

UGANDA EPISCOPAL CONFERENCE
(CATHOLIC SECRETARIAT)

HEALTH COMMISSION

**TASK FORCE ON THE FUTURE OF NURSE TRAINING
IN THE PNFP NURSE TRAINING INSTITUTIONS.**

FINAL REPORT

OF THE TASK FORCE'S
RESEARCH FINDINGS AND PROPOSALS
AND THE OUTCOME OF THE CONSULTATIVE PROCESS WITH THE
PNFP HEALTH TRAINING INSTITUTIONS REGARDING:

***THE FUTURE OF NURSE TRAINING IN SUPPORT OF
THE MISSION OF THE PRIVATE NOT FOR PROFIT
HEALTH CARE SECTOR IN UGANDA.***

May 2005

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ACKNOWLEDGEMENTS

The in-depth assessment of the challenges faced by the PNFP Health Training Institutions presented in this report is the work of the Task Force on the future of the Nurse Training Institutions of the PNFP health services network.

The Task Force members hope that this assessment, together with the proposals developed, will go along way in assisting the PNFP Health Training Institutions in improving their contribution towards better health care in Uganda.

They especially hope that the unique decision, of all the PNFP HTI together, to install a Partnership Organisation, will enable them to work effectively together to realise the Joint Mission: *To train an optimal range of health care staff of high moral and professional standard for the PNFP and national health care institutions.*

The Health Commission of the Uganda Episcopal Conference installed this Task Force, first to find answers to the problems reported by the RC Nurse Training Institutions. When the Task Force proposed to include the colleague PNFP institutions, and later still to include all PNFP Health Training Institutions, the Health Commission wholeheartedly supported these propositions. In a later stage, when the PNFP HTI's requested the Commission to extend the period of the Task Force, to develop the plans for their close cooperation more in detail, the Commission again provided its full support.

The Task Force members thank the Health Commission members for the great trust placed in them as well as all the guidance and support given during these ten months.

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LIST OF ABBREVIATIONS

BTVET	Business Technical Vocational Education and Training
CNE	Continuous Nursing Education
DHC	Diocesan Health Coordinator
DHRD	Department of Human Resource Development
DP(s)	Development Partner(s)
ECN	Enrolled Comprehensive Nurse
EN	Enrolled Nurse
EM	Enrolled Midwife
Epsy	Enrolled Psychiatric Nurse
ESA	Education Standards Agency
EU	European Union
GOU	Government of Uganda
HC	Health Commission
HC II or III	Health Centre level two or three
HSSP	Health Sector Strategic Plan
HR	Human Resources
HTI	Health Training Institution
JRM	Joint Review Mission
LLU	Lower Level Unit (group name for all the HC's)
MOES	Ministry of Education and Sports
MOH	Ministry of Health
MOU	Memorandum of Understanding
NA	Nurse Assistant
NHA	National Health Assembly
NTI	Nurse Training Institution
NTS	Nurse Training School
PATS	Pharmacy Assistant Training Course of the Eastern African Church Umbrella Organisations.
PHC-CG	Primary health Care Conditional Grant
PNFP	Private Not for Profit
RC	Roman Catholic
RCN	Registered Comprehensive Nurse
RN	Registered Nurse
RM	Registered Midwife
TF	Task Force
UCMB	Uganda Catholic Medical Bureau
UEC	Uganda Episcopal Conference
UNMC	Uganda Nurses and Midwives Council
UMMB	Uganda Muslim Medical Bureau
UPMB	Uganda Protestant Medical Bureau

EXECUTIVE SUMMARY

In May 2004 the Health Commission of the Uganda Episcopal Conference installed a Task Force on the future of the Nurse Training Institutions of the Roman Catholic health services network.

The assignment of the Task Force was to advise and assist the Health Commission and UCMB in developing a strategy to:

- improve the use of the capacity of the affiliated training institutions (with their hospitals)
- train nurses in a way that is compatible with the perceived need in the country and to ensure access to training for rural candidates.

The Health Commission came to this initiative as, for over four years, the Training Institutions reported serious under-utilisation of their training capacity while at the same time the Health Units complained of shortages of nurses. Efforts of the Schools and the Medical Bureau had not resulted in improvements. The Health Commission feared that a persisting very low enrolment would aggravate the shortage of nurses.

The Commission and the Schools perceived a number of changes at national level as the main underlying causes. These were the strict application of the minimum entry criteria for Enrolled Nursing and Midwifery, the transition to Enrolled Comprehensive Nurse training, and the transfer of the responsibility for training of Health Workers to the Ministry of Education and Sports.

Methodologies and Evolution of the Work of the Task Force

The Task Force started its work in May 2004. From the beginning it chose to co-opt members from colleague PNFP Training Institutions and the Uganda Protestant and Muslim Medical Bureaux, as these proved to share the same problems. It also included representatives of the health units and coordination level to assure that their concerns were taken on board.

The activities of the Task Force, to answer to the questions of the Health Commission, consisted of a survey among the schools, several additional rounds of information collection and analysis, curricula comparisons, studies of national and international literature as well as extensive meetings with - and interviews of - external partners.

In an early stage the Task Force gave its assignment the motto: *The Future of Nurse Training in support of the Mission of the Private Not for Profit Health Care Sector in Uganda*. The reason for this choice was that the members felt the need to have a clear guiding principle for their work.

Then, early in its research, the Task Force established that the problems were quite different than expected. The actual common challenges indicated that solutions would have to come from joint efforts through stronger internal cooperation of the PNFP Training Institutions as well as a more effective coordination with other partners in training. The same motto proved helpful to determine the way forward and enable others to recognise that way as well.

In line with the findings and first proposals, presented to the internal Stakeholders, the assignment and work period of the Task Force was extended once to facilitate the

development of the proposal for the cooperation among the Institutions and include the other training programmes in the research and development activities.

Findings of the Task Force

1. Utilisation of the PNFP NTI

The under-utilisation reported by the RC and other PNFP NTI is not substantiated by the research of the TF. It is more likely that they over-estimated their actual enrolment capacity and use inadequate planning instruments. The actual total annual enrolment capacity would appear to be between 900 and 1200 places. With an annual number of candidates for final examinations between 833 and 1098 the utilisation would reach between 80 and 90%.

The regional disparities are cause of concern as the disadvantaged areas of the North and East, have the least training capacity.

The minimum entry requirements remain a cause of concern, as they do not correspond to the needs and the academic level of interested candidates from the rural areas. In addition there is a significant pressure to continue to increase them for basic as well as extension courses.

Most importantly the research found that there is an urgent need to improve the management information systems and actual management of the PNFP NTI.

2. Shortages of Nurses in PNFP Health Units

The findings of the TF do not confirm the HC's feared connection between low enrolment of students for nurse training and increasing staff shortages. The main reason is that the serious under-utilisation of the schools cannot be substantiated. Secondly there are no certain yardsticks to measure staff shortages. The staffing norms, presently applied in Uganda, indicate a national shortage of nearly 4000 nurses and midwives. This shortage can be bridged in three years with the existing training capacity of 1500 - 1700 places. However, if the national staffing norms will be adjusted, to the need to scale up services, the shortage of nurses and midwives will increase enormously. The calculated requirement of 18,000 nurses will require 12 years to train with the present training capacity.

The difficulties that the PNFP health units experience in attracting and retaining staff are much more related to the financial constraints to employ more staff and offer competitive salaries. Human Resource Management and Development inadequacies also form a significant obstacle.

The combination of, a low training capacity, and very important shortage of staff, in the Northern and Eastern Regions cause serious concerns. It really calls for corrective action within the PNFP health sector.

3. Enrolled Comprehensive Nurse Training

The transition from the traditional enrolled training programmes to the training of Enrolled Comprehensive Nurses was initiated in 2000. Implementation is far behind schedule, mainly due to the late implementation of support projects. Thus also the phasing out of the traditional enrolled training has not yet taken place. The latter is now to be completed by 2006. The capacity planned for the training of ECN's may not be achieved before 2009. The combination of the last two developments may entail that the output of Nurses will be too low in the years 2006/07 to 2009/10.

The PNFP NTI's agree, in principle, with the need for a multi purpose nurse for the Primary Health Care level. However they have considerable legitimate concerns regarding

the transition. These are first of all related to conflicting information regarding the number of NTI to convert and the national needs for other nursing cadres. Other concerns are related to the curriculum content, quality assurance during practice in health centres, particularly in areas with security problems, as well as the coverage of the high investment and recurrent costs. These questions need more explanations and attention before the remaining PNFP NTI's can decide how to proceed in this matter.

The PNFP NTI are interested in taking on the conversion curriculum EN/M to ECN to use their capacity well and enable their hospitals to offer staff development opportunities. The obstacle is that it is unknown who is to decide which schools are to implement this course.

4. *Categories to be trained*

There is an evident need to develop clear plans regarding the categories of nurses and midwives required for all levels of health care provision. Until these are available it would not be wise to take drastic decisions. The PNFP health sector requires a broad nursing skill mix and the NTI can and should play a key role in assuring that this skill mix becomes and remains available. This means that they should resist external pressure to limit their training to ECN's. Serious consideration should also be given to training a cadre that can assist qualified nurses in assuring effective bedside care. This cadre would also enable hospitals to improve their quality of care while containing employment costs. Serious candidates without the required academic qualifications would benefit, as it offers them the possibility to enter the profession while improving their grades to enter registered courses.

The need for tutors in the PNFP NTI, and the low national capacity to train tutors, may require some action by the PNFP NTI to enable them to maintain quality of the training.

5. *Training Capacity Required*

If the data, provided by the PNFP HTI regarding the number of hostel beds, are correct, their present annual intake capacity is between 900 and 1200 places. The under-utilisation of that capacity is at most between 10 and 18%.

This capacity is well in line with the existing staffing norms and plans. There are no gains to be had from pursuing a 100% utilisation of the earlier assumed capacity, as this would cause an overproduction and add considerable costs to the institutions.

The PNFP should formally recognise and state their actual training capacity to facilitate their own planning and that of the external partners.

The newly determined capacity, compared to the capacity planned for the PNFP to train ECN's, leaves the Schools with ample room to continue training other nursing and midwifery levels. They should also consider diversifying to include the training of the new care cadre, allied professional training, or the specialised nurse training. In particular the PNFP HTI are advised to use capacity that is freed by the conversion to ECN to start refresher / postgraduate courses to assist health workers in responding adequately to new care and treatment requirements. The training in HIV/AIDS treatment and care should be given priority in view of the rapid changes in this field.

6. *Funding and Costs of PNFP Nurse Training Institutions*

The scarcity of separate financial reports of the NTI's hardly allows definite conclusions regarding the funding and costs of training in the PNFP sector, leave alone their sustainability. Separate Management Information Systems should be installed very soon to ensure transparent accountability to external partners as well as to be able to manage adequately.

The evidence is clear that the presence of a Training Institution pushes up the costs of the Parent Hospital. This entails that Hospital Boards and Managers should opt for continuation of the Training Institutions for reasons related to the Mission and quality of training and care, not for any other reasons.

It is important to keep monitoring the origin of the subsidies (PHC-CG) and advocate for a fairer share of the national budget for training of health workers as the PNFP NTI train more than fifty percent of the national output in nurses and midwives.

7. *Quality of PNFP Nurse and Midwifery Training*

There is objective evidence that the PNFP NTI continue to assure training of high standards. Internally though there is also a growing realisation that this quality is strained and endangered. ECN training poses very new challenges to quality assurance considering the lack of tutors and the need to assure effective practical experience periods far from the school, in the health centres. For these reasons assuring quality will require continuous attention and common action if it is to be maintained.

8. *Training Allied Professionals and Specialised Nurses in the PNFP Sector*

The present involvement of the PNFP HTI in other than traditional nursing courses is limited. Though the information, regarding the needs and training capacity available, is far from complete, there do seem to be needs that are not covered. In particular pharmacy, nursing specialisations, and refresher / postgraduate courses are areas requiring additional training capacity (see also 3.4.2). If the PNFP HTI would have an excess capacity and / or wish to diversify these should be priority areas.

9. *Governance of the PNFP Health Training Institutions*

The PNFP HTI clearly do, and wish to, share the mission of the Government, to train capable staff. To this effect they will continue to abide by the policies, plans and standards of the Ministries, in so far as they do not contradict the Ethical Codes of the Church. This alignment is largely voluntary, with the understanding that accepting subsidies (PHC – CG) from Government brings obligations to adhere to the policies and standards as well as account transparently.

When the Public Schools were transferred to the MOES it was understood, and implicitly agreed, that the PNFP HTI would remain part of their parent hospital. However, there is continuous pressure on the schools to become fully autonomous identical to the Public Schools.

The representatives of the Hospitals/HTI reasserted their views that training is an integral part of their Mission. The TF strongly advised to avoid separating the Board of the HTI from the Board of the Hospital. Instead it is necessary to enhance governance and management of the schools by the assigned hospital structures with effective participation of the management of the HTI. To improve transparency and accountability each HTI has to be established as a clearly identified cost centre, in the hospital accounting system, with protected budget lines and clear spending and accountability procedures.

The Task Force also found that the unique organisational position of the PNFP HTI has enabled them, in the past, to be innovative and creative. These abilities need to be reawakened and used effectively to innovate training and services. The adherence to governmental policies and standards, for recognised and registered professional training courses, does not mean that training of new cadres, or training in new skills, is not possible.

10. Internal Coordination of the PNFP Health Training Sector

In the past coordination with and between the PNFP HTI's by the MOH, UNMC, and the Medical Bureaux was reasonably adequate. This became much more complicated and less evident when the responsibility for Health Training programmes was transferred to the MOES. First attempts, in 2001, to strengthen internal and external coordination failed. As the Bureaux mainly have a technical advisory role they cannot compensate for the lack of formal coordination mechanisms. The absence of effective coordination contributed to the problems and has certainly prolonged their existence. There is a high need to install formal mechanisms for dialogue and cooperation internally as well as externally.

11. The External Environment of the PNFP Health Training Institutions

The external environment of the PNFP HTI has become much more complex since the transition of the Health Training programmes to the Ministry of Education. A number of implications of that transition still require final resolutions, particularly the division of responsibilities regarding developing policies and plans, coordinating all the stakeholders, and setting standards. In addition, all the partners in training are faced with the need to increase the quantity and quality of staff, to ensure that the health outcomes can be achieved. But at the same time the budget for health is hardly growing.

All these challenges at national level have now been recognised and the key ones, such as the development of a Human Resource policy and strategic plan are to be addressed in the coming year. This process is to be consultative and this means that the PNFP HTI's will be invited to participate. This would represent a huge step forwards in their recognition and will greatly facilitate the resolution of the present problems.

The crucial obstacle is that the PNFP HTI's do not have a mechanism to coordinate and cooperate among themselves and formulate a common view towards the external partners. If they really want to exert influence on the national debates and plans, the PNFP HTI's will have to install a mechanism that will enable them to coordinate their efforts and have a clear and unanimous representation in national fora. This mechanism will have to be in place soon as the process for the policy development has actually already started.

12. Insights from International Literature and Experiences

The study of Nursing Acts from a wide variety of countries indicates that the Uganda Professional Councils have a high degree of autonomy and hold the key powers in setting standards for the training of the professionals. This still corresponds to the situation where one Ministry was responsible for the entire trajectory, from basic training to the performance of the employed health professionals. In countries where the responsibilities for training have been transferred to another Ministry long since, the Professional Councils are concentrating more and more on verification of the standards of the new professionals through registration examinations. The impact on the content and quality of the training is the same as no professional training school wishes to train persons that cannot access the professional registers. This change of role enables these Councils to focus much more on continuous improvement of the registered professionals.

The same review did show that the Uganda Nursing Act does allow to develop and implement training programmes for other cadres, not covered by the register, and own examinations (hospital certificates).

The main message from the international literature is that qualitative and quantitative shortages in Human Resources are now widely recognised as a key obstacle to achieving the desired health outcomes in developing countries. The underlying causes, however, are

multiple and complicated. This means that recipes, to solve them, have to be developed per country and sometimes even by region, when these are particularly disfavoured. An important recognition, in relation to the problems in Uganda and the PNFP sector, is that there is a direct link between an increase in standards of professional training and the increase in mobility of professionals (from rural to urban and from developing country to developed countries). Another important lesson is that offering staff professional training near to their home area and career development possibilities greatly enhances the ability to retain them also in disfavoured areas.

Even in this complex context health training institutions can play a significant role in improving the number, motivation, and skills of the health workers. The international examples inspired the Task Force in developing the options for the future, or proved the validity of the proposals presented in chapter four.

The Proposals of the Task Force

The findings above show that the problems, the PNFP HTI face, are not what they expected. It is not a serious under-utilisation, or excess capacity, they are experiencing but much more a sub-optimal utilisation due to planning and management difficulties. These difficulties are aggravated by the large number of uncertainties with respect to what is expected from them as they form sixty percent of the national training capacity.

The Task Force also found that there are a number of particular concerns: regional imbalances in access to staff as well as access to training, lack of certain categories of health workers, lack of tutors and tutor training capacity, risks to the quality of training, and emerging needs for special skills.

Based on the Mission of the PNFP HTI and the findings, the goal for the selection of the options for the future was: *To contribute optimally to the availability of competent health care staff for the PNFP and national health care institutions, at all levels, to enable these to provide comprehensive and effective services.*

This goal and the objectives derived from it, enabled the Task Force to arrive at the following recommendations and proposals for the PNFP Health Training Institutions:

1. Establish a Form of Close Cooperation between the PNFP Health Training Institutions

This proposal follows the findings that there is a high need to cooperate internally as well as assure a constructive dialogue with the external partners.

The TF proposed that an organisation be installed because the level of internal and external cooperation requires considerable professional capacity, a formal and recognised status, and the ability to assure that all the members adhere to common policies and plans.

The goals of this organisation are:

- Ensuring coordination, consensus building, and cooperation between the Health Training Institutions of the PNFP health care sector.
- Ensuring an effective representation of the PNFP Health Training Institutions in - and coordination with - the common external partners, including advocating for the interests of the Health Training Institutions, and their students.

This proposal was the main subject of the second and third consultations the TF organised with all the PNFP HTI Internal Stakeholders. In February 2005, they decided to install the Partnership Organisation. It will start as a moral organisation, for which the secretariat

will be hosted by one of the Medical Bureaux. The aim is to assure that the Partnership of the PNFP HTI becomes a legally recognised organisation.

An Interim Executive Committee has been elected and has started operations. It is hoped that a Delegated Secretary can be recruited soon.

2. *Improve Planning, Management, and Accountability of the PNFP Health Training Institutions*

The main finding that prompted this area of proposals was the fact that the HTI's own perception of the problems proved to be considerably different from the actual problems. The first cause of the difference proved to be the absence of adequate collection, compilation, and analysis of the own data. The installation of a standardised Management Information System, including the establishment of the HTI as a cost centre, with protected budget and clear spending and accounting procedures is proposed. These are prerequisites to improve governance management and transparent accountability. These in turn will form the best ways to ensure that the HTI remain integral parts of their parent hospitals.

To ensure effective short and long-term planning at school as well as at national level the schools urgently need to determine and declare their real intake capacity.

The representatives of the PNFP HTI have already decided that they will start using the annual reporting format proposed at the end of this financial year.

3. *Optimise the Contributions of the PNFP Health Training Institutions.*

The Task Force is convinced that the present real capacity (calculated on the basis of the key limiting factor: hostel beds) of the PNFP HTI, to train nurses, should be maintained. As yet there is no need to try to reach the perceived capacity (this might change if the new national norms are to be implemented). The PNFP schools should rather concentrate on:

- Improving the use of their present capacity through division of tasks and diversification of the training programmes provided.

Under this strategy several options are proposed ranging from regional division and planning of the programmes, developing and implementing new training programmes, such as pre-graduate patient carer course, considering training allied professionals, and providing refresher / postgraduate for specific needs such as HIV/AIDS care and treatment.

The options to accelerate the conversion to ECN training and implementing the EN/EM to ECN conversion course also belong in this group. However the Task Force strongly recommends that the key questions then be answered before final decisions are taken (see annex VII).

- Improving the quality of the candidates and access for candidates from disadvantaged areas.

The proposals ranked here include developing and implementing a bridging course to enable candidates to obtain the required entry criteria, increasing access to sponsorship for students from poor / rural areas, and obtaining permission to apply the entry criteria for EN/EM flexibly if this training is maintained until the ECN capacity is online.

The Task Force also proposed a number of support measures to support the cooperation and implementation of the options. These include the development of a common position regarding the governance of the PNFP HTI as integral part of their parent hospital,

standardisation and harmonisation of rules and regulations for the PNFP HTI's, and the gradual development of an accreditation programme.

Information from the PNFP HTI and from national level regarding the training needs and training capacity for Allied Professionals and Specialised Nurses only became clear during the last weeks of the Task Force Activities. The Task Force identified some areas of particular concern that the Partnership might wish to take up in the mid-term. The subjects are: the need to increase the number of tutors and clinical instructors, considering training pharmacy assistants using the PATS curriculum, and developing additional measures to correct regional disparities in training capacities.

The Outcome of the Consultative Process and Final Recommendations

The Health Commission had purposefully included consultation of the internal stakeholders, in the assignment of the Task Force. The aim was to ensure that the proposals to be adopted would be feasible for the majority of the Training Institutions and that they would fully endorse and own them. The problems identified were different and thus the main proposal, of establishing an organisational form of close cooperation, was unexpected. The PNFP HTI representatives required more time and several consultations to consider the findings and obtain more insight in how the cooperation could be set-up and made operational. During the third consultation conference they unanimously decide that the Partnership Organisation should become a reality and that it should start operations as soon as possible.

All the options to optimise the utilisation of the HTI, proposed by the Task Force require joint planning and cooperation. The representatives of the PNFP HTI therefore concluded that final decisions regarding the selection and implementation of options should be taken once the Partnership Organisation is operational and more information about the plans at national level becomes available.

In line with the decisions of the PNFP HTI the main final recommendations of the Task Force are addressed to the Health Commission, UCMB, and the Interim Executive Committee. The recommendations all concern the start-up of the Partnership Organisation. The main aim is facilitate a speedy start of the operations as well as the smooth preparation of the formal inauguration and formalisation of the Partnership.

In particular the establishment of the formal representation of the PNFP HTI is needed soon in view of the development of policies and plans at national level. In addition there are quite a number of questions that require answers from the external partners to enable the partnership to finalise the plans to optimise the use of the PNFP HTI. Lastly the HTI would greatly benefit from early professional support in determining their definite capacity and improving their management information system.

For these reasons the Partnership Secretariat should become functional as soon as possible with a well qualified Delegated Secretary and a clear embedding in one of the Medical Bureaux. The Health Commission is requested to assist this start-up phase with financial, moral, and technical support.

1. INTRODUCTION

In May 2004 the Health Commission of the Uganda Episcopal Conference installed a Task Force on the future of the Nurse Training Institutions of the Roman Catholic health services network.

The assignment of the Task Force is to advise and assist the Health Commission and Uganda Catholic Medical Bureau (UCMB) in developing a strategy to:

- improve the use of the capacity of the affiliated training institutions (with their hospitals)
- train nurses in a way that is compatible with the perceived need in the country and to ensure access to training for rural candidates.

1.1. Back ground and Problem Statement

The eleven Catholic, together with the seven Protestant, and one Muslim Nurse Training Institutions represent sixty percent of the national capacity to train nurses for Uganda. In 2000/01 the external environment of these Private Not for Profit (PNFP) Nurse Training Institutions started to change significantly:

- The decision was taken to convert the traditional enrolled nurses and midwives training to one Enrolled Comprehensive Nurse (ECN) training programme to ensure the availability of multi-skilled nurses for Primary Health Care Services (e.g able to provide all services needed at Health Centre II and III level). Once this new programme will be implemented the traditional Enrolled programmes are to be phased out.
- In 1998 the responsibility for the Training of Nurses and Allied professionals was transferred to the Ministry of Education and Sports. The responsibility for the Governmental Schools was handed over to the Ministry of Education and Sport (MOES).
- In 2002 the Uganda Nurses and Midwives Council (UNMC) decided to enforce the entry criteria as they are stipulated in the curricula for each training programme.

The Catholic Schools and the other PNFP Nurse Training Institutions were of the opinion that the combination of developments, but particularly the strict application of the entry criteria, resulted in a serious reduction of the number of students entering the Enrolled Nurse training programmes. They estimated the reduction of their utilisation at around 50%. The two schools that started ECN training only succeeded in enrolling a near full class in the first year.

In 2001, the Managers and Principles of all the PNFP Nurse Training Institutions / Hospitals¹ met and formulated constructive recommendations to assure that the training of nurses in the PNFP schools could convert to the new training programme.

When the strict application of the entry criteria was announced, the Medical Bureaux presented the possible implications for the schools in the rural areas². They showed that, in the PNFP schools, the former application of flexible criteria did not have a negative effect

¹ Memorandum of Workshop of Hospital Administrators and Principal Tutors in PNFP Hospitals with Health Training Schools Institutions, July 2001.

² Position Paper prepared for the HPAC: Issues Emerging from the Stringent application of the Entry Criteria in Nurse Training, December 2002.

on the quality of the graduates and advocated for a continuation through the implementation of objectively verifiable selection procedures. The proposals were not accepted and ongoing lobby activities of individual Schools and UCMB brought no significant changes.

In the beginning of 2004 the RC Nurse Training Institutions (NTI) continued to report a too low enrolment of students while the Health Units continued to report serious difficulties in recruiting sufficient numbers of nurses. The Health Commission (HC) recognised the potential aggravating effect of the low enrolment of students on the availability of nurses for the health units. It acknowledged that neither the NTI nor UCMB had been able to find durable solutions and felt therefore that action was needed. It decided to install a Task Force to undertake an in-depth investigation of the problems and develop feasible and sustainable proposals to improve the contribution of the schools towards the availability of nurses.

1.2. The Assignment of the Task Force on the Future of the Nurse Training

The general purpose of the assignment was:

To advise and assist the Health Commission and UCMB in developing a strategy to improve the capacity of affiliated Training Institutions (Hospitals) to train nurses in a way that is compatible with the huge demand in the Country and access to training for rural candidates.

The key objectives were:

1. Develop proposal for a bridging curriculum to allow entry to potential candidates that do not satisfy entry criteria, and test reaction of the regulators to such proposal.
2. Develop a proposal for accelerated transition to Comprehensive Nursing if feasible and desirable in the light of the current and foreseeable constraints.
3. To explore avenues / possibilities / acceptability of training nursing cadres specifically of intermediate level (between current Nursing Assistants and Comprehensive Nurses) for the internal consumption of the RCC health services (or for the PNFP sector / or for Uganda – not for export).
4. Consolidate proposals and advice in a report to the Health Commission within maximum 6 months.

The complete Terms of Reference of the Health Commission are presented in annex I.

In summary, the detailed objectives, activities, and methods proposed by the HC aimed to ensure that all relevant information would be taken into consideration and that all directly and indirectly involved partners in training nurses would be consulted. This reflected the HC's wish to ensure that the proposals of the Task Force would be feasible for the majority of the RC NTI and that they would be the owners of the final decisions. To this effect two activities were of key importance for the HC:

- An Internal Consultation Conference: to enable all the internal partners in the training of Nurses to understand the findings and decide on the best way forward;
- An External Consultation Conference: once internally the decisions for the future would be clear, this consultation Conference, with all external and internal stakeholders, or partners, should aim at creating understanding and reaching consensus on the way forward for the PNFP Nurse Training Institutions.

The timeframe given for the assignment was from May to end of August 2004.

1.3. Composition of The Task Force

The Health Commission appointed seven persons to form the Task Force. These members were first of all selected on the basis of their expertise and experience in Nurse Training within the RC health care network. In addition the Health Commission (HC) ensured that the members reflected the diversity of the RC Nurse Training Schools (NTS) with respect to the diversity of training programmes (from Enrolled to Registered Nurse training), as well as the diversity of the locations (urban and rural, central, western, eastern and northern regions).

The HC gave the Task Force the responsibility to elect a chairperson and a secretary, and to co-opt other members as deemed necessary. It also included in the budgetary provision to enable the Task Force to recruit a process facilitator.

1.4. Content of this Final Report

This report forms the final report to Health Commission in answer to the assignment given to the Task Force on the future of the Nurse Training. This is the second report to the HC. In September 2004, the Chairperson of the Task Force presented an interim report to the HC and requested, on behalf of all PNFP Nurse Training Schools, an extension of the Task Force's activities. The aim of this extension was to enable the internal partners to absorb the findings, and the Task Force to further develop the proposals for the future, particularly the proposal for a close cooperation between the PNFP Health Training Institutions. The HC granted the extension and thus the Task Force was able to finalise its work to the point where it could be handed over.

In February 2005 all the PNFP Health Training Institutions unanimously decided to set up an organisation that will enable them to work closely together and to assure an effective dialogue with the external partners. An interim Executive Committee was elected and the Task Force has handed over to this Committee on April 5, 2005.

As can be understood from the above paragraph the actual scope and content of the work of the Task Force changed during the assignment period. This was in answer to the findings of the research into the causes as well as the priorities that emerged from there. Thus this final report will not follow in detail the Terms of Reference as set by the HC. These Terms of Reference concentrated on a number of predetermined solutions, which proved important for the longer-term future while in the short term the setting up of the Cooperation had to take precedence.

It should also be noted that, in line with the original assignment, this report concentrates on Nurse Training. However, the cooperation established will include all health training activities and institutions of the PNFP health sector.

Chapter two provides a general overview of the evolution of the work of the Task Force. Chapter three presents the essential findings and chapter four the main proposals together with the motivation for each choice. In chapter five we provide an overview of the evolution and the outcome of the internal consultative process. The report concludes with recommendations for the Health Commission and the Interim Committee of the Partnership of the PNFP Health Training Institutions.

2. EVOLUTION OF THE WORK OF THE TASK FORCE

In this chapter we want to summarise the steps and activities undertaken by the Task Force for the future of the Nurse Training in the RC and PNFP health care network.

2.1. The Final Composition of the Task Force

The Health Commission appointed the following persons as members:

- Rev Sr. Joseph Donatus, Principal Tutor Rubaga NTS (until September '04)
- Rev Sr. Maria Teresa Ronchi, Principal Tutor St. Kizito, Matany NTS;
- Rev Sr. Stella Josephine Namatovu, Principal Tutor Nsambya NTS;
- Rev Sr. Rosemary Namaganda, Administrator Rubaga Hospital and representative of the nurses working in the UCMB affiliated health units in the UNMC;
- Ms Ineke Huitema, nurse Tutor and coordinator / lecturer for the Health Promotion diploma course at UMU (she had to leave the TF after the first retreat due to departure for the Netherlands);
- Ms Marcella Nsenga, Nurse Tutor Mutolere NTS;
- Ms Nabadda Emerin Rose, Nurse Tutor NTS Villa Maria NTS.

The members elected Sr. Maria Theresa Ronchi as the Chairperson of the Task Force and Mr. Isaac Kagimu Mpoza, the Human Resource Advisor of UCMB as secretary. They selected Ms. Marieke Verhallen as facilitator for the Task Force (TF).

Recognising that the colleague PNFP NTS were facing the same situation, the members also decided to co-opt representatives from institutions affiliated to – and / or representatives of - the Uganda Protestant Medical Bureau (UPMB) and the Uganda Muslim Medical Bureau (UMMB).

In addition, to assure that the different levels of health care services would be able to contribute and participate the TF co-opted representatives of Health Centres and Diocesan Coordination Offices.

The Task Force was thus enlarged with the following members:

- Rev. Sr. Sofia Bwesigye, Principal Tutor Virika NTS, ECN programme;
- Mrs. Rose Orach, Diocesan Health Coordinator Nebbi Diocese;
- Rev. Sr. Serafine Othira, In Charge of Orussi HC III;
- Mrs. Hajat Safina Museene, Nurse Tutor Mulago NTS and UMMB representative;
- Ms. Georgina Kajik, Nurse Tutor Kiwoko NTS UPMB;
- Ms. Naomi Kafeero, Mengo NTS UPMB;
- Mr. Benon Sabiiti, Assistant Executive Secretary UPMB;
- Later: Mr. Ambrose Muhumuza, Information, and Data Manager UPMB.

2.2. Methodologies and Activities of the Task Force

The Task Force held three retreats between May 15 and September 2004. The fourth retreat was held before the Second Internal Consultation in December 2004. As the members came from all over the country and each had a full time job this proved the most appropriate and fruitful way of working.

In line with the conclusion that all PNFP NTS were facing the same problems, the Task Force included all PNFP schools in its research and consultation activities.

The following activities were planned and undertaken to establish the causes of the problems of the NTS' and to develop options for the future:

- Collection of information from all PNFP Nurse Training Institutions through, a questionnaire, and where possible a visit to the schools.
- Two rounds of follow-up questions by telephone calls and email.
- Collection and study of national documents, reports, and information (a.o. Nursing Act, Allied Professional Act, Health Policy and Sector Strategic Plan, Bukenya report on the transition of the Health Training Institutions to the MOES {2001}, Human Resource Development Plan Scenario IV of Group Five {2000}).
- Comparisons of existing curricula: Nursing Assistants (NA), Enrolled Nursing (EN) and Midwifery (EM), Enrolled Comprehensive Nursing (ECN), Conversion course EN/M to ECN, Registered Nursing (RN) and Midwifery (RM).
- Collection and study of international documents and information (nursing acts, reports, research articles).
- Meetings with -, and interviews of – representatives of the External Partners in Nurse / Health Worker Training: Ministry of Health, Department of Human Resource Development (MOH – DHRD), Ministry of Education and Sports, Bureau for Technical Vocational Education and Training (MOES-BTVET), Uganda Nurses and Midwives Council (UNMC), the Development Partners (DP's) involved in support to Health Training Institutions (DANIDA, Development Cooperation Ireland, European Union – Project Human Recourse for Health).
- Organisation and implementation of the First Internal Consultation Conference, in September 2004. Representatives of Boards of Governors, Management teams and NTI Management of all PNFP Nurse / Health Training Institutions were invited to this Conference.

In answer to the request of the participants of the First Internal Consultation Conference the HC extended the work period of the Task Force. This enabled the TF to undertake additional activities in function of the findings and the wishes of the PNFP HTI:

- Development of a proposal for the organisational set-up of an organisation for the close cooperation between the PNFP HTI.
- Development of a draft Constitution for the Partnership Consortium of the PNFP HTI.
- An additional survey to establish the present involvement of the PNFP in the training of Allied Professionals and Specialised Nurses.
- Formulation of a proposal for the Management Information System for the Schools and a format for annual reports
- A second round of meetings and interviews of the External Partners.
- Formulation of a reaction to the Report of the MOH Study “Tracking Human Resource and Wage Bill Management in the Health Sector” of September 2004.
- Formulation of a Position Paper for DANIDA in view of their assessment of needs for the next period of support.
- Organisation and implementation of the Second and Third Internal Consultation Conferences, in respectively December 2004 and February 2005. The participants invited were the same as for the first Internal Consultation.

One activity could not yet be implemented, as the chosen Internal Cooperation needs to be installed first. This concerns the External Consultation Conference.

Originally it was foreseen that the TF would end its activities by the end of August 2004. This period was extended to end January 2005 in the hope that the proposed organisation for the cooperation would then be able to take over. The HTI's required more time to come to a decision reason why the TF ends its activities mid April 2005.

2.4. Adjustments in Scope of Works and Assignment Period

As can be understood from the detailed objectives in the Terms of Reference, the HC and the RC Schools were quite convinced that the main obstacles, to optimal utilisation of the NTS, lay in the minimum entry criteria set by the UNMC and the transition to training Enrolled Comprehensive Nurses (developing a proposal for a bridging course, developing a proposal for the accelerated transition to ECN training, and explore avenues / possibilities / acceptance to train a nursing cadre specifically for internal consumption). The findings of the survey among the schools indicated that the reality was somewhat different. The under-utilisation proved to be less severe than thought and there could even be reason to think that an excess capacity and / or inadequate planning were more immediate problems. However, to determine the training capacity needed per school, a comparison to the national plans for training of Health Workers was required. This proved less obvious as these plans are not yet well developed.

Regarding possible proposals to improve the utilisation of the schools, respectively, optimise their contribution to the availability of well qualified and motivated staff, the same detailed objectives, in the Terms of Reference, indicated a set of specific choices. Here again the first findings showed that these might not all be needed. More importantly, the Task Force found that the majority of the indicated solutions could not be implemented by one NTS, or one denomination, alone. To a certain extent the failures, in the past, to resolve the problems of the PNFP HTI could be traced to the absence of a structured dialogue and cooperation among these Schools. A joint effort is very much needed to succeed.

This area of cooperation among the RC NTS, or among the PNFP NTS, had been given little attention in the Terms of Reference. However, in the first period of the TF's activities, it was exactly this area that emerged as the area requiring the highest priority. It proved essential for the development and selection of feasible solutions.

In addition the TF found that, as the Schools form such a large percentage of the national training capacity, the, directly related, area of dialogue and negotiation with the External Partners required comparable priority attention. The reason is that to be able to maximise the utilisation of the PNFP HTI they need to be able to determine which training courses to concentrate on and what capacity per School is then required. As national plans are still to be developed, this calls for active participation in the development of the new policies and plans at national level.

When the PNFP HTI representatives, present at the First Internal Consultation Conference, learnt of the findings of the TF and of its proposal to first install a form of close cooperation between the HTI, they requested the Health Commission to extend the assignment and period of the Task Force.

During the Third Internal Consultation the PNFP HTI decided that a Partnership Organisation is to be installed and elected an Interim Executive Committee. The Task Force can therefore now hand over to this Committee.

3. FINDINGS OF THE TASK FORCE

The Task Force spent much time on research to be able to understand the problems in depth and to determine which solutions would be feasible and sustainable. As can be concluded from the activities listed in chapter 2.2. the range of the research activities was very broad. In this chapter we present the main findings that are relevant for the proposals done in chapter 4. Key data are summarised in Annex VI.

3.1. Utilisation of the Nurse Training Schools

The PNFP sector has 19 Nurse Training Institutions: 11 affiliated to UCMB, 7 to UPMB, and 1 to UMMB³. The country counts 8 Governmental and an uncertain number of Private Nursing Schools. This means that the PNFP sector operates more than 60% of the recognised public purpose NTI. It was not possible for the TF to establish whether this percentage remained the same in a comparison of the annual enrolment capacity of the governmental NTS versus the annual enrolment capacity of the PNFP Schools. There are two reasons for this. Firstly all schools have difficulties in defining their annual enrolment capacity (see below 3.1.2.). Secondly the governmental schools are often over-enrolled at present. One thing is certain, annually between 800 and 1200 nurses and midwives pass the final UNMC examinations, and of these between 500 and 850 (e.g. 60 to 70%) are PNFP NTS graduates.

3.1.1. Information Systems

The utilisation of the schools was investigated through a questionnaire sent to all PNFP schools. This questionnaire had to be followed by several additional questions to all schools. The latter proved necessary, as the information collected through the first questionnaire was often unclear or incomplete. Also the additional information did not always give the required answers. Specifically the question of the actual annual enrolment capacity per school was difficult to assess. The underlying causes are firstly the absence of a structured information system for the training institutions and related to this, a large variability in the interpretation of the definitions of “enrolment capacity”.

This problem is not unique for the PNFP sector: the EU Human Resources for Health project and the researchers of the MOH Tracking Study ran into the same problems in all schools.

The findings of the Task Force suggest that, if a structured information system had existed, combined with a system of annual reporting to the Medical Bureaux, the actual problems would have been identified much earlier. The huge concerns and failed individual attempts may even have been avoided. The evidence collected would have enabled the PNFP NTI to initiate a dialogue with the External Partners from a position of strength in an early phase. In other words, the need to install effective Management Information System is large and should be given priority.

3.1.2. Actual Enrolment versus Capacity Indicated

The questionnaire covered the last four years of the NTS (2001 – 2004). According to the first answers, the 19 PNFP NTS, together, have a total annual enrolment capacity of 1662

³ Other sources indicate that the PNFP sector has 18 NTI. The reason is that Kibuli NTS has not yet started operations. As this is scheduled for May 2005, the TF included them in all activities.

places. In 2001 the PNFP Schools had filled 52% of these available places. In other words the under-utilisation existed before the strict application of entry criteria.

In 2002 the total enrolment dropped to 41% of the annual capacity. The cause for this was clearly the strict application of the minimum entry criteria for the training of Enrolled Nurses and Midwives, by the UNMC. This decision took the NTI by surprise and resulted in a significant number of students that were not accepted by the UNMC and / or lower numbers of students that could be accepted for the training.

In 2003 the enrolment increased again to 48% of the indicated capacity. In 2004 the same percentage was reached in August, when the enrolment for November was not yet known, e.g. it was likely to return to the level of 2001. Annex 1 provides a graphic overview of the evolution of the utilisation of the schools over these four years.

When the information received from the schools remained unclear as to the actual annual enrolment capacity, the TF undertook a theoretical exercise to try and establish this capacity. The calculation was based on the number of hostel beds⁴, the number of courses per school, and their duration. The TF thus found that a total annual enrolment capacity of around 995 places is probably more correct than the 1662. A comparison of this figure with the 833 students, which sat for the final examinations in 2003, puts the total utilisation of the PNFP NTS at 82% in 2003. Or, in other words: the under-utilisation is closer to 18%⁵, than the indicated 52% (annex II).⁶ Using this calculation method regional utilisations differences become more apparent: the central and western schools have a lower average of utilisation (annex III).

This finding then explained a phenomenon that the TF had found during the review of the data over four years per school. These showed a remarkable swinging pattern: one year a large number of students were recruited for one course and the next year a very low number or no students were recruited for the same course. If the schools had more than one training programme the same pattern, with one-year difference, could be noted there. The combination of these findings strongly suggests that annual planning of the student enrolment, based on well-defined capacity per course, is not generally done in the PNFP NTS.

3.1.3. Regional Disparities

Though known implicitly, the statistics collected put in stark evidence the unequal distribution of training, capacity in the PNFP sector, between the Central & Western Region and the Eastern & Northern Regions: the Northern Region has an annual enrolment capacity of 311 = 17% and the Eastern Regions has 120 places = 7%. Together they represents 24% of the total of 1662 places all schools have together. According to the calculations based on hostel beds this would be respectively 222 (22%) and 68 (6%) = 290 places out of the total of 995 = 28%.

Considering the data based on hostel beds, surprisingly the schools in the North and East are better used⁷ than the other two regions. In 2003 these had reached a 70% utilisation

⁴ This was possible as all Schools confirmed that they only enrol resident students.

⁵ Unfortunately these figures are still not final, as two schools have not yet completed their data.

⁶ The MOH Tracking Study, version February 2005, reports the PNFP design capacity (annual enrolment capacity according to available facilities and resources) at 1208. It calculated the actual average intake over 2001 – 2003 at 1098. This points at a utilisation of 90%. The TF could not yet establish how the authors arrived at these new figures.

⁷ The figures for 2002 even show a 105% utilisation because Lacor only took in a large number of EN's and these all opted to do their O levels after finalising their EN training.

again and in 2004 77% (excluding the November intake). While the North and East have respectively 91% and 89%.

The TF could not do an in-depth study on this but generally this is ascribed to the well-known high quality of schools such as Lacor and Matany. In addition the fees can be kept low here as these schools receive considerable external support.

Training Capacity per Region		
Region	Self declared capacity	Capacity based on Hostel beds
Central	594 (36%)	399 (40%)
Western	637 (38%)	306 (30%)
Northern	311 (17%)	222 (22%)
Eastern	120 (7%)	68 (6%)
Total	1,662	995

3.1.4. Minimum Entry Requirements versus level of Candidates

The strict application of the minimum entry criteria for EN and EM training caused the huge dip in utilisation of the Schools in 2002. These criteria are five mandatory O level passes in English, Mathematics, Biology, Physics and Chemistry.

Though the effect of the strict application of the criteria has decreased to some extent, the concern remains as strong. First of all because the entry criteria for Enrolled Comprehensive Nurse training (ECN) are even higher: O level five credits. The NTS' that started ECN training only succeeded in the first year to recruit a full group. Since then they have had to skip one year or stop temporarily.

Secondly the TF noted that there is a distinct wish within the UNMC to raise the profile of Nursing Professions considerably. In this the Council follows the umbrella Council⁸ of the East and Southern African Countries that is aiming at phasing out all enrolled levels in favour of registered level. The claim is that all East African Countries should achieve a standard comparable with developed countries. This goal inspires quite a number of choices at present, for instance refusal to recognise Nursing Assistants and the setting of high and strict entry criteria. But these plans stand in contrast to the need for staff in the rural areas and the standard of the secondary schools in these areas. Senior Secondary Schools in the rural areas have limited abilities to teach the sciences⁹. Candidates who do have the required entry level, have many more professional education opportunities which are more attractive in terms of future income as well as future living environment (urban)¹⁰.

Thirdly evidence is mounting that academic grades alone are not adequate to assess the suitability of candidates. The UCMB first provided evidence for the limited value of academic grades in 2002¹¹. The MOH Tracking Study reaches a similar conclusion when reviewing the success rates of graduates from PNFP NTI's (page 19).

⁸ ECSACCON: East and Southern African Countries Council of Nurses.

⁹ The PEAP assessment of 2003/04 showed that less than 50% of the GOU SSS have the manpower, infrastructure, and equipment to teach sciences.

¹⁰ To the PNFP health care network, it appears as if the Professional Councils are more focussed on ensuring correspondence of the professional cadre levels, with the employment structures in civil services, than on the content of the profession itself.

¹¹ Position Paper prepared for the HPAC: Issues Emerging from the Stringent application of the Entry Criteria in Nurse Training, December 2002.

Fortunately other External Partners are now recognising the negative effects of the high entry criteria on the production of ECN's. The decision to convert to the training of ECN's first and foremost aimed at training a multi purpose staff that can implement Primary Health Care services in rural and peri-urban health centres. The high entry criteria seem in fact to be defeating the purpose as too few candidates from the rural areas can be enrolled. Thus the Inter-Ministerial Standing Coordination Committee, which consists of representatives MOES-BTVET, MOH, UNMC, the Development Partners, and the Medical Bureaux, has decided that the minimum entry requirements for ECN would be adjusted to O level 5 passes with English and Biology as the only mandatory passes. The actual decision was taken mid 2004 and the official Circular, to the NTI, confirming the new entry criteria came out in February 2005. The new entry criteria are now O passes in English and Biology as core subjects and three other non-core sciences. However, the UNMC does not agree with the revised minimum entry requirements, meaning that there is still no final solution.

NB. The revised entry criteria for ECN do mean that the entry criteria for the traditional Enrolled Nurse and Midwifery training are now actually higher as for these courses all the subjects are core (e.g. mandatory): O level passes in English, Mathematics, Biology, Chemistry and Physics.

The Task Force is of the opinion that there are considerable reasons to continue to lobby for a return to flexible entry criteria for the remaining years of the existence of the EN / EM training. The main reason lies in the need for nurses. Secondly the evidence that the secondary schools in rural areas are not yet able to educate students in the science subjects is a strong argument. The last reason is that the MOH now has evidence that the annual output of ECN will not reach the required level until 2009 / 2010¹².

A new area of concern, regarding entry criteria, emerged during the Task Force's period of work: More and more the UNMC (or MOES this is not always clear) demands that candidates, for extension courses and specialisation courses, have the same O or A levels than those demanded for direct entry. This is contrary to the curricula. The TF is quite concerned about this development as it means that vertical progression in the nursing professions will hardly be possible. Candidates for extension and specialisation courses rarely have the possibility to take time off to (re-)do their O or A levels.

The Tutor training college is the only one that has formally published this new entry requirement for this specialisation course (candidates should have O level credits demanded for direct entry to Registered Nursing). As the PNFP sector has a significant need to increase the number of tutors, and already had grave difficulties in identifying double trained Registered Nurse candidates, this new additional criterion will mean that no candidates for tutor training will be forthcoming.

3.1.5. Conclusions

The under-utilisation reported by the RC and other PNFP NTI is not substantiated by the research of the TF. It is more likely that they over-estimated their actual enrolment capacity and use inadequate planning instruments. The actual total annual enrolment capacity would appear to be between 900 and 1200 places. With an annual number of

¹² MOH / AMREF Tracking Study Human Resources and Wage bill management in Health Sector, September 2004, revised in February 2005.

candidates for final examinations between 833 and 1098 the utilisation would reach around 90%.

The regional disparities are cause of concern as the disfavoured areas have the least training capacity as well as the largest need in staff.

The minimum entry requirements remain a cause of concern, as they do not correspond to the health workforce needs and the academic level of available and interested candidates. In addition there is a significant pressure to continue to increase them for basic as well as extension courses.

Most importantly the research found that there is an urgent need to improve the management information systems and actual management of the PNFP NTI.

3.2. Shortage of Nurses in PNFP Health Units

The Health Commission's main motivation to install the Task Force was the fear that a prolonged under-utilisation of the NTI would translate into more severe shortages of nurses for the health units. This area of investigation took on an even greater importance, for the TF, when it became apparent that it needed to be able to answer the question "How does the existing PNFP training capacity compare to the need to train nurses and / or the plans for the future to train nurses?" However, time and manpower constraints meant that this research had to concentrate on documents and sample interviews of key persons.

3.2.1. Quantitative Information

It is far from evident to determine the extent of shortages in Health Care workers as there are few certain yardsticks, e.g. defined norms against which the shortage can be measured. In addition the data on available staff is often weak. The TF found that the WHO advises one nurse per 500 persons. It recognises that this is beyond the means of developing countries. In practice most African countries have, or strive at, a ratio of 1 nurse per 2000 persons. The Health Sector Working Group in Uganda aims, with the staff establishment norms for the Health Sector Strategic Plan I (HSSP), at 1 nurse / midwife per 2,048 persons. At present the Government and PNFP health services count 7,952 qualified nurses and midwives. To reach the HSSP I norms a total of 3,763 nursing staff would be needed (2,776 nurses and 987 midwives). UCMB has calculated that, against the same norms, its hospitals and health centres have a shortage of 1,096 nurse and 747 midwives (a total of 1,843). As these figures are from one PFNP sub-sector only, it would seem likely that the national staffing gap is underestimated.

	HR gap UCMB Hospitals	HR gap UCMB LLU's	Total gap UCMB	HRSWG HR gap assessment (GOU and PNFP)
Nurses	1,045	51	1,096	2,776
Midwives	643	104	747	987
Total	1,688	155	1,843	3,763

Based on the figures reported in the MOH Tracking Study report of February 2005, the average annual output of nurses and midwives by the Public and PNFP NTI together is 1400. The total annual design capacity is given as 1718. This would mean that the gap could be filled in 2 to 3 years time, excluding staff attrition. In other words the present national training capacity and annual output are reasonably at par with the present staffing norms.

3.2.2. Regional Disparities

The TF could not establish the exact regional variety of the national vacancies. UCMB data show that the largest shortage of staff in its hospitals and health centres is found in the Northern and Eastern regions: of the total of 1,688 nurses and midwives needed in hospitals, 1,014 are needed in the units in the North and East (e.g. 60%). There would seem to be a clear link between a low training capacity and a low availability of staff. The MOH Tracking Study and international literature confirm this assumption and show that training close to home areas is a powerful means to retain staff in disfavoured areas.

	Nr. of UCMB Hospitals	Total Declared Training Capacity (capacity based on hostel beds)	Nursing Staff Gap
Northern and Eastern	13	431 (or 290)	1,014
Central and Western	14	1,231 (or 705)	674
Total	27	1,662 (995)	1,688

3.2.3. Effect of Future Plans on Shortages

During the Joint Review Mission of October 2004, the MOH announced that it was considering revising the staffing norms to assure that the scaling up of services, foreseen in HSSP II, would be possible. The new calculations would bring the shortage of nursing staff up to 18,000! It is not yet certain that this plan will materialise as this would have considerable implications for the budget of the Health Sector and this budget is not allowed to grow during the coming two years.

Internationally the concern, regarding the effects of Human Resource shortages on health outcomes, is growing rapidly. All international calculations show that to obtain the Millennium Development Goals and the objectives of the Global Initiatives for HIV/AIDS, Malaria, and TB the required increase in Human Resources is huge. The High Level Forum on the Health MDG's¹³ concluded that to achieve the international development goals in health 2.5 health workers (all cadres) per 1000 inhabitants would be needed. Uganda presently has 1.2 (30,000 health workers on a total population of 25 million)

3.2.4. Labour Market

There is a quite large spread perception in Public Service, that there is a pool of nurses "on the street" ready to be recruited. The TF could not substantiate this claim as all PNFP health units report losses of staff whenever the Health Services Commissions at national, or district, level initiate a new recruitment drive. A similar movement of staff is then also reported between districts and between district hospitals and regional hospitals.

In all cases, if the new norms will be adopted, it will not be possible to fill the then emerging gap through recruitments only. The training capacity will have to be increased.

3.2.5. Qualitative Information

The TF was not able to do in-depth research into the causes of shortages of nurses and midwives at the level of the health units. Interviews with hospital and health centre managers and with Diocesan Health Coordinators indicated that for them other factors

¹³ Reports High-Level Forum on the MDG's: 1.) Health Workforce Challenges: Lessons and Experiences and 2.) Addressing Africa's Health Workforce Crisis: An Avenue for Action, Abuja December 2004.

form more important obstacles to recruiting the number of staff required. In the first place the financial constraints entail that the PNFP health units cannot recruit the number required nor can they offer salaries that can compete with Public Service salaries¹⁴. In second place, PNFP health units in the North and East, as well as hard to reach areas in the West, (the disadvantaged areas) have much more difficulties in attracting and retaining staff. The reasons here are that staffs perceive the work conditions as hard and amenities as bad (housing, schooling for children, transport, electricity, water, etc.). Human Resource Management and Development difficulties and inadequacies form another area of obstacles. In the PNFP health sector Terms and Conditions of Services are often not clear and the opportunities for further training / career development are very scarce.

It is important to note that the present staffing norms are based mainly on the factors related to physical size of the institutions and level of care to be provided, and not on actual workload. On the other hand perceptions of shortages are mostly based on workload.

In addition, experiences in PNFP institutions and international literature indicate that staff perceptions of being overburdened (e.g. that the unit has a shortage of staff) can often be traced to other factors. These are inadequate planning, inadequate HR Management, and harsh living conditions.

3.2.4. Conclusions

The findings of the TF do not confirm the feared connection between low enrolment of students for nurse training and increasing staff shortages, for now. The main reason is that the serious under-utilisation of the schools cannot be substantiated. Secondly there are no certain yardsticks to measure staff shortages. The staffing norms presently applied in Uganda indicate a national shortage of nearly 4000 nurses and midwives. This shortage can be bridged in three years with the existing training capacity. However, if the national staffing norms will be adjusted, to the need to scale up services, the shortage of nurses and midwives will increase enormously. The calculated requirement of 18,000 nurses will require 12 years to train with the present training capacity!

The difficulties that the PNFP health units experience in attracting and retaining staff are much more related to the financial constraints to employ more staff and offer competitive salaries. Human Resource Management and Development inadequacies also form a significant obstacle.

The combination of a low training capacity and very important shortage of staff in the Northern and Eastern Regions, is cause for serious concerns. It really calls for corrective action within the PNFP health sector.

3.3. Enrolled Comprehensive Nurse Training

The training of this new cadre aims at assuring the availability of a multi-purpose nurse for first line Primary Health Care (PHC) services. This is understood to cover curative and preventive services at Health Centre II and III level as well as outreach services and health promotion in / with the community. In 1998/99 it was agreed that this type of nurse would be essential to achieving the HSSP objectives in rural and peri-urban areas. The transition to this three-year training programme was to start in 2000 and be finalised between 2003

¹⁴ Since November 2004 this has even worsened as salaries for the health workers in Public Service have been increased substantially and the MOH has not yet been able to increase the subsidies to the PNFP health units to enable them to raise the salaries with comparable percentages.

and 2005. When announced it was indicated that all NTI were to convert and the traditional EN and EM training programmes were to be phased out between 2002 and 2004.

The TF found that the transition is far behind schedule both in governmental NTI as in PNFP NTI. The main reason is that the development and implementation of support projects for the transition took relatively long to take off¹⁵. The EU HRH project for instance only started in 2003/04 and is still in the start-up phase. Of the PNFP Schools to convert only Virika and Lacor received support to date.

The second reason is that, at the time, the UNMC set the minimum entry criteria at O level, five mandatory credits. The four PNFP Schools that started in 2002 could barely fill one group in the first year and had to abandon the plans for the next two years, because of shortage of candidates.

Up to November 2004, only one group had graduated: 24 ECN's from Virika.

Several External Partners expressed their concern, as they perceived a reluctance, or even unwillingness, at the level of the PNFP NTI to start the transition. The TF thereupon made an inventory of the views within the PNFP sector of the proposed transition to ECN training.

The main conclusion is that the PNFP health sector is, in principle in favour of improving the skills of nurses that are to run Primary Health Centres and implement community health activities. The hesitations to initiate the conversion are caused by several factors.

3.3.1. Questions regarding the Number of Schools to convert

The information that can be gleaned from the MOH HR Plan of 2000, Scenario 4, learns that the total national annual enrolment capacity / annual output for ECN and RCN is planned at 1253¹⁶. The calculations that could be made, from the detailed information sheets, indicates that the PNFP would be expected to produce 629 ECN's, as none of the PNFP HTI train RCN's.

During the meetings and interviews with MOH and MOES, the representatives stressed that only 14 Schools are expected to convert. This stands opposed to directives given in 2001, when all PNFP NTS were informed that they were to convert. The Ministries did not indicate which criteria were / are to be used in selecting which NTS should convert.

In September 2004, 14 NTS were included in the EU HRH project, 3 were assisted by DANIDA, and Development Cooperation of Ireland had earmarked 2 for support. This would mean that no other schools would be required to convert. However, in October the TF learnt that DANIDA was considering including another 6 PNFP Schools in its plans for the next three years. In other words, the DP's seemed unaware of the decisions of the MOH and MOES.

An additional complicating factor, to deciding how many and which schools should convert tot ECN training, is caused by incomplete views on – and plans for – other nursing and midwifery cadres.

¹⁵ See also MOH Tracking Study and the Reaction of the TF to this report.

¹⁶ MOH Human Resource plan 1999/2000, Scenario IV. Group Five developed this Development Plan for Nursing and Allied professionals for the MOH between 1999 and 2000. The report contained several scenario's, of which the fourth was retained as the most appropriate and feasible.

The TF suggested, to the participants of the Internal Consultations, that the PNFP HTI should develop criteria to decide which PNFP schools should convert. These could include the needs of the rural health centres and the comparative advantages of the various schools. For instance NTS affiliated to rural hospitals have a higher need to concentrate on ECN training and have better access to health centre practicum sites. Whereas schools affiliated to urban referral hospitals have better possibilities to train registered level hospital nurses.

3.3.2. The Content of the ECN Curriculum

The first set of concerns, the PNFP sector has here, regards the entry criteria (see above 3.1.4.). The next set of questions is related to the duration of the ECN training. Many feel that three years might be too short to cover all the tasks at health centre level adequately. Particularly the midwifery tasks may be underestimated, considering that these nurses will have to be able to perform without supervision. In comparison the double trained enrolled nurse / midwife was trained during five years to be able to perform the same tasks (excluding the two years work experience demanded before being allowed to enter the extension course)¹⁷.

Lastly the ECN curriculum is fully focussed on health centre care and community action. In practice this means that graduates lack knowledge and skills to function adequately in a hospital setting¹⁸. Hospitals will continue to need enrolled level nurses, next to other levels of nurses. To compensate for the shortcomings in their training, the PNFP HTI's are considering developing an internship period for ECN graduates wishing to work in hospitals.

3.3.3. Infrastructure and Manpower Requirements

The curriculum for ECN training puts very high demands on the available infrastructure and manpower. The PNFP HTI's are not able to realise the required improvements without external support.

The largest obstacle is formed by the manpower needs. The survey findings indicate that the majority of the PNFP have around 50% of the number of tutors they should have, excluding the ECN demands. Access to tutor training for PNFP candidates is limited numerically, but even this quota cannot be used fully as it is difficult to identify sufficient candidates. The new entry criteria will only make it more difficult (see 3.1.4.)

The TF learnt that there is a considerable number (+/- 100) of trained tutors who are not employed as tutor. They do not want to leave the employment of the MOH as employment conditions in MOES are less attractive. As these conditions are even less favourable in the PNFP sector, the chances that the PNFP sector can attract them are practically zero.

3.3.4. Recurrent Costs of ECN Training

The additional infrastructure and manpower needs, inevitably, generate an increase in the recurrent costs needed to train ECN's. On top of these, the practice periods in the health centres entail considerable additional recurrent costs for board and lodging for the students; allowances for health centre staff and teaching staff; and transport of students and teaching staff.

¹⁷ Verbal information the TF obtained from Kenya, where the Community Nurse training is comparable to the ECN programme, indicated that this programme is being reconsidered exactly because the Community nurse lack skills and experience to work without supervision.

¹⁸ With respect to RCN curriculum this limitation applies even more.

Though the information is not yet complete, due to limited experience with the implementation of the curriculum, the first indications point towards a 50% increase in recurrent costs (EN training generally costs 1 million USHS per student per year, while ECN training costs 1,5 million USHS per student).

The PNFP HTI mainly fund the training costs through student fees. There are no indications, as yet, that the GOU subsidies, or support from DP's will be increased to cover the higher recurrent costs. Thus the Schools are uncertain how to cover these costs without endangering access for candidates by increasing student fees.

3.3.5. Quality of the ECN Training

Up to November 2004, only 24 ECN's graduated from the PNFP NTI Virika. Thus there is as yet little scope to assess the effectiveness and quality of the training.

For the PNFP HTI's the relatively long periods of practice in Health Centres are of particular concern. This namely entails that the In Charges of the Health Centres require skills as clinical instructors and extra time to assist the students. However, these units generally have a high turnover rate of In Charge Nurses and are often under-staffed. The regular supervision visits by HTI tutors and clinical instructors cannot fully compensate for a lack of continuous on-the-job training.

Where the HTI's have limited access to health centres for the practical periods, hospital practice cannot adequately replace the health centre experiences (hospitals in insecure areas and referral level hospitals).

But the main concern lies with the overall lack of tutors and with the limited possibilities to prepare the existing staff for the transfer and the effective implementation of the ECN programme.

3.3.6. Particular concerns of the PNFP HTI's in the North

In the light of the above assessment the PNFP Health Training Institutions in the North are hesitant to convert to ECN training for the following additional reasons:

- the number of candidates with the required entry criteria from the districts surrounding the schools is very low and will remain so for the mid- to long-term;
- the insecurity means that students fear posting to health centres and teaching teams do not have easy access to these health centres for adequate supervision. Thus the possibilities to ensure the full implementation of the ECN curriculum are seriously limited.
- uncertainty regarding continuous availability of the required number of tutors. Already the present staffing requirements cannot be filled, as tutors are not willing to work in insecure areas.
- inability to cover the additional recurrent costs. These hospitals are already heavily subsidised and external subsidies are more and more difficult to obtain. An increased need for external support can hardly be considered.
- the lack of a clear vision on which other cadres will need to be trained for the nation and / or for the PNFP sector. Before committing themselves to a conversion to ECN training they need to be sure that the course they provide now will no longer be expected from them.

3.3.7. Conversion Curriculum

A general curriculum to enable traditionally trained Enrolled cadres to convert to ECN's was finalised in May 2004. The Inter-Ministerial Standing Coordination Committee concluded at the same time as the Task Force, that this curriculum is very general and does not reflect the fact that the enrolled cadres have different backgrounds: nursing, midwifery, psychiatry, and combinations of these. The advice is that it would be valuable to have conversion curricula adjusted to each different group that needs to access this training.

It would be very interesting for the PNFP HTI to implement the conversion curricula. The first reason is that this would enable them to use the existing capacity more optimally. In the second place, access to this training enables PNFP health units to offer their staff development opportunities and thus enhance their staff retention.

The largest obstacle to starting implementation of the conversion curriculum is that it is not clear who is to decide on the selection of the schools and / or who is to give permission to the HTI's for these courses. During a meeting of a sub-committee of the Inter-Ministerial Standing Coordination Committee, a plan was announced that the new private schools would be assigned this role. This plan gives rise to concern as these schools have little to no previous experience in nurse training, leave alone in ECN training.

More recent information seems to indicate¹⁹ that a number of GOU HTI's and one PNFP HTI (Virika) have been selected for this training. According to the information of the Task Force the latter school has not yet been informed, nor has it been consulted regarding this decision.

3.3.8. Phasing-out of the Traditional Enrolled Nurse and Midwife Training

When the plans for the transition to ECN training were announced it was foreseen that by 2004 the traditional enrolled nurse and midwife training programmes would be phased out. As the transitions were delayed this schedule was not actively pursued. However in 2004, the Inter-Ministerial Standing Coordination Committee directed that the Public NTI should stop taking students in for enrolled nurse and midwife training at the end of 2004 and the PNFP NTI in 2006.

The MOH Tracking study found that the planned full capacity to train ECN would only be reached in five years from now (2009). If the present plan to phase out the EN / EM training is maintained there is a danger that from 2005/06 to 2009/10, the number of graduating nurses and midwives will be too low to fill the existing gaps (see 3.3.1.) and compensate for attrition.

3.3.9. Conclusions

The transition from the traditional enrolled training programmes to the training of Enrolled Comprehensive Nurses was initiated in 2000. Implementation is far behind schedule, mainly due to the late implementation of support projects. Thus also the phasing out of the traditional enrolled training has not yet taken place. The latter is now to be completed by 2006. The capacity planned for the training of ECN's may not be achieved

¹⁹ Volume II of the draft HSSP II chapter on Human Resources.

before 2009. The combination of the last two developments may entail that the output of Nurses will be too low in the years 2006/07 to 2009/10.

The PNFP NTI's agree, in principle, with the need for a multi purpose nurse for the Primary Health Care level. However they have considerable legitimate concerns regarding the transition. These are first of all related to conflicting information regarding the number of NTI's to convert compared to the national needs for other nursing cadres. Other concerns are related to the curriculum content, quality assurance during practice in health centres, particularly in insecure areas, as well as coverage of the high investment and recurrent costs. These questions need more explanations and attention before the remaining PNFP NTI's can decide how to proceed in this matter.

The PNFP NTI are interested in taking on the conversion curriculum EN/M to ECN to use their capacity well and enable their hospitals to offer staff development opportunities. The obstacle is that it is unknown who is to decide which schools are to implement this course.

3.4. Categories of Nurses Required

As a first step to determine the capacity of training the PNFP HTI should have, the TF needed information on the categories of nurses the country and the PNFP health units require.

3.4.1. Levels of Nurses and Midwives

At present the PNFP NTI train Enrolled and Registered level nurses and midwives, through direct entry and extension courses.

The governmental NTI also provide enrolled and registered, direct entry and extension, courses in nursing and midwifery. In addition Makerere and Mbarara public universities have a Bachelor Nurse (Bsc) training programme. The Agha Khan foundation also runs a Bsc Nursing programme.

The Ministries and the Scenario IV report concentrate on the plans to train ECN's and are less clear on plans for other levels of nursing and midwifery cadres. The Ministry of Education and Sports is reviewing the present ECN and RCN curricula. The TF could not establish whether it has, or will, also develop a career development programme.

The Development Partners focus on the transition to ECN and a selected number of Allied Professional training courses (mainly laboratory assistants and technicians). The reason for this is that they wish to contribute to the improvement of Primary Health Care services, specifically in rural / disfavoured areas.

The recent Human Resource Tracking Study of the MOH concentrates on Human Resources required for Health Centres II to IV (Primary Health Care level) and thus only compares the present production of RCN's and ECN's compared to the HSSP I norms for these units.

The UNMC had initiated the training of Registered Comprehensive Nurses (RCN's, a multi-purpose nurse of higher level) a few years before the plans for the Enrolled level Comprehensive Nurse Training were developed by the MOH. This initiative followed the UNMC's wish to raise the professional standards and improve international comparability. Very few of the RCN graduates are working in rural and peri-urban health centres at present. Hospitals report that their training does not enable them to fit into hospital nursing easily.

The present draft Nursing Career Development Plan, of the UNMC, builds on the RCN training. This entails that ECN's will first have to go through RCN training before they can enter a specialisation course. The PNFP hospitals are concerned that this will mean that training for hospital nursing will be practically non-existent as both Comprehensive Nursing curricula have serious shortcomings with respect to hospital nursing.

In 1996, the Nursing Act, that rules the UNMC, was amended by parliament as Nursing Assistants (NA's) were to be phased out and thus would no longer be registered under the act, e.g. would no longer be recognised as a category of the nursing profession. During its working period the TF found that the MOH, is sending mixed signals regarding this category. In 2001/02 a series of crash courses started to train 6648 Nursing Assistants which ended in 2004. In 2003/04 the NA's were taken of the official staff establishment lists and the health units were directed to count them under support staff.

The PNFP health units indicate that they would certainly require a broad mix of skills to cater for the different levels of care in health centres and hospitals. Certainly a range from basic nursing to specialised nursing care is needed in hospitals.

A recent study²⁰ indicates that there is significant scope to improve quality of care while containing employment cost by employing Nursing Assistants for tasks that do not require a high level of technical knowledge and skills. These findings combined with the obstacle of the high entry criteria for candidates from rural settings, inspires the Task Force to recommend the development of a high standard "Patient Carer" (Nurse Assistant new style) training course. This proposal corresponds with the objective of the HC regarding the intermediate course for internal consumption. However, the willingness of HTI's to reconsider the training of Nursing Assistants is very low. This reluctance is caused by the negative experiences of the last two years with the crash courses for Nursing Assistants²¹, and the views of the UNMC regarding this cadre. A change of name and a more detailed curriculum will be required to swing their opinions. The Boards and Managers of the hospitals are very much in favour.

It is important to note that, as this course is not included in the UNMC register the PNFP HTI's can decide to train this cadre for internal consumption of the PNFP health units.

3.4.2. Specialised Nurses

The PNFP HTI's are not involved in training specialised nurses at present.

There are three recognised nurse specialisation-training courses in the country: Psychiatry Nursing Butabika (enrolled and registered level), Paediatric Nursing in Jinja, and Public Health Nursing in Kyambogo. Mulago has an annual intake capacity for all Health Tutor training of 25.

The present Human Development Plan, Scenario IV, provides no information regarding the number and categories of specialised nurses required and thus nothing can be concluded regarding the existing training capacity.

The TF could not establish what plans exist within the MOES – BTVET department with respect to specialised nurse training programmes.

²⁰ Optimal Medical Staffing levels and skill mix for patient care departments of UCMB Hospital, Dr. G. Namaganada, August 2004.

²¹ A curriculum comparison, by the Task Force, indicates that the course aspired to a similar level as enrolled nurses in a period of three months only.

The TF is particularly concerned about the low number of places for tutor training and the absence of a formal clinical instructor-training course. Unfortunately estimates of the needs are not available. The PNFP NTI's presently have around 48 tutors and clinical instructors together. To answer to the standards they would need between 20 to 40 more tutors, excluding ECN training. The recognition of tutors trained in Tanzania by CEDHA is still pending in spite to an assessment report that showed that the difference with the Mulago course is minimal and could be resolved by a short additional course.

International literature shows that other countries have a broad variety of specialised nurses and also that the present Global Initiative and Millennium Development Goal programmes call for more specialised skills of nurses and other primary care workers. In particular the need to prepare nurses and midwives for HIV/AIDS treatment and care is being put high on the agenda. There are no signs yet that Uganda is planning specialised courses to scale up services to achieve the international goals. The TF recommends that the PNFP HTI take the initiative in developing refresher / postgraduate courses that can enhance the ability of health care workers to respond to new care and treatment needs. The area of effective treatment and care to of HIV/AIDS patients should be among the first to be considered.

3.4.3. Conclusions

There is an evident need to develop clear plans regarding the categories of nurses and midwives required for ALL levels of health care provision. Until these are available it would not be wise to take drastic decisions. The PNFP health sector requires a broad nursing skill mix and the NTI can and should play a key role in assuring this skill mix becomes and remains available. This means that they should resist external pressure to limit their training to ECN's. Serious consideration should also be given to training a cadre that can assist qualified nurses in assuring effective bedside care. This cadre would also enable hospitals to improve their quality of care while containing employment costs. Serious candidates without the required academic qualifications would benefit as it offers them the possibility to enter the profession while improving / obtaining their grades to enter registered courses.

The need for tutors in the PNFP NTI's and the low national capacity to train tutors may require some common action by these schools to enable them to maintain quality of the training.

3.5. Training Capacity Required

In the absence of detailed plans for the categories and numbers of nurses required for all health services it is hardly possible to determine the training capacity needed.

3.5.1. Training Capacity Plans

Through a detailed search through the HR Development Plan Scenario IV the Task Force could establish that the total training capacity for nurses and midwives, all categories, here was set at 1575 places (annual intake = annual output). Retaining the present 40 – 60% division between Public and PNFP sectors this would mean that the PNFP should plan to have a total training capacity of 945 places. This plan also indicates that a total training capacity for RCN and ECN is foreseen at 1253 places. Of these 629 are foreseen for the PNFP NTI.

As indicated this plan was developed in 1999-2000 and mainly concerned the Primary Health Care level. Neither the hospital level nor the need to scale up services was included. The draft new staffing norms for the HSSP II would put the nurse / midwife gap at 18,000. More modest calculations to scale up reproductive health services and Anti Retroviral Treatment services put the additional number midwives at 406 and the number of nurses at 1266, bringing the total gap at 5,435.

To obtain some indication / measure for verification the TF calculated the number of training places required to fulfil a norm of one nurse for a population of 2000, by 2010, taking the present attrition rate of 3% into consideration. The outcome was that the country would need 1600 training places in total (e.g. an output of 1600).

If the staffing norms are increased and the shortage would increase to 18,000 nurses and midwives, the present training capacity would not be sufficient, as it would take around 15 years to fill the gap, excluding attrition.

3.5.2. Present Training Capacity of the PNFP Nurse Training Institutions

According to the PNFP Schools themselves they have an annual intake capacity of 1662. If this were true, the PNFP Schools alone would be able, in three years time, to train the number of 3763 nurse and midwives required to fill the gap between the present number and the HSSP I norms.

The adjusted calculations of the PNFP capacity, based on number of hostel beds, would put it between 900 and 1000 places. The MOH Tracking Study (version February 05) puts the PNFP design capacity at 1208²² and that of the Public Schools at 510. Thus together the present NTI would have an annual intake / output capacity of 1718. This capacity amply covers the capacity needed to ensure nurse to population ratio of 1:2000.

In other words the present PNFP capacity is close to what it should be with respect to the present general plans. If the Schools would pursue a 100% utilisation of the assumed capacity they would cause an over production.

If the Government planning of 629 places for the PNFP NTI for ECN training is upheld and taken up by the PNFP NTI, they would have between 300 to 600 places to train other categories of nurses and midwives. Another option would be to diversify the training courses to include the proposed new cadre (see 3.4.1) and / or to include allied professional, specialised nursing courses, and / or refresher or postgraduate courses (see 3.4.2. and 3.8.2.).

	Total	Planned for ECN / RCN (Scenario 4)	Available for other training course
PNFP capacity based on hostel beds	900 - 1000	629 (ECN only)	300 – 400
PNFP capacity acc MOH Tracking Study	1208		600
Capacity Public Schools	510	624	???
Total	1718 (Or 1418 – 1518)	1253	

²² This figure came to light in the revised version of the MOH Tracking Study. The TF could not yet establish the basis of this information to determine how / why it differs from the calculations it reached by using the hostel beds as starting point.

3.5.3. The need for a Formal Recognition / Statement of the Actual Capacity

It would be very important that each PNFP NTI's formally recognises and states its own capacity as it has now been calculated (or based on other sound calculations / evidence of real ability to provide training of a high standard).

The principle reason is that it will enable each HTI to improve its own planning and thus optimise the use of the capacity. Secondly it will contribute to better planning at national level. Thirdly it will allow to provide transparent evidence for the contribution of the PNFP HTI. And last, but far from least, it will take away the scope for errors in national assessment and statements: at present the Tracking Study and other MOH / MOES documents have started repeating the PNFP's own perception that they are under utilised and / or have an excess capacity. How wrong information can lead to wrong conclusions, is evidenced by calls, and registered by the TF, that some PNFP HTI's should close so that others can use their capacity better. The TF hopes that the evidence that there is little under-utilisation / excess capacity will annul these calls.

3.5.4. Conclusions

If the data, provided by the PNFP HTI regarding the number of hostel beds, are correct, their present annual intake capacity is between 900 and 1200 places. The under-utilisation of that capacity is at most between 10 to 15%.

This capacity is well in line with the existing staffing norms and plans. There are no gains to be had from pursuing a 100% utilisation of the earlier assumed capacity, as this would cause an overproduction and add considerable costs to the institutions and the sector as a whole.

The PNFP HTI's should formally recognise and state their actual training capacity to facilitate their own planning and that of the external partners.

The newly determined capacity, compared to the capacity planned for the PNFP to train ECN's leaves, the Schools with ample room to continue training other nursing and midwifery levels. They should also consider diversifying to include the training of a new cadre, allied professional training, and / or specialised nurse training. In particular the PNFP HTI are advised to use capacity that is freed by the conversion to ECN to start refresher / postgraduate courses to assist health workers in responding adequately to new care and treatment requirements. In particular, training in HIV/AIDS treatment and care should be given precedence.

3.6. **Funding and Costs of the PNFP Nurse Training Institutions**

The key question for the HC was to know to which extent the under-utilisation endangered the sustainability of the NTI'S. But here again the TF could not obtain a full overview, due to absence of complete and clear information. The Hospitals / HTI's only installed separate accounting systems for the HTI a few years ago and few have succeeded a complete separation by now. Therefore the following cautious indications have been drawn from four NTI's for which the TF had complete separate financial reports for two years or more. Information from other documents, interviews, and discussions has been added where relevant.

3.6.1. Sources of Funding

In general the PNFP NTI's have three main sources of funding: student fees, Primary Health Care-Conditional Grants (PHC-CG), and donations & other income. The

percentage of income derived from student fees ranges from 40 to 70%. The contribution of the PHC-CG is around 25-30%. Donations & other income can form between 15 and 30% of the income. This category includes subsidies from the parent hospital. As these are rarely reported separately, but in combination with donation and other income, the level of these contributions could not be assessed. There is a general perception that hospital subsidies are considerable, and that even if reported faithfully, this might still be underestimated as the numerous in kind exchanges often escape attention.

The NTI in the north show a very different picture: around 50% of their income comes from external donations, 30% from PHC-CG and 20% from student fees.

Funding for capital investments invariably comes from external donors.

Student fees have two possible sources: the family of the student or an institution sponsoring the student. The available reports do not allow to make an assessment of which is the more important. The level of the student fees range from 184,000 (school in the North) to 1 million USHS per year. There is a general perception that the level of the fees represents an access obstacle to candidates from rural areas.

The allocation of PHC-CG's to the PNFP HTI started in 1999-2000. It followed the transition of the Public Schools to the MOES. This Ministry did not yet have a budget for the Health Training Schools. It was evident that the PNFP HTI would be the last to be added to the budget, and that this could take years to materialise. The MOH decided that part of PHC-CG for the PNFP hospitals should be allocated to HTI. The level of the allocation is decided annually during the budgeting exercise. The PHC-CG contribution to the total PNFP NTI training capacity averaged USHS 639,000,000 during the three years 2002/03 - 2004/05. This translates into an average contribution per graduate of 1 million USHS (2362 students graduated in these three years).

The TF noted that some confusion is arising as to the origin of the subsidies to the PNFP HTI. New staff within the MOES claims the present allocations as originating from the MOES budget. The MOH PHC-CG allocation documents, however, clearly show that the allocations per HTI are derived from the allocation to the parent PNFP hospital.

To date there are no plans to add the PNFP HTI to the budget of the MOES. The Tracking Study²³ confirms that the PNFP NTI will not be able to cover the additional costs of ECN training if no supplementary funds become available for them.

In February 2005, the EU HRH project initiated an external study to assess the present funding of the PNFP NTI and develop a proposal for the future Funding Mechanisms²⁴.

3.6.2. Costs of Training

The reports available show that, for the traditional enrolled courses, the annual recurrent costs per student vary between 1 and 1.7 million USHS per student. The reports reviewed would indicate that present income and expenditures are more or less balanced. The main reason for the variety in costs, that could be identified, is the employment cost: Schools with a more complete number of tutors have higher costs.

It should be noted that most schools do not have the required number of tutors (HR is a main expenditure line) and the available information may not include in kind contributions from the parent hospital (see 3.6.1.).

²³ Page 16, version February 2005

²⁴ Project: Developing Human Resources for Health, No: 8 / ACP / UG / 035, Terms of Reference for the Development of a proposal for the Funding Mechanisms for the PNFP Schools.

There is only one school that has trained a full course of ECN's and the information does not yet allow any firm conclusions. Rough estimates of UCMB and the 2002 Costing Study by AMREF put the additional recurrent cost (see 3.3.4.) at 500,000 to 750,000 USHS per year per student.

3.6.3. Benefits and Costs to the Parent Hospital

The Task Force found that a considerable number of managers think the presence of a Training Institution is a source of income and other benefits for the Parent Hospital. It is an important reason for their concern about the utilisation of the NTI. One PNFP HTI has even started to over-enrol its classes in a bid to increase income.

However, the above analysis of the available reports certainly does not substantiate this assumption. To the contrary the additional costs to the hospital can be considerable. A research among a number of UCMB Hospitals²⁵ indicated clearly that the presence of the Training School pushes up the total costs of a hospital. The main causes are the need for staff with higher qualifications, requiring a higher salary, and increased administration costs. The availability of students as "cheap labour" can never off-set these increased costs. The absence of complete financial overviews of the income and expenditures of the Schools will certainly have contributed to this misconception.

The TF hopes that this information corrects the above erroneous assumption and will urge Hospital Boards and Managers to decide on issues related to the capacity and enrolment of the Training Institutions on the basis of sound evidence, clear ideals, and concern for quality of the training and the health services.

3.6.4. Accountability

The finding that a minority of the PNFP Hospital / NTI's produce complete separate financial reports is a cause for serious concern. A key condition for the allocation of PHC-CG was, and still is, transparent accountability. Accounting for the allocations to the NTI in the overall hospital report is not sufficient. The Schools and Parent Hospitals are risking the continuation of the PHC-CG in this way. In addition they are not able to prove the funding shortages, in particular to cover ECN training costs.

Of equal importance is that this absence of separate budgets and complete financial reports actually means that the School Managements, Hospital Managements, and Boards are not planning, monitoring, and controlling the funding of the training adequately. Together with activity reporting this is an area that requires priority attention.

Some Hospital / School managements expressed the view that separation of information and financial systems would mean that the School becomes separate from the Hospital. They are of the opinion that this should not be allowed to happen as this would endanger continuity and quality of the training. This perception needs to be corrected as there are various options to set up Management Information Systems that allow to have a full overview and control of the performance, income and expenditure per department of an organisation. A good example is the cost-centred accounting system that UCMB is assisting its hospitals to install. There are ample arguments to advocate for similar systems in all PNFP Hospitals/HTI's. The most important are comparability, harmonisation, and standardisation.

²⁵ Albert Beekes, Cost effectiveness in Hospital Services, 2002.

3.6.5. Conclusions

The scarcity of separate financial reports of the NTI's hardly allows definite conclusions regarding the funding and costs of training in the PNFP sector, leave alone their sustainability. Separate Management Information Systems should be installed very soon to ensure transparent accountability to external partners as well as to be able to manage adequately.

The evidence is clear that the presence of a Training Institution pushes up the costs of the Parent Hospital. This entails that Hospital Boards and Managers should opt for continuation of the Training Institutions for reasons related to the Mission and quality of training and care, not for any other reasons.

It is important to keep monitoring the origin of the subsidies and advocate for a fairer share of the national budget for training of health workers as the PNFP NTI train more than fifty percent of the national output in nurses and midwives.

3.7. **Quality of PNFP Nursing and Midwifery Training**

The quality of Nurse Training in PNFP Institutions has been recognised as good in the past and this still continues. The MOH HR Tracking Study reports that the PNFP NTI's have the highest success rates among the NTI's. During the past two examination rounds nine Schools had 100% pass rates and all nine were PNFP NTI's. These success rates covered the full variety of courses provided by the PNFP. This performance was achieved in spite of relatively less resources compared to the Public Schools. The authors relate the success to the use of a larger variety of criteria to determine the suitability of candidates. The refined selection even proves to offset the fact that the PNFP students often have lower academic grades than the students in Public Schools.

The report does not relate the success rates to other factors that influence Quality. The Task Force is convinced that number of students per class and the student / tutor ratio are of key importance as well. The same examination rounds provide some proof, as the failure rates were highest in the Schools that are known to over-enrol.

The lack of tutors is fairly wide spread among the NTI. The reasons, though, are different. For Public Schools it is strongly related to Public Service and MOES rules and regulations. For the PNFP NTI the reasons are the lack of internal candidates for tutor training, the raised entry requirements for tutor training, unwillingness of governmental workers to leave PS, and financial constraints to offering competitive salaries.

Though the examination results confirm that the PNFP Institutions continue to assure quality of training, the Task Force is convinced that there is no place for complacency. During the Internal Consultations complaints of the quality of nursing students and graduates abounded. The serious lack of tutors and clinical instructors is one of the main causes. Other causes reported are lack of communication between the School and the Hospital, absence of clear assignments for the practicum's, as well as disinterest in practical experience and lack of discipline among the students. The demands of the ECN curriculum are much higher and will demand very new attention to issues of quality as a large part of the training takes place far from the school: in the health centres (see 3.3.5.)

A complicating factor is that presently the responsibilities to set standards and quality assurance systems are divided among three parties MOH, MOES, and UNMC. Each party has specific focus and interests entailing a great difference in priorities (see 3.11.3.)

If the PNFP NTI wish to maintain their high standards they will have to actively pursue quality assurance, preferably through common action to ensure a collective outlook, harmonisation, and standardisation. The Task Force recommended that an accreditation system be installed by the new PNFP HTI Partnership organisation.

3.8. Training of Allied Professionals and Specialised Nurses in the PNFP Sector

During the First Consultation the participants requested the Task Force to include all health training programmes in its research and proposals. This request prompted the change of name to Health Training Institutions (HTI).

Again it proved far from easy to obtain complete information about the training courses provided, the capacity available, and the actual utilisation, as the Schools do not collect, compile and analyse their own data systematically.

3.8.1. Present Contributions of the PNFP Health Training Institutions

Of the 19 NTI, 6 also provide other training courses. Two Schools (Nyenga and Kitovu) were added to the list as they provide other courses but are not involved in Nurse training. This brings the total number of PNFP HTI to 21.

The Allied Professional courses provided are: Laboratory Assistants (6 schools with a total actual annual intake, for 5 schools, of 60²⁶, the Tracking Study indicates a total assigned design capacity for the PNFP schools of 137), Laboratory Technicians (2 schools with a total annual intake of 25, which tallies with the design capacity indicated in the Tracking Study).

The other training courses provided are: Theatre Assistants (1 school with an annual intake per year of 10). In addition two schools provide Nursing Assistant training with an intake capacity per course of 15 and 70 (!). The theatre and nursing assistant courses are not formally recognised courses. Verbal information would put the number of informal courses higher than reported to the TF.

The above information shows that the present involvement of the PNFP sector in these courses is quite limited.

3.8.2. Required Training Capacity for Allied Professionals and Specialised Nurses

The HSSP II annex regarding Human Resources indicates that the main shortages in Allied Professionals for all levels of care, compared to the HSSP I norms, are found in: clinical officers (660), diagnostic staff (mainly laboratory 1089, scaling up ART will increase the need by 420 lab technicians), pharmacy (311, scaling up ART will increase the need with 136). The present annual design intake capacity²⁷ and actual output for these groups is:

- Clinical officers: design capacity 220 and the actual average intake between 2001 and 2003 was 282. Actual output per year was an average of 258. Recently a private school opened with a design capacity 150 and a first enrolment of 266 (!).
- Laboratory assistants: total annual Public and PNFP design capacity 187, actual annual intake +/- 101, and average annual output 73.
- Laboratory technicians: total annual design capacity 75 (Public and PNFP), average annual intake 68, and average annual output 49.

²⁶ Kitovu laboratory assistant schools has just started.

²⁷ According to MOH Tracking study version February 2005. The design capacity is the annual intake capacity according to the facilities and resources put in place. This capacity can then be compared to actual intake each year.

- Pharmacy technicians: design capacity 20 with an average annual output of 17.

It is not known yet how the recently proposed HSSP II staffing norms will affect the estimates for the above cadres. For many of the other allied professions the Tracking Study and other documents do not provide information on the training capacity available nor on the estimated numbers required.

From the above data it would be evident that no additional capacity would be required for clinical officers. The training capacity for laboratory staff is still low compared to the needs, but the PNFP HTI already assure the major share of the capacity (137 places to 50 in public schools).

The area of most concern is pharmacy. With the present capacity to train technicians it would take around twenty years to cover the gap. The Professional Council has long resisted the start of a pharmacy assistant training course as this would “lower” the standard and recognition of the technician course. During the Joint Review Mission, of October 2004, it was announced that a pharmacy assistant course will be started soon (official confirmation awaited). This course will not be recognised, e.g. registered by the Professional Council. The Task Force is of the opinion that the PNFP HTI should seriously consider the training of pharmacy staff. Up to 2004 the Church Umbrella Organisations of the Eastern African Countries had a joint programme to train Pharmacy Assistants (PATS). When this programme had to be handed over to the individual countries, Uganda could not identify an interested Training Institution. This had everything to do with the position of the Pharmacy Council and Association. As now even the MOES / MOH are initiating an unregistered course²⁸ because of the huge need, there is little reason why the PNFP Institutions could not do the same. The UCMB and UPMB are still co-owners of the PATS curriculum.

3.8.3. Conclusion

The present involvement of the PNFP HTI in other than traditional nursing courses is limited. Though the information, regarding the needs, and training capacity available, is far from complete, there do seem to be needs that are not covered. In particular pharmacy and nursing specialisations are areas requiring additional training capacity (see also 3.4.2). If the PNFP HTI would have an excess capacity (after the ECN capacity has been finally decided upon) and / or wish to diversify their involvement in training health workers, these should be priority areas.

3.9. **Governance of the PNFP Health Training Institutions**

The PNFP Health Training Schools are integral parts of the Hospitals that started them. This means that the Board of Governors of the Hospital has been delegated the responsibility to govern the Hospital / HTI by the Owning Organisation. The Board thus also sets the policies and plans for the HTI and supervises and controls its operations. The Hospital Management assures daily management and implementation of the policies and plans. For this the Principle Tutor is a member of the management team.

During the Internal Consultations it was very evident that none of the PNFP Hospital/HTI's wishes this governance situation to change. The main reasons are that

²⁸ According to information the TF received this initiative is actually not new, as the re-start of the Laboratory Assistants training followed a similar route.

training is seen as an essential component of the Mission of these institutions and that the interconnection is seen as crucial to assuring quality of the training.

To some extent the additional aim to have a larger pool of workers, through the presence of nursing students, is still present. This is rapidly waning with the growing realisation that practical training is more than mere work experience.

Since the transition of the responsibility for the training of health workers to the MOES, the Public HTI's, have been made autonomous institutions with their own Board of Governors and Management Teams. At the time of the transition it was understood, and implicitly agreed, that the PNFP HTI's would retain their position as part of the parent hospital. In spite of this agreement, the MOES is exerting some pressure on PNFP Schools to install a separate Board and become independent of the hospital. From the discussions during the Consultations, it became apparent that young NTI staff did not clearly understand the specific position of the PNFP schools and tended to think they have to follow these instructions.

This led to a reassertion of the basic principles of the PNFP HTI's organisational embedding²⁹:

- The PNFP HTI's are not governed by the Ministry (e.g. they are not "under" the MOES). They remain operationally independent from the Ministry and thus do not have to follow the directives to detach themselves from their parent hospitals.
- The PNFP HTI's share the Government's Mission to train capable staff and therefore they refer to, and abide by, the policies, plans, and standards of the Ministry, to the extent that these do not contradict the Ethical Codes of the Churches.
- This alignment is largely voluntary, with the understanding that accepting subsidies from Government brings obligations to adhere to the policies, plans, and standards as well as to account transparently.
- The subsidies do not entail that the Institutions have to become part of the governmental system, e.g. be absorbed into the Ministry systems.

The TF realised and pointed out that the errors in the perceptions of new PNFP HTI staff, probably found their origin in a lack of clear governance and management by the parent hospital. To some extent this is borne out by the four-year persistence of the problems of the NTI's and inadequate management information systems. The TF urged the Board and Management representatives to enhance the governance and management of the Schools. Especially the accountability of the HTI needs to be improved. The HTI have to be established as clearly identified cost centres in the hospital accounting system with protected budget lines and clear spending and accountability procedures. This is already being done in some schools, but it has to become a universal and consistent practice.

Even more widespread is the perception that the PNFP HTI's cannot deviate from the policies and plans of the Government and the UNMC. The Executive Secretary of UCMB, reviewing the history of the PNFP HTI's, showed that in the past the same schools were forerunners in innovating training³⁰. Particularly their independence from the

²⁹ These principles are confirmed in the draft Policy for Public – PNFP Partnership formulated in 2002-2003. The formal adoption by cabinet of this Policy is awaited since 2004.

³⁰ The review of international experiences taught the TF that in other developing countries this is still the case. The most recent example came from Ethiopia, where a RC NTS took the initiative to extend the training duration to improve the practical skills of the graduates and the MOH subsequently adopted this for all the schools.

governmental organisational system enables them to respond to calls for change and experiment with new approaches and training programmes. It would be a great loss if this unique ability would no longer be used to innovate health care skills and health care services.

In this sense there are no organisational impediments to consider starting the training of a new cadre, e.g. a cadre that is not recognised by the governmental partners.

3.10. Internal Coordination of the PNFP Health Training Sector

In the past coordination of the PNFP HTI's, by MOH, UNMC, and the Bureaux, was reasonably adequate to ensure harmonisation of curricula and training capacity. Thus the PNFP HTI's did not perceive the need to install coordination mechanisms.

The transfer of the Health Training programmes to the MOES considerably complicated coordination. This was firstly recognised in July 2001, during the Workshop of Hospital Administrators and Principal Tutors of PNFP Hospitals/HTI's³¹. A number of measures to improve exchange of information and coordination between the PNFP Institutions and with the Bureaux were agreed during this workshop. However, the TF found that the Schools had hardly adhered to any of these measures. In other words coordination and cooperation between the PNFP HTI are virtually absent.

This lack of coordination and cooperation certainly contributed to the problems experienced by the individual PNFP schools and prolonged the period of their existence. Each School was trying to find its own solutions to problems that could not be solved at their level. In addition a constructive dialogue and search of solutions in dialogue with the external partners was not initiated, as there was no structure to take the lead and speak in the name of all.

The Medical Bureaux (UCMB, UPMB, and UMMB) mainly have a technical advisory function towards the Schools. Since the installation of the Inter-Ministerial Standing Coordination Committee for Training Human Resources in Health, they represent the PNFP HTI's in this forum. However, this is far from easy, as they often lack the required information to represent them well.

The above conclusions led the TF to recommend that the PNFP HTI establish a mechanism for internal and external dialogue, coordination, and cooperation.

3.11. The External Environment of the PNFP Health Training Institutions

The PNFP HTI's have a capacity that is larger than that required by their own network. This came about as the founders, as well as their successors, recognised that all health units required well-qualified health care workers. Thus the PNFP HTI opted to share the Mission of the MOH. This inevitably meant that the PNFP HTI's had, and still wish, to cooperate closely with the national network and to align their policies and plans with the national policies and plans. Seen from the opposite perspective, the developments, policies, and plans of the external partners influence and affect the PNFP internal plans and operations.

³¹ See Aide Memoire Workshop of Hospital Administrators and Principal Tutors in PNFP Hospitals with Health Training Schools Institutions, July 2001.

3.11.1. Policy Development and Planning

As indicated in earlier paragraphs, there is currently a great degree of un-clarity and uncertainty with respect to the Human Resource training policy and plans. In addition, it is not clear where the responsibility for policy development and planning presently lies. To some extent this situation also existed, in the past, when the main actors were the Ministry of Health (MOH) and the Uganda Nurse and Midwives Council (UNMC). But it has worsened significantly since the transition of the GOU Health Training Institutions to the Ministry of Education and Sports (MOES).

At the same time, or shortly thereafter, other new developments came in:

- The accelerated training of Nurse Assistants to bridge the staffing gap that existed at the beginning of the HSSP I;
- The plans to convert the traditional Enrolled Nurse Training programmes to Enrolled Comprehensive Nurse Training.

The first development was not welcomed / supported by the UNMC. The second did not fully coincide with the pursuit of the UNMC to raise the standards of Nursing.

In 2001 a study was initiated to determine how the transition of the Health Training Institutions to the MOES should be completed. The report of this study is known as the Bukonya report. To date the implementation of the recommendations of this study have not yet been taken up. The most important recommendation of this report is that the roles and responsibilities of the three main actors (MOES, MOH, and Professional Councils) need to be revised to correspond with the new division of the tasks.

In the year 2000, the GOU installed the Inter-Ministerial Standing Coordination Committee for the Training of Human Resources for Health. This body is to ensure the development of policies and plans as well as assure coordination between all the actors. However, to date it has not met regularly and has mainly been occupied with urgent implementation problems.

The result is that at present no comprehensive plan for the training of Health Workers exists. The only document that the TF could refer to, is the Scenario IV of the Human Resources for Health Study of 2000, by Group V. Unfortunately this plan does not cover all health care service levels nor all health training courses.

The recent MOH Human Resources Tracking Study stresses the urgent need for a comprehensive HR Policy and Strategic Plan to guide the development and deployment of HR in the health sector. The TF and the representatives of the PNFP HTI wholeheartedly welcome this recommendation.

3.11.2. Coordination of all Actors involved in Human Resource Development

The Inter-Ministerial Standing Coordination Committee is still in the process of installing coordination between all the parties involved in training. The Committee does consist of representatives of the main actors: MOES, MOH, Professional Councils, Development Partners, and the Medical Bureaux. But as urgent issues have taken precedence to date, and the meetings are rare, a complete comparison of concerns, capacities, and plans has not really taken place.

The present lack of internal and external coordination within the health-training network entails that Ministries, UNMC, and several donors interact with individual schools or

tutors but rarely with the PNFP network as a whole. In turn this exacerbates the existing confusion and complicates planning at individual school and national level. Systematic consultation of the PNFP network would enable all to adjust the plans in accordance with needs and comparative strengths.

3.11.3. Standards and Quality Assurance

In the past the MOH covered all functions related to Human Resources for Health (from policy setting and planning to implementation and quality assurance). In this perspective the Professional Councils (which fall under the same Ministry) were given the responsibility to assure quality of all phases of the training of health workers combined with the responsibility of controlling the professionals. To this effect they were given a relatively independent status.

In the present situation there are three bodies concerned with the quality of training health workers: the MOH, the MOES, in particular the Education Standards Agency, and the Professional Councils. However, the focus of attention and the interests differ:

- The MOH requires staff that is well qualified to handle the health care needs of the population and achieve the objectives of the Health Sector Strategic Plan;
- The MOES is concerned about the quantity and quality of health care workers trained and the functioning of the training institutions;
- The Professional Councils are mainly concerned about the standard of the professions.

There is a high need to redefine the roles and responsibilities as these interests do not always coincide. Next to this, there is a need for effective mechanisms to build consensus on issues of common interest. At present the three parties either act fairly independently or have difficulties in agreeing on essential issues. The adjustment of the entry criteria for ECN is a case in point. For the HTI the directives can be confusing and some times even conflicting.

But mostly the UNMC, and other Professional Councils still take the lead role in determining training standards. For instance, following the umbrella Council³² of the East and Southern African Countries, the UNMC is aiming at raising the profile of the Nursing Professions considerably. To enable all East African Countries to achieve a standard comparable with developed countries³³ all enrolled levels are to be abandoned in favour of registered level³⁴. The UNMC had already initiated the training of Registered Comprehensive Nurses and, in 2002 and decreed the strict application of the entry criteria for all training courses, for this purpose. The latest development in this respect is that entry to tutor training is now also subject to candidates being able to prove possession of the initial O level credits. The next step would seem the determination of a career structure that passes through Registered Comprehensive Nurse training.

Similar developments can be found in the other Professional Councils (see for instance the refusal to recognise Laboratory and Pharmacy Assistant training).

³² ECSACCON: East and Southern African Countries Council of Nurses.

³³ More and more stakeholders voice their perception that an underlying goal would be to increase the number of staff emigrating to developed countries.

³⁴ In the past years Ghana, Malawi, Zambia, and Zimbabwe faced serious nursing staff shortages due to Nursing Council decisions to stop enrolled training and only train at registered level. In all these cases the Ministries of Health were obliged to overrule the Nursing Council to avoid crises in service delivery.

As shown elsewhere also, these plans do not correspond with the high need for staff in the rural areas and the standard of students in the same areas³⁵. This incongruence between the needs and standards baffles the TF and many other actors, as it is not in the interest of the people needing care³⁶. Moreover the low level of protest, against the raises in standards, from the two other key actors is surprising (see also 3.12.2).

3.11.4. Expected Developments in the Short-term

There are two important sources of pressure to address the challenges described above very soon. The main source is the rapidly increasing awareness that the absence of a clear and detailed Human Resource Development Policy and Strategic Plan is obstructing progress not only in training health workers, but also in health service provision. The mid-term review of the HSSP I already indicated that shortages in quantity and quality of Human Resources represented one of the main obstacles to achieving the objectives. In the HSSP II the need to scale up services, to improve health outcomes, is clearly recognised. Both nationally and internationally there is now a wide spread call to increase the availability of HR's to scale up the provision of services (see f.i also the Report of the High Level Forum on the MDG's). For Uganda there is one important restriction: the budget for health is not allowed to grow until 2007/08. However, if the required HR's are to be available then, their training should start now, as the lead time for the production of HR's is in function of the duration of the training.

The second source of pressure, but very much related, will be formed by the EU HRH project. This project, among others, has the assignment to develop a HR Policy and Strategic Plan. As the start of this project was delayed, the process of developing the Policy and Plan will mainly fall in 2005/06. It is the express wish of the Ministries and the Development Partners that the policy and plan be formulated through a consultative process that includes all the stakeholders. Inevitably the roles and responsibilities of each actor in Human Resource development and deployment will have to be clarified to assure the policy can be adhered to.

In addition to the above key developments, 2005/06 will be a crucial year for the transition from the traditional enrolled training programmes to the training of Enrolled Comprehensive Nurses. A review of the curriculum is already on the way. But translating the findings into an improved curriculum and address the other key questions will require a lot of attention and negotiations (see chapter 3.3.)

3.11.5. Conclusions: Implications for the PNFP HTI

It will have become evident, from the earlier chapters, that the above un-clarities and uncertainties at national level (e.g. in the external environment of the PNFP HTI's) are seriously hampering the PNFP HTI's performance. They entail that it is very difficult to determine the best solutions for the problems identified and that effective mid- to long-term planning is hardly possible (see 3.3, 3.4, 3.5, 3.6, and 3.8.).

In the coming year an important number of activities are scheduled to address the challenges at national level. Thus the PNFP HTI's have a huge interest in being actively

³⁵ The PEAP assessment of 2003/04 showed that less than 50% of the GOU SSS have the manpower, infrastructure, and equipment to teach sciences.

³⁶ To the TF and many PNFP managers, it appears as if the Professional Councils are focussed more on ensuring correspondence between the professional cadre levels and the employment structures in civil service, than on the content of the profession itself.

involved in these activities. This will enable them to ensure that their capacity continues to be recognised, their interests and concerns are taken into consideration, and that plans match, as much as possible, with their Mission and capabilities. In particular participation in the formulation of the policies and plans and resolving the ECN training questions is essential. The fact that the first process is to be consultative facilitates participation of the PNFP HTI's.

The crucial obstacle is that the PNFP HTI's do not have a mechanism to coordinate and cooperate among themselves. Twenty-one individual schools cannot participate effectively in these fora for dialogue, and the Bureaux cannot do it from a distance. If they really want to exert influence on the national debates and plans, the PNFP HTI's will have to install a mechanism that will enable them to coordinate their efforts and have a clear and unanimous representation in national fora. As the process to formulate the HR Policy has actually already started, there is no time to lose.

3.12. Insights from International Literature and Experiences

The Task Force also reviewed international information and literature on Human Resource development and management, health care developments, country experiences with nurse training, and Nursing Acts. The aim was to identify information and experiences that could assist in understanding the problems and in establishing valid solutions.

3.12.1. The Position and Powers of the Professional Council

Uganda Nurses and Midwives Council (UNMC), the body responsible for the registration, regulation, and supervision of professionals has a very high level of powers and autonomy compared to Councils in other countries. It has the powers to determine entry criteria and training curricula as well as accredit new training institutions. In addition it sets the final examinations and decides on registration and the criteria for re-registration of Nursing and Midwifery professionals. The powers of the Allied Professional Council are comparable to those of the UNMC.

This concentration of powers is closely related to the situation when the Ministry of Health was responsible for the full trajectory from basic training to performance of the employed health professionals. It required agencies that could act as standard setting and controlling bodies. These responsibilities were assigned to the Professional Councils. As these agencies were, and still are, subsidised by the MOH, they had to be allocated a semi-independent status.

The Nursing Act was last revised in 1996 (the transfer of the Health Training Schools dates from 1998/99). The reason then was the decision to end the registration of Nursing Assistants.

The review of the Nursing Acts of England, South Africa, Kenya, and Australia taught the TF that the Nursing Act of Uganda is the most far reaching. Compared to the others, the Uganda Act only allows very few non-nurse representatives on the council. It does not oblige the Council to consult other stakeholders before major changes are decided, and it does not define the subjects, for instance, in which the MOH has the final say.

The review, however, also proved that the Act does not exclude the training of other cadres not covered by the register, and that own examinations (hospital certificate) are still allowed. If an individual, or an institution, wishes to have a professional training registered the Council is obliged to examine the request fully.

In Uganda, the Professional Councils are seriously opposed to changes in their responsibilities and tasks. The Task Force could not clearly establish their arguments. When reviewing their main activities at present, these seem to concentrate on the issues related to professional training (setting entry requirements, verifying the qualifications of entrants, verifying the standards of the training schools, setting and implementing final examinations etc.) As far as the TF could assess monitoring, supervising, and improving the functioning of the professionals is given much less attention and time. In other countries the Professional Councils concentrate on verifying, at registration, the abilities of graduates with the determined professional standards. They leave the training issues to the MOES or the Schools themselves. The net result is the same, as no school can continue to train at a level that does not enable graduates to become a registered professional. At the same time these Councils have much more time to pursue continuous improvement of the quality of the registered professionals.

In a similar line, the TF observed a contradiction between the UNMC's aim to protect patients from professional misconduct and their refusal to include Nurse Assistants in the professional registers. For this same reason, England and other countries have taken-up registration of Assistant Health Care workers again. They found that protection of patients as well as the improvement of professional standards could be pursued more consistently if all professional groups fall under the registers and thus the control of the Councils.

3.12.2. Human Resource Crisis in Health Sector in Developing Countries

International literature indicates that there is a wide spread recognition that the present shortages in Human Resources for health care, in developing countries, resembles a crisis situation. It severely hampers improvements of health outcomes, as the provision of services cannot be scaled up to the level required to be effective. The underlying causes found are multiple and very complex. In developing countries, like Uganda, three overlapping pyramids influence the needs and the availability of HR: 80% the population lives in rural areas, 80% of the health care needs should be catered for by primary health care services near to the population, and, lastly, the main education level is primary school level. These overlapping pyramids entail that, important underlying causes for HR shortages are: mismatches between training programme standards and available candidates, between training programme contents and the main health care needs / skills required, and between the expectations created in the individual professionals and the realities of the working conditions.

The difficulties, reported by the PNF health units, with respect to retention and development of staff, are widely covered in the literature. It is also internationally recognised that increasing training standards accelerates migration of workers to urban settings and from there to other countries. International experiences confirm that, one of the best ways to retain staff, is to be able to offer them opportunities to develop professional careers close to home.

Entry criteria are an issue in the training of nurses in various countries. Neighbours like Malawi, Zambia, and Zimbabwe learnt, the hard way, how a decision of the Professional Council can cause acute shortages in candidates and graduates. In these cases the Ministries of Health had to overrule the Councils to avoid disaster.

The findings of the TF did not show a clear link, in Uganda, between the present utilisation of the NTI and the shortages of staff. But this is mainly due to the fact that the original problem statement proved to be wrong (overestimation of the capacity and thus

overestimation of the under-utilisation.). Other countries do experience a direct connection between a reduction in ‘production’ of staff and worsening shortages of nurses.

3.12.3. Options to Optimise the Contribution of Health Training Institutions

The international documents did provide ample examples as to what Health Training Institutions could do to assist in improving the number, motivation, and skills of the health workers. While assessing the value of the experiences the Task Force kept in mind that, PNFP HTI’s have a call and the ability to be innovative. The examples that appealed most to the Task Force members are:

- A. *Reviewing and adjusting training programmes on own initiative, or stimulating others to undertake this:*
 - A.1. This can be undertaken to improve the match between the training provided and the competencies needed at service level. The TF proposal to develop an internship to enable ECN’s to function well in hospital nursing fits here.
 - A.2. Another reason is to increase the number of candidates that can access the training programmes, or the level of entrants into the profession. The TF proposal to develop and implement a bridging curriculum to attain required O levels corresponds with these ideas.
 - A.3. A third area concerns improving career path opportunities. This is an area for refresher and postgraduate training programmes.

- B. *Implementing existing programmes to enable staff and health units to access skills that are in short supply, and for which the training capacity is limited.*

In our situation this corresponds with diversifying and taking on allied professionals and specialised nurses training.

- C. *Initiating new, or alternative, training programmes.*
 - C.1. The aim here is to develop additional or new skills: In this area many examples speak of substitution³⁷. This term is somewhat unfortunate as it sounds demeaning. However, when considering the field examples they are all by now well-recognised cadres. The classical examples are Clinical Officers (in other countries Medical Assistants), Assistant Medical Officers, Nurse Anaesthetists, Pharmacy Assistants, Physiotherapy Assistants. All these training courses were started to complement the shortages of the high cadres (Medical Officers, Anaesthetists, Pharmacists, etc.) in countries which could not hope to fill all the vacancies in a very long time, while the skills were needed.

Research shows that provided the training is well done and supervision is assured these cadres can provide a very comparable quality of care. It also indicates that these training are most successful if they provide access to a career path (f.e. clinical officer can continue training become an assistant medical officer and even medical officer). Exactly these features stimulated the TF to consider the training of Patient Carers (or Nurse Assistant new style) to complete the needs to assure bedside nursing while offering a low instep into the profession.

³⁷ Delanyo Dovlo, Using Mid level cadres as substitutes for internationally mobile health professionals in Africa, A Desk Review, Human Resources for health, June 2004.

- C.2. Providing access to Continuing Medical and Nursing Education.
This is an area that needs much more attention in Uganda. The TF recognised this as similar to its proposals that the schools take an active role in refresher courses.
- C.3. Improving career opportunities.
Here the schools could think in terms of pre- and post-graduate courses.
- D. *Developing alternative training methods, like distant learning.*
As yet the TF has no proposals in this area, as it demands very specific capabilities. However UCMB Information and Data Management department is engaged in a pilot project here that might open new avenues in the future.
- E. *Redistributing training programmes in view of improving efficiency / effectiveness and compensate for regional imbalances.*
This proposition is mainly found for situation where regional disparities in training capacity seriously hamper availability of staff in disfavoured areas. The TF proposal to divide training programmes per region between the PNFP HTI corresponds very much with this international suggestion.

As can be concluded from the explanations and additions, these international experiences both provided evidence that the ideas of the Task Force were valid or they inspired new proposals. The options developed are presented in the next chapter (4.5.).

The TF members found one experience, of the Philippines, specifically appealing. This programme is called the “Step ladder” programme. In this programme a worker enters at basic / on-the-job training level and can gradually climb up to become a medical doctor. In analogy the TF suggests that the PNFP sector could develop a bedside / patient carer (not to use the name Nursing Assistant) training programme and enable graduates to access ECN training via a practice period and access to a ‘O’ level bridging course.

Lastly the TF found ample evidence during the reviews of recent and historical documents that PNFP Schools, the world over, have forged innovations and have thus influenced policy changes, of Governments and Councils, through the years and to date. The TF urges all PNFP Tutors, Managers, and Governors to remember this heritage and build on it in the choices they will make for the future.

3.12.4. Conclusions

The study of Nursing Acts from a wide variety of countries indicates that the Uganda Professional Councils have a high degree of autonomy and hold the key powers in setting standards in training of the professionals. This still corresponds to the situation where one Ministry was responsible for the entire trajectory, from basic training to the performance of the employed health professionals. In countries where the responsibilities for training have been transferred to another Ministry long since, the Professional Councils are concentrating more and more on verification of the standards of the new professionals through registration examinations. The impact on the content and quality of the training is the same as no professional training school wishes to train persons that cannot access the professional registers. This change of role enables these Councils to focus much more on continuous improvement of the registered professionals.

The same review did show that the Uganda Nursing Act does allow to develop and implement training programmes for other cadres, not covered by the register and own examinations (hospital certificates).

The main message from the international literature is that qualitative and quantitative shortages in Human Resources are now widely recognised as a key obstacle to achieving the desired health outcomes in developing countries. The underlying causes, however, are multiple and complicated. This means that recipes, to solve them, have to be developed per country and sometimes even by region, when these are particularly disfavoured. An important recognition, in relation to the problems in Uganda and the PNFP sector, is that there is a direct link between an increase in standards of professional training and the increase in mobility of professionals (from rural to urban and from developing country to developed countries). Another important lesson is that offering staff professional training near to their home area and career development possibilities greatly enhances the ability to retain them also in disfavoured areas.

Even in this complex context health training institutions can play a significant role in improving the number, motivation, and skills of the health workers. The international examples inspired the Task Force in developing the options for the future, or proved the validity of the proposals presented in chapter four.

4. THE PROPOSALS OF THE TASK FORCE

In order to keep the mission of the PNFP HTI insight the TF chose as motto for its work as well as for the Consultations:

The Future of Nurse Training in support of the Mission of the Private Not for Profit Health Care Sector in Uganda.

The Task Force concluded from all the findings, reported in chapter three, that the problems, the PNFP HTI face, are not a serious under-utilisation, or excess capacity, but much more a sub-optimal utilisation caused by planning and management difficulties. These difficulties are aggravated by the large number of uncertainties with respect to what is expected from them as they form a sixty percent of the national training capacity.

The PNFP schools were started with a Mission to train competent and compassionate nurses for the population in disadvantaged areas and to emancipate staff from the same areas. Today the needs and opportunities may be less evident, but they are still there. The patients still need loving professional care and regional imbalances in access to care still need to be resolved. The 21 PNFP HTI represent an enormous potential to achieve lasting improvements. The more so if they act together and in harmony. The options, the TF presents here, aim at enhancing the combined contribution to the common mission in health and training.

In this chapter the basic principles applied in the selection and the outline of the options will be presented. The details can be found in the related documents of the TF. These are:

- The Proposal for the Close Cooperation between PNFP HTI and the Draft Constitution for the Partnership;
- Options for the future, Proposals to maximise the Utilisation of the PNFP HTI in the Short-Term, Health Commission, Task Force on the future of Nurse Training, December 2004:

4.1. Mission of the PNFP Health Training Institutions

The Task Force wished to determine a guidance to direct the choices for the future. For this purpose it summarised the Mission of the Training Institutions of the three denominational groups as follows:

To train an optimal range of health care staff of high moral and professional standard for the PNFP and national health care institutions.

This mission is inspired by, and builds on, the mission of the PNFP health care institutions to provide holistic, comprehensive, and effective services, at all levels, but particularly for the disadvantaged population.

4.2. Goal and Objectives of the Options Proposed

In line with the Mission of the PNFP HTI's, the goal of the options for the future is:

To contribute optimally to the availability of competent health care staff for the PNFP and national health care institutions, at all levels, to enable these to provide comprehensive and effective services.

The objectives for the PNFP HTI's to achieve this goal are:

- I. Act together to develop consistent and joint development plans;
- II. Clarify the training capacity and adjust it, if required, to match the PNFP and Country requirements;
- III. Assure that the training of the recognised cadres is of high quality and in accordance with the nursing care requirements of the various levels of health service delivery;
- IV. Facilitate access to nurse training for candidates from rural areas;
- V. Diversify the training programmes provided to match the needs in basic care providers, specialised nurses, allied professionals, as well as special skill requirements;
- VI. Assure that the quantity and quality of the training actions can be well assessed, monitored, evaluated, and documented;
- VII. Use the monitoring and evaluation findings to ensure that training programmes are continuously improved and adjusted to needs in the health care facilities.

4.3. Close Cooperation between the PNFP Health Training Institutions

The first strategy, proposed to achieve the above goal and objectives, is the installation of an organisation for the close cooperation between the PNFP HTI's. This follows the findings that lack of coordination and cooperation contributed to the persistence of the present problems and misconceptions. Individual schools tried to take action on their own but did not succeed. The TF concluded that most of the options, available to improve the utilisation and contributions of the Schools, require intensive cooperation as they can hardly be undertaken by an individual school or single denominational group.

As important, or may be more importantly, the absence of coordination mechanisms meant that a constructive dialogue with the external partners was not initiated. The possible threats and imminent developments in the external environment (3.11.), recognised by the TF, now mean that an effective representation and common voice is needed more than ever.

The Task Force proposed that an organisation be set up for the internal cooperation and external representation and dialogue, rather than a simple mechanism or forum for exchange of information. The reason is that the extent of the cooperation and representation, required, calls for professional capacity, a formal recognised status, and a form that can assure adherence of members to commonly agreed actions. Awaiting the final decisions of the PNFP HTI's, the TF gave the organisation the name PNFP HTI Partnership.

The Task Force stressed the need to install the cooperation as soon as possible as the most important steps to address the challenges at national level are scheduled for 2005/06. If the PNFP sector wants to be heard and have their capacity and concerns taken on board, as well as become partner in the new policy and plans, it has to be able to participate through a mandated representation.

In the proposed constitution for the organisation, the mission of the Partnership Organisation is formulated as:

Supporting the Mission of the Health Training Institutions by:

- I. Ensuring coordination, consensus building, and cooperation between the Health Training Institutions of the PNFP health care sector.
- II. Ensuring an effective representation of the PNFP Health Training Institutions in - and coordination with - the common external partners, including advocating for the interests of the Health Training Institutions, and their students.

For further details on the proposed Partnership we refer to paragraph 5.2. and the document entitled “The Proposal for the Close Cooperation between PNFP HTI and the Draft Constitution for the Partnership”.

4.4. Improving the Planning, Management, and Accountability of the PNFP Health Training Institutions

The findings of the Task Force indicate that planning, governance and management as well as accountability are important areas to improve, if the HTI are to use their capacity optimally.

4.4.1. Governance

The Task Force recommended, and the representatives of the Hospitals / HTI’s reconfirmed their own conviction, that the HTI should remain integral parts of the parent Hospital’s organisation. The calls from the MOES, that the PNFP HTI should become autonomous institutions in analogy to Public HTI, can best be answered by enhancing the governance of the HTI. The respective Hospital Boards of Governors and Management Teams have to ensure, with active participation of the HTI management, that all aspects of governance and management of the school are effectively taken in hand.

In addition, the Task Force recommends that the entire group of PNFP HTI’s, develop a common and clear position towards the MOES directives to make the HTI autonomous institutions. This position should aim to safeguard the belonging of the school to the hospital while indicating clearly how the governance and accountability will of the training programmes will be assured.

4.4.2. Determination of the Actual Annual Intake Capacity / Training Capacity

The Task Force findings indicate that the schools determined their actual intake capacity on undefined grounds. The declared (or perceived) capacity and the physical capacity proved to differ greatly. In turn the comparison between the perceived capacity and the actual enrolment led to the perception of serious under-utilisation. The comparison between physical capacity and the actual enrolment proved that the under-utilisation (or excess capacity) is far from serious. However, in the meantime several external partners are basing their assessments and views on the first comparison.

To ensure effective planning at HTI level and at national level, it is imperative that each PNFP HTI determines its real annual intake capacity as soon as possible. This can be done by using the most prominent physical limitation, of the number of hostel beds, divided by the number of training courses, and then divided by the duration of each course, as done by the TF. Other calculation methods are also possible as long as they are transparent and lead to a realistic estimate.

Once the HTI has determined its real capacity this should be declared to all internal and external partners. A speedy decision of each PNFP HTI is especially needed for the development of the national plans in the coming months (2005/06).

The declared capacity per course then has to become the key tool for short and longer term planning.

If a particular HTI wishes to diversify its training programmes, as proposed by the TF in the next chapter, this would be the moment to decide to assign a part of the actual capacity to another course.

4.4.3. Installation and Use of a Standardised Management Information System

A key finding of the Task Force pertained to the considerable difficulties it experienced to obtain clear and complete information from the PNFP HTI's. It would seem they do not systematically collect, compile, and analyse their information and data. An effective and regular analysis of their own information, combined with compilation and analysis at national level of the data of all the schools together, would have allowed to identify the misconceptions and the actual problems two to three years ago.

What worried the TF even more is that the absence of an adequate Management Information System, and of the proper use of such a system, means that the HTI's are not really being steered, planning is hardly done, and most importantly transparent accountability to external partners is not adhered to (PHC-CG obligation). For the future, accurate and complete information will be essential to negotiate support and assure commitment from the external partners.

An adequate Management Information System consists of a set of clear indicators, a registration system that captures the information required to measure change versus the indicators, as well as clear arrangements and assignment of responsibilities for the periodic compilation and analysis of the data. The system should cover activities (services) and finances equally.

The installation of a Management Information System aims at assuring that planning, monitoring, and evaluation of performance are possible. These in turn should allow the Board and Management of a HTI to:

- Establish whether the goals and objectives set are being achieved;
- Assess the effects of the activities and draw lessons from the experiences;
- Implement improvements and adjust programmes timely to assure achievements;
- Assure efficient allocation of scarce resources as well as their optimal use;
- Account to the Owner, Government, and donors.

The Task Force proposed a standard format for the Annual Reporting of HTI's. The overarching objectives of a standardised Management Information System for all PNFP Training Institutions, and a standardised annual report is to improve, at all levels:

- Strategic planning: identify and address the training needs systematically;
- Evaluation of the utilisation of the schools, access, capacity, quality and cost effectiveness;
- Operational planning (annual work plan) aiming to achieve the objectives in the most effective and efficient manner.

In addition the standardisation will facilitate inter-school comparisons and harmonised reporting to the external partners.

However, to be successful monitoring and evaluation has to become an integral part of the HTI activities and the routine of collecting and managing information correctly, will have to be developed as soon as possible.

4.4.4. Improving Financial Transparency and Accountability

As said, the installation of the Management Information System would not be complete without a sound Financial Accounting System. This system has to enable each internal and external partner (from Hospital Board to Development Partner) to obtain a complete overview of the HTI budgets as well as actual annual income and expenditures. The Task Force strongly recommends that each HTI be set-up as a clearly identified cost-centre in the hospital accounting system with protected budget lines, clear spending, and accountability procedures.

This “separation” of the HTI accounts from the hospital accounts in no way entails that the school actually becomes autonomous. The aim is to enable the school and the hospital to account fully for their resources. An annual consolidation of the two financial reports remains possible as long as the underlying detailed reports provide a full and transparent insight in each of the two sections.

4.5. **Optimising the Contribution of the PNFP Health Training Institutions**

All the options presented here aim at ensuring that the PNFP HTI can use their capacity as optimally as possible. At the same time, though, the Task Force wished to assure that the HTI could meet the needs in competent staff of all health units in view of improving the comprehensiveness and quality of care. It will be evident that many of the options are interlinked and will be far more effective if implemented in combination.

All the findings convinced the Task Force that the present real capacity to train nurses should be maintained (e.g. not extended according to the original perceptions the schools had of their capacity). This led to the choice of two main strategies to be pursued here:

- Improving the utilisation of the available capacity through the division of tasks and diversifying the training programmes provided;
- Improving the quality of the candidates entering the training.

As the information regarding the PNFP HTI involvement in the training of Allied Professionals and Specialised Nurses was not yet complete when the options had to be presented to the Second and Third Internal Consultation, the TF could not yet identify clear options for these areas.

4.5.1. Improving the utilisation of the available capacity through the division of tasks and diversifying the training programmes provided

A. *Dividing the Nurse Training Programmes among the PNFP NTI, per region, and developing and implementing the programmes in close cooperation (internal specialisations).*

This will allow optimising the use of each HTI, adjusting the programmes per school to the needs of the surrounding population (e.g. addressing regional imbalances), and it will allow to free capacity for other training needs. This solution will demand a strong will and commitment from all internal stakeholders.

B. Enabling a selected number of PNFP HTI to accelerate their transition to ECN training.

This option matches the national policy and the needs of the Health Centres II and III. However, before deciding how many and which PNFP HTI should convert to ECN, in addition to those that have already started, it is imperative to obtain definite indications from the External Partners regarding the number of ECN's that need to be trained. In addition it is important to assure that the other concerns regarding the training of ECN's and other cadres be clarified (see annex VII)

C. Accelerating the development of capacity for - and the implementation of – the ECN Conversion Course (Bridging course EN-EM-EPsy to ECN)

Here the aim is to answer to the needs of the Health Centres II and III, as well as increase the professional career opportunities for enrolled nurses. It will improve utilisation of the HTI and could have a long-term positive effect on the HTI as its capacity is enhanced. It could be used as a first phase in the transition to full ECN training.

D. Developing and implementing an Internship period for ECN's to ensure competencies for hospital nursing.

This proposal aims at compensating for the deficiencies identified in the ECN curriculum and assure that there will be sufficient enrolled level nurses for clinical services in the future.

E. Developing and implementing a new training programme for a basic care provider pre-graduate / (multi purpose assistant to qualified nurses / nursing assistant new style).

The proposal is first of all motivated by the staff needs in rural and disadvantaged areas. But it has a large range of advantages:

- assure that trained staff is used optimally;
- provide a low step into the nursing profession, certainly if it is combined with other measures like the 'O' level bridging course;
- facilitate staff retention for disfavoured populations;
- facilitate quality improvements while containing employment costs;
- enable the HTI's to use their capacity to contribute to increasing staff levels.

There are important obstacles: the governmental partners are not in favour, and the negative perceptions regarding the NA's demand careful curriculum development and a careful selection of the name for the cadre.

F. Investigating and determining whether a number of Nurse Training schools should transfer to training Specialised Nurses and / or Allied Professionals.

This would optimise the use of the existing training capacity and increase the availability of special cadres for the rural hospitals.

Unfortunately little is known about the need and plans for these cadres. It is also not certain that governmental partners are interested in sharing these training programmes. Since the Second and Third Consultation Conference the Task Force has identified the high need in pharmacy staff. See further 3.8.2 and 4.7.

G. Providing Refresher and Post Graduate Courses for health care staff for Dioceses and Districts.

Some NT Schools are already experimenting with this approach to contribute to improving the skills of health care workers as well as to answer the demand for Continuous Education. This approach also assists in maintaining staff motivation. This option increases the range of ways through which the HTI can put their capacity and expertise to effective use.

The TF particularly identified the need to train health workers for the effective treatment and care of HIV/AIDS as a high priority for the immediate future. The majority of the present professionals have not received training in this field on top of which it is changing rapidly.

4.5.2. Improving the Quality of the Candidates and Access to Candidates from disadvantaged areas

H. Developing and implementing a Bridging Course to enable candidates to obtain the required Entry Criteria.

This proposal aims at increasing access to nursing careers for candidates from the rural areas, especially girls. It will enable the HTI's to train students from the region and according to the needs of the communities. Agreements with the UNMC and the UNEB will have to be secured³⁸.

I. Increasing access to sponsorships for students from poor areas and enhance bondage arrangements.

Increased access for rural candidates to a nursing career is the main objective here. At the same time it allows to answer the need of communities to have nurses from their own areas. It will increase career possibilities and assist in improving staff retention.

J. Sensitising senior school students and teachers to opt for nursing.

Here increasing the interest for nursing as well as increasing the level of the candidates form the key reasons to opt for this approach.

K. Obtain permission to apply the entry criteria flexibly for Enrolled Nurse en Midwife training.

This option would only be applicable if the phasing out of EN/EM training is postponed for four years (e.g. up to 2009 when the full training capacity for ECN will have been reached). The motivation is that if the ECN entry criteria are formally set at O level five passes, of which three are optional, then the EN/EM entry criteria³⁹ could be made flexible again for the last years to ensure that the number of enrolled graduates continues to answer to the needs while the NTI are going through eh transition phase.

4.6. Measures to support Cooperation and the Implementation of the Options

To facilitate joint action and to enhance effectiveness of the options selected, the Task Force also identified a number of support measures. These are:

³⁸ Depending on the outcome of the dispute regarding the revised entry criteria for the ECN training this option may only be required for the North and the Eastern regions.

³⁹ The EN/M criteria are now in fact higher as the revised criteria proposed for the ECN: five mandatory passes in English, Maths, Biology, Physics, and Chemistry.

- i. Develop a common and clear position of PNFP authorities, hospital owners, and Boards, with respect to the major issues affecting PNFP Training Institutions, e.g.:
 - o The MOES requirement that the Nurse Training Schools become autonomous institutions with their own Board;
 - o School participation in extra-curricular activities like sport contests throughout the country.
- ii. Develop more harmonised and standardised rules and regulations for the PNFP HTI's;
- iii. Improve communication between MOES, MOH, UNMC, the Bureaux, the PNFP Institutions, as well as with the communities.
- iv. Develop and implement a HTI accreditation programme to assure verifiable continuous improvement of our quality of training.
- v. Develop a structured plan to ensure the vertical career progression of the pre-graduate patient carer to be trained and where possible for other cadres.
- vi. The Partnership and the Bureaux should continue advocating for financial support from Government to assure that students from the disfavoured areas would have access to professional health training courses (be included in the budget of MOES or increased PHC-CG delegated fund increases).

4.7. Subjects to be addressed in the Mid-Term

During the formulation of this report the Task Force continued to receive new information and realised that some subjects remain to be tackled. They are listed here for the interest of the Partnership Organisation in the hope it will be able to take them up later.

1) *Developing additional measures to correct the regional disparities in training capacity:*

The main aim should be to assist the health units in recruiting and retaining well-qualified staff. The measures should also enable motivated candidates to enter the profession at an adjusted level and gradually develop a career.

2) *Increasing the availability of tutors for the PNFP HTI:*

A first step should be to assure the recognition of the Tutors trained by CEDHA in Tanzania. Already two years ago a study was undertaken to assess the difference between this course and the Tutor Training course of Mulago. The outcome was that both courses require improvements. The CEDHA trainees, however, could be brought up to the standard of Mulago, via a short course covering specific deficiencies in science subjects. To date this course has not been implemented and the CEDHA trained tutors remain unrecognised.

The national capacity to train Tutors is 25 places for all Nursing and Allied Professional tutor training requirements. If this remains the only recognised course it will not be feasible to increase the number of tutors for the PNFP sector as rapidly as needed. The PNFP Partnership should endeavour to obtain permission to negotiate with CEDHA to adjust the course to the findings of the above-mentioned assessment. If the CEDHA course could then be recognised the PNFP HTI would be able to increase the number of tutors much faster.

In addition to these measures, candidates for tutor training will require assistance to access recognised training courses (bridging courses, scholarships, support to families).

If these actions do not result in the required increase in tutors, the development of adjusted PNFP training courses should be considered.

3) *Training clinical instructors for the PNFP HTI:*

As no course for clinical instructors is currently available, and as it is not a registered course, the development and implementation of such a course should be considered seriously by the PNFP HTI. The possibilities, to develop the course in such a way that it can serve as preparation for a fully recognised tutor course, should be explored and used if feasible.

4) *Training Pharmacy staff:*

The need for well-qualified pharmacy staff is high and the training capacity is low: The MOH/MOES have set the example by deciding to have a non-recognised course at assistant level. The PNFP HTI's should review their possibilities, and, if feasible, take up training pharmacy staff as well. They already have access to a curriculum that has proven to be valid. This is the PATS programme that was run for candidates from the PNFP sector of the East African countries.

5) *Improving Stability of Staff:*

The TF had established the willingness of staff to continue to work in the PNFP health units, particularly in rural and disadvantaged areas, is determined by remuneration, living conditions, and career possibilities. The PNFP HTI can mainly contribute to the latter, reason why options in this direction are suggested in 4.5. For the other two areas the Partnership of the PNFP HTI cannot undertake much on its own. Cooperation with the health units and the Bureaux and joint lobbying for improvements are the main strategies that the TF was able to identify for these.

5. OUTCOME OF THE CONSULTATIVE PROCESS

The Health Commission correctly insisted that the Task Force consult the internal stakeholders to determine the options available for the schools to improve their utilisation. The main aims of the HC were to ensure that the proposals would be feasible and fully endorsed by the majority of the RC (and later PNFP) HTI.

At the outset the HC also foresaw a Consultation of the External Partners to assure understanding, and if possible reach consensus, regarding the choices for the future of the PNFP HTI. This last consultation remains to be done. The reason is that the TF and the representatives of the PNFP HTI recognised that, before final decisions for the future could be taken, the Close Cooperation between the HTI needed to be set in place. In addition there proved to be too many uncertainties, with respect to the national policies and plans, to take drastic decisions at this point in time.

5.1. The Internal Consultation Conferences

The Task Force organised three Internal Consultation Conferences. The motto for the Internal Consultations was the same as for all the TF activities:

The Future of Nurse Training in support of the Mission of the Private Not for Profit Health Care Sector in Uganda.

5.1.1. The First Internal Consultation

This conference took place from September 9 to 10, 2004. Representatives of the Hospital / HTI Board of Governors, Management Teams and HTI Management of all the PNFP HTI were invited. Nearly all the institutions attended though not all with three participants.

The goals were formulated as:

- To enhance the understanding of the complexity of the challenges the Nurse Training Institutions (NTI's) are experiencing in relation to their utilisation.
- To reach consensus on a joint approach that will enable the entire group of PNFP NTI's to turn the challenges into opportunities to contribute effectively to the improvement of health services.

The main findings of the Task Force, as presented in chapter 3, were presented to these internal stakeholders. With the difference that, at this time, the findings of the TF pointed towards a considerable under-utilisation, or excess capacity, of the NTI. The evidence collected indicated that the under-utilisation was not new and was to some extent already being corrected. This in turn indicated that the causes could not only be sought externally. In addition the complexity of the entire training environment and the evolution of the problems the schools perceived indicated that a hitherto unidentified priority was emerging. This pertained to high need for a close cooperation between the schools and an effective representation of the schools at national level.

The participants needed more time to absorb the information that the under-utilisation did not have its principal cause in the actions / decisions of the external partners. They had assumed that the strict application criteria were the main cause and thus expected that the solution proposed would be in this line.

That the new insights, meant that the first decisions to adjust / improve utilisation would have to be their own was difficult to consider in this first phase.

The proposal of the TF to install a mechanism, or organisation, for close cooperation and effective representation, however, was immediately recognised as very much needed.

The resolutions of this First Consultation thus were that the HC would be requested to enable the TF to continue its work to:

- continue the research into the causes of the perceived under-utilisation and the options to solve it, including the other training courses;
- develop a detailed proposal for the close cooperation, including the best option for the organisational form for this cooperation.

5.1.2. The Second Internal Consultation

This conference was held on December 16 and 17, 2004. The same participants, as for the first consultation, were invited. The number of schools, only represented by one or two persons, was slightly higher than during the first conference.

The main goal was to reach an agreement on a joint approach to enhance cooperation and turn the challenges, the Health Training Institutions face, into opportunities. Or said more directly: to reach an agreement whether an organisation for the close cooperation between the PNFP HTI should be installed.

The participants were very enthusiastic about the proposed organisation form, constitution and terms of reference / proposed way of working for the cooperation. Their main questions concerned the legal correctness of the texts and the possibilities to seek a legal recognition / status for the new organisation.

As not all the governance levels, of all the HTI, were represented the participants could not decide to initiate the installation of the organisation. The participants decided to return to their respective institutions and sensitise the Board and Management Team to opt for the installation of the proposed Partnership organisation.

They requested the HC and TF to organise one more Consultation to enable all the HTI, and each level of each HTI, to decide formally whether the Partnership should become a reality.

During this Second Consultation, the TF presented its new estimates of the actual training capacity of the PNFP HTI, based on the theoretical calculation using the hostel beds as the deciding factor. Again the participants required time to understand that their perceptions of the actual problems were not correct. They fully embraced the proposal that they needed to improve their management information systems and their actual use of the information to improve management.

The completely changed perspective on the actual problems did not allow them to decide on any other proposal of the TF at this stage.

5.1.3. The Third Internal Consultation

The representatives of the all the PNFP HTI gathered in Kampala on February 17 and 18, 2005 to take the final decision regarding the installation of the proposed PNFP HTI Partnership organisation. The majority of the schools were represented by members of the three Hospital / HTI governance levels. In the few cases where one or more representatives could not attend the conference, the respective Board had sent in a formal mandate to vote in favour of the Partnership organisation.

The Task Force had assured a presentation by the lawyer of the Uganda Episcopal Conference to answer to the legal questions posed by the participants of the second consultation. The lawyer clearly mapped out the steps required to secure legal recognition in the future. He also gave concise information how the organisation could start operations while preparing for legal registration. This was in answer to the TF's recommendation that the organisation should start its operations as soon as possible, if it was to participate in the national policy and planning debates.

The decisions taken by the participants regarding setting up the PNFP HTI Partnership Organisation are summarised in the chapter 5.3.

The Task Force had continued its analysis of the data, research into the other training courses, and development of proposals to optimise the use of the capacity of the schools. It was now able to show that the new capacity calculations and the annually swinging utilisation patterns, of most schools, clearly indicated that improving planning and management should be given priority attention by all concerned.

The information on the national needs and training capacity for non-nursing cadres could not yet be completed to the extent that clear propositions could be developed.

The interactions with the external partners and the publication of the MOH / AMREF Human Resources Tracking Study confirmed the high need for the entire group of PNFP HTI to have a professional and united voice at national level as soon as possible.

The options for future common actions by the schools did not change considerably after the second consultation. The participants chose to concentrate first on the erection of the new organisation and referred decisions regarding further plans to the time when the Partnership was officially launched and fully operational. It was hoped that by that time some more information about the national plans would have become available.

5.2. The Agreements Reached during the Third Internal Consultation Conference

The representatives of the twenty-one PNFP Health Training Institutions decided as follows, during the Third Internal Consultation of February 2005:

Unanimously:

- Cooperation between the PNFP HTI is needed and wanted;
- This cooperation should be formalised in the form of an organisation;
- The end point should be a legally registered / recognised organisation;

With a large majority:

- The cooperation should start immediately;
- The gradual development towards a legally recognized organization should be pursued at the same time;
- To expedite the start of operations, and assure the necessary protection against liabilities, the secretariat should be housed under one of the Medical Bureaux until legal recognition is secured;
- The steps to be taken to obtain legal recognition are:
 - Enhance and register the constitution;
 - Initiate the process to register as NGO;

- Pursue the process to be registered as a Company Limited by Guarantee not having Shared Capital. The members of an Interim Executive Committee were elected, following the criteria proposed in the draft constitution; The Interim Executive Committee (IEC) was mandated to negotiate with the three Bureaux to determine which to assume the responsibilities to act as host / secretariat of the PNFP Partnership;

- The IEC is to start activities and prepare the formal launching of the Partnership;
- The IEC will also recruit and appoint a Delegated Secretary for one year.
- The Hospital / HTI's will contribute to the operational costs from the start and the IEC is mandated to collect the contributions;

In addition, to the decisions regarding the start-up of the HTI Partnership, the participants adopted the Annual Reporting Format and decided that each HTI will install the registration system that will enable them to present the first annual report in August 2005.

5.3. The PNFP Health Training Institution Partnership Organisation

The PNFP Hospitals with Health Training thus decided to set-up a new organisation to enable them to optimise their contributions to the availability of competent health care staff for the PNFP and national health care services.

The main features of the organisation they envisage are presented here. For detailed information please be referred to the document "The Proposal for the Close Cooperation between PNFP HTI and the Draft Constitution for the Partnership".

5.3.1. The Mission of the Partnership of the PNFP Health Training Institutions

The Partnership is installed to support the Mission of the Health Training Institutions (see 4.1) by:

- I. Ensuring coordination, consensus building, and cooperation between the Health Training Institutions of the PNFP health care sector.
- II Ensuring an effective representation of the PNFP Health Training Institutions in - and coordination with - the common external partners, including advocating for the interests of the Health Training Institutions, and their students.

5.3.2. Aim of the Partnership of the PNFP Health Training Institutions

The aim of the partnership is to arrive at policies, plans, and implementation strategies for issues of common concern and for training purposes that surpass the individual institutions, while leaving the internal organisation and responsibilities of the Hospital-Health Training Institution in tact.

5.3.3. The Guiding Principles of the Partnership of the PNFP Health Training Institutions

The guiding principles that the Task Force used to make the choices for the organisational structure and the Terms of Reference for each structure are:

- The Hospital / HTI's are independent organisations that wish to work together for common goals;
- Each of them also has other goals, which entails that they wish to maintain an own identity and a significant degree of autonomy;
- They are equal to each other and partners on equal terms for their common actions (this is reflected in the word Partnership)
- Partners have an equal voice in decision making;

- In a partnership, differences of opinion are resolved through dialogue and amicably.

In addition to these, if the organisation is to work effectively:

- All partners have to perceive the organisation as theirs (ownership);
- This ensures commitment and loyalty to the common actions;
- The organisation must ensure that it responds effectively and comprehensively to developments and needs: it has to have, and maintain, an added value.
- The organisation has to be fully accountable to the owners.

5.3.4. The Structures of the Partnership of the PNFP Health Training Institutions

The organisation is to have the following structures:

- The General Assembly: composed of all the members to set the policies and supervise / control implementation. Each member Hospital / HTI to be represented by one Board member, one Management Team member and the Principal Tutor.
- An Executive Committee: to assure implementation of policies and strategies, prepare decisions for the members, and guide the secretariat. The EC will consist representatives of HTI elected by the General Assembly.
- The Partnership Secretariat: the technical unit that implements the policies and strategies, assists the PNFP HTI's in implementation at their level, and represents the Members in the dialogue and negotiations with the External Partners and in national fora. The Secretariat will be headed by a professional Delegated Secretary.
- The three Medical Bureaux will have the role of the: technical advisors to General Assembly, the Executive Committee and the Delegated Secretary.

6. RECOMMENDATIONS

In this chapter recommendations for the immediate future are proposed for the Health Commission and the Interim Executive Committee of the new Organisation. The main aim is facilitate a speedy start of the operations of the Partnership as well as the smooth preparation of the formal inauguration and formalisation of the Partnership. In particular the establishment of the formal representation of the PNFP HTI is needed soon in view of the development of policies and plans at national level. In addition there are quite a number of questions that require answers from the external partners to enable the partnership to finalise the plans to optimise the use of the PNFP HTI. Lastly the HTI would greatly benefit from early professional support in determining their definite capacity and improving their management information system.

6.1. Health Commission and UCMB

Facilitate the start-up of the new organisation both through moral, technical, and financial support so that the required capacity can be set in place. Once the Partnership is formally launched, and first results can be achieved, the organisation will be able to access other sources of funding for its activities.

If technical and financial support can be made available, present the Interim Committee with clear terms of reference how to access and use this support together with the budget ceiling. This will enable the Interim Executive Committee members to respond adequately and initiate operations.

The Terms of Reference could include:

- A clear choice be made for the organisational embedding, and clear procedures determined to guide, and supervise the Partnership Secretariat;
- Availability of a work plan with clear and feasible targets together with a budget for the coming six months;
- An appropriate profile and job description for the Delegated Secretary,
- The selection of Delegated Secretary who's profile corresponds largely with the profile agreed;
- If a Delegated Secretary cannot be identified within a predetermined period, a plan to enlist the support of Technical Assistance combined with a set of clear Terms of Reference for this assistance;
- The collection of the first contributions from all PNFP HTI+
- An agreed quarterly monitoring and reporting plan covering the activities and financial resources of the Interim Executive Committee and the Partnership Secretariat.
- Timely and complete quarterly reporting.

Support the efforts of the Interim Executive Committee and the Partnership Secretariat by stimulating the RC hospitals to improve the governance and management of the HTI's.

Stimulate the RC Hospitals / HTI's to become full owners and participants in the Partnership.

6.2. The Interim Executive Committee of the PNFP Health Training Institutions Partnership

6.2.1. Recommendations for the short-term (first two months)

Finalise the work plan for the first six months and develop a budget for it.

In the event the UEC Health Commission is willing and able to provide technical and financial support, contact the Health Commission Chairperson as soon as possible. The aim should be to reach an agreement regarding the Terms of Reference and modalities of the support.

Reach an agreement with the Medical Bureaux regarding the hosting of the Partnership Secretariat until the organisation is legally recognised.

Elaborate, with the hosting Medical Bureau, the necessary arrangements for representation in national fora and exchange of information until the Delegated Secretary is in place.

Pursue the speedy recruitment and appointment of a Delegated Secretary so that representation at national level can be assured, the HTI can be assisted in the implementation of the management improvements, and the plans to optimise their utilisation can be developed further.

Enable the PNFP HTI to decide soon on what their actual annual enrolment capacity is per course. This will enable them to plan better. But more importantly this will enable them to enter the dialogue with the External Partners with a clear purpose. It will also assure that nationally the training capacity can be better evaluated and adjusted to the actual needs.

Assure that the PNFP HTI express their support and adherence to the Partnership by contributing to the budget for the first six months.

6.2.2. Recommendations for the mid-term (six months)

Assist and assure that the HTI install, as agreed, the Management Information System and as well as the accounting system to enable them to plan, monitor and evaluate their operations, and report transparently

Assure that the HTI compile and send in an annual activity and financial report by the end of August 2005 according to format agreed (this could be the first accreditation criterion to start-up the accreditation system)

Install a system that enables the Secretariat to compile and analyse the reports and provide feed-back to the HTI.

Assure that an External Consultation Conference is organised as soon as possible to enable all external partners to acquaint themselves with the new organisation and to discuss the plans and key issues concerning the training of Health Care professionals. In addition to this, establish the answers to the urgent questions for nurse and midwives training for the future.

Assure that the Draft Constitution is finalised and presented to the registrar of documents. Take the necessary steps to assure that the Partnership can be officially installed and inaugurated.

ANNEXES

ANNEX I

TERMS OF REFERENCE FOR THE TASK FORCE ON NURSE TRAINING SCHOOLS

Preamble:

In the year 2002, the Uganda Nurses and Midwives Council (UNMC) revived the entry criteria for aspirants to the nurse training schools. As a result of that decision, the PNFP nurse training schools have been battling with dwindling numbers of entrants to the schools. To date many of these schools are operating well below their training capacity because the rural constituencies they serve cannot raise sufficient numbers of qualifying candidates to join the schools. Yet urban-based students who actually do qualify are not willing to go and study from these rural schools, let alone remain there to work on completion of training.

In the future all nurse training schools, unless a policy change occur, shall have to convert to training comprehensive nurse cadres whose entry grades are even more prohibitive to the many students from the disadvantaged rural secondary schools which may not offer science subjects satisfactorily.

It is this situation that has led to the need to institute a task force to look critically into the situation of the nurse training schools so as to determine the best option to ensure that the RCC Hospitals and Health Units will be able to recruit sufficient nurses and assure the cost effective operation of the schools.

Composition of the Task Force:

Rev Sr Joseph Donatus
Rev Sr Maria Teresa Ronchi
Rev Sr Stella Josephine Namatovu
Rev Sr Rosemary Namaganda
Ms Ineke Huitema,
Ms Marcella Nsenga
Ms Nabudda Emerin Rose

Other co-opted members

General Purpose of the Task Force:

To advise and assist UCMB in developing a strategy to improve the capacity of affiliated Training Institutions (Hospitals) to train nurses in a way that is compatible with the huge demand in the Country and access to training for rural candidates.

Detailed objectives:

5. Develop proposal for a bridging curriculum to allow entry to potential candidates that do not satisfy entry criteria, and test reaction of the regulators to such proposal.
6. Develop a proposal for accelerated transition to Comprehensive Nursing if feasible and desirable in the light of the current and foreseeable constraints.
7. To explore avenues/possibilities/acceptability of training nursing cadres specifically for the internal consumption of the RCC health services (or PNFP/Uganda – not for export; of intermediate level between current Nursing Assistants and Comprehensive Nurse).
8. Consolidate proposals and advice in a report to the Health Commission within maximum 6 months.

Time Frame:

Asap. End of work ideally by 31st August

Method of work:

The Task force will have a dynamic chairperson, capable of steering the force's work, to be selected by the Members. The Chair of the Task force will take responsibility for the work of the members and, once installed and availed with a portfolio, will be independently answerable to the Executive Board of the Health Commission.

It will develop its own activity plan and schedule of work complete of Budget and submit it to the Bureau within two weeks from its installation. This will be inclusive of fact findings missions and meeting costs.

It will avail of secretarial services and other office services requested from the Bureau, whose cost will be deducted from the budget.

The Bureau will have a representation in the force as member, not to be Chairperson.

Budget: To be drafted by the Task Force

Draft specification of the Terms of Reference:

To achieve the objectives the following activities and out puts will be required:

- I. Selection and invitation of co-opted members able to broaden the representation of important stakeholders and enhance the expertise in the Task Force.
- II. Research and multiplication of national and international reference documents.
- III. Study of the national documents to extract pertinent questions. Study international experiences that enable the TF to clarify understanding of the key issues and detect possible alternatives.
- IV. Formulation of a set of key questions that require answers from the major external stakeholders and ensure that the answers are obtained.
These questions will be related to the responsibilities for -, legal and regulative aspects of - the present Nurse Training and the possibilities for changes in the future.
The major external stakeholders concerned are:
- MoH - MoES - Uganda Nurses and Midwives Council.
Examples of the questions are:
 - Are nurses (students) allowed to perform medical / clinical acts under supervision?
 - What exactly are medical / clinical acts that need to be performed by persons possessing a professional (licensed) status?
 - Who is / should be responsible for the regulation of the Nursing profession?
 - Who is / should be responsible for the regulation of the training of professional nurses?
 - Where do the principle interests of the UNMC lie: with the quality of the Nurses that enter Civil Services or with the quality of the profession as a whole?
 - What does the legal protection of the UNMC entail precisely?
 - What would be the legal implications if training a different level of cadre proves the only feasible option?
- V. Analysing the present curricula for nurse training, using a prepared grid of comparison, to identify the gradient of differences in competencies and responsibilities between the various cadres (nurse assistants / enrolled nurses and midwives / registered nurses and midwives / enrolled comprehensive nurses / registered comprehensive nurses).
- VI. Identify the extent of the future shortage of Nurses and determine to which extent the strategic choices to transfer the entire training of nurses to Comprehensive training and phase out the existing training levels, particularly the Enrolled nurse training, are further magnifying the shortage.
In addition assess the present level of certainty and consensus to implement the strategic choices as foreseen (e.g. test willingness to adapt the strategic choice to reality and continue enrolled training in the mid-term).
- VII. Identify and assess the alternatives available and test the extent of acceptability of the main stakeholders for each.
Alternatives recognised to date are:
 - a. Developing and implementing a propedeutic (preparation) course to bring students not possessing the required school grades to a level of knowledge similar to that of the formal entry requirements.
 - b. Continuing the Enrolled Nurse training as before but issuing a hospital certificate and assuring the quality of the training through a PNFP (or RC) education and examination board.

- c. Developing a training programme for a new cadre of nurses specifically for the PNFP (or RC) network.
- VIII. Identify schools willing to transit to comprehensive nursing in the short term and developing a proposal for accelerated transition to Comprehensive training for the identified schools.
- IX. Formulation of the best option for the future and the best alternative option for consultation during Internal and External Stakeholder Conference.
- X. Organise an Internal Consultation Conference with all PNFP Nurse Training Schools to inform them of developments, discuss the options identified and the TF's proposal (best options) for the future with them and reach consensus on which to develop further.
- XI. Developing a programme and list of participants and speakers for an External Stakeholder Conference in August / September 2004. Assist in the organisation of the Conference. The outcome of the Conference should be a sharing of experiences with international colleagues and a consensus regarding the future Nurse Training to be pursued, among, at least internal stakeholders, but preferably also the external stakeholders and international participants.
- XII. Formulating a report with the findings and proposals for the Health Commission.
- XIII. Drafting a report of the Conference reflecting the consensus reached and the main arguments for the conclusions.
- XIV. Developing the final proposal for the future of Nurse Training and presenting it to the Health Commission.

This proposal should be complete with lists of tasks, time schedule, and assignment of responsibilities to assure speedy implementation.

(NB if in the preliminary contacts there is a sufficiently high level of acceptance – both in the network of PNFP schools and in the external stakeholders - for the proposal to implement a propedeutic course this task can also be assigned to a group of identified experts. The eventual proposal should include determining who should assess the equivalence of the propedeutic course.)

Methods of Work:

In view of the extent of the work a form of regular retreats would seem the best option. It could be considered to request the support of a Facilitator to assist the Task Force chairperson and members with the work.

Proposals for co-opted members:

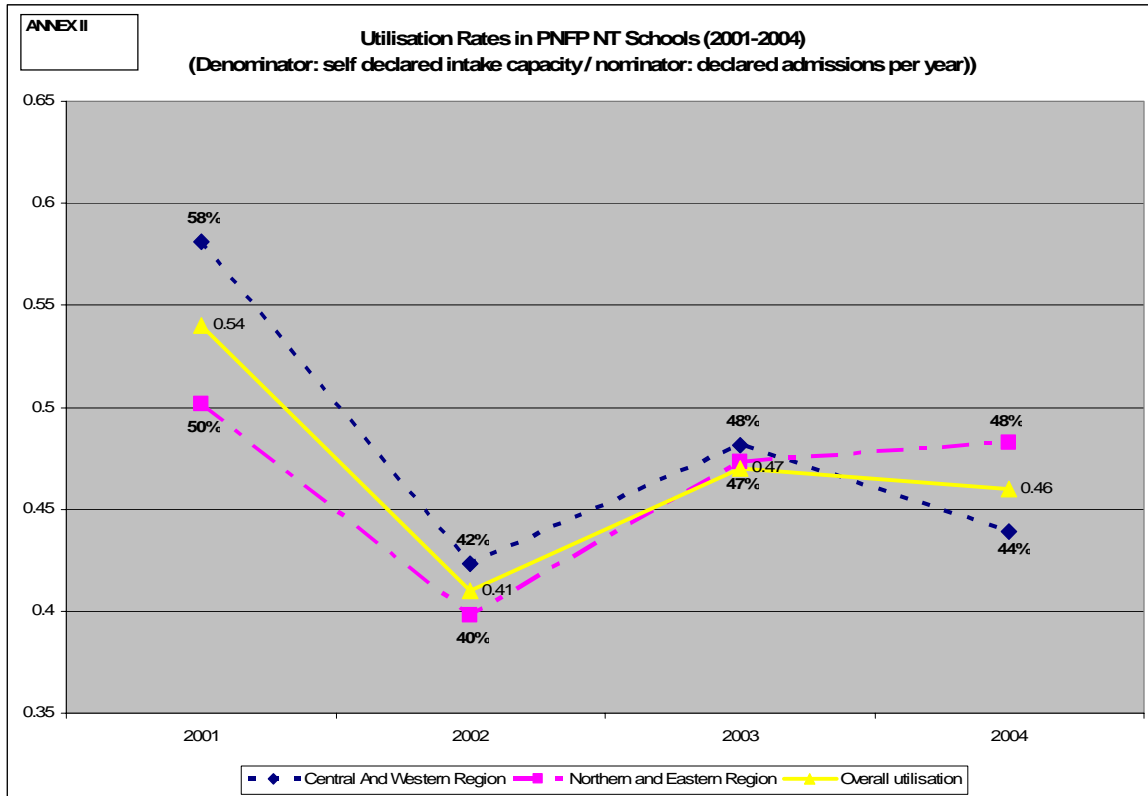
- One or two Senior Nurses
- A representative of UPMB
- A representative of a UPMB Nurse Training Institute.

List of reference documents

1. Nurses and Midwives Act 1996
2. Health Commission Act 2001
3. The Allied Professional Act ?
4. The training curricula of:
 - Nurse Assistants
 - Enrolled nurses and midwives
 - Registered nurses and midwives
 - Enrolled comprehensive nurses
 - Registered comprehensive nurses.
5. Bridging Curriculum Enrolled Nurse- - Enrolled Comprehensive Nurse
6. Formal Job-descriptions of each above cadre
7. The report of the Bukenya Commission 200?
8. Conditions under which hospitals are approved as training hospitals. UNMC/MOH Nov. 2001.

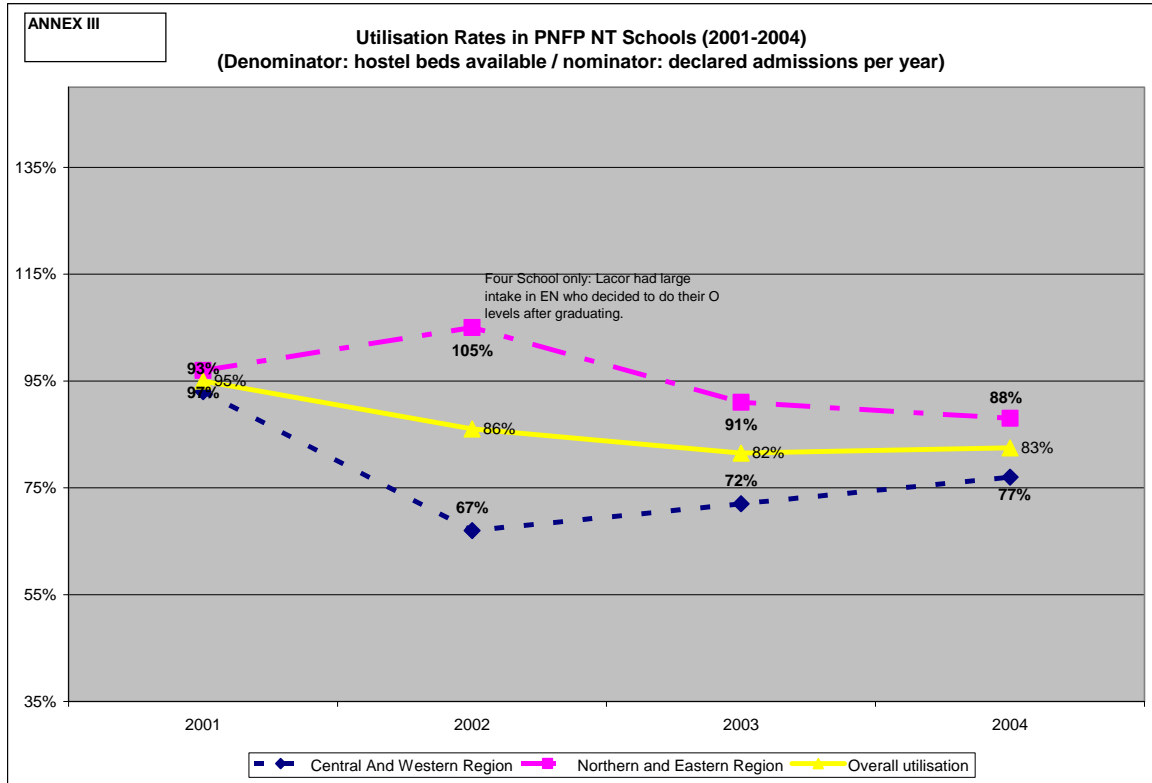
ANNEX II

THE FOUR-YEAR OVERVIEW OF THE UTILISATION OF THE PNFP NURSE TRAINING INSTITUTIONS BASED ON DECLARED CAPACITY



ANNEX III

THE FOUR-YEAR OVERVIEW OF THE UTILISATION OF THE PNFP NURSE TRAINING INSTITUTIONS BASED ON HOSTEL BED CAPACITY



ANNEX IV

LIST OF KEY DOCUMENTS CONSULTED

1. Reference documents of the Health Commission:
 - a. Nurses and Midwives Act 1996
 - b. Health Commission Act 2001
 - c. The Allied Professional Act (year unknown)
 - d. The training curricula of:
 - Nurse Assistants
 - Enrolled nurses and midwives
 - Registered nurses and midwives
 - Enrolled comprehensive nurses
 - Registered comprehensive nurses.
 - e. Bridging Curriculum Enrolled Nurse- - Enrolled Comprehensive Nurse
 - f. Formal Job-descriptions of each above cadre
 - g. The report of the Bukenya Commission 200?
 - h. Conditions under which hospitals are approved as training hospitals. UNMC/MOH Nov. 2001.
2. Memorandum of Workshop of Hospital Administrators and Principal Tutors in PNFH Hospitals with Health Training Schools Institutions, July 2001.
3. Position Paper prepared for the HPAC: Issues Emerging from the Stringent application of the Entry Criteria in Nurse Training, December 2002.
4. Group Five / MOH: Human Resource Development Plan for Nursing and Allied Professionals, Scenario IV, 1999 – 2000.
5. The Health Sector Strategic Plan 2001 – 2005;
6. UCMB, Calculations of the Staff gaps in RC Health Units, 2003/04
7. HSSP Human Resource working group, Staff gap calculations of the 2003/04.
8. Nursing acts of United Kingdom, Australia, Botswana, Kenya, and Tanzania.
9. Dr. Grace Namaganda, *Optimal Medical Staffing levels and Skills mix for Patient care departments of UCMB Hospitals*, A study report, by Uganda martyr's University, August 2004.
10. USAID, Bureau for Africa, Office of Sustainable Development, *The Health Sector Human Resource Crisis in Africa*, an Issues Paper, February 2003.
11. Delanyo Dovlo, *Using Mid level cadres as substitutes for internationally mobile health professionals in Africa*, A Desk Review, Human Resources for health, June 2004.
12. MOH / AMREF: *Tracking Study Human Resources and wage bill management in Health Sector*, September 2004 and February 2005.
13. Reports High-Level Forum on the MDG's:
 - 1.) Health Workforce Challenges: Lessons and Experiences and
 - 2.) Addressing Africa's Health Workforce Crisis: An Avenue for Action, Abuja December 2004.
14. Beekes, Albert, Study Report: *Cost effectiveness in Hospital Services*, 2002.

ANNEX V

LIST OF DOCUMENTS PRODUCED

1. Interim Report to the Health Commission, power point presentation, September 2004.
2. Report of the First Internal Consultation Conference, September 2004.
3. Reaction to the MOH / AMREF Tracking Study Human Resources and wage bill management in Health Sector, September 2004.
4. Proposal for the Constitution of the Partnership Consortium of the Private Not for Profit Health Training Institutions, December 2004.
5. Position Paper for DANIDA: “Overview of the issues pertaining to the actual Training of Nurses in the PNFP Health Training Institutions”, December 2004.
6. Options for the future, Proposals to maximise the Utilisation of the PNFP HTI in the Short-Term, Health Commission, Task Force on the future of Nurse Training, December 2004:
7. Proposal for the management Information System of the PNFP HTI.
8. Proposal for the Annual Reporting format of the PNFP HTI
9. Report of the Second Internal Consultation Conference, December 2004.
10. Report of the Third Internal Consultation Conference.

ANNEX VI**LIST OF STATISTICAL INFORMATION**

NR.	SUBJECT	INFORMATION	REMARKS
1.	Total number of Nurse Training Institutions:	27	
2.	Number of PNFP NTI:	19	
3.	Annual enrolment capacity according to the PNFP NTI:	1662	
4.	Annual PNFP enrolment capacity according to physical capacity:	900 - 1000	TF Data to be completed The Tracking Study reports this as 1208
5.	Total number of Nurses and Midwives graduating per year:	Varies between 800 - 1200	Tracking Study reports an average annual output between 2001/2 and 2003/04 of 1414.
6.	Total number of nurses and midwives graduating from PNFP NTI:	Varies between 500 and 850	The Tracking Study reports an annual average of 905 (=64% of the total output)
7.	Number of nurses and midwives required nationally to fill the HSSP I norms:	3,763 (2776 / 987)	
8.	Number of nurses and midwives required in all UCMB HU's to fill the HSSP I norms: Hospitals alone:	1,843 (1,045 / 643) 1,688	
9.	Indication of regional disparity: the UMCB hospitals in Northern and Eastern regions require:	1,014 (= 60%)	
10.	Number of nurses and midwives needed in addition, nationally, to scale up Reproductive Health and ART:	406 midwives 1266 nurses	
11.	HR Plan Scenario IV training capacity planned for all categories:	1575	
12.	Retaining 40-60% division between Public and PNFP, the number of PNFP should plan for:	945	
13.	HR Plan Scenario IV total number of ECN graduates planned per year:	1253	
14.	Number of ECN places allocated to PNFP NTI:	629	

NR.	SUBJECT	INFORMATION	REMARKS
15.	Total number of Institutions training allied professionals:	27	
16.	Number of PNFP institutions training allied professionals or specialised nurses	7	
17.	Number of Pharmacy staff required to fill the HSSP I norms: If ART to be scaled up:	311 + 136	
18.	Total national annual enrolment capacity to train pharmacy staff	20	
19.	Number of diagnostic staff (mainly laboratory staff) required to fill the HSSP I norms: If ART to be scaled Up	1089 + 420	
20.	Total national annual enrolment capacity to train laboratory staff:	262	
21.	Number of PNFP Laboratory Assistants Schools: - Annual assigned / design training capacity: - Actual annual enrolment:	6 137 60	
22.	Number of PNFP Laboratory Technician Schools - Annual assigned / design training capacity: - Actual annual enrolment:	2 25 25	
23.	Number of PNFP Theatre Nurse Training courses: Annual intake:	1 10	Only known course
24.	Number PNFP Nurse Assistant training Schools: Annual intake:	2 85	One school enrolls 15 students per year and the other 70.

ANNEX VII:

LIST OF QUESTIONS OF THE PNFP HTI REGARDING NURSE TRAINING REQUIREMENTS AND PLANS.

1. Enrolled Comprehensive Nurse Training:
 - How many training place are needed (what should be the annual output)?
E.g. How many schools need to convert?
 - Who decides which schools are to convert?
 - Which criteria are applied for the selection?
 - What are the training capacity needs for other categories of nurses and allied professionals
 - For the entire health system
 - And / or for the PNFP sector
 - What will be the minimum entry requirements and when will they be decided in definitely?
 - What programmes should the EN / EM Schools, not converting, take on:
 - Nursing: RCN / RN / RM
 - New cadre (Nurse Assistant new style)
 - Allied Professionals
 - New programmes (Polyvalent HIV/AIDS carer)
 - Are the rapidly increasing number of private schools going to be assigned a quota in the ECN training? If so where will this quota be subtracted?
 - When will the EN / EM conversion courses be started?
 - How can schools apply to take on the conversion courses?
2. Phasing-out of traditional Enrolled Nursing and Midwifery training:
 - Is the final date of May 2006 definite (last intake)?
If so:
 - If the ECN training capacity will only be fully developed by 2009/10, what about the annual output during the years 2007 and 2010? (it will be too low to fill the staff gaps that exists / the gap will increase)
 - Why then are new schools, in 2005, obliged to start with EN and EM?
 - Can schools opt to continue EN / EM training? E.g up to which year will graduates be accepted to register?
 - Can the PNFP HTI opt to continue and give them a hospital certificate?
3. Tutor and clinical instructor training?
 - When will the procedure to recognise the CEDHA trained tutors and the course be finalised?
 - Will the Clinical Instructor course be restarted? What will be the capacity?
 - What are the requirements to set up a Clinical Instructor course?