Private Not for Profit

Health Training Institutions

Consultative Meeting

Options for a more sustainable support to training in PNFP Health Training Institutions

Kampala
Cardinal Nsubuga's Leadership Training Centre
June 12th, 2007

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EXECUTIVE SUMMARY

For some time the Bureaus had been holding discussions with the Ministry of Health and Development Partners (namely Danida) on the way forward vis-à-vis support extended to PNFP Health training institutions. Until now the support of the Ministry of Health has been in the form of earmarked PHC Conditional Grants to Hospitals with Health Training Institutions. Development Partners have had a variety of approaches ranging from support for capital developments, provision of supplies in kind and bursaries.

The dialogue aimed at identifying ways and means to harmonise the various approaches and, also, in view of enhancing the availability of Human Resources in units (both GoU and PNFP) in underserved areas.

Some scenarios had been envisaged, but considering the objective complexity of the situation and the fact that the newly developed approach might change the modalities of support from GoU and from Donors that have prevailed in the last few years, the Bureaus felt that they could not give a final opinion to the Ministry and its donors without first holding a consultation with the beneficiary institutions. For this reason a consultative meeting was jointly organised by UCMB and UPMB for representatives of management of hospitals and health training institutions with their Boards' representatives.

The envisaged aim of the meeting was to arrive at a participated design of a sustainable support to Training of Health Workers in PNFP Health training institutions. Forty three participants from 19 PNFP schools attended and had the opportunity of getting information of the overall situation of human resource distribution and its inequalities, of the human resource policy of the Ministry of Health and related Plans, of the various options for protecting investment in health training and secure that more human resources become available in hard to reach and hard to stay areas.

The participants had the opportunity of expressing their preferred choice between the continuation of budget support through PHC CG earmarked for schools and bursaries. The pros and cons of each option were carefully weighted. Eventually the group agreed that the shifting to bursaries is a desirable development.

They indicated that the bursary approach will make more subsidies available (at least at macro level) and will introduce a more rational allocation. It will also allow to direct subsidies towards the desired objective of increasing the availability of staff in areas of the Country that are currently understaffed.

At the same time they expressed some words of caution for the implementers and a series of recommendations aiming at mitigating the possible undesirable effects of the new approach and boosting the positive effects.

The most important concern with regards to the new approach was its sustainability. A second strong concerned is the manageability of students who do not contribute personally in any way to their training and are guaranteed of employment afterwards. A third concern is related to the scanty information available about unit cost of production in HTIs. A fourth concern regards the enforceability of bonging by all (public and PNFP). Other

concerns, comments and reflections emerged during the discussion following the group work presentations.

The recommendations emerging can be summarised as follows:

1. The selection interview of the candidates for training and the assessment of the students' progress must remain prerogative of the school.
2. The selection of the bondable students must occur after the selection interview and should involve both the schools and the bonding authority.
3. Guidelines for implementation of the scheme must be developed in collaboration with the PNFP schools.
4. The cost of training should be assessed in an objective way through a proper study.
5. The bonding agreement must be proven to be legal and its enforcement mechanism must be approved by all stakeholders and applicable to both Government and PNFP.
6. A proportion of the bursaries should be assigned for bonding of students by the PNFP health sector
7. The number of students that a school considers amenable to bonding is to be decided by the school itself in the first instance.
8. The PNFP schools together should decide whether an affirmative action should be applied by providing more bursaries to the schools in the underserved districts.
9. training year and be disbursed directly to the schools. Financial accountability should be following the systems already in use.
10. For the first year the PHC CG flows should be allowed to continue. Full merging of the Government and Donors money should occur only in year 2 and be guided by the experience gained in the first year.
11. The Bureaus should be kept in the loop of information flows.

1. INTRODUCTION

The production of Human Resources for health is of critical importance in a Country, like Uganda, having a net deficit of Health Workers for the delivery of the of the Minimum package foreseen by the HSSP. To compound this critical situation, the distribution of the existing Human Resources is particularly uneven: rural areas and particularly areas defined hard to reach (and hard to stay) take the largest share of the existing deficit, thus making the achievement of equity in the access to health care very elusive. Among the most needed resources are nursing professionals. The Private-not-for-Profit Health Sector is a major actor in the production of nursing cadres: strong of 22 Health Training Schools located mainly in rural environment and with a long tradition of quality of training, these PNFP Health Training Institutions represent an asset that the Ministry of Health recognises as critical for the achievement of equity in the distribution of Human Resources for Health. With the transfer of responsibility for training from Ministry of Health to Ministry of Education and Sports, the Ministry of Health has lost its capacity of effectively influencing prioritisation of production of HR for Health: the priorities of the Ministry of Education are, at the moment, primary and secondary education. The PNFP HTI, although answerable to MoES, enjoy a certain degree of flexibility that allows them to respond more rapidly to the identified priority for health (i.e. production of HR). They anyway suffer the same fate of the hosting hospitals: chronic under-funding. For this reason they have to charge a large amount of the cost of training on the students: this creates a barrier to access to training, especially in the hard to reach and hard to stay areas of the Country. This is the reason why, in the last 5 years, the Ministry of Health has earmarked part of the PHC Conditional Grant to Hospitals for HTIs. In addition, some donors have joined hands with the Ministry of Health by offering to a number of HTI either budget support or bursaries in support of training. This arrangement has anyway created an uneven distribution of resources and has reduced the effectiveness of the investment made with regards to the objective of achieving better distribution of HR, privileging the underserved areas of the Country. In the last month a dialogue between the Ministry of Health, some donors and the Bureaus has allowed the development of a hypothesis of funding that better addresses inequalities: the implementation of the options identified requires anyway a thorough understanding of the new mechanisms to be created and urges also the introduction of tools for the protection of the investment in HR production (bonding). Given that proposed radical change of approach, the Bureaus felt the need of consulting with their constituency before expressing their consensus with the Ministry of Health and the concerned donors. For this reason a one day consultation has been arranged before the closure of the Financial Year 2006/7 so that, if the case arises, the new financing options could be finalised and introduced in the course of the FY 2007/8. The invitees to the consultation were managers from hospitals and related HTIs, plus Board members of the hospitals having HTIs. Speakers from the Ministry of Health were asked to provide all the necessary inputs to the understanding of the scenarios and options. A session of group

worked was designed to provide opportunity to the PNFP stakeholders to express their concerns, their recommendations and, eventually, expressing consensus (or lack of) for the new course.

2. SUMMARY OF THE PRESENTATIONS AND DISCUSSIONS

2.1. Prayer and welcome address

Rt. Rev. Bishop Jackson Nzerebende, South Rwenzori Diocese
Dr. Lorna Muhirwe, ES UPMB
Chair: Dr Deus Mubangizi, MS Virika Hospital.

The Executive Secretary of UPMB expressed the welcome to the participants on behalf of the conveners (i.e. the Bureaus). She appreciated the fact that the quasi totality of the schools decided to participate in the event with a good representation, extending to the key decision makers (i.e. the Board Members). She guides the participants through round of self-introductions and asked one of the Board Members present, R. Rev. Bishop Jackson Nzerebende, to et the right tune for the work at hand by opening the consultation with a prayer.

2.2. Introductions and objectives of the meeting.

Dr Sam Orach Orochi, AES UCMB

Dr Orach, Ass,t Executive Secretary of UCMB, gave a brief background of the consultation (here summarised in the introduction) and clarified the aim of the day as "arriving at a participated design of a sustainable support to Training of Health Workers in PNFP Health training institutions". He then proceeded with the presentations of the objectives of the day, namely:

- Understanding bonding and options for enforceability
- Understanding new mode of support to PNFP Health Training Institutions via bursaries
- Providing suggestions on how best to manage bursaries

To conclude he gave a summary overview of the titles of the scheduled presentations and of the purpose of the group work.

2.3. Overview of human resources for health Policy, Strategic and Operational Plan of the Health sector

Presenter: Mr. Charles Matsiko, PhD, Assistant Commissioner of Health (HR department), MoH

Mr. Matsiko started by setting out the Vision of the MOH for the development and management of staff in the health sector:
A Highly competent, motivated and equitably distributed Human Resources for Health effectively contributing to a healthy and productive life of the people in Uganda.
To realise this vision the Mission stated in the National Strategic Plan for the Development of Human Resources for Health is:
To *engage, maintain and develop adequate and competent health workforce to avail people in Uganda equal access to quality essential health services in line with the development goals of the country.*

During the development of this plan it was established that the core problem is that the health workforce now and in the future is not adequate to deliver the Uganda National Minimum Health Care Package equitably to all. This problem leads to excessive workloads among health staff, unsatisfactory client-provider relationship, and poor quality of care.
To enable the government to correct the present situation it was necessary to identify the key underlying causes.

The main causes are:
- Weak policy development and enforcement capacity
- Poorly developed HRH planning function
- Training of Health Workers not practical and not aligned with health priorities
- Poor management, inequitable distribution, and lack of supervision
- Weak regulatory and disciplinary capacities and mechanisms
- Weak partnerships in multi-partner sector
- HRH processes inadequately informed and not evidence based
- Motivation and empowerment wanting
- Weak institutional capacities
- Under-funding is a fundamental problem

The key questions for the development of the HR Strategic Plan were therefore: how many and what type of staff do we have now, what is the right workforce composition for the future, and how can we ensure that the right workforce becomes available. To answer these questions the expected changes in the population and health situation had to be established first. The key changes taken into consideration are: the considerable growth of the population (from 27 million to 43 million), the shift of the population towards the urban areas, an the increase of non-communicable diseases in addition to the ongoing high burden of communicable diseases. Lastly, the government's commitment to Primary Health Care and to ensuring access in the rural areas had to be integrated into the plan.
The planners then defined the assumptions on which the plan has build:
- public expenditure for health is to decline in the coming years but will later then increase significantly;
- greater attention will have to be given to improving terms and conditions of service;
- greater attention will need to be given to PHC, in particular to preventive and promotive health services;
- multi-skilling and expansion of mid-level cadres (nurses and allied professionals) relative to higher cadres.

The presenter then highlighted the key principles underpinning the projections of the future workforce. Those additional to the above assumptions are: improved quality of care; improved access to all levels of care in the districts; improved efficiency of district health services; strengthened support and referral processes; enhanced public-private partnerships; and aligned infrastructure development.

All these considerations lead to the following overall strategic direction: To *strive towards a constant supply and maintenance of an adequately sized, equitably distributed, appropriately skilled, motivated and productive health workforce.*

The Strategic Objectives of the Strategic Plan for Human Resources are:

1. Strengthen HRH Policy capacity for advocacy, monitoring, analysis and further policy development.
2. Institutionalize evidence based HRH planning.
3. Support HRH training and development to ensure constant supply of adequate, relevant, well mixed and competent health workforce.
4. Manage HRH efficiently and effectively, to attract and maintain sufficient, equitably distributed, well motivated and productive health workforce.
5. Instil and maintain HRH regulations, ethical standards, right attitudes, and commitment towards the highest quality and equitable health service provision
6. Mobilise adequate financial resources in support of HRH and manage them in a cost-effective and efficient manner.
7. Build sustainable partnerships and strengthen coordination among HRH stakeholders including the community.
8. Create, maintain and use a strong knowledge and information base for evidence based and effective HRH functions.
9. Empower and motivate the health workforce toward effective and equitable service provision with special attention for hardship areas.
10. Enhance the image and strengthen institutional capacities for HRH.

Mr. Matsiko subsequently explained how the future workforce was modelled and which scenarios had been developed to arrive at the best option for the coming fifteen years. The final choice has been determined by the expected budget constraints as well as the present workforce composition and an annual loss out of the health sector of 2.5 to 6.5% (depending on the cadre considered).

The chosen scenario will lead to an increase of health personnel to 98,000 (currently 59,000 of which 45% in the government). This translates in to one health worker per 438 citizens (compared to the present 1: 452). He presented overviews of the current health personnel in public and PNFP facilities as well as the projections up to 2020. The latter overview also indicates the requirements, e.g. the number per cadre that will need to be trained between now and 2020 to reach the 98,000. It is presented in annex 4.

To meet the service demands, and balance the workforce supply with requirements, the staffing norms will be made flexible and they will based on the workload of general hospitals and Health Centres. In addition, efficient staff utilisation, optimal skill-mix, and pro-active management will be pursued. In turn these will require better management and control, an effective monitoring of performance.

The presenter concluded by summarising the budget implications of the Strategic Plan. The bottom line is that the budget will be overshot by 13% compared to the Midterm Projections while the real annual growth in salaries of health personnel will be less than 1% during the planned period.

2.4. Understanding Contextual issues: inequalities in health staff distribution and current arrangements in health staff training and its financing. The possible future of health training financing: investing for retention (bonding).

Presenter: Mr. Moses Arinaitwe, Principal Personnel Officer MoH (also on behalf of Mrs. Catherine Behangana Tumusiime, Senior Personnel Officer MoH)

This presentation was in two parts: one focusing on understanding the context; inequalities on health staff distribution and current arrangements in health staff training and its financing while the second part was about the possible future of health training financing, investment for retention (bonding). Mr. Moses Arinaitwe; Principle Personnel Officer MOH, covered both parts because his colleague had other commitments and was unable to come.

2.4.1. Inequalities in Health Staff distribution and current arrangement in training its funding:

In his introduction, he put a lot of emphasis on the importance of understanding the context. This was summarised as human resource issues of training, distribution and financing which were covered under 8 points as follows.

- Maximum stakeholder participation and involvement in the training, distribution and financing of the HRH. The key stakeholders are the public or government, the PNFPs and the private for profit health providers. The government being the primary stakeholder, through its ministries and decentralized structures, has a task of developing a good and supporting policy framework to promote effective human resources for health.
- The distribution of the HRH throughout the country should have a special consideration and focus for the “hard to reach” but also “hard to stay” areas. Although the criteria for the above definitions is not very clear, the parameters applied in the perspective of HRH include the geographical, ,environmental, economical, etc against the MOH staffing norms. These staffing norms are also based on the UMHCP. Therefore the issues of definition of hard to reach or hard to stay needs to be resolved f.i What is the criteria and within which period will this criteria be applicable; because an area which is categorized as hard to reach today may not be hard to reach after 2 or 3 years!
- Training of health workers is an important element and a determinant in the distribution phenomenon. Hence training has to focus on the skills needed and required in all the regions of the country with the objective of

equitable distribution. So it becomes imperative that in order to achieve the above, there must be a harmony between the current training curriculum and the identified health needs in the respective regions.

- The training, distribution and financing of the HRH is also affected by changes in the environment. Key changes in the environment include the decentralization policy which has had several challenges, changes at policy levels, the population growth, disease pattern, technological developments like e-medicine spreading to the third world, competitiveness in delivery of health services e.g. the recent successful open heart surgery in Kampala International Hospital, a private health provider etc. All these do affect significantly the entire National Health Service delivery system.
- The movement and migration of health workers like health workers moving from the PNFPs to the public health facilities, health workers also moving to the international agencies, etc. Important however is the fact that at policy level, not much is being done, either to regulate or stop this migration of health workers. Yet the fact is that, these movements will apparently be there. So the presenter advised PNFPs to always put deliberate effort on managing this migration rather than avoiding it. Under this approach, PNFPs should endeavour to focus or review their retention strategies of their health workers.
- The changing function of the human resource management. First this function started as establishment officers who were mostly concerned with records and other paper work. Later these establishment officers, as a HRM function, were transformed into personnel officers but still with only organisational regulation especially about staff welfare implementation, etc. But now, human resources management has to focus on strategic issues like human resource planning, HR information systems of managing HR i.e. linking and integrating into bigger national systems.
- There are also changing pressures in the MOH and the decentralization structures during the process of posting adequate numbers of health workers in various health facilities. These pressures are also aggravated by the demands for the same health workers from the PNFPs, private for profit as well as the international health projects.
- The challenge and the demand to pay health workers on equal basis of in their respective cadres among all health providers; public, PNFP, private for profit and others, is an area which is very evident but not getting the attention and actions it deserves.

Questions and answers:

Q: What are the criteria used to define the hard to reach areas and what are the incentives that are going to benefit the health workers in these areas?

A: The MOH and other stakeholders have a rough definition of the hard to reach areas. Those criteria constitute 7 points among which insecurity is rated very high, hence the focus on the 16 districts mainly in the

northern and north eastern Uganda. This is the area that has experienced insurgence for over 2 decades. However the challenge is that the MOH should concretize these criteria by making it these national criteria and also bring on board other elements that could facilitate bringing on board other areas with similar health needs.

The incentives to the health workers in these defined areas are that they will get 30% of the basic salary, per respective cadres, (following the government scales) as an extra or top-up allowance. Health workers in both public and PNFPs health institutions in the above 16 district will equally benefit from this incentive.

Q: How could the PNFPs achieve or tackle the dilemma of encouraging competitiveness for best health care services amidst cost sharing and the general poverty among the Ugandan population.

A: An example of the first successful open heart surgery in Kampala International hospital re-awakened the government and Mulago hospital heart institute. And so far there has been a deliberate reallocation of Ushs 2 billion for the Mulago Heart Institute geared at improving its services. Also this should be an eye open for the PNFPs to identify areas where they can excel and thereafter pressurize government for that particular support. However, the cited challenges are enormous but the way forward is to strict a balance amidst the various options and what can be done with the available resources.

Q: Government is ever increasing the salaries in the public service; what does government think about those health workers in the PNFPs. Is government concerned at all with the PNFP sector as partners in health service delivery to the population?

A: There was no clear answer but the advice the presenter gave to PNFPs was for PNFPs to always identify strategies of being as near to government as possible in order to make impact. The PNFPs were also advised to repackage their demands, learn how to best advocate and lobby as well as identifying where and which decisions-making, or power, centres lie in order to target them.

2.4.2. The possible future of health training financing: investing for retention (bonding)

The presenter then went ahead to make a second presentation that addressed the possible future of health training financing: investment for retention (bonding). Here also his presentation was given under the following 5 points.

- Under the “secondment”, “or “posting”, or “deployment”, the MOH has recently recruited 60 Medical Officers and posted them to the PNFPs. But unlike the previous postings, MOH first asked PNFPs to identify the gaps in

their respective health facilities, which they did and sent to MOH. These 60 positions in the PNFPs were among the established 107 MOs position in the earlier arrangement i.e. Establishment for MoH Posted staff to PNFP. However, one of the key reactions was that government should consider the best and sustainable option of giving comprehensive budget support to PNFPs in order to recruit and manage effectively their staff. On the other hand, the presenter reiterated the importance of writing a thank you or acknowledgment letter by the PNFPs to the MOH after receiving these posted health workers as well as the need to provide continuous updates to the MOH about the status of these health workers; are they still at the respective work stations, have they gone for further studies, etc.

- The transfer of the governmental HTIs from the MOH to the MOES was at the highest level of policy and decision making i.e. cabinet level. So this cannot easily be changed. However, the issue is how best can HTIs coordinate and identify the key areas for change. The strength is in the coordination as well as focusing on staff retention and continued lobbying for improved government support.
- Bonding of health workers in both the government and PNFPs health facilities. The medical superintendents of the respective hospitals should be in control and be able to direct the working environment of the posted medical officers as well as other health workers f.i. the correspondence between the posted MOs to the MOH should be through the medical superintendent and vice versa. In so doing this relationship and work performance of the posted or seconded MOs and all other health workers will be improved.
- Financing the health worker training, in Uganda, is mainly through the government, development partners, and the PNFPs, among others. The question is, however, whether these sources can be consolidated, is it possible to have a pool of resources in one basket! Therefore the proposal of introducing the bursaries is an attempt to bring together the government support to the HTIs as well as the development partners' support to some selected HTIs into a single basket. The bursaries will benefit a proportion of students at the HTIs who will later be bonded for a specific period of time to serve in the needy areas of the country. This proposal attempts to address and facilitate the training of health workers, equitable distribution, as well as enhanced financing of the HTIs and the health sector at large.
- If the above proposal is approved, what would be the bonding level of the sponsored students? Will it be at the level of MOH, or District, or particular health institution especially with the priority to the hard to reach areas, etc. Through this initiative, there will be improved staff retention and equitable distribution of health workers especially to those hitherto disadvantaged places.

Questions, answers and recommendations:

Q: Under the perspective of scarcity of tutors in the PNFPs HTIs, is it possible for the MOH to second tutors to these HTIs like it is done for the other PNFP health facilities?

A: If secondment of tutors to PNFP has to be done, then it should by the MOES but the PNFP have to discuss this option and if viable, then they have to take it up with the concerned ministry.

Q: The seconded MOs to PNFPs usually serve for only one year and either go for further studies or get other employment. Bonded staff may prove cumbersome to manage, knowing that the disciplinary actions are limited because, in whichever case, their services are needed or have been conditioned by the bonding period. Can the MOH follow up these issues more closely and provide guidelines.

Can the MOH provide the PNFPs with guidelines to streamline this arrangement and the general management of seconded health workers as well as bonded staff during this period of some how "mandatory stay" and service to that particular health facility?

Q: While bonding staff to the hard to reach areas, can there be an opportunity for the particular staff or student to visit the area or facility to which he/she is being bonded prior to the signing of the bond agreement? This will facilitate the process of the candidate accepting after being exposed to the environment of his/her future work.

Q: Can MOH explore the legality of the concept of bonding and its enforceability? Is it morally correct especially for students being bonded as they enter into training? Are they not too young to make such a decision, how about the moral and ethical as well as individual human rights concerns? PNFPs have already been investing in training of their staff and subsequently bonding them. Can this also follow the same legal concerns? And can the government bonding also respect this other bonding by the PNFPs. So it means that if one staff is being bonded by government then PNFP cannot bond him/her at the same time and vice versa. And if the bonding arrangement is legally acceptable then even other bonding schemes should are also be legally accepted, which has not been the case until now.

Q: The recruitment and deployment under the bursary scheme, who is going to be responsible? Is it the MOH on behalf of the public or the Bureaux on behalf of the PNFPs, or the HTIs, etc.?

Q: Can students presently in school also benefit i.e. those students already in years II and III?

Q: How will the flow and management of this fund, the common basket, be? This is the perspective of the management of the PHC-CG with its demands and challenges. What role will the Bureaux have in the management of this fund? What will the reporting channels be; to MOH, or to DPs?

Q: How will the posting of the bonded staff be agreed? Will it be by MOH, district service commission, or who? What happens if the bonded candidate fails the district service interviews, a district to which the bond applies?

Q: Does this bursary arrangement cover each and every other detailed costs and requirement of the HTI's?

General concerns:

- The selection of the candidates to benefit from this bursary scheme should be balanced between the rural and urban areas as well as among the districts.
- The district leadership should have an opportunity to determine or to endorse the candidates to be bonded otherwise they may not be deployed on completion of studies.
- MOH should develop a standard of performance for the bonded staff to facilitate their work performance and expectation from the respective employer institutions.
- Since opting for the bursary scheme would automatically cancel the PHC-CGs from government, then government and the development partners should ensure its sustainability/continuity.
- While opting for this new direction of funding, it could be of great assistance to research into the key reasons why health workers do not want to work in the hard to reach areas despite the fact that in some of the hard to reach areas, the salaries are very high.
- Instead of completely abandoning the PHC-CG option, could MOH explore another option of awarding scholarship for those particular hard to reach areas and then bonding them respectively?
- The bursary scheme seems to be focusing on the tuition, feeding, etc. but leaving out some other requirements necessary for running the HTI's.
- Matany hospital has had some experience on the sponsorship and bonding of especially the nurses and midwives. So far the availability of their staff is heavily dependant on this arrangement. So should the coming bursaries be allocated differently and limited to a certain number, especially the 40% only, then Matany will not have an adequate number of nurses and midwives. However since there are a number of lessons, it would a good idea for the MOH to take this as a case study.
- A special consideration should be made for the HTI's of Rubaga and Nsambya. Their fees per student especially for the registered nurse

courses are beyond Ushs 2 million per student per year, yet the bursary contribution per student per year were made basing on the requirements for the enrolled nursing and enrolled midwifery, or laboratory assistants, courses.

- One of the fundamental recommendations was the need for a costing study that will reveal the details of what it really takes to train an average enrolled nurse, etc. This information would to some extent facilitate the fixing of a more realistic figure for the bursary contribution towards the training of a single student in a particular course per year.

2.5. Improved Availability of Health Personnel in Underserved Areas through Pooled Government of Uganda and Development Partner Funding combined with Strategic Bonding.

Presenter: Dr. Claes Broms, Technical Assistant of DANIDA to the Ministry of Health

Chair: Rev Canon Benson Baguma, Chairperson Board of Governors Kagando Hospital

The subtitle of Dr. Broms presentation was: *Design of the possible scenario: option for transition from budget support to bursaries.*

He introduced the DANIDA's Health Sector Programme Support III and explained that component four, Support for ECN Training in PNFP Health Training Institutions now had the following revised goals:

- Ensure improved staffing levels in underserved areas, through strategic use of Government of Uganda (GOU) and Development Partner (DP) investment in health worker training;
- Improve predictability and level of funding to PNFP HTI's through equity and transparency in resource allocation.

The revision resulted from an in-depth analysis of current funding to GOU and PNFP health training institutions. This study revealed:

- GOU funding to PNFP HTI's is very limited but also quite inequitable as some schools get an amount per student / per year that is 9 times higher;
- DP funding to selected schools is also far from equitable: the former DANIDA programme allocated amounts that could were +/- 34 times higher and the Development Cooperation of Ireland / AMREF current support programme, for students from disadvantaged districts, allocates an amount per student that is around 31 times higher to some schools.
- This inequitable flow of funds is not very useful to assure predictable funding to all PNFP HTI;
- Moreover it does not ensure that trained health workers are assigned to underserved areas;
- The current funding from GOU and DP's is poorly coordinated and lacks transparency form two sides: unclear allocation criteria and no accountability obligations;

- The coordinated support from donors combined with individual and independent search for funds by schools distracts from the basic problems of under-funding and creates the misleading perception that the PNFP schools receive substantial funding from undisclosed sources;
- In the health sector donors are rapidly replacing fragmented project support by general budget support as preferred mechanism. This means that transparent and equitable funding modalities are needed to ensure predictable and sustainable funding for the health training sub-sector.

Dr. Broms went on to explain why government and the development partners are considering bonding of students for which either party has paid their tuition. The key reason is that a large proportion of the Uganda population is denied good quality health services due to the shortage of health workers in the areas where they live. This happens while GOU and DP's invest substantial resources in the training of health workers. To use these investments more optimally there has to be a way to ensure that the staffing levels in the underserved areas is improved. Presently 40% (= 2000 out of approximately 5000 enrolled) of the students in public HTI are paid for by government, e.g. they get their training for free. If the government would bond these students it could post them to the areas in need.

In the same way if government and DP funds for the PNFP HTI would be pooled and used to sponsor a defined number of students, e.g. offer them free training, in these schools these should also be bonded and posted to underserved areas. The amount available from GOU and DP's will translate into bursaries for 40% of the PNFP HTI students (=1200 out of 3000[1]).

[1] Note from UCMB: the total number of PNFP HTI student places was taken as 3000. We still do not have certainty as to how many students place there are in all PNFP HTI as the numbers provided keep changing. In particular during the last two years the number seems to be increasing without consideration for the actual design capacity giving rise to considerable quality concerns!

Thus the bonding arrangement will enable GOU to post approximately 1000 health workers annually to the underserved areas (3200 divided by an average duration of the courses of 3 years).

He then reviewed some of the most important implementation issues.

- As the funds are basically government funds the bonding should be done by government;
- The bonding should be for a limited time, comparable with the duration of the training period;
- The posting should be determined by the needs in government and PNFP HTI in the concerned districts using the MOH-headquarters vacancy list (HR data base);
- The bonding arrangement that is developed has to enable the District Service Commissions to recruit the required staff;
- The bonding arrangement will guarantee all bursary students employment after graduation.

Dr. Broms recognised that the enforcement of the boding agreement requires specific attention. The best option is to retain the graduate's school certificate / diploma, at the level of the MOH-Personnel Office until the bonding period has been served. Whether this can be done is being investigated.
In this perspective, he asked all to consider the following question: *"Whose rights should be respected?"* The right to access health services of the poor Ugandans, or the right to seek "greener pastures" of the young graduates who obtained their training through government money (e.g. through money of the tax payer and donors)? He reminded the participants that the students remain free to choose: free professional training plus bonding, or to pay for their own professional training.

He concluded the presentation by summarising the strategies available for the support to HTI versus their potential to ensure improved staffing levels in underserved areas:

A. Bonding: will ensure that the MOH can post around 1000 graduates (700 GOU and 400 PNFP) to the underserved districts irrespective of where they come from or where they have been trained.
B. Affirmative Action: the above strategy can be enhanced by giving preference, in the allocation of bursaries, to students from the underserved areas. On its own this strategy gives no guarantees.
C. Extra funds to HTI in the underserved districts: this strategy will not be effective unless it is undertaken in combination with the above two strategies.

Finally Dr. Broms presented his points for the discussions and on which agreement will be needed before going ahead with the boding strategy:

1. What is a fair amount payable per student from the pool? Present assessments indicate 2 million USHS should cover tuition and board and lodging.

2. Which proportion of the GOU/DG fellowship students, trained in PNFP HTI, should be posted to PNFP health facilities in the underserved areas? (50%?)
3. How should the fellowships (bursaries) be distributed among the PNFP HTI? Should it be 40% of the students in each schools? Or should a higher proportion be allocated to the schools in the remote rural areas where it more difficult to attract paying students?
4. When should this bonding arrangement start? At the next intake of new students (November 2007), meaning that the first batch of bonded students become available in 3 years from then (November 2010)? Or should we start also to bond students that are now in second and third year of their training?
5. Can the MOH-Office of the Principal Personnel Officer retain the academic and professional certificates until the bonding period is completed?

Before wishing the participants fruitful deliberations he briefly explained three slides he had added which could be used for the discussion.

3. GROUP WORK

3.1. Introduction

Given the delay on the program it was not possible to reserve time for the discussion prior to the group work. Dr Giusti introduced the group work by outlining the two fundamental options possible:

To introduce **bursaries for students** who will be bonded to Public Service.
To **retain** the existing funding mechanisms of general recurrent budget support through the **PHC-CG** from government.

He also mentioned the implications of either option and asked the groups to

1. consider these implications carefully
2. bring them to the fore as advantages and disadvantages
3. express one of the two preferred option
4. express recommendations to be taken up for the option chosen, to make it workable.

Participants were grouped according to the location of the respective schools of provenance, to guarantee a certain homogeneity of context, as follows:

Group One	Nsambya
	Mengo
	Rubaga
	Kibuli
Group Two	Lacor
	Kalongo
	Matany
	Kuluva

Group Three	Kamuli
	Kiwoko
	Ngora
Group Four	Nyakibale
	Mutolere
	Ishaka
	Virika
Group Five	Kagando
	Kisiizi
	Ibanda
	Villamaria
	Kitovu

Groups expressed the fruit of their discussion and deliberation in Plenary and the results are detailed in the following pages.

3.2. Outcome

For the detailed outcome of the group work cfr annex 6. The summarised version of the outcome is in the following chapter.

4. CONSENSUS EMERGED AND RECOMMENDATIONS

Chair: Rev Sr Carmel Abwot, Principal Tutor Kalongo HTI

The presentations of the group work reflected the objective complexity of the problem addressed. Both options had several advantages but also quite a number of disadvantages. It was clear anyhow that there was consensus around the first option (introduce a bursary approach).

The group therefore agreed that the shifting to bursaries is a desirable development.

The reasons for this choice (either identified as advantages foreseen or as disadvantages of the other option to be overcome) could be summarised in the following statements:

The bursary approach will make more subsidies available (at least at macro level) and will introduce a more rational allocation.

It will also allow to direct subsidies towards the desired objective of increasing the availability of staff in areas of the Country that are currently understaffed.

The most important concern with regards to this approach is its <u>sustainability</u>, especially if

- **the commitment of Government to maintain its contribution to the bursary account is not guaranteed**
- **the Development Partners' horizon does not go beyond three years.**

A second strong concern is the creation of two populations of trainees: one fully guaranteed by the bursary support and subsequent employment by Government, another facing more precarious conditions during training. Perhaps more important is the doubt that students in the group receiving bursaries may feel so assured of its future to such an extent to undermine discipline and dedication to study (i.e. answerability and accountability to the training institution).

The third concern expressed refers to **the absence of reliable information about cost of training.** The figure proposed is a reasonable guess estimate but managers would feel more reassured if a costing study provided the assessment of the unit cost of training.

The fourth concern regarded the legal enforceability of the bonding agreement by all stakeholders and the arrangements chosen.

The recommendations emerging can be summarised as follows:

12. **The selection interview of the candidates for training and the assessment of the students' progress must remain prerogative of the school.**
13. **The selection of the bondable students must occur after the selection interview and should involve both the schools and the bonding authority.**
14. **Guidelines for implementation of the scheme must be developed in collaboration with the PNFP schools.**
15. **The cost of training should be assessed in an objective way through a proper study.**
16. **The bonding agreement must be proven to be legal and its enforcement mechanism must be approved by all stakeholders and applicable to both Government and PNFP.**

During the discussion following the presentation of the group work some new element emerged that were not adequately captured by the reports. Although generally speaking a 40% quota of bonded and sponsored students seems reasonable at macro level, there are schools linked to hospitals that, at the moment, have a 100% capacity of absorption due to the high attrition of staff. Ironically, these schools are in some of the areas considered hard to reach and hard to stay (i.e. where the bonded quota of students should be higher). If these schools opted to retain all the staff trained they would have to forfeit the support through bursaries and loose also the PHC Conditional Grants, hence they would be in a worse situation than at present. This revealing insight lead the group to recommend that it may not be fair to

allocate the entire amount of the funds available to the purpose of bonding students for public employment. It should be considered fair and wise to have an equitable distribution of funds for bursaries to bonding for public employment in the understaffed districts and also for private employment in PNFP institutions in the same districts. It is not assured, in fact, that students bonded and employed by Government will be posted, in fair and equitable proportion, to PNFP. After all, these latter are the most affected by the high attrition caused by Government recruitment. Two recommendations emerged from this insight:

17. **A proportion of the bursaries should be assigned for bonding of students by the PNFP health sector**
18. **The number of students that a school considers amenable to bonding is to be decided by the school itself in the first instance.**
19. **The PNFP schools together should decide whether an affirmative action should be applied by providing more bursaries to the schools in the underserved districts.**

The following discussion brought to the fore concerns about the flow of bursaries, the timing for the introduction of the option and its applicability to students in second and third year. As many schools have experienced problems with the flow of funds (cash flow problems) under the PHC CG arrangement, the prevailing opinion was that disbursements should occur in bulk at the beginning of the year and go directly to the schools, avoiding the districts' intermediate step. With regards to the timing of the introduction of the option, schools did not have an objection to indicate how many students in second and third year could be bondable. On the other hand, it was deemed prudent, for the first year, to allow disbursement of PHC CG to continue while the sums provided by donors become available later in the year. On the whole, given the need to identify critical areas and solutions in course of action, the Bureaus need to be kept informed of the developments. These wishes can be summarised by the following recommendations:

20. **Releases of bursaries should occur in bulk at the beginning of the training year and be disbursed directly to the schools. Financial accountability should be following the systems already in use.**
21. **For the first year the PHC CG flows should be allowed to continue. Full merging of the Government and Donors money should occur only in year 2 and be guided by the experience gained in the first year.**
22. **The Bureaus should be kept in the loop of information flows.**

5. CONCLUSION AND PRAYER

Rev. Fr. Fred Tuswegire, Chairperson Virika Hospital
Dr. Sam Orach Orochi

Dr Sam Orach delivered the concluding remarks by underlining that the extensive works done in one day shows the interest of the participants for

what is an otherwise uncharted territory. He stressed that fact that it was worth deciding to go for something new, but that this decision will require compliance with the new demands created, especially with regards to reports. It is also an interesting development of the PPP, more focused on what Government "wants to purchase" than of the way money is administered. Local Governments will need to be adequately informed to avoid wrong impressions and expectations that are not commensurate to the support we shall receive. He added that some critical information is still missing (i.e. especially related to costing) and will have to be obtained. He thanked all the presenters and the participants for their lively and impressive contribution. He expressed a special thank for the Board Members that have decided to attend the meeting, recognising the critical importance it has. He assured that that the Bureaus are quite aware of the sacrifice demanded from them and considers their participation an accorded privilege. He finally thanked the chairperson who have accepted, at short notice, to conduct the proceeding of the day. He wished to all a safe return home and announced that the report of the meeting will be circulated in the shortest possible time. He then invited Rev. Fr. Tuswegire to conclude the meeting with a prayer.

Annexes:

1. Program
2. Participants' List
3. Documents Handed out
4. Table from Dr Matsiko's Presentation
5. Group work instructions
6. Outcome of group work

ANNEX 1

Consultative Meeting for PNFP Hospitals and Health Training Institutions.
Title of the meeting: Options for a more sustainable support to training in PNFP HTIs
Venue: Cardinal Nsubuga Leadership Training Centre
Date: Tuesday 12th June
Invited participants: The Chief Executive of the Hospital or delegate, The Principal Tutor of the School or delegate, The Chairman of the Hospital Board or delegate Board Member.
More details can be found in the attached annex.

Time	Activity	Person carrying it out	Chair
8.30-9.15	Registration	Ms Luwedde	
9.15-9.30	Welcome	Dr Lorna Muhirwe	
9.30-9.45	Objectives of the Meeting	Dr Sam Orach	
9.45-10.10	Presentation: Overview of the Human Resource for Health Strategic Plan 2005-2020 and Operational Plan 2007-2010	Dr Charles Matsiko Ag. Ass.t Commissioner MoH HR Division	
10.10-10.30	Presentation: Understanding the context: inequalities in health staff distribution and current arrangements in health staff training and its financing	Mrs Catherine Behangana Tumusiime MoH	
10.30-11.00	Questions and answers		
11.00-11.30	Break		
11.30-11.50	Presentation: The possible future of health training financing: investment for retention (bonding)	Mr Moses Arinaitwe PPO MoH	
11.50-12.30	Presentation: Design of possible scenario: from budget support to bursaries: options	Mr Claes Broms, TA MoH	
12.30-01.00	Questions and answers		
01.00-02.15	Lunch		
02.15-02.45	Statements: The role of the Bureaus in the process and the Bureaus perspectives	Dr Lorna Muhirwe Dr Ahmed Kiswezi Dr Daniele Giusti	
02.45-03.30	Group work: the give an takes of each option		
03.30-04.00	Presentations and identification of the emerging consensus		
04.00-04.15	Recap of the meeting understanding and agreement - Conclusion		
04.15-05.00	If possible: satellite meeting for the schools covered by the Danida HSPS/MoH project		

ANNEX 2

I) List of Participants

HTI Name	Name of Attendants	Function Held	Postal Address	Telephone	email address
Ibanda	Msg Baignana Muntu	Board Member	P. O. Box 467	772464659	
Ibanda	Sr. Ntegamane Rose	SNO	P. O. Box 103 Ibanda		
Kalongo	Sr. Carmel Abwot	Principal Tutor	P. O. Box 47	772440173	midwiferys@satsignis.net
Kamuli	Katende George	Board Member	P. O. Box 99 Kamuli	772674961	katendegeorge2005@yahoo.com
Kamuli	Sr. Regina Mbuliro	Principal Tutor	P. O. Box 99 Kamuli	772360967	
Kamuli	Sr. Gilder Pacuwengi	Administrator		772365225	kamuli@ucmb.co.ug
Kamuli	Sr Regina Atimo	Health Tutor		782529642	
Kitovu	Fr. Deus Ddamulira	Chairperson BOG	P. O. Box 76 Masaka	772451729	
Kitovu	Byaruhanga valentina	Principal Tutor	P. O. Box 524 Masaka	712683047	
Kitovu	Ssimbwa J. Chriso	ADMINISTRATOR / HRM	P. O. Box 524 Masaka	752610429	
Lacor	Sr. Grace Acan	TUTOR	P. O. Box 180 Gulu	774006464	
Lacor	Dr. Odong E. Ayella	Deputy director	P. O. Box 180 Gulu		
Matany	Br. Tarcisio Santo	Administrator / CEO	P. O. Box 46 matany		
Matany	Sr. Maria Teresa Ronchi	Principal Tutor		774047195	
Mutolere	Sr. Invialate Baganizi	Principal Tutor	P. O. Box 26 Kisoro	772850544	
Mutolere	Msgr.Julius Turyaturanwa	Chairperson BOG	P. O. Box Kampala	772682167	
Mutolere	Dr. Mugisha Jerome	Medical Superintendant	P. O. Box Kisoro	772470648	mutolere@ucmb.co.ug
Nsambya	Miss. Namukasa Jane Francis	Principal Tutor	P. O. Box 7146 Kampala	772627599	
Nsambya	Dr. Nsubuga Martin	Medical Superintendant	P. O. Box 7146 Kampala	772304846	
Nyakibaale	Dr. Joseph Baguma	Medical Superintendant	P. O. Box 31 Rukugiri	772673691	
Nyakibaale	Tumwesigye Richard	Principal Tutor	P. O. Box 31 Rukugiri	772560005	mwesirich@yahoo.com
Rubaga	Sr. Joseph Donatus	Principal Tutor	P. O. Box 14130 Kampala	772558055	
Rubaga	Lwanga Fredd	Administrator		772627531	
Villa Maria	Fr. Kakumba Anthony	Board Member	P.O. Box 341 Masaka	772330423	
Villa Maria	Sr. Jane Frances Namuddu	Principal Tutor		772467014	

Virika	Dr. Munube Deogratius	Medical Superintendant	P.O. Box 233 Fortportal	772505643	ibanda77@yahoo.com
Virika	Mrs Tumwebaze Margareth	TUTOR	P.O. Box 233 Fort Portal	782554200	
Virika	Fr. Fred Tusingire	Chairperson BOG	P.O. Box 76 Fort Portal	772421354	fredt@infocom.co.ug
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Kagando	Biira Antoinette	Principal Tutor		772974587	
Kagando	BP Jackson Nzerebende	Chairperson BOG	P.O. Box 142 Kasese	772713736	
Kagando	Rev. Benson Baguma	Administrator		772425150	karudec@yahoo.com
Kibuli	Mbulambago Sinan S.	Administrator		041236476 / 7	sinamisirye@hotmail.com
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Kiwoko	Serwadda Peter	Medical Superintendant		782386870	
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Mengo	Musisi Erasmus	Representing MD	P.O. Box 7161 Kampala	772586395	musisimugerwa2006@yahoo.com

ANNEX 3

Documents handed out

1. Report of the First Technical Workshop for PNFP Health Training Institutions, held March 29-30, 2007. The report was handed to the chairperson of the BOG of the PNFP HTI's present as well as to the members to the UCMB HTI&T Standing Committee.

2. Data sheet about the capacity of each PNFP HTI

3. An article on the public private partnership (UMU Press 2007): "Funding mechanisms for the PNFP Health Training Institutions in Uganda" by John F. Mugisha and Everd Maniple, of UMU, and Senga k. Pemba and Peter Petit, of the EU-DHRH project.

ANNEX 4

Table: Comparison between 2020 requirements and 2005 supply

	2020		2005
	Supply	Requirement	Supply
Spec Med Doctor&Dentist	1,680	1,642	1,007
Gen Med Doctor&Dentist	3,089	3,035	2,000
Pharmacy Professional	654	640	150
Nurse/midwife Professional	856	670	623
RegN.& PsyN Ass.Prof.	6,882	6,872	3,338
Mdwife Ass.Prof.(Registered)	2,947	2,936	826
Comp. Nurse (Registered)	2,801	2,788	1,614
EnrN.& EnrPsyN. Ass.Prof.	12,251	12,040	10,069
Comp. Nurse (Enrolled)	7,300	7,300	285
Mdwife Ass.Prof.(Enrolled)	6,441	6,460	3,432
Allied Health (professionals)	514	424	106
lied Health Ass.Prof.(P.Hlth)	7,287	7,276	5,226
Allied Health Ass.Prof.(Clin)	8,287	8,254	3,785
lied Health Ass.Prof.(Diagn)	5,774	5,761	1,387
Senior admin/managers	1,247	1,244	1,437
Skilled Prof. (Non-Medical)	1,975	1,027	3,178
Health Related Professional	1,740	1,821	481
Support Staff (Clin Services)	11,656	11,617	15,228
)ther non-health semi-skilled	1,501	1,463	1,542
Support Staff (Other)	14,036	14,182	3,473
Totals -----	98,919	97,452	59,187

ANNEX 5

GROPUP WORK INSTRUCTIONS
Consultative Meeting for PNFP Hospitals and Health Training Institutions:
Options for a more sustainable support to training in PNFP HTI.

June 12, 2007.

Group Work: **The Gives and Takes of Each Option**
Objective: Arrive at a consensus regarding the way forward.

Group composition: Representatives of three to four Health Training Institutions per Region (see list in annex).

Summary of the Proposal and Options for the future funding of PNFP HTI recurrent cost:
The aim of the new arrangement to fund the training of health workers in PNFP HTI is to increase the number of health workers in the hard-to-reach / underserved districts. For this purpose funds from Development Partners and the MOH PHC-CG will be put into one pool to pay bursaries to PNFP HTI. These bursaries are to be allocated to candidates willing to work as civil servants in underserved areas for a specified period of time. A bondage agreement will be signed between the MOH and the candidates to this effect. In principle all bonded graduates will be assigned to government health units in these districts. If the PNFP health units in these districts require staff they can apply for bonded graduates to be seconded to their unit.

At present the total PHC-Conditional Grants, allocated to the PNFP schools, stands at around 0.6 billion per year. The allocations per school range between 26 million and 55 million per PNFP HTI, translating into 100,000 to 1 million per student enrolled depending on the PNFP HTI considered.

The amount that will be available, in the new pool fund, per year for bursaries will be approximately 2 billion USHS. With an estimated bursary amount per student, per year, of 2 million, this translates into +/- 1000 sponsored students per year. This represents close to 40% of the total capacity of all PNFP HTI together and nearly the total annual intake capacity of one year. In other words, in the first year of the new arrangement all new entering students could be sponsored. If the scheme is introduced gradually (f.i. annually 330 new students are added while the sponsored students already taken-in continue their subsequent years) the total of 1000 bonded students is reached in year three. Compared to the annual intake capacity of all PNFP together this means around 670 other students (self paying or sponsored by PNFP health units) can be taken in. The distribution of bursaries / sponsored students among the PNFP HTI will be a subject to decide on later.

The options for the HTI are:

1. To agree with the proposal and **apply for bursaries for students** who will be bonded to Public Service. This means that the level of funding will increase and be distributed more equitably. It also means that the number of government bonded students, for the underserved districts, in the school will be relatively high.

2. To **retain** the existing funding mechanisms of general recurrent budget support through the **PHC-CG** from government. This means the present level of funding is continued. It also means that the school can continue to accept all eligible students.

Discuss the following questions. One member of the group to write answers on a flipchart and another on the sheets given to the chair of the group. There follows a brief presentation in Plenary.

Questions for the group discussion:

1. Advantages and disadvantages of option one: payment of bursaries for bonded students:
   a. Which advantages and disadvantages do you recognise regarding the way the school will receive funding under option one)?
      List the advantages and disadvantages on a flipchart.
   b. Do you recognise one, or more, advantage(s) that outweigh the disadvantages? If so, which advantage(s) and what are your reasons for this conclusion?
   c. Do you recognise one, or more, disadvantages that outweigh the advantages? Or represent considerable risks for the school? If so, which and what are the reasons for your conclusion(s)?
   d. Which methods, strategies, or additional arrangements could enable you to avoid, or reduce these risks?

   Write your conclusions and main arguments on a flipchart for the plenary presentation.

2. Advantages and disadvantages option two: continuing PHC-CG allocations:
   a. Which advantages and disadvantages do you experience regarding the present way of allocating funds to the school
      List the advantages and disadvantages on a flipchart.
   b. Do you recognise one, or more, advantage(s) that you would not want to loose through a change of the funding arrangement? If so, which advantage(s) and what are the reasons for this conclusion?
   c. Do you recognise one, or more, disadvantage(s) that would be annulled by the new funding arrangement? Which are these disadvantages and how would the new arrangement dispel these?

   Write your conclusions and main arguments on a flipchart for the plenary presentation.

3. Advantages and disadvantages of government bonded students:
   a. In your opinion, what are the advantages, for the school, of accepting to train a considerable number of students that will be bonded to government?
   b. Which possible effects do you expect this will have for candidates from the PNFP health units? Are these effects desirable or not desirable? What are the reasons for your conclusions?
   c. Which possible effects will the bonding of a considerable number of the graduates have for the PNFP health units? Are these effects desirable or not desirable? What are the reasons for your conclusions?
   d. Which measures could you propose to mitigate the undesirable effects that you have identified?

   Write the conclusions, main arguments, and measures on a flipchart for the plenary presentation.

4. Your conclusions and recommendations:
   a. Reviewing the conclusions of your group per above question, which option for the funding of the PNFP HTI do you opt for?
   b. What are your main reasons for choosing this option?
   c. Which modifications do you think are absolutely necessary to address the disadvantages / risks / possible negatives effects of the option you have selected?

   Write the conclusions, arguments, and the proposals for modification on a flipchart for the plenary presentation.

Composition of the Groups

The Representatives of the 1st school in the list pick from the Secretariat the flip charts, markers and sheets.
The choice of the chair and rapporteurs (one for flip charts and one for the sheets) should take no more than 2 minutes. Flip charts must be filled first. The sheets will be filled even during the presentations and will be handed in to the secretariat at the end of the group's presentation.

Group One	Nsambya
Main Hall	Mengo
	Rubaga
	Kibuli
Group Two	Lacor
Main Hall	Kalongo
	Matany
	Kuluva
Group Three	Kamuli
Entrance verandah	Kiwoko
	Ngora
Group Four	Nyakibale
Garden	Mutolere
	Ishaka
	Virika
Group Five	Kagando
Main Hall	Kisiizi
	Ibanda
	Villamaria
	Kitovu

ANNEX 6

Outcome of the
GROUP WORK:

QUESTION	RESPONSE	FREQUENCY				
		GROUP I	GROUP II	GROUP III	GROUP IV	GROUP V
OPTION ONE: **Moving from the current arrangement to BURSARIES for students who will be bonded by Public Service. (i.e. increased funding per student, a quota of posts in the school "earmarked" for future public servants).**						
List a maximum of three advantages on flipchart (and here)	More students will get access to training	/				/
	Fair distribution of funds (equity)	/				
	Regular and complete flow of funds	/	/		/	
	Easy to plan since the amount is known in advance		/	/		
	Improve the staffing situation in the hard to reach areas through the bonding scheme		/		/	/
	It will reduce on the burden of pestering for school fees from students			/		
	Gives students maximum concentration			/		
	More funds available from bursaries than PHC-CG (increased incomes)				/	/
	Strengthened PPPH					/
List a maximum of three disadvantages on flipchart (and here)	In the absence of proper costing of training a student there, could be unmet needs of the school	/				
	Loss of autonomy	/				
	Lacks equitable (special focus) distribution of funds especially the HTIs in the hard to reach and hard to stay areas		/			
	Not honouring the bonding agreement after training		/			
	Selection of the candidate for the bursaries may be difficult and not transparent		/			
	Only small percentage of students is catered for			/		
	It may create arrogance and indiscipline among students			/		/
	Lack of sustainability after initiating the programme			/	/	
	Administrative problems because of two student groups in schools				/	/
	Likely government interference in PNFP HTIs					/

QUESTION	RESPONSE	FREQUENCY				
		GROUP I	GROUP II	GROUP III	GROUP IV	GROUP V
List any advantages that outweigh the disadvantages? Why?	Sure deal of accessing education	/				
	Sure deal of getting employment	/				
	Timely payment of school fees	/				
	Funding is available and in full amount, therefore it is easy to plan the functioning of the institution		/	/		/
	It will reduce on the burden of pestering for school fees from students			/		
	Health workers will be made available for the hard to reach areas				/	
	More funds available from bursaries than PHC-CG				/	/
List any disadvantages that outweigh the advantages or represent a serious risk? Why?	In the absence of proper costing of training a student, there could be unmet needs of the school. Performance will be affected.	/				
	Possibility that HTIs are excluded from the selection of the candidates		/			
	PNFPs excluded in the bonding arrangement		/			
	Creating arrogance and indiscipline among students			/		
	Delayed funds will halt HTIs operations					/
What do you suggest to reduce or avoid the risks (if any)?	Carryout a unit cost for training a nurse, in relation to the different disciplines.	/				
	Considerations should be made for inflation	/				
	Regular monitoring and evaluation	/				
	Funds should be committed for the long-term period	???				
	Applications should be received by the district and interviews conducted by schools		/			
	Involvement of the district through prior discussion		/			
	Include PNFP hospitals in the bonding agreement		/			
	Carrying out career guidance and counselling			/		
	Involving tutors in the selection of candidates			/		
	Participation by all stakeholders in the formulation of clear guidelines on recruitment and training			/		
	Annual allocations of funds should be released once directly to school accounts (once a year)				/	/
	Bureaux to follow up the releases and accountabilities					/

QUESTION	RESPONSE	FREQUENCY				
		GROUP I	GROUP II	GROUP III	GROUP IV	GROUP V
OPTION TWO: **Retain the existing funding mechanisms of general recurrent budget support through the PHC-CG from government (a known mechanism, no real strings attached)**						
List a maximum of three advantages on flipchart (and here)	Schools have autonomy over the money	/			/	
	It is an additional funding to the school	/			/	
	Schools are not limited to the numbers they want to recruit	/				
	Sustainability / continuity		/		/	/
	Flexibility in using the funds e.g. for salaries		/		/	
	It could work on specific identified areas			/		
	Local government involvement in monitoring			/		
	Improved cooperation between government and PNFPs			/		/
List a maximum of three disadvantages on flipchart (and here)	Poor students are not catered for	/				
	Late, Irregular and Inadequate flow of funds	/	/	/	/	/
	Inequitable distribution	/				
	Utilisation within a limited time frame		/			
	Strict conditionalities			/	/	
	Too much bureaucracy in accessing funds			/		
List any advantages that you do not want to loose? Why?	Autonomy in using the money	/				
	Schools remaining accountable to the funding bodies	/				
	Sustainability / continuity i.e. assurance of long term funding		/		/	/
	Linkage, partnership and collaboration between government and PNFP			/		
List any disadvantages that would be annulled by the adoption of option 1? Why?	Inability of the poor to access training	/				
	Inadequate distribution of funding in the training schools	/				
	Irregularity and inadequacy in the release of funds		/			
	Bureaucracy in accessing funds			/		
	Strict conditionalities will be dealt away with			/		
	Retention of trained personnel				/	

QUESTION	RESPONSE	FREQUENCY				
		GROUP I	GROUP II	GROUP III	GROUP IV	GROUP V
What do you suggest to reduce or avoid the risk (if any)?	Establish unit costs for training of each nurse	/				
	Regular release of funds	/				
	Adequate funding	/				
	Clear guidelines, proper planning, budgeting, implementation and accountability			/		/
	Strengthen the PPPH				/	
	Continued collaboration, networking and advocacy among the Bureaux					/
BONDING BY GOVERNMENT:						
Advantages <u>for the school</u> in having a sizeable quota of government bonded students?	Improved and stable enrollment	/	/		/	/
	Assured of school fees for that particular group	/			/	
	Reduces number of needy students i.e. reduction in absenteeism	/				
	The money flows in a lumpsum			/		/
	Increased income from bursaries				/	
Effects of government bonding, if any, for the non-bonded students? Are these effects likely to prove advantages or disadvantageous for non bonded students?	Disadvantageous: Creates categories of students (discrimination of the government sponsored and private students)	/				/
	Unbonded students relax to pay school fees	/				
	Excessive demands from the bonded	/				
	Indiscipline among students	/				/
Effects of government bonding, if any, for the PNFP health units? Are these effects likely to prove advantageous or disadvantageous of PNFP health units?	The effects are advantageous – there is sure deal of acquiring a certain amount of school fees	/				
	Reduction in absenteeism	/				
	Needy students are catered for.	/				
	Advantageous in the sense that PNFP will be able to retain their staff			/		
What do you suggest to mitigate the non desirable or disadvantageous effects identified?	Through network, collaboration and consultation			/		
	Prolonged bonding duration			/		
	Increased percentage of the bursary scheme					/

QUESTION	RESPONSE	FREQUENCY				
		GROUP I	GROUP II	GROUP III	GROUP IV	GROUP V
CONCLUSION:						
Which option do we recommend, all things considered? Why?	Option One because of its advantages	/				
	Option One – better funding which is regular and supports the disadvantaged		/			
	Option One: Improved retention of staff Reduced burden of fees collection Improved health services in the disadvantaged areas			/		
	Option One – increased income to PNFP HTIs				/	
Given the option chosen/recommended, and in the light of the possible undesirable effects, what must absolutely be addressed/secured to obtain the maximum possible advantages from this option?	Unit costing for training a nurse in reference to training the other disciplines	/				
	Stakeholder involvement	/				
	Extend bonding to PNFP hospitals		/			
	PNFPs must have a say in the bonding agreement		/			
	Freedom of selection as to who is to be bonded		/			
	Proper recruitment guidelines			/		
	Legalized bonding			/		
	Availability of adequate, qualified and competent tutors			/		
	Clear guidelines for disbursement of funds, bonding, selection of students should be available				/	
	Involvement of PNFP HTIs in the formulation of the above guidelines				/	
	Government should ensure timely release of funds				/	/