UGANDA MANAGEMENT INSTITUTE

GULU CENTRE

FOLLOW-UP AND MENTORING OF

Health Officers in Acholi and Lango Sub-Regions who participated in the Human Resource Management and Management Skills Improvement Training at UMI

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1. INTRODUCTION

A tailor – made training for the Medical Officers in the Acholi and Lango Sub-regions was conducted between 16th October, 2010 and 6th March, 2011 in the areas of Human Resource Management and Management Skills Improvement. The training need was identified by NUMAT in consultation with Uganda Management Institute (UMI).

The training was tailored to empower the staff with skills, knowledge and attitude necessary for human resource management and responsive management in the health sector, thus improving the quality of health service delivery. Sixty seven (67) Health Managers were trained in three (3) intakes from twelve (12) districts from the Acholi and Lango Sub-regions.

As part of assessing the outcome of the training, it was agreed during a feedback meeting on the training program with NUMAT Senior Management that a follow study of the trainees be undertaken with a view of assessing use of the skills and knowledge acquired by the participants and mentoring of the trainees be done in the assessment process especially in areas of weaknesses that were identified.

1.1 Purpose of the Follow-up and Mentoring exercise

The purpose of this assignment was to assess the level of adoption and practice of the knowledge, and skills imparted during the training program, at the same time providing on job-mentoring for the trainees.

The findings from this assignment are to be shared with NUMAT Management, the participating Districts Leadership, and to inform the design of similar future trainings aimed improvement the management capacities of Health Sector Managers.

1.2 Specific Objectives of the Follow-up and Mentoring

1. To assess the level of knowledge, attitude, practice and skills acquired following the training on Human Resource Management and Management Skills Improvement training.
2. To an opportunity for an on-job mentoring for the trainees.
3. To provide a basis for a feedback to the key stakeholders of the training program.
4. To provide a basis for coming up with a way forward for similar future capacity building training programmes.

1.3 Methodology

1.3.1 Target population

The target population of for this evaluation were the participants who attended the trainings during the three intakes, the other staff whom they supervise, the supervisors of the trainees and the Health Unit Management Committees of the health centres where the trainees came from.

1.3.2 Sampling method

The participants for this assessment were purposively sampled. Samples were drawn from the list of participants who attended the training. Their supervisors and members of the Health Unit Management Committees were equally selected purposively. A snow-ball sampling method was used to identify additional respondents.

The respondents were drawn from six of the twelve districts that participated in the training, especially those districts that sent largest number of participants for the trainings. The districts selected for the assessment were; Agago (11), Alebtong (4), Gulu (11), Kitgum (12), Lamwo (21), and Oyam (7) participants.

1.3.3 Data collection methods

A number of data collection methods were used by the team; among which included the use of structured questionnaires, interview guides for key informants, discussions respondents. These methods were accompanied by observations made by the researchers while in the field. These data were collected from sampled training participants, their supervisors, those they supervise and members of the health unit management committees.

1.3.4 Data Analysis

The qualitative data collected has been analysed using content and discourse analysis method based on the themes and sub-themes of the study. Quantitative data was analysed using the Microsoft Excel computer programme. Conclusions and recommendations were drawn based on the patterns and validity on the contents of the data collected from the respondents and observations made by the researchers.

1.3.5 Study Limitations

The study is limited in the sense that this was a case specific study that used mainly qualitative methods for data collection and analysis, as such the findings may not be generalised to the entire health sector. Secondly there may be some inherent limitations due to the non-response in some areas that were being assessed either due to the questioning by the researchers or the limited knowledge of the issues being assessed by the research team.

1.3.5 Mentoring

The researcher's provided hands on technical support for the trainees on specific skills and knowledge areas that the trainees are having difficulties with while trying to adopt and adapt at their work places. The mentoring sessions were held with the trainees as individuals, the other staff who were interviewed for this assessment.

1.3.6 Research Team

A team of six researchers from UMI (2) and NUMAT (4) were engaged in the data collection and analysis process. The Consultants were responsible for the management of the research process with support from the Research Assistants who were involved in the data collection and data cleaning processes. The Capacity Building Manager of NUMAT played a central role in coordinating with the NUMAT Field Officers, District Officials and the respondents.

2. STUDY FINDINGS

2.1 Background information

2.1.1 Categories of health facilities visited

The study was conducted among staff and Health Unit Management Committees from various levels of health facilities. The respondents were drawn from a Regional Referral Hospital (1), Health Centre IVs (6), Health Centre IIIs (22) and a Health Centre II (1).

2.1.2 Gender and Categories of Respondents

Of the sixty seven respondents interviewed, thirty four (34) of them were females, and thirty three (33) of them were males, making 51% and 49% respectively.

The respondents were comprised of Health Officers, Clinical Officers, Nursing Officers, Health Inspectors, Health Assistants, Laboratory Technicians, Personnel Officers, Hospital Administrators, Bio-statisticians, Midwives, Vector Control Officers, Health Unit Management Committee chairpersons and members among others, who were serving at various levels of health facilities.

2.2 TOPICAL AREAS OF ASSESSMENT

During the trainings, the participants covered a number of training topics, however, of them all, based on the action plans drawn by the participants, ten (10) of the topics were selected for assessment. These included the following;

2.2.1 Report Writing

The health facilities are expected to produce different types of reports, ranging from daily to annual reports. The types of reports produced by the respondents include among others; daily OPD attendance, In-patients reports, ART clinic reports, Disease surveillance reports, Activity Reports, Reproductive Health Reports, Antenatal and Postnatal reports, Nutrition reports, Child Health Clinic reports, Sex and Gender Based Violence reports, among others.

The study sought to assess if there were any change noticed by the other staff in the report writing by the training participants over the last six months (a period after the training, long enough to see changes after the training). Of the respondents, 63% of the reported noticing some changes in reporting of participants, 37% of the respondents reported having not noticed any changes in the reporting of the training participants.

Most of the changes noticed in report writing had to do with the timeliness in report writing by the training participants and the improvement in the structures of the reports. The training participants equally reported improvement in the structure and timeliness of their reports which they attributed to the training they attended. However, due to the structured nature of some of the reports developed by the Ministry of Health, the changes in the structure of the reports may be due to the training. Some of the participants had got some training in report writing before.

The respondents were asked about the timeliness of the reports. 91% of the respondents reported timeliness in the reports, 8% did not see any changes and 1% of the respondents reported that reports are at times timely, pointing to inconsistencies in the timeliness in reporting. However this represents the smallest percentage. The largest percentage reported timeliness in report writing.

The study sought to assess the feedback on the reports written by the respondents and the use of the reports produced. 40% of the respondents reported that they get feedback on the reports that they produce, 35% reported they do not get any feedback on the reports they produce while 25% reported that they sometimes get feedback on the reports they produced.

On report use, 84% of the respondents reported that their reports are used, 7% reported that they are not used and 9% of the respondents do not know if the reports are used or not. The respondents reported that their reports are used for various purposes. These include; planning and delivery of drugs and consumables, allocation of equipment, monitoring disease prevalence, evaluating the performance of health facilities staff, progress assessment on assignments, accountability for resources, lobbying for more resources and planning staff leave.

The study also sought to investigate the challenges faced by the respondents in the process of their report writing and report use. They reported the following as being some of the main challenges regarding reporting.

- Poor attitudes towards report writing,
- Few personnel to facilitate the report writing process
- Heavy workload,
- Complicated reporting formats,
- Multiple authorities to report to,
- Data collection and analysis challenges,
- Data storage and retrieval is a challenge in the health facilities due to manual storage of information and lack of proper information management systems.
- Difficulty in transmitting reports to the relevant authorities due to logistical challenges,
- Some report forms at times get over and it takes time before they are brought,
- Some reports could best be made by some specific staff that is at time missing in some health facilities due to under staffing.
- Negligence on the part of some staff in filling in some report forms thus leading to incomplete, thus inaccurate information.
- Most times there is no feedback on the reports produced or it takes time for the relevant offices to respond to the issues raised in the reports thus making the health facilities nonresponsive on some critical issues, especially in cases of emergencies.

2.2.2 Public Relations and Customer Care

The respondents who were training participants were asked for the customer care and public relations activities or measures that they took ever since they attended the training. They reported having undertaken a number of activities among which included;

- Mentoring other staff on customer care and public relations issues,
- Shared materials they got from the training on customer care and public relations with colleagues who did not attend the training,
- Used the notice boards to publish information on the services available and when drugs arrive and their quantities and in cases where there are no drugs,
- Carrying out more community outreaches for public health education for preventive care,
- Using the Health Unit Management Committees and local councils to bridge the information gap between the health facilities and the communities,
- Providing tea breaks for staff.

The respondents were also asked about the challenges that they face in the process of conducting public relations and customer care activities. They reported that their main challenges included mainly the following;

- Poor attitude of communities towards the health staff who are seen to be corrupt and stealing drugs and consumables,
- Refusal by some clients to accept referrals to other health facilities,
- Poor transport and referral systems,
- Most staff residing away from the health facilities,
- Use of local FM stations to discredit the work of health staff thus leading to low morale among the staff,
- Poor lighting especially for inpatients management,
- Poor time keeping among some staff,
- Coming to work while drunk,
- Limited time and manpower for community outreach services,
- Political interference in health service delivery, where politicians want preferential treatment of themselves and their supporters,
- Drugs and consumable outages,
- Staff burnout due to work overload and thus becoming rude to clients,
- Passive involvement of the Health Unit Management Committees in the management issues in the health facilities,
- Poor and inadequate information dissemination to the communities and clients,
- Inadequate skills among health centre staff in public relations and customer care,
- Impatient clients who do not want to wait to be served.

The respondents were asked to suggest ways in which they think public relations and customer care could be improved in the service delivery in the health facilities. They suggested the following as measures for improving customer care and public relations in the health care service provision;

- Improvement of the staffing levels in the health facilities so as to speed up the attendance to clients,
- Training of staff in customer care and public relations skills,
- Improving the transport and general referral systems for clients,
- Timely delivery of drugs as per schedule and specific requests made,
- Improve on and increase staff accommodation so that they are accommodated within the health facilities, and thus making them more available to attend to clients,
- Improve on the information processing and dissemination within the health facilities and to the communities,
- Support supervision to the staff to enable them cope with the workload,
- Improving lighting systems to take care of service delivery at night, especially for maternal and child care services,
- Improve on mechanisms for getting feedback from communities on the quality of service delivery and promotion of dialogues with communities.
- Minimise the use of local FM stations as means of addressing health facilities management issues since it does not address the problems but demoralises staff.

2.2.3 Time Management

Time management was one area for assessment in the study. The respondents were asked about how well or poorly time is managed at the health facilities, what time management measures have been put in place and in cases where time is not well managed why, whether the measures are effective or not, and were they are effective why that is so. Of the respondents interviewed, 39% reported that there is good time management in the health facilities while 61% reported that there is poor time management in the health facilities.

The respondents advanced the following reasons for poor time management in the health facilities:

- Not many staff appreciate the need for effective time management,
- Inadequate supervision of staff,
- Lack of actions taken on those who do not keep time,
- Most times patients tend to first do their domestic and garden work before coming for treatment. Most come in the mid morning of afternoon,
- In some cases, few or no clients in the afternoons,
- Constant absence of In-charges of some health facilities from their duty stations,
- Most staff reside outside the health facilities,
- Poor time management is a norm.

A number of time management measures have been put in place by the health facilities to ensure proper time management. These measures include;

- Use of daily attendance login and logout registers,
- Reminders and warnings about time keeping during meetings,
- Monitoring of staff by the Health Unit Management Committee Members,
- Random checks on the duty locations of staff by the In-charges.

The study sought to assess the effectiveness of the time management measures that have been put in place. 62% reported that the measures were effective in ensuring effective time management while 38% reported that the measures were not effective in ensuring effective time management in the health facilities. The ineffectiveness of the measures was mainly attributed to the lack of actions taken on those who do not keep time, dishonest way in which the attendance registers are filled, the In-charges of the health facilities being absent from the duty stations and being poor time managers themselves.

The respondents were asked what measures could be taken to improve time management in the health facilities, they suggested the following measures to ensure effective time management;

- Taking on disciplinary actions on those who do not keep time,
- Improve the management of the attendance registers by withdrawing the attendance after a specific time and attendance book analysed at the end of month,
- Accommodate staff within and around the health facilities,
- Improved supervision,
- Attaching monetary value, rewards and recognition for good time management,
- Improved monitoring and supervision by the Health Unit Management Committees and Local Governments,
- Train on time management techniques for all staff.

2.2.4 Performance Appraisal

The respondents were interviewed about the status of staff appraisals, why performance appraisals were not up-to-date? Where appraisals were done were appraisal meetings held and whether there was any follow-up done during the appraisal period on the action plans? The timeliness of the appraisals, openness during appraisal meetings and satisfaction with the appraisal process were also assessed during the study.

Of the training participants interviewed, 89% of them were confirmed staff and 11% were on probation. Of these, 17% supervise 0-5 staff, 36% 6-10 staff, 20% 11-15 staff, 17% 16-20 staff, 10% 21 and over staff. Less than half of the staff supervised by the training participants had an up-to-date performance appraisals. Most appraisals were done in retrospect to meet the conditions for confirmation into service which requires that the staff have complete sets of appraisal forms that are dully signed by the responsible officers.

Of the other health staff (non-training participants), 69% of them were confirmed into service and 31% were on probation. 92% reported having had their performance appraised for confirmation purposes and 8% have never had any performance appraisal done.

A number of reasons were given for the staff under their supervision not having up-to-date performance appraisals. These included mainly the following;

- Role conflict on who is to appraise who?
- Some staff are not bothered about the appraisals,
- Some not sure of who is to initiate the appraisal process,
- Failure to fill appraisal forms in time,
- Inadequate knowledge of performance appraisal process by both the supervisors and supervisees,
- Not many appreciate the need for performance appraisal,
- Poor records management system.

Of the respondents that had appraisals done with their supervisors, 70% of them reported having had timely appraisal while 30% reported not having had timely performance appraisal done. 74% reported having had performance meetings with their supervisors while 26% did not have a performance appraisal meeting with their supervisors.

For those who had performance appraisal meetings, 80% reporting to have had open discussions on their performance and having reached agreed positions on the performance levels. 20% reported that they did not have an open discussion of their performance. In addition, 58% reported that they had follow ups made on their performance during the performance period while 42% reported they did not have any follow up of their performance during the appraisal period. 74% of those appraised where satisfied with the manner in which the performance appraisal was conducted while 26% were not satisfied with the manner in which the appraisals were conducted, largely due to the absence of performance appraisal meetings. Forms were simply filled and signed without any form of discussion of the performance.

Even in the cases where performance appraisals were reported to have been conducted, meetings held, most of the respondents could not in concrete terms describe how the entire performance appraisal process went.

2.2.5 Ethics and Code of Conduct

The respondents were interviewed on the presence and absence of unethical code of conduct among staff, the types of unethical conducts, measures put in place to combat them, effectiveness of the measures, if they were not being followed, why the measures were not

being followed? And suggested ways of how the staff thing ethical code of conduct can be upheld in the health facilities.

Of those interviewed, 71% of the respondents reported that there are unethical code of conduct in the health facilities while 29% reported that there were not unethical code of conduct among the health staff.

The respondents reported the following as being the main forms of unethical conducts in the health facilities;

- Breach of confidentiality while dealing with patients and staff issues,
- Neglect and rude treatment of clients,
- Absenteeism from duty without,
- Not following dress codes like putting on uniforms,
- Reporting to duty while drunk,
- Charging clients for services that should be free,
- Poor time management,
- Inter-staff conflicts and poor interpersonal relationships,
- Gossips and rumour mongering among staff,

The respondents were asked about the measures that are to be taken to ensure that ethical code of conduct is observed. The measures included the following;

- Support supervision,
- Dissemination of codes of conducts,
- Disciplinary measures,
- Transfers,
- Demotions in cases of gross misconduct,
- Holding meetings to address the issues of ethics,
- Peer counselling,

The respondents were asked about the effectiveness of the measures put in place to ensure ethical code of conduct is observed. 70% reported that they were being observed while 30% reported that it is not being followed. The main reason for noncompliance is due to poor attitudes of staff and the inability of the authorities to take actions in cases where unethical codes of conduct have been reported.

The respondents suggested that strict disciplinary measures be taken, mentoring, trainings and continues meetings to address the ethical issues be held so as to uphold ethical codes of conduct in the health facilities.

2.2.6 Delegation

The study sought to assess the level of delegation done in the health facilities, when delegation is done, support given for performing delegated duties, how delegation is done and feedback got in the process of delegation.

85% of the respondents reported that there is delegation done in the health facilities, and 15% reported that there is no delegation done. Most of the delegation is done when the supervisors go out of their duty stations. 61% of these delegations is done verbally while 39% is done in writing.

Apart from handing over key and provision of materials for doing work, not much is done as support to those who have been delegated to perform certain duties. The delegation process is mainly affected by the manner in which delegation is done. For example, often delegation is done over phone. Another challenge is withholding of the instruments and power to perform

the delegated duties. Most feedbacks to those who have delegated are mainly the challenges faced in performing duties and not much feedback to those to whom delegation has been done.

2.2.7 Conflict and Grievance Handling

The study sought to assess the presence of conflict in the health facilities, the causes of the conflict, whether the conflicts have been settled from within the health facilities or not, how the conflicts have been managed in case they were settled internally and why they were not settled from within the health facilities and the conflict prevention mechanisms put in place.

On the presence of conflict, 85% of the respondents reported that there is conflict in the health facilities, and 15% reported that there were no conflicts in the health facilities. The main causes if conflict in the health facilities reported included;

- Allocation of staff houses,
- Lack of transparency in the use of funds like the PHC funds,
- Absenteeism and no actions being taken,
- Poor time management,
- Insubordination,
- Gossips among staff,
- Loss of health facility equipment and materials,
- Poor delegation of duties,
- Inadequate information sharing,
- Influence of politicians in the management of health service delivery,
- Delays in returning back from off-duties and leaves,
- Poor handling of staff grievances,
- Love relations going bad among staff members,
- Selective disciplining of staff,
- Use of health facility land for cultivation by staff,
- Role conflicts,

On whether the conflicts have been managed internally within the health facilities, 85% reported that the conflicts have been handled from within and 15% reported that the conflict were handled externally by others outside the health facilities.

The conflicts were mainly handled through holding meetings, discussions with the affected parties, clarifying on roles, transfers, use of arbitrators, and warning letters. The reasons why some of the conflict could not be handled from within the health facilities were mainly due to the nature of the conflicts. Some of the conflicts in the health centre IIIs and IVs could best be handled by the district officials. In some cases the conflict involved the in-charges of the facilities so they could not arbitrate and the constant absence of some in-charges from the health facilities made other staff to seek help from outside to have their conflict resolved.

The respondents suggested that conflict in the health facilities could best be managed through the following means;

- Transparent ways for sharing the scarce resources and opportunities for career advancement,
- Clarification on roles and responsibilities,
- Proper delegation of duties to subordinates,
- Frequent meetings at different levels,
- Promotion of trust among staff,

- Impartial disciplinary and grievance handling mechanisms be adopted,
- Improvement of communication among the different stakeholders of the health sector.

2.2.8 Staff Motivation

The study sought to assess the level of staff motivation and why the respective levels of motivation among the staff, presence of local measures to improve staff motivation and why there are no local measures for motivation staff. 8% of the respondents reported that there was high level of motivation among the staff, 46% reported that the level of motivation was medium and another 46% reported that the level of motivation among the staff was low.

The reasons for high staff motivation were the appreciation of the work of the staff by some community members and district, prompt payment of allowances, good team spirit among staff.

A number of reasons were given by the staff for the medium and low levels of motivation among the staff members of the health facilities. These included;

- Heavy workload due to few manpower against poor working conditions like poor housing and enumerations,
- Low appreciation of work by health workers by the politicians and members of the communities,
- Lack of promotion opportunities,
- Inadequate facilities, equipment, uniforms and materials for doing work,
- Lack of transparency in the way in which administration is done,
- Poor handling of conflicts and grievances,
- Few capacity building and career development opportunities,
- Delays in confirmation into service,

The study assessed the presence of local initiatives put in place at the health facilities levels to improve on the motivation levels of the staff. 50% of the respondents reported having local initiatives for motivating staff and 50% reported the absence of local initiatives for motivating staff. Some of the local initiatives to motivate staff include the following;

- Transparent sharing of the scarce resources,
- Providing soap to staff on quarterly basis,
- Starting local savings and support group for the staff called “Boli cupe” and “Ber bedo”,
- Proper scheduling of work and sharing workloads,
- Delegating staff to go for workshops on a rotational basis,
- Involvement of staff in decision making on issues concerning their work and welfare,
- Provision of transport allowance,
- Regular staff meetings,
- Off duties,
- Secondments for trainings,

It was reported that there are no local initiatives for staff motivation due to the misunderstanding of motivation as being only provision of financial resources.

2.2.9 Teamwork

The study examined the level of team work among the staff in the health facilities, why the various levels of teamwork, and measures put in place to ensure good teamwork among the staff. 48% of the respondents reported that there was high level of teamwork, 45% reported medium level of teamwork and 7% reported low level of teamwork. The high level of teamwork was attributed to the high level of cooperation among the staff and the appreciation of the contribution of each staff to the functioning of the health facilities.

Medium and low team work was associated with staff only sticking to their job descriptions and refusing to support others in their work even when they are overloaded with work. Poor communication among staff, conflict and grievances and discriminatory ways of treating staff was identified as causes of medium and low levels of teamwork.

Some of the measures reported for enhancing teamwork among the staff included;

- Proper allocation of duties, and assigning duties across departments,
- Planning for the health facility as a team,
- Regular staff meetings,
- Open communication among the staff,
- Setting team performance targets,
- Job rotations,
- Support each other in case one staff member has some personal or family problems.

2.2.10 Planning and Budgeting

The study assessed the planning and budgeting functions in the health facilities. It looked at whether plans and budgets are made for the health facilities, the types of plans and budgets made, the persons involved in the planning and budgeting for the health facilities, challenges faced in the planning and budgeting process and in the implementation of the plans and budgets for the health facilities. Suggestions were sought on measures for improving both the planning and budgeting process and plan and budget execution.

Of the respondents interviewed, 76% reported that plans and budgets are made for the health facilities and 24% reported that no plans and budgets are made for the health facilities. The plans and budgets are mainly made for recurrent and capital development activities. The persons involved in the planning and budgeting process are the health facility in-charges and the other staff and at time with support from the district and Subcounty level officials.

Various challenges were reported at the planning and budgeting stages and during the implementation of the plans and budgets. The challenges included the following among others;

- In-charges of some health facilities plan and execute the plans and budgets alone without the participation of other stakeholders.
- Little and late allocations of the Indicative Planning Figures (IPF),
- Inadequate knowledge of what to plan and budget for,
- Limited knowledge and skills for planning and budgeting,
- Inadequate support from the higher authorities in the planning and budgeting processes in the health facilities,
- Low interest in planning and budgeting due to its routine nature of the process , coupled with the inadequate resource allocations to the health facilities for the entire financial year, which funds often far less than the IPFs,
- Inadequate harmonisation of the planning and budgeting process at the various levels of government,

3. DISCUSSION OF THE FINDINGS AND RECOMMENDATIONS

3.1 Report Writing

Reports play very critical roles in the management of organisation. A report can be a very good tool for accountability and becomes a reference point for planning future activities. Due to this, all due attention must to given to reporting and reporting procedures as set by organisations. Different organisations have different reporting requirements and reporting formats. The health sector equally has its own formats and use of reports.

There was a change in the timelines of reporting and the structure of the narrative reports. However, timeliness could to some extent be attributed to the training but the structure of reports could not be attributed to the training since most of the reports already have specific forms for reporting.

There is need for those who receive reports to give feedback to the persons who produce the reports as an incentive for writing reports. Feedback plays a key role in letting the responsible officers know that their reports have been acknowledged. The acknowledgement should indicate the use of the reports.

The report formats need to be made user friendly so as to enhance the interest of the Officers in writing these reports. In addition, an integrated reporting formats need to be developed to take care of the various reporting needs of the various stakeholders. This need to be observed especially when it comes to dealing with partnerships, where there is need for harmonisation of reporting formats and information needs.

3.2 Public Relations and Customer Care

Customer care and public relations are very critical for the management of the image of an organisation. The first interaction one makes with a member of an organisation has a lasting influence on the way they perceive such an organisation, no matter who that person whom they may have made the interaction with.

Customers make their decisions based on a much wider range of requirements. The organisations which will be able to satisfy the largest number of these wins support of its customers' in the long run. Customer care or support adds to the perceived value of your product or service and will encourage customers to come back to your organisation and refer others to your organisation as well.

The health sector in Uganda has been known for poor customer care and public relations. However, from the study, it was observed that a number of ways are being put in place to enhance customer care and public relations at the health facilities. However this still remains a big challenge since this effort seems to me undermined internally or locally.

Timely information sharing and courtesy in provision of services is critical in determining the level of satisfaction that the public can derive for the health service delivery. There is need to develop mechanisms for information sharing on the available services and where they are not there for one reason or another, the public need to be kept informed in order to avoid roamers.

The local authorities are important stakeholders in the health service delivery; however, they seem to be in the fore front of giving negative publicity for the health service delivery in their areas of jurisdictions. There is need for the local leadership to appropriately manage how the interaction between the officials and the media takes place so as to minimise the damage caused by negative publicity given about the health service delivery.

Most focus seems to be on improving customer care and public relations with those outside the health facilities while forgetting the internal customers (the staff) who are very critical in this process. The welfare of the staff has am implication on how they treat the external customers. A more holistic approach needs to be developed when it comes to the customer care and public relations concerns in the health sector service delivery.

Specific trainings need to be organised for the health workers of issues of customer care and public relations management.

3.3 Time Management

The study shows that there is poor time management in the health facilities. A number of reasons were advanced for the poor time management. However more prominently was the issue of lack of accommodation for the staff within the health facilities and lack of action taken on those who are routine late comers.

Much as lack of or limited accommodation may be a factor in the poor time management in the health facilities; this may not be the whole story. Many of the staff who lives outside the health facilities lived within walking or riding distance. During the field study, a number of times, those staff who lived within the staff quarters were often late for work. On a number of occasions, the study team had to send for the staff to come and attend to the team.

However, there is also need to take into consideration the health seeking habits of the local communities when it comes to the issue of time management in the health facilities. In some communities they prefer doing their domestic and field work first in the morning them go to the health facilities in the afternoon as was witnessed by the research team. But this was not the case everywhere. On the other hand, many health facilities were found to be only operational in the morning. In the afternoons, some health facilities were found to be closed and staff out of the facilities.

There is need for improvement in support supervision by the district health management teams and the local health unit management committees' whole involvement in the management of the health facilities seem to be very minimal.

Actions need to be taken in forms of reprimands so that the time management can be taken seriously by the staff. In addition, there is need for improvement in the way in which the daily attendance registers are filled and rewards given for those who are consistently good in time management.

3.4 Performance Appraisal

"Performance management is a systematic process for improving organisational performance by developing the performance of individuals and teams" (Armstrong, 2006). This process requires creating a shared understanding and managing performance within an agreed framework of goals, standards and competencies.

The study findings show that much as there is a system put in place for performance management, the systems seem not to be followed. Most of those interviewed could not describe how the system operates. Performance appraisal seems to be only done as a formality for meeting the conditions for confirmation into serve but thereafter, it becomes immaterial since the staff cannot make any linkages between the performance appraisal and the overall performance management in the health sector.

There is need for the staff to be oriented into the understanding that performance appraisal in part of the overall performance management system and not just for the confirmation into service.

The supervisors need to take a leading role in the performance appraisal and make it a continuous process of performance assessment which is not just linked to confirmation into service.

There is need to clarify on the responsibilities of who is to appraise who, especially in the Health Centre IVs and Health Centre III and training conducted to orient the staff on the new performance management system in public service and its linkage to career development.

3.5 Ethics and Code of Conduct

Ethics as codes or moral principles set standards of what is percieved to be "good" or "bad" and "right" or "wrong". As a concept the purpose of ethics is to establish principles of behaviour that help people make choices among alternative courses of actions. The health profession apart from being guided by the general public sector ethical code of conduct, is guided by ethical code of conducts that are specific to some professions within the health sector.

The study shows that there are a number of unethical code of conduct that is exhited by the health workers. These range from issues of breach of confidentially to poor interpersonal relations that have effect on who people perceive the manner in which health services are being delivered.

Much as the health workers seem to be knowledgable about the ethical code of conduct for the health workers, following these ethical code of conduct seem to be a proble. Most of the challenge emernates from weak mechanisms for enforcing them. It is one thing issueing booklets with the codes of conduct and the associated penalities in cases of breach of the codes and staff actually following the code of conduct.

There is need to take a deeper look into the mismatch between the knowledge about the code of conduct and the rampant cases of unethical behaviour that were reported. Actions can be taken at various levels, right from the health facility level to the ministry level. There is need to revisit the approaches used in imparting the professional code of conduct and enforcment of these principles.

3.6 Delegation

Taking into account the workload that most of the health facilities have to deal with against a small workforce, delegation can play a critical role in facilitating the delivery of health services at various levels. The findings show that the manner in which delegation is done in the health facilities cannot enable the health facilities to reap from the advantages of delegation. Most of the delegation is done verbally (often on phone) thus making it hard for the delegated to have point of reference. This also minimises the authority for those to whom duties have been delegated to make certain decisions.

To effectively delegate, there is need to delegate clearly and completely. The issue with delegation as was found by the study is that the delegated often do not understand the limits of their task or authority. It is important to delegate while taking care to make tasks and authority clear.

Another way to improve delegation is to ensure that subordinates are 'empowered to achieve the task' and that their authority matches their responsibility. Most of those to whom delegation were done were found not to be given the delegated support to do their delegated work.

3.7 Conflict and Grievance Handling

Conflict and grievances are not bad in themselves but how they are managed is critical in determining their effects on the organisational performance. 85% of those interviewed reported cases of conflict and grievances in the health facilities. The main causes of conflict seem to be evolving around the use of scarce resources like housing, transport facilities, lack of transparency in the management of PHC funds and partial handling of grievances.

There seem to be no well laid down procedures for conflict and grievance handling. Where they are there, the staff are either not aware of they are not followed. One of the principles of management says that an organisation is stable if the members have the right to express their differences and solve their conflicts from within the organisation. The study shows that for most of the cases of conflict, these have been solved internally. However, most of the staff members seem not satisfied with manner in which their conflict and grievance issues have been handled.

Management of the health facilities need to ensure that they put in place proper conflict and grievance handling mechanisms. These mechanisms need to be made aware to all the staff members. The mechanisms for conflict and grievance handling should encourage handling such issues from within the health facilities. Third parties should only be involved in extreme cases.

3.8 Staff Motivation

Motivation refers to and inner drive that causes initiatives, and persistence of behaviour. Different people are motivated by different factors. The study shows a low level of motivation among the health workers, mainly due to lack of appreciation for the work being done by the health workers, minimal opportunities for career development and working conditions.

There are very few local initiatives for motivating staff in the health facilities. Most understand motivating drivers in terms of money. However, not all motivators require money. They health managers need to be creative within the available means to motivate their staff. Initiatives like the local savings and welfare funds need to be encouraged in other health facilities as well.

3.9 Team Work

Contrary to the low level of motivation among the staff, there is high level of team work among the staff. Most of this team work is associated with the way in which work is scheduled among the works. Most staff are will to work across departments especially in areas where they have expertise.

Taking into account the fact that the health facilities are staff constrained, the staff need to be trained in such a way that they are multi skilled so as to be deployed across the department. The institutional policies and procedures should be made to be responsive to such circumstances.

3.10 Planning and Budgeting

The planning and budgeting in Uganda is guided by the National Development Plan which prioritises the planning and budgeting for the various sectors. The study shows that almost all the health facilities do plan and budget for their facilities. However there is a big disconnect between the planning and budgeting process and outcomes. The plans and budgets are done on an annual basis but the funds to implement the plans are inadequate.

The planning and resource allocation and resource realisation need to be harmonised such that those involved in the process do not loss interest in the process.

There is need for a more participatory process, especially one that involves the staff and health unit management committees.

The planning and budgeting cycle need to be harmonised in such a way that it allows room for the integration of the needs at the lower level into the district and national development planning and budgeting priorities.

Poor planning and budgeting has adverse effect on the quality of service delivery. It is therefore in the interest of those who seek to improve the planning and budgeting for the health sector to allocate the necessary resources for the planning and budgeting functions in the health sector. This must be accompanied by timely allocation and delivery of the allocated resources.

4. CONCLUSION

Whereas this study was a case specific one, the findings and observations made can be of use to the wider health sector service delivery. Special need has to be given to the issues raised concerning reporting and report use, improvement of public relations and customer care, time management especially the enforcement of the time management measures, linking performance appraisal with overall performance management in the health sector, not just for confirmation into service.

Ethical conduct in the process of health service delivery plays a key role in the building of the image of the health sector. Enforcement of the codes of conduct need to be taken into consideration with making appeal to the hearts of the health workers more than just issuing threats to ensure compliance. Proper delegation minimises conflict in the health facilities and putting in place local measures for conflict and grievance handling enhances a better working environment.

Staff motivation need to be taken into consideration by the various levels of health sector managers and emphasis need to be put in developing non-financial means of motivation staff since these may be with the reach of the health facilities management teams. Team work plays a critical role in enhancing the level of motivation that the staff have. Deliberate efforts need to be put in place to enhance team work in the health facilities, especially in light of the limited human resource capacities of the health facilities.

There is currently a big disconnect between the planning and budgeting functions in the health facilities. There is need to harmonise the planning and budgeting processes for the various levels of health sector management. The concerned levels responsible for allocating and disbursing the allocated resources need to ensure consistency in the allocation and the actual amounts released to the various levels at which the health services are being delivered.

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