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Rural Staffing in the Health Sector: Attraction and Retention Options For Uganda

Authors: *Esther Namugoji*[1]

Author Affiliation
1 Department of Research Services - Parliament of Uganda

1.0 INTRODUCTION

Uganda is committed to universal health coverage and promoting the wellbeing for all its citizens at all ages, as per Goal 3 of the UN Sustainable Development Goals. This commitment includes the challenge to end the epidemics of HIV/AIDS, malaria, tuberculosis and non-communicable diseases.

According to the 2016 Uganda Demographic and Health Survey (UDHS), the country's maternal, infant and child mortality rates remain among the highest globally. Maternal mortality is at 336 deaths for every 100,000 live births, while infant mortality is at 43 deaths per 1,000 live births[1]. Although the UDHS also shows that more women are giving birth in health facilities and receiving antenatal and postnatal care, rural areas still lag behind urban areas on all these indicators.

Malaria prevalence in Uganda in 2016 was at 30%, and the burden was worse in rural areas. The UDHS also shows that children in rural areas were almost three times more likely to test positive for malaria than those in urban areas, with the highest incidence in Karamoja.

These kinds of inequalities reflect the inadequate healthcare provided to rural populations. In order to tackle these challenges, Uganda needs more health workers. However, there have been difficulties attracting and retaining key health workers, especially in rural and hard-to-reach areas[2].Regardless of several interventions over the years, the rural health workforce shortage persists[3].

World Health Organization's Joint Learning Initiative, a consortium of 100 health professionals from around the world, noted that where there is a higher density of staff for every 1,000 people, the rates of mortality and other indicators of poor health go down[4]. Uganda therefore needs to improve on the number of health workers in rural areas to better serve the healthcare needs of the rural populations.

1.1 Objective of the study

This policy paper analyses the effectiveness of the government of Uganda's interventions in trying to attract and retain health workers in rural and hard-to-reach areas. The paper explores how these and other strategies can better serve the purpose of increasing the number of rural health workers.

1.2 Statement of the problem

The shortage of health workers in rural areas is a setback to universal health coverage goals. The majority of the population lives in rural areas, meaning that their health needs are not adequately met. This shortage also leads to overworked and demoralised staff in rural facilities. A 2015 report indicates that the health workers in lower level health centres find themselves overworked, task shifting and multitasking[5] due to staff shortages.

1 Uganda Bureau of Statistics (2017), Uganda Demographic and Health Survey 2016: Key Indicators Report, UBOS, Kampala, Uganda, P21

2 The Minister of Public Service told Parliament on 30th January 2018 that currently 88 sub counties and town councils in 21 districts qualify as hard-to-reach/hard-to stay areas. The criteria for hardship include lack of transport facilities, accommodation and social amenities; insecurity and hostility of locals.

3 World Health Organization, Africa health Workforce Observatory, Human Resources for Health, Country Profile – Uganda, October 2009

4 Human Resources for Health: Overcoming the Crisis, Joint Learning Initiative, 2004, Global Equity Initiative, Havard University.

Available at http://www.who.int/hrh/documents/JLi_hrh_report.pdf

5 Grace Namaganda, Evard Maniple, Vincent Oketcho, Claire Viadro, 'Making the transition to workload-based staffing: Using

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Eventually neglected patients migrate to risky alternative care options, such as traditional birth attendants, faith healers and traditional medicine men.

2.0 SITUATION ANALYSIS

The difficulty to attract and retain rural health workers in Uganda manifests in the following ways:

2.1 General shortage of health workers in Uganda

Out of 118 health facilities assessed by the Auditor General in December 2017, 98 (83%) were experiencing a high rate of understaffing6. The ideal health workforce density is 23 health workers for every 10,000 population, based on the World Health Report 2006 recommendation[7]. In 2017/18 Uganda had only [4] health workers per 10,000 population[8]. According to the 2015 Human Resources for Health Audit Report[9] Uganda needed 81,000 nurses, midwives and doctors.

2.1.1 Challenges in rural areas

Efforts to recruit more health workers have not led to sufficient increase in the number of health workers in rural and hard-to-reach areas. Intra Health's Uganda Capacity Programme noted how collaborative innovations in recruitment practices had led to new applicants for health service positions, but districts had difficulty filling positions for qualified midwives, anaesthetic assistants and officers, public health nurses, ophthalmic clinical officers, senior medical officers, and cold chain assistants[10].Many medical doctors in training are biased against working in rural areas. A 2009 survey of medical students revealed that 50% were unwilling to work in rural areas, and the rest were split between those who would be willing and the undecided. The dominant perception was that there are no physical facilities, good communication and other services[11].

The workforce in health centres rose to 71% of the staffing needs by 2017, according to the Annual Health Sector Performance Report 2017/18[12], but the report also shows that distribution remains biased in favour of urban areas, leaving rural populations underserved.

2.2 Demand-supply inequalities

A general increase in Uganda's population and a high fertility rate (an average of 5.4 births per woman[13]), means there is greater demand for health services, especially for maternal and child healthcare. There is also increased demand for health workers to service new programmes, such as Prevention of Mother to Child Transmission of HIV, Safe Male Circumcision and HIV counselling.

2.3 Performance management and absenteeism

Absenteeism in government health facilities is worse in rural and hard-to-reach areas where supervision tends to be limited. Many of those deployed to rural facilities, may not report for duty. Reports by the State House Health Monitoring Unit[14] revealed that many health facilities from HC IV to HC II level do not open 24 hours as the Ministry of Health guidelines require. Many opened after 10am, closed before sunset, and stayed closed on weekends. Some facilities were open, but more than half of the staff absent, reportedly on official duty elsewhere or on training. Some officers in charge of facilities would be absent for months, so others also absconded, in addition to failed supervision of staff, equipment and drugs at the facilities.

In extreme cases, there have been media reports of security guards, cashiers, porters and relatives of health workers treating patients. The State House Health Monitoring Unit also found similar practices during spot checks in health centres around the country.

2.4 Rural-urban deployment disparities

Health worker distribution patterns show that almost 70% of Uganda's health workers are working in urban areas[15], yet the majority of Ugandans (75%) live in rural areas[16]. In the midwifery profession, while Kampala had filled its positions for midwives by 2015, areas such as Karamoja, Bukedi, West Nile and Teso continue to suffer staffing gaps of over 50%[17].

the Workload Indicators of Staffing Need method in Uganda', International Journal of Public Health Research, Published online August 30, 2015, 254-263

6 Annual Report of the Auditor General on the Results of Audits for the Year 2017, December 2017, p90

7 World Health Organization, Africa Health Workforce Observatory, supra

8 Ministry of Health Annual Health Sector Performance Report, 20176/18, p39

9 Ministry of Health Human Resources for Health Audit Report 2015

10 A Surge of New Recruits for Uganda's Health Workforce, Intra Health, May 15, 2013. Available at https://www.intrahealth.org/news/a-surge-of-new-recruits-for-ugandas-health-workforce

11 Wandiraa Geoffrey and Evard Maniple, 'Do Ugandan Medical Students Intend to Work in Rural Health Facilities after Training?' Health Policy and Development 7, no. 3 (2009), pp203-214.

12 Ministry of Health, Annual Health Sector Performance Report 2017/2018

13 UBOS, 2018

14 See, for example the State House Health Monitoring Unit Annual Report 2013/2014

15 World Health Organization Africa Health Workforce Observatory: Human Resources for Health, Country Profile Template. 2012. Geneva: WHO.

16 Uganda Bureau of Statistics, National Population and Housing Census (2014), Kampala, Uganda.

17 Midwifery Services In Uganda, UNFPA Issue Brief 02, April 2017

In addition, recruitment and management of health workers in lower health facilities by the district local governments, in line with decentralisation has affected the quality and numbers of health workers in rural settings. For instance, in 2004, Anokbonggo et al[18], found experiences of political harassment of civil servants, increased nepotism, poor availability and management of financial resources. A 2011 study in four districts in Eastern Uganda found widespread political interference and nepotism in district health sector management[19].

Many applicants for the jobs in lower health units located in rural areas are indigenous to the districts, yet rural districts may lack the trained and qualified health personnel required to fill the vacancies.

2.5 Ban on recruitment

In 2017, government resolved not to recruit new doctors, while the budget for financial year 2018/2019, did not plan for new recruitment into the public service, citing financial challenges.

For years, the employment of trained Comprehensive nurses into government service remained in balance, with confusion about whether they were adequately trained. Most comprehensive nurses took their skills into other sectors, while others remained unemployed. The IntraHealth Uganda Capacity Programme noted that many applications for advertised healthcare jobs were received from comprehensive nurses for positions of midwives, but this category of nurse was limited from crossing into midwife practice[20].

Competing market dynamics

The central and local governments have to compete for the services of Uganda's medical workers with non-governmental organisations, private healthcare providers and other countries. Where other employers offer better pay, emoluments, opportunities and less stressful work environment, many health workers find that working for the public service or the districts less attractive.

3.0 PAST INTERVENTIONS TO SOLVE THE PROBLEM

Over the years, the government of Uganda, through the Ministry of Health and with support from development partners, devised several strategies and policies for health worker attraction and retention in rural areas. Uganda Human Resource Strategic Plan 2005–2020set out goals and strategies for the purpose of achieving key healthcare successes. This birthed the Uganda Human Resources for Health Policy 2006 which focused on planning for the number and composition of the health workforce; distribution characteristics; staff dynamics and attrition; education and training; management issues, among other issues of concern to enable Uganda reach global standards. Table 1 shows some interventions over the years:

18 Anokbonggo WW, Ogwal-Okeng JW, Ross-Degnan D, Aupont O.,'Attitudes and perceptions of stakeholders on decentralization of health services in Uganda: the case of Lira and Apac districts', East Africa Medical Journal, February 2004

19 George William Lutwama, 'The Performance of Health Workers in Decentralised Services in Uganda', University of South Africa, June 2011

20 A Surge of New Recruits for Uganda's Health Workforce, IntraHealth, supra

Table 1 Government interventions to solve health workforce shortage

Intervention	Results	Challenges/opportunities
3.1 Surge in recruitment Government needed to recruit more health workers to address the general shortages. In 2012, government set out to recruit more staff for health centre IIIs and IVs. Under the Health Sector Development Plan 2015/16-2019/20, government planned to raise staffing to 80% by 2019/20, by increments of 5% annually[21].	Between 2009-2016 there was an overall increase in health staff from 53% to 71%. By 2015, Health Centre IVs and IIIs achieved 71% and 70% staffing respectively[22]. **Figure 1** shows the growth in health worker numbers since 2013.	Some vacancies for the lower level health centres were not filled. Health Centre IIs, only achieved 41% staffing by 2015[23]. Data used to inform recruitment and deployment may be based on health facility staffing needs, rather than the growing population need and staff workload. A Workload Indicator Survey tool could reveal differences between government staffing norms and actual staffing need[24]. When computing staffing, non-medical workers, such as security guards recruited to work in health facilities are also included on the staffing numbers.
3.2 Wage adjustments Government has progressively improved health worker salaries, but within limits. Since 2004, staff working in hard-to-reach areas got a better pay in order to attract and retain them in those areas. In 2018, the government agreed to modestly enhance the pay of medical workers[25].		Emerging challenges include the obvious salary disparities that arise. Other public servants start to demand higher pay, which contributes to government's fears of radical increases to medical workers' pay. Supervisors, for example, might demand greater pay because of hierarchical position above them.
3.3 Incentives for rural staff A variety of incentive packages for workers in rural areas. For example, in 2010 a hardship allowance was granted for all public servants. In October 2012 government doubled the pay for doctors working in health centres IV. Government planned for accommodation near health facilities, especially in areas considered hard-to reach and hard-to-stay. For example, in the 2015/2016 budget provided for construction of 69 housing units at Health Centre IIIs in seven districts of Karamoja).	The availability of safe and appropriate housing for health workers in rural areas greatly contributes to their willingness to stay and work there.	Some workers are wary of living so close to the health facilities, because they are easily called to the workstation during odd hours, even on their designated days off. This increases their workload.

21 Ministry of Health, Health Sector Development Plan 2015/16-2019/20

22 Ministry of Health Annual Health Sector Performance Report 2015

23 Ibid. However, this could be linked to plans to phase out Health Centre IIs

24 See, for example, findings in Grace Namaganda, Evard Maniple Bakaitwoha, Vincent Oketcho, Claire Viadro, 'Making the transition to workload-based staffing: using the Workload Indicators of Staffing Need method in Uganda, BioMed Central, 2015

25 Ministry of Public Service Circular Standing Instruction No.5 of 2018, Salary Structure for Financial Year 2018/19

3.3.1 Training of staff for rural areas and bonding schemes Initiatives to train health workers for rural areas have taken place. The World Bank and other partners set out to build capacity of rural health workers and motivate them to stay. MOH, Uganda Private Midwives Association and United Nations Population Fund (UNFPA), with Swedish government support, collaborated to promote the training, retention and motivation of midwives working in hard-to-reach areas. This intervention included a scheme bonding the trained staff to work in the selected rural areas for a time.	The UNFPA programme supported over 18 midwifery schools. Between 2010 and 2017, 510 midwives had been trained, of which 336 (66%) had completed training and qualified. Of these, 247 (74%) had been bonded to various health facilities in underserved communities across the country[26]. Government of Uganda recently decided to budget for training sponsorships for health workers to upgrade their qualifications. Priority is to those who work in rural/hard-to reach areas.	It is key to follow through to ensure that the trained staff will be deployed in the underserved areas. Coordination and tracking will need to be improved.
3.4 Contract staff and supplement NGO staff Health workforce numbers were supplemented with the recruitment of contract staff to cover specific gaps.	Indirect contract staff boosted the workforce through donor projects such as PEPFAR and Global Fund For Malaria, HIV/AIDS and Tuberculosis at health centre level.	In 2016, government announced plans to phase out a huge number of contract staff[27]. Their expertise was lost to the health service. When the projects close, most contract staff working in the facilities also leave. Given that government's lower pay is not attractive enough, few would respond to advertisements for jobs.

So far, there has been a general increase of staffing for health facilities, as Figure 1 shows.

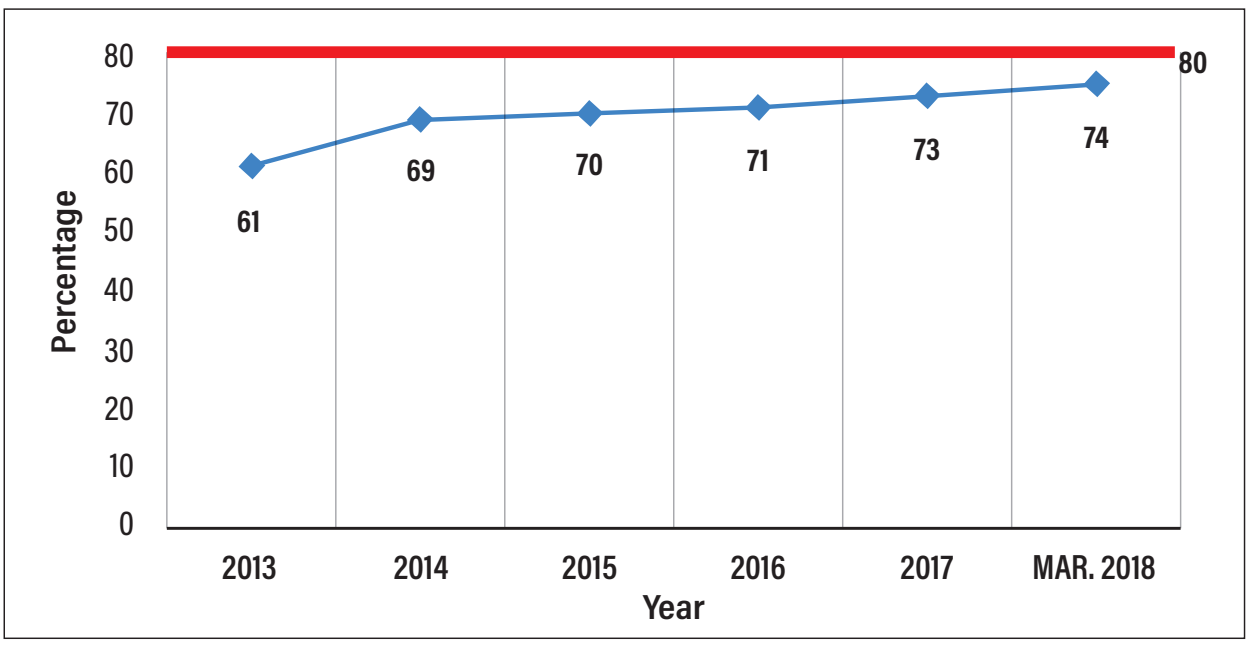

Figure 1: Staffing level trends as at 30th March 2018

Source: *Strengthening Human Resources for Health Monitoring and Evaluation Report, April 2018*

26 Umar Weswala, 'Uganda needs more midwives', May 5, 2017. Available at https://uganda.unfpa.org/en/news/uganda-needs-more-midwives

27 Emmanuel Ainebyoona, 'Health Ministry drops 200 workers', The Monitor Newspaper, Sunday August 7, 2016. Available at https://www.monitor.co.ug/News/National/Health-ministry-drops-200-contract-workers/688334-3334110-g2786y/index.html

However, outstanding obstacles remain. Table 2 shows an example of recruitment/retention challenges in hard-to-reach areas (Kotido District in 2007/2008, even with incentives of 30% at the time.

Table 2: Kotido District recruitment for health services in 2007/2008

Sector jobs advertised	Applications received (all were interviewed and offered jobs)	Accepted the job	Professional medical workers	Administrative / support staff
118	41	36	6	30

***Source**: Sandra Kiapi, Right to Health: Challenges in funding health systems and universal access in development polities, (paper presented in Madrid, June 2010). Action Group for Health, Human Rights and HIV/AIDS*

4.0 WHAT WORKS, WHAT CAN BE IMPROVED?

The goal of any interventions is to improve rural health worker density, more so for maternal and child healthcare services which are on high demand. Through guidelines developed with the input of contributors from around the world[28], the World Health Organisation came up with four categories of actions that could be taken to improve attraction, recruitment and retention of health workers in rural areas. The four categories are: education, regulatory, financial incentives, personal and professional support. Improving retention of health workers in rural areas will likely involve a mix of actions, based on the strategies discussed below.

4.1 Financial and non financial incentives

The effectiveness of incentives has not been well documented, but monitoring and evaluation could be improved to better assess the effectiveness. Many findings show that financial incentives encourage retention of staff, while additional non financial incentives play a great role in keeping staff motivated, leading to willingness to continue working even in difficult conditions.

Motivation needs to include financial and non-financial incentives, including continued hard to reach allowance, adequate and regular salaries in line with promotion levels; facilitation, access to good schools for health workers' children and recognition for their heroic roles are also important.

A study done in three districts of eastern Uganda in 2017 shows that continuous encouragement and recognition for dedicated and exemplary service has positive effect on health worker motivation. The study recommends that "District health leaders and managers can identify and implement appropriate and affordable incentive schemes for health workers in order to improve productivity and the quality of services"[29].

4.2 Targeted grants to functionalise rural facilities for key services

Uganda chose to roll out a 'Minimum National Health Care Package 'to deliver cost-effective services with maximum impact to its population. A focus on maternal health and family planning was envisioned to have great impact. Aligning rural health staffing strategy with this goal could channel funds towards maternal and child healthcare services in rural settings.

The UNFPA states that midwives working in a functional health system can avert about 87% of all maternal and newborn deaths[30]. Functionalisation of lower health centres improves the work environment for health workers and their morale goes up. A 2012 study revealed that work environment and facility-level strategies meant as much to prospective health workers as financial incentives[31]. Another study shows that health workers consider the availability of reliable equipment and well-stocked pharmaceuticals as most important for prospective places they would work in[32]. Availability of medicines, equipment and sundries at facilities is part of the core responsibility of the government and would make health workers deliver better on their mandate. Basics like electricity (for some, solar kits could be provided), running safe water (provision of water harvesting and storage tanks might help), equipment in laboratories and theatres should be available. There is also a need to protect available equipment through regular maintenance schedules.

28 World Health Organization, 'Global policy recommendations: Increasing access to health workers in remote and rural areas through improved retention'. WHO, Geneva, 2010. Available at: http://www.who.int/hrh/retention/guidelines/en/

29 Health Workers Recognition as a tool for Increasing Motivation, February 2016, issue brief No 6. MANIFEST. Available at: https://www.mnh.musph.ac.ug/wp-content/uploads/2016/10/6-Motivating-Health-Workers-Through-Recognition_MANIFEST-Study.pdf

30 Midwifery Services in Uganda, supra

31 Peter C Rockers, Wanda Jaskiewicz, Laura Wurts, Margaret E Kruk, George S Mgomella, Francis Ntalazi, Kate Tulenko, Preferences for working in rural clinics among trainee health professionals in Uganda: a discrete choice experiment, BMC Health Services Research, 2012. Available at https://www.springermedizin.de/preferences-for-working-in-rural-clinics-among-trainee-health-pr/9529844

32 Peter Rockers, Wanda Jaskiewicz, Laura Wurts, George Mgomella, Determining Priority Retention Packages to Attract and Retain Health Workers in Rural and Remote Areas in Uganda, February 2011. Available at https://www.capacityplus.org/files/resources/Determining_Priority_Retention_Packages.pdf

4.3 Stronger management of staff working in rural facilities

Central government and district local governments need to address the system challenges in the recruitment and deployment of health workers. There is need to implement measures to monitor and regulate the staff deployed to rural areas. Because health workers are such a critical force in the delivery of health services, a hard stance and coercive measures against them can have a backfiring effect. Deploying newly recruited medical graduates in rural/hard to reach areas for a few years, after which they can access promotional and study opportunities, may be a positive approach that can motivate staff to stay in rural health facilities.

Certain standards that are normal in regular public service need to become the norm for health workers to avoid them feeling overworked. Sengooba and Kiwanuka (2015)[33] suggest exploring a work shift system (eight-hour shifts), which allows certain staff to be officially off duty, while others are at the station, hence the health facilities can remain operational full time.

On decentralised recruitment and management, local governments can be engaged to plan better for rural health staffing. They can focus on the needed workforce for the rural health centres. Closer partnership with policy makers on what is being done would help track and address shortages as they occur. Through ministry-led coordination, networking and benchmarking, districts could learn from other local governments on how they addressed their staffing challenges.

There is a constant need to study distribution patterns of existing workforce and strategise on whether a more equitable redistribution can be done to place more key staff needed in rural settings. For instance, in 2016, some districts had reportedly achieved 100% staffing (for example Maracha had achieved 107% health staffing), while others (for example Amudat with only 29% staffing) still had over 50% vacancies[34].

4.4 Targeted training/scholarships

Since training on a private basis is expensive, the government (together with development partners, if need be) should prioritise training and in some cases, grant scholarships for further education to promising staff. This resolves some of the issues of career stagnation and inadequate skills, but also can be employed in staff bonding schemes to retain key workforce in rural areas. The government can consider granting these scholarships to accredited institutions located upcountry and promote the taking of internships and vacancies in the health centres within those regions. The WHO guideline on education suggests focusing on students and training schools in non-urban areas, as those students are more likely to stay and work there after training.

4.5 Focus on lower cadre health workers

Future recruitment drives for rural facilities should focus on the lower cadre staff who are less likely to resist being deployed in rural settings. This could mean increasing the number of nurses, laboratory technologists and midwives to be present at rural health centres. Midwives handle most of the complicated cases that come to the facilities, that is maternal and neo-natal issues.

Attracting and retaining doctors, pharmacists and other 'higher cadre' health professionals into rural settings has been difficult, as they are fewer in number and they tend to prefer living and working in urban centres. Incentives and other perks have not had great success with this set of health workers. They are also prone to migrating to better-paying labour markets outside Uganda. Focusing on the bigger number of lower cadre staff who are also more willing to live and work in rural areas will obtain more success.

Government can utilise the comprehensive nurses trained since 1993, who were meant to provide basic promotive, preventive, curative and rehabilitative health care at lower level health centres, but were not easily absorbed into the health service. Notably, the 2017 Scheme of Service for Nursing and Midwifery cadres[35]finally integrated qualified comprehensive nursing graduates into the service, as enrolled nurses and assistant nursing officers, to be deployed as general nurses. This can reduce staff shortages in lower health centres located in mostly rural areas.

Another potential solution may be to focus on allied health workers who can deliver the basic services needed at rural facilities, as a complement to the work of doctors, midwives and nurses.

4.6 Strengthen public-private partnerships in rural areas

Small clinics and drug shops tend to give first line of care for common conditions across the country. There are also private-not-for-profit health units which offer services on humanitarian grounds in underserved areas where government will take a long time to penetrate. These contribute to the general health of the population,

33 Ssengooba Freddie and Suzanne N. Kiwanuka, Health Workforce Developments: Challenges and Opportunities to Secure Universal Health Coverage in Uganda, in Universal Health Coverage in Uganda: Looking Back and Forward to Speed Up the Progress, edited by Freddie Ssengooba, Suzanne N. Kiwanuka, Elizeus Rutebemberwa and Elizabeth Ekirapa-Kiracho, Makerere University School of Public Health, 2018, Kampala. p245-270

34 Ministry of Health, Annual Health Sector Performance Report 2016/2017

35 Schemes of Service for the Nursing And Midwifery Cadre, Ministry of Public Service, 2017, p15

although often at a high cost. The government already partners with private healthcare providers for key issues like supply of essential drugs and immunisation programmes.

Strengthen strategic partnerships with private health sector actors in the rural areas. Government could provide funds for incentives, training opportunities and other strategies that would boost retention of non-public service staff in these areas. The private sector competes for the same pool of health workers in the country, therefore stronger partnerships with private actors would help monitor and regulate health worker migration and 'moonlighting' away from public facilities into private facilities. It would also foster learning from Private Not For Profit facilities on personnel supervision, which has been found to be better managed than in government facilities[36].

4.7 Regular sector-wide monitoring and evaluation

The mechanisms for monitoring progress and achievements in relation to the interventions put in place should be institutionalised at all levels, both in central and local government management of the health workforce. Government has taken up mechanisms such as development of tools for studying workloads (Workload Indicator Staffing Needs tools); for staff monitoring through Human Resource Information Systems (HRIS); tools for calculating the cost of appropriate interventions to motivate health workers in rural areas, and instituted performance management systems in some of the districts. However, the level of implementation, supervision and accountability is still low.

It is important to keep track of the activities of different actors and outcomes of different actions, whether in the private, donor or faith-based agencies. This way, policy adjustments can be made in line with the situation on the ground, while it improves accountability at all levels.

4.8 A mix of action

There is no singular approach to solving rural health worker shortages. A mix of actions based on evidence updated from time to time may have more success. IntraHealth in 2012[37] found that the incentive package that health workers preferred the most was a comprehensive approach that included improving work environment and facility infrastructure; better salaries and management support for continuing education.

Suzanne Namusoke Kiwanuka, et al[38] studied the drivers of long-term retention and health worker coping mechanisms in three districts of rural Uganda. Staff interviewed had stayed an average of 13, 15, and 26 years for Kamuli, Kibuku, and Pallisa respectively. The factors for staying were mostly personal; such as having family and community ties, and opportunities to invest, but financial benefits mattered a lot.

For nurses, the biggest cadre of health workers, ILO Nursing Personnel Convention No. 149 recommends, among others, training opportunities and career prospects, fair remuneration and a safe work environment[39].

SHORT TERM ACTION POINTS

Focus on the most impactful policy choices to attract and retain critical health staff may lead to gains in the struggle to attract and retain health workers in rural areas.

Most of the desired interventions have cost implications, but government can make short term priority actions that can garner quick returns, within existing budget frameworks. Table 3 shows three suggested points for immediate action:

36 Orochi Orach Sam, Is there a case for contracting health services delivery to PNFPs in Uganda?, Uganda Catholic Medical Bureau, 2015. Available at https://www.ucmb.co.ug/files/UCMBdocs/Reports/ARTICLES/Is%20there%20a%20case%20for%20contracting%20health%20services%20delivery%20to%20PNFPs%20in%20Uganda.pdf

37 Using Evidence for Human Resources for Health Decision-making, Uganda Capacity Programme, IntraHealth, 2012. Available at https://www.capacityplus.org/files/resources/using-evidence-human-resources-health-decision-making.pdf

38 Suzanne Namusoke Kiwanuka, Martha Akulume, Moses Tetui, Ronald Muhumuza Kananura, John Bua & Elizabeth Ekirapa-Kiracho (2017), Balancing the cost of leaving with the cost of living: Drivers of long-term retention of health workers: an explorative study in three rural districts in Eastern Uganda, Global Health Action, 10:sup4, 1345494.

39 ILO Nursing Personnel Convention No. 149

Table 3: Proposed short term action points

Proposed action	**Merits of action**
1. Target efforts (incentives) on the staff who already work in the rural/hard-to-reach areas and show more willingness to stay. Research shows that nursing and midwifery cadres (including comprehensive nurses) and those who originate and receive their training in non-urban areas are more willing to stay in rural areas.	Being already inclined to stay, the incentives will be extra motivation and fair compensation for their service. It also focuses on retention, to avoid attrition of key staff.
2. Implement staff performance management mechanisms. Working to eliminate absenteeism; better tracking of leave rosters and training schedules to reduce random absence of staff at the same time.	This reduces absenteeism, and general workplace indiscipline.
3. Ensure reward and recognition of existing staff for their efforts. These can be managed within existing budgets at facility level.	This will motivate them and show support.

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