ACODE

ADVOCATES COALITION FOR DEVELOPMENT AND ENVIRONMENT

Assessing the Management and Administration in Public Health Facilities of Uganda and the Implications for the Healthcare Service Delivery and Utilization
Evidence from the CODES Project

Moses Mukundane I Annet Nannungi I Dennis Bataringaya
Adelaine Aryaija-Karemani I Patrick Ssesanga I Winstons W. Muhwezi

ACODE Policy Research Series No. 77, 2016

■ Acknowledgements

■ Table of Contents

List of figures

List of Acronyms

ACODE	:	Advocates Coalition for Development and Environment
AHSPR	:	Annual Health Sector Performance Report
BNA	:	Bottleneck Analysis
CA	:	Causal Analysis
CME	:	Continuous Medical Education
CFI	:	Child Fund International
CODES	:	Community and District Empowerment for Scale-up
DHMTs	:	District Health Management Teams
DHTs	:	District Health Teams
EMHS	:	Essential Medicines and Health Supplies (EMHS)
GOU	:	Government of Uganda
HC	:	Health Centre
HSD	:	Health Sub-district
HSDP	:	Health Sector Development Plan
HSSIP	:	Health Sector Strategic Investment Plan
HSSP	:	Health Sector Strategic Plan
HUMCs	:	Health Unit Management Committees
ICT	:	Information, Communication and Technology
LSTM	:	Liverpool School of Tropical Medicine
MOH	:	Ministry of Health
QI	:	Quality Improvement
QoC	:	Quality of Care
RPMTs	:	Regional Performance Monitoring Teams
SMI	:	Supervision Monitoring and Inspection
UNICEF	:	United Nations Children's Fund
UNMHCP	:	Uganda National Minimum Health Care Package
VHTs	:	Village Health Teams

■ Executive Summary

This Policy Research Paper is an outcome of the field activities carried out under the Community and District Empowerment for Scale-Up (CODES) project- a five-year initiative (2012-2016) designed to reduce child deaths caused by diarrhoea, pneumonia and malaria—the three of the top childhood killer diseases in Uganda today.

The paper presents an assessment of one of the critical determinants of quality of healthcare provision – the health facility level management and administration. The paper is premised on the argument that the existing weaknesses in health facility management and administration immensely jeopardize the quality of health care service delivery in public health facilities as well as effective utilization of healthcare by the community. This is to the extent that even when the issues and challenges that require government intervention seem to be improving or being addressed at health facilities, with outstanding weaknesses in facility management and administration, the quality of care does not correspondingly improve.

The paper focuses on four (4) health facility management and administration issues; (1) Time management among health workers (2) Human resource management and development practices (3) The role of Health Unit Management Committees (HUMCs), and (4) Enforcement of health workers' professional ethics and code of conduct. These issues were commonly mentioned across all the CODES project participating districts. The project targets 21 districts throughout the country, randomly divided into two groups: intervention districts and comparison districts. There are eight (8) intervention districts (Buhweju, Bugiri, Buvuma, Luuka, Masindi, Apac, Arua and Maracha) and eight (8) comparison districts (Kasese, Sheema, Mitooma, Iganga, Kamuli, Kiryandongo, Kole, and Albetong). An earlier two-year 'Proof of Concept" phase (2012 and 2013) involved five (5) districts in the central region of Uganda, namely, Mukono, Buikwe, Masaka, Bukomansimbi, and Wakiso. In the CODES project context, the five (5) participating districts in the 'proof of concept' were code-named- "Wave Zero" districts while the eight (8) intervention districts are code-named "Wave One" districts.

Data was obtained from three main sources (CODES project main activities). (1) Baseline survey which was conducted in 2014 in 16 districts of Uganda in Wave One districts both intervention and comparison districts. (2) Community Dialogues which have been conducted in 13 districts both in the communities and health facilities from 2012-2014 (5 Wave Zero districts) and 2014-2016

(8 Wave One intervention districts); (3) Dissemination workshops with District Political and Technical leaders in 13 districts (2014-2016). Additional data was elicited from government documents, journal articles and edited books.

The findings indicate that there is poor time management among health workers as evidenced by late reporting for duty and early departure from duty in health facilities, rampant cases of absenteeism and 'presenteeism' among health workers. This results into self-created work-overload, and creation of long queues for patients to access healthcare at health facilities which jeopardizes the quality of health care service delivery, and healthcare seeking behaviour among service users.

There is poor human resource management and development practices in a number of health facilities. This is attributed to inadequate managerial skills among health facility in-charges, poor human resource development approaches by the facility in-charges, improper planning, implementation and monitoring of health-based activities by facility in-charges, and other responsible authorities such as the sub-county and district officials. A number of health facilities are still facing challenges of staff attraction, motivation and retention. In addition, performance drivers such as induction / orientation, mentorship, and refresher training are not given the attention they deserve.

The role of Health Unit Management Committees (HUMCs) remains untapped. HUMCs are responsible for linking health facilities with the community by organizing community meeting and accounting for all the decisions at the health facilities. Unfortunately very few health facilities have functional HUMCs. Some of them had just been instituted and others had never been oriented about their roles and responsibilities. This creates a linking gap between health workers and the community especially in information sharing which compromises the ability of the community to hold the health facility accountable and ensure effective healthcare service delivery and utilization.

There is gross professional misconduct among health workers and defective enforcement of professional ethics and code of conduct at the health facilities. There are numerous cases of use of abusive / insulting language among the health workers while attending to patients, health workers charging patients illegal fees, health workers discriminating patients on the basis of economic, and social statuses, some health workers attend to patients while drunk, among others. Amidst such circumstances, a number of health facility in-charges appear to be less bothered to rectify the situation. Yet, these unprofessional behaviors discourage patients from seeking and utilizing health services as expected and in a timely manner.

The paper presents recommendations in the perspective of policy, practice, and training/educational implications;

- Ministry of Health and District Health Office should organize periodic capacity building and training in leadership and human resource management and development for health facility in-charges. These would be short-term courses that can build their capacity in leadership and human resource management.

- Health facility in-charges need to employ appropriate innovations and motivation practices for health workers. They should be innovative to identify appropriate motivators and use them effectively and efficiently to induce individual health workers to perform their mandated duties. The in-charges need to strike a balance between the use of 'carrot and stick' motivators-reward and penalties.

- Building a trust model in healthcare service delivery by encouraging a 'knight' kind of behaviour among frontline health workers- A 'knight' cadre is an individual whose principal concern is with the welfare of others instead of pursing self-interests. At the national and local government levels, the trust model requires a high degree of stewardship---leadership through policy, regulation, monitoring and coordination---- the effective trusteeship of national health.

- Strengthen supervision, monitoring and inspection for lower level health facilities by various stakeholders at different levels ranging from the Ministry of Health staff, District leadership, Health Sub-Districts, Health Unit Management Committees (HUMCs), and health facility administration (in-charge). This would ensure the quality of health care service delivery at health facilities. Supervision, monitoring and inspection require sufficient financial resources which the Ministry of Health, District local governments and Sub-counties have to commit to.

- The Ministry of Health and District Local governments should consider organizing and facilitating periodic peer to peer learning sessions for health workers. These can be either inter-district or intra-district levels. Such sessions provide opportunities for health workers to learn the best practices from their counterparts from other districts or within the same district but different places of work (health facilities).

- There is need for a coherent, coordinated and holistic approach in addressing healthcare challenges. This requires concerted efforts from all key stakeholders- Ministry of Health, District, and Sub-county officials, Health Unit Management Committees, Health facility in-charges and frontline health workers. This would make it possible to address both systemic and health-facility Management and Administration challenges which are always logically interlinked.

1. Introduction and Background

Uganda has had a rich health policy framework over the years. This policy framework among other things encompasses the national health policies (1999; 2010); the framework for Uganda National Minimum Health Care Package (UNMHCP); the Health Sector Strategic Plans (HSSP) I, II and III (2000/1-2004/5; 2005/06-2009/10; 2010/11-2014/15), the Health Sector Quality Improvement Framework and the Strategic Plan (2010/11- 2014/15), the Health Sector Strategic Investment Plan (HSSIP) (2010/11-2014/15), and the Health Sector Development Plans (HSDP) I and II (2010/11 – 2014/15; 2015/16 - 2019/20). The ultimate goal of this broader framework has always been to improve the quality of and access to healthcare.

Over the years, Uganda's Ministry of Health appears to have focused more on increasing geographical and financial access to health services but little emphasis has been put on efficiency gains and quality of health services provided (Ministry of Health 1999, 2000, 2005, 2010a, 2010b, 2011). Incidentally, it is known that the quality of care (QoC) is not only one of the key elements of the right to health, but it is also a major determinant of health care seeking behaviour among the service users (Le Grand 2009; Ministry of Health 2011; Musoke et al. 2015).

In the context of public services and particularly health services, 'quality' is considered in terms of 'inputs' such as the number of and type of the staff who offer services at a health facility, the level and degree of specialization of the medical professionals in a health facility, or the qualifications and experience of the health workers in a health facility, size and condition of the services' facilities (number and size of the functional rooms, admission beds, and age of relevant buildings among other things) (Le Grand 2009). Quality can also be interpreted in the terms of the 'process' of service delivery such as the courtesy or consideration with which users are treated, or the amount of time they have to wait for the service (ibid). Alternatively, quality can be measured in terms of 'outputs' or the activities undertaken in the process of delivering a service such as the number of operations undertaken in a health facility or the number of medical tests (investigations) done in a health facility per day. Finally, quality could be interpreted in terms of the 'outcomes' that result from using the service-such as the improvements in patients' health that result from medical treatment (Le Grand 2009).

The Uganda's Ministry of Health equally regards quality to imply the extent to which health care, services, systems, and programs conform to national or international standards/requirements/specifications (Ministry of Health 2011). Health care is considered to be of high quality if it is safe, effective, patient-

centered, timely, efficient, and equitable (Ministry of Health 2011). Community surveys and media reports in Uganda indicate that the quality of services in public sector leaves a lot to be desired. First of all, Ugandans do not receive the services they need in terms of missed opportunities leading to waste and inefficiency, delayed care leading to dissatisfaction and ineffective services or systems (Ministry of Health 2011). Secondly, Ugandans receive services they do not need. Thirdly, Ugandans are at times harmed by services they receive. For instance, medical errors generate additional costs and waste leading to inefficiency and dissatisfaction (Ministry of Health 2011). According to (Colenbrander et al. 2014) while health indicators for Uganda have seen modest improvements over recent decades, healthcare quality and access remain very relatively poor and the total health envelope is increasingly stretched by the high population growth rate.

Ensuring quality of care at health facilities might be regarded as a 'systemic' issue necessitating a great deal of government interventions particularly on staffing, drugs and other medical supplies and infrastructural development. However, health facility management and administration plays an equally important role in ensuring the quality of health care service. Unfortunately, despite the existing rich national policy framework on general health sector governance issues, public health facility management and administration appears to be lacking sufficient attention, moreover, considering its critical element in the quality of care. Over the years, there have been efforts by the Government of Uganda (MOH) to prioritize stewardship, resource mobilization, standards and guidelines development, monitoring and supervision (Government of Uganda 2010; Ministry of Health 1999, 2000, 2005, 2010a, 2010b, 2010c, 2015b). However, there seems to be slow progress. This is largely attributed to various reasons, among others. Firstly, there is a small resource envelop as the health budget has consistently been low the level required to fund the proposed health expenditures (Colenbrander et al. 2014; Kajungu et al. 2015). Secondly, there is contentious/conflicting priority setting processes and politics of resource allocation (involving divergent priorities between the Government and Donors- Development Assistance for Health). This results into disparities between health funding and planned expenditure as well as discrepancies between health policy framework and the implementation of the policy options (Colenbrander et al. 2014). Thirdly, there is waste in health sector spending including financial mismanagement (diversion and embezzlement of funds), improper procurement and breach of regulations, inter alia (Okwero 2010).

One critical aspect of quality of care and improvement is supervision, monitoring and inspection (SMI) system. According to the Annual Health Sector Performance Report (AHSPR) (Ministry of Health 2015a), there is inadequate leadership at all levels to demand and enforce regular SMI and ensuring follow-up of the recommended actions. The established structures such as Regional

Performance Monitoring Teams (RPMTs), District Health Teams (DHTs), Hospital Boards and Health Unit Management Committees (HUMCs) for monitoring health sector performance are not functioning optimally. There is also lack of comprehensive plans, poor coordination of the Supervision, Monitoring and Inspection (SMI) activities of different programs and at all levels; thus overwhelms districts and facilities (ibid).

Various sets of literature (Kajungu et al. 2015; Ministry of Health 2011, 2015a, 2015b) show notable improvements in the health sector ('inputs') which have direct impact on quality of care. These include human resources for health, procurement and supply of essential drugs, health infrastructure and equipment. On staffing levels for instance, there are presently 42,530 health workers employed in the public health facilities. This number consists of health workers already on payroll (40,938), new recruits who had reported on duty but are not yet on payroll (1092); and health workers hired on contracts by various implementing partners (500). This overall national staffing level of 42,530 health workers in the public sector represents a fill-up rate of 70% of approved positions (norm) in the sector (ibid). On health infrastructure and equipment, there has been continuous investments in health infrastructure over the years including construction of new and rehabilitation of old infrastructure at various levels, provision of medical equipment and hospital furniture; provision of solar lighting, construction of staff houses, maternity wards, strengthening the referral system by providing ambulances particularly for hospitals, Health Sub Districts (HSDs) and/or HC IVs, general transport and Information Communication and Technology (ICT) equipment and services in selected health facilities; and renovation/construction of selected health facilities (Ministry of Health 2015a)

The medicines situation in the public health facilities has also improved in the last five years with an increase in facilities reporting no regular stock outs of the indicator items. To-date, the pharmaceutical sector has made an improvement in availability of and access to Essential Medicines and Health Supplies (EMHS) from 43% in 2009/2010 to 63.8% in 2014/2015. There has been an increase in funding for medicines through both Government of Uganda and donor streams from USD 92 million to USD 410 million (including USD 85 million for procurement of Long Lasting Insecticide Nets (LLIN)) over the same period, resulting into increased public confidence in the health system. However, the greater proportion (81%) of this funding is still from Development Partners, and largely skewed to HIV/AIDS, malaria and TB. The per capita government expenditure on EMHS in the FY 2013/14 was about US$ 2.4 which is below the estimated requirement in the HSSIP of US$ 12 (Ministry of Health 2015b). There is also still a challenge of inadequate and poorly maintained medical equipment (ibid).

With regards to availability of and access to health facility, physical access to health facilities (proportion of the population leaving within 5 km of health facility) is currently at 72%. Despite this, there are still major geographical inequities in the coverage / availability of public health facilities (Ministry of Health 2015b)

Despite the above good strides made in the improvement of health sector, issues concerning improving individual public health facilities' health worker motivation, retention, commitment, performance, and productivity and how these are related to quality of care not only remain superficial in most health sector documents but they are also insufficiently attended to by both the district local government and health facility administration. Yet the health workforce is still a key bottleneck for the appropriate provision of health services, with challenges in adequacy of numbers and skills, retention, motivation, and performance. The situation is even dire in the hard-to-reach districts / areas such as Buvuma, Buhweju and some Islands of Mukono district. The health facilities suffer inadequacy numbers of health facilities, retention and motivation of health workers (Advocates Coalition for Development and Environment 2014). This partly explains the poor performance among these districts according to the district health performance league table (Ministry of Health 2015a).

2. Methods

2.1 The CODES Project: Description and Rationale

This paper draws on a spectrum of activities under the Community and District Empowerment for Scale-up (CODES) project namely; the baseline survey, community dialogues and District Health Management Team (DHMT) meetings.

Community and District Empowerment for Scale-up is a learning project to show how a district health system management & community empowerment strategy can be taken to scale. It is a five-year initiative (2012-2016) designed to reduce child deaths caused by diarrhoea, pneumonia and malaria—the three of the top childhood killer diseases in Uganda today. Developed jointly by Uganda's Ministry of Health, UNICEF, and Karolinska Institute in partnership with Advocates Coalition for Development and Environment (ACODE), Child Fund International (CFI), Liverpool School of Tropical Medicine (LSTM) and Makerere University School of Public Health (MUSPH), the project is designed to help the government of Uganda through the Ministry of Health to boost its own capacity to implement policies and interventions that lead to a wide array of improvements in health outcomes, especially concerning the control of the above mentioned childhood diseases (Katahoire et al. 2015; Waiswa et al. 2015). The project is funded by UNICEF- Uganda, a grantee of the Bill and Melinda Gates Foundation through the United States Fund for UNICEF.

The project targets 21 districts throughout the country. Sixteen (16) "Wave One" districts were randomly divided into two groups: An intervention and a comparison group. Thus, there are eight (8) intervention districts (Buhweju, Bugiri, Buvuma, Luuka, Masindi, Apac, Arua and Maracha) and eight (8) comparison districts namely; (Kasese, Sheema, Mitooma, Iganga, Kamuli, Kiryandongo, Kole, and Albetong). An earlier two-year 'Proof of Concept" phase (2012 and 2013) involved five (5) districts in the central region of Uganda, namely, Mukono, Buikwe, Masaka, Bukomansimbi, and Wakiso. In the CODES project context, the five (5) participating districts in the 'proof of concept' were code-named- "Wave Zero" districts while the eight (8) intervention districts are code-named "Wave One" districts. The CODES intervention districts were selected on the basis of having a high burden of child mortality as set by the United Nations Children's Fund (UNICEF) using data based on estimated absolute numbers of annual under 5's deaths.

2.2   CODES Supply and Demand-side baseline study

2.2.1   The Supply-side component

The CODES supply side component is handled by Child Fund International (CFI) and Liverpool School of Tropical Medicine (LSTM). The component is concerned with strengthening the district health systems and health facilities through quality improvement initiatives.

In order to make their interventions evidence-based, CFI conducted quantitative health facility assessment VHT and household baseline surveys. The objectives of the supply side (quantitative) study were (1) To assess the coverage and quality of key child survival interventions offered at health facility levels in the 16 Wave One districts (both Intervention and Control districts), (2) To build capacity of District Health Teams (DHTs) to plan and implement Lot Quality Assurance Sampling (LQAS)-based survey and subsequently use the resulting data to plan and improve service provision within the district, (3) To provide data that would be used in identifying managerial bottlenecks and generate possible solutions and inform the development of the operational annual work plan for the health department, and (4) To estimate baseline values of selected household-level child survival indicators in the 16 Wave One districts (both Intervention and Control districts).

2.2.2. The demand side component

The CODES demand side component is handled by Advocates Coalition for Development and Environment (ACODE). The component is concerned with mobilizing and galvanizing communities to demand for and receive better healthcare services.

Just like CFI & LSTM, ACODE conducted a qualitative baseline study both at health facilities and households in order to make appropriate and evidence-based interventions. The objectives of the demand-side (qualitative) baseline study were (1) To understand the kinds of barriers to health care-seeking experienced by caretakers of children in the 16 project districts (both intervention and Control districts), (2) To understand better the quality of health service provided to the under-five children in the districts, and (3) To use findings from the survey to develop Citizen Report Cards that would be used as a tool in conducting community dialogues.

The Makerere University School of Public Health and Karolinska Institute jointly handle quality assurance and science agenda of both components of the CODES project.

2.2.3 Baseline study design and data collection methods

Child Fund International and Liverpool School of Tropical Medicine employed Lot Quality Assurance Sampling (LQAS) survey methodology to conduct the quantitative study in all the 16 districts. Data collection tool for the Health Facility Assessment (HFA) was developed following the child survival and health services indicators and strategies from the Ministry of Health. For baseline household survey, with exception of Buhweju and Buvuma, districts were divided into 5 Supervision Areas (SAs) and 19 samples were taken from each SA to provide the complete sample size of 95. Buhweju and Buvuma districts were divided into four (4) SAs from which 24 villages were sampled. The sub-division was based on specific criteria i.e. having 4-5 strata (sub-divisions or sub-county clusters), strata be non-overlapping (existing LQAS district subdivisions could be used for ease of data comparability). Selection of villages was based on an updated list of villages in a SA and the number of households therein. The project team then selected using Probability Proportional to Size (PPS) technique.

The indicators assessed the following service areas: Antenatal Care and Delivery, Immunization, infant feeding, Vitamin A supplementation, HIV prevention including Prevention of Mother To Child Transmission (PMTCT), Integrated Community Case Management (ICCM) interventions, Water supply, Hand washing practices, Latrine Coverage, Care seeking behaviour for ARI, diarrhoea and malaria, Treatment/Management of ARI, diarrhoea and malaria, Caregiver knowledge of child danger signs, Prevalence of diarrhoea, ARI and malaria and Long Lasting Insecticide-treated Bed Net (LLIN) Coverage (ownership and use).

On the other hand, ACODE's qualitative baseline study was purposive and conducted as operational research in all the Wave One CODES districts (16 districts; 8 intervention and 8 control districts). The questions that were asked covered a range of themes which included; common health problems affecting children in the community; the availability and accessibility of health units; the conduct of health workers; health facility users' perception of quality of healthcare (public versus private facilities) as well as diagnosis and disease recognition (diarrhoea, pneumonia, and malaria). Other questions focused on barriers to the three demand-side determinants of care and health facility user satisfaction (specifically regarding how the quality of health services could be improved in the target communities, and what could make health service planning and implementation better) (Advocates Coalition for Development and Environment 2014).

ACODE's data collectors conducted focus group discussions (FGDs) and in-depth interviews (IDIs) with caretakers of children under five in each of the 16 Wave One districts, plus key informant interviews (KIIs) with health workers at

the sampled public health facilities. This was because these methods could help to solicit respondents' views and perceptions regarding health service provision and utilization.

2.2.4 Baseline Study Sample size and selection criteria

Child Fund International and Liverpool School of Tropical Medicine generated a sampling frame for health facility assessment which consisted of all HC IIs, HCIIIs, HC IVs and Hospitals. Both government-owned and Private not for Profit (PNFPs) health facilities were enrolled in the survey. A hyper geometric formula was used to calculate the LQAS sample size of HFs per district, using the following pre-set standards: At least 80% of HFs in each district was expected to demonstrate adequate performance for each specific indicator included in the assessment. Health Facilities were then selected using stratified random sampling method, with the strata being facility type.

For household selection, a household was taken to be a group of persons who share the same kitchen, or a group of persons who eat from the same cooking pot. A clear definition to differentiate a household from a homestead was crucial. Where a village had up-to-date household list, a reference household was randomly selected using a random number table. Where there was no household list, or if the existing list could not be brought up-to-date, the reference household was obtained through the use of a village sketch map, which was developed with the help of the community leader.

For selection of respondents, once the reference household was selected, the interviewer selected the first household to call upon by going to the next nearest front door from the current front door– walking distance. This was termed as the start household. Subsequent respondents were found by going to the next nearest front door from the current front door – walking distance. A maximum of one interview was administered for anyone household. If a household had more than one potential respondent, one adult respondent (over 18 years) was selected randomly using a table of random numbers and the questionnaire respondent selection table.

For qualitative study, within each district, ACODE conducted five (5) Focus Group Discussions (FGDs) each with between 8-10 caretakers. One in-depth interview was held in each district with a mother who had recently (two weeks prior to the study) either lost a child to, or had a child suffer from any of the three diseases (malaria, pneumonia, and diarrhea). Two Key Informants Interviews (KIIs) were held in each district with health workers; one with the in-charge of a health facility while another was with a health worker preferably in maternal and child health department. Data collectors worked with each district's District

Health Office (DHO) and members of the District Health Management Team (DHMT) to identify a sub-county in which the study was to be conducted, and within which, a public health facility whose in-charge and staff were to be key informants. The selection targeted a health facility that treated a large number of under-five cases of diarrhoea, pneumonia, or malaria with the help of recent facility-level data on incidents of disease. Where data was unavailable, the DHO and DHTs used their own knowledge of a given facility's catchment area.

Villages from which FGDs were conducted were selected with the assistance of the health facility in-charges or managers. In some districts, this was done with the assistance of sub-county official(s). Three villages in each sub-county were purposively selected basing on their distance from the selected health facility; 3-5 Kms; 5-7 Kms; and 8-10 Kms. The purpose of stratifying the villages by distance was to get a sense of the ways in which distance affected respondents' care-seeking behavior, and to tease out whether and how distance or barriers of transportation could influence the ways in which people discussed the facility and its services. FGDs were conducted in three gender-based categories; women only, men only, and mixed men and women.

2.2.5 Data management and analysis

For CFI/LSTM's quantitative study, data quality was ensured through cross-checking one another's questionnaires for completeness and correctness. This allowed for easy clarification since they would still be at the health facility.

A database was developed in EPIDATA software version 3.1 and was tested for accuracy and consistency. The database was developed based on the final version of the questionnaire used for data collection. A double data entry system was used to allow for data cleaning. Both entries were done centrally at the project office. The cleaned data was then exported from EPI Data to SPSS (v18) for analysis.

For qualitative study, ACODE's data collectors tape recorded all the FGDs and IDIs (with consent) and transcribed verbatim from the dominant native languages in participating districts into English. The transcripts were later typed in MS Word and reviewed by members of the ACODE team to ensure that the methods used captured the expected data. For transcripts from FGDs and Interviews that lacked sufficient data, data collectors had to return to the field collect additional data. The ACODE team analyzed FGDs and Interview transcript using Atlas.ti software. This involved creating data analysis guide, and using Atlas.ti to create query reports that coded key themes and sub-themes according to the survey questions.

2.2.6 Ethical Considerations

The study obtained ethical clearance from the Uganda National Council for Science and Technology (UNCST-SS-2548). Data collectors obtained informed consent from study participants. Data collectors also fully explained the confidentiality safeguards, and participants were informed about probable inconvenience likely to arise because of their participation in the study. They were made aware of the fact that participation was voluntary, confidential, and that they could freely withdraw their participation at anytime during the interview or discussion.

2.3 Community Dialogues

2.3.1 Theoretical and practical underpinnings

During implementation of the demand side component of CODES, ACODE employed a behavioral change communication approach of *'Community Dialogues'.* Community dialogues were meant to be a vehicle for empowerment of people in communities to demand for and receive better health services. The central model for the community dialogues in the CODES project was inspired by the earlier randomized controlled trial community participation by (Björkman and Svensson 2010). The Björkman and Svensson study focused on health care delivery in rural Uganda. In the study, communities were first presented with citizen report cards (CRCs) that contained baseline data on the state of health care provision in a nearby health facility. Community dialogues were held within communities and with health care workers to identify key problems within healthcare system. Dialogue participants devised a series of action plans that they could act upon to improve health care delivery and utilization. Communities themselves were tasked with sustaining the effort, with little help from outsiders (either researchers or NGOs). Through the dialogue process, communities were tasked with organizing management teams, deciding upon priorities (development planning), and executing their plans (development implementation). According to the model, community participation in the planning and decision-making process was critical to strengthening local accountability and demand-responsiveness (Björkman and Svensson 2010; Svensson and Björkman 2009).

2.3.2 Design, Structure, and Composition of the Community Dialogues under the CODES project

2.3.2.1 Production of Citizen Report Cards (CRCs)

The CRCs captured recent project-generated data on a variety of district and sub-county indicators through the qualitative and quantitative baseline survey

carried by ACODE and CFI at the onset of the project. The captured data was on healthcare service utilization and the functioning of health facilities. Data on functioning of health facilities included; stock-outs of essential drugs and the proportion of health workers within a given district who were following nationally recommended guidelines for treating diarrhea, pneumonia, and malaria in children under-five years.

2.3.2.2 Identifying locales for community dialogues

Prior to the facilitation of community dialogues, ACODE staff met with the District Health Management Teams (DHMTs) from each of the 13 CODES intervention districts (five from Wave Zero and eight from Wave One) to select the locales that would host the community dialogues. The CODES dialogues are typically parish-level, with DHMTs often choosing areas that have poor child health outcomes relative to other locales throughout the district, are located far from a nearby health facility, or are comprised of populations that pose unique health challenges for health workers (for example, fishing communities with transient populations).

2.3.2.3 Conducting community dialogues

The two-day robust dialogues were conducted both in communities and at health facilities that served the selected communities. Day one involved discussions on CRC in separate four groups of the targeted dialogue participants; (i) caretakers of children under five (a cross-section of which are mobilized by LCs and VHTs); (ii) community leaders (which include LCIs, LCIIs, LCIIIs, and religious and cultural leaders from the villages mobilized); (iii) Village Health Teams throughout the parish (all the above convened at a selected nuetral venue in communities) as well as (iv) health workers (at respective health facilities).

All dialogue participants discussed findings captured in the Citizen Report Cards and later on developed separate group action plans which consisted of those activities that participants committed to implement using the available resources at their disposal, with the goal of improving the various indicators presented in the CRCs. On day two of the community dialogues, an interface session that brought together all the participants happened to allow presentation of group action plans and creating a joint action plan (community contract) to address some of the identified healthcare challenges in their community. The community contracts outlined largely health-related activities that dialogue participants committed to implement for themselves with less or nor external support. Each dialogue involved approximately 70 to 100 individuals mobilized from villages throughout the parish, in addition to the officials who represented the sub-county and district on the second day of the dialogue (interface session).

By end of June 2016, a total of 151 community dialogues had been conducted across all the CODES intervention districts. This is over approximately five-year period involving 55 community dialogues in wave zero districts (2012-2014) and 96 in wave one districts (2014- 2016).

2.3.3 Community dialogue data management and analysis

After each community dialogues, notes (written by dialogue facilitators for each separate group of dialogue participants) were reported within a provided report format. The notes were then analyzed according to various theses (thematic analysis) to make conclusions on people's perceptions about health service delivery and utilization across all the CODES districts.

3. Findings

This section presents the rationale for our focus on management and administration at public health facilities, and the health facility management and administration issues which require policy attention notably, (i) Time management among health workers, (ii) Human resource management and development practices, (iii), The role of Health Unit Management Committees (HUMCs), and (iv) Enforcement of health worker's professional ethics and code of conduct.

3.1 Why management and administration at public health facilities: Evidence from the CODES project?

Anecdotal evidence from CODES project shows that in much of rural Uganda, majority of healthcare seekers go to nearest public health facilities when they are afflicted by common illnesses. These are usually hospitals, health sub-districts/health centre IVs often at the county level, health centre IIIs often at sub-county level, and health centre IIs often at parish level. Implementation of both the demand and supply side components of the CODES project shows that the existing weaknesses in health facility management and administration immensely affects the quality of health care in public health facilities as well as effective utilization of health services by the community. This is to the extent that even when the so-called 'systemic' issues and challenges seem to be improving or to be addressed at health facilities, the quality of care does not correspondingly improve because of the outstanding debility in facility management and administration.

The CODES project baseline study of 2014 and a series of community dialogues between 2012 and 2016 revealed the kinds of challenges and problems that healthcare users experience when seeking services from public health facilities. These ranged from delays on the part of health workers to attend to patients, abusive or uncaring health workers, demand for illegal fees, long queues to poor queue management. Similarly, health facility-based dialogues revealed the inability of most health facility in-charges to effectively use their authority and discretionary powers to enforce ethics and codes of conduct in their subordinated, poor planning and implementation of health facility-based activities, poor records keeping, poor coordination between health workers, HUMCs and VHTs, and generally poor working relations between health workers and the community members (health service users). This impinges on the quality of service delivery as well as the willingness to seek health services. It is imperative to note that these findings are consistent with previous studies within Uganda which demonstrated the effect of poor health facility management

and administration on the community health seeking behaviour (Björkman and Svensson 2010; Bukenya 2012; Ensor and Cooper 2004; Musoke et al. 2015).

Compared to 'systemic' challenges such as drug stock-outs, inadequate staffing, inadequate health infrastructure and equipment; health facility management and administration challenges appear to be a "low-hanging fruit"— relatively cheaper to address, depending on the root cause of the challenge. With a clear and elaborate policy framework in place, the Ministry of Health, district and sub-county leadership, HUMCs and the health facility in-charges can ably address health facility management and administration challenges with minimal or no financial resources.

3.2. Health facility management and administration issues which require policy attention

This paper focuses on four (4) health facility management and administration issues;

1. Time management among health workers

2. Human resource management and development practices

3. The role of Health Unit Management Committees (HUMCs)

4. Enforcement of health worker's professional ethics and code of conduct.

The choice of these issues is based on the fact that they were commonly mentioned across all the 13 CODES project participating districts according to findings from the CODES project baseline study, community dialogues and district health management team (DHMT) meetings. Having analyzed dynamics at health facilities, there appears to be a consensus among district and sub-county leaders, health workers and health service users that these issues have far reaching effects on the quality of healthcare service delivery and community health-seeking behaviour as the section provides details below.

3.2.1 Poor time management among health workers

Time management seems to be a perpetual problem in these health facilities. Time management deficits at health facilities manifest in different ways but mainly through health workers reporting late for duty, leaving early from duty, and absenteeism.

3.2.1.1 Late reporting for duty and departing early from duty

Reporting at work late among health workers appeared to be a common practice in health facilities across districts participating in CODES. Health workers had a tendency of reporting on duty past 8 O'clock, which is the official time of opening the health facility according to the 'Code of Conduct and Ethics for Public Service' (Government of Uganda 2005). Some even departed from the facility before the end of their duty time. In the event that patients arrived very early in the morning or presented with critical conditions; there would be no health workers to attend to them. By the time health workers would arrive and start attending to patients, the latter would already be disgusted due to over waiting in the long queues as illustrated by a case of one woman quoted below:

> "... you leave home very early in the morning going to health centre X, so that you do not get hungry by waiting. But when you reach there, you wait or even sleep then wake up and wait again. When it reaches 10:00 am, then the health workers come and start working. By this time, the line is too long and you are tired. Then, in-between 1:00 pm and 2:00 pm, the health workers stop working ..." (2014 Baseline study in-depth interview in Buhweju district)

A long queue found at one of the health facilities in Maracha district before the health workers' dialogue was conducted.

Figure 1: Time spent waiting for healthcare services at public health facilities
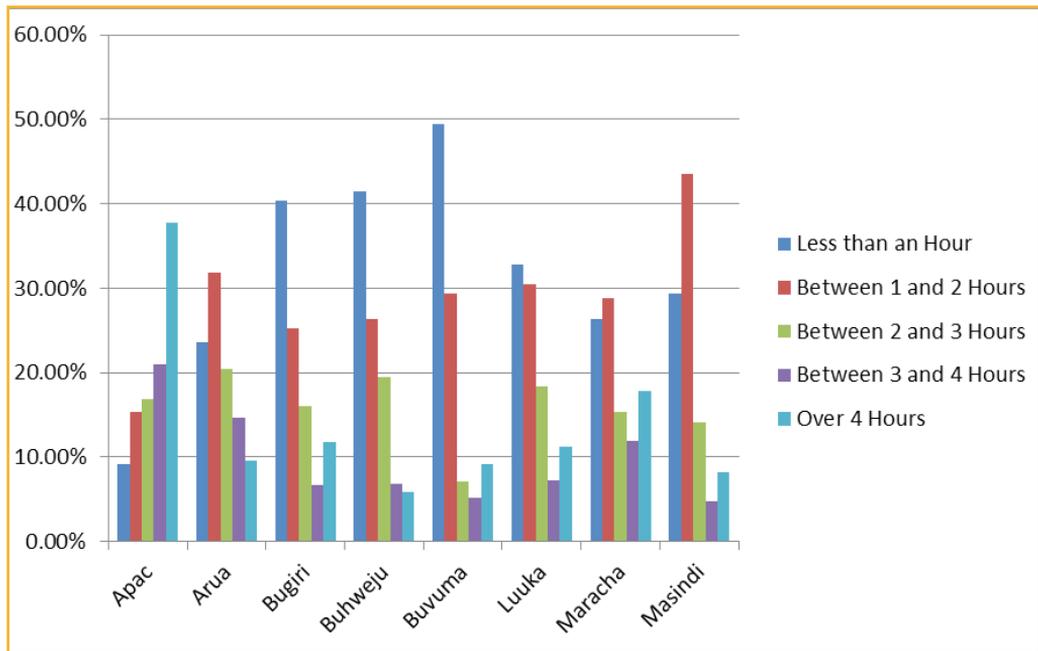
Source: Health Facility Assessment Baseline Survey (2014), CFI&LSTM

Figure 1 above shows that healthcare service seekers wait for long hours at public health facilities to access services. Although data in the figure shows that the average waiting time for majority of healthcare seekers was less than an hour, there was a sizeable proportion of those who waited for more than one hour to access the services in districts like Apac and Maracha having significantly more numbers of healthcare seekers who wait for over four hours. This jeopardizes the quality of care and also adversely affects continuous utilization of healthcare at public health facilities.

Queue management was also a known element of facility management and administration. In most cases, long queues at the health facilities were found to result from the late opening of health facilities coupled with sluggishness of some health workers while attending to patients. This would lead to patients spending long hours at the facility waiting for services. Findings from the baseline study and community dialogues implemented in the demand-side component of CODES indicated that most health facilities did not have in place mechanisms for handling the queues effectively. Most crucial was lack of a triaging mechanism in most health facilities to identify and provide priority treatment to patients; especially children who would be in a critical condition.

Absence of triaging was known to have led to loss of life at some health facilities as illustrated the FGD of women only in Bugiri district during the 2014 baseline study:

> ". . . *some of us like her* (one of the members in the FGD) *lost a child at Bugiri Hospital . . she first took him to a private clinic and when the condition worsened, she went to Bugiri Hospital . . . she found very many people in the queue. They sympathized with her and she took the child straight to the health worker. The health worker quarreled and told her to go back and follow the queue. The child died when she was still in the queue. She went back home and buried the child . . "(*Women FGD, 2014 Baseline study, Bugiri district).

Figure 2: Children under-five in critical condition who received priority treatment in the queue.
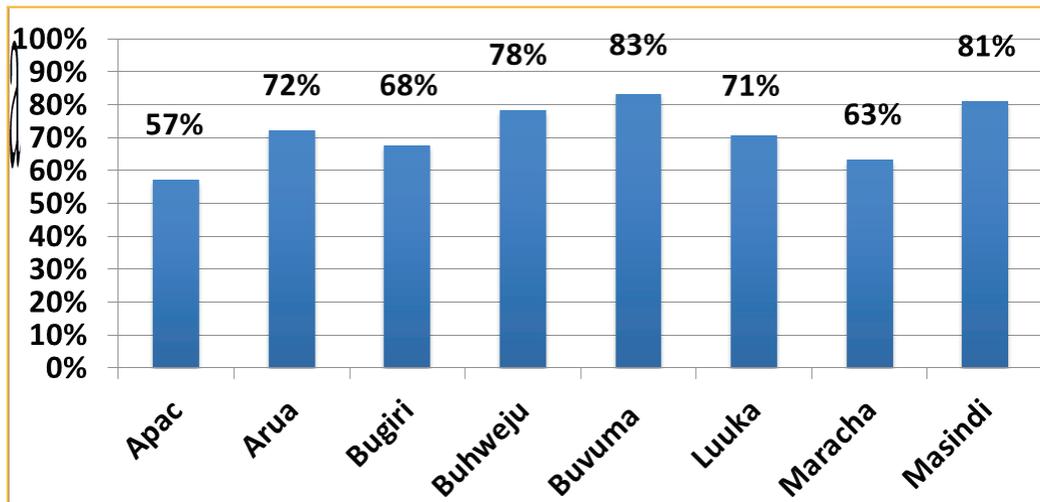
Source: Household Baseline Survey (2014), CFI&LSTM

Figure 2 above, indicates that on average, 70% of children under-five who were in critical condition received priority treatment across the CODES intervention districts. Although this seems to paint a good picture, it should be borne in mind that under normal circumstances, all patients in critical condition deserve priority treatment to avoid complications, some of which might lead to either disability or even death.

It is imperative to note that late reporting for duty and early departure from duty by health workers is a systemic challenge that requires urgent attention. The likely explanation for this undesirable habit could be the inadequacy of staff accommodation and rampant drug stock-outs at the health facilities. Inadequate

staff accommodation at a number of health facilities is known to compel health workers to reside far away from the facility. In cases where there are transport difficulties, health workers are not only susceptible to arriving late for duty but they are also likely to leave early. However, findings from the CODES baseline study and community dialogues both at the health facility and in the community show that it is not only a systemic issue but largely a facility management issue. It is evident that some health facilities actually have staff accommodation for health facility in-charges and a few other staff but some opt to reside away from the work station and leave these services as illustrated by health workers quoted below:

> *"I sleep away from the health facility because there is no enough staff accommodation for all of us. I gave out what would have been my accommodation to the midwives to sleep in so that they can attend to pregnant women at night. But still, these houses are not well furnished compared to the one I rent which has electricity and water; and I can use electricity to do my personal things when I am at home"* (Health workers' dialogue, Maracha district).

> *"… even when there was staff accommodation here, I would not prefer sleeping here considering the assignments that necessitate me to stay in town. I would rather ride my motorcycle every day to come and work and go back in the evening"* (Health workers' dialogue, Bugiri district).

It is probable that health workers who reside in the available staff quarters close to the health facility also report late for duty. Health facility in-charges who arrive late at the facility may not know which health workers arrive late or on time. He/she may not therefore take any disciplinary action against those that arrive late but earlier than him or her. Generally, there seems to be no effort and mechanisms put in place by management/administration at most health facilities to address the vice of poor time management among the health workers. Even the facility in-charges who reside at these facilities seem not to be bothered to take any disciplinary action as expected against fellow staff who arrive late for duty or depart earlier from duty.

> *"…How do you expect a facility in-charge who comes to work late discipline those who arrive late though earlier than him. He does not definitely know who arrived on time or late, so he decides to keep quiet"* (A health worker, at the health workers' dialogue, Arua district).

Most health facilities were found to have registration books for reporting the time of arrival. However, these books were often misused and abused by health workers. There was a common tendency for health workers to report inaccurate

time of arrival and departure. Due to guilty consciousness among some health workers, some health workers had made the registration books to disappear mysteriously and the administration had not bothered to replace it.

> *It is nowadays difficult to follow-up with cases of late reporting for duty since the time our arrival registration book disappeared under mysterious circumstances, and we have not got the money to buy another one."* (Health facility in-charge, at the health workers' dialogue, Buikwe district)

Besides inadequate staff accommodation at health facilities, drug stock-outs were reported to tempt health workers to report late or leave early from duty. During health workers' dialogues, some health workers admitted that sometimes they report late to work or even leave earlier. They attributed it to drug stock-outs at the facility which renders them redundant. One health worker said:

> *"…when there are no drugs at the facility, i don't need to rush there because there will be no work to do other than being redundant".* (*Health workers' dialogue, Buhweju district)

> *I don't see the reason why I should remain at the health facility the whole day when there are no drugs. Moreover, when the patients find you at the facility while redundant because there are no drugs, they start insulting you…..what are you doing here when you can't give us drugs?"* (Health workers' dialogue, Arua district)

3.2.1.2   *Absenteeism of health workers from health facilities*

At the heart of health facility management and administration is the challenge of habitual absence of health workers on duty in their respective health facilities of deployment. Despite the government and partners' effort to improve the staffing levels at all health facilities in the country from 56 % in 2010 to 69 % in 2013/2014 of much needed staff (Ministry of Health 2015a), health facilities continue to suffer from health worker absenteeism. Health worker absenteeism represents one of the sources of waste in the Uganda's health sector (Okwero 2010). A previous study presented 52 % of health worker's absenteeism using unannounced visits in a sample of 50 government health facilities (Björkman and Svensson 2010). An earlier study had suggested that on average, 37 %t of health workers were absent from work costing government the equivalent of UShs 26 billion per year, or 37%t of the fiscal 2005/06 PHC wage expenditure (Björkman and Svensson 2010)

Findings from the community dialogues show that absenteeism among health workers greatly affects the quality of delivery and utilization of healthcare services. For example, one dialogue participant reported:

"One day I accompanied my sister in-law to give birth at X health centre III and there was no health worker until the labor pains became unbearable and she sought the services of an ambulance from Masindi hospital...by the time the ambulance arrived, the woman was almost giving birth…indeed she gave birth in the ambulance while we were on our way to Masindi hospital." (Community dialogue, Masindi district).

Although most health facilities had duty rosters for health workers, these were not effectively enforced by the facility in-charges. Some health workers including the facility in-charges were found to habitually be absent from work stations even on days they were expected on duty, according to duty rosters. Once absent, some health workers would either give unsound reasons while others would not inform the management or send apologies in advance for possible replacement. Once such happens, no replacements would be put in place resulting into work-overload to co-workers on duty. This has been found to be worse in HC IIs where there are few health workers. Once a health worker on duty is absent, the health facility was found to close thereby denying patients' healthcare. In some cases, patients were reported to be diagnosed by security guards (askaris).

"I will not mention the facility but when we investigated, we discovered that the askari (security guard) just uses the back of his hand. When he feels that the child is hot, he concludes that he has malaria. This is unacceptable," said the Uganda's Minister for Primary Healthcare (Karugaba December 11, 2015).

Findings from community dialogues show that most public health facilities lack a mechanism to address health workers' absenteeism from their work stations, and most especially when the in-charge is a culprit. Unfortunately, a number of HUMCs that interacted with CODES seemed not bothered about health worker absenteeism. Even when some were aware of this vice, they appeared to be uninformed of what they could to address it.

3.2.1.3 *'Presenteeism' among health workers*

Besides health workers' absenteeism, a tendency among health workers of being on duty but not doing what they presupposed to do was observed. In this situation, they are present but invisible. This is what has been termed as 'presenteeism', alternatively described as a loss of workplace productivity resulting from employee health problems and/or personal issues (Aronsson et al. 2000; Aronsson and Gustafsson 2005; Johns 2010). Even though the employee is physically present at work, he/she is unable to fully perform his/her work duties. It is more dangerous than physical absenteeism from duty

because it does not only portray a high degree of negligence of duty but also the unproductive employee may distract other co-workers from performance as well (Aronsson et al. 2000; Reyes 2015). Contrary to the common manifestation of 'presenteeism' which is associated to ill-health (Aronsson et al. 2000; Aronsson and Gustafsson 2005), 'presenteeism' as seen in CODES Project districts seems to take a different but related form. Some health workers have been found to be present at the facility but not to be engaged in service delivery even when they are on duty. It has been found to involve unnecessary movements in and out of the facility, concentration on private tasks and responsibilities within the facility premises, and neglect of performing expected roles especially by health workers who reside at the health facility. They have been observed to remain in their residences and to keep asking about happenings at the facility even when they are purportedly on duty. Ultimately, patients at the facility look at the health worker as present but not providing the expected service. Some sets of literature relate 'presenteeism' to 'absenteeism'. For example, (Johns 2010) hypothesizes that factors that reduce absenteeism are more likely to increase presenteeism while (Aronsson et al. 2000) argue that some factors which influence absenteeism (such as ill-health, burnout, stress and low morale among others) can also influence presenteeism. Due to its breadth, 'presenteeism' is hard to address than absenteeism (Reyes 2015). Similar to any other problem, acknowledging that it exists is the first step toward resolution. Therefore, health facility management and administration ought to understand its manifestations and take corrective steps towards addressing the vice through close supervision and monitoring.

Evidence from the CODES project indicates that presenteeism creates a negative attitude among healthcare seekers towards not only health workers but also public health facilities and this in turn greatly affects their healthcare seeking behaviours in served communities. This has promoted the increased utilization of alternative health service providers in communities, including but limited to drug shops at times manned by unqualified staff, self-medication and traditional healers. This finding is well illustrated in this quotation:

> *"… they want you to sit and wait despite the pain you may be feeling. Even if you find the doors open, they may be inside doing their own things, chatting with one another, forgetting that there are patients waiting for them outside"* (Women Only FGD, 2014 Baseline survey, Apac district)

3.2.2 Poor Human Resource Management and Development Practices

Human resource management is a vital aspect of any organization's management because it concerns the management of an organization's most valued assets

- human resources. It is imperative to note that all organizations whether public or private at whatever level must give attention to the issue of human resource management and development because human resources are a pivot around which the success or failure of an organization depends (Armstrong 2010). This therefore calls for appropriate human resource management and development techniques and system in which the staff are properly managed and developed by the organization's authority without compromising efficiency, effectiveness, and professionalism (ibid). In CODES, the focus was on three aspects of human resource management and development which portrayed weak health facility management. This include; weak managerial skills of most health facility in-charges, poor human resource management and development approaches, and poor planning and implementation of health facility-based activities.

3.2.2.1. Inadequate managerial skills among health facility in-charges

Community dialogues across health facilities in CODES project participating districts indicates that most health facility in-charges lack basic leadership and managerial skills. A number of them demonstrated lack of capacity and skills to mobilize staff, lobby for desired staffing and resolve conflicts. The situation is worse in the lower level health facilities, especially those managed by the newly appointed persons in the health service who have just completed studies. They are appointed health facility in-charge by virtue of their academic qualifications but a number of them lack basic managerial skills since they have not had prior exposure in leadership and health facility management. As a result, they encounter challenges in managing fellow staff especially those who are senior to them (in terms of working experience and time spent at the facility).

Further evidence from health workers' dialogues reveals that some of these in-charges displayed inferiority complexes before staff they lead. They seemed to lack capacity and confidence to manage, motivate, discipline, and make fellow staff feel their authority. Fellow staffs then tend to take advantage of the weak management to prioritize their personal interests at the expense of the health facility mission. Thus they tend to deliberately practice all sorts of misconduct contrary to the health workers' Ethics and Professional Code of Conduct but also Code of Conduct and Ethics for Public service (Government of Uganda 2005). They behave in such a way, after all, knowing that they are no possibilities for punitive actions against them by the facility in-charge. This kind of permissive situation at the health facility in which every individual health worker chooses to behave the way he/she wants, greatly jeopardizes health care service delivery.

Some examples of Weak managerial skills among health facility In-charges: Evidence from health workers' dialogues in three districts.

1: Arua district:

On the day of the health facility –based dialogue, a newly appointed in-charge appeared to be inferior to the senior serving health workers at the facility. It was observed that some health workers did their own things without informing the in-charge in advance… for instance, attending seminars or workshops unknown to the in-charge, and he does not take any disciplinary action against such errant health workers.

2: Maracha district:

A health workers' dialogue turned into a 'peace-talk', as health workers confronted the facility in-charge accusing him of what they called 'inhumane administration' characterized by irresponsiveness and impassionate to the needs of subordinates. There seemed to be deep-rooted conflicts among the staff but also between the in-charge and fellow staff. These issues were first discussed through accusations and counter-accusations among the staff. Later on, the CODES dialogue resumed.

3. Buhweju district:

On the day of the health workers' dialogue, the in-charge was seen struggling to mobilize subordinates to attend the dialogue even when earlier communication about it had happened. Subordinates kept dodging him through unnecessary movements from the facility to staff houses . . . until he threatened to close the facility . . . they later on appeared for a dialogue.

3.2.2.2 Poor human resource development approaches

Poor human resource development is another manifestation of weak management and administration in health facilities. This is evidenced by lack of staff orientation, mentorship, and inequity in offering opportunities for staff development. A number of health facilities in the CODES participating districts appear not to have a mechanism in place to orient and mentor newly posted health workers. Therefore, they fail to adapt easily and appreciate the health facilities' dynamics, working environment and health seeking behaviors among the clients. This precarious situation breeds other vices such as habitual absenteeism, 'presenteeism', and poor working relations between new and senior staff but also between new staff and the community members---clients. This affects both delivery and utilization of healthcare services.

> *"Since I arrived here six months ago, I always see everyone doing his/her own things and no one seems interested in assisting a fellow staff who could be stuck with a challenge. I am not yet aware of the procedures they use here for staff problem-solving"* (Health worker, at health workers' dialogue, Bukomansimbi district).

In addition, CODES has found limited opportunities for staff development such as refresher courses organized by either government or development partners. During health facility-based dialogues, health workers reported that opportunities for staff development are frequently dominated by the facility in-charges and a selection of few individual health workers. The dialogues also revealed that sometimes, invitations to such capacity building opportunities specifically require the attendance of either the in-charge or certain specialized health workers, notably laboratory technicians or midwives. The problem only arises when the facility administration does not properly communicate to the rest of the staff about the criteria for selection of who is supposed to attend. Another drawback is that those who get such training and capacity building opportunities often do not share the acquired knowledge with the rest of the staff when they come back at the facility. This leads to not only 'unbalanced' professional growth among health workers at given health facilities but also lack of common positions on standard treatment guidelines which lead to mismanagement of illnesses. Inequity in the selection of staff for capacity building opportunities also creates division, conflicts among the health workers and mistrust of the health facility leadership as one health worker said during a dialogue:

> *"…what demotivates me is being on duty whenever I am supposed to but I have never been offered any opportunity to attend a workshop or training."* (Health workers' dialogue, Buvuma district).

3.2.3   Improper planning, implementation and monitoring of health-based activities

Health facilities are engaged in different activities in line with their mandate to deliver health care services to the clients. Some of these activities are core, stipulated and directed by Ministry of Health while others are introduced by development partners. Others are as a result of innovation and creativity of the facility management. These activities range from facility to facility, according to size/level and the innovation and creativity of the management.

Evidence from the CODES project shows that lower level health facilities claim to be carrying out various activities such as health facility-based (static) and community-based (outreach) health education, immunization outreaches, continuous medical education (CME) sessions and staff meetings, among other

activities. However, most health facilities lack documented evidence of these activities. They lack work plans/schedules for the activities to be carried out and reports for the accomplished activities. During health facility-based dialogues, health workers in some health facilities admitted that such activities are either not planned at all and therefore are done on an ad hoc basis or are planned but not implemented as planned. Health facility-based dialogues further revealed that some facility in-charges appear not to be making follow-ups/monitoring the progress of the implementation of the planned activities. One in-charge said:

> *"…I am not sure how many community outreaches have been conducted so far in this quarter, but our EPI focal person knows the programme very well, and he is here, so he is in a better position to explain it*" (Health workers' dialogue, Masaka district).

3.2.4 The untapped role of the Health Unit Management Committees (HUMCs)

The Uganda national health policy (Ministry of Health 2010a) and Health Sector Strategic Plans (Ministry of Health 2005, 2010b, 2010c) and the development plan (Ministry of Health 2015b) provide a legal framework of HUMCs. It is upon this that Ministry of Health developed guidelines for the roles and responsibilities of HUMCs. HUMCs are supposed to oversee the day-to-day running of health units as well as oversee management of finances; decisions on budgets and expenditure. They are an important cog in ensuring that that the public and/or healthcare users are in the know of what goes on in a health facility. HUMCs are also supposed to link health facilities to communities by organizing community meetings and accounting for all decisions (Kajungu et al. 2015; Ministry of Health 2003, 2011). However, evidence from community dialogues in the CODES participating districts shows that few health facilities have functional HUMCs. Some of the HUMCs had just been instituted at the time of community dialogues while others had never been oriented about their roles and responsibilities.

In some communities, members were unaware of the existence of HUMCs and they had unanswered questions:

> *"We don't know whether that committee exists at our health facility. If it exists, then who elected it? who are its members and what is its role?"* (Community dialogue, Buhweju district).

> *"We have heard about that committee, but we don't know how it was formed, who the members are and what they are supposed to do".* (Community dialogue, Masindi district).

Incidentally, it is supposed to be the responsibility of the health workers, most especially the in-charge of the health facility and the Chairperson of HUMC to sensitize the community about the role of HUMCs. In the event that most HUMCs are not functional, one would be justified to believe that the responsible authorities (sub-county, district and Ministry of health) did not fully play their part. In such a scenario, the in-charges of health facilities and fellow health workers tend to be lax in the way they perform their duties. It was found that the gap between health workers and the community, especially in information sharing was too wide which compromised the ability of the community to hold the health facility accountable and effective healthcare service delivery and utilization.

3.2.5 Defective enforcement of health workers' Professional Ethics and Code of Conduct at the facility level.

Like any other professionals, health workers are guided in their profession by nationally established sets of rules, regulations and guidelines stipulated in the Health Workers' Ethics and Code of conduct, Code of Conduct and Ethics for Public Service, Professional Oaths, and the Patients' Charter. All these regulations are intended to inculcate in health workers professional conduct and commitment to provide quality healthcare, serve diligently, equitably, and effectively. It is thus the responsibility of health workers to abide by these sets of rules and regulations while health managers at different levels are tasked with the duty to enforce these regulations among their subordinates with a view to ensure quality of care delivery and utilization.

Professional misconduct among the health workers in health facilities seems to a larger extent to be a pointer of weak facility management and administration and an indication of defective enforcement of professional ethics and conduct by health facility in-charges. Findings from CODES project baseline survey and a series of community dialogues revealed that professional misconduct among health workers manifested through different ways. Notably, there was use of unprofessional (abusive/insulting) language, neglect of duty as evidenced by unnecessary absenteeism and presenteeism, charging illegal fees, late reporting to duty, coming to duty under the influence of alcohol, among others. These unprofessional behaviors discouraged patients from seeking and utilizing health services in a timely manner. One respondent from the baseline study said:

> "… *health workers in government facilities look at us as a burden to them when we go for treatment for our sick children, that's why if I have money I don't waste time going there." (*2014 Baseline survey, Men FGD, Arua district*).*

Figure 3: Mothers of children under five who reported having health workers speak to them in an abusive or unprofessional manner at least once within the last two weeks
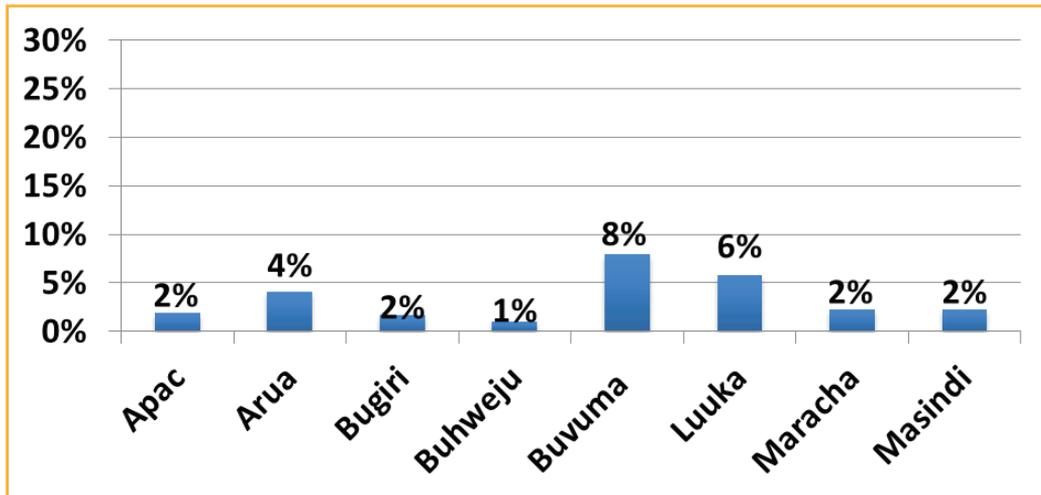
Source: Household Baseline Survey (2014), CFI&LSTM

The Figure above illustrates the percentages of mothers who reported having health workers speak to them in unprofessional manner at least once within the last two weeks. The respondents were at the facility, at the time of the survey. This implies that the percentages could have been higher if the time and sample space would have been expanded. Nevertheless, even with low percentages, it is evident that health workers use abusive/insulting language while attending to patients. This kind of behavior often deters patients from continuously seeking health services.

Throughout the community dialogues, health workers admitted that abusive health workers was the reason why children sometimes never got the healthcare they needed from the health facilities. Health workers further admitted that the working environment sometimes compelled them to behave unprofessionally--tiredness due to too much work-load, meager and untimely salary payments, and provocation by patients. One health worker in a community dialogue in Luuka district reported that sometimes, patients were also abusive and provocative to health workers. He gave the case of one patient who attacked a health worker after telling her to go and buy some drugs;

> *"…If you cannot give us drugs then why don't you close the facility and go back in your beds and sleep, what are you paid for?"* Health workers' dialogue, Luuka district.

It is worth noting that though some of these factors that cause unprofessional conduct among the health workers were seemingly systemic in nature which required government intervention, some of them could be mitigated by a credible health facility management and administration using different avenues such as regular staff meetings, mentorship sessions, staff counseling and guidance, among other things. Unfortunately, evidence from health facility based dialogues showed that district, sub-county and health facility management and administration were still grappling without remarkable success on effective enforcement of professional ethics and conduct among frontline health workers.

Further evidence from a series of health workers' dialogues showed that the misconduct of health workers in public health facilities was at times caused by the ineffective implementation of the sanctions for the non-performing staff. The fact that power to recruit staff (health workers) was vested in the District Service Commission which exercises no control over the people it hires had negatively impacted on health service delivery. In some health centres, the facility in-charges reported that though they have powers to manage the health facilities, they did not have powers to discipline the errant staff since they did not recruit them. They could not withhold their salaries for instance, because these were paid directly into their bank accounts without questioning their performance. One In-charge said:

> *"some health workers are "**untouchables**" because they have '**God fathers'** at the district, even if you write one hundred warning letters to the responsible offices nothing will ever be done"* (Health workers' dialogue, Bugiri District).

4. Conclusions

The Government of Uganda has a rich health policy framework that has helped the country to make improvements in the health sector. However, fundamental deficits remain and derail the rich policy framework from making remarkable achievements. The persistent underfunding of the health sector remains a challenge. There is a challenge in priority-setting processes both in policy targets and resource allocations to various health sector activities. There is overconcentration on macro health policy planning and investment at the expense of micro health policies that have a direct impact on public health facilities. This policy research paper singles out a micro health policy issue that the government needs to provide sufficient attention to. Strengthening health facility management most especially at lower level health facility level is one way of improving quality of health care and effective utilization of health services, for children aged 5 years and below.

From the findings, it is clear that health facility management and administration is such an area that requires specific policy attention because of its critical locus in ensuring quality of health care. The existing sections of health facility governance in Uganda's health sector development plans and strategies remain too generalized that peculiar aspects of health facility management and administration are not explicitly addressed. Issues of time management among health workers; human resource management and development practices; the untapped role of HUMCs, and defective enforcement of health worker's professional ethics and codes of conduct, all have far reaching implications on the service delivery and health seeking behaviour in the community. The Ministry of health is commended for the attempt to address the 'bigger' healthcare issues such as staffing, drug stocks, facility infrastructure, among others, but when the so-called 'minor' issues at the health facility level, are not adequately addressed, the quality of care cannot be expected to improve steadily.

It is imperative to note that issues to do with health facility management and administration are not a preserve of the central government alone, but rather require a concerted effort of various stakeholders including the district, sub-county, HUMCs, health facility in-charges and frontline health workers. At the level of the district and sub-county, health facility/workers' support supervision, monitoring and inspection becomes vital. While at the health facility level, it requires the in-charges to be well trained managers, 'knight' cadres, with a sense of assertiveness, innovativeness, and diligence. At the community level, it requires that the HUMCS be well oriented and trained to perform their mandated roles of linking the community and the health facility as well as taking constructive decisions at the health facility.

It is worth noting that financial resources are undoubtedly a great determinant of these efforts. There is a need for a great deal of commitment in terms of time and financial resources and proper prioritization on the side of the central government, and the lower level local governments regarding financing of health sector activities. Short of it, the country will continue to experience discrepancy between the general health policy framework and the existing health status of the population characterized by high morbidity (disease burden) and mortality rate / ratio.

Finally, it is hoped that this paper would stimulate intellectual health policy debate among the readers especially the key stakeholders in the health sector that would culminate into emerging of more coherent and interdependent micro health policies that fit within the existing broader spectrum of national health policy arena. The sound and holistic health policy can undoubtedly improve the quality of health care provision and stimulate a positive healthcare seeking behaviour among the service users.

5. Policy recommendations (What is it that needs to change?)

5.1 Organize periodic capacity building and training in leadership and human resource management and development for health facility in-charges

It is necessary that health facility in-charges should be enabled by the Ministry of Health and District Health Offices to participate in short-term courses to build their capacity in leadership and human resource management. Training in leadership and human resource management would build the capacity and confidence of this cadre of health workers to manage, motivate and authoritatively discipline their subordinates. Since plans to establish an autonomous health manpower development center (HMDC) at Mbale through an *'Act of Parliament'* had already been mooted (Ministry of Health 2015a, 2015b), there was need to roll-out governance, leadership and management training courses for health managers. The managers from district and health-sub districts deserve to be prioritized. The training once it starts should be extended to the lower level health facility in-charges.

5.2 There is need to employ appropriate innovations and motivation practices for health workers

Management and motivation scholars and theorists suggest that a highly motivated workforce is more productive (Armstrong 2010; Koontz et al. 1986). Management requires the creation of and maintenance of an environment in which individuals work together in groups toward the accomplishment of common objectives. This partly requires that managers have the knowledge of what motivates staff in order to perform. In the context of health facility management, the in-charges should identify appropriate motivators and use them to ignite individual health workers into performance in their mandated duties. The health facility in-charges need to creatively use *'carrot and stick'* techniques (reward and penalties) to enlist performance. It is recognized that use of *'carrot'* techniques could involve rewards such as promotion and salary increment, bonuses and many others which the health facility in-charges has no control over. However, the in-charges need to acknowledge the fact that they equally have a role to play here. For instance, they can make a follow-up on staff salary payments every month, reporting cases of unpaid salaries, submitting performance appraisals/management results all of which could cause some one's promotion. Succinctly put, showing concern for the welfare of fellow staff is good enough to motivate them. Over and above that, districts are required to functionalize their '*Awards and Sanctions'* committees to be able to

institutionalize rewarding systems within health facilities in close collaboration with facility management and administration to motivate staff. This would involve for example putting in place meritorious public recognition of best performing health workers according to indicators designed by the districts and shared with health facility management and administration and other health workers.

Besides, the health facility in-charges need not to underestimate the role of *'stick'* techniques that take the form of threats to penalize, warning about likely job loss or loss of income, demotion and many others that are known to be strong motivators for desired behaviour in a workforce. However, this should not include a common tendency for causing staff transfers from one facility to another as a way of penalizing the non-performing or misbehaved health workers. Health facility in-charges need to acknowledge the fact that the power of their position to give or withhold rewards or impose penalties of various kinds gives them an ability to control the economic and social well-being of their subordinates.

It is thus worth noting that, motivation of health workers within a health facility requires both *'carrot and stick'* techniques, and it is not only a preserve of health facility management and administration but it involves a spectrum of other authorities, particularly at the Central and Local Government level. It is important to appreciate that efforts and processes of motivating health workers is an immediate requirement. This motivation is needed both for health facility in-charges and their subordinates since it is a known that a demotivated manager cannot motivate a subordinate.

5.3 Building trust in healthcare service delivery

It is important to have health professionals, managers and public service workers who are trusted to deliver a high-quality service. Building trust in the sector implies (1) having sufficient resources in the form of drugs, equipment and infrastructure, (2) having requisite professional qualifications and (3) having a workface that has morale and is motivated (Le Grand 2009). At the level of a health facility, building trust requires that health workers, especially the in-charges of health facilities are altruistic cadres ('knights') rather than self-interested cadres ('knaves'). A 'knight' cadre is an individual whose principal concern is with the welfare of others while a 'knave' cadre is the one whose main concern is with his or private self-interest (ibid). Thus, knightly behaviour would be the expected because it is concerned with meeting the needs and wants of the service users along with those of the wider community with an interest in promoting social welfare of health service users. They would be trusted to deliver quality services in an efficient, responsive, accountable, and equitable fashion (Le Grand 2009Le Grand 2009). At the level of the Central Government, the

trust model requires a high degree of stewardship---leadership through policy, regulation and coordination---- the effective trusteeship of national health. It requires a long term vision and influence primarily by Ministry of Health. The model implies setting rules and ensuring their compliance by the public as well as the private health sectors.

5.4 Strengthening supervision, monitoring and inspection of lower level health facilities

Supervision, monitoring and inspection for health facilities is a mandate of various stakeholders at different levels ranging from the Central to Local Governments. However, supervision, monitoring and inspection has remained irregular and inadequate which breeds laxity among health facility in-charges and other health workers to maintain quality of care service delivery. As a result, the in-charges and health workers care less about their presence at the facility, time of arrival, opening the facility, quality of interaction with patients and departure from facility. Support supervision from the technical personnel from Ministry of Health, District, and Sub-District Health facilities to the lower level public health facilities is inadequate and requires to be stepped up. Support supervision is very critical in ensuring the quality of health care service delivery. It is intended to ensure continuous adherence of health facilities/health workers to nationally recommended clinical and health facility operational guidelines. Therefore once it is inadequate, there is a possibility for health facilities and health workers to deviate from the recommended guidelines.

Supervision, monitoring and inspection requires sufficient financial resources which the Central and Local Governments must commit to if they are concerned with quality of service delivery. For the reason that resources are inadequate for district and sub-county supervision team, reinvigorating, empowering, and motivating the HUMCs (whose members are in close proximity to the facility) to become more active and functional while playing their roles of facility oversight and bridging the gap between the health workers and the community, would be a good alternative action to consider. This can work best particularly for spot supervision since they lack technical capacity to handle support supervision.

5.5 Organizing periodic cross-district and intra-district peer to peer learning sessions

Central and Local Governments should consider organizing and facilitating periodic peer to peer learning sessions for health workers. These can be at either inter-district or intra-district levels. Such sessions provide opportunities for health workers to learn the best practices from their counterparts from other districts or within the same district, which are comparatively better than others

in some various aspects of health service delivery. Experience of working with district health officers and health facility in-charges in the CODES project districts shows that there are some districts and health facilities which have relatively good management and administration practices as well as other best practices in the delivery of healthcare service delivery that others can borrow a leaf from. For example, some health facilities had instituted or were piloting good mechanisms for addressing health workers' absenteeism, proper queue management (triaging system), proper health facility-based planning and monitoring, good health worker-community working relations, and good human resource management and development practices. However, there were no opportunities organized to share such best practices. The CODES project introduced and facilitated annual cross-district peer to peer learning lessons among district health management teams (DHTs) from the 13 participating districts. During peer to peer sessions, district teams share experiences and practices in the provision of healthcare services. At the end of the session, district teams learn from each other good practices in the area of bottleneck analysis (BNA), causal analysis (CA), work planning, implementation, monitoring and evaluation, quality improvement (QI) and priority strategies/interventions to be implemented in each district within a cycle of one year. This initiative can be rolled-out to all the districts in the country organized and facilitated by the Ministry of Health and District Local Governments.

5.6   Ensuring holistic approach in addressing systemic challenges to service delivery

There are numerous systemic challenges to service delivery which are logically linked to health facility management and administration. For example, inadequate staff accommodation at health facilities, lack of reliable means of transport, lack of information and communication facilities were some of the most common. Some health facilities do not have adequate staff accommodation leading to a number of health facility in-charges and other health workers renting accommodation away from the health facility. Coupled with lack of reliable transport means to reach the facility in the morning and other eventualities, it complicates attempts to reach at the health facility in a timely manner. On the side of health facility in-charges, this creates a room of temptation for 'moonlighting' and a choice to manage the facility remotely. Ministry of health and district local governments need to embark on a holistic approach in planning and budgeting in an attempt to address systemic challenges in all health facilities. Issues of staff accommodation, reliable means of transport, and information and communication facilities at health facilities among others require proper prioritization and financial commitment.

References

Advocates Coalition for Development and Environment, (ACODE) (2014), 'Qualitative Baseline Study for the Community and District Empowerment for Scale-up (CODES) project. ', *ACODE Policy Research Series* (Kampala, Uganda: ACODE).

Armstrong, Michael (2010), *Armstrong's essential human resource management practice: A guide to people management* (Kogan Page Publishers).

Aronsson, Gunnar and Gustafsson, Klas (2005), 'Sickness presenteeism: prevalence, attendance-pressure factors, and an outline of a model for research', *Journal of Occupational and Environmental Medicine,* 47 (9), 958-66.

Aronsson, Gunnar, Gustafsson, Klas, and Dallner, Margareta (2000), 'Sick but yet at work. An empirical study of sickness presenteeism', *Journal of epidemiology and community health,* 54 (7), 502-09.

Björkman, Martina and Svensson, Jakob (2010), 'When is community‐based monitoring effective? Evidence from a randomized experiment in primary health in Uganda', *Journal of the European Economic Association,* 8 (2‐3), 571-81.

Bukenya, Badru (2012), 'Can NGOs build states and citizenship through service delivery?: evidence from HIV/AIDS programmes in rural Uganda', (University of Manchester).

Colenbrander, Sarah, Birungi, Charles, and Mbonye, Anthony K (2014), 'Consensus and contention in the priority setting process: examining the health sector in Uganda', *Health policy and planning*, czu030.

Ensor, Tim and Cooper, Stephanie (2004), 'Overcoming barriers to health service access: influencing the demand side', *Health policy and planning,* 19 (2), 69-79.

Government of Uganda, (GOU) (2005), 'Uganda Code of Conduct and Ethics for Public Service', (Kampala, Uganda: Ministry of Public Service).

--- (2010), 'National Development Plan (2010/11 - 2014/15', in National Planning Auhtority (ed.), (Kampala, Uganda: National Planning Authority).

Johns, Gary (2010), 'Presenteeism in the workplace: A review and research agenda', *Journal of Organizational Behavior,* 31 (4), 519-42.

Kajungu, Dan, Lukwago Daniel, and Tumushabe, Godber (2015), 'Assessing Public Expenditure Governance in Uganda's Health Sector: The case of Gulu, Kamuli and Luweero Districts. Application of an Innovative Framework.', *ACODE Policy Research Series* (Kampala, Uganda: ACODE).

Karugaba, Mary (December 11, 2015), 'Minister decries absenteeism as askaris diagnose patients', *New Vision*.

Katahoire, Anne R, et al. (2015), 'Improving child survival through a district management strengthening and community empowerment intervention: early implementation experiences from Uganda', *BMC public health,* 15 (1), 797.

Koontz, Harold, O'Donnell, Cyril, and Weihrich, Heinz (1986), *Essentials of management* (McGraw-Hill).

Le Grand, Julian (2009), *The other invisible hand: Delivering public services through choice and competition* (Princeton University Press).

Ministry of Health, (MOH) (1999), 'National Health Policy.', (Kampala, Uganda: MOH).

--- (2000), 'Health Sector Strategic Plan I - 2000/01 - 2004/05.', (Kampala, Uganda: MOH).

--- (2003), 'Guidelines on Health Unit Management Committees for Health Centre III.', in Quality Assurance (ed.), (Kampala, Uganda: MOH).

--- (2005), 'Health Sector Strategic Plan II - 2005/06 - 2009/10', (Kampala, Uganda: MOH).

--- (2010a), 'The Second National Health Policy; Promoting People's Health to Enhance Socio-economic Development.', (Kampala, Uganda: MOH).

--- (2010b), 'Health Sector Strategic Plan III- 2010/11 - 2014/15', (Kampala, Uganda: MOH).

--- (2010c), 'Health Sector Strategic and Investment Plan 2010/11- 2014/15', (Kampala, Uganda: MOH).

--- (2011), 'Health Sector Quality Improvement Framework and Strategic Plan 2010/11 - 2014/15', (Kampala: MOH).

--- (2015a), 'Annual Health Sector Performance Report for Financial Year 2014/2015', (Kampala, Uganda: MOH).

--- (2015b), 'Health Sector Development Plan 2015/16 - 2019/20', (Kampala, Uganda: MOH).

Musoke, David, et al. (2015), 'Health seeking behaviour and challenges in utilising health facilities in Wakiso district, Uganda', *African health sciences,* 14 (4), 1046-55.

Okwero, Peter (2010), *Fiscal space for health in Uganda* (World Bank Publications).

Reyes, Stephanie (2015), 'Presenteeism: The one thing worse than absenteeism.', *TribeHR* (Boston Massachusetts, USA: NetSuite Inc).

Svensson, Jakob and Björkman, Martina (2009), 'Power to the People: Evidence from a Randomized Field Experiment of a Community-Based Monitoring Project in Uganda', *Quarterly Journal of Economics,* 124 (2), 735-69.

Waiswa, Peter, et al. (2015), 'Community and District Empowerment for Scale-up (CODES): a complex district level intervention to improve child survival in Uganda-study protocol for a cluster randomized controlled trial', (Forthcoming).

Publications in this Series

Elizabeth Ann P. A., Mukundane M., Bataringaya D., Nannungi A., Ssesanga P., Golooba-Mutebi F., (2016). Barriers to Care-Seeking among Caretakers of Children under five in Uganda: Qualitative Evidence from the Demand-side-Component of the CODES project. ACODE Policy Research Series No. 76, 2016. Kampala.

Anyuru, M. A., Rhoads, R., Mugyenyi O., Manoba, J.A., Balemesa, T., Balancing Development and Community Livelihoods: A Framework for Land Acquisition and Resettlement in Uganda. ACODE Policy Research Series No. 75, 2016.

Bogere G., and Mukaaru J. A., Assessing Public Expenditure Governance: A Conceptual and Analytical Framework. ACODE Policy Research Paper, No.74 2016.

Rwengabo, S., Mugyenyi O., Okwir, R., Birete, S. and Bainomugisha, A., Resolving Intra-State And Cross-Border Conflicts Driven By Oil Exploitation In Uganda's Albertine Graben: Policy Options for Multi-Level Conflict Resolution. ACODE Policy Research Series 73, 2016.

Mushemeza, E.D., and Okiira, J., Africa Regional Evidence Paper, Local Content Frameworks in the Africa Oil and Gas Sector: Lessons from Angola and Chad, ACODE Policy Research Series, No. 72, 2016

Mushemeza, E. D., The Legislative and Budget Oversight: A Comparative Study of Selected Countries in the East Africa Community, ACODE Policy Research Series, No. 71, 2015

Bainomugisha, A., Muyomba – Tamale, L., Muhwezi, W., W., Cunningham, K., Ssemakula, E., G., Bogere, G., Rhoads, R. and Mbabazi, J. Local Government Councils Scorecard Assessment 2014/2015: Unlocking Potentials and Amplifying Voices, Kampala, AOCDE Policy Research Series No. 70, 2015.

Kajungu, D., Lukwago, D., and Tumushabe, G., Assessing Public Expenditure Governance in Uganda's Health Sector: The case of Gulu, Kamuli, and Luweero Districts: Application of an Innovative Framework. ACODE Policy Research Series, No. 69, 2015.

Rhoads, R., Muhumuza, T., Nabiddo, W., Kiragga, H., Ssango, F., Nampewo, S., and Muzira, Z. (2015). Assessing Public Expenditure Governance in Uganda's Agricultural Sector: Application of an Innovative Framework. Kampala. ACODE Policy Research Series, No. 68, 2015.

Makaaru, J., Cunningham, K., Kisaame, K., Nansozi, S., and Bogere, G., Public Expenditure Governance in Uganda's Education Sector: Application of an Innovative Assessment Framework, Kampala. ACODE Policy Research Series, No. 67, 2015.

Bogere, G., Kayabwe, S., Kabasweka, F., G., and Achola, I., Assessing Public Expenditure Governance in Uganda's Road Sector: Application of an Innovative Framework and Findings from the Sector, Kampala, ACODE Policy Research Series, No. 66, 2014.

Tumushabe, G, W., Ngabirano, D., and Kutegeka, S., (2014). Making Public Procurement Work for Sustainable Forest Use: Excluding Illegal Timber from Uganda's Market. ACODE Policy Paper Series No. 65, 2014.

Bainomugisha, A., Muyomba-Tamale, L., Muhwezi, W.W., Cunningham, K., Ssemakula, E. G., Bogere, G., Rhoads, R., Local Government Councils Score-Card Assessment Report 2013/14: A Combination of Gains, Reversals and Reforms, Kampala, ACODE Policy Research Paper Series No. 64, 2014.

Naluwairo, R., and Barungi, J., Ensuring the Sustainable Availability of Affordable Quality Seeds and Planting Materials in Uganda: A Review of Uganda's Draft National Seed Policy, Kampala, ACODE Policy Research Series, No.63, 2014.

Ngabirano, D., and Karungi, S., A Comparative Analysis of Laws & Institutional Regimes on Public Expenditure Accountability in East Africa, Kampala, ACODE Policy Research Series, No.62, 2014.

Barungi, J., Agri-Food System Governance and Service Delivery in Uganda: A Case Study of Tororo District, Kampala, ACODE Policy Research Series, No.61, 2013.

Tumushabe, G., Muyomba-Tamale, L., Ssemakula, E. G., and Muhumuza, T., Uganda Local Government Councils Scorecard 2012/13: The big Service Delivery Divide, Kampala, ACODE Policy Research Series, No. 60, 2013.

Bogere, G., Tumushabe, G. W., and Ssemakula, E. G., Governance Aspects in the Water and Roads Sectors: Lessons from Five Districts in Uganda, Kampala, ACODE Policy Research Paper Series, No.59, 2013.

Opiyo, N., Bainomugisha, A., and Ntambirweki-Karugonjo, B., Breaking the Conflict Trap in Uganda: Proposals for Constitutional and Legal Reforms, Kampala, ACODE Policy Research Series, No. 58, 2013.

Ntambirweki-Karugonjo, B., and Barungi, J., Agri-Food System Governance and Service Delivery in Uganda: A Case Study of Mukono District, Kampala, ACODE Policy Research Series, No. 57, 2012.

Natamba, E. F., Muyomba-Tamale, L., Asiimire, I., Nimpamya, E., and Mbabazi, J., Local Government Councils' Performance and Public Service Delivery in Uganda: Ntungamo District Council Score-Card Report 2009/10, Kampala, ACODE Policy Research Series, No. 56, 2011.

Ssemakula, E., Ekwe, B., Agute, B., Jones, W. B., Local Government Councils' Performance and Public Service Delivery in Uganda: Soroti District Local Government Council Score-Card Report 2009/10, Kampala, ACODE Policy Research Series, No. 55, 2011.

Mbabazi, J., Massa, D., Rupiny, R. R., Ogamdhogwa, M., Local Government Councils' Performance and Public Service Delivery in Uganda: Nebbi District Local Government Council Score- Card Report 2009/10, Kampala, ACODE Policy Research Series, No. 54, 2011.

Adoch, C., Emoit, R., Adiaka, R., Ngole. P., Local Government Councils' Performance and public Service Delivery in Uganda: Moroto District Council Score-Card Report 2009/10, Kampala, ACODE Policy Research Series, No. 53, 2011.

Bainomugisha, A., Asiku, M., and Kajura, R., Local Government Councils' Performance and Public Service Delivery in Uganda: Buliisa District Council Score-Card Report 2009/10, Kampala, ACODE Policy Research Series, No. 52, 2011.

Tumushabe, G. W., and Mugabe, J.O., Governance of Science, Technology and Innovation in the East African Community: Inaugural Biannual Report, Kampala, ACODE Policy Research Series No. 51, 2012.

Muyomba-Tamale, L., Ssemakula, E. G., Musisi, G., Segujja, J., and Asimo, N., Local Government Councils' Performance and Public Service Delivery in Uganda: Luwero District Council Score-Card Report 2009/10, Kampala, ACODE Policy Research Series, No. 50, 2011.

Naluwairo, R., In Quest for an Efficient Agri-Food System: Reflections on Uganda's Major Agri-Food System Policies and Policy Frameworks, Kampala, ACODE Policy Research Series, No. 49, 2011.

Muyomba-Tamale, L., Ssemakula, E. G., Ssempala, D., and Jones, E., Local Government Councils' Performance and public Service Delivery in Uganda: Mpigi District Council Score-Card Report 2009/10, Kampala, ACODE Policy Research Series, No. 48, 2011.

Adoch, C., Ssemakula, E. G., Killing the Goose that Lays the Golden Egg: An Analysis of Budget Allocations and Revenue from Environment and Natural Resources Sector in Karamoja Region, Kampala, ACODE Policy Research Series No. 47, 2011.

Adoch, C., Emoit, R., and Illukol-Pol, M., Local Government Councils' Performance and public Service Delivery in Uganda: Nakapiripirit District Council Score-Card Report 2009/10, Kampala, ACODE Policy Research Series, No. 46, 2011.

Muyomba-Tamale, L., Tumushabe, G. W., Amanigaruhanga, I., Bwanika-Semyalo, V., and Jones, E., Local Government Councils' Performance and public Service Delivery in Uganda: Mukono District Council Score-Card Report 2009/10, Kampala, ACODE Policy Research Series, No. 45, 2011.

Mugabe, J. O., Science, Technology and Innovation in Africa's Regional Integration: From Rhetoric to Practice, Kampala, ACODE Policy Research Series, No. 44, 2011.

Naluwairo, R., Investing in Orphan Crops to Improve Food and Livelihood Security of Uganda's Rural Poor: Policy Gaps, Opportunities and Recommendations, Kampala, ACODE Policy Research Series, No. 43, 2011.

Tumushabe, G. W., Muyomba-Tamale, L., and Ssemakula, E. G., Uganda Local Government Councils Score -Card 2009/10: Political Accountability, Representation and the State of Service Delivery, Kampala, ACODE Policy Research Series, No. 42, 2011.

Naluwairo, R., Promoting Agriculture Sector Growth and Development: A Comparative Analysis of Uganda's Political Party Manifestos (2011 -2016), Kampala, ACODE Policy Research Series, No. 41, 2011.

Lukwago, D., Increasing Agricultural Sector Financing: Why It Matters for Uganda's Socio-Economic Transformation, Kampala, ACODE Policy Research Series No. 40, 2010.

Natamba, E. F., Muyomba-Tamale, L., Ssemakula, E. G., Nimpamya, E., and Asiimire, I., Local Government Councils Performance and the Quality of Service Delivery in Uganda: Ntungamo District Council Score Card 2008/09, Kampala, ACODE Policy Research Series, No. 39, 2010.

Muyomba-Tamale, L., Ssemakula, E. G., Ssempala, D., and Segujja, J,. Local Government Councils Performance and the Quality of Service Delivery in Uganda: Luwero District Council Score Card 2008/09, Kampala, ACODE Policy Research Series, No. 38, 2010.

Muyomba-Tamale, L., and Akena, W., Local Government Councils Performance and the Quality of Service Delivery in Uganda: Amuru District Council Score Card 2008/09, Kampala, ACODE Policy Research Series, No. 37, 2010.

Muyomba-Tamale, L., Owor, A., Kumakech, J., and Rupiny, R. R., Local Government Councils Performance and the Quality of Service Delivery in Uganda: Nebbi District Council Score Card 2008/09, Kampala, ACODE Policy Research Series, No. 36, 2010.

Ssemakula, E. G., Muyomba-Tamale, L., Ekwe-Ocen, B., Ajolu, J., and Ariko, C., Local Government Councils Performance and the Quality of Service Delivery in Uganda: Amuria District Council Score Card 2008/09, Kampala, ACODE Policy Research Series, No. 35, 2010.

Tucungwirwe, F., Ssemakula, E. G., Muyomba-Tamale, L., Merewoma, L. W., and Kahinda, C., Local Government Councils Performance and the Quality of Service Delivery in Uganda: Mbale District Council Score Card 2008/09, Kampala, ACODE Policy Research Series, No. 34, 2010.

Tucungwirwe, F., Ssemakula, E. G., Muyomba-Tamale, L., Merewoma, L. W., and Kahinda, C., Local Government Councils Performance and the Quality of Service Delivery in Uganda: Kamuli District Council Score Card 2008/09, Kampala, ACODE Policy Research Series, No. 33, 2010.

Tumushabe, G., Muyomba-Tamale, L., Ssemakula, E. G., and Lukwago, D., Uganda Local Government Councils Score Card Report 2008/09: A Comparative Analysis of Findings and Recommendations for Action, Kampala, ACODE Policy Research Series, No. 32, 2010.

Tumushabe, G., Mushemeza, E. D., Muyomba-Tamale, L., Lukwago, D., and Ssemakula, E. G., Monitoring and Assessing the Performance of Local Government Councils in Uganda: Background, Methodology and Score Card, Kampala, ACODE Policy Research Series, No. 31, 2010.

Muhwezi, W., W., Bainomugisha, A., Ratemo, F., and Wainnier, G., Crafting an Oil-Revenue Sharing Mechanism for Uganda: A Comparative Analysis, Kampala, ACODE Policy Research Series No. 30, 2009.

Tumushabe, G., Bainomugisha, A., and Mugyenyi, O., Land Tenure, Biodiversity and Post Conflict Transformation in Acholi Sub-Region: Resolving the Property Rights Dilemma, Kampala, ACODE Policy Research Series No. 29, 2009.

Tumushabe, G. W., and Gariyo, Z., Ugandan Taxpayers' Burden: The Financial and Governance Costs of a Bloated Legislature, Kampala, ACODE Policy Research Series, No. 28, 2009.

Tumushabe, G. W., The Anatomy of Public Administration Expenditure in Uganda: The Cost of the Executive and its Implications for Poverty Eradication and Governance, Kampala, ACODE Policy Research Series, No. 27, 2009.

Muhumuza, F., Kutegeka, S., and Wolimbwa, A., Wealth Distribution, Poverty and Timber Governance in Uganda: A Case Study of Budongo Forest Reserve, Kampala, ACODE Policy Research Series, No. 26, 2007.

Kivengere, H., and Kandole, A., Land, Ethnicity and Politics in Kibaale District, Kampala, ACODE Policy Research Series, No.25, 2007.

Nkabahona, A., Kandole, A., and Banura, C., Land Scarcity, Ethnic Marginalisation and Conflict in Uganda: The Case of Kasese District, Kampala, ACODE Policy Research Series, No. 24, 2007.

Bainomugisha, A., Okello, J., and Ngoya, J. B., The Tragedy of Natural Resources Dependent Pastoral Communities: A Case of Teso-Karamoja Border Land Conflict between Katakwi and Moroto Districts, Kampala, ACODE Policy Research Series, No.23, 2007.

Keizire, B. B., and Muhwezi, W. W., The Paradox of Poverty amidst Plenty in the Fish Product Chain in Uganda: The Case of Lake George, Kampala, ACODE Policy Research Series, No. 22, 2006.

Keizire, B. B., and Mugyenyi, O., Mainstreaming Environment and Natural Resources Issues in selected Government Sectors: Status, Considerations and Recommendations, Kampala, ACODE Policy Research Series, No. 21, 2006.

Bainomugisha, A., Kivengyere, H., and Tusasirwe, B., Escaping the Oil Curse and Making Poverty History: A Review of the Oil and Gas Policy and Legal Framework for Uganda, Kampala, ACODE Policy Re-search Series, No. 20, 2006.

Bainomugisha, A., and Mushemeza, E. D., Monitoring Legislative Representation: Environmental Issues in the 7th Parliament of Uganda, Kampala, ACODE Policy Research Series, No. 19, 2006.

Naluwairo, R., and Tabaro, E., Promoting Food Security and Sustainable Agriculture through Facilitated Access to Plant Genetic Resources for Food and Agriculture: Understanding the Multilateral System of Access and Benefit Sharing, Kampala, ACODE Policy Research Series, No.18, 2006.

Tumushabe, G. W., and Musiime, E., Living on the Margins of Life: The Plight of the Batwa Communities of South Western Uganda, Kampala, ACODE Policy Research Series, No.17, 2006.

Banomugisha, A., Political Parties, Political Change and Environmental Governance in Uganda: A Review of Political Parties Manifestos, Kampala, ACODE Policy Research Series, No.16, 2006.

Naluwairo, R., From Concept to Action: The Protection and Promotion of Farmers' Rights in East Africa, Kampala, ACODE Policy Research Series, No.15, 2006.

Mugyenyi, O., and Zeija, F., The East African Customs Union Protocol: An Audit of the Stakeholders' Participation in the Negotiation Process, Kampala, ACODE Policy Research Series, No.14, 2006.

Bainomugisha, A., and Mushemeza, E. D., Deepening Democracy and Enhancing Sustainable Livelihoods in Uganda: An Independent Review of the Performance of Special Interest Groups in Parliament, Kampala, ACODE Policy Research Series, No. 13, 2006.

Tumushabe, G.W., The Theoretical and Legal Foundations of Community-Based Property Rights in East Africa, Kampala, ACODE Policy Research Series, No.12, 2005.

Musiime, E., Keizire, B., and Muwanga, M., Organic Agriculture in Uganda: The Need for a Coherent Policy Framework, Kampala, ACODE Policy Research Series, No. 11, 2005.

Tumushabe, G. W., and Bainomugisha, A., Constitutional Reforms and Environ-mental Legislative Representation in Uganda: A Case Study of Butamira Forest Reserves in Uganda, Kampala, ACODE Policy Research Series, No. 10, 2004.

Kabudi, P. J., Liability and Redress for Damage Caused by the Trans boundary Movement of Living Modified Organisms (LMOs) under the Cartagena Protocol on Bio-safety: A Review of Tanzania Legal System, Kampala, ACODE Policy Research Series, No. 9, 2004.

Kameri-Mbote, P., Towards a Liability and Redress System under the Cartagena Protocol on Biosafety: A Review of the Kenya National Legal System, Kampala, ACODE Policy Re-search Series, No. 8, 2004.

Mugyenyi, O., and Nuwamanya, D., Democratizing EPA Negotiations: Challenges for Enhancing the Role of Non State Actors, Kampala, ACODE Policy Research Series, No.7, 2003.

Mugyenyi, O., and Naluwairo, R., Uganda's Access to the European Union Agricultural Market: Challenges and Opportunities, Kampala, ACODE Policy Research Series, No. 6, 2003.

Tumushabe, G. W., Bainomugisha, A., Makumbi, I., Mwebaza, R., Manyindo, J., and Mwenda, A., Sustainable Development Beyond Rio + 10- Consolidating Environmental Democracy in Uganda Through Access to Justice, Information and Participation, Kampala, ACODE Policy Research Series, No. 5, 2003.

Tumushabe, G. W., Mwebaza, R. and Naluwairo, R., Sustainably Utilizing our National Heritage: Legal Implications of the Proposed Degazettement of Butamira Forest Reserve, Kampala, ACODE Policy Research Series, No.4, 2001.

Tumushabe, G. W., The Precautionary Principle, Biotechnology and Environmental Litigation: Complexities in Litigating New and Emerging Environmental Problems, Kampala, ACODE Policy Research Series, No.3, 2001.

Kameri-Mbote, P., The Operation Environment and Constraints for NGOs in Kenya: Strategies for Good Policy and Practice, Kampala, ACODE Policy Research Series, No. 2, 2000.

Tumushabe, G.W., Bainomugisha, A. and Muhwezi, W. W., Towards Strategic Engagement: Government NGO Relations and the Quest for NGO Law Reform in Uganda, Kampala, ACODE Policy Research Series, No. 1, 2000.