Human Resources for Health

Workforce Analytics for Design and Planning Report

UGANDA CASE STUDY

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UGANDA

Health System Overview

Uganda's public health system has been decentralized since 1997 and delivers services alongside a robust private sector. The public sector, consisting of government health facilities and health services departments of various ministries, benefits from a high level of donor funding for the health sector at 42.5% (WHO Global Expenditure Database). It is the main provider of all health services, delivering at district level via hospitals, health centers, and CHWs. Over the years the private sector has become an increasingly important contributor to health service delivery at the primary level, and is estimated to provide between 60-70% of frontline health services (National Bureau of Statistics, Uganda, 2010).

Current State of Health Workforce Information Ecosystem

Figure 8 – Summary of HRH in Uganda

Knowledge of...

...where and who health workers are	...how they perform	...if they show up for work	Salary Payment Processes
• Multiple systems and data sources in place. • Staff lists updated annually by facilities and can be generated by personnel and payroll system. • HRIS contains duty post information.	• Paper-based system used annually. • Data are not used routinely to inform rewards or sanctions.	• Attendance tracked manually using a paper-based attendance register or via biometric system linked to HRIS and reported monthly.	• Payroll seen as important source of HRH data and used to pay all public employees. • Salary delays reported. • CHWs paid by development partners.

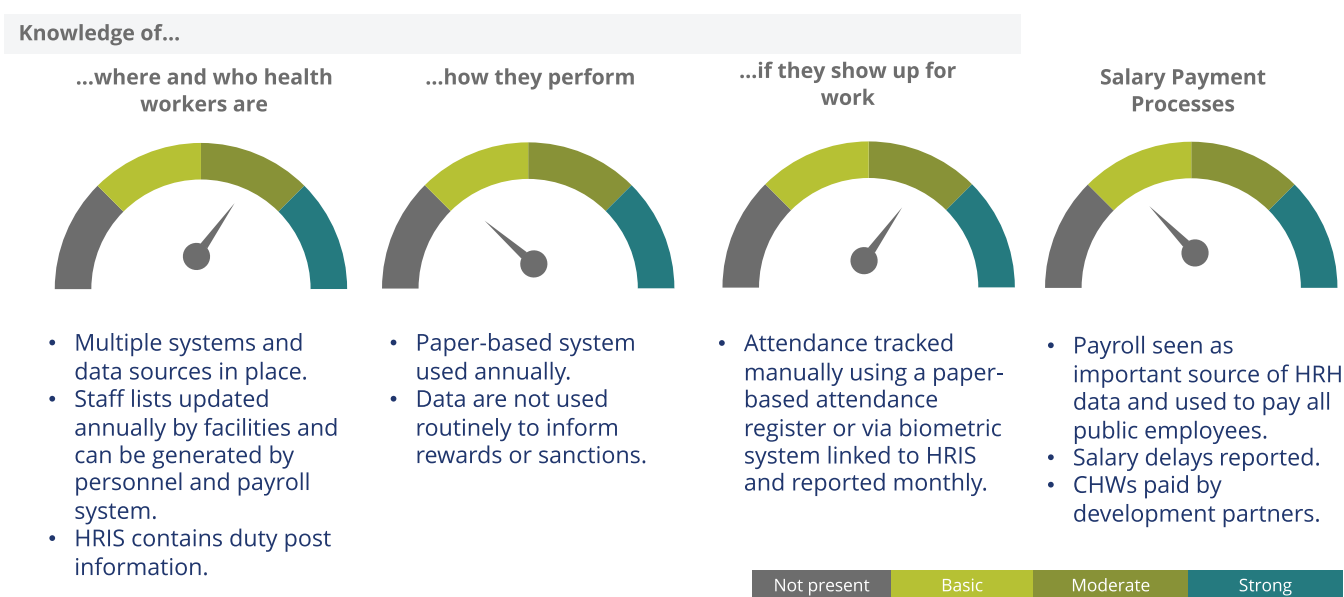| Not present	Basic	Moderate	Strong

Figure 8 above provides an overview of the state of HRIS in Uganda. Uganda has seen many years of investment in HRIS since 2006, with support from several different donors, including USAID, the European Union, WHO and UNICEF, including IntraHealth's open source HRIS software – iHRIS – with both iHRIS Qualify and iHRIS Manage in place since 2006. Even considering this history, uneven adoption and engagement can be observed across subnational units and at the national level (Figure 9), with high levels of data fragmentation due to a lack of interoperability and data sharing practices, possibly reflecting the donor driven nature of the system development. The lessons learned from Uganda would suit country contexts that want to expand and scale their existing digital investments.

Several policies have been developed related to HRH planning and management, including the use of HRIS to guide these efforts, but according to key informants there is variable implementation. The broad range of applicable policies represents a complex policy context. In Uganda there are a high number of ministries involved in the health sector. For example, at recruitment, four ministries (Ministry of Health, Ministry of Local Government, Ministry of Civil Service, and Ministry of Finance) come together to approve new hires. The large number of different, relevant policies in place means there is no single reference document that could guide investments and implementation. This re-emphasizes the importance of a "whole-of-government" approach.

The graphic below (Figure 9) illustrates the different information sources pertaining to HRH in Uganda. There are 16 in all, across seven ministries and departments, along with analysis of service coverage conducted through the WISN methodology. The primary sources of HR data include:

- iHRIS Qualify which supports the health professional councils' information systems (established in 2006)

- iHRIS Manage, the HRIS (established in 2007), including a registry which compiles the HRIS information across all districts.

- The service's integrated personnel and payroll system (IPPS), introduced in 2007 and used by the Ministry of Public to manage payroll, which currently contains 43,530 workers.

Figure 9 – Uganda Information Systems Overview
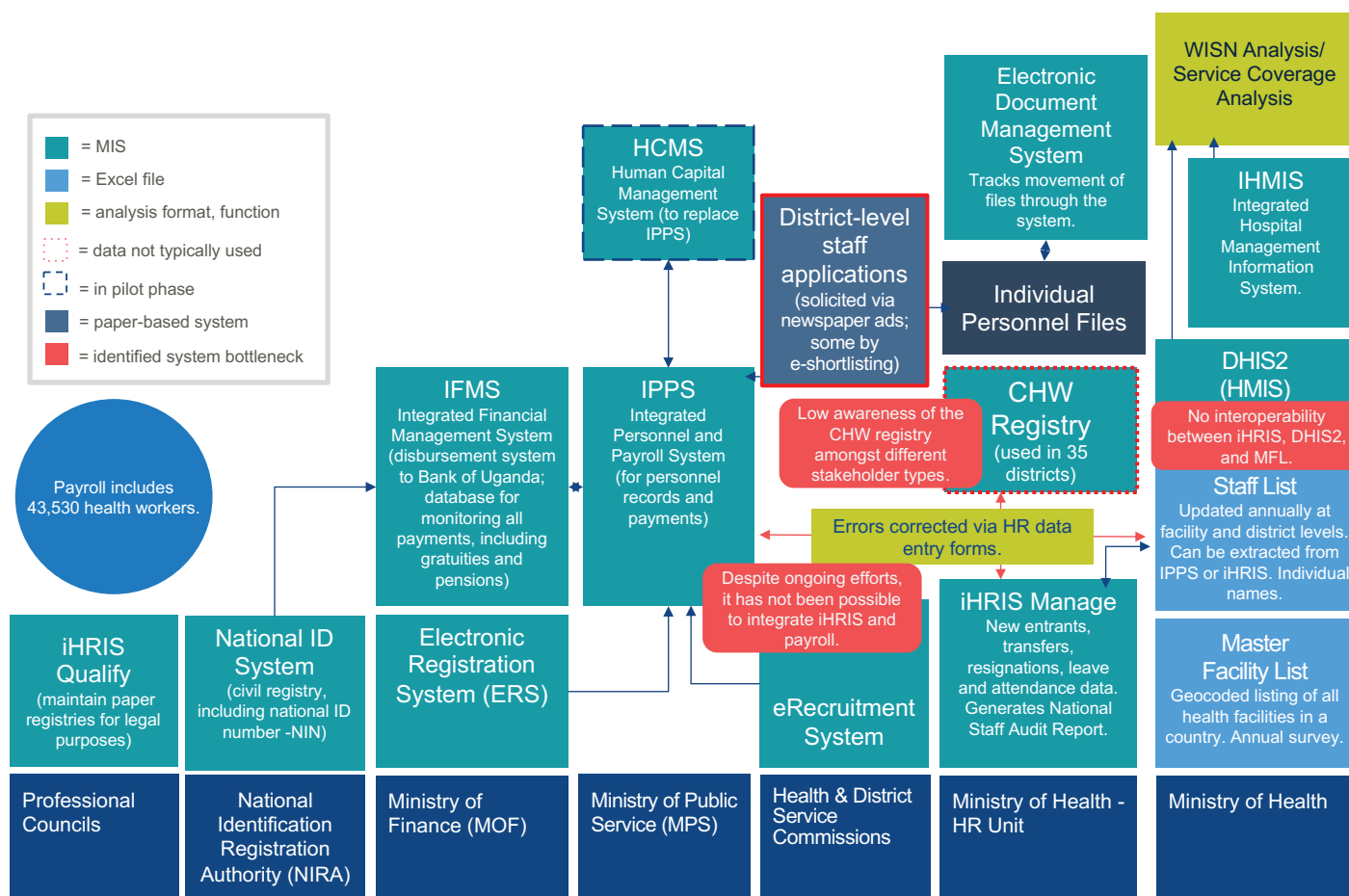
Recent activities by the government to improve its ability to better plan, manage, and track the public-sector health workforce include the MoH's efforts to expand iHRIS Manage functionality by adding more modules (attendance, performance appraisal, file tracking, leave, accommodation and also iHRIS Train for pre-service data). The country is now in the process of introducing a new Human Capital Management System (HCMS) that will include performance management functions and replace IPPS, covering the entire public sector workforce. This has been underway since 2018, and respondents estimated it was 80% complete.

Despite the multiple systems in place, there is limited interoperability between them (specifically the payroll system – IPPS, the health workforce information system – iHRIS, DHIS2, the master facility list, and the staff list). This lack of information exchange or data sharing across systems leads to duplication of efforts and requires manual analysis to, for example, calculate staff workload. Furthermore, multiple systems in place require different login passwords and result in system fatigue, which acts as a barrier to data use.

Visibility Outside Formal Public Sector
Looking across the multiple information systems and the capabilities they provide, visibility into the private sector and the CHWs are major gaps.

Established in 2018, the CHW registry has not been kept up to date and is only used in 35 out of 135 districts. There is a newly established Department of Community Health that presents an opportunity to expand this further, but the assessment found a general lack of awareness of the CHW registry within the department and its leadership.

Unlike Mozambique and Burkina Faso, the medical and nursing professional councils in Uganda have a comprehensive listing of both public and private sector health workers that is routinely consulted at recruitment to ensure the health worker is in good standing with the council. Interoperability across systems, however, is lacking, resulting in duplicated efforts and siloed HRH data. Some public-salaried health workers are seconded into faith-based, non-governmental organization (NGO), or trust hospitals, and the iHRIS records their details. Private sector facilities also register with and report to local government (described below), but the assessment did not learn of this data being used for HRH decision making.

Findings Across Priority Use Cases

Looking across the priority use cases in Uganda, what emerges is an ecosystem with significant donor investment in HRIS over the years but that still sees uneven ownership and data use across the health system. System design has generally been driven by top leadership and has not necessarily kept up with user needs at subnational or facility levels, despite the decentralized structure of health system.

Recruitment and Deployment

iHRIS puts Uganda in a strong place for HRH recruitment and deployment, but engagement with the system is uneven across different districts depending on the strength of subnational leadership and HR governance and budget allocation. The CHW registry's limited use hampers its utility to track and manage these frontline workers.

Unique to Uganda across the deep dive countries, professional councils are consulted by service commissions during recruitment of health worker to check that applicants are in good standing. Councils consult comprehensive electronic registries for this (using iHRIS Qualify). However, a legal requirement to maintain paper registers alongside electronic systems is time consuming. The following bottlenecks were also identified:

- For both national and district level recruitment, there are often insufficient funds to cover salaries and the actual recruitment processes, which takes place across various ministries for a single health worker.

- At every level, while there are data sources available for equitable deployment, there are also strong preferences on the part of health workers about where they would like to be deployed that need to be considered.

- The identification of health workers is not assured. It is possible for health workers to be fired and then reapply, claiming not to have worked with government before.

- Updating data in IPPS and iHRIS is not always done in a timely manner, undermining the utility of the data.

- Not having visibility into CHW or private sector health workforce limits government's ability to deploy needed staff and make effective referrals and workforce plans with the 'big picture' perspective.

Salary Payments and Reconciliation

Despite there being an HRIS in place, key respondents regarded IPPS (payroll data) as the most important source of HRH information, with many steps involved in ensuring its integrity; essentially, this data flow creates a valued and most often used data set for HRH decision making. Challenges identified include:

- Only Ministry of Public Service-contracted workers are paid through IPPS/IFMIS, limiting visibility into non-gratuity contract workers and project hires

- Administrative functions like pay change reports are not streamlined and can be time consuming for payroll managers to complete

- Salary delays have also been reported for health workers.

CASE STUDY: PRIVATE SECTOR HEALTH WORKER DATA

Data about the private sector is typically captured through facility registries or the professional councils.

One private hospital administrator interviewed in Uganda described reporting requirements to both the government and the council. The facility registers with the Uganda Medical and Dental Practitioners Council and reports its service delivery data monthly to Kampala Capital City Authority (KCCA), under Nakawa Division where the hospital is located. The government ensures that the facility operates according to the law and health standards. Reporting is paper-based, manual, and requires a close to full-time person to complete. The facility risks losing its annual license if it does not report.

HR data management is conducted manually and used for staff management, deployment, emergency planning, staff tracing, and calculating salary and benefits. Payroll is manually calculated and processed.

BEST PRACTICE: ACTIVELY WORKING WITH PROFESSIONAL COUNCILS AND POPULATION ENGAGEMENT

Health Professions Council ensure that all data for registration and licensure of doctors and nurses is current using iHRIS Qualify. Before hiring a health worker, the District Service Commission checks with the councils to ensure they have an active practice license and have a good service record.

Citizen engagement is also supported - Ugandans can send an SMS text message to the medical council to ensure that their doctor is in good standing.

Individual Performance Management and Attendance Tracking

Performance appraisal is based on an annual plan but is out of sync with other systems planning processes. Health worker attendance tracking is biometrically enabled through mobile phone applications or manually tracked through attendance registries, with health worker absenteeism resulting in reductions to salary payments in some facilities. For the performance management and attendance tracking data flow, there were many bottlenecks identified, these are described below:

- Attendance data are tracked either through paper registers or a biometric system, which is not at national scale at this stage. Where attendance is tracked manually, the data can be difficult to aggregate. Health workers may also sign in on behalf of their friends, undermining the quality of the data.

- In some districts if there are absences, the district health office docks the salary of health workers manually. However, this link between attendance and salary payment is uneven across districts.

- Performance review meetings are scheduled to occur quarterly. Appraisals are scheduled to occur annually. There are no automated reminders; quarterly review meetings are often skipped, and the process only occurs annually. The performance review process is out of sync with other health system factors such as budgeting and procurement, undermining its utility as an aligned planning tool.

- Performance reports are kept in personnel files and are often missing or incomplete. The data are not easily accessible for management review. HR must verify all the reports, but this is often not done.

- The Rewards and Sanctions committee meets quarterly to review any performance issues. The committee relies on perceptions of performance by supervisors and others and not data, which are in hard copy and not available quarterly.

- While there are options to reward high-performing staff, the process is quicker to punish than reward.

- As of this year, performance-based financing will be implemented nationally, supported by the World Bank (Ministry of Health, Republic of Uganda, 2019). DHIS2 data are used to assess facility performance outputs.

While there are opportunities to strengthen this process, the fact that performance appraisals are based on annual plans for all health workers puts Uganda ahead of the other deep dive countries. In addition, plans for digitizing this process through HCMS for the entire public-sector workforce are promising. It is likely that the data and the process will improve if the data have more perceived use in decision making.

Bottleneck Identified

Data Availability	Data Quality and Use	Systems and Tools	Human Capability
• Project and contract work hires not captured.	• Data on health worker post location not always up to date.	• Multiple data systems result in systems fatigue and fragmented data.	• Professional councils led by volunteers.
• CHW data not widely accessible or shared - registry only used in 35 out of 135 districts.	• Performance reports incomplete or missing; data not easily accessible for management review.	• Insufficient access to HRIS reports by key decision makers.	• Engagement with the system is uneven across different districts.
• Data on private sector workers available through council databases registrations for doctors and nurses.	• Mismatch between number of graduates and registered HWs	• Councils must maintain parallel paper and electronic systems which is time consuming.	