UGANDA HUMAN RESOURCE FOR HEALTH STRATEGIC PLAN: Potholes in the planned path to 2020.

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Abstract

"Too few overburdened and overstressed health workers, without the support they so badly need – losing the fight. Many are collapsing under the strain; many are dying, especially from AIDS; and many are seeking a better life and more rewarding work by departing for the richer countries". This is typical of Uganda. Uganda has just produced its Human Resource for Health Strategic Plan aiming to improve HRH situation. Forced by macroeconomic straight jackets, and not by foreseen needs, the plan is very conservative. This paper argues that the plan contains some weak premises and contradictions all which may negatively affect it in the implementation period and questions whether it is strategic enough to achieve its goal.

Introduction

Uganda's Ministry of Health has just concluded and published its first Human Resource Strategic Plan that covers the period 2005 – 2020 (MoH, June 2007). The goal of the plan is "*To supply and maintain an adequately sized, equitably distributed appropriately skilled, motivated and productive workforce matched to the changing population needs and demands, health care technology and financing.*" It is supposed to respond to the Health Sector Strategic plan and operationalize the Human Resource for Health Policy. The Health Sector Strategic Plan II (HSSP II) that runs from 2005/06 through 2009/10 aims to deliver a minimum health care package (MHCP). HSSP II observes that "Availability of trained health workers is one of the most critical limiting factors for the delivery of the minimum package".

The Human Resource for Health Policy (MoH, April 2006), and therefore the Human Resource Strategic Plan, has been made in the context of the Uganda vision 2025 that targets a well reduced burden of disease and a subdued population growth rate. It foresees Uganda having a population growth of 1.7 % (from 2.5%), HIV infection rate of 0.5% (from 2.5%), Infant Mortality Rate of only 10 per 1,000 live births and a maternal Mortality Rate of 200 per 100, 000 live births and total fertility rate of 3.4 children (from 6.9). It foresees Ugandans having 5,000 persons per doctor (from 18,600) and 1,000 persons per nurse (from 7,700) and assumes that the Poverty Eradication Plan (PEAP) developed in 1997 and revised in 2000 will have improved life of the poor. By implication these mean there will be less disease burden to deal with.

The Plan has been drawn on seven assumptions amongst which are that public expenditure will decline in the short to medium term but will increase significantly in the long run and that there will be some shift in the recurrent budget with a higher proportion assigned to personnel costs than currently. In the process of drawing the HRH strategic plan three scenarios were considered that took into account projected population, disease burden and public expenditure for health growth/decline amongst

others. The scenario chosen was the most conservative that had to fit with an inelastic projection of health public expenditure.

Is the health sector willing to fight for more money for human resource?

The plan portrays the health sector as having proactively resigned from convincing government to commit more money to health care than it foresees currently. So rather than struggle to convince government to adjust its expenditure for health to need, the plan orders the health sector to restrict the demand for health care to what government may allocate it even if the need is already seen to be higher. Moreover the service demand on health workers is also not likely to reduce as expected even if HIV infection rates were to reduce significantly. HIV prevalence in Uganda is currently 6.4% (UHSBS 2004-05). Interventions like antiretroviral therapy are being scaled up and these life-long treatments will not reduce to follow fall in infection rate. Instead, scaling up of such labour-intensive interventions will continue to cause unproportionate pressure on health workers and act as push factors for attrition. It has been estimated that the scale up of antiretroviral therapy (ART) alone in Uganda between 2005 and 2012 would demand a doubling or tripling in staff time given to ART (Rudolf Chandler and Stephen Musau, 2005). To scale up anti-retroviral therapy alone to meet the PEPFAR target would require about 10% of Uganda's doctor workforce as at 2004 level (Smith O. 2004). But Uganda has moved the scale-up of ART even faster than originally planned while health workforce growth instead remains over conservative and affected by increasing attrition.

Weak starting point for planning

The HRH plan targets to have 98,000 health workers in the public and private sectors by 2020. One problem is that this projection is based on a baseline number of 59,680 health workers obtained from secondary analysis of the 2002 census data (Human Resource policy, April 2006). The figure includes persons with either a health occupation, or a non-health occupation, but working in the health sector. These included 2,929 medical doctors, 88 dentists, 150 pharmacists, 20,186 with nursing and midwifery occupations, 3,785 clinical allied health workers, 15,228 nursing aids / assistants, and 4,530 traditional practitioners / faith healers. The combined number of health workers in government and Private-Not-For-Profit facilities, were 30,000 in 2004 (HSSP II). In June 2005 there were about 9,500 health professionals working exclusively in the private sector, commonly called the private-for-profit (Andrea Mandelli, Lennie Bazira Kyomuhangi and Susan Scribner 2005). This means that excluding the 4,530 traditional / faith healers, Uganda had about 15,650 health workers practicing other trades. One finds it difficult to comprehend that there is all this big number of health workers outside there who are inaccessible. One group though that might be contributing to this number is the one not recognized by the professional regulatory bodies but are contributing significantly to scaling up of Global Initiatives, especially HIV/AIDS care. They work as complementary cadres mainly with civil society organisations but also in government facilities and projects and are known by various names in different organisations e.g. "HIV medics", "Community volunteers" etc.. Another group are the lots of untrained persons illegally running drug shops and clinics calling themselves nurses or nursing aids. The latter, better considered as "impostors" deserve to be removed from practice and would not form a baseline from which to plan. Having used a doubtful baseline, the

target of 98,000 can already be assumed to have a short fall of about 20,000 health workers even before the strategic plan becomes operational because it is likely that that number or something close to that is non-existent from the baseline.

Non-professional human resource for health

The HRH strategic plan recognises that by 2020 there will still be 11,617 "clinical support staff" besides 1,463 "other non-health semi-skilled" and 14, 182 other support staff. The clinical support staffs will still make a good 11.9% of the workforce then, down from the baseline of 15,228 (25.7%). These will include the nursing aids, nursing assistants, and complementary cadres mentioned earlier. While regulatory bodies are aware of the existence of this big pool of non-professional complementary cadres and their importance to especially the Global Initiatives in Uganda, their official position seems to be that they are unaware of these cadres and do not recognise their existences; yet they are recognized in the formal planning of the human resource strategic plan. The point is that if the plan recognizes both their existence and usefulness in the current and the foreseeable context it is better that they are made relevant to the evolving need through some form of standard and harmonized preparation. Government is aware that currently the various civil society organisations use various curricula for training these complementary staffs. A deliberate plan to harmonise these training efforts and curricula would benefit the country until their numbers are probably overtaken by real health professionals after 2020. That would offer opportunity for innovations to learn from. But the human resource strategic plan has no plan for such training.

Export agenda

The HRH strategic plan has also branded some of the health professionals with international nomenclatures. For example nurses or midwives having degrees will be called Professional Nurses or Midwives. Those hitherto known as Registered Nurses or Midwives will be known as Associate Professional Nurses or Midwives. But what is in a name? Does it matter if we call our nurses and midwives differently? Yes, it does. The Human Resource policy (MoH, April 2006) observes that "a more insidious effect of global market is that through professional lobbying and education, practice standards have become geared towards overseas requirements, rather than the needs of the presently underserved Ugandan residents". The renaming can be construed as part of the education standard geared towards overseas requirement rather than local needs. The policy and plan are thus marking Uganda's health professionals for easier identification by the global market. This is despite recognition by the policy document that "International recruitment practices are threatening to deplete Uganda of its scarce, highly skilled professional health cadres". But this contradiction is not surprising. Government recognises that "Ugandans abroad contribute considerably to the Ugandan economy". Signing of memorandums of understanding with receiving countries, proposed by the policy as one of the measures to mitigate effects of globalisation will most like promote the exportation of Uganda's health workforce. Government may use the proceeds to increase training capacity. But this will only ensure that Ugandans remain with new inexperienced health workers as the more experienced ones run abroad. The other policy measures include "training of locally relevant health workers as well as measures that will make local working conditions attractive". It is hard to see how the strategic plan will translate this into reality when

it is at the same time putting markers on the health workers and waving the more attractive bate to bring in income to the country while generally having a projected tight health sector budget. At the same time the false baseline workforce of 59,680 may lend confidence to the advocates of turning health workers into export commodity that after all the situation is not that bad and we can afford to let a few out expecting that they will not only remit hard currency back but also return with better skills. It is however common knowledge that the vast majority of technocrats or non-political "refugees" have failed to come back to Uganda hence causing permanent loss of capacity from the country.

Conclusion

In conclusion one wonders whether Uganda's Human Resource Strategic Plan is being strategic enough in:

- Having the adequately sized health workforce when the projection starts from a misleading baseline.
- Maintaining the appropriate skills for Ugandans when the plan increases their loss to the global market.
- Addressing population needs when it fits into a tight budgetary jacket despite clear expansion of that need that could cause necrosis of the squeezed population.
- Having a motivated workforce when we are likely to have an overworked health workforce due to scale up of labour intensive services over a conservative workforce volume depleted of experience.

Government needs to take a serious look at the plan sooner than later in the implementation period and reconsider the proposed position. Ways need to be worked out to cover the potholes in the projection and the export agenda. The Ministry of Finance, Planning and Economic Development needs to revisit its prioritization of the health sector and give it more budgetary space.

References

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