developed for the Ministry of Health in the context of ROM and agreed with top management of the Ministry. They relate to the key outputs of the Ministry plan. The plans had earlier included indicators which were either too detailed for strategic management purposes or aimed at final outcomes which could not readily and directly be related to the results of strategic decisions within the Ministry. The project to improve health management information systems already mentioned is now being extended across the country having been successfully piloted in two districts. The total quality management initiative arranges quarterly visits to the districts to discuss and agree quality improvement. ROM is developing clearer performance measures, indicators and targets which should enhance the utility of these visits. There was not at the time of the report (1997) much reporting on performance at the centre. Donor-sponsored programmes were assessed but against the objectives of the donors rather than the key outputs of the Ministry.

The only existing measure of staff competency at that time was the annual confidential report. This, however, was judged not to be very useful. Its design, based on activities and personal characteristics, precludes competency analysis. “The incidence of disciplinary warnings might have been a useful indicator, were it not for a general reluctance of managers to take any form of disciplinary action in the present climate of low pay, low performance and insecurity about future prospects. These latter factors also make most current annual confidential reports very inaccurate – everybody is rated from good to outstanding.” (KPMG report). This report was, of course, produced in January 1997. Since then, the position may have improved substantially in this as in other areas in Uganda. However, even if new systems have been effectively put in place, the likelihood that the attitudes and practice of individual managers will have changed materially in the interim is not very high. The required level of, first, introductory training and, then, practice in the implementation of appraisal systems suggests that the time needed to have it operating effectively is much longer than the almost two years that have elapsed since the emergence of the report.

Overall, the weakness of the information systems to date and the unfamiliarity of managers with use of available information hinders the effective operation of performance

appraisal. However, the growth of the ROM initiative, the enhancement of management capacity and the new work culture should see an improvement in this position.

Remuneration of civil servants appears to have substantially improved in Uganda in the last few years. This was a central element of the reform programme but it proved difficult to progress with it as quickly as had been hoped. At the workshop in Berlin which formed part of this study, Dr. Sam Lyomoki, General Secretary of the Uganda Medical Workers' Union (and a member of Parliament of workers) expressed the view that there are still many pay-related problems. Low remuneration has led to the adoption of "external survival strategies". He said that a report of the Makerere Institute of Social Research of 1997²¹ listed part-time work, informal charging, leakage of drugs, leakage of revenues from user charges, professional reconversion into agriculture and non-health-related activities, brain drain and treatment of patients in health workers' homes as examples of such strategies. He also pointed out that there were anomalies in relation to the levels of remuneration across sectors. For example, staff of the judiciary are paid at a significantly higher level than those in other parts of the service. A factor of 4 was mentioned as the difference between the judiciary and health service counterparts.

There has been progress on the delinking of staff benefits. Housing and other allowances have been monetized. However, the view among lower paid workers appears to be that this has not been to their advantage. Information from Dr. Lyomoki indicated that only 40 per cent of the housing allowance paid to lower cadres was consolidated while, at some (higher) levels, non-cash benefits were monetized and paid in full.

2.2.7. Work environment, staff performance and perceptions, attitudes, absenteeism

Despite considerable efforts to improve the situation, the condition of health buildings and the availability of services are very bad in many parts of the country. The long period of civil unrest left a large number of rundown facilities. The current proposal is to develop a cascading system for health care where patients (and their records) can enter the system at the basic level and progress up the chain of facilities as their conditions demand. However, in this instance, one can see how interdependent development of health services is with other services. With regard to the transfer of records, this would be in the control of the service but the weak information system means that it is not always possible to locate them. Transfer to higher level facilities generally means travel. Here, lack of transport – public or private – and sometimes impassable roads make this an unachievable objective. These are difficulties which it is not within the ambit of the health administration to solve itself. These difficulties allied to the lack of social infrastructure in the rural areas make it difficult to attract staff to these areas and so further compound the difficulties to be faced in providing equal access to good quality health services.

With regard to office layout and accommodation, there is a move at present to change from traditional "closed door" offices to large work spaces with dividing partitions.

²¹ Makerere Institute of Social Research: *Report on informal, health markets and formal health financing policy in Uganda*, July 1997.

2.2.8. Occupational health effects (especially hazard protection)

The minimum provision is the Factories Act, 1953. This applies to health institutions. It provides for a first-aid box and a room to ensure immediate treatment of all injuries occurring in the workplace.

Health service personnel are open to risk from infectious diseases many of which – such as malaria, tuberculosis and AIDS and its related illnesses – are widespread in Uganda. The degree of risk has to be considerably increased by the lack of resources – equipment, accommodation, etc.

2.3. Effects on public-private mix in the health sector

2.3.1. Participation of NGOs, local communities, and the private sector in service delivery systems

Some 25 per cent plus of the health facilities in Uganda are provided by the not-for-profit (NGO) sector. (It has been suggested that, in the rural areas, this figure may be nearer 50 per cent.) These facilities include hospitals, health centres and maternity units. Apart from the hospitals, which are in the urban areas, these facilities are in the rural areas. The NGOs are regulated by the Government under the provisions of the Non-Governmental Organizations Registration Statute, 1989. Another piece of relevant legislation still in force is the Grant-in-Aid to Voluntary Medical Services Regulations, 1961 (General Notice No. 245, 1961).

Only about 2 per cent of facilities belong to the for-profit private sector. These comprise hospitals, clinics, nursing and maternity homes, pharmacies, drug manufacturers and importers, drug shops as well as traditional sector healers and birth attendants. They are located in the large towns and rural trading centres. These also operate under registration, certification and licencing by the Government.

The following table gives an overview of health care providers in Uganda in 1996.

Unit	No. of units				No. of beds			
	Govt.	NGO	Pte	Total	Govt.	NGO	Pte	Total
Hospitals	55	39	4	98	8 959	6 343	265	15 567
HC	449	248	17	714	4 214	2 799	74	7 087
Sub-MC	529	71	7	603	579	119	17	715
Mat-unit	13	11	9	33	172	128	37	337
Aides post	43	14	0	57	6	5	0	11
Total	1 089	383	37	1 505	13 930	9 394	393	23 717

Source: Inventory of health services in Uganda, MOH.

Incentives have been introduced to help increase the contribution of the non-governmental sector to the provision of health services. NGOs are integrated in the district health management team; their hospitals are designated district hospitals where there is no government hospital. They have tax exemptions on the import of drugs and equipment. In addition to some subsidies and training opportunities, the Government provides vaccines and essential drug kits. Some services are contracted out to the private for-profit sector. It, too, gets training opportunities, vaccines and essential drug kits as well as condoms and some grants.

In relation to the public-private mix, it has been stated (see Health Service Profile, May 1998) that the greatest change in recent years is the move towards greater collaboration with the whole private subsector. This includes providing direct support to some private facilities to facilitate their functioning and contracting some services to the NGOs. Private sector organizations and individuals are seen as partners who can have equal access to programme resources. Plans for the future development of health service provision include contracting private hospitals and private practitioners to offer services on behalf of the Government, promotion of private wings in public hospitals and health insurance. This integration of the public and private service providers is viewed as a move towards a more coherent service delivery system for improved complementarity, effectiveness and efficiency.

The establishment of the regulatory bodies listed at 2.1.5 above are also seen as contributing to the promotion of the private sector. They provide a regulatory environment within which this sector can practise. The Uganda Investment Act of 1991 and the activities of the Uganda Investment Authority set up in 1994 have helped to increase investment in pharmaceutical manufacturing and in the health service industry. However, it has been mentioned that liberalization has led to poor quality drugs on the market and to the emergence of some unethical practices such as drugs shops in health units.

The comments on TASO included in 2.2.1 above are also relevant in this connection.

2.3.2. Repartition of roles for enforcing standards, quality, fair competition and appropriate service

Most of the information sought under this heading is contained in the section on the roles of the Ministry and the district and the involvement of civil society outlined in 2.1.1 above. The district staff commissions have a role in ensuring fairness in relation to staff recruitment and promotion matters. The Inspection Service of the Ministry of the Public Service as well as the TQM programme are involved in the overview and supervision of overall management performance. The professional bodies are concerned with the setting and maintenance of professional standards for the sections of the health service staffs coming within their respective jurisdictions (see 2.1.5 above).

In terms of fair competition, there seems to be an accepted overlap between civil service employment and private practice (even during working hours) and that this cuts across all levels of service provision. In such cases, public money would, in effect, be subsidizing private provision. This is perceived by the private sector which relies heavily or completely (depending on whether it is for or not-for-profit) on user fees, as unfair competition.

Apart from the financial aspects, there is another issue here. Even if the involvement of civil servants is in the not-for-profit sector, it is not difficult to imagine conflicts of interest in relation to service provision which would not help the optimum use of resources for the population as a whole. Clearly, this risk is greater when the for-profit sector is involved.

2.3.3. Budgetary repercussions

On the organizational side, the main budgetary effect on which it is possible to comment is the change in procedures arising from the decentralization process. Responsibility for the management of budgets legally rests with the district in this situation. However, this represents a change of mammoth proportions. Not only does it involve major skills development to provide the necessary financial management capacity at district level and at individual institution level, it also requires the introduction of systems and the development of procedures to make them operational. The complex web of interrelationships between the different sources of funds and the lack of clarity between development (donor) and recurrent expenditure has to be analysed and external funding agencies need to know where they fit into the new dispensation. They have their own accounting requirements and must be able to satisfy these. For example, who will fund what in an NGO hospital that is designated as a district hospital and who has primary responsibility for determining the mix and level of services to be paid for.

On the personnel side, the question of salaries arises. The recent improvement in the salaries of public officials has meant that the gap between civil servants and employees of the not-for-profit NGO sector is growing. Even though indirect benefits such as housing and conduciveness of working conditions are generally better in the NGO sector, the salaries there are not as good as those in the public service. This situation is likely to lead to problems. At present, the freeze on recruitment to the public sector means that there is little movement from the NGOs to the central government service. But according to one experienced member of the NGO community, this situation could change. The sector will find it difficult to finance salary increases to keep in line with the government levels of remuneration without endangering the ability to continue provision of services to the weakest section of the population. The MOH is aware of the potential problem and, as already mentioned, provides some subsidies. However, according to the NGO representative, increased costs absorb most of these subsidies.

The proposed structural changes involving denomination of NGO hospitals as district hospitals are likely to bring any salary differences into sharp relief.

Salary budgets are difficult to aggregate at present because they are not earmarked for health in the district unconditional grant. This creates a difficulty in estimating the cost of health services nationwide and in turn complicates the task of prioritizing services.

3. Lessons to be learned from the cases: Comparison and transferability of reform experiences

A recent comparative study on the management of public service reform involving six African countries both francophone and anglophone and five northern industrialized countries revealed a significant degree of agreement in relation to the relative importance of certain strategic policy approaches and operational practices.²² There were divergences in experience but these related to the degree of importance of certain issues rather than to their nature. Writing specifically about health service reform, Andrew Cassell,²³ a health systems development consultant, points to a similar conclusion. He suggests that the agenda for reform will be defined by reviewing how well existing policies, institutions, structures and systems deal with issues of efficiency, access, cost-containment and responsiveness to popular demand. The relative importance of these issues will vary across the economic spectrum. In industrialized countries, reform arises to deal with such things as economic downturns, ageing populations, rising costs resulting from advances in medical technology, popular expectations against the background of near universal coverage and functioning institutions. In developing countries, reforms start on a different base. They face issues of extending coverage of basic services, improving poor service quality and addressing inequitable distribution of resources in the context of very limited institutional capacity.

From this it can be presumed that lessons can be drawn from experience anywhere but the experience has to be interpreted in the particular environment – political, economic, social and cultural – in which it is to be applied.

1. Reform is inherently political

There is little argument now about the fact that reform of any part of government machinery is a highly political process with a large and a small “P”. The upper case letter represents the interest of politicians, the lower case the interest of all the other actors and stakeholders – staff, users and, in the case of developing countries at least, providers of funds.

Decentralization is a political philosophy. It is a central element of the Government of Uganda. It serves to highlight the intrinsically political character of reform.

It is often said that it is not easy to engender political interest in administrative and management reform. In the abstract that is possibly true. But since, in modern times, reform almost always means reduction of employment in the public service and often devolution of functions, actions taken to implement what might have looked like apolitical

²² See Corkery, Ould Daddah, O. Nuallain and Land, A.: *The management of civil service reform*, IIAS/IASIA, 1998.

²³ Cassell, A.: “Health sector reform: Key issues in developing countries”, *Journal of International Development*; special issue on health issues, 1995.

reform proposals become matters of high interest to government ministers and members of parliaments.

Those represented by the lower case “p” may be even more immediately affected. For some, reform proposals may mean that their jobs disappear. If they are in high places, it would not be surprising to find that they try to influence change to mitigate its effects on themselves.

In Uganda the fact that the reform process has been informed throughout by the political approach of decentralization has meant that there is a strong legislative base starting with a clear delineation in the Constitution of what is meant by decentralization. The reform programme has been in the context of structural adjustment but, despite substantial outside financial involvement and some technical assistance, its direction and control are in national hands. It is clearly government policy and as such the public service may be expected to implement it as they would any other government policy.

2. Reform is a complex process

The institutional infrastructure through which the Government directs its affairs can be seen as a collection of interacting parts each with its own function but touching other parts at several points. It can also be seen as a tangled mass where lines of demarcation between the functions of individual elements are fuzzy and policy lines are difficult to follow through from formulation to implementation. Whichever way one sees it, the fact is that each policy portfolio in a government is likely to depend on many others to reach its goals. This is clear in Uganda as elsewhere. Leaving aside the influence on the Ministry of Finance and the Ministry of the Public Service, we have seen that functions of the ministries responsible for roads, transport, communications and education have a significance for one or more policies of the Ministry of Health. The fact that the country has a comprehensive programme within which health reforms are being carried out is a positive aspect. The existence of a strong representative governance structure to direct and monitor the reform means that there is an overview of progress in all sectors. Hopefully, this means that adverse effects of possible delays in one area may be anticipated and minimized.

3. Reform must be adequately resourced

One of the most critical aspects of reform which had to be addressed in Uganda was public sector pay. This remains critical but not as much so as it was, say, five years ago. The structural adjustment programme focused on economic reform but the Government succeeded in having the need for social implications taken into account in achieving economic recovery. The importance of this has been learned in more than one country on the African continent. The change of policy of a number of external funding sources to allow supporting such policies as retrenchment has been of great benefit. Without it, it is doubtful if the retrenchment programme could have been so successfully realized. It is certain that the progress that has been seen in developing primary health care services and in rehabilitating some of the hospitals could not have been achieved without considerable outside financial support.

The tenet that a developing private sector which is a feature of many reform programmes will absorb retrenched civil servants has not proved reliable in developing countries in the shorter term at any rate. Private sector development is not achieved overnight and, in any event, not all employees of the central Government adapt very well to life in the private sector. This is not only in developing countries. Many industrialized countries and, more recently, countries emerging from centrally planned economic systems, the so-called economies in transition, have similar experiences to relate.

4. Reform programmes must be well managed on a continuing basis

If there is not a strong management capacity, reform will languish. Resistance to change is common and will come into play unless there is an authority with the mandate and the capacity to overcome it. Uganda, in common with other countries which have had success with reform initiatives, is concerned to create a sense of ownership of reforms at various levels to engender interest and support for actions. The first phase of the reform programme got off to a good start but, as has been noted, the enthusiasm began to peter out in the last one-and-a-half years of the phase. Momentum was lost and the second phase had to begin with efforts to breathe new vigour into the programme. Again, this is not unique to Uganda or to the developing world. More than one of the cases in the comparative study referred to earlier demonstrates this. Support can wax and wane over the course of implementation as different implications of the programme are realized. Continuing dialogue is of fundamental importance to maintain confidence between the parties and to try to forestall problems before they emerge or at least minimize them by dealing with them at an early stage.

5. Management capacity is essential

Decentralization has the potential to increase the standard of services and their delivery. It brings their management closer to those immediately affected, i.e. the population of the district and subdistrict. Thus, it may be said that there is greater accountability, greater transparency of decision-making. Representation of users of the services in the governance structures of these services gives them more opportunity to have an input to the determination of priorities within overall national policy. But decentralization of responsibility brings with it enormous increases in the quantity and level of work to be discharged locally in relation to finance, personnel, planning, organization and management of physical infrastructure. The local authority is also responsible for their staffing. The MOH no longer has a mandate to transfer staff to a district and, even if it wished to do this, the district does not have to accept such transfers. The overall inadequate supply of management capacity in the country means that, in many instances, the local authorities lack the technical capacity and competence to manage the services. This can result in a decline in the standard of service delivery

In services with such a high specialized professional character as the health service, there is a tendency to look first at these capacities. But capacity to manage is essential both for the administrative staff and the medical and allied staffs. All are involved in the use of resources and, therefore, must be able to use these to the best effect in pursuit of agreed policy objectives.

The professional training of health professionals does not include much on this aspect of work. Indeed, the initial professional training period may not be the appropriate time to do so. But, when these professionals are in situations where they are responsible for the allocation and disposal of resources, they have to have parameters within which to make judgements just as they have in relation to the physical treatments they prescribe. As one medical consultant in an industrialized country put it:

When I am acting as a clinician I want to demand all the available services for my patients. When I am acting as a manager, I have to balance the cost of an escalation of treatment against the percentage improvement it will offer in one case in comparison with another. The final decision is likely to be different depending on which hat I am wearing at the time.

6. The pace of reform must be measured

Maintaining momentum is important but so also is keeping within the bounds of available capacity. Reform measures must be prioritized to start with but their implementation must be carefully monitored to try to avoid breakdowns or serious delays. They need to have a certain degree of in-built flexibility in relation to scheduling and content. But this is a difficult matter to keep in balance. If target dates are too soft, the degree of slippage will increase and if content is too malleable, those wishing to impede implementation of change will be likely to take advantage of it. The KPMG report considered the targets of the Ministry of Health to be too optimistic, resulting in achievements being often very short of planned output. “Moving towards the ideal levels of service delivery is often easier if done a successful step at a time – rather than continually failing to make it in one impossible leap.” Targets should be SMART: sustainable, measurable, attainable, realistic and time-bounded.

7. Reform proposals must have credibility

Acceptance of reform proposals by the staff affected is generally based on a balance of factors – quid pro quo. It is important that this balance be maintained, that favourable provisions be honoured at the same time as disadvantageous ones are brought into force, if there is to be any hope of continuing support. To maintain good faith between the several parties, any changes – for whatever reason – must be promulgated and discussed. An effective communications system is critical in this context.

8. Communications must be constantly attended to

Communications between those affecting or being affected by the reforms is an essential thread running through the whole length of the process. At the design stage, it is needed to elicit necessary data and information. The reform programme must be “sold” and its provisions must be clearly understood by those who have to implement it. Misunderstandings arising during the implementation phase must be heard and dealt with in good time before they fester and give rise to major obstacles of mistaken interpretations. Finally, good communication is essential to an effective monitoring and feedback system.

In Uganda, one of the main concerns voiced about the present situation in relation to reform in the health service is the relative failure to promulgate national policy throughout the districts and the related failure to monitor the degree to which national priorities are being honoured. This situation, if allowed to continue, could undermine the whole concept of decentralization of responsibility for delivery of health services within the stated government aim of equal access for all parts of the population.

9. Good decisions need good information

Reform is about more efficient and effective use of available resources towards a stipulated end. This implies selection of priorities. Without good, complete and accurate information, priorities will be set on a fairly arbitrary basis. It is not enough to have good information. There must also be a capacity to use this not only for priority setting but also for monitoring progress, adapting and reformulating as necessary and also and very importantly, for publicizing the achievements of reform.

10. Reform has to manage tensions

Decentralization is on the way to successful realization in Uganda. Whatever the reservations of some, it is now established in the Constitution. But that does not mean that it is "safe". There are and will continue to be tensions associated with it. There are tensions between the need to direct the affairs of the country on a universally equitable basis and the need to give authority for implementation of policies to individual management levels or even managers. There are tensions between the centre and the districts, between the districts and the subdistricts, between different single interest groups in the population at large. There are tensions between claims for hospital and primary health care with powerful though different lobbies on both sides. There are tensions between those responsible for the public purse and those charged with delivering a modern service. The strength of the tensions will rise and fall but it needs to be kept under review. "A delicate balance will have to be established between ... emergent, strong and viable centres of local governance and a strong, but not dominant, central Government. Relations between the centre and local authorities will have to be grounded in negotiation and bargaining."²⁴

Conclusion

There are undoubtedly lessons to be learned from the Ugandan experience. But a comment of James Katorobo, a Ugandan professor and consultant who was a member of the PSRRC and a consultant to the Government on civil service reform, should be remembered. He is quoted by Petter Langseth as saying that "rebuilding Uganda involves remaking all aspects of Ugandan society – from physical infrastructure to the soul and spirit of the nation".²⁵ Building (or rebuilding) a nation is not only about economic policies

²⁴ Langseth, Petter: *The civil service reform programme in Uganda: Lessons Learnt*; Public Administration and Development, Vol. 15, No. 4, Oct. 1995.

²⁵ Langseth, Petter. *op. cit.*

or about infrastructure. These things are important but if they are not grounded in the soul and spirit of the people of the country, they will be unlikely to succeed. This is one of the clearest and most general lessons to come out of review of experience with reform programmes right across the economic and cultural spectrum.

Uganda was coming from a very low base. It had been brought to this not only because of unhelpful changes in the world economic environment which had such adverse effects on much of the African continent with its preponderance of infant economies but also and perhaps mainly because of civil strife and gross mismanagement of the economy. Uganda knew from experience that it could do better. The signs are that it is doing so.

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Appendix

Uganda: A background note

The Republic of Uganda is landlocked and lies on the Equator. It faces Lake Victoria on the south-east. The United Republic of Tanzania and Rwanda lie to the south-west. The eastern, western and northern boundaries adjoin Kenya, Congo and Sudan respectively. It covers an area of 236,000 km², has a population of 20.4 million with a population density of 86 per km². Its capital is Kampala. Its official language is English.

The growth rate of the population is 2.94 per cent (1995). Life expectancy is 40.2 years (1994). In the same year, adult literacy was given as 61.1 per cent and enrolment in education stood at 34 per cent. Thirty-eight per cent of the population had access to clean water in 1995.

Uganda has a developing market economy based mainly on agriculture. Manufacturing accounts for less than 7 per cent of GDP and less than 1 per cent from mining. Both agriculture and industrial production fell sharply from the 1970s to the mid-1980s because of political instability and civil war. It is now in a period of good economic growth, social progress and economic stability. The priority now is to maintain the correct formula to continue with this growth.

Imports still exceed exports in value. Main imports are road vehicles, pharmaceuticals, petroleum and iron and steel, while exports are coffee, gold and gold compounds, fish and fish products, cotton and tea. Uganda imports mainly from Germany, Kenya, India, Japan and the United Kingdom. Its main trading partners for exports are France, Germany, Italy, the Netherlands and Spain.

Since 1986, the political system is "no-party". The National Resistance Movement is the ruling authority. Parliament has 276 members of whom 214 are elected by universal suffrage. The remainder are chosen by electoral colleges with seats reserved for women, army representatives, the disabled, youth and trade unions. Elections are held every five years. The last was held in June 1996.

The Head of Government is the President. Presidential elections are also held every five years. The current President, Yoweri Kaguta Museveni, who has been in office since 1986, was re-elected at the last election on 9 May 1996. According to *The Courier* of the EU, Uganda has come to symbolize the new optimism in Africa and its President is cited by Western politicians as an example of a new school of African leader.

The challenges facing the Government are formidable. Two-thirds of the population still live in poverty (defined as less than a dollar a day) and the ten-year long insurgency in the north goes on. There are also questions about the nature of the political system. Up to now, the President has held that the country was not ripe for multi-partyism. In his 1996 autobiography, he said that: "What is crucial for Uganda now is to have a system that ensures democratic participation until such time as we get, through economic development, especially industrialization, the crystallization of socio-economic groups upon which we can then base healthy political parties." There is to be a referendum on the issue in 2000.