Performance Evaluation of the Uganda Capacity Program

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PERFORMANCE EVALUATION OF USAID/UGANDA CAPACITY PROGRAM

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ACRONYMS

BTC	Belgium Technical Corporation
CAO	Chief Administrative Officer
CPD	Continuing professional development
DHO	District Health Officer
DHP	Development health partner
DHRO	District Health HR Officer
DHT	District Health Teams
DO	Development Objective
DSC	District Service Commission
DSC	District Service Commission
FB-PNFP	Facility-based PNFP
FGD	Focus group discussion
GOU	Government of Uganda
HC	Health center
HMIS	Health management information system
HPC	Health professional council
HRD	Human resource development
HRH	Human resources for health
HRH TWG	Human Resources for Health Technical Working Group
HRIS	Human resource information system
HRM	Human resource management
HSC	Health Services Commission
HSSIP	Health Sector Strategic and Investment Plan
IP	Implementing partner
IR	Intermediate Result
IRIS	Human resource information system
KII	Key informant interview
L&M	Leadership and Management
MOES	Ministry of Education and Sports
MOFPED	Ministry of Finance, Planning and Economic Development
MOGLSD	Ministry of Gender, Labour, and Social Development
MOH	Ministry of Health

MOPS	Ministry of Public Service
NFB-PNFP	Non-facility based PNFP
NGO	Nongovernmental organization
NU-HITES	Northern Uganda Health Integration to Enhance Services
OSH	Occupational safety and health
PBF	Performance-based financing
PI	Performance improvement
PM	Performance management
PMTCT	Prevention of mother-to-child transmission
PNFP	Private not-for-profit
PSC	Public Service Commission
SOW	Scope of work
SUSTAIN	Strengthening Uganda's Systems for Treating AIDS Nationally
TASO	The AIDS Support Organization
UCMB	Uganda Catholic Medical Bureau
UCP	Uganda Capacity Program
UHSSP	Uganda Health Sector Strengthening Project (World Bank)
UMMB	Uganda Muslim Medical Bureau
UOMB	Uganda Orthodox Medical Bureau
UPMB	Uganda Protestant Medical Bureau
WISN	Workload indicators of staffing need
WHO	World Health Organization

EXECUTIVE SUMMARY

BACKGROUND AND METHODOLOGY

IBTCI conducted an evidence-based performance evaluation of the USAID/Uganda Capacity Program (UCP), a $12.5 million, five-year program implemented by lntraHealth International since September 29, 2009, to independently establish the effectiveness of the interventions of the program. UCP focuses on rolling out and bringing to scale human resource for health interventions initiated by the previous Capacity Project to the district level, and consolidating HRH systems to sustain HRH initiatives. The evaluation relied on a mix of qualitative and quantitative methods, including a UCP and country-specific document review, key informant interviews with relevant stakeholders, focus group discussions, and direct observations. A team of four experts, two international and two Ugandan professionals conducted the performance evaluation of UCP between October and December 2013. Evaluators interviewed 104 people, including 49 stakeholders at the central level and 55 key informant interviews in six districts. During district visits, evaluators conducted FGDs with staff at 11 health center IVs.

Four specific questions guided the UCP Performance Evaluation, as stated as in the evaluation's scope of work. The four questions and highlights of the evaluation team's findings are provided below.

FINDINGS

Question 1: How effective has the project been in achieving its Intermediate Result 1: "Increased Capacity for HRH Policy and Planning" by the third year? Are the outcomes expected by September 2014 still valid and achievable, or do they need to be adjusted to reflect realities of the current context?

UCP is on track to achieving targets set by USAID. UCP established the HRIS system in the MOH, MOPS, MOES, national and regional referral hospitals, health professional councils, and medical bureaus (PNFPs). With support from DHPs and IPs, the program advanced district HRIS coverage to 72.3% of the 112 districts; with additional support from the World Bank, 100% coverage will be achieved by the end of 2014. UCP supported the development of a masterful advocacy and lobbying strategy for increasing funding for additional health worker recruitment. As a result, Parliament approved a total allocation of 49.5 billion Ugandan shillings (U.S. $20 million) to recruit over 7,200 additional HC III and HC IV staff in 2012, which the MOH considers to be an unprecedented number of health workers. This is without a doubt a program high point. The evaluation found weaknesses within the operations of the HRH TWG and central-level MOH divisions—especially HRM and HRD—that limited coordination, planning, and implementation of national HRH interventions. The team also found ambivalence among MOH about the task-shifting strategy, which was reflected in UCP's performance on this target.

Question 2: Does performance in the last three years demonstrate an appropriate technical and strategic approach by UCP to performance management and performance improvement in the current context? What interventions are yielding, or have the potential to yield, the greatest impact and what interventions are not, and are there any additional interventions that could be more effective?

In 2012 a UCP assessment of the impact of the performance improvement intervention on selected health outcomes failed to find substantial improvement. On the other hand, most districts that applied performance management interventions reported significant increases in the proportion of staff appraised annually. However, the proportion of staff whose performance appraisal forms are available at the district HQ on time declined, with reports of supervisor shortages and delays in supply of appraisal forms. Other potentially effective interventions include: developing a rewards and sanctions strategy with both non-financial and financial incentives, bearing in mind lessons from the literature that suggests non-financial incentives are stronger motivators than financial incentives; and exploring options for a public-private venture to establish a National Health Leadership, Management and Professional Development Institute.

Question 3: How well has UCP strengthened country ownership and sustainability of their HRH- related interventions, and are there any additional interventions/activities that could enhance country ownership and sustainability?

From the onset, UCP facilitated ownership through dialogue, leadership, and decision making among stakeholders, bringing together government ministries, PFNPs, DHPs, IPs, and others to drive the implementation of interventions. UCP's approach to foster district-level ownership was equally comprehensive, involving district administration, district health teams, and facility-level staff. This generated a high degree of buy-in for many but not all districts. It should be noted that HRIS and HRH recruitment planning and advocacy were the foundation of UCP's strategy and galvanized buy-in and satisfaction at all levels, although PNFPs were concerned that mass recruitment resulted in loss of their staff to the public sector. There are early indications of HRIS sustainability, with reports from UCP that show an estimated 20 districts continue to use HRIS with funds secured from local government grants and other sources.

Question 4.a: How well has UCP strengthened and supported the private not for profit (PNFP) sector?
Question 4.b: How well has UCP supported the work of USAID IPs?

There was minimal focus on PNFPs in the original UCP design. The primary focus was on HRH in public health sector institutions. UCP's current approach engages the PNFP subsector primarily through its umbrella entities (UCMB and UPMB) and provides support to train staff and install HRIS. Both UCMB and UPMB acknowledge that HRIS is a useful intervention that has helped them better understand their staffing levels and gaps and develop short- and long-term HR strategic plans. UCP provided technical support to USAID IPs and PEPFAR-funded projects for health worker recruitment for hospitals, HC IIs, and PNFP facilities as part of efforts to scale up HIV/AIDS services. UCP developed staff recruitment guidelines, adapted salary and benefits to PEPFAR-funded projects to recruit more than 1,200 PEPFAR staff, conducted planning meetings with district stakeholders, and trained IP staff in using a computer-aided shortlisting tool. UCP leveraged support from USAID IPs to provide training and fund installation of HRIS in additional districts and develop refresher training for HRIS data managers and users.

CONCLUSIONS

The UCP Program is an ambitious venture that effectively increased national and district HRH policy and planning capacity, galvanized a wide range of stakeholders from the public and private sectors and the donor community to collaborate in rolling out new HRH systems and policies nationally. Together, UCP and MOH mounted an outstanding advocacy and lobbying effort to address a well-documented shortage of health workers in the country, resulting in allocation of substantial funding to recruit and deploy more than 7,000 health workers across the country, and contributing considerably to reducing national health worker shortages. Evaluators agree with MOH officials, that while the program made great strides, the capacity at central and district levels to manage, coordinate, and sustain HRH policy and planning is still not optimal, due in part to structural and motivational issues. Some central-level managers and district level units lack the necessary capacity to use and sustain the HRIS system for planning, decision making, and reporting due to structural and motivational issues. Performance management fits well within the UCP's HRH strategic focus and was an identified priority by stakeholders. Overall, GOU is now in a better position to lead, prioritize HRH issues, and but independent implementation, performance and accountability with regards to key interventions are still variable.

RECOMMENDATIONS

At the Technical Level (USAID and UCP)

- Review, reduce and rationalize the intervention mix to focus on those most essential to reinforce the capacity of MOH and districts to lead, prioritize, monitor, and be accountable for national HRH functions
- Expand use of the extensive HRIS data to advance workforce analyses and projections to include but not be limited to analysis of disaggregated data to advance health workforce planning.

At the Policy Level (USAID and GOU)

- Enhance engagement of multiple stakeholders, and create strategic alliances, including public-private partnerships with non-traditional partners such as businesses and electrical and Internet companies to strengthen sustainability of HRIS.

- Reinvigorate stakeholder ownership to review, strengthen, and upgrade pre-service nursing and midwifery education to ensure that the country produces the number and quality of nurses and midwives needed to meet national health priorities, especially reduced maternal mortality.
- Negotiate a plan between GOU, multilateral stakeholders, and the private sector to continue to strengthen HRH policy, planning, systems development, and continuity with clearly defined activities and dates for a full hand over of all functions to the government, and explore opportunities to setting up a public-private venture for establishing a National Health Leadership, Management and Professional Development Institute.

I. EVALUATION PURPOSE AND EVALUATION QUESTIONS

1.1 EVALUATION PURPOSE

IBTCI conducted an evidence-based performance evaluation of the USAID/Uganda Capacity Program (UCP) implemented by lntraHealth International. The UCP Performance Evaluation provided an opportunity to independently establish the effectiveness of UCP interventions, documenting those that have worked well and those that have not. The evaluation team shared its initial findings within the Mission and with the implementing partner (IP). The evaluation report will be used to analyze current approaches and the UCP work plan, and will form the basis for subsequent planning meetings between USAID, the Ministry of Health (MOH), and lntraHealth to incorporate lessons learned and recommendations for improvement. UCP will share the final report with the Uganda Human Resource for Health Technical Working Group (HRH TWG) and other relevant stakeholders, including development partners.

1.2 EVALUATION QUESTIONS

Four questions guided the UCP Performance Evaluation, as stated in the evaluation's scope of work (SOW):

1.a. How effective has the project been in achieving its Intermediate Result 1: "Increased Capacity for HRH Policy and Planning" by the third year?
1.b. Are the outcomes expected by September 2014 still valid and achievable, or do they need to be adjusted to reflect realities of the current context?

2.a. Does performance in the last three years demonstrate an appropriate technical and strategic approach by UCP to performance management and performance improvement in the current context?
2.b. What interventions are yielding, or have the potential to yield, the greatest impact and what interventions are not, and are there any additional interventions that could be more effective?

3. How well has UCP strengthened country ownership and sustainability of their HRH- related interventions, and are there any additional interventions/activities that could enhance country ownership and sustainability?

4.a. How well has UCP strengthened and supported the private not-for-profit (PNFP) sector?
4.b. How well has UCP supported the work of other USAID Health and HIV/AIDS implementing partners, and are there any additional interventions/activities that could have strengthened the PNFP sector more effectively?

Audience: The aim of this performance evaluation was to provide USAID/Uganda, the Government of Uganda (GOU), and other in-country stakeholders with objective information on what has been achieved to date, what is and is not working, and why, with recommendations for short-term program modifications and recommendations for longer-term strategic planning and future programming.

II. PROGRAM BACKGROUND

While the inception report provides a detailed background of the status of human resources for health (HRH) in Uganda and a full description of the Uganda Capacity Project, a summary of key points follows:

Uganda is one of the 57 countries identified by World Health Organization (WHO) with critical human resources for health (HRH) shortages, characterized by inadequacy in the number and skill mix of the health workforce, low retention and motivation, and poor performance. Although the number of health workers has increased in the last

several years, recent estimates show that it remains low compared to the WHO Minimum Standard. In addition, there are noted disparities in the distribution by type of health worker and by geography (i.e., inadequate numbers of health workers in hard-to-serve populations). High absenteeism rates negatively impact the productivity of available staff.

UCP is a $12.5 million five-year program awarded to IntraHealth International that began on September 29, 2009. The program's focus is on rolling out HRH interventions initiated by the previous Capacity Project to the district level and consolidating HRH systems to sustain HRH initiatives.

The program's activities are implemented in accordance with health sector HRH priorities, as determined by the GOU and MOH, in collaboration with a broad array of key stakeholders including: the Ministry of Public Service (MOPS), Ministry of Education and Sports (MOES), Health Services Commission (HSC), Public Service Commission (PSC), District Service Commissions (DSC), local governments, medical bureaus, health professional councils (HPCs), development health partners (DHPs), USAID IPs, and nongovernmental organizations (NGOs). UCP is currently in its fifth year of implementation.

UCP supports the operationalization of the HRH Policy and Strategic Plan and other HRH interventions that need to be rolled out and scaled up to achieve the goals and objectives of the Health Sector Strategic Plan III (2010/11). UCP aims to strengthen human resources for the delivery of health and HIV/AIDS services. It contributes to USAID/Uganda's Country Development Strategy Development Objective (DO) 3: "Improved Health and Nutritional Status in Focus Areas and Population Groups," as well as several Intermediate Results (IRs) and sub-IRs that constitute DO 3. Some of these include: IR 3.1: More effective use of sustainable health services; IR 3.1.2: Improved quality of health services; IR 3.1.3: Increased availability of health services; IR 3.1.4: Increased accessibility of health services; IR 3.1.2.1: Increased availability of resources for health care; IR 3.1.3.1: Enhanced enabling environment for health care; and IR 3.1.4.1: Improved organization and management.

III. EVALUATION METHODS AND LIMITATIONS

A team of four experts, comprised of two international and two Ugandan professionals, conducted the UCP performance evaluation: Dr. Rosemary Barber-Madden, Team Leader, Mr. William Kiarie, an international HRH expert, Dr. Paul Bukuluki, and Ms. Constance Shumba, whose responsibilities are outlined in the Inception Report (Annex II). The project was directed by Dr Rachel Jean-Baptiste. The team conducted the evaluation between October and December 2013, submitting an initial Inception Report to USAID/Uganda on October 19, 2013, and a second draft with methodological and timeline changes on November 14, 2013. A change in international team members caused a short delay in data collection. While IBTCI's rapid deployment of new team members ensured a smooth transition, it required that each team member carry out the remaining interviews and district visits individually rather than in sub-teams.

This performance evaluation used a mix of qualitative and quantitative methods including a UCP and country-specific document review, key informant interviews with relevant stakeholders, focus group discussions (FGDs), and direct observations. Evaluators interviewed 104 people. At the central level, evaluators interviewed 49 stakeholders including government officials, academic and civil society representatives, health professional councils, donors, and USAID implementing partners. The team interviewed an additional 55 key informants during visits to six districts—Mityana, Kabarole, Namutumba, Dokolo, Mbale, and Nakasongola—selected based on receipt of six or more UCP interventions, UCP district performance ratings, and geographical distribution. During district visits, evaluators conducted FGDs with staff at 11 Health Center (HC) IVs. The team categorized qualitative data by the key themes, defined in six domains in the evaluation methodology. Key informant quotations in the Findings section of this evaluation illustrate different opinions and points of view across informant groups. The team used multivariate linear regression to assess the impact of UCP district interventions on recruitment and efficiency, and carried out a trend analysis of health management information system (HMIS) data to evaluate preliminary impact of national recruitment on the use of selected health services.

3.1 EVALUATION LIMITATIONS

The evaluation team identified the following study limitations:

Unavailable and Incomplete Data: The team relied on quantitative data from UCP performance and monitoring plans but was unable to validate information from other reliable quantitative sources. The team used qualitative means to obtain additional insight, but this was not always possible.

Inadequate Disaggregation of Data: HRH data in most reports, including the Biannual HRH Reports and Annual Health Sector Reports, were inadequately disaggregated by gender and other variables. The evaluation team therefore found it difficult to discern trends in the gender composition of the health workforce or to define the impact of UCP interventions on gender equity. Another example of a missed opportunity is staff recruited during the 2012 national recruitment were not disaggregated by previous employment history. As a result, the team could not quantify the extent of the reported movement of health workers from the PNFP to the public sector.

Study Design Limitations: The study was not designed to determine the impact of UCP interventions, as the team did not have access to intervention and control districts for comparison. Because selection of participating districts was not done at random, the evaluation's findings cannot be generalized. Instead, the team focused on ensuring the validity of results by including most or all stakeholder groups in data collection and posing questions from multiple angles.

IV. FINDINGS

Question 1.a: How effective has the project been in achieving its Intermediate Result 1: "Increased Capacity for HRH Policy and Planning" by the third year? Are the outcomes expected by September 2014 still valid and achievable, or do they need to be adjusted to reflect realities of the current context?

> Definition of capacity: "*The relevant development of knowledge, skills, and attitudes in individuals and groups of people and ability to implement design, development, management, and maintenance of institutional and operational infrastructures and processes that are locally meaningful.*"
> Source: Adapted from the World Bank

4.1 OVERALL PROGRAM FOCUS AND SCOPE

As in many countries in Africa, the planning, training, deployment, and management of the health workforce processes are highly fragmented in Uganda. Several agencies, ministries, and government departments have different HRH roles that are not always well defined and are often poorly coordinated. The constitutionally mandated decentralization of service delivery further compounds this situation. In order to increase capacity for HRH policy and planning, UCP developed its interventions considering these complexities. The program's interventions span the multiplicity of players at the central level, including the MOH, MOPS, MOES, Ministry of Finance, Planning and Economic Development (MOFPED), Ministry of Gender, Labor, and Social Development (MOGLSD), HSC, HPCs, DHPs, and USAID IPs. At the district level, the program reached 112 districts, including the DSC, Chief Administrative Officers (CAOs), District Health HR Officers (DHROs), District Health Teams (DHTs), and public and PNFP health facilities, and training institutions, as outlined in the section above. Overall, UCP navigated this complex landscape without losing focus on the critical goals. UCP became the "clearing house" for HRH ideas and data in Uganda. The UCP team did an excellent job of supporting, mobilizing, and aligning partnerships for HRH initiatives. This allowed the program to leverage its financial resources and technical capacity and helped minimize duplication. The program established good relations with district-level administration, especially CAOs, DHROs, District Health Officers (DHOs), and DSC secretaries and members. This was a critical element of the program, since district officers maintain responsibility for the management of all civil service functions across sectors.

4.2 CAPACITY TO USE HRIS

Since 2009, UCP and MOH and their partners established the human resource information system (HRIS) in the MOH, MOPS, and MOES in 81 districts (72.3% of the 112 districts); two national and 13 regional referral hospitals; four health professional councils; and in the private sector (PNFP). UCP provided staff training, and assisted with the

installation, set up, management, and use of HRIS, and assisted in uploading data onto the system. MOH officials emphasized that establishing the HRIS and making the data available "*was a huge success, contributing to improving monitoring of HRH indicators in the HSSIP."* Other MOH managers highlighted the need to train more people to use HRIS, since "*MOH still relies on UCP and a few MOH staff with expertise*." UCP also provided support to MOH in human resource development (HRD) by building an in-service training database to track information on numbers of health workers completing in-service training/continuing professional development (CPD) by type, time period, and implementer.

MOES officials emphasized that by providing data on the current health workforce supply and existing training capacity, the pre-service training database enables a more rational use of training capacity. MOPS officials noted that a major benefit is that the HRIS provides data on health workers by health facility rather than by district, as had been the former reporting practice. This allows for more insightful and flexible decision making on staff deployment and reassignment.

One of the major interventions that UCP has undertaken in the past four years has been the development and roll-out of a comprehensive HRIS at the central and district levels. The evaluation team found that UCP had largely succeeded in introducing a comprehensive HRIS that covers a wide range of health sector employers and regulators, including central-level ministries, national and regional referral hospitals, districts, PNFPs, and HPCs. The program extended HRIS to 49 districts and leveraged additional funds and technical support from DHPs and IPs to cover 81 districts. With proposed financial and technical support from the World Bank, all districts will have HRIS access by the end of 2014. CAOs, PPOs, and DHTs reported that HRIS installation has allowed districts to capture information for health workers including recruitment, training, promotion, and exit management; it assists in identifying attrition and filling gaps, and generates reports on facility-level staffing needs. One DHO reported, "*HRIS is very easy to track and update. We are linking it to payroll.*" (Dokolo); while another related, "*We have issued warning letters to those not registered.*" (Mbale). The national referral hospital, Mulago, employs nearly 2,500 staff. With HRIS, it has now gone from a laborious manual management system to one in which "*data now informs hospital recruitment plans, succession-planning, permitting a mentoring process for managerial positions, new recruits or transfer-ins with data entered on a daily basis.*" (Key informant interview [KII] with staff from Mulago Hospital).

In addition to developing HRIS, the evaluation team found that UCP has succeeded in enhancing the capacity of organizations to update and share data. Virtually all key informants highlighted HRIS and the 2012 national health worker recruitment as the two major UCP achievements. Uganda now leads the region in terms of possessing a comprehensive HRIS that is available at both the national and sub-national level. The team found that HRIS uses providing the greatest impact include the following:

- Many districts are using the HRIS for all public service employees, not just health workers. Districts reported that having all staff in one system allows for greater responsiveness in making a wide range of HR decisions, including making projections for staff due to retire and advocating for additional staff.
- Some of the districts reported that they used the HRIS to eliminate "ghost workers" by using HRIS data to validate the payroll database, helping save money.
- The new HRIS module iHRIS Train is being used to support in-service training. The module will be invaluable in tracking health worker training and linking it to the registration of health professionals; it will also provide valuable support for health worker recruitment and promotion.
- The HRIS website and health professional council website have been very useful in strengthening regulation and health worker recruitment. Employers can easily verify the registration status of job applicants through the website. Members of the public can also verify if health providers are registered with health professional bodies by using an innovation SMS service.
- The HRIS provided invaluable information for the advocacy effort that led to the 2012 national recruitment.

Health professional councils were the most dedicated HRIS users and have fully integrated the HRIS into their business processes. HPCs reported a large increase in both the number of health professionals registered and revenue generated due to the fact that their databases now accessible to employers and the public. They underscored that "*HRIS brought in new data to the office, we now have knowledge of numbers of people who need to be licensed.*" The HPC HRIS is linked with MOH HRIS, facilitating regular updates to the MOH central HRIS database.

A negative HRIS finding was the lapse of Internet subscriptions in most districts after UCP stopped paying for Internet service. The evaluation team found HRIS usage had decreased considerably, given that data sharing—even within districts—is constrained by a lack of Internet access. The lack of Internet connectivity has also meant that central-level databases are not updated in real time as districts make changes to HRIS databases. The evaluation team found that while usage of HRIS data for decision making was quite high in most districts, it was low at the central level at the MOH, MOES, and MOPS.

HRH Planning and Budgeting: The district-planning process covers recruitment, in-service training, and other HRH interventions. In conjunction with partners, with UCP support, districts are now capable of HRH planning and have integrated this process into district-planning cycles. Many have developed multiyear, rolling, and costed HRH plans. The districts' HRH plans have provided valuable support for advocating for the recruitment of additional health workers.

Health Worker Recruitment: UCP supported the development of a masterful advocacy and lobbying strategy for increasing funding for additional health worker recruitment. As a result, Parliament approved a total allocation from the GOU of 49.5 billion shillings (U.S. $20 million) for recruiting more than 7,211 additional HC III and HCI V staff in 2012. UCP worked with MOFPED and the PSC to design a streamlined recruitment process. While the recruitment represents a significant increase in government support, the MOH reports that the national average of 8% GOU support for the health sector still falls short of the Health Sector Strategic and Investment Plan (HSSIP) target of 10% and the Abuja target of 15%.[4]

Without doubt, a major result of UCP's efforts to increase capacity for HRH can be seen in the recruitment and contracting of an unprecedented large number of health workers for HCs III and IV. As substantiated by the Permanent Secretary of the MOH, the GOU engaged UCP at all stages of this process, making good use of specific approaches that the project promotes, including developing staffing projections, lobbying key policy makers and Parliament, running joint advertisements, and promoting the use of a computer-aided shortlisting tool. UCP provided extensive support beyond the recruitment process as well, including assisting with new staff induction, ensuring that staff were entered into the payroll swiftly, and tracking the progress of individual districts.

> *"We were recruiting approximately 1,000 to 1,500 staff annually. We would not have been able to recruit over 7,000 new staff in such a short term without the support of UCP. They were involved at all levels of the exercise:*
> - *Creating projections and staffing gaps, advocating for resources, advertising, short-listing, recruitment, induction and ensuring employee data was entered into the payroll system without undue delays*
> - *Developing systems and building the capacity to recruit staff at the district level, reducing rampant abuse prevalent in the recruitment of health workers for many years.*
>
> *The results were 50,000 applicants for the advertised positions and 30,000 shortlisted. UCP took the big lead, generated inventory and captured the status of each district. The system was able to come up with solid numbers. The system was able to recruit about 7,000 and about 4,000 are already on the payroll. The Civil Service Commission did not have a system and did not fill posts."*
>
> Permanent Secretary, MOH

All district-level respondents in the six districts visited, including CAOs, DHOs, and DHROs and DSC secretaries, were full of praise regarding the role UCP has played in this recruitment. As one District Human Resources Officer stressed, *"T*he biggest achievement is *i*n lobbying and advocacy in relation to recruitment and the wage bill. Previously recruitment was a challenge but when UCP came up, recruitment plans were made and this led to adjustments to the conditional wage bill. We were able to recruit 200 health workers in Kabarole district." The recent recruitment also led to improvements in under-served districts that have the highest staffing levels, as shown in Table 1. Of the 15 districts with the lowest staffing levels in 2011, more than half increased staffing levels; five districts moved beyond the 50% staffing threshold that UCP uses to categorize hard-to-reach districts (see Annex VI for maps showing changes in staffing levels in 2013 for the 15 districts with the lowest staffing levels in 2009). It is also noteworthy that the majority of recruited staff were at the primary health levels of HC IV and below, where most ambulatory care is provided.

Table 1: Improvement in District-level Staffing

Facility	Total Posts Required	Posts Filled 2009	Posts Filled 2013	No. of Additional Staff	% Increase in No. of Staff (2013 Over 2009)	Filled Positions 2009 (%)	Filled Positions 2013 (%)
General Hospital	7980	3990	4842	852	21	50	61
HC IV	8112	4462	5731	1269	28	55	71
HC III	17214	7918	12070	4152	52	46	70
HC II	14364	5171	6428	1257	24	36	45
Total	**47670**	**21541**	**29071**	**7530**	**35**	**45**	**61**

Source: UCP Data

According to the Health Service Commissioner, *"The massive recruitment not only increased staffing but it also opened room to be promoted for many workers who had stagnated in one position. Funding was made available for all positions; this has had a major impact on staff motivation. Also there had been health workers trained by partners to stem the staffing gaps in underserved districts. Many of these staff had completed training and had signed bonding papers but could not be absorbed as there was no funding for positions. This recruitment exercise allowed most of these to be absorbed."*

However there were areas where UCP was less successful. The MOH established the HRH Technical Working Group to guide national multisectoral coordination of HRH policy development and planning. Several stakeholders reported that UCP had not been successful in developing the HRH TWG into a truly functional body able to independently implement HRH-related infrastructure, policy, and processes for Uganda. From their reports, the HRH TWG has not met for nearly a year. Several stakeholders also reported that central-level MOH divisions, especially the Human Resources Management (HRM) and Human Resources Development (HRD) Divisions, were not adequately executing their coordination and advisory roles. MOH officials and other key informants noted that the structures of these divisions had not been reviewed for years despite major national changes such as decentralization and the transfer of health training schools from the MOH to the Ministry of Education and Sports.

Task Shifting Strategy: UCP made less progress operationalizing this intervention, due in large part to the reasons voiced by MOH officials and managers, which differ from stakeholder points of view. As one MOH manager stated, *"MOH doesn't believe task shifting is necessary. It is only for countries with large shortages of health workers, instead concentrate on the efficient use of current HRH resources. It's better to do specialization rather than task-shifting with proper preparation; special training is needed for clinical officers."* At the same time, one DHP representative noted, *"MOH has a lukewarm attitude, but task shifting is already ongoing, family members and patients are taking care of patients in hospital."*

The project supported a study to document existing task-shifting practices in the country and developed policy options on task shifting during its first two years. Without MOH support, the project was constrained to move forward. A senior MOH official discussed the issue with the evaluation team, emphasizing, *"We need UCP to make a proposal, define issues, propose strategies and arrangements, and define what other sectors need to be on board, and forecast roles. UCP's role should be to help the country customize task shifting to fit the Uganda context."* UCP may need to re-evaluate the role of task shifting as an official MOH practice for HRH development in Uganda.

While capacity has been largely built successfully for HRIS, the PNFPs noted several challenges. In particular, UCMB emphasized *"HRIS is rather sustainable but we would like it upgraded to aggregate all reports—more needs in HRIS will keep coming. It was strategic for MOH because they did not have data on HR for PNFPs."* Another PNFP, namely the UMMB, reported that although UCP trained staff on HRIS use, it lacked the server and software. As Internet access is paramount to success of this intervention, respondents noted the challenges to maintaining gains once UCP support for Internet access comes to an end. Some district-level officials say they will use paper-based files and Excel spreadsheets to maintain HRH files (Nakasongola), while others intend to use local government funds to continue Internet access (Mbale).

Question 1.b. Are the outcomes expected by September 2014 still valid and achievable, or do they need to be adjusted to reflect realities of the current context?

The evaluation team's response to this question is directed solely to assessing the achievability of IR 1 interventions. Overall, IR 1 interventions were on course to achieving program targets set for September 2014, with the exception of the task-shifting strategy, as discussed above. UCP appeared to duplicate some PMP indicators, such as: "Percent of supported districts using HRIS data for decision making," "Percent of targeted districts with functional HRIS databases," "Existence of national (Health Professional Council) databases that enable stakeholders to access relevant data for policy formulation and program management and improvement," and "Percent of districts with HR managers that have access to Health Professional Council databases." The team also found that UCP is measuring efforts by means of output indicators, rather than by outcomes or impact, which would optimize intervention design, support advocacy, and eventually help USAID better understand the impact of its investment in HRH through UCP.

The team also found that UCP did not disaggregate program achievements although HRIS data can be disaggregated. Analysis of data from the recent national recruitment, including by gender, age cohort, percent of new recruits posted to underserved districts, and employment history, could have provided useful insights and possibly enable UCP and the MOH to produce a series of projections for the health workforce. Further, UCP did not present data on the proportion of newly recruited staff who joined the public sector from the PNFP sector. Yet PNFPs reported having lost a significant number of staff to the public sector during the national recruitment. It is important for the MOH to understand whether or not a sizeable proportion of new recruits came from the PNFP, since that could impact the quality of services provided by the PNFP who serve nearly half of Ugandans. It would also mean that the actual increase in new health workers is less than current thinking.

UCP expended considerable effort in developing HRIS systems and putting them in place nationally. Stakeholders at all levels underscored the importance of these databases for planning and monitoring. While evaluators found this to be one of the program's most important interventions, the team also identified vital constraints hampering mid- to long-term maintenance of the HRIS system, including access to Internet and electricity that require considerable attention in the program's fifth year. UCP efforts to strengthen and reinforce MOH and district capacity are critical to ensuring that capacity is firmly in place by the end of 2014. UCP should continue mentoring and providing technical support via email and phone, knowledge management port, Google Groups, and other mechanisms designed to assist with HRIS management and use.

Other efforts to expand HRIS system development and national use are equally important. UCP has proposed realistic strategies for leveraging advocacy with IPs and DHPs to increase HRH budgets and improve communication and collaboration between HR managers and HPCs. In addition, UCP has efforts firmly in place to support districts in putting HRH policy into practice; its continued support for consolidating district capacity to develop and use costed annual HRH plans are essential for ensuring that these processes are institutionalized. It is essential for UCP continues its work with the MOH to develop and roll out the three-year recruitment plan, with an emphasis on addressing shortages in health worker cadres. The evaluation team agrees that UCP should continue its support to the MOH to advocate at the national level, including with Parliament.

Several stakeholders, both governmental (including all MOH interviewees) and non-governmental, emphasized the MOH's considerable dependence on UCP for such efforts. Continued "handholding" will compromise efforts to strengthen ownership and sustainability; as a result, the evaluators urge UCP to re-double its efforts to turn over key HRH functions to the MOH early in Year 5. This may require considerable advocacy with the MOH and districts to ensure the continuity of trained staff, availability of adequate equipment, and Internet access. Evaluators agree with UCP's assessment that there was no significant MOH buy-in for task shifting over the life of the project, despite concerted program efforts, and that priority should be given to other interventions. Finally, the evaluation team noted that UCP developed and carried out a broad range of interventions to achieve IR 1 results spanning a multiplicity of players at the central and district levels. Moving forward, UCP should focus its efforts to ensure that the main interventions are embedded within national structures in this final year of the program.

Question 2. Does performance in the last three years demonstrate an appropriate technical and strategic approach by UCP to performance management and performance improvement in the current context? What interventions are yielding, or have the potential to yield, the greatest impact and what interventions are not, and are there any additional interventions that could be more effective?

UCP implemented both performance improvement (PI) and performance management (PM) interventions in the beginning, but later PI was integrated into the PM model, discussed in this section.

Performance Improvement: According to UCP documents, the goal of the performance improvement (PI) initiative is *"To improve provision of high quality sustainable health services and hence contribute to improved health outcomes."* The objective is to "*Contribute to improving the quality of health care through targeted interventions that address performance-related gaps associated with health service quality."* UCP developed its approach around five key PI steps: describe the desired and actual performance, identify gaps between desired and actual performance, identify the root causes of the gaps, develop and implement interventions to fill the gaps, and measure changes in performance through monitoring and evaluation.

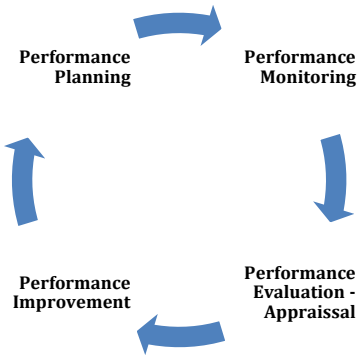
UCP introduced PI in 16 districts. The intervention aimed to strengthen supervision of health services with a focus on prevention of mother-to-child transmission (PMTCT) and reproductive health. The UCP's PI effort made use of existing MOH health clinical standards and protocols.

Performance Management: Beginning in 2007, MOPS developed an integrated performance management framework aimed at optimizing organizational and individual performance in the civil service. One of the areas addressed in the framework is the performance appraisal process. The goal of UCP's performance management (PM) initiative is "*to improve performance in the health sector by enhancing the management of individuals' performance"* while the general objective is *"to provide technical support to health managers in the Ministry of Health, National Referral Hospitals, Regional Referral Hospitals, districts, and health facilities to enable them to systematically manage performance of their staff for improved performance of their institutions and hence the health sector."* UCP established the following specific objectives for the performance management intervention:

- Equip health managers with skills and knowledge to manage performance of their staff
- Provide health managers with performance management tools
- Provide technical support to health managers to be able to implement performance management

UCP uses the classical performance management cycle, shown below in Figure 1, with performance improvement in the figure referring to the identification of knowledge gaps and training support needs for staff, as opposed to the above definition of PI:

Figure 1: Performance Management Cycle



UCP first introduced PI and later introduced PM, working with 15 districts. The initiatives were implemented under two separate UCP Intermediate Results and by different program managers. UCP reported that this created confusion, especially at the district level. Results of the program's assessment suggested that the two interventions would be best implemented as a single intervention, leading to the integration of the two approaches. Now part of PM, the UCP **team uses district or hospital plans to** identify the desired and actual performance of the facility, document gaps, and develop individual performance improvement plans geared to addressing the identified gaps. They use PI-type indicators to guide staff in setting their individual performance appraisal targets.

UCP's Performance Indicative of Technical and Strategic Approach to Performance Improvement and Performance Management Interventions

Performance Improvement

The approach adopted by UCP for PI is technically sound and was developed based on internationally recognized performance improvement approaches and frameworks. However, PI focuses on improving the clinical performance of healthcare workers; in Uganda, HSSIP prioritizes improving the clinical performance of health workers as a clinical and service delivery intervention, not as a management or HRH issue. This is illustrated in the strategies and interventions defined in the HSSIP "*Objective 3 - Accelerate Quality and Safety improvements."* The strategy is to build the capacity of health workers to improve the quality of service delivery at all levels of the health system, with activities that include planning, self-assessment, and continual monitoring and evaluation of clinical performance with participation of both internal and external clients and all healthcare providers. There are plans to provide an incentive scheme for health facilities that conform to standards of quality of care. This is largely considered to be quality improvement, an activity already supported by other USAID investments within the same district that UCP operates. At the request of USAID, UCP undertook a study in 2012 to evaluate the impact of the PI initiative on selected health outcomes. The main findings was that there were no substantial improvements resulting from the PI intervention. Evaluators therefore concluded that the fit between this intervention and UCP's program goal and objective was tenuous, and that PI was not a strong technical or strategic intervention for HRH at this time.

Performance Management

The PM concept implemented by UCP is technically sound and is clearly anchored in the HSSIP and the MOPS integrated performance management framework. The program's support has several components, including the development of manuals, training, and distribution of performance-appraisal tools that help establish guiding principles for PM. Respondents interviewed at the facility and district levels had high praise for PM. The sentiment was well summarized by an In-charge at HC III in the Mbale district: "*PM helped the HR and me and our clinical staff trained the others, including managers on key result areas and outputs. Recently, I appraised new staff and the PM tools helped me a lot. I compared what I did this time and what I had done previously and there was a big difference. If you go by their plan, staff cannot say you are biased. It helps in transparency and objectivity, but PM has too much paper work."* In Namutumba district, evaluators were told, *"The most helpful intervention has been PM for staff at health facility level and now staff embrace it. PM had been looked at as an obligation or only for promotion or confirmation but now it is seen as a way of agreeing on targets and a means to an objective assessment*." (KII with a PPO)

Participants reported that the use of PM tools has made performance appraisal more objective, and that the PM intervention "*improved communication between health managers and staff*." District managers also reported that "*performance appraisal results are being used to make personnel decisions such as confirmation of new staff, staff training, and promotion*." During district visits, evaluators heard reports indicating improvement in staff uptake and completion of performance appraisal: *"People used to wait until they are supposed to be confirmed or promoted to fill the appraisal forms, but now it is done annually and objectively."* (Kabarole)

Overall, most districts reported that the proportion of staff appraised annually has risen significantly and currently stands at above 90%. However, the proportion of staff whose performance appraisal forms are available at the district HQ on time as per the MOPS calendar declined from 56% in 2011/12 to 26% in 2012/13. The difference between the proportion of staff appraised and proportion of staff whose appraisals reach the district headquarters on time was attributed to a shortage of supervisors and to delays in the supply of appraisal forms, leading to appraisals not being conducted as per the set calendar. Respondents reported that the performance management initiative has improved staff performance and has contributed to better facility performance in terms of coverage and quality of services. However, there has been no assessment to show if this is indeed the case. An assessment of the number and types of staff decisions made on the basis of performance appraisal data would provide a clearer picture. To move toward broader effective implementation of PM, UCP will need to work with the health sector to strengthen PM and provide more support at the district level to ensure adequate implementation and monitoring.

UCP is working on a number of initiatives that have the potential to improve the performance of the health workforce. An example is the support UCP has provided to PEPFAR IPs to improve the recruitment and

management of linkage facilitators (health facility and community-based volunteers) by developing job descriptions and standardizing remuneration.

Evaluators found evidence that district managers are engaged in PM activities, but overall found only limited evidence on the impact of the PM approaches and improvements developed by UCP. For example, basic issues such as lack of paper and pens, challenges commonly found in Africa, were reported to be an obstacle to timely completion and submission of staff appraisals. Lack of public sector capacity to utilize the output of the appraisal process for decision making due to a shortage of trained human resources staff and staff turnover was also reported. Another obstacle is the inability of managers to hold subordinates accountable for their performance and to reward excellence. The team heard reports that the "appraisal process became an annual ritual, that is an end in itself." These challenges are not uncommon around the region and require innovation. Nevertheless, findings from the field led the evaluation team to conclude that PM is both technically and strategically important to HRH and to UCP's performance in Uganda.

Question 2. b. What interventions are yielding, or have the potential to yield, the greatest impact and what interventions are not, and are there any additional interventions that could be more effective?

As discussed above, the approach taken by UCP is firmly based on internationally recognized practices. It is solidly grounded on the HSSIP strategy and on MOPS policies and guidelines. The evaluation team found that the PM intervention is yielding results, but cautions that results from 15 districts should be reviewed quantitatively before plans for national expansion and rollout are developed. The main PM intervention discussed with the evaluation team was performance appraisal, and this is yielding positive results. District-level managers and PNFP stakeholders expressed an interest in advanced PM that would strengthen supervision, make appraisals more objective and fair, and strengthen staff coaching and supervision. DHOs from districts that had not received PM training and intervention reported interest in introducing it. One DHO told the team, "*We participated in a meeting on PM, but are still waiting for the training and tools.*"

Evaluators found that while the approach to PI adopted by UCP is technically sound, PI adds only marginal value to an HRH project of this magnitude. If pursued in the future, UCP's role in PI should be limited to human resources dimensions, such as identifying and addressing gaps in skills and knowledge that contribute to poor quality of healthcare.

Additional Interventions for Improving and Strengthening Performance Management

In this section, the team suggests a set of interventions that will build on PM accomplishments thus far, and improve, strengthen and innovate future programming, based on review of progress to date, a review of the literature, and our experience with similar programs in the region.

1. Improve the existing performance management initiative

UCP should consider conducting periodic surveys focusing on indicators such as employee satisfaction and achievement of individual and institutional goals to assess if the performance management initiative indeed results in better individual, team, and organizational performance. Data and insights gathered from this exercise could be used to adjust PM strategies already in use. UCP may also consider including PM within the HRIS, and could pilot the use of online performance appraisal, especially for regional and referral hospitals. This may help alleviate constraints due to paper and other materials that sometimes interfere with timely completion of performance appraisals and data transfer to the district and higher levels. Additionally, significant opportunities exist for UCP to further build the capacity of health facilities and districts to make greater use of performance appraisal output to support training, rewards, and sanctions (discussed in more detail below).

2. Expand leadership and management training

While districts found great value in the leadership and management training that UCP offers, evaluators found its reach—and hence its potential for effectiveness—to be limited. UCP could consider offering training to a much wider pool of health managers at the central and district levels, emphasizing development of local ownership and sustainability, strengthening the capacity of health managers to mobilize resources, developing a more proactive management culture, and strengthening teamwork. The team urges USAID to consider developing a health leadership professionalization program, as described in greater detail below.

3. Promote professionalization of health leadership

Most health leadership positions are not formally established in many countries in Africa. As a result there is no clear career path for health leaders, job descriptions and competencies are poorly defined, remuneration and benefits are unattractive, and key leadership positions are dominated by doctors who lack management skills and are more needed in service delivery and research. As previously noted, the team urges USAID to consider developing a health leadership professionalization program, either through outsourcing via sub-contracting or other mechanism with an internationally recognized public or private institution/organization specialized in health leadership development in partnership with a national institution. This may require a public-private venture to generate the resources needed to sustain the initiative.

4. Explore the introduction of rewards and sanctions to improve health worker and manager performance

Experience and evidence suggest that a comprehensive strategy to maximize health worker motivation in developing countries requires a mix of financial and non-financial incentives. In a study of doctor and nurse motivation in public and NGO facilities in Benin and Kenya, health workers were strongly guided by their professional conscience and similar aspects related to professional ethos. In fact, health workers in the study reported demotivation and frustration because they were unable to satisfy their "*professional conscience*" and felt *"impeded in pursuing their vocation*" due to lack of means and supplies and inadequate or inappropriately applied human resources management (HRM) tools (Mathaur et al. 2006). The authors highlighted that instituting non-financial measures first requires acknowledging worker professionalism and addressing professional goals such as recognition, career development, and further qualification, meaning that human resources management/quality management (HRM/QM) needs to ensure an adequate work environment so health workers can meet both personal and organizational goals (Mathaur et al. 2006).

In the current evaluation, the team heard from several DHOs that had instituted efforts to reward individual health workers and health teams based on performance measures. These activities were not supported by UCP, but had been spontaneously initiated by the districts themselves. Rewards varied across districts; some districts awarded animals (chickens and goats; DHO, Dokolo district), while others provided notebooks and travel cases as rewards (DHO, Mbale district). The team urges USAID to support development of national and regional health worker recognition schemes, assess the results of supporting improved health worker remuneration, continue supporting the improvement of career paths, and galvanize high-level stakeholder support and advocacy to improve the overall work environment. Availability of and access to appropriate supplies, clean and adequate offices with furniture and minimally up-to-date equipment, along with access to the Internet, and clean toilets are well known approaches for improving worker motivation.

Performance-based financing (PBF) in human resources for health schemes are being used in some countries to provide financial rewards to healthcare workers to perform well. However, data is limited on PBF effectiveness in improving health worker performance in the public sector. One study in Rwanda found that while some of the clinical indicators in participating hospitals had improved, it was difficult to attribute gains solely or largely to the PBF program (Friederike, 2009) The study also showed undesired results, including crowding out intrinsic health worker motivation. In our view, performance-based financing should be a low-priority intervention for the Ugandan public sector due to other major weaknesses in the health system, including challenges with supply of commodities and limited financial resources. USAID/UCP could encourage districts that are paying top-up salaries to scarce cadres such as doctors to link these to performance targets that could be built into the performance appraisal process.

Question 3. How well has UCP strengthened country ownership and sustainability of their HRH- related interventions, and are there any additional interventions/activities that could enhance country ownership and sustainability?

The evaluation team defined country ownership as: "*Government, communities, civil society and private sector able to lead, prioritize, implement and be accountable (e.g., financing/cost sharing, providing technical assistance, and oversight) for country's health response"* (adapted from the OECD). Using this definition, the evaluators found that UCP has played a catalytic role in laying the groundwork for country ownership and sustainability of HRH interventions. From the onset, UCP facilitated dialogue, leadership, and decision making among multiple stakeholders, bringing together government ministries, PFNPs, DHPs, IPs, and others to drive the implementation of program interventions. Inter-sectoral

collaboration and ownership was essential due to the multifaceted nature of most HRH interventions, including HRIS, HRH planning and recruitment, performance management, performance improvement, OSH, WISN, and health workforce planning, deployment, and management. A case in point is the collaboration between MOES and MOPS, government agencies that had not worked well together until this program. At the same time, building consensus among such disparate entities with differing HRH roles, functions, and distinct points of view was a challenge. Most stakeholders lauded UCP's support, persistence, and commitment to producing joint goals and working through challenges and gaps.

The approach to foster district-level ownership was equally comprehensive, engaging key stakeholders, such as CAOs, DSCs, DHROs, DHOs, and DHTs. This approach appears to have generated a high degree of buy-in in many, but not in all districts. To bolster engagement and implementation, UCP also involved a number of USAID IPs and DHPs in providing technical support and reinforcement at the district level, particularly with HRIS (training, technical support, and funding for database installation). Table 2 summarizes evaluation findings for ownership and sustainability of key HRH interventions.

Table 2: Country Ownership and Sustainability of UCP Interventions

UCP Intervention	Country Ownership	Sustainability
Performance Management	High level buy-in with MOPs; MOH HRM very supportive, and district governments rate this highly. The approach is harmonized and aligned with MOPS policy and guidelines, and MOPS reports this as high priority. However, there is no financial commitment from the GOU to continue technical support needed for this at the district level	Most tools developed and adapted from MOPS policy and guidelines. However, MOPS lack sufficient budget to operationalize, and fully roll out at the district level
HRIS	High ownership across stakeholders interviewed. HRIS provides access to important HRH data previously not available, and is used to prepare reports for decision making. MOH and districts can take the lead in deciding what data is needed for advocacy and annual reporting, and most respondents at district and lower levels reported frequent use of the system. However, MOH officials reported weak capacity of technical staff to use the system, and a high dependence on UCP.	Concerns about sustainability of HRIS especially technical expertise to maintain the hardware and software, cost of hardware, cost of Internet subscription and high turnover of trained staff. MOH officials reported weak capacity of technical staff to use HRIS now, and their dependence on UCP. In addition, weak infrastructure, including lack of access to electricity and internet nationwide presents a major obstacle to continual use.
OSH	High ownership for the program as it meets an identified need.	Concerns about sustainability of OSH given lack of structures to support the initiative at MOH, district and facility level and also lack of budgetary support to implement OSH work plans. MOGLSD has the national OSH mandate has however integrated support to the health sector in their plans. A pool of trainers have also been developed.
HRH Action and Recruitment Planning (e-shortlisting and Adverts)	High buy-in for recruitment interventions within the MOH and at the district level. Adverts, e-shortlisting, and other tools were	Approaches to recruitment- e-shortlisting were sustainable.

UCP Intervention	Country Ownership	Sustainability
	used by all districts in national recruitment process. At the highest levels in the MOH (PS and DG), and in some districts, there is capacity to define the needs for using these tools and the type of analysis necessary. UCP reports indicated that a number of districts were using these tools to support recruitment in other sectors as well.	Note: 7,000 health workers recruited by the government, their employment in terms of the wage bill is sustainable, and is the most important result arising from UCP interventions (with some caveats). However, some DSCs reported that budgetary constraints make sustainability of certain elements of the program, such as financial support for recruitment advertising, procurement and maintenance of computers to manage e-tools questionable
HRH Leadership and Management Training	Very positive reports from the MOH. UCP set up partnerships with national and regional institutions, and district staff that participated reported new skills and tools. However, the number of districts that did participate were too few to determine effect, and training may not have led to uniform skills building. Furthermore, it was not clear to the evaluation team whether the MOH or other governmental bodies were ready to lead and prioritize their needs for leadership training, and there appears to still be a dependency on UCP or other providers for this type of training.	UCP did build a pool of local trainers, thus the potential for sustainability is there. However, much work is needed to institutionalize leadership and management training that would make regular and systematic use of these trainers.
WISN	At the buy-in was mixed; while this tool was seen by some districts and by PNFPs as meeting an area of need and so had high ownership, others did not find it helpful.	This is a low-cost intervention that, if applied appropriately and technical capacity is developed, could be sustained over time.

The evaluation team reviewed opinions and experiences of government, civil society and the PNFP sector to assess their experience with UCP technical assistance on key interventions from data collected in stakeholder interviews and focus group discussions. As shown in Table 2, most interventions were reported to have met an important gap in HRH management at different levels. At the same time, it is important to note that HRIS and HRH recruitment planning served as the foundation of UCP strategy, galvanizing buy-in and satisfaction at all levels. The exception were PNFP concerns that mass recruitment resulted in loss of staff to the public sector, where employee benefits and salary level are reported to be somewhat better.

With both public and PNFP sectors, evaluators found that districts and facilities were using interventions for performance management, WISN, and performance improvement. However, they failed to find evidence or indicators to provide insight into the quality, effectiveness, and impact of their use. The team also did not find evidence of critical discussion on the adequacy of these interventions to meet the unique needs of each system.

Sustainability

The evaluation team defined sustainability as: *"degree that services or processes continue, over medium and long term, once inputs (funding, materials, training, etc.) provided by the original source(s) decreases or discontinues"* (adapted from the OECD). Using this definition, stakeholder groups concurred that while laudable progress has been made in HRH in Uganda, challenges remain that will affect maintenance and continuity of these gains over the medium to long term. UCP and GOU ministries from different sectors introduced essential tools—for example, HRIS and sub-systems such as iHRIS

Manage and iHRIS Train, PM, performance appraisal, WISN, OSH, and supported capacity development through training, materials, and equipment to promote their use. There is still much work needed to institutionalize processes that promote their continued use; this is threatened in part by challenges that are beyond the purview of the program (e.g., access to electricity and Internet and other materials). Other challenges are related to human capacity and management issues and the need to make the use of these tools indispensable to normal work processes. While this will take time and continued technical support, the team's discussions with stakeholders and observations made during field visits on suggest that some of the interventions, like HRIS, are more advanced than others in this regard.

There is no doubt that recruiting and contracting more than 7,000 health workers during the mass recruitment represents a substantial increase in the number of health workers who will remain in the system, primarily at the district HC II and HC IV levels. UCP provided first-rate technical support in marshalling and systematizing HRH data to show human resource shortages convincingly and in assisting MOH officials in mounting an advocacy and lobbying strategy that has led to budget allocations. This was a bold, well-substantiated effort that appears to have built confidence of senior-level officials to press forward.

However, the fact that the UCP strategy in Uganda was so successful does not mean that the competence to undertake such ventures in the future was transferred to ministry officials and technical staff to a degree where, even gradual and phase out UCP support is appropriate or advisable. In fact, both MOFED and MOPS stakeholders informed the team that the MOH will need to continue and improve recruitment planning and advocacy to maintain gains achieved in 2012-2013. For example, the MOFED official explained that "*HRH funds raised by the health sector during the sector review in 2012 were prioritized, and cuts were made in other sectors to finance the mass recruitment. We are not sure how they will maintain the operational costs of the 2012 recruitment. Discussion regarding operating expenses for HRH is still on-going."* And a MOPS official emphasized that the MOH will need to *"continue advocating for funding; examine the issue of infrastructure versus service delivery and which will result in better outcomes. Currently half of the budget goes to infrastructure. If the percentage of the GOU budget is examined, the MOH receives a decent share including donor funds."*

Equally relevant were reports from other stakeholder groups, including PFNP, IPs, and DHPs. These reports stressed the continued need to deal with the substantial HRH issues that remain in retention, attrition, and absenteeism. There are still threats to consistent and sound HRIS database use for planning and projections, as discussed in former sections. The team found evidence in UCP reports that an estimated 20 districts continue to use HRIS with funds secured from local government grants and other sources to maintain databases and Internet connectivity. Yet there are still a large number of districts that are struggling to adequately use HRIS. In several cases, district governments have already expanded and adapted HRIS to other sectors, a goal voiced by MOPS officials but is as yet unrealized. Evaluators learned from three HPCs, two medical bureaus, and Mulago hospital that they have the capacity to maintain and use HRIS databases within their systems, although they will need technical assistance to make adjustments as new challenges and gaps emerge.

In summary, evaluators found that there is considerable political support and buy-in from high-level officials at MOH, MOPS, medical bureaus, DHPs, and IPs. However, they failed to find evidence that the systems and competencies at the central and district levels are sufficiently advanced to support an immediate turn over to central and district government entities. UCP carefully monitored the progress of its interventions over the program, but there was no evidence that the program had assessed stakeholder capacity to assume full or partial responsibility to lead and continue these activities. This is not intended as an indictment of the program; rather, given UCP's excellent programmatic performance as measured by the stated evaluation questions, the evaluators concluded that UCP, with USAID, has the capability at this point to undertake a serious assessment of stakeholder capability and tailor a solid and viable plan for phased turn-over to the MOH and GOU.

Question 4.a. How well has UCP strengthened and supported the private not for profit (PNFP) sector? B. How well has UCP supported the work of USAID IPs?

According to the Health Sector Strategic Plan III (2010/11–2014/15), the PNFP sub-sector is divided into two categories: facility-based (FB-PNFPs) and the non-facility based PNFPs (NFB-PNFPs). The FB-PNFPs provide both curative and preventive services while the NFB-PNFPs mainly provide preventive, palliative, and rehabilitative services. FB-PNFPs account for 41% of the hospitals and 22% of the lower-level facilities that complement government facilities, especially in rural areas. PNFPs operate 70% of health training institutions. More than 75% of

FB-PNFPs exist under four umbrella organizations: the Uganda Catholic Medical Bureau (UCMB), the Uganda Protestant Medical Bureau (UPMB), the Uganda Orthodox Medical Bureau (UOMB), and the Uganda Muslim Medical Bureau (UMMB).

Documents reviewed and key informant interviews conducted at the national and district level revealed that there was minimal focus on the PNFPs in the original UCP design. The primary focus was on HRH in public health sector institutions. According to medical bureau stakeholders, UCP changed its original approach and engaged the PNFP sub-sector, primarily through its umbrella entities (medical bureaus) during program implementation. UCP supported PNFPs by building capacity at the national level through the training of faith-based medical bureaus, for the most part. UCP interventions were not uniform across the medical bureaus: It provided more interventions to UCMB and UPMB, due in part to their capacity to take up the interventions. Key PNFP informants reported HRIS was the prime intervention provided to the PNFP Bureaus. Both the UCMB and UPMB received servers and training from UCP. The program did not introduce HRIS at UMMB. Representatives of UMMB indicated that they had at most received only PM/PI-related interventions.

Both UCMB and UPMB acknowledged that HRIS is a useful intervention and has helped them better understand their staffing levels and gaps. HRIS enabled both organizations to develop short- and long-term HR strategic plans. UPMB and UCMB identified high levels of attrition of staff trained in HRIS, especially in hospitals, as a major challenge to HRIS continuity. Another reported concern is that current HRIS databases used by PNFPs facilities lack a mechanism to aggregate data at the medical bureau level across all facilities. Having such a mechanism would greatly facilitate their ability to make strategic HRH-related decisions.

UCMB representatives reported that training in workload indicators of staffing need (WISN) was useful and helped improve staff workload rationalization in the facilities. UCMB provided training to 26 hospitals in WISN in partnership with UCP. UCMB stated that its staff continues to provide follow-up support to ensure the proper use of WISN. UCMB hospital staff continue to carry out their own internal assessments and generate reports for use at the hospital and by UCMB. Other UCP support to UCMB and UPMB was in L&M training for UCMB hospital managers and in PM and OSH training and tools for UPMB hospitals.

All the medical bureaus and about half of the PNFP facilities that the evaluation team visited reported that UCP provided support and training in performance management and improvement. Some PNFPs developed individual and facility performance plans with clear targets. They stated that UCP conducted quarterly reviews to assess progress with respect to targets set by individuals and facilities. However, it is unclear whether UCP followed up with the medical bureaus and PNFPs to assess the extent to which these entities were using WISN, PM, and PI effectively, and the results that have been achieved.

Medical bureau and PNFP representatives emphasized a number of HRH challenges at the national and district levels that UCP and the MOH should consider within the context of future planning. These include limited capacity to attract and retain qualified staff; limited career growth opportunities for staff; budgetary constraints including limited funds for training; negative attitudes and low commitment of public sector health workers seconded to PNFPs; limited participation of the PNFP sub-sector in decision making at the national and district levels; poor HR systems and management practices; and weak leadership and governance practices. Additionally, UCP and other stakeholders should pay attention and be sensitive to any potential negative impact that the recent recruitment may have had on the quality of care provided by PNFPs, since they provide nearly half of all health services in the country.

Question 4.b. How well has UCP supported the work of USAID IPs?

UCP provided technical support for eight PEPFAR implementing partners and projects (SDS, Walter Reed, NU-HITES, TASO, Baylor, Mildmay, SUSTAIN, and IDI) for health worker recruitment for hospitals, HCs II, and PNFP facilities as part of efforts to scale up HIV/AIDS services in the country. According to IPs, UCP support consisted of developing staff recruitment guidelines; adapting salary and benefits to PEPFAR-funded projects for recruitment for more than 1,200 PEPFAR staff; conducting planning meetings with district stakeholders; and training IP staff in the use of the computer-aided shortlisting tool. UCP also provided technical support for PEPFAR efforts to develop a common nomenclature and job descriptions for PEPFAR volunteers and a benefit package for PEPFAR linkage facilitators.

Evaluators interviewed four IPs, one of which emphasized that "*UCP's role was crucial*"; another described UCP's greatest contribution as *"standardizing the guidelines for PEPFAR recruitment, harmonizing the recruitment process across implementing partners at the national level, as well as, providing M&E support."*

UCP also leveraged support from Baylor College of Medicine, SDS, NU-HITES, and DHPs (WHO and Belgium Technical Corporation [BTC]), which provided training and funded installation of HRIS in additional districts, as noted under Question 1. Working collaboratively with these partners, the UCP HRIS team provided technical guidance, monitoring tools, and training materials to support HRIS implementation. The program worked with NU-HITES to carry out refresher training for HRIS data managers and users in districts in northern Uganda. UCP also assisted NU-HITES in implementing UCP interventions in that region, and provided NU-HITES with training and tools for PM and OSH. UCP supported districts in developing proposals for Grant B projects in collaboration with SDS.

In addition, UCP worked synergistically with other DHPs. It worked with the World Bank-funded Uganda Health Sector Strengthening Project (UHSSP) to develop HRIS roll-out plan in target districts. It also worked with BTC to implement HRIS in eight districts. UCP provided support to UHSSP in performance management and in finalizing PM guidelines for the health sector.

Overall, there was consensus among IPs on the importance of the interventions that UCP developed. The evidence shows that capacity building is moving in a positive direction, but more work is needed. As one IP representative underscored, *"UCP has a unique model of working with government, but MOH needed to own the interventions and tools, and roll them out."*

V. DISCUSSION AND CONCLUSIONS

Overall, UCP advanced substantially in supporting HRH policy development and planning processes; it also helped ensure the availability of tools at the central and district levels with a broad array of stakeholders. Successful HRIS development and national roll out, coupled with advocacy and lobbying at the highest levels of government, led to substantial GOU funding for mass recruitment, galvanizing enthusiasm and a strong sense among stakeholders at all levels that necessary tasks were doable and gratifying. Although the team heard reports of bottlenecks and frustrations, stakeholders at all levels expressed enthusiasm and satisfaction with these achievements. The team concluded that a major success of UCP to date has been elevated stakeholder confidence in the HRH processes and tools now available in the country.

The evaluation team's review of HRH initiatives in Africa reveal that, while other countries like Malawi and Tanzania are using HRMIS systems, there is little information on the experience of national data system roll out or involvement of non-health sectors. From a more global perspective, a number of countries have developed HRIS systems. Riley et al. (2012) reviewed 63 documented national HRIS experiences. The authors could only confirm that while crisis and non-crisis countries tend to generate basic HRH supply and deployment data, few seem to be explicitly using this information for making workforce decisions. As the authors point out, countries that need to use their HRH resources most efficiently frequently lack the capacity to collect, retrieve, analyze, and use the insights gained from data to make important, well-informed decisions on different workforce dynamics, including type, distribution, and retention (Riley et al. 2012). In this study, researchers found few HRIS that were collecting workforce demographic data in such areas age and sex that are essential for effective HRH planning. In addition, the authors reported that only a small number of countries were collecting data on workforce attrition.

Compared to other countries, Uganda embarked on a daring enterprise, and with support from UCP, USAID, and others, produced solid results. The current UCP-implemented HRIS has the ability to collect demographic data and could potentially monitor workforce attrition, if capacity for analysis is further (and more widely) strengthened. Nevertheless, the team calls attention to the obstacles, bottlenecks, and frustrations encountered in implementation by the program and its stakeholders, and urges USAID and GOU to carefully advance with a new program initiative with a prudent focus, directed toward improving and consolidating central- and district-level competencies that will transfer capacity for the implementation of key interventions.

CONCLUSIONS

UCP is an ambitious venture that has significantly increased national and district HRH policy and planning capacity and has galvanized a wide range of stakeholders from the public and private sectors and the donor community to collaborate and put new HRH systems and policies in place. Together, UCP and MOH mounted an outstanding advocacy and lobbying effort to address a well-documented shortage of health workers in the country, resulting in allocation of significant funding to recruit and deploy more than 7,000 health workers across Uganda, substantially contributing to reducing national health worker shortages.

There is consensus across stakeholders, and evaluators agree, that while the program made great strides, the capacity at the central and district levels to manage, coordinate, and sustain HRH policy and planning is still not optimal, due in part to structural and motivational issues. Within the public sector, uptake and potential for maintaining HRIS and other HRH systems and functions is mixed. Officials at the MOH and district levels and other stakeholders agree that some central-level managers and districts lack necessary capacity to continue to use and sustain the HRIS system for planning, decision making, and reporting. At the district level, a number of districts and other stakeholders, including HPCs and medical bureaus, have installed and are maintaining HRIS systems after receiving training and equipment from UCP.

UCP also developed other HRH interventions such as performance management and improvement. Evaluators found performance management fits well within UCP's HRH strategic focus and was an identified priority, especially the need to further align with the MOPS Results Oriented Management Framework. There are logistical and capacity challenges within MOPS and at district level that require more concerted follow up on PM activities. There is stakeholder consensus that performance management should be strengthened at the district level and rolled out nationally in the health sector.

Some initiatives had mixed effect. For example, the PI initiative does not fit into the UCP mandate and results thus far do not show considerable effect. There is a clear consensus for the need for OSH, and that the current approach is appropriate to the country's situation. However, the initiative was highly dependent on health systems strengthening measures as well as adequate logistics and distribution for critical equipment, materials, and supplies to have an optimal effect. Similarly, the midwifery skills enhancement program lacked the support of key stakeholders and fell short of strategically addressing the gap of sufficiently qualified mid-wives to have a lasting effect. Evaluators found that some of UCP's major interventions had high political and technical buy-in among major stakeholders and across sectors, in the case of the HRIS and HRH actions and mass recruitment. PM, leadership and management training, WISN, and OSH have benefitted from considerable uptake, primarily in the case of districts that received interventions.

Overall, the team found that GOU is now in a better position to lead, prioritize HRH issues, and implement key functions to an extent at the central and in some district levels; at the same time, performance and accountability are still variable. MOH officials are concerned that if the UCP program ends, many advances will "*fall off the track and there will be insufficient funds to sustain and continue to progress.*" The evaluation team concurs with the MOH's assessment and foresees the need for a follow-on program to support consolidation of the systems and tools already in place.

VI. RECOMMENDATIONS

AT THE TECHNICAL LEVEL (USAID AND UCP)

- Refine UCP's strategic direction and interventions to consolidate HRH advances at the central and district levels, focusing on the most essential interventions that will reinforce the capacity of MOH and districts to lead, prioritize, monitor, and be accountable for national HRH functions. For the remaining of the project, UCP should:
    - Recruit resident advisors to strengthen the three ministries (MOH, MOPS, and MOES) to manage HRH policy, plans, and systems (including HRIS) through written agreement with the GOU to assume the advisors as public service staff after a two-year period.
    - Continue to develop MOH capacity to advocate for HRH, including advocating for appropriate budgeting to support newly recruited staff and the recruitment of additional health workers, especially for under-served

districts. Also, continue to build MOH capacity to advocate for the review of staffing norms in line with WISN findings.

- Build effective GOU buy-in to support these efforts, and engage USAID and the multi-bilateral community to support PNFPs and ensure that PNFPs' HRH policies and practices are applied at the local level.
- Expand the skill base of staff to use HRIS; leverage the private sector to enhance inter-connectivity and provide multiple ways of accessing HRIS data to ensure its institutionalization and sustained use.
- Strengthen the focus on PM by tracking key indicators, including health worker job satisfaction and absenteeism.
- Build the capacity of the health sector and other players to use information communication technology to support the development and management of health workers with access to e-learning and mobile apps. There are opportunities for the GOU at the central and district level to leverage public-private partnerships, as well as opportunities for USAID to support initiatives that will increase the use of low-budget, low-technology efforts to increase connectivity.

AT THE POLICY LEVEL (USAID AND GOU)

- Enhance engagement of multiple stakeholders, and create strategic alliances, including public-private partnerships with non-traditional partners such as businesses and electrical and Internet companies, among others**,** to strengthen sustainability. This includes building on other government initiatives to improve access to Internet connectivity and electricity in local areas.
- Support policy initiatives that promote a pre-service training strategy that addresses the shortage of health cadres identified in the 2012 national recruitment. In particular, reinvigorate stakeholder ownership to review, strengthen, and upgrade pre-service nursing and midwifery education to ensure that the country produces the number and quality of nurses and midwives needed to achieve national health priorities, especially reduced maternal mortality.
- Negotiate a plan between the GOU, multi-bilateral stakeholders, and the private sector to continue to strengthen HRH policy, planning, systems development, and retention, with clearly defined activities and dates for a full hand over of all functions to government.
  - Explore opportunities to establish public-private ventures, national universities, and professional training institutions. These would be linked with internationally recognized institutions that are known for leadership training, with the goal of establishing a National Health Leadership and Management, and Professional Development Institute.

PROMOTING THE USE OF HRIS FOR ANALYSIS

- Expand the use of the extensive HRIS data that is currently available to advance workforce analyses and projections, to include but not be limited to the following:
  - Analysis of the association between gender, age cohort, employment history, professional education, pre-service/in-service training and recruitment, retention, absenteeism and other variables to enable MOH to gain insight for planning, recruitment, and retention campaigns
  - Link HRIS and HMIS data to conduct analyses of recruitment and deployment and the effect on health service delivery outputs and health outcomes
  - Conduct an assessment of the effects of the mass recruitment to better understand the source of new recruits, whether public, PNFP, or other
  - Conduct studies to document and better understand retention, absenteeism, and professional motivation and satisfaction; identify the best reward/recognition schemes

ANNEX I: EVALUATION SCOPE OF WORK

1. OBJECTIVE

The purpose of this Task Order is to conduct an evidence-based performance evaluation of USAID/Uganda Capacity Program implemented by lntraHealth International.

This evaluation is expected to independently establish the effectiveness of the interventions of UCP and document what has worked well and what has not. Lessons from this evaluation will be integrated in future programming within the Mission and the Ministry of Health (MoH) to support national efforts in strengthening the health system in Uganda.

Initial findings of the evaluation will be shared within the Mission and with the Implementing Partner. The evaluation report will be used to analyze current approaches and work plan of UCP and will form the basis for subsequent planning meetings between USAID, the MoH and lntraHealth to incorporate lessons learned and proposed recommendations for improvement. The final report will be shared with Uganda Human Resource for Health (HRH) technical working group and other relevant stakeholders, including development partners.

2. BACKGROUND

Uganda is among the 57 countries with a critical shortage of the human resources for health (physicians, nurses and midwives), according to World Health Organization (WHO). Although the production of health workers has significantly increased over the last five years, and it was estimated that there are approximately 1.8 health worker per 1,000 of population in 2011, this is still below the WHO minimum standard of 2.3 health workers per 1,000 of population. Additionally, there is a problem of absorption of trained health workers into the health system. In the public sector, only 56% of approved positions are filled, and the Government of Uganda (GOU) has not allocated adequate funds to increase the recruitment and retention of health workers. Moreover, health workforce performance continues to be a major concern in Uganda, given high rates of absenteeism.

Human Resources for Health (HRH) is a top-priority issue for USAID/Uganda health and HIV/AIDS programs, as a means to achieve better health outcomes and improved quality of services. USAID/Uganda's Uganda Capacity Program (UCP), a $11-million, five-year program awarded to lntraHealth International, began on September 29, 2009. The program's activities are implemented in accordance with health sector HRH priorities as determined by the GOU Ministry of Health (MOH) and in collaboration with other ministries and agencies including the Ministries of Education (MOES) and Public Service (MOPS); the Health Service Commission, Public Service Commission and the District Service Commissions; local governments, medical bureaus, health professional councils, and NGOs. UCP is now in its third year of implementation.

The objective of UCP is to enhance the capacities of central ministries, districts, and Professional Councils[1] to effectively and efficiently manage their human resources for delivery of health and HIV/AIDS services, ultimately contributing to the achievement of the Health Sector Strategic Investment Plan (HSSIP) objectives. The HSSIP objectives are: improved equity and access to health services; accelerated quality and safety

[1] These include the Uganda Nurses and Midwives Council, Uganda Medical and Dental Practioners Council, Uganda Pharmacy Council and the Allied Health Professionals Council.

improvements in health services; and improve efficiency and effectiveness in the management of health services. The goal of the program is to contribute to the reduction of mortality and morbidity through strengthened health workforce systems and practices for improved delivery of health and HIV/AIDS services. The program goal contributes to USAID Development Objective 3 (003): "Improved Health and Nutritional Status in Focus Areas and Population Groups."

Specifically , UCP aims to: (1) Increase Capacity for HRH Policy and Planning at the National Level, through both direct and indirect activities that include establishing Human Resource Information systems at national and district levels to provide data for evidence based HRH planning and decision making, translating national HRH policy guidelines into operational plans for effective implementation at district level and mobilizing and advocating for increased funding to HRH activities; (2) Strengthen Systems for an Improved-Quality, Performance-Based Health Workforce, through activities to develop systems to streamline implementation of quality-of-care initiatives in the health sector, implementing strategies for Performance Improvement (PI) in districts, and supporting central ministries to develop plans for strengthening Pre- and In-service training and (3) Improve Health Workforce Management Practices, including recruitment of new health workers and the development and implementation of Performance Management (PM) strategies.

The scope of work and expected outputs from the UCP Cooperative Agreement include:

Result Area 1: Capacity of Key Institutions (35% level of effort)

While the Ministry of Health is the main counterpart, the UCP will work with other line ministries, including Public Service, Local Government, and Finance; district local governments; GOU health workforce recruitment authorities; the four professional councils; and key stakeholders for HRH, to develop their capacity to plan, develop policies and guidelines, and implement them. Work under this result is expected to be done in such a way that outcomes are sustainable.

Outputs

- A rational and sustainably costed strategic workforce plan developed
- A functional and sustainable HRIS at national or sub-national level
- National or sub-national level workforce data systems developed/strengthened
- A task shifting strategy developed
- Human Resource policy guidelines in use at district level
- Support and advocacy for increased budget for HRH (actual and percentage)

Result Area 2: Performance Management Systems for Improved Service Delivery (25% level of effort)
The UCP will work with line ministries and the professional councils to develop or improve systems to improve the quality of health service delivery, and increase performance-based incentives. This result should also be done in such a way as to ensure sustainable outputs.

Outputs

- Health workforce performance monitoring plan developed and implemented .
- Each Professional Council with a continuing professional development (CPO) strategy and implementation plan.
- Training plan for in-service training is developed and implemented

Result Area 3: Management Practices for Rational Recruitment, Deployment, and Retention
(40% level of effort)
The UCP will work with line ministries, recruitment authorities, districts, and other key stakeholders to identify and promote health workforce management practices to improve rational recruitment, deployment, and retention.

Outputs

- Improved availability of personnel monitoring tools like job descriptions, time sheets, appraisals, etc.
- lmproved availability of protection tools/drugs/supplies at health facilities

Overall Expected Outcomes of UCP include:

- An increased number and percentage of approved posts filled by appropriately-
- Trained health workers;
- Improved rates of recruitment and retention, both in targeted districts/areas and nationally;
- Improved service coverage of personnel in underserved or "hardship" areas, including northern Uganda; and
- Improved availability of health workers to deliver health and HIV/AIDS services (decreased rates of absenteeism)

Key Questions for this Evaluation

The evaluation will answer the following specific questions:

- How effective has the project been in achieving its Intermediate Result 1: "Increased Capacity for HRH Policy and Planning" by the third year? Are the outcomes expected by September 2014 still valid and achievable, or do they need to be adjusted to reflect realities of the current context?
- Does performance in the last three years demonstrate an appropriate technical and strategic approach by UCP to performance management and performance improvement in the current context? What interventions are yielding, or have the potential to yield, the greatest impact and what interventions are not, and are there any additional interventions that could be more effective?
- How well has UCP strengthened country ownership and sustainability of their HRH- related interventions, and are there any additional interventions/activities that could enhance country ownership and sustainability?
- How well has UCP strengthened and supported the private not for profit (PNFP) sector? How well has UCP supported the work of other USAID Health and HIV/AIDS implementing partners, and are there any additional interventions/activities that could have strengthened the PNFP sector more effectively?

3. EVALUATION DESIGN AND METHODOLOGY

USAID is looking for the most realistic, scientifically sound and cost-effective design and methodology to conduct an evaluation that meets the stated purpose and responds to all the evaluation questions listed above. Proposed design/methodology will include the right mix of qualitative and quantitative methods, such as document review, key- informant interviews, focus groups, client surveys, etc. The Design should bear in mind the different roles of the various stakeholders listed above, and clearly show how reliable and meaningful evaluation information will be collected in an objective manner. The proposal should describe the information required to answer above questions, and briefly explain how any new data will be collected. Where existing data will be used, it is required that the contractor identify the data source. An evaluation design matrix, such as the one in Exhibit J.1 is required.

The following information documents and sources are available and relevant to the evaluation:

From USAID: Original Request for Applications

From UCP: Original agreement and a summary of subsequent amendments/modifications; Results Framework; Performance Management Plan and the project M&E system; Annual work plans ;Annual and quarterly reports; Annual HRH audit data; Any other relevant reports and information as required and available

From MOH: Memorandum of Understanding with UCP; Other relevant government documents as identified

ANNEX II: EVALUATION METHODS AND LIMITATIONS – FINAL INCEPTION REPORT

FINAL INCEPTION REPORT
Performance Evaluation of USAID/Uganda Capacity Program (UCP)

DRAFT Inception Report
Performance Evaluation of USAID/Uganda Capacity Program (UCP)

November 14, 2013
Order No.: AID-617-TO-13-00001

ACRONYMS

CA	Cooperative Agreement
DHO	District Health Officer
DO	Development Objective
FGD	Focus group discussion
GoU	Government of Uganda
HRH	Human resources for health
HRIS	Human resources information system
HSSP	Health Sector Strategic Plan
IBTCI	International Business and Technical Consultants, Inc.
IP	Implementing Partner
IR	Intermediate Result
KII	Key informant interview
MoES	Ministry of Education and Sports
MoH	Ministry of Health
MoPS	Ministry of Public Service
NGO	Nongovernmental organization
PI	Performance improvement
PM	Performance management
PMP	Performance management plan
PNFP	Private not for profit
SOW	Scope of Work
TWG	Technical working group
UCP	Uganda Capacity Program
USG	United States Government
WHO	World Health Organization

1. INTRODUCTION

Although the number of health workers in Uganda has increased during the last several years, it was recently estimated that there are approximately 1.55 health worker per 1,000 population.[1] This is below the World Health Organization (WHO) minimum standard of 2.28 health workers per 1,000 persons. Additionally, there has been a problem of absorption of trained health workers into the health system. Historically, in the public sector, less than 60% of approved positions were filled, and the Government of Uganda (GOU) did not allocate adequate funds for the recruitment and retention of health staff. A nationwide health worker audit in September 2011 found that only approximately 66% of the established positions were filled. The proportion of approved positions filled for local governments was lower, at 55%. Moreover, health workforce performance continues to be a major concern with high rates of absenteeism. Finally, studies have indicated that the available health workforce is inequitably distributed, with about 71% of the doctors and 41% of the nurses and midwives located in urban areas where only 13% of the population lives.[2]

2. CONTEXT – UCP PROJECT OVERVIEW

The USAID/Uganda Capacity Program (UCP) was developed to respond to a human resources for health (HRH) situation in Uganda characterized by an inadequate number and skill mix of the health workforce, low retention and motivation, poor performance, and high rates of absenteeism. Additionally, underpinning the HRH shortage were weak leadership and management, low and delayed pay, underfunding, weak HRH information and other personnel system. Work environments were identified as having inadequate supervision, a shortage of supplies and basic equipment, a lack of staff accommodation and other amenities. UCP is a $12.5 million, five-year program awarded to lntraHealth International and began on September 29, 2009. The program's activities are implemented in accordance with health sector HRH priorities, as determined by the GOU Ministry of Health (MOH) and in collaboration with stakeholders such as: other central-level ministries; the Health Service Commission; the Public Service Commission; the District Service Commissions; local governments; medical bureaus; health professional councils; and non-governmental organizations (NGOs). UCP is now in its fifth year of implementation.

UCP is intended to consolidate the HRH systems strengthening initiated by the MOH with assistance of development partners, and to support operationalization of the HRH Policy and Strategic Plan, and the various HRH interventions that need to be rolled out and scaled up to realize the goals and objectives of the Health Sector Strategic Plans (HSSP) II, and of HSSP III. UCP aims to strengthen human resources for the delivery of health and HIV/AIDS services. It contributes to USAID/Uganda's Country Development Strategy Development Objective (DO) 3: "Improved Health and Nutritional Status in Focus Areas and Population Groups," as well as, several Intermediate Results (IRs) and sub-IRs which constitute DO 3. Some of these include: IR 3.1: More effective use of sustainable health services; IR 3.1.2: Improved quality of health services; IR 3.1.3: Increased availability of health services; IR 3.1.4: Increased accessibility of health services; IR 3.1.2.1: Increased availability of resources for health care; IR 3.1.3.1: Enhanced enabling environment for health care; and, IR 3.1.4.1: Improved organization and management.

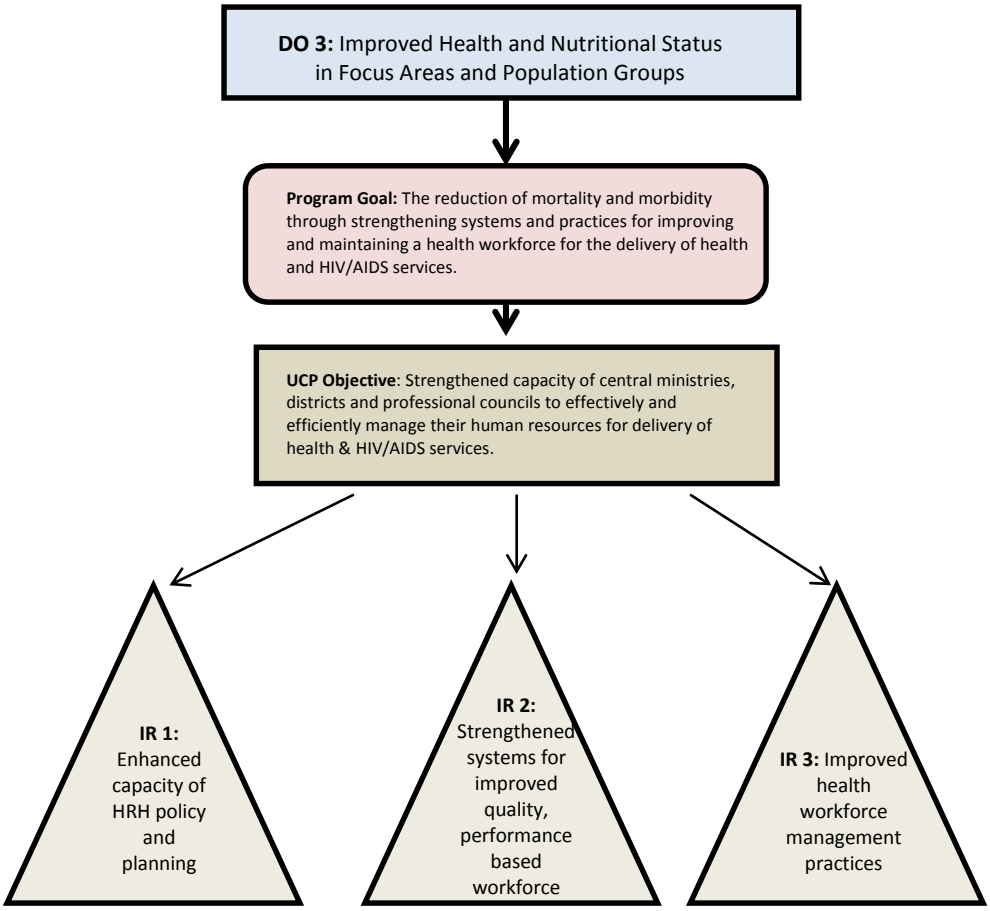
The objective of UCP is to enhance the capacities of central ministries, districts, and Professional Councils to effectively and efficiently manage their human resources for delivery of health and HIV/AIDS services, ultimately contributing to the achievement of the HSSP objectives. Specifically, UCP aims to: 1) increase capacity for HRH policy and planning at the national level, through both direct and indirect activities that include establishing Human Resource Information Systems (HRIS) at national and district levels to provide data for evidence-based HRH planning and decision making, translating national HRH policy guidelines into operational plans for effective implementation at district level and mobilizing and advocating for increased funding to HRH activities; 2) strengthen systems for an improved-quality, performance-based health workforce through activities to develop systems to streamline implementation of quality-of-care initiatives in the health sector, implementing strategies for Performance Improvement (PI) in districts, and supporting central ministries to develop plans for strengthening pre- and in-service training; and, 3) improve health

[1] Uganda Capacity Program, Year 3 Annual Report, October 2012.

[2] Ibid.

workforce management practices, including recruitment of new health workers and the development and implementation of Performance Management (PM) strategies. This is outlined in the basic Results Framework given below.

Figure II-1: Abbreviated Results Framework



Some of the activities implemented to support the Results Framework include: the development of a functional and sustainable HRIS at both the central and district level; the development and implementation of a task shifting strategy, a health workforce monitoring plan, and an in-service training plan; various activities to increase the percentage of approved posts filled by trained health workers; and, improving the availability and use of personnel monitoring tools like job descriptions, time sheets, and appraisal forms. The GoU has demonstrated its commitment to UCP and human resources for health in general by placing HRH issues on the decision-making agenda at all levels. This resulted in an increase in HRH funding of 49.5 billion shillings (U.S. $19,800,000) for the recruitment of over 6,000 health workers and increased pay for doctors in FY 2012/13.[3] Given the substantial investment by both the GoU and the United States Government (USG) in UCP, a Performance Evaluation was commissioned via International Business and Technical Consultants, Inc. (IBTCI) to examine a number of different issues as given in the Evaluation Purpose below.

2. PERFORMANCE EVALUATION PURPOSE

Evaluation Purpose

Per the Scope of Work (SOW), the purpose of this assignment is to conduct an evidence-based performance evaluation of the USAID/Uganda Capacity Program implemented by lntraHealth International. The

[3] Uganda Capacity Program, Year 3 Annual Report, October 2012

Performance Evaluation is expected to independently establish the effectiveness of the interventions of UCP and document what has worked well and what has not. Lessons from this Performance Evaluation will be integrated in future programming within the Mission and the GoU MoH to support national efforts in strengthening the health system in Uganda. Initial findings of the Performance Evaluation will be shared within the Mission and with the Implementing Partner (IP). The evaluation report will be used to analyze current approaches and work plan of UCP and will form the basis for subsequent planning meetings between USAID, the MoH and lntraHealth to incorporate lessons learned and proposed recommendations for improvement. The final report will be shared with Uganda Human Resource for Health Technical Working Group (HRH TWG) and other relevant stakeholders, including development partners.

Evaluation Questions

Specific questions that will guide the Performance Evaluation are stated in the Evaluation Matrix. Those questions can be classified into four broad categories, which were given as "Key Questions" in the Evaluation SOW. Those four questions are:

How effective has the project been in achieving its Intermediate Result 1: "Increased Capacity for HRH Policy and Planning" by the third year? Are the outcomes expected by September 2014 still valid and achievable, or do they need to be adjusted to reflect realities of the current context?

Does performance in the last three years demonstrate an appropriate technical and strategic approach by UCP to performance management and performance improvement in the current context? What interventions are yielding, or have the potential to yield, the greatest impact and what interventions are not, and are there any additional interventions that could be more effective?

How well has UCP strengthened country ownership and sustainability of their HRH- related interventions, and are there any additional interventions/activities that could enhance country ownership and sustainability?

How well has UCP strengthened and supported the private not for profit (PNFP) sector? How well has UCP supported the work of other USAID Health and HIV/AIDS implementing partners, and are there any additional interventions/activities that could have strengthened the PNFP sector more effectively?

3. METHODOLOGY

Guiding Principles

This Performance Evaluation is specifically designed to occur at the beginning of Year 5 of project implementation. Thus, it is neither a Mid-Term Evaluation (focusing on potential corrective actions) nor a Final Evaluation (focusing on overall project impact). Evaluation Questions #1 and #2, stated above, will be applied to the four years of implementation.

As a fourth -ear evaluation, its primary aim will be to derive lessons learned, based on the four Evaluation Questions, to provide guidance for similar activities in the future, either funded by the USG or other funders, including the GoU. Additionally, the focus will be narrower than a Final Evaluation, given the limited level of resources and time available to conduct this Performance Evaluation. To some extent, this will limit the generalizability of lessons learned.

In addition, it will not be possible to determine whether many changes or differences are statistically significant; considering that the UCP has been implemented for four years and had, to some extent, a staggered roll-out. Descriptive statistics will be generated.

The evaluation will draw a sample of six (6) districts based on criteria set out in Table 1 below. Two (2) to three (3) facilities in each district will be selected as described in the Data Collection Section below. The team will be divided into two sub teams, each collecting data in three (3) districts. Since UCP has implemented at least one activity in all 111 districts and in Kampala, the team will attempt to do pre- and post-intervention comparative analyses (based on the availability of baselines), recognizing that both the margin of error and confidence intervals will be very large.

Qualitative data will be primarily based on interviews carried out with key project stakeholders at the central and district levels. This will include stakeholders such as GOU officials (MOH, Ministry of Public Services, Ministry of Education and Sports), including training institutions (Makerere University) the project has worked with; members of the HRH TWG; project managers (USAID and IntraHealth), USAID Implementing Partners, and other donors such as WHO, BCT and World Bank. Additional qualitative information on opinions and perceptions of changes in human resources for health based on the four Evaluation Questions and incorporating the 13 project interventions, will be ascertained from in-depth interviews with facility managers, and district health officials, and focus group discussions with health workers.

Quantitative data will be derived from interviews at the facility level, and from existing secondary data produced by UCP and data available at the central and/or district level. All of the proposed tools have quantitative questions. This information will be used in combination with qualitative input to show the actual effect at the district level and the reported status of management practices, with a specific focus on the recruitment, retention, supervision, and distribution of health staff.

The project's effects on facility functioning and on other beneficiaries and partners will focus on UCP interventions and will be determined using the Evaluation Questions and sub-questions as guidance. Questionnaires will seek opinions on UCP activities and estimates of potential results to ascertain intervention effectiveness. This will produce quantifiable data.

The Final Report will be structured around the four Evaluation Questions with Findings, Conclusions, and Results for each question clearly delineated and summarized. The Report will primarily focus on the qualitative analyses from the KIIs on perceptions of project progress and impact on changes in human resources for health attributable to UCP. The objective is to show whether stakeholders think the project is moving in a direction that will achieve the desired objectives or if changes/corrections should have been implemented to improve the project's probability of success. Qualitative information will be used to provide evidence to support sustainability and institutionalization of activities and processes. Together, the information will provide the basis for recommendations for any actions that need to be undertaken during the remaining life of the project and recommendations for future programming.

In addition, the Final Report and its findings and recommendations must be qualified by challenges that are beyond the project's control. The report will document how the project has responded to challenges and sought solutions. For example, project implementation delays due to bureaucratic issues (such as ministry leadership changes), accessibility of sites, or changes in the overall working environment will be documented. The team will note if any activities not explicitly stated in the UCP's Cooperative Agreement (CA) may have diverted resources from other contracted activities.

The team will also examine the management structure of UCP to determine how well it has functioned during the first four years—that is, the project's internal management structure. It will examine how well USAID has managed UCP and the relationships that USAID maintains with various stakeholders that may affect UCP's success.

Evaluation Design

UCP has begun its fifth and final year of implementation, and has generated a considerable amount of data over the past four years. The quantitative information that has been generated will be combined with information derived from qualitative methods to reach conclusions and develop recommendations, with a focus on lessons learned. These data sources will be triangulated to support the judgments made by the Evaluation Team.

Evaluation Team

A team of four experts, two international and two Ugandan professionals, will conduct the Performance Evaluation of UCP, as follows:

Dr. Rosemary Barber-Madden, Team Leader, will be responsible for project management and will be responsible for key informant interviews mainly with central-level stakeholders, including the Ministry of

Health and other government officials, the USAID and IntraHealth project management team, and technical support stakeholders.

Mr. William Kiarie, international human resources for health expert, will be responsible for examining the project's performance in reaching its objectives, appropriateness of the technical approaches and activities utilized by the project, and UCP's collaboration and support with other implementing partners. He, too, will conduct key informant interviews mainly with central-level stakeholders, including the Ministry of Health and other government officials, the USAID and IntraHealth project management team, and technical support stakeholders.

Dr. Paul Bukuluki will be responsible for assessing the project's activities and results within the greater Ugandan context. He will assess the project's activities and Performance Management Plan as they relate to the Ugandan Human Resources for Health Strategic Plans and other related documents, and will examine UCP's interaction with and support to the private sector.

Ms. Constance Shumba will concentrate her efforts on the functioning of the HRIS system; MOHR recruitment, retention, and distribution policies and practices; and facility-level management practices and corresponding staff satisfaction.

All four (4) team members will conduct Key Informant Interviews with government, civil society, and international stakeholders, and will be involved in data collection in six (6) districts.

Data Collection Plan

Data Sources

Review of Project Documents (UCP quarterly and annual reports, work plans, Performance Management Plans, GOU HRH strategies, and plans). UCP reports and planning documents have been provided. As additional relevant documents are identified, they will also be reviewed. These include but are not limited to: a) the costed strategic workforce plan; b) human resource policy guidelines; c) the task-shifting strategy; d) health workforce performance monitoring plans; e) district-level plans for supportive supervision; and f) training plans for improving pre- and in-service training. Questionnaires and checklists designed for this evaluation will examine and verify the completeness and effectiveness of certain project activities along with country ownership of these activities. These instruments include:

- Key Informant Questionnaire
- Health Facility Questionnaire
- District Questionnaire
- Quantitative HR Data Checklist
- Focus Group Discussion Guide

Key Information Interviews (KIIs) using structured interview guides: These will be tailored to the group of individuals being interviewed to elicit information to: a) validate and, where possible, verify project approaches, interventions, and achievements and their current technical and strategic appropriateness; b) secure opinions and perceptions of project implementation effectiveness and issues, and identify gaps in project activities; c) obtain first-hand reports on training received, health system process changes, and overall capacity building; d) determine how stakeholders and beneficiaries interact with the project regarding issues of leadership, ownership, partnership, and collaboration; and e) determine how the project has enabled change in the area of human resources for health. KIIs will be conducted with the following groups of people:

1. MOH officials
2. MOPS and MOES officials
3. District level health officers, management teams, service commissions
4. UCP (field and HQ)

5. Members of the HRH TWG
6. Technical support partners
7. USAID
8. Private sector partner
9. Additional USAID-funded implementing partners working on similar issues

Focus Group Discussions (FGDs): A structured interview with a question guide for specific topics. The discussions will focus on work environment, training opportunities, staff commitment and performance, and use and/or potential use of ICT and mobile phones. The FGDs will be conducted at district-level facilities and will be conducted with facility staff.

All data collection instruments are provided in Annex 4.

Selection Criteria (Districts, Facilities, Key Informants):

Six districts will be sampled by the Evaluation Team. These districts were chosen via purposive sampling based on the following ranked criteria:

1. Total number of activities implemented in the district were greater than six[4]
2. HRIS was implemented by UCP in the district
3. District performance has been estimated[5]
4. Districts both geographically accessible and not accessible

Districts with a range of 6-11 intervention activities undertaken during the life of the project were given priority. This enables an examination of lessons learned and intervention effectiveness. A cut-off of a minimum number of six activities was chosen as it was slightly lower than the mean in the range of the total range of activities (1-13). Four districts (as well as at the central level) were selected to examine HRIS implementation with UCP support, since this has been one of the significant undertakings of UCP. Two districts where HRIS had been implemented by WHO, were also selected to examine potential differences in implementation. Other criteria includes past performance, that is at least, three "high," one "medium," one "low," and one "not known" performing district were chosen. Finally, the Team considered the geographical access as a factor. This resulted in the preliminary selection of six (6) districts for the field visits (marked in green in Table 1):

- Mityana
- Kabarole
- Namutumba
- Dokolo
- Mbale
- Nakasongola

The final selection of districts will be made in collaboration with UCP and USAID and may include additional criteria such as district-level leadership. Details of the results are given below in Table 1.

Table II-1: District Selection Criteria

[4] UCP Annual Report, October 2012 (Year 3).

[5] Ibid.

District	Total Activities	HRIS	Performance Known*	Geographically Accessible
Oyam	13	UCP	Y = **H**	Y
Busia	12	WHO	Y = M	Y
Amolatar	11	UCP	Y = L	N
Kabarole	10	UCP	Y = H	N
Namutumba	11	UCP	Y = **L**	Y
Kamuli	11	UCP	Y = H	Y
Dokolo	10	UCP	Y = H	N
Mubende	10	WHO	Y = H	Y
Mbale	8	WHO	Y = H	N
Mityana	9	WHO	Y = **M**	Y
Butaleja	7	UCP	Y = H	N
Sironko	8	UCP	N	N
Iganga	7	UCP	N	Y
Gulu	6	UCP	N	Y
Apac	6	UCP	N	N
Lira	6	UCP	N	Y
Pader	6	UCP	N	N
Nakasongola	6	UCP	N	Y
Bududa	6	UCP	N	N
Bugiri	6	UCP	N	Y
Budaka	6	UCP	N	N
Manafwa	6	UCP	N	N

H = Ranking of 1-37; M = Ranking of 38-75; L = > 75

Site Visits Within Districts: In selecting sites to visit within districts, the team will visit 2-3 health facilities (HC IV, III, II) in each district visited. In each district, the team will attempt to interview district level health officers (DHOs), management teams, and service commission members in each district visited, depending on their availability. At each facility, the Team proposes to interview administrative and health worker staff using in-depth interviews and a health facility check list. Three focus group discussions will be undertaken at health facilities with health workers representing the categories of cadres deployed at each level of facility (HC IV, III, II). And, at the national level, the Team will meet with key stakeholders who will be identified based on input from the USAID and UCP management teams (see proposed list above under Data Sources).

Data Analysis

The general procedure for data analysis will be that the Team will enter the quantitative data in Excel tables, compiling and coding it appropriately. The Team will analyze the quantitative data using Excel to provide descriptive statistics (means, frequencies, and distributions, when applicable), and, if possible, examine baseline and post-intervention changes to see if there is a trend. These descriptive statistics will be presented in a variety of graphic representations, which may include bar charts, line graphs, and other appropriate visual tools. Analysis of quantitative data will be primarily descriptive to summarize key results. Comparisons of before and after UCP interventions will be carried out if appropriate data are available through secondary databases. When possible, both quantitative and qualitative data will be disaggregated by gender (gender questions will be included within relevant questionnaires and other tools).

Qualitative data will be analyzed using a Qualitative Data Analysis Matrix. The team will analyze the emergence of opinions, perceptions, and issues. The data will be synthesize to determine recurrent themes and issues. Where appropriate, these data will be presented in tables.

Quantitative and qualitative data will be analyzed on the basis of the four (4) major questions of the Performance Evaluation. This analysis will be further enhanced by examining the data within the context of the domains within the four evaluation questions.

Table II-2: Evaluation Questions and Key Themes/Domains for Analysis

Evaluation Question Number	Key Themes/Domains To Be Summarized
1. How effective has the project been in achieving its Intermediate Result 1: "Increased Capacity for HRH Policy and Planning" by the third year? Are the outcomes expected by September 2014 still valid and achievable, or do they need to be adjusted to reflect realities of the current context?	1) capacity building (policy and planning) 2) effectiveness (project implementation and management)
2. Does performance in the last three years demonstrate an appropriate technical and strategic approach by UCP to performance management and performance improvement in the current context? What interventions are yielding, or have the potential to yield, the greatest impact and what interventions are not, and are there any additional interventions that could be more effective?	2) effectiveness (project implementation and management) 3) technical appropriateness (performance management and improvement) 4) strategic appropriateness (performance management and improvement)
3. How well has UCP strengthened country ownership and sustainability of their HRH- related interventions, and are there any additional interventions/activities that could enhance country ownership and sustainability?	5) ownership 6) sustainability
4. How well has UCP strengthened and supported the private not for profit (PNFP) sector? How well has UCP supported the work of other USAID Health and HIV/AIDS implementing partners, and are there any additional interventions/activities that could have strengthened the PNFP sector more effectively?	2) effectiveness (project implementation)

As stated above, the report will list each evaluation question followed by Findings, Conclusions, and Recommendations section with Analysis section and summary at the end of the Final Report. The end summary will focus on priority issues for UCP to address and major lessons learned based on the answers provided in examining the four Evaluation Questions. Additionally, this summary section will note if there were any differences of opinion among the Evaluation Team members. This approach should aid the Team in finding gaps in the current activities and processes. Specifically, the Team will:

1. Review UCP reported achievements against the PMP and current work plan.
2. Summarize commonalities related to the topics covered in the KIIs. Main topics will cover the project implementation process including: ownership; practicality; effectiveness; gaps; suggestions for improvements; and lessons learned. The focus will be on:
    a. Project management and implementation process, including communication between the UCP and stakeholders
    b. Awareness and perceptions of effectiveness of project inputs and activities to date and probable long-term impact

c. Ownership and processes to support sustainability

d. Perception of UCP priority activities and inputs and recommendations to improve these/make them more relevant to the GoU

3. Develop descriptive statistic tables highlighting key themes.
4. Develop tables presenting details on grouped items relevant to management and systems to support services that have been addressed by UCP.
5. Develop tables summarizing key quantifiable items from staff satisfaction surveys/focus groups discussions done at the district-level facilities. Qualitative information will be used in the text to supplement these tables.
6. Develop tables summarizing availability of staff and experience with supervision by province.
7. Examine data and conduct analysis for any trends during the life of the project including HRH expenditure data using spreadsheet and charts, data on recruitment, retention, deployment. Specific HRH outcomes such as recruitments, retention, etc. will be examined and compared with UCP targets.

Ethical Considerations

The Evaluation Team will for all key informant interviews and focus group discussions implement a policy of informed consent (see Annex 3 for an example) and all interviews will be done on a voluntary basis. Interviewees will be given the option to opt-out of particular questions or the whole interview, if at any time they believe a response would contain sensitive information. The information provided as part of these interviews and discussions will not be linked to any specific person in the Final Report and all information provided will be kept confidential and used for planning purposes only. Only general identifying information (organization, geographical unit, gender, and age if reported voluntarily) will be utilized. Any information that could be directly linked to an individual will not be used. Only members of the Evaluation Team will have access to the transcripts and raw data. The Final Report will be a synthesis of the Team's analysis drawn from interviews from numerous respondents. Any included quotes to highlight particular issues will not include names.

Study Limitations

The limited resources and time frame for the Performance Evaluation will constrain the sample size and the depth of evaluation to some extent. The bulk of the Performance Evaluation will depend upon qualitative information generated through key informant interviews and focus group discussions, and document review, with both primary and secondary quantitative data collected being used to provide more depth and perspective to the views gathered and provide illustrative examples of issues; but, not to draw statistically significant comparisons or analyses. As previously mentioned, the findings may not be generalizable beyond UCP and Uganda. However, the data will be collected objectively and will measure change between project start and the period of this evaluation using the proposed tools. Qualitative methods will produce more limited information on the quality and effectiveness of the interventions that may limit drawing solid conclusions.

4. PREPARATIONS FOR FIELD WORK

The evaluation will be carried out by the Evaluation Team in cooperation with USAID and UCP teams. To ensure quality of data collection, the HRH expert will brief team members on data collection for all instruments proposed in this Inception Report that is use of all instruments, and how to conduct interviews and participate in data collection and analysis.

1. Accordingly, the Performance Evaluation will include the following steps:
2. Finalization of data collection tools
3. Formation of two data collection teams who will conduct visits to three districts each
4. Review and training on tools
5. Conducting the data collection with quality-control checks interspersed

6. Data entry and analysis
7. Report writing

5. TIMELINE

	Tasks and Deliverables* ***(Bold italics = deliverable)***
Sept. 9–27	- Document review by all 4 team members - Draft protocols and instruments, analytical plans - Virtual Team Building: review SOW & background reading; discuss evaluation report, work plan & individual assignments; review logistics - Develop evaluation design & methodology, sampling, analytical plans/tools, work schedule ***USAID IN-BRIEFING Week of September 23***
Sept. 30	**Draft Inception Report due to IBTCI Sept. 30 COB 1700**
Oct. 1 COB	**IBTCI reviews draft report and provides comments**
Oct. 2–3	Team addresses IBTCI comments
Oct. 3 COB	**Team submits revised Draft Inception Report to IBTCI**
Oct. 4 COB	**IBTCI submits Draft Inception Report to USAID**
Oct. 11	USAID provides comments on Draft Inception Report
Oct. 14–15	Team addresses USAID comments
Oct. 16 COB	**Team submits revised Inception Report to IBTCI**
Oct. 18	**IBTCI submits Final Inception Report to USAID**
Oct. 7–18	- IBTCI team/logistics mobilization - LC makes IP, IntraHealth, MOH appointments for following week - Contract enumerators
Travel Oct. 20	*ARRIVAL IN COUNTRY* International Experts arrive in Uganda
	Field Days
Oct. 2–26	Begin data collection , discuss SOW and evaluation work plan - Meet IntraHealth & MOU POC
Oct. 28–Nov. 2	Continue data collection - Begin analysis
Nov. 13–15	Data collection in 2 districts (Team A) Data collection in Kampala (UN, USAID partners, and MOH), data synthesis and analysis (team B)
Nov. 18–19	Data collection in 2 districts (Team B)
Nov. 20–21	Data synthesis

	Tasks and Deliverables* ***(Bold italics = deliverable)***
	Informant Interview with Dr. Navaratnasa**my** Paraniethara/health technical reps from USAID
Nov. 23	HRH Expert returns to Kenya
Nov. 23–Dec. 1	Report writing and preparation of PowerPoint presentation of findings to USAID
Dec. 4	Preliminary Out Briefing with USAID team (changed from Nov 13-15, to allow HRH specialist to be present)
Dec. 6	Out Briefing with USAID Mission Front Office
Dec. 11	Submission of draft report to USAID (changed from Dec 9)
Dec. 26	USAID returns draft report / feedback to Team
Jan. 10	***FINAL REPORT submitted to USAID*** *(63 WORKING DAYS AFTER FIRST WORK DAY IN-COUNTRY) & CD OF ALL DATA RECORDS*
Jan. 31	FINAL REPORT POSTED

* This timeline does not include the weekly updates that the team will provide to USAID. These weekly updates will also provide the Team the opportunity to request any reasonable assistance from USAID, if needed.

6. DELIVERABLES

1. In Briefing
2. Inception Report
3. Weekly Progress Reports
4. Oral Presentation
5. Draft Evaluation Report
6. Final Report

7. EVALUATION MATRIX

Evaluation Questions	Sub-questions	Indicator/Performance Measure	Data Source (Primary and or Secondary)	Data Collection Instrument	Data Analysis Plan
1) How effective has the project been in achieving its Intermediate Result 1: "Increased Capacity for HRH Policy and Planning" by the third year? Are the outcomes expected by September 2014 still valid and achievable, or do they need to be adjusted to reflect realities of the current context?	To what extent are outputs and targets achieved? *The out puts relating to Result 1 include:* a rational and sustainably costed strategic workforce plan; a functional and sustainable HRIS at national or sub-national level; workforce data systems; task shifting strategy developed; HR policy guidelines in use at districts level; support and advocacy for increased budget for HRH (actual and percentage). What outputs have been achieved? What are those that have not been achieved? What is the Level of the participation of the different stakeholders in the development of the plans and strategies above? To what extent do the above strategies, guidelines, and plans respond to HRH issues at national and sub-national level? Has the budget for HRH increased (actual and as a % of total expenditure on health) over the years?	Evidence of existence of a: costed strategic workforce plan; a functional and sustainable HRIS at national and sub-national levels; workforce data systems; task shifting strategy; HR policy guidelines at districts level. Review of indicators and targets, and costed (budgeted) prioritized work plan for implementation and monitoring at the national and sub-national levels for the above. Strategies/plans/guidelines: Evidence of use of the strategies, plans, and guidelines above at national and sub-national level. Extent to which the above strategies, guidelines, and plans respond adequately to issues affecting HRH at national and sub-national levels. HRH expenditure, actual and as a proportion (%) of total expenditure on health national and sub-national levels. Trend analysis of # and % of posts filled.	Desk review of UCP documents (e.g. activity reports, program status report, Background to the budget and National Health budget etc.). Interviews with project management. Key informant interviews with informants at national and sub-national level (public service commission, ministry of health, district service commission etc.). Project M&E system data. HRIS at national and sub-national level Focus Group Discussions incorporating with health workers and other governance structures such as HUMCs (to assess if there have been policy changes related to performance support	Semi-structured interview guide. Structured (document) review checklist. Data extraction form. Survey questionnaire.	Content and thematic analysis of using Atlas Ti/NVivo. Trend analysis of HRH expenditure data using spreadsheet and charts. Trend analysis data on recruitment, retention, deployment using spreadsheet. Specific HRH outcomes such as recruitments, retention, etc.) will be examined and compared with UCP targets. Questionnaire data will be entered and analyzed using Excel.

Evaluation Questions	Sub-questions	Indicator/Performance Measure	Data Source (Primary and or Secondary)	Data Collection Instrument	Data Analysis Plan
	What is the current number and percentage of approved posts filled by appropriately trained health workers? Has number and percentage improved since the outset of the UCP? What is the trajectory going forward? Has there been improvement in the rates of recruitment and retention, both in targeted districts/areas and nationally? Is there improvement in service coverage of personnel in underserved or "hardship" areas, including northern Uganda? Is there improvement in the availability of health workers? Improved availability of health workers to deliver health and HIV/AIDS services? (Decreased rates of absenteeism)?	Rates of recruitment & retention, both in targeted districts/areas and nationally. Retention rates will be calculated, based on the ratio of exits from the health workforce i.e. No. of health workers who left the active labor force in the last year/total # of health workers. Assessment of management practices for improved recruitment, deployment, and retention. Assessment of Health Workforce Performance Support systems and staff satisfaction policies. Distribution of HRH: Service coverage of personnel in underserved or "hardship" areas, including northern Uganda. Rates of absenteeism among health workers, calculated as # of days of employee absences over a given period in the health workplace/ Total # of scheduled working days among employees over the same period in the same place.	systems in place e.g. jobs aids, appraisals, in-service training, staff satisfaction, absenteeism etc.).		
2) Does performance in the last three years	To what extent is the program aligned to national HRH	Information on: Program design and program	KIIs UCP management teams,	Semi-structured interview guide.	Content and thematic analysis of

Evaluation Questions	Sub-questions	Indicator/Performance Measure	Data Source (Primary and or Secondary)	Data Collection Instrument	Data Analysis Plan
demonstrate an appropriate technical and strategic approach by UCP to performance management and performance improvement in the current context? What interventions are yielding, or have the potential to yield, the greatest impact and what interventions are not, and are there any additional interventions that could be more effective?	priorities? Does it address critical needs of the HRH? Was the program based on adequate diagnostic/ feasibility studies? What management and implementation arrangements were put in place to supports the achievement of results? Did the program adopt the most efficient approaches in implementation? Was program management responsive to changing conditions on the ground? How well does the program management structure support/facilitate project implementation? To what extent does the UCP collaborate or work with other institutions and stakeholders in the health sector? How beneficial have these collaboration/partnerships been? What is the impact of the different program activities on the expected outcomes? Which activities are contributing to or more likely to yield the greatest impact?	implementation and management: structures, implementation arrangements, coordination arrangement, partnerships, stewardship and management of resources etc.	policy makers, e.g. members of the HRH technical working group in the ministry of Health, other key stakeholders. Project M&E system data. Document/record review (e.g., activity reports, program status report).	Structured (document) review checklist. Questionnaire to rate performance may be used.	qualitative data using Atlas Ti/NVivo. Statistical analysis.

Evaluation Questions	Sub-questions	Indicator/Performance Measure	Data Source (Primary and or Secondary)	Data Collection Instrument	Data Analysis Plan
3) How well has UCP strengthened country ownership and sustainability of their HRH- related interventions, and are there any additional interventions/ activities that could enhance country ownership and sustainability?	What is the level of the participation of the Government at national and sub national in the development of the plans and strategies in HRH?	Evidence of use of the HRH strategies, plans, policies and guidelines at national and sub-national level.	Key informant interviews with informants Government officials at national and sub-national level. Documents review: HRH plans, guidelines.	Semi-structured interview guide.	Content and thematic analysis of qualitative data using Atlas Ti/NVivo.
4) How well has UCP strengthened and supported the private not for profit (PNFP) sector? How well has UCP supported the work of other USAID Health and HIV/AIDS implementing partners, and are there any additional interventions/activities that could have strengthened the PNFP sector more effectively?	To what extent does the UCP collaborate or work with PNPF sector, other institutions, and USAID, HIV/AIDS partners, stakeholders in the health sector? How beneficial have these collaboration/partnerships been?	Information on: Program design and program implementation and management: structures, implementation arrangements, coordination arrangement, partnerships, stewardship and management of resources etc.	KIIs UCP management teams, policy makers e.g. members of the HRH technical working group in the ministry of Health, other key stakeholders. Document/record review.	Semi-structured interview guide.	Content and thematic analysis of qualitative data using Atlas Ti/NVivo.

Evaluation Questions	Sub-questions	Indicator/Performance Measure	Data Source (Primary and or Secondary)	Data Collection Instrument	Data Analysis Plan

Note: Appropriate key informants for key informant interviews will be identified in collaboration with Project, USAID, and the HRH TWG.

ANNEX 1: SCOPE OF WORK

See Annex I for the full scope of work for this evaluation.

ANNEX 2: ILLUSTRATIVE POTENTIAL LIST OF CONTACTS / ORGANIZATIONS (TO BE FINALIZED IN COLLABORATION WITH UCP AND USAID)

1) UCP
2) USAID
3) Ministry of Health
4) Ministry of Public Services / Public Services Commission
5) Ministry of Education and Sports
6) Human Resources for Health Technical Working Group members
7) Health Professionals Councils
8) District Service Commissions
9) District Health Management Teams
10) District Health Officers
11) District-level facilities (chosen at random; management and clinical staff)
12) Private sector (UCMB, UMMB, UPMB)
13) Makerere University School of Public Health
14) WHO
15) UNICEF
16) The World Bank
17) Belgian Technical Cooperation (BTC) – Capacity Building Project – Contact: Hans Beks
18) USG Implementing Partners
    a. NU-HITES
    b. SURE
    c. HCI/ASSIST
    d. Baylor Uganda (CDC Partner)
    e. STAR (E, SW, EC)

ANNEX 3: (SAMPLE) INFORMED CONSENT STATEMENT

Introduction and Consent Form
Good day. My name is _____, and we are conducting an evaluation of the Uganda Capacity Program in collaboration with the Government of Uganda (GoU), USAID and other stakeholders. The purpose of the mid-term performance evaluation of USAID/ Uganda Capacity Program (UCP) implemented by IntraHealth International is to **determine the effectiveness of the interventions of UCP and document what has worked well and what has not.** Lessons from this evaluation will be integrated in future programming within the Mission and the Ministry of Health (MoH) to support national efforts in strengthening the health system in Uganda.

You were selected as a Key Informant to provide information for this evaluation. The information collected will only be used for the evaluation. All the information is strictly confidential. *[Interviewer collects signed consent forms]*.
I would also like to clarify that this interview is voluntary and that you have the right to withdraw **from interview at any point without consequence.**

Thank you very much.

At this time, do you have any questions?
Are you willing to participate in this study?
Yes 1) Proceed
No 2) Thank the KI and STOP HERE
May I begin the discussion now?
Yes 1) Continue with the Key Informant Interview
No 2) STOP HERE
Start Time: ____:____
Interviewee signature _____ Date _____
Interviewer signature _____ Date _____
Thank you

ANNEX 4: DATA COLLECTION INSTRUMENTS

See Annex III: Data Collection Instruments.

ANNEX III: DATA COLLECTION INSTRUMENTS

I. KEY INFORMANT QUESTIONNAIRES

(For HRH stakeholders including government leaders, PNFPs, HRH TWG members, and donors)

	Question/Information Required
00	Date: _____ Organization _____ Name of respondent :_____ Age _____ Gender: M F ☐ ☐ Designation: _____
01	Has your organization worked with or received support from the Uganda Capacity Project (UCP)? Yes No If **YES**, Please prov☐etails☐e type of interaction: _____ _____ _____ _____
02	To what extent has UCP succeeded in achieving its goal of strengthening HRH in Uganda in its three result areas shown below- Where appropriate give specific examples to support your views **Result Area 1: Enhanced capacity of HRH policy and planning** _____ _____ _____ **Result Area 2: Strengthened systems for improved quality, performance based workforce** _____ _____ _____ **Result Area 3: Improved health workforce management practices** _____ _____ _____ _____
03	In you view, what are the three main achievements of UCP? _____ _____ _____ _____
04	Suggest three areas that UCP needs to improve so as to be more effective _____ _____ _____
05	How has UCP performed in the areas below and what suggestions do you have on how this can be improved? A) Development of country/local ownership for programs and interventions _____ _____ _____ B) Strengthening sustainability of programs and interventions

	Question/Information Required
	_____ _____ _____ C) Ensuring interventions are technically sound and appropriate for the Uganda context _____ _____ _____ _____
06	What are your views of the usefulness of task-shifting as an approach to address the HRH challenges Uganda faces? _____ _____ _____ _____
07	Describe the three main HRH challenges that Uganda faces and for each propose some solutions **Challenge 1**:_____ Solution:_____ **Challenge 2**:_____ Solution:_____ **Challenge 3**:_____ Solution:_____
08	Please provide us with any other additional information on ways in which the HRH situation in Uganda can be improved. _____ _____ _____ _____ _____

2. DISTRICT LEVEL QUESTIONNAIRE

(For DHTs, DHOs, HR Officers)

	Question/Information Required
00	Date: _____ District: _____ Name of respondent :_____ Designation: _____ Gender: M F Age ____ ☐ ☐ District Classified as a "Hardship" area: Yes No ☐ ☐
01	Have you received any support from the Uganda Capacity Project (UCP)? Eg OSH, HRIS, PM, PI, L&M, WISN Yes No ☐ ☐ If **YES**, Please provide details of the support provided: _____ _____ _____ _____
02	Please describe the extent to which the support from UCP has been helpful (Or not helpful) in addressing your district's HRH challenges - Give specific examples _____ _____ _____ _____ _____
03	Describe the ways in which you have been involved in the selection, design and implementation of UCP supported interventions: _____ _____ _____ _____
04	Are the interventions supported by UCP relevant to your district's health and HR priorities? Yes No ☐ ☐ Give reasons for your answer: _____ _____ _____
05	Going forward, are you able to sustain the interventions that have been supported by UCP? Yes No To some extent ☐ ☐ ☐ Give reasons for your answer: _____ _____ _____ _____
06	Describe the three main HRH challenges that your district faces and for each propose some solutions **Challenge 1**:_____ Solution:_____ **Challenge 2**:_____ Solution:_____ **Challenge 3**:_____ Solution:_____
07	Do you have a current in-service training plan?

	Question/Information Required
	Yes No ☐ ☐ If **YES**, Please describe its content and if possible share a copy with us _____ _____ _____ _____
08	Please describe your approach to the following and share challenges and successes: A) Development and review of job descriptions _____ _____ _____ B) Staff performance appraisals _____ _____ _____ C) Staff time management _____ _____ _____
09	Do you have a district HRH plan? Yes No ☐ ☐ If YES" A) Who was involved in its development? _____ _____ _____ B) How are you using this plan and with what success? _____ _____ _____
10	Do you have a functional Human Resources Information System (HRIS) in your district? Yes No ☐ ☐ If **YES**, Please provide details including successes and challenges _____ _____ _____ _____
11	Provide us with the following information regarding your recruitment process: A) What successes have you had in improving your recruitment process? _____ _____ B) On average how long does it take from the time a staff leaves to when a replacement reports? _____ C) What challenges do you still face in recruiting staff? Suggest solutions to these challenges. _____ _____ _____

	Question/Information Required
12	Provide us with the following information regarding staff retention: A) What successes have you had in improving staff retention? _____ _____ B) What challenges do you still face in staff retention? Suggest solutions to these challenges? _____ _____ _____
13	Do staff in your district have access to Internet services? Yes No ☐ ☐ If **YES**, Please provide details including how the internet is being used to support staff performance and development and availability of computers _____ _____ _____ _____
14	A) How (if at all) are you using mobile phones to support and develop staff? _____ _____ _____ B) What suggestions do you have on how ICT and mobile phones can be used to support and develop staff? _____ _____ _____
15	Please provide us with any other additional information on ways in which the HRH situation in your district can be improved. _____ _____ _____ _____ _____
16	Please provide us with the data listed in the *"Quantitative HR Data checklist"*

3. HEALTH FACILITY QUESTIONNAIRE

(For Health Facility In-charges)

	Question/Information Required
00	Date: _____ District: _____ Name of Health Facility_____ Health Facility Level_____ Health Facility Ownership: Public Sector PNFP ☐ ☐ Respondent Name :_____ Designation: _____ Gender: M ☐ F ☐ Age ____
01	Have you received any support from the Uganda Capacity Project (UCP)? Yes No ☐ ☐

	Question/Information Required
	If **YES**, Please provide details of the support provided: _____ _____ _____
02	Please describe the extent to which the support from UCP has been helpful (or not helpful) in addressing your facility's HRH challenges. Give specific examples. _____ _____ _____ _____ _____
03	Describe the ways in which you have been involved in the selection, design and implementation of UCP supported interventions: _____ _____ _____ _____
04	Are the interventions supported by UCP relevant to your facility's health and HR priorities? Yes No ☐ ☐ Give reasons for your answer: _____ _____ _____
05	Going forward are you able to sustain the interventions that have been supported by UCP? Yes No To some extent ☐ ☐ ☐ Give reasons for your answer: _____ _____ _____ _____
06	Describe the three main HRH challenges that your Health Facility faces and for each propose some solutions **Challenge 1**:_____ Solution:_____ **Challenge 2**:_____ Solution:_____ **Challenge 3**:_____ Solution:_____
07	Please describe your approach to the following and share challenges and successes: D) Development and review of job descriptions _____ _____ _____ E) Staff performance appraisals _____ _____ _____ F) Staff time management _____ _____ _____

	Question/Information Required
08	Provide us with the following information regarding staff retention: C) What successes have you had in improving staff retention? _____ _____ D) What challenges do you still face in staff retention? Suggest solutions to these challenges. _____ _____ _____
09	Do staff in your health facility have access to Internet services? Yes No ☐ ☐ If **YES**, Please provide details including how the internet is being used to support staff performance and development. _____ _____ _____ _____
10	A) How (if at all) are you using mobile phones to support and develop staff? _____ _____ _____ B) What suggestions do you have on how ICT and mobile phones can be used to support and develop staff? _____ _____ _____
11	Please provide us with any other additional information on ways in which the HRH situation in your health facility can be improved. _____ _____ _____ _____ _____
12	Please provide us with the data listed in the *"Quantitative HR Data checklist."*

1. QUANTITATIVE HR DATA CHECKLIST

(For Districts and Health Facilities)
Number of respondents: ___
Number Male ___ Female ___

Please provide us with the following data for your district or health facility

1. What no/% of the approved positions are filled currently? **Note:** Disaggregate data by cadre, and gender and if available give data for previous three years.
2. How many staff attended in\–service training in the last financial year? **Note:** Give additional details including number of staff that have attended online courses and the courses done. Disaggregate by cadre and gender.

How many of your staff are currently away on study leave?
How many employees have left your health facility/district in the last financial year? **Note:** Disaggregate data by cause - For resignation_____ termination_____
death_____training_____transfer_____retirement_____ and if available give

data for previous three years disaggregated by cadre and gender.
How many staff did you get through the last major recruitment (2012?)? **Note:** Disaggregate by cadre and show recruited staff as a percentage of posts approved for recruitment
Of the above staff, how many have since left? **Note:** Disaggregate by cadre.

2. FOCUS GROUP DISCUSSION GUIDE

(Target audience – health workers)

- Opening activities
- Explain the purpose of conducting the focus group.
- Ask participants to sign the consent forms.
- Records the names of the FGD participants, their job titles, and gender. Participants should be selected to represent different cadres within the facility but should be of similar seniority.
- Explain that the evaluation team is committed to confidentiality.
- Encourage participants to share openly.
- Ask the following questions and record the responses.

Note: Please document the number of male and female participants and **note** differences in opinions made M ___ F ___

Discussion Questions

1. Have you interacted and, if yes, with which UCP?

_____
_____
_____
_____

What aspects of your work including the terms and conditions of work are you happy with and why?
What aspects of your work including the terms and conditions of work would you like changed and in which ways?

2. What suggestions do you have for improving staff commitment and performance?

What are your views on in-service training opportunities available to you?

3. What suggestions do you have for ensuring that you work in your current station longer?
4. What are your suggestions on ways that ICT and mobile phones can be used to support and develop staff?

Closing: In closing, thank the participants for taking part in the focus group discussion.

6. SIGN IN

District _____

Name	Designation	Gender Male/Female	Age (Optional)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

7. INTRODUCTION AND CONSENT FORM

Good day. My name is _____, and we are conducting an evaluation of the Uganda Capacity Program in collaboration with the Government of Uganda (GoU), USAID and other stakeholders. The purpose of the mid-term performance evaluation of USAID/ Uganda Capacity Program (UCP) implemented by IntraHealth International is to **determine the effectiveness of the interventions of UCP and document what has worked well and what has not.** Lessons from this evaluation will be integrated in future programming within the Mission and the Ministry of Health (MoH) to support national efforts in strengthening the health system in Uganda.

You were selected as a Key Informant to provide information for this evaluation. The information collected will only be used for the evaluation. All the information is strictly confidential. *[Interviewer collects signed consent forms]*.

I would also like to clarify that this interview is voluntary and that you have the right to withdraw from interview at any point without consequence.

Thank you very much.

At this time, do you have any questions?

Are you willing to participate in this study?

Yes 1) Proceed

No 2) Thank the KI and STOP HERE

May I begin the discussion now?

Yes 1) Continue with the Key Informant Interview

No 2) STOP HERE

Start Time: ____:____

Interviewee signature _____ Date _____

Interviewer signature _____ Date _____

Thank you

ANNEX IV: LIST OF PERSONS INTERVIEWED (FORMALLY THROUGH KIIS OR INFORMALLY THROUGH MEETINGS)

USAID/Uganda

Mark Meassick	Deputy Mission Director	**mmeassick@usaid.gov**
Lane S. Pollack	Learning Advisor	Office: (256) 414-306-001 ext. 6672 Email: lpollack@usaid.gov
Dr Navaratnasamy Paranietharan	Senior Health Systems Strengthening Advisor	Email: nparanietharan@usaid.gov
Tracy Miller	Contracting/Agreement Officer US Agency for International Development	Email: trmiller@usaid.gov
Rand Robinson	Organization, Program and Project Development Officer	
Joseph Mwangi		jmmwangi@usaid.gov
May Mwaka		mmwaka@usaid.gov

UGANDA CAPACITY PROJECT

Dr. Vincent Oketcho	Chief of Party	Email: voketcho@intrahealth.org
Dr. Grace Namaganda	Deputy Chief of Party	Email: gnamaganda@intrahealth.org
Rogers Enyaku	Senior Advisor, HRH Policy and Planning	Email: renyaku@intrahealth.org
Allan Agaba	Senior Monitoring and Evaluation Officer	Email: aagaba@intrahealth.org
Christine Nomatovu	Knowledge Management and Communication Manager	
Ruth M. Olwit	HRD Program Officer	
Ismail Wadinibere	HRIS Manager	
Paul Ouma	HR and Admin Officer	

Nobert Mijumbi	HRIS Developer	
Sarah Murungi Senior Advisor	Human Resources Management	

MINISTRY OF HEALTH

Dr. Lukwago Asuman	Permanent Secretary	Email: ps@health.go.ug
Dr. Ruth Aceng	Director General	
Dr. Allie B Kibwika – Muyinda	Assistant Commissioner, Human Resources Development	Email: kibs_moh@yahoo.co.uk
Dr. Isaac Ezati	Director Planning and Development	
Arthur Agaba Turyahikayo	HRM MIS Strengthening Advisor Uganda Health Systems Strengthening Project	Email: atryanhhikayo@yahoo.com
Dr. E. Mukooyo	Assistant Commissioner, Resource Center	Email: emukooyo@gmail.com
Francis Ntalazi	Assistant Commissioner, HRM	Francisntalazi@yahoo.com
Charles Isabirye	Human Resources Development	
Aliyi Walimbwa	Planning Officer/Desk Officer Human Rights and Gender	Tel: 0702447241
Lynn Owor	HR Officer/Desk officer OSH	Tel: 0714213616

MINISTRY OF EDUCATION AND SPORTS

Rose Nasali	Permanent Secretary
Sarah Namuli	Commissioner BTVET

MINISTRY OF PUBLIC SERVICE

Turyatemba Joseph	Assistant Commissioner	Email: josturya@yahoo.com

Bukulu Steven	Senior Management Analyst	Email: bukulusteven@yahoo.com
Joseph Nansera	Commissioner HRM	
Kiguli Herbert	Assistant Commissioner HRM	hkiguli@yahoo.co.uk
Savia Nankya Mugwanya	Assistant Commissioner HRM	Mugwanya.savia473@gmail.com

HEALTH SERVICE COMMISSION

Pius Okong	Chairman	Health Service Commission
Charles Twinomugisha	Commissioner	Health Service Commission

MEDICAL BUREAUS

Dr. Sam Orach	Executive Secretary Uganda Catholic Medical Bureau	sorach@ucmb.co.ug
Dr. Patrick Kerchan	Head of Programs Uganda Protestant Medical Bureau	pkerchan@upmb.co.ug

HEALTH PROFESSIONS COUNCILS

Dr. Katumba Ssentongo Gubala	Uganda Medical and Dental Practitioners Council	Gubala2000@yahoo.com
Training Officer UNMC		
Sebuwufu AHPC		
Maureen AHPC		

MULAGO HOSPITAL

J.B. Semakula	Asst. Commissioner, HRM Mulago Hospital	

DONORS

Dr. Juliet Bataringaya – Wavamunno	Country Advisor – Health Systems Development World Health Organization	Email: bataringayaj@ug.afro.who.int

Sean Blaschke	Health Systems Strengthening Specialist UNICEF	Email: sblaschke@unicef.org
Peter Okwero	Senior Health Specialist World Bank	pokwero@worldbank.org
Hans	Technical Adviser, BTC	

USAID IMPLEMENTING PARTNERS

Dr. Bazeyo	Dean, School of Public Health Baylor College of Medicine	
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Ella Hoxha	Chief of Party SDS Programme	Ella.hoxha@uganda-sds.org
Henry Kamau Kuria	Grants Director SDS Programme	Henry.kuria@uganda-sds.org
Robert Kalemba	Director of Programs SDS Programme	Robert.kalemba@uganda-sds.org
Charles Matsiko	Director HSS, NU-HITES	

DISTRICTS - MITYANA

Dr. Fred Lwasa Mpija	DHO	
Nanyanzi Florence	Personnel Officer	
Margaret Kawooya	DSC Chairperson	
Hussein Mukyibi	HR Officer	
CAO	District HQ	
Namuddu Margaret	Medical Records Asst. Mwera HC IV	
Livingstone Matovu	Clinical Officer Maanyi HC III	

KABAROLE

Tony Mugisa	Senior Clinical Officer District HQ	Tel: 0772373505

Tukahirwa Ana	District Malaria Focal Person/ Nursing Officer Mugusu HC III F	
Baguma Joseph	District Health Inspector	
Elizabeth Manyimake	District MCH Coordinator, Kabarole	
Natukunda Paul	Clinical officer Bukuku HC III	
Katusabe John Baptist	Asst CAO District HQ	Tel: 0704315617
Kamuhanda Gideon	Principal HR Officer District HQ	
Dr. Richard Obeti	Medical Officer Kibito HC IV	Tel: 0774979417
Makomi Steven	In-charge Karambi HC III	Tel: 0700770409
Mr. Godfrey	In-charge Iruhura HC III	Tel: 0772970436

MBALE

Dr. Waniaye John Baptist	District Health Officer	

NAMUTUMBA

Zainab	Personnel Officer	Tel: 0703668623
Tito Kayigwa	Principal Personnel Officer	Tel: 0782066705/0703132244
Balyejusa Mohamadi	Nursing Officer Magada HCIII	
Alinganyira Prossy	Enrolled comprehensive nurse Magada HCIII	
Mutesi Amulasi	Nursing assistant, Magada HCIII	
Tegule Asadi	Enrolled nurse, Magada HCIII	Tel: 0773293370
Kasadha Eric	Health assistant, Magada HCIII	
Mugonero Alex	Health assistant, Magada HCIII	
Konso Tabisa	Enrolled midwife Nsinze HC IV	
Baluka Joshne	Laboratory assistant Nsinze HC IV	
Nakyesa Irene	Nursing assistant Nsinze HC IV	

Wandera Thomas	Entomological assistant Nsinze HC IV	
Mutesi Margaret	Nursing assistant Nsinze HC IV	
Dr. Kiriya	DHO, District HQ	

DOKOLO

Dr. Okullo Obong	Medical Officer, Health Centre IV	
Judith Awino	Nurse/Facility I/C	
Achar Carrine	Nursing Office (Midwifery) Kangai HC III	
Ochen Simon Alengo Renison	Pharmacy Technician Health centre IV	
Omara Ejedio	Stores Assistant Health centre IV	
Ogwang Lawrence	Laboratory Technician Health centre IV	
Acen Betty	Nursing Officer Health centre IV	
Idong Judith	Nursing Officer (Midwifery) Health centre IV	

NAKASONGOLA

James Fred Obello	District Chief Administrative Officer (CAO)	
Zziwa Moses	District Health Inspector	Email: moseszziwaBG@yahoo.com
Karahukayo James	Biostatistician	Email: karahukayo@yahoo.com
Nakajju Allen	Midwife	HC IV Nakasongola
Brenda Nassolo	Clinical Officer, HC IV Our Lady	

ANNEX V: LIST OF DOCUMENTS REVIEWED

UCP Documents

- UCP Year 4 Work Plan
- UCP Year 4 Annual Report
- UCP Year 4 Work Plan
- Biannual HRH Report, September 2012 – March 2013
- Gender Inequality and Discrimination Analysis (GDIA) Assessment, 2012
- UCP Interventions Matrix by District
- Effect of Performance Improvement Implementation on Selected health Outcomes In UCP Supported Districts: Case of Mbale District, June 2013
- The Effect of Leadership and Management Training on The Performance Of Human Resources For Health Managers in Selected Districts, November 2012

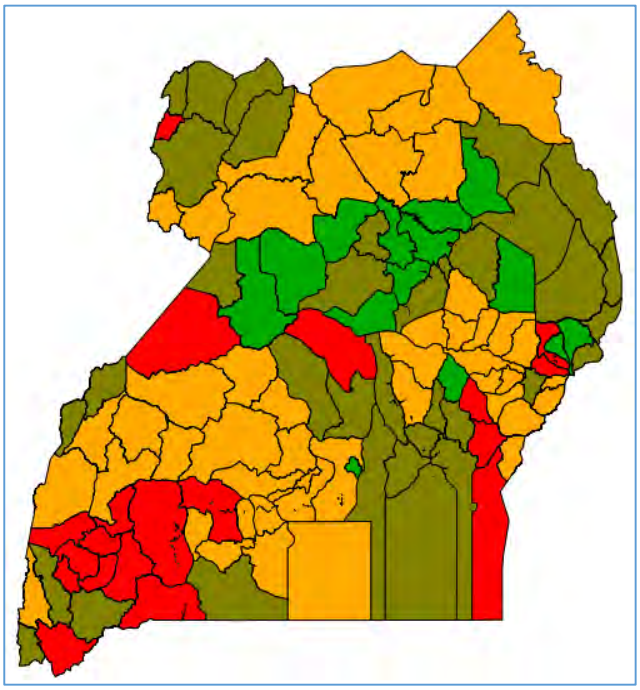
National Reports and Policy Documents

- Health Sector Strategic and Investment Plan, 2010/11–2014/15
- Annual Health Sector Performance Report, 2012–2013
- Uganda Health System Assessment, 2011
- Framework for Attracting and Retaining Public Officers in 'Hard-to-Reach' (HtR) Areas, march 2010
- Uganda HRH Strategic Plan – 2005–2020

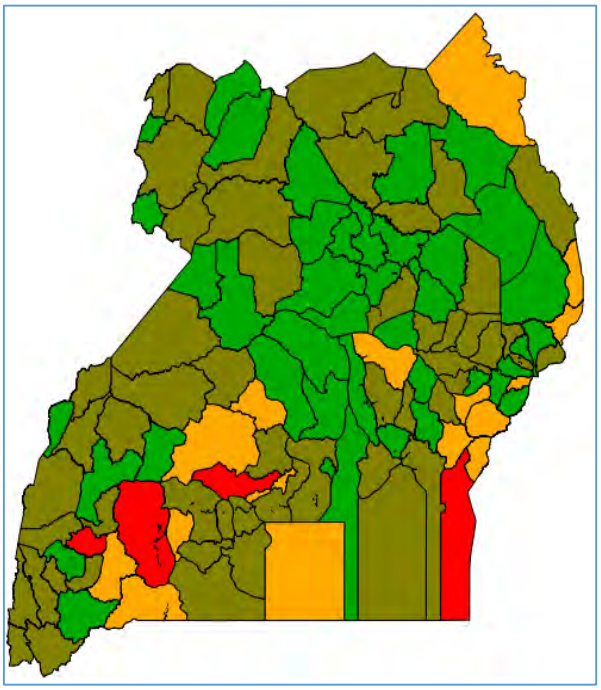
ANNEX VI: DISTRICT STAFFING IMPROVEMENT MAPS

The charts below show how the staffing levels of districts (% of approved positions filled) has improved between 2009 and June 2013

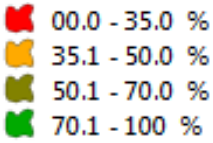
2009



2013



Key



Districts

The districts are ranked based on the level of staffing in 2011, with Namayingo having the lowest staffing of all districts in 2011.

#	District	No. of UCP Interventions Implemented	Staffing Norms	Posts Filled 2011	Posts Filled June 2013	% Increase in No. of Posts Filled	Staffing Levels - 2011 (%)	Staffing Levels – June 2013 (%)	Exits Under-served District Category *
1	Namayingo	1	315	60	103	72	19%	33	No
2	Buhwenju	3	193	46	68	48	24%	35	No
3	Kyankwanzi	4	257	69	176	155	27%	68	Yes
4	Ntoroko	3	173	48	101	110	28%	58	Yes
5	Amudat	1	115	32	52	63	28%	45	No
6	Kiruhura	5	737	218	205	-6	30%	28	No
7	Gomba	2	248	83	83	0	33%	33	No
8	Rubirizi	2	216	74	108	46	34%	50	Yes
9	Busia	13	517	180	215	19	35%	42	No
10	Ibanda	5	513	179	254	42	35%	50	Yes
11	Lamwo	1	343	120	111	-8	35%	32	No
12	Kaboong	3	483	174	167	-4	36%	35	No
13	Butaleja	11	530	192	264	38	36%	50	Yes
14	Sheema	1	544	211	218	3	39%	40	No
15	Luuka	1	326	131	131	0	40%	40	No

*UCP classifies underserved districts as those with a staffing level of below 50%

Key

Districts that exited "Under-served District" category

Districts whose staffing levels deteriorated

ANNEX VII: TABLES, CHARTS, AND FIGURES

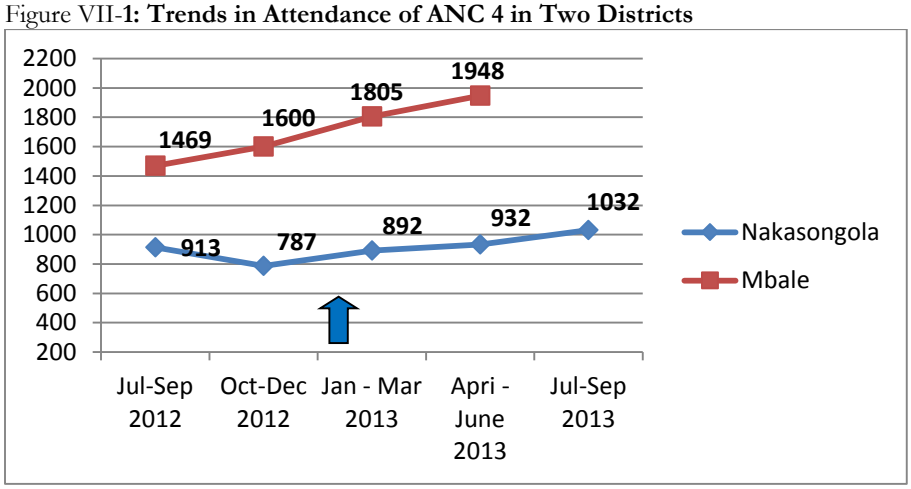
ANNEXES: QUESTION 1

Table VII-1: Alignment of UCP Interventions with HSSIP HRH Strategies

HSSIP HRH Strategies	UCP Interventions
Attain and retain the right HRH numbers and skills mix in the health sector	• Advocacy for increased HRH budgets • National and District HRH planning and budgeting • WISN • Occupational safety and Health (OSH)
Develop a comprehensive, well-coordinated, and integrated HRH information system	• HRIS
Strengthen capacities for HRH policy, planning, leadership, and management	• HRH Leadership and Management Training • Introduce Human Resources policy guidelines to districts
Improve HRH training and development to ensure adequate, relevant, well-mixed and competent community-focused health workforce	• Develop national and district plans for pre- and in-service training of health workers • Strengthen Health Professional Councils s to improve medical regulation and CPD • Support training of scarce cadres including midwives and pharmacy technicians • Build the capacity of health training institutions including the number and quality of tutors
Strengthen HRH systems and practices	• Strengthening of recruitment processes and capacity at the central and district level • Strengthening of District Service Commissions • Performance Management and Performance Improvement • E-short listing
Improve the utilization and accountability for HRH resources in respect of HRH management	• Strengthen supportive supervision • Build the capacity of Health Unit Management Committees

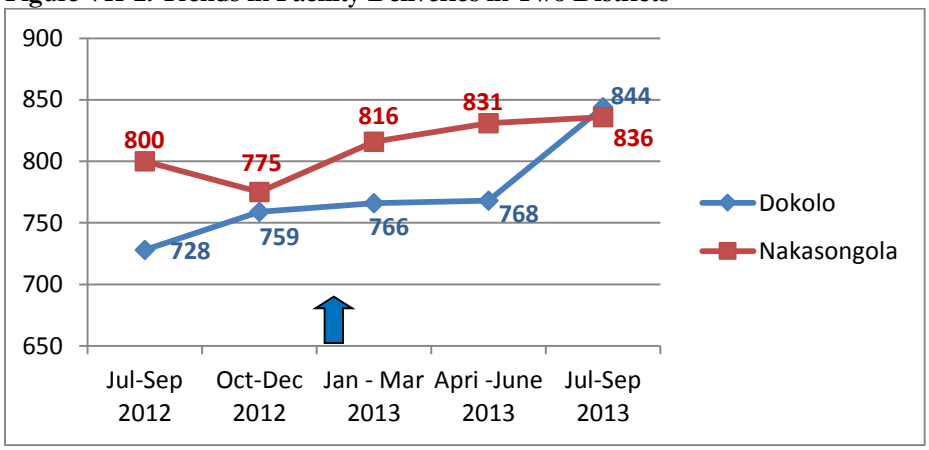
Trends in Service Coverage Indicators After the 2012 National Recruitment

Figure VII-**1: Trends in Attendance of ANC 4 in Two Districts**



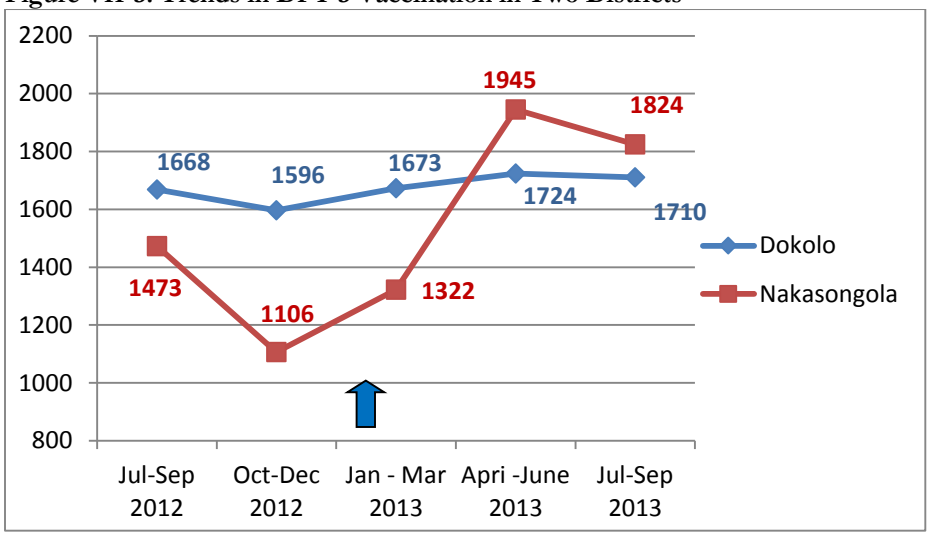
Source: District HMIS Data (arrow indicates timing of the national recruitment)

Figure VII-2: Trends in Facility Deliveries in Two Districts



Source**:** District HMIS Data (arrow indicates timing of the national recruitment)

Figure VII-3: Trends in DPT 3 Vaccination in Two Districts



Source: District HMIS Data (Note arrow indicates timing of the national recruitment)

ANNEX VIII: LEVEL OF OWNERSHIP AND SUSTAINABILITY OF UCP INTERVENTIONS

Findings: Ownership and Sustainability	KEY INTERVENTIONS						
	HRIS	**HRH Action and Recruitment Planning**	**Performance Improvement**	**HR Leadership and Management Training**	**OS&H**	**WISN**	**Performance Management**
Ownership	High ownership of HRIS and respondents interviewed: HRIS meets an important gap. Most respondents reported frequent use of system for developing reports and for decision making	High ownership for recruitment interventions as has been challenging area especially at the district level. A tool like the e-short-listing filled an identified gap and was used by almost all the DSCs in the recent national recruitment	The heath sector owned this intervention as they had an interest in improving quality standards	There was high ownership and especially at the district level	High ownership for the program as it meets an identified need	This tool was seen by some districts and by PNFPs as meeting an area of need and so had high ownership. However some districts did not find it helpful and hence ownership was low.	High ownership at central and district level
Sustainability	Concerns about sustainability of HRIS especially technical expertise to maintain the hardware and software, cost of hardware, cost of internet subscription and high turnover of trained staff	Some DSCs felt some elements of the program such as financial support for recruitment advertising and procurement and maintenance of computers was not sustainable due to budgetary constraints.	Sustainability on this intervention was low implementation of most IP work plans required resources that were not available especially in respect to infrastructure and supplies	This intervention is fairly sustainable due to the fact that a pool of local trainers has been build.	Concerns about sustainability of OSH given lack of structures to support the initiative at MoH, district and facility level and also lack of budgetary support to implement OSH work plans.	WISN is sustainable as it is a low cost intervention	Most tools developed by MoPS but the Ministry lacks funds to operationalize, especially at the district level

Findings: Ownership and Sustainability	KEY INTERVENTIONS						
	HRIS	**HRH Action and Recruitment Planning**	**Performance Improvement**	**HR Leadership and Management Training**	**OS&H**	**WISN**	**Performance Management**
		Approaches to recruitment- e-short-listing was sustainable. Note: 700 health workers were recruited by the government, their employment in terms of the wage bill is sustainable.			MOGLSD has the national OSH mandate has however integrated support to the health sector in their plans. A pool of trainers have also been developed		

ANNEX IX: STATUS OF UCP IRI PERFORMANCE INDICATORS

UCP Performance Indicators On-track or Not On-track by End of Year 4

Performance	Actual Year 4 (2013)	On-track	Not On-track	Comments
Project Strategic Objective: Strengthen the capacities of central ministries, districts, and professional councils to effectively and efficiently manage their human resources for delivery of health and HIV/AIDS services				
1. Percent of approved posts filled by trained health workers in UCP-supported districts	Baseline 2009 (48%) 2013 (60.5%)	✓ **Exceeded**		Target exceeded following nationwide recruitment of health workers in 112 districts. Activities contributing to this result by UCP were: -Supported MOH to develop a costed national recruitment plan that was used to advocate for increased funding, resulting in allocation of 49.5 billion Uganda shillings for hiring over 7,200 health workers in 112 districts & provided finances to run advertisements for 10,210 vacant positions in 112 districts. -Membership of National Recruitment Task Force provided technical guidance in execution of the overall national recruitment exercise.
2a. Percent of supported districts using HRIS data for decision making	100% (49)	✓ +		UCP supported district HR managers in analyzing data from existing information systems to produce costed HRH plans such as recruitment plans, deployment plans.
2b. Number of supported ministries using HRIS data for decision making	3	✓ MOH Partially MOES/MOPS		HRH managers at MOH, MOPS, and MOES provided access to HRH data from information sources supported by the program, including HRH audit reports, recruitment plans, HPC registration and licensure reports, electronic HRIS databases to make evidence-based plans, e.g. recruitment plans.
Project Intermediate Result 1: Enhanced capacity of HRH policy and planning				
Sub IR 1.1. A Functional and sustainable HRIS in use at the national and selected district level				
3. Percent of targeted districts with functional HRIS databases	100% (49)	✓		HRIS databases in districts kept functional through continuous monitoring and technical support to districts.

Performance	Actual Year 4 (2013)	On-track	Not On-track	Comments
4a. Existence of national (ministry) databases that enable stakeholders to access relevant data for policy formulation and program management and improvement	1 (MOH)	✓		Only MOH HRIS database is established and accessible online through the Internet link http://hris.health.go.ug/ **MOES:** Pre-service component of the iHRIS Train database is functional; currently working with MOES to provide IP address to put database online. **MOPS**: Has IPPS and IFMS. The process of linking to HRIS slowed by changes in staffing of trained personnel.
4b. Existence of national (Health Professional Council) databases that enable stakeholders to access relevant data for policy formulation and program management and improvement	4	✓		All 4 HPC HRIS databases and 49 district HRIS are accessible online through the Internet link http://hris.health.go.ug/
4c. Existence of sub national (district) databases that enable stakeholders to access relevant data for policy formulation and program management and improvement	49	✓		All 49 district databases can be accessed online through the Internet link http://hris.health.go.ug/. District HR managers have access to their district HRIS database locally as it is installed within the district headquarter premises.
5. Percent of districts with HR managers that have access to Health Professional Council databases	100% (49)	✓		HR managers in all districts given access to HPC online reports to obtain up to date information on professional standing of health workers through the Internet link http://hris.health.go.ug/. This was supplemented by mailed lists of registered/ licensed health workers to the districts during the nationwide health worker recruitment exercise.

Performance	Actual Year 4 (2013)	On-track	Not On-track	Comments
Sub IR 1.2.1 Human resources policy guidelines in use at district level				
6. National recruitment plan in place and is used to advocate for increased funding for HRH	1	✓ +		Recruitment plan for FY 2013/2014 developed. UCP further supported MOH to develop a 3 year recruitment plan (FY 13-FY 16) as part of strategic forecasting.
Sub IR 1.2.1 Rational and sustainably costed strategic workforce plan implemented				
7. Percent of districts with costed annual HRH Plans	59% (66)	✓ +		Worked partners (ICB & SDS) to provide technical support to 66 districts to develop HRH action plans and integrate them into overall district annual plans for FY 13/14. Target partially achieved. Partners delayed to release resources for supporting the remaining districts.
8. Number of people trained in HRH policy and planning	74	✓ +		Supported MOH and Uganda Catholic Medical Bureau (UCMB) in training HRH managers in leadership and management. 47 were district managers, 27 were managers of UCMB hospitals.
Sub IR 1.2.2 Task shifting strategy developed				
9. A task shifting strategy developed and is formally accepted by the ministry	0		–	Target for task-shifting strategy piloted in selected districts and selected cadres not reached due to lack of clear consensus on task shifting by MOH.

ANNEX X: MULTIVARIATE DATA ANALYSIS OF UCP INTERVENTIONS VS RECRUITMENT EFFICIENCY

1. ANALYSIS OF THE RECRUITMENT DATA

One of the objectives of UPC was to improve the health workforce management practices, including the recruitment of new health workers. UCP has been working with a number of districts to help them strengthen their human resource systems and capacity. This has included strengthening the capacity of districts to attract, recruit, and retain health workers. In 2012, the government of Uganda approved the recruitment of a large number of health workers so as to reduce the health worker shortages the country faces. This is the largest ever recruitment of health workers in Uganda.

In all, 15 initiatives were implemented in the 113 districts targeted by UPC to promote the recruitment of health worker.

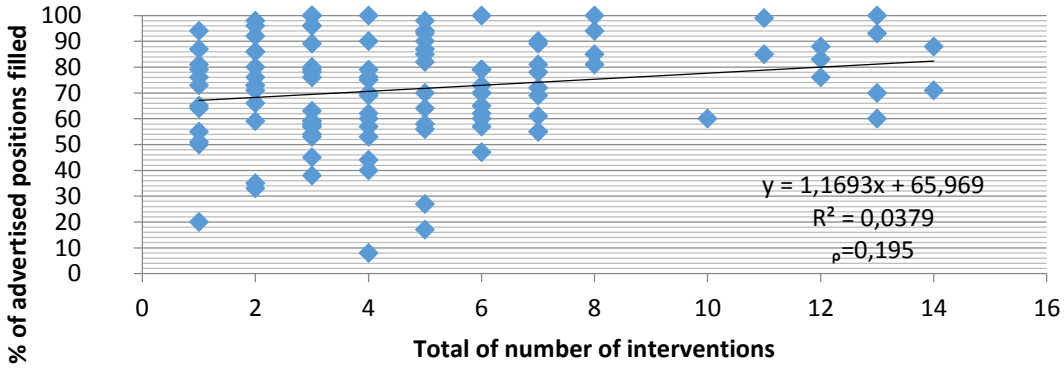
The percentage of positions filled in each district was analyzed using statistical methods in an attempt to answer the following questions:

1. Is it true that the higher the number of interventions implemented in a district, the higher the percentage of jobs filled?
2. Which intervention had the highest impact on the recruitment of health workers i.e. which intervention, if any, resulted in the highest percentage of jobs filled?

Results

The coefficient of correlation *r* was calculated to asses if there is a relationship between the interventions and the percentage of jobs filled. The results are presented in Figure 1.

Figure 1
Linear Relation between the Total Number of Interventions and the % of advertised positions filled for all districts



The result shows that there is a slight correlation between the number of interventions and the percentage of jobs filled and the interventions that were implemented in the districts with the population correlation coefficient$\sigma = 0.195$. If σ is ≥ 0 , this means that the greater number of intervention implemented, the higher will be the percentage of jobs that will be filled. Conversely if σ is < 0 then the greater the number of interventions, the percentage of positions filled will be smaller.

ANNEX XI: REFERENCES

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