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Monitoring Report (2005-06)

EFFECTS OF GLOBAL INITIATIVES PROJECTS ON ROMAN CATHOLIC HOSPITALS IN UGANDA – 2005-2006

Uganda Catholic Medical Bureau
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Acknowledgement

Uganda Catholic Medical Bureau wishes to thank the management of the 20 hospitals that cooperated in returning the filled questionnaire. They have helped to initiate the understanding of what problems are being experienced by the RCC hospitals. These may be problems being experienced by other PNFP as well as government health facilities as well. The 20 hospitals were Virika, Naggalama, Matany, Angal, Nkokonjeru, Lwala, Villa Maria, Rubaga, Kitgum St. Joseph, Maracha, Kamuli Mission, Aber, Ibanda, Nyapea, Kilembe Mines, Kisubi, Nyenga, Kalongo, Nkozi, and Mutolere.

The bureau is also grateful to its internal staffs who coordinated the collection of the questionnaire and management of the data and information.

Acronyms

AIDS	Acquired immunodeficiency syndrome
ALOS	Average Length of Stay (*of patients on the ward*)
ART	Antiretroviral Therapy
ARV	Antiretroviral drugs
FBOs	Faith-based Organisations
GI	Global Initiatives
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
MDGs	Millennium Development Goals
NSF	National Strategic Framework
OVC	Orphans and Vulnerable Children
PEPFAR	President's (Bush) Emergency Fund for AIDS Relief
PHAs	Persons Having AIDS
PNFP	Private-not-for-profit
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PSS	Psychosocial Support
RCC	Roman Catholic Church
TB	Tuberculosis
UCMB	Uganda Catholic Medical Bureau
VHT	Village Health Teams
WHO	World Health Organisation

Abstract

Human resource is a global crisis that is greatly affecting provision of health services. The global initiatives to fight HIV/AIDS, TB and malaria often mean scaling up a number of services based on existing low levels of human resource. The effects of these global initiatives on the functioning of the health facilities need to be understood to avoid achieving targets in the short term while destroying the basis for longer service provision. UCMB undertook to do an initial overview look at the situation in the hospitals within its network. Only 20 of the 27 RCC hospitals reported on the global initiatives projects in their hospitals in 2005-06. The number of GI interventions per hospital ranged from 1-5 with a median of 4. There were 23 different intermediary funding organizations mentioned in total. The median number of intermediary organizations supporting GI projects per hospital was 3. The most commonly supported interventions reported were provision of ART, HIV counseling and testing, PMTCT, and TB control.

Problems of GI projects reported were mainly about their overwhelming demands on the few health workers, the pressure to satisfy varying targets, reporting formats and other conditions of the different funding agencies. The main reported effects included exhaustion and demotivation of health workers and less time spent to care for other cases especially out-patients and mothers in antenatal clinics. There were also additional costs incurred on administration, drugs, hiring additional staffs, and maintenance of infrastructure and vehicles.

There is need for continued follow-up with a revised tool to inquire more deeply into the nature and magnitude of these effects.

INTRODUCTION AND BACKGROUND

Globally there is renewed effort to fight HIV/AIDS, TB and Malaria. In Uganda government is working through a multisectoral approach and intersectoral partnership to implement various initiatives under this global initiative. The Roman Catholic Church is one of the main "faith-based organizations" working in partnership with Uganda government to provide health services including those related to the global initiatives to fight HIV/AIDS, TB and malaria. Coordinated by the Uganda Catholic Medical Bureau (UCMB), the network of Catholic health facilities comprise of 27 hospitals and 230 lower level health facilities (Health Centre II – IV). Most of these are rural. Of the estimated 30,000 strong already constrained workforce in Uganda, about 6,000 are within this network.[1] As of January 2006 there were 25 (now 26) Roman Catholic health facilities providing antiretroviral therapy of which 23 are hospitals and 3 are community-based non-governmental organizations. A number of facilities also implement many other projects related to HIV/AIDS control, malaria control projects and TB control with funds from the Global Fund, President Bush's Emergency Fund for AIDS Relief (PEPFAR) and other sources. In districts where training of village health teams (VHT) and the home-based management of fever have been introduced, the PNFP facilities participate in training, supervising and monitoring of the performance of the VHTs in addition to other outreach activities. Some of these interventions place a lot of pressure on human resources, space, equipments, transport etc. Moreover, following increased salaries for health workers in government service, attrition from the private-not-for-profit (PNFP) started going high well above physiological level especially for a few key cadres. While worried of the possible effects of attrition on the quality of services in the health facilities and especially hospitals, UCMB was

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[1] The Private-not-for-profit network comprising the Catholic, Protestant and Muslim health facilities together have had about 10,000 (about a third) of Uganda's health workforce by end of 2005.

worried that this could even be further accelerated by the pressure caused by scale up of activities related to HIV/AIDS, malaria and TB control under the various Global Initiatives funds. A simple study was therefore designed and carried out to get a "bird's eye" view of the possible effects of these interventions on the hospitals of the UCMB network.

Objective of the Study

To monitor and understand the possible effects of the Global Initiatives on the hospitals and be able to give advice to the management of the hospitals as well carry out appropriate advocacy to governments, donors and other stakeholders to address them.

Specific Objectives

i. Get a view of number of hospitals carrying out interventions as part of the global initiatives to fight AIDS, TB and Malaria.
ii. Find out the number of such project interventions being carried out by the hospitals.
iii. Get to know the number of donors or intermediary organizations who are working with or supporting the hospitals to carry out the projects.
iv. Find out if the hospitals find it easy to fulfill the performance targets set by those projects.
v. Find out what constraints, if any, the hospitals may be having as a result of such projects.
vi. Find out if there were already any felt or observed effects of such projects on other services and management of the hospitals.

Hypotheses

The working hypotheses were that:
i. Most hospitals, if not all, were failing to meet output and other performance targets as set in the conditions of the global initiatives projects the hospitals were implementing.
ii. The number of different donors or intermediary support agencies working with each hospital is too high thus causing stress over the hospitals in coping with different demands.
iii. Other routine services of the hospital were being compromised in quality and output because much more attention and effort were put to fulfill demands of the global initiatives projects.

METHODOLOGY

Study Sample

The study was carried out in 20 Roman Catholic Hospitals scattered in different parts of Uganda. The 20 were the ones who returned filled questionnaires out of the expected total of existing 27 RCC hospitals.

Study Tools

A simple tabular open-ended questionnaire was designed and submitted to be filled by the each of the 27 RCC hospitals' chief executive or administrator and return to Uganda Catholic Medical Bureau at the end of each quarter of 2005/06 financial year. All the questions were designed for qualitative answers.

Data and Information processing

Throughout the period of this study all the hospitals were electronically connected to UCMB and could complete and return questionnaires through electronic mails, which the 20 hospitals did.

Compilation and analysis of data were done using excel.

Some answers were coded into either "yes" or "no". Other long answers where grouped by their similarities and given one short code. Dissimilar answers were recorded individually but in their shortest possible forms. The answers were then entered into an excel spreadsheet and analysed. Any similar experience reported from same facility for two or more quarters was simply counted once. Any new experience from the same facility reported in subsequent quarters was added onto the list of previous of experiences. Similarly any funding agency mentioned by any hospital was counted once only for that hospital.

Limitations

By design this study was not meant to give detail quantifiable information. It therefore only opens room for possible deeper inquiries. The questionnaire did not have a written working definition of "Global Initiatives for HIV/AIDS, TB and Malaria". It was realized towards the end of the reporting period that some hospital managers equated it to the Global Fund to fight HIV/AIDS, TB and malaria. This seems to have affected reporting on other GI projects. It probably also affected reporting on such programmes that came in through the district health departments.

RESULTS / FINDINGS

Although there were 23 RCC hospitals providing antiretroviral therapy besides other HIV/AIDS interventions or GI projects, only 20 hospitals responded. Some hospitals being supported to provide ART, PMTCT, malaria control by the ministry of health through the district health departments did not realize these were part of the global initiatives to accelerate the fight against HIV/AIDS, TB and malaria. All the 20 admitted carrying out one or more of GI-related project activities.

Range of interventions

There was a wide range of interventions reported. The commonest were provision of antiretroviral therapy (ART) (18 hospitals), Prevention of Mother-to-child transmission (PMTCT) (15 hospitals, HIV counseling and testing (HCT) (18 hospital), malaria control (9 hospital), TB control (5 hospital) and Home care and support (7 hospitals). Others mentioned were "Youth-

friendly services" (although this could mean a combination of other services), palliative care, "basic care", orphans and vulnerable children (OVC) services, Psychosocial services (PSS), and "community support". It is however very likely that the frequency with which these services should have been mentioned were higher but that they were most likely not understood in the context of GIs by hospital managers. For similar reason other interventions could have missed being mentioned all together.

Organisations supporting the interventions

Twenty three different organizations were mentioned to be either directly or indirectly supporting the hospitals. The Uganda Catholic Secretariat's Global Initiatives Fund management unit, for example, only functions as a technical support unit and channel for soliciting and transmitting and coordinating grants (where possible) to the hospitals. It does not initiate projects in the hospitals. Its role is therefore indirect. The number of intermediary organizations working on or supporting GI projects in each hospital ranged from 1 to 5 with a median of 3.

Problems met in implementing, achieving agreed output and reporting targets

Ten hospitals (50%) reported that they found it relatively easy to achieve the set targets while the other 10 said they found it difficult.

The problems sighted as hindering achievement of set targets were:
  i.   Inadequate staffing (understaffing) both in total numbers and in numbers of qualified personnel.
 ii.   Lack of training in logistics management.
iii.   Extra workload hampering performance.
 iv.   Irregular supplies of antiretroviral drugs.
  v.   Logistical problems / shortages.
 vi.   Lack of fund to meet costs not provided for in the project.

However, even those who said they found it relatively easy to deliver on the agreed targets said they encountered some problems. These included:
  i.   Working under pressure to implement and absorb project funds within short periods despite having other hospital activities to perform.
 ii.   The different organizations supporting same hospital having different requirements.
iii.   Shortage of HIV testing kits.
 iv.   Delays in project funds.

Project reporting

All the ten (50%) who reported having had relative ease in achieving targets reported having had no problems with reporting. However of the other 10, 3 reported also having found it relatively easy to report thus making a total of 13 (65%) finding no problem with reporting. Five found problems with reporting and 2 did not state their experiences.

The problems sighted as making reporting not easy were:
  i.   Different organizations supporting same hospital sometimes demand reports on different formats even for same types of interventions.

ii.   In one instance it was reported the health management information officer found it difficult to write such technical reports alone, the higher managers having got overloaded with other work.

iii.   In one case new reporting format was introduced without the users getting retrained on using it (no capacity building for new challenge).

iv.   Inaccuracy of some data made work difficult for the person writing the report. Delays were caused by having to keep cross-checking data.

v.   One hospital complained of lack of budgetary provision to meet communication costs.

But even those who said they had no problem with reporting still did it with some difficulty, mentioning:

i.   Difficulty in getting some required information.

ii.   Having to report to too many different organizations.

iii.   Late communications in changes in reporting formats.

iv.   And also having to deal with inaccuracies in data.

Other problems variously sighted by the hospitals were:

i.   During trainings of staff to introduce new projects / interventions only skeletal staffs were left to provide services in the hospital.

ii.   Staff demotivation due to overwork, exhaustion and not being able to use otherwise free times for their own family or personal activities.

iii.   Concern was expressed on some projects not providing additional staffs, hinging all the new initiatives on existing already constrained staffs.

iv.   Overuse of existing infrastructure including vehicles

v.   Increased wage bills due to staff recruitments forced by increased workload due to the new projects.

vi.   One hospital reported that ART and PMTCT alone had taken away 17 of its staffs on full-time basis thus draining other departments of workforce.

vii.   Congestion of space as most projects did not provide for expansion of infrastructures.

viii.   Other unplanned costs met by the hospitals e.g. drugs (e.g. increased consumption cotrimoxazole not provided by the projects, and other drugs due to crowding-in of other diseases due to the HIV/AIDS clinic), administrative costs, maintenance of vehicles.

ix.   Anxiety among PHAs on antiretroviral therapy created by moments of shortages of ARVs.

x.   Delay in disbursement of project funds in some cases.

xi.   Some also saw no strategies in place for integrating the projects into routine functioning of the hospitals and were worried about sustainability of the interventions.

Coping Mechanisms

In order to cope with or overcome the effects of the increased demands and other problems affecting implementation of and reporting on the projects hospital managers and staff tried various mechanisms that included:

i.   Staffs working extra hours which in some cases meant giving up days they were meant to be off-duty to rest.

ii.   In some cases administrative staffs increased delegation to free them from participating in the project activities. While delegation is a normal management strategy, the fact that it was sighted could mean it went beyond what was recognized as normal by the hospital management.

iii.   One hospital trained the secretary to do most of the reporting under supervision of the medical superintendent.
iv.   Some hospitals hired additional staffs to manage data.
v.   Two hospitals reported having recruited additional staffs specifically to help cope with the load of work.
vi.   Meanwhile one hospital created committees to follow-up different project activities in order to give some time to the management to do other work. The effectiveness of this committee could not be assessed through the questionnaire.

Effects of the GI Projects on other services

Arising from the various problems and pressures mentioned earlier leading to staffs spending more efforts to achieve set project targets and reporting deadlines, staff exhaustion and demotivation etc. 10 hospitals (50%) admitted having noted some negative effects on other services of the hospital. Four clearly stated they had not noted such effects while 6 gave no comments. The effects reported were that patients, particularly in the out-patient departments and antenatal clinics, tended to have less staff-time available for them. Consequently it was felt that patients waiting time had increased. Hospitals also reported staffs having less time for routine / core activities. The questionnaire was not designed to capture the length of such waiting time and other objective measures of possible changes in quality of services e.g. cure / mortality rates, average length of stay on wards, patient's satisfaction level etc.

Perceived "Positive" effects of the projects on other services

Although this was not asked in the questionnaire, one hospital mentioned that the AIDS clinic had also had an increase in overall utilization of the out-patient services. Although this hospital could have seen this as a positive development, it is likely that this was as a result of the "crowding –in" effect. This is due to AIDS patients coming for ART and other services in the clinic but also turning up with ailments that could have been treated in lower level health facilities. Such a hospital thus becomes a centre of self-referral for minor conditions (secondary) of patients whose primary conditions deserved referral (AIDS).

DISCUSSION and CONCLUSION

For a health facility to provide services effectively it needs to operate as a system i.e. coordination of activities, the allocation of infrastructures, human resources, finances, must ensure that different parts of the facility are able to effectively provide services that support each other and link up to the totality of the desired care for all patients. The management, accountability, monitoring and reporting processes must all link up. Account must be taken of the fact that when one disease condition crowds-in it does not remove the burden of the other diseases and those too must continue to get adequate attention and that the same management machinery and space are needed for all the diseases.

While this quarterly monitoring / study was purely qualitative, it has given insight into many issues that can and should now be followed up more definitively to establish their magnitudes, thus giving a measure of the cracks that may be appearing in the systems of the hospitals. RCC

Hospitals are indeed facing problems due at least partly to the implementation of global initiatives projects to fight HIV/AIDS, TB and Malaria.

The majority of the problems reported revolved around the issues of human resource for health. Staffs have to provide more of their time and energy to the GI projects than to other services of the hospital. They are getting exhausted. Although demotivation of staffs was reported by some hospitals, it was not possible to establish from this study whether the continued extra working hours dedicated to these GI projects were due to mandatory compliance or due to some extra pay in form of allowances by the projects. Other problems were relates to congestion and "wear and tear" of infrastructures and vehicles, unplanned expenditures.

Human resource crisis is global and took centre stage in the 2006 world health report launched in April 2006 (WHO 2006). There is increased effort to fight HIV/AIDS, TB and Malaria globally. Halting and reversal of trends of these diseases is part of the Millennium Development Goals. In developing countries, however, most of these are done using existing human and infrastructural resources. WHO estimates that the minimum level of health workforce density required to achieve the MDGs, is 2.5 health workers per 1000 people[2]. Uganda is reported to have only 0.08 physicians per 1000 people, 0.61 nurses/1000, 0.12 midwives/1000 and 0.01 pharmacists/1000 people.[3] Health workers are a particularly constrained resource globally, reaching crisis levels in some countries. As Guy Kegels and Bruno (2005) observe, all the HIV/AIDS care and the "crowding-in" effects in absence of commensurate increase in capacity all inevitably translate into an increased workload for staff. Quoting Shisana et al 2003 they report that 73% of health workers surveyed in a South African study reported that their workload had increased and for one third of these the workload had increased by 75%. Although Uganda is yet grouped among those sub-Saharan countries with "stable" chronic health workforce problems (Guy Kegels and Bruno Marchal 2005), at micro levels there is a worsening that leads to reduced coverage and health service performance, also in areas previously well-served. In fact Uganda is among the 57 countries in the world with "critical shortage" of health workforce (WHO 2006). The micro level crisis situation is true of the network of RCC hospitals and other PNFPs because of the increased attritions. In 2005/06 although total attrition rate was more like for the preceding year (16%), attrition of key staffs like medical officers, clinical officers, midwives short up significantly, for example - clinical officers (32%), Enrolled Nurses (25%), Registered Midwives (28%), Enrolled Midwives (28%) and Registered Nurses (13%).[4] The picture was even worst at regional levels with the RCC

Trend of attrition rates for key cadres of health workers in the RCC hospitalsin Uganda (2005/06)

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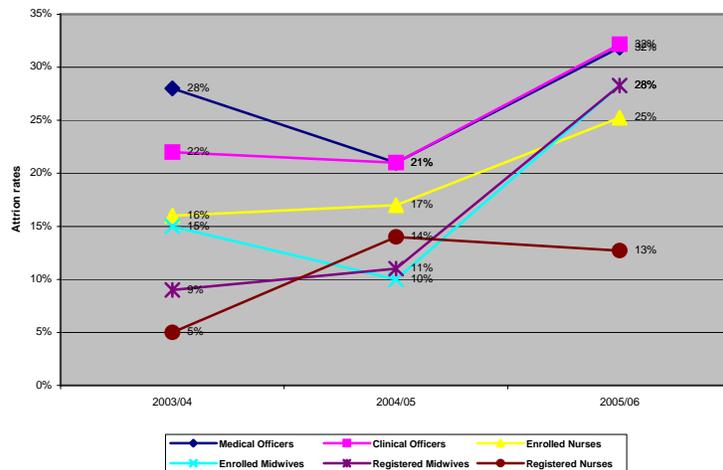
2 Keynote Address Delivered by Dr. Olusegun A. Babaniyi, WHO Representative to Ethiopia on the occasion of the 2006 World Health Day Celebration at the Conference Hall of the Federal Ministry of Health of Ethiopia

3 World Health Report 2006

[4] From attrition data available at UCMB

hospitals in northern region registering the biggest attrition in the year e.g. 72% for medical officers, 67% for Registered Nurses, 20% for Enrolled midwives and 81% for Clinical Officers.

In spite of all these human resource problems HIV/AIDS, malaria, and TB control activities are getting scaled up. In the effort to scale up access to antiretroviral therapy, for example, and aware of the constraints faced particularly by poor countries in terms of human resources, it is recommended that treatment procedures and the monitoring of clients are simplified so that lower cadres of health workers can be trained to carry out some of the simpler functions hitherto carried out by physicians and community mobilized to assist in monitoring clients to improve adherence (WHO 2003), an approach called "A public health approach to ARV therapy" for which Uganda is credited among others. But apart from medical officers, attrition of these key lower cadres was high as seen earlier.

The "Revised National Strategic Framework (NSF) for HIV/AIDS Activities in Uganda 2003/04 – 2005/06" (UAC, February 2004) recognizes that "Institutional capacity and existing structures and expertise of NGOs and FBOs are generally weak, yet these are vital actors in the fight against HIV/AIDS". The concern about numerous funding mechanisms is also expressed in the NSF. This report shows a median number of intermediary donor agencies working with the hospitals being 3, confirming the concern expressed in the NSF. They have expressed problems of differing demands, targets, reporting formats, among others, that have come with these numbers.

While it remains to be established more concretely, it begins to emerge from the report that most of the donors and government are supporting hospitals to scale up activities without "scaling up" or bolstering the systems or "the central nervous systems" of the institutions. This study did not explicitly solicit information about possible existence of parallel human resource management, parallel financial and reporting channels, parallel data and information management and reporting channels though may be done by same people. Sooner or later the effects of less staff time in outpatients departments and wards may be observed on the quality of care if not observed already. This study also did not explicitly solicit for such information.

A separate but concurrent study of 7 RCC hospitals (UCMB 2006) showed that while there appears not to have been visible deterioration of quality of services or drop in non-clinical services as a result of staff attrition, there was steady prolongation of median value of average length of hospital stay of in-patients. In most cases recruitments of staffs took place in attempt to cover for the attrition (30% of recruits were new from training schools). Although the staff attrition – recruitment interval periods could have affected staff availability to patients, it is likely that these pressures from GI initiatives activities that divert apparently more staff time away from routine hospital activities could have also themselves had effects on prolonging patients average length of hospital stay (ALOS).

RECOMMENDATIONS

i.   RCC hospitals already providing interventions aimed at scaling up access to HIV/AIDS care / treatment and prevention, and the prevention and control of TB and malaria need to be cautious in attempting to further scale up these services especially due to their low health workforce strengths. Those who have not started need to be even more cautious in attempting to start.

ii.   Hospitals should learn from these experiences and clearly discuss them with any donor wishing to support them in starting or scaling up GI projects. Support to and maintaining

of an integrated system of the hospital should form a forefront agenda. It is advised that support to human resource in terms of salaries in an integrated system of work and payment and issuance of other routine or core functions of the hospital must be an early commitment before starting of such projects.

iii. The temptation to work with more and more donors with varying interests with the probable hope of getting more resources needs restraint. Hospitals are encouraged to solicit compliance of funding agencies with uniform systems. One donor supporting more related interventions is better than more donors supporting same type of intervention or different but related intervention in the same hospital. Harmonisation of data collection tools and information management systems in general in the hospitals is important.

iv. The Uganda Catholic Medical Bureau needs to continue this monitoring exercise but should use a revised tool to enable deeper inquiry and better understand of the nature and magnitude of the reported problems.

References:

1. Guy Kegels and Bruno Marchal; AIDS and the Health Workforce in Africa: making sense, Medicus Mundi International 2005 (*Department of Public Health, Institute of Tropical Medicine, Antwerp)*
2. WHO; A public health approach to antiretroviral treatment: Overcoming constraints, WHO 2003 (ISBN 92 4 159085 8)
3. UAC; The Revised National Strategic Framework (NSF) for HIV/AIDS Activities in Uganda 2003/04 – 2005/06 (UAC, February 2004)
4. WHO; Working together for health, World health Report 2006, WHO 2006 (ISBN 92 4 156317 6)

Annex 1

UCMB Questionnaire to monitor and evaluate the effects of Global Initiative Projects on Hospital Services

Name of the Hospital			
Name and position of reporting officer			
Date:			
Reporting Deadline:			
Nr	Question	Reply	Observation / Remark
1	Are you implementing projects funded by PEPFAR, Global Fund or any other Global Initiative?		
2	If yes, please list these		
3	Through which intermediary organization(s) did you obtain the funding? (If you are implementing more that one project indicate the organization for each project) NB: By intermediary we mean organization from which you actually received money and to whom you account (even if the money might actually have come from PEPFAR, GF etc)		
4	Did you find it reasonably easy to achieve the targets set for the reporting period just concluded? If not, list the main problems:		
5	Did you find it reasonably easy to meet the reporting guidelines for the period just concluded?		

	If not, list the main problems encountered:		
6	Did the reporting requirements cause additional administration work? If so how did you cope with the extra work?		
7	Did you experience any other problems related to these projects? If so please list examples of these problems encountered:		
8.	Were there other services of the hospital affected by the projects? If so, list examples		