THE EFFECT OF DECENTRALISATION ON THE PERFORMANCE OF DISTRICT PERSONNEL IN UGANDA: A CASE-STUDY OF TORORO DISTRICT HEALTH DIRECTORATE

BY

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DECLARATION

I, AUGUSTINE MUTUMBA, do hereby declare that this is my original work and has not been published and/or submitted for any other degree award to any other university before.

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DEDICATION

I am profoundly honoured to dedicate this piece of work to my family with whom I closely shared the joy and sweat of this study process as and when need to balance academic and social responsibilities arose. My wife Ruth N. Mutumba Nnaalongo, my children and a few other relatives Margaret Nansereko, Mark W. Male, Gerald K. Kawuma, Jessica C. Geera, Emmanuel Kayongo, Teopista N. Nantege, Josephine Nabulya and Agnes Nanseko who shared the same roof with me during this study, you are my source of inspiration, courage and determination.
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LIST OF ABBREVIATIONS

CAO – Chief Administrative Officer

CME – Continuing Medical Education

DDHS - District Director of Health Services

DHC - District Health Council

DHMT - District Health Management Team

DHT - District Health Team

DSC – District Service Commission

FGD – Focus Group Discussion

HCII – Health Centre II

HCIII– Health Centre III

HCIV– Health Centre IV

HMIS – Health Management Information System

HSD - Health Sub-district

HUMC - Health Unit Management Committee

KI – Key Informant

LGDP – Local Government Development Programme

NGO – Non-governmental Organisation

PSC – Public Service Commission
ABSTRACT

This study examined the effect of decentralisation on the performance of Tororo district Health personnel; it assessed the personnel performance in terms of their quantity and quality, personnel accessibility to local people, the clients’ satisfaction of personnel services and constraints to personnel performance under decentralisation. In the process, it followed up the personnel performance factors; that is performance definition or job expectation, performance facilitation and encouragement, and the quality of service.

The research used a descriptive case-study design. Both quantitative and qualitative data collection methods were utilized. The study targeted personnel and politicians at district, municipality, sub-county and parish levels. It also targeted NGOs and the private sector, and the health services consumers in Tororo district.

Results show that decentralisation had both positive and negative effect on the performance of the Health personnel of Tororo district. The improvement of the personnel’s ability to know what they are expected to do on their jobs led to improvement on personnel quality as being focused in their performance. Understaffing with a staffing gap of 70%, under-qualified staff especially in lower cadre level and a non-existent District Service Commission; reduced the quality of staff and coupled with lack of funds for recruitment this constrained personnel performance.

Personnel job knowledge and skills improvement were partially realized through short-term training for some staff. Regular verbal and written performance feedback improved on quality of personnel, but was constrained by meagre funds for transport and stationery.
Personnel quality and accessibility was negatively affected by the general lack of equipment, supplies (especially drugs were scarce and irregular), and workspace that was inadequate thereby hindering accessibility; this contributed to the dissatisfaction of citizens of the personnel performance.

Personnel accessibility was improved with posting more staff to lower new and old health units and setting up administrative structures at HC IV. Politicians were, on one hand, helpful to health workers in improving performance, while on the other, they constrained personnel performance. Personnel were constrained by poor job rewards; this made personnel less accessible as they sought for supplementary income activities; hence dissatisfying the citizens.

To improve the quality of personnel in knowing better their jobs, there is need to strengthen the capacity of HCIV, HClII and HC II administrative units in giving reminders to personnel. The quality, quantity and accessibility of personnel will be enhanced with recruitment of relevant personnel to fill the Health personnel gap in Tororo, the presence of an active DSC, facilitation of staff with equipment, supplies and workspace. Regular training for all staff, should be a must to update personnel on new technologies for better performance. This also calls for better means of financing Local Government programmes commensurate to the tasks they are required to perform and to satisfactorily reward their personnel. Continuous team building between politicians and personnel should be held to reduce frictions between the two factions that hinder personnel performance.
CHAPTER ONE - INTRODUCTION

1.1 Background to the study

Decentralisation in Uganda aims at improving performance through District Council set plans and objectives getting implemented by a developmental, professional and motivated human resource (Republic of Uganda, 1999, p.1). Decentralisation has been advanced as a process that promises the transfer of legal, political, administrative and financial authority to plan, make decisions and manage public functions and services. The transfer is normally from the central government and its agencies to lower levels of administration or organisations (Nsibambi 1998, p.6). Uganda's current decentralisation policy is embedded in Chapter eleven of the 1995 Constitution of the Republic of Uganda (hereinafter called the 1995 Constitution) and the Local Governments Act, 1997. The above 1997 Act has the following in its introduction of the Decentralisation/Local Government Law defining it as "An Act to amend, consolidate and streamline the existing law on Local Governments in line with the Constitution to give effect to the decentralisation and devolution of functions, powers and services; and to provide for decentralisation at all levels of Local Governments to ensure good governance and democratic participation in, and control of, decision-making by the people; and to provide for revenue and the political and administrative set up of Local Governments; and to provide for election of Local Councils and any other matters connected to the above".

The policy is undertaken with the aim of improving activities involved in the delivery of services (governmental, non-governmental and private) for better citizens’ welfare. The policy’s administrative component transferred in Uganda, has involved the decentralisation of personnel matters from the Public Service Commission (PSC) to the District Service Commissions (DSCs) of all districts that form the top administrative authority centres of Uganda's decentralisation/Local Governments.
Uganda’s decentralised personnel management aims at enhancing district personnel motivation to perform. Performance in this case refers to the personnel’s achievement of the goals of effective and efficient delivery of services to the citizens. This is supported by Labanga’s (1998, p.70) presentation that “personnel decentralisation enhances good governance from a management accountability point of view in that it overcomes some of the omissions and commissions engendered by centralised systems”. Further, Article 176 section 2 g of the 1995 Constitution also states that “the local governments shall oversee the performance of persons employed by Government to provide services in their areas and to monitor the provision of Government services or the implementation of projects in their areas”.

Personnel performance as noted by Cascio (1986, p.423) is broadly determined by three key factors: (1) performance definition (describing what is expected of employees, plus the continuous orientation of employees toward effective job performance); (2) performance facilitation (eliminating roadblocks to performance, providing adequate resources, and careful personnel selection); and (3) performance encouragement (providing a sufficient amount of highly valued rewards in a fair, timely manner). Therefore, any policy geared towards addressing personnel performance, must attend to the above key factors in theory and practice.

At independence in 1962, the Uganda Government started off with a separate personnel system where Local Governments in Uganda had statutory obligations to provide services such as primary education, feeder roads and pre-hospital medical and health services to their constituents. Come the 1966 crisis when the centre-local relations came under stress. The result was that in 1967, a new Constitution was introduced which centralised power and severely limited the powers of Local Governments in human resources development and management thereby affecting the personnel
inputs and outputs. Article 104 of the 1967 Constitution empowered the President to hire and fire even the lowest established officers of Local Government. The personnel management system that was introduced under the 1967 Constitution created a local service that did not owe allegiance to local leadership. It, therefore, reduced the degree of staff responsiveness to the service beneficiaries. The gap between the service providers and the service beneficiaries manifested itself in the unprecedented degeneration of personnel management in Local Governments and in poor service delivery. The above conditions of personnel management under the 1967 Constitution continued through the Amin and Obote II era. In 1987, the Government of Uganda Commission of Inquiry into the Local Government system reported that personnel management and development was one of the functions of local authorities that had been grossly mismanaged hence the response to change the trend through personnel decentralisation to district levels as the managing apex for all personnel within their boundaries (Asiimwe et al, 2000, p. 2; Lubanga, 1998, p. 73).

That done, there is anecdotal evidence suggesting that though decentralisation was supposed to improve, among others, the personnel and its services in districts, this is far from being achieved. District jobs are not done in time, an indication that there is a problem with the decentralised personnel supposed to carry out these duties. In connection to the above, Ariko in New Vision (2001, August 8, p.6) quoted the Minister of Local Government as saying that “The problem... currently facing decentralisation is lack of accountability by some local councils.” On the other hand, New Vision (2001, August 17, p.6) reported: “The Local Government accounts committee has summoned the Local Government minister to explain why he has not presented to Parliament the districts’ audited reports. ...Parliament has not been given districts’ audited reports for the last three years.” These are general problems to all districts; but in particular in the case of Tororo, for purposes of this study, a lot is yet to be done to get personnel capacity to the required levels for use
in service delivery in the district. For example, Tororo district was included on the list of the Ministry of Finance, Planning and Economic Development for Local Governments that had failed to submit monthly accountability statements for the Financial Year 2000/01 (New Vision, 2001, September 10, p.36).

1.2 Statement of the problem

Tororo was among the first twenty-seven districts decentralised in 1993/94 as a result of the enactment of the Local Governments (Resistance Councils) Statute, 1993. Personnel decentralisation as part of the decentralisation process in Tororo district was designed with the general objective of transforming the human resource system into a more responsive public machinery for better service delivery. A lot of legal, political, administrative and economic changes have taken place as a result of personnel decentralisation to try to improve the personnel capacities. However, the resultant quantity, quality, output timing, accessibility and consumer’s satisfaction of the services have not measured up to the local demand due to several factors that have lagged behind the required amounts and combinations to enable the decentralised personnel perform at full scale. In a Situation Analysis of Women, Adolescents and Children in Uganda, health service delivery, it was reported: “Decentralisation had not been matched by increase of resources and capacity to enable Local Governments to perform their roles effectively” (Child Health and Development Centre, 1999, p.61). Factors that are of concern to the performance of the decentralised personnel include mainly: performance definition or job expectation (what is expected of employees); performance facilitation; and performance encouragement. The above three exhibit themselves in the district work-plans, quality and quantity of personnel, the finances and other resources, the political dynamics within the decentralisation process and the performance outputs.
Without a clear attention to the right personnel dimensions in the decentralisation process, the whole policy may fail to make the desired impact because personnel is a cross cutting ingredient in all sections of policy implementation. This study, therefore, assessed the effect of the decentralisation policy on the performance of the district personnel.

1.3 Objectives of the study

1.3.1 General objective
The general objective of the study was to assess the effect of decentralisation on the performance of district personnel in Uganda and Tororo District Health Directorate in particular.

1.3.2 Specific objectives
The specific objectives of the study were as follows:

- To assess the nature of the performance of personnel in terms of their quantity and quality;

- To assess the extent to which the personnel are accessible to the local people;

- To explore perceptions from consumers of services on the current level of performance in terms of accessibility and satisfaction; and

- To identify the key constraints affecting the effectiveness of the decentralised personnel in the district.

1.4 Scope of the study

Decentralisation in Uganda has manifested itself in legal, political, administrative and financial aspects in the various districts. Due to limited resources in terms of time and finances, this study
confined its focus to the effects of decentralisation to performance of the Health Directorate personnel in Tororo district since the enactment of the legalisation of the decentralisation policy in 1997 in the Local Governments Act. The period from 1997 to date is important to this study because it spells out the Local Government terms enacted by a directly elected Parliament under which the decentralised personnel has been operating. The data for the study was collected from the District, the Municipality, Sub-county and Parish levels of Tororo Local Government with focus on the personnel operations vis-a-vis the Health directorate structural set up for service delivery in the decentralised system. Tororo district was purposively selected because it was one of the first districts to embrace the current decentralisation policy. It had gone through the whole cycle of decentralisation by Ugandan standards.

1.5 Significance of the study

The decentralisation policy increased the levels of roles and responsibilities of the Local Governments of the districts. Personnel being a key player in the realisation of the decentralisation policy's goals, has inevitably had to contend with challenges in the process. Through this study, the magnitude of the challenges faced by health personnel in the decentralised district of Tororo was assessed empirically. This has brought out new knowledge of how health personnel in Tororo is prepared in relation to the decentralised roles and responsibilities, human resource gaps and the factors that need to be addressed for a better district personnel. The knowledge generated will assist the district Local Government, Central Government and other stakeholders in improving human resources management leading to better service delivery.
CHAPTER TWO - LITERATURE REVIEW

2.1 Introduction

This chapter presents the study theoretical and conceptual frameworks and reviews literature on Uganda’s Decentralisation policy, personnel performance, staffing and training of personnel. It also reviews literature on district personnel and national reforms, personnel facilitation and motivation and DSCs and their capacity to handle personnel.

2.2 Theoretical Framework

The theories of decentralisation include: the liberal theory, the economic theory/public choice theory and the Marxist theory. The theories have informed much of contemporary academic, practitioner and political argument about local government issues. The theory found to be most relevant by this study is the liberal theory as it directly advocates for the goodness of personnel decentralization for better performance. In support of the above, Lubanga (1998, p. 70-71) quotes Vincent Ostrom and also adds that;

Personnel decentralisation has its origin from the liberal school of political thought. … Under personnel decentralisation, because of the proximity of the employer and the employee and given their mutual interest, effective attachment is likely to develop and, along with it, reciprocal accountability – i.e. improving performance and eliminating organizational failure.
2.2.1 The liberal theory
This theory has developed a forceful case for autonomous, elected local authorities. First local
government is grounded in the belief that there is value in the spread of power and the involvement
of many decision-makers in many different localities. The second argument rests on the view that
there is strength in the diversity of response. That needs vary from locality to locality; as do wishes
and concerns; local governments allow these differences to be accommodated. The third argument
rests on the view that local government is local. This facilitates accessibility and responsiveness
because councillors and officers live close to the decisions they have to make, to the people whose
lives they affect and to the areas whose environment they shape. The theory further argues that its
small scale makes local government more vulnerable to challenge than central government. Its
visibility makes it open to pressure when it fails to meet the needs of those that live and work in its
area. Lastly, the forth argument rests on the view that local government has the capacity to win
public loyalty. It can better meet local needs and win support for public service provision because it

2.2.2 Public-choice theory
The assumption is that decentralisation, as a mode of governance will enhance speedy delivery of
social services. Public-Choice theory is built on the proposition that individual preferences for local
public services vary from place to place, because tastes and willingness to pay differ for geographic,
cultural and historical reasons (and that preferences within each locality are reasonably
homogenous). For this reason, it is argued that central provision of local public good, (if it tends to
be uniform across the country), is likely to please nobody. It therefore is argued, that States should
only offer those services that correspond to local needs (Klugman, 1994). It is also argued that
information is an important factor bearing on social service delivery. When there is insufficient or
asymmetrical information, it is difficult for government decision-makers’ to predict the
consequences of their decisions. The probability of disparities between decision-makers ideas and the actual local impact of the decision is much greater in a centralized context. This problem can be alleviated; it is argued, by virtue of having autonomous centres of decision-making which function independently of the central authority.

Economists who explore the issues of efficiency and decentralisation in neo-classical theoretical terms raise another theoretical justification for decentralisation. It is argued that decentralisation reduced the unit cost of providing public goods and services. That it tends to lower unit costs, through simpler delivery procedures and building upon existing local resources, knowledge, technology and institutional capacities (Allen, 1987; Klugman, 1994).

Therefore, from a ‘public-choice’ angle, decentralisation is a situation in which public goods and services are provided through the revealed preferences of individuals by market mechanisms. “Public-choice” theorists contend that under conditions of reasonably free choice, the provision of some public goods is more economically efficient when a large number of local institutions are involved than when the central government is the provider. The argument here is that a larger number of providers of goods and services offer citizens more options and choices that they need.

2.2.3 The Marxist theory
The main ideas of this theory were put forward by among others, Katzelson, Cowson and Saunders. According to this theory, provision and consumption of goods and services are influenced by class differences. It is in light of this that the theory contends that any local government with intentions of implementing decentralisation programmes must take into account the issue of the local state and the reproduction of the capitalist class. Here the theory argues that local government institutions
play a role in the state’s reproduction of the conditions in which capitalist accumulation can take place. That the local state usually supports the national capitalist state because its institutions are part and parcel of the national capitalist. The theory tackles the distinction between social consumption functions and social investment policies. The argument is that social investment policies are aimed at maintaining the production of goods and services in the economy by supporting the profitability of the private sector. Social consumption policies, in contrast, are aimed primarily at supporting the consumption needs of diverse groups in the population who for various reasons cannot fulfil all their requirements through market purchase. In this theory, local authorities are seen as fundamentally constrained by the dominance of politics at the centre.

2.3 Conceptual framework
The conceptual framework below presents the key study themes and summarises how key elements of Uganda’s decentralization (legal, political, financial and administrative powers) affect the factors that influence personnel performance, which is later explained in personnel quality, quantity, accessibility, effectiveness and client satisfaction. The status of the legal, political, financial and administrative powers decentralised to the district have a positive or negative effect on the sub-themes under the factors influencing personnel performance. This effect consequently dictates the effect of decentralisation on the personnel performance in terms of personnel quality, quantity, accessibility, their effectiveness and finally the client satisfaction of the delivered performance.
2.4 Uganda's Decentralisation policy

Asiimwe et al (2000, p.2) and Nsibambi (1998, p.2) present Uganda's decentralisation policy objectives as follows:

- Transfer real power to the local governments and thus reduce the work load on remote and under-resourced central officials;

- Bring political, managerial and administrative control over services to the point where they are actually delivered and thereby improve accountability, effectiveness and promote people’s ownership of programmes and projects executed in their districts;

- Free managers in local government from constraints of central authorities to allow them to develop organisational structures that are tailored to local conditions;

- Improve financial accountability and responsible use of resources by establishing a clear link between the payment of taxes and the provision of services they finance; and

- Improve the capacity of local councils to plan, finance, and manage the delivery of services to their constituents.

Therefore, Uganda's decentralisation policy aims at empowering the local populations through democratisation, participation, accountability, responsibility, efficiency and effectiveness.

The Ugandan system of Local Government/decentralisation is based on the District as a unit under
which there are lower Local Governments and Administrative Units. The Local Government is based on a Council which is the highest political authority within its area of jurisdiction and which has legislative and executive powers (Article 180 of the 1995 Constitution). One-third of each Local Government Council seats is reserved for women; the Article also provides attention to affirmative action for all marginalised groups of persons.

The created District Councils were legally empowered to handle personnel matters at the Local Government level through the District Service Commissions. “Personnel decentralisation may be manifested in two classic typologies: the separate personnel system, and the unified personnel system” (Lubanga, 1998, p.69). In the separate personnel system, Local Governments become the ultimate employers and have powers to hire and fire their employees. While in a unified personnel system, the Local Government service runs parallel to that of the central government. Here the local employees are appointed, promoted and disciplined by a national or Local Government Service Commission. Another typology is the hybrid system, which tends to blend the separate and unified personnel systems. Uganda, like many developing countries, that have adopted a separate personnel system, at the same time has some traces of the unified system. As a result, it has taken systemic precautions against possible irregular practices by the District Service Commissions (DSCs) which replaced the Public Service Commission (PSC) in handling Districts’ personnel matters (Lubanga, 1998, p.70). The Local Governments Act, 1997 testifies to this where it stipulates in section 60, subsection 2 that “a person aggrieved by a decision of the DSC may appeal to the PSC, provided that the ruling of the DSC shall remain valid until the PSC has ruled on the matter.”

Uganda’s personnel decentralisation therefore took a leaning towards a district separate personnel system starting with the provisions of the Local Governments (Resistance Councils) statute, 1993
later replaced by the Local Governments Act, 1997.

The statute provided for instant change of status of Central Government officers who were serving the districts in newly decentralised departments. Effective 31 December 1993, when the statute came into force, all staff were "frozen" in the districts: they were assumed to have been appointed by the District Service Committees even though those committees were yet to be appointed (Lubanga, 1998, p.75).

Each district has a DSC consisting of members as the District Council determines, at least one of whom represents urban authorities. All members are appointed by the District Council with the approval of the PSC as per Article 198 of the 1995 Constitution. The result is that the DSC has power to manage her personnel, that is, to appoint, confirm, develop and discipline district personnel.

The advent of decentralisation brought together politicians and technocrats in the Local Governments. Staff in Local Governments have to interact and work with the political leaders much more closely than ever before. It also changed reporting relationships and the working environment for staff in the Local Governments. The working together of decision-makers and implementers in one locality has several advantages. There are reduced bureaucratic delays in terms of making decisions, preparation and approval of plans, budgets and funds. Accountability can be made much faster and so is the feedback (Lubanga, 1998, p.82).

The Local Governments Act, 1997, in relation to district personnel further states the following:

That the Standing Orders, training and qualifications of Local Government staff shall be determined by the District Council but shall conform with those prescribed by Government generally.

DSC in consultation with the PSC with the approval of the Council shall make staff regulations
prescribing the manner in which the personnel of the Local Government shall be controlled and managed. The Chief Administrative Officer shall be the head of the Public Service in the District and the head of the administration of the District Council and shall be the Accounting officer of the District. All District staff shall be responsible to the District Council.

The above review indicates that the human resource issues in all Districts of Uganda and Tororo district for purposes of this study, were handed over to the Local Governments at District level, to plan and develop within the general prescriptions of the Central Government.

2.5 Performance of personnel

The Uganda Parliamentary Sessional Committee on Public Service and Local Government report on the national budget for the financial year 2002/03 re-echoes the need to monitor the effect of decentralisation on performance. The report recommended: “the Local Government Finance Commission should design the Local Governments Data Base reflecting the levels of service performance for each of them” (Parliament of Uganda 2002).

As noted earlier in the background, based on Cascio’s three key factors that determine performance of personnel, the personnel performance is a policy-propelled process that culminates into outputs/services to intended beneficiaries (Cascio 1986, p.423). Cascio’s three key factors of personnel performance, that is; performance definition, facilitation, and encouragement, are well taken care of in the Ugandan Decentralisation Policy through the powers and functions spelt out in the Local Governments Act, 1997 as summarised below:
Concerning district personnel matters, the Central Government establishes terms and conditions of service; seconds staff requested by District or Urban Councils; the Public Service Commission (PSC) approves, guides and coordinates members of DSC. The PSC also hears and determines grievances from persons appointed by DSCs and its ruling on appeals is final.

Roles played by the District/Municipal/Town Council for personnel management include: determining the structure, establish or abolish offices in the District Public Service; pay salaries of established staff; responsible for Human Resource Management and Development including staff training; The Council through the DSC recruits all persons in the service of Local Governments including Health, Education and the Traditional Civil Service

Regarding service delivery, the Central Government sets national standards, national policy and issues guidelines; handles arms and defence; the judiciary, foreign relations and external trade; taxation and taxation policy; banks and banking; referral hospitals; national elections, epidemics and disasters, and demonstration/pilot projects, among others.

The District Councils in relation to service delivery are mandated to manage nursery, primary schools, secondary schools, trade schools, special schools and technical schools; District hospitals, health centres IV, III, II and I; maternal and child welfare; control of communicable diseases; primary health care; vector control; provision and maintenance of water supplies. They also manage construction, rehabilitation and maintenance of feeder roads; all decentralised services including crop, animal and fisheries; husbandry extension; entomological services and vermin control; land administration; land surveying; physical planning; forests and wetlands; licensing of produce buying; district information etc. They monitor the administration and provision of services in the District;
monitor and supervise projects undertaken by Government; Local Governments and Non-Governmental Organisations in the District; issue standards and policy guidelines to lower Councils; regulate, control or license any of the services which the Council is empowered to do; and registration of marriages, births, and deaths for transmission to Registrar General.

Though the Decentralisation policy intended to improve performance, there are studies that have found results to the contrary. Jitta, Nangendo & Sekiwunga, (2002, p.vi) while studying health service delivery in Gulu district found out: “The free government health services were generally poor such that people went to Mission health units ... . The staff were generally few and under-trained.... In addition drugs were not available ... Politicians sometimes divert funds meant for health activities.” While studying health in Moroto district, the team reported “the drugs were inadequate in health units due to erratic release of funds, drugs take long and some people get discouraged to seek health services. The capacities of staff are poor and, need to be strengthened” (Jitta, Higenyi, Nangendo & Sekiwunga, 2002, p.v).

Based on the outgoing literature on District personnel performance, in order to understand the effect of decentralisation on performance of personnel, it was felt necessary to make a thorough study of such issues as the district work-planning; roadblocks to performance, adequacy of resources and staffing. It was also necessary to understand the rewards for performance; and the perception of the consumers of the services resulting from the performance.

2.6 Staffing

The personnel question in management has for long been of great importance to scholars of
management seeking to improve service delivery. Tukahebwa (1997, p.110-113) points out that organisation theorists like Frederick Taylor, Max Weber, Chris Argyris and Abraham Maslow have tried to answer the question of how human activity could best be organised to achieve societal goals in an efficient and effective manner. For decentralised Local Governments in Uganda being corporate public organisations, it is therefore important to know how best their personnel are organised and as such whether they are capable of handling the jobs assigned to them.

On staffing, Stoner and Wankel (1986, p.319), Pigors and Myers (1981, p.421-2) argue that, the most important resources of an organisation (like the District) are its human resources - the people (personnel) who supply the organisation with their work, talent, creativity, and drive. Thus the most critical tasks of a manager are the recruitment, placement, training, and development of people who will best help the organisation meet its performance goals handled through the staffing management function. Stoner and Wankel conclude that the staffing process includes (1) human resource planning, (2) recruitment, (3) selection, (4) induction and orientation, (5) training and development, (6) performance appraisal, (7) transfer, promotion, and demotion, and (8) separation.

There are indications that most districts suffer from under-staffing while a few have overstaffing problems. The five districts under study in 2000 by Asiimwe and others found out that the average staffing strength of four districts of Arua, Mbale, Mbarara and Rakai stood at 77% with a shortfall of 23%. On the other hand, Kampala district was overstaffed with the total standing at 115%. The shortfall in staffing was more pronounced in the Directorates of Health, Production and Marketing, Education, and Gender and Community Based Services amidst overstaffing in other Departments. Under-staffing in such Directorates that require field staff at sub-county and lower levels signals a major human resource capacity problem, while on the overstaffing, it is abuse of the confidence
vested in the independence of personnel decentralisation.

Generally Districts in Uganda have a problem of under-qualified staff. Apart from staff at higher positions such as Chief Administrative Officers (CAOs) and Heads of Directorates who generally meet the stipulated minimum qualifications, staff in the middle management level generally lack the minimum required qualifications. Areas of health, agriculture, auditing, surveying, physical planning and works and technical services are most affected. This was partly attributed to the limited number of qualified personnel nationwide and insufficient funds to pay their salaries when recruited. For instance, in Mbale District, Accounts Clerks were reportedly doing auditing work. Interestingly, Rakai district which had received relatively sufficient support for human resource development by DANIDA, the Principal Personnel Assistant who was acting as Head of Personnel Department only had an ‘O’ level certificate.

2.7 Training of personnel

Initial and continuous training provided to districts by the central government through the Decentralisation Secretariat prepared the district personnel to meet the new challenges of working independent of the centre. Lubanga (1998, p.84) basing on his 1996 study, reports that Government had funded a programme to strengthen registries and management information systems of all districts and urban councils, the study also reported the launching of intensive training of officers of district planning units. According to the same study, decentralised planning guidelines had been developed and planning units were being equipped. Personnel decentralisation obliged the Ministry of Local Government to issue guidelines and procedures which have gone a long way in creating reference documents essential for the management of the implementation of the new system of decentralisation to ensure harmony in the districts’ personnel management.
Donor funded programmes are another major source of funding and technical support for human resource development in districts. Programmes that were noted included “United Nations Capital Development Fund (UNCD) programme for Uganda, USAID sponsored Teacher Development and Management Support (TDMS) Programme” (Asiimwe et al, 2000, p.29). Other donors like the World Bank have been supporting the Capacity Building project, while DANIDA has played an important role in development of Rakai district.

Decentralised districts have exhibited willingness to plan and fund training district personnel. In their study of districts of Arua, Kampala, Mbale, Mbarara and Rakai, Asiimwe and his team found that all districts had allocated funds for training in their budgets; this gave evidence of deliberate efforts to improve capacity of the staff in the districts. In general, the reported skills acquired by staff indicated that efforts to raise capacity have been more in administration, finance, health and community development rhyming well with Local Governments’ new roles of planning, resource and community mobilisation. They also reported that all districts were able to raise personnel training funds to the level of short-term courses in form of workshops and seminars. Despite the efforts made to build capacity of staff, there still remained a number of gaps at all levels of Local Governments to perform effectively more so in areas of Administrative, Information Communication Technology (ICT), Communication Skills, Civil Works and Financial Management.

2.8 District personnel and national reforms

Asiimwe et al (2000, p.22) pointed out that Decentralisation has been implemented alongside other national reforms. Notable among these reforms are privatisation (private sector development), civil service reform, Universal Primary Education (UPE) and Agricultural Modernisation. They note that the decentralised personnel capacity has not proportionately matched the above changing
2.9 Personnel facilitation and motivation

Stoner and Wankel (1986, p.438) note that in management, motivation is very important since managers must channel people’s motivation so as to achieve personal and organisational goals. In Uganda, the under-staffing problem at the district and sub-county levels is largely explained in the context of local governments’ inability to raise sufficient funds to recruit, adequately remunerate and facilitate suitably qualified and skilled personnel. The Asiimwe study found out that engineers recruited could not stay long because the monthly salary paid of Ug. Shs. 670,000/= was a-third of what private companies were paying. Ssali in Monitor (2000, December 21, p.11) reported that Masaka Municipal council workers had gone on strike for non-payment of their salaries for four months; the Town Clerk attributed it to low revenue collection.

2.10 District Service Commissions (DSCs) and their capacity to handle personnel

There is evidence to suggest that the DSCs’ hands are tied in so far as taking effective disciplinary measures are concerned. In Arua and Rakai the interdiction of Town Clerks have ended up in courts of law with direct costs to the districts amounting to millions of shillings. The interdictions have been found to be more common than dismissals. This was partly because of the controversies arising between DSCs and the politicians, donors and weaknesses in the Local Governments Act 1997. The result has been a large number of officials in acting positions in many Directorates. Mutumba in New Vision (2001, September 7, p.5) reported that the PSC noted the low capacities of ‘A’ level or diploma as minimum qualifications required of the DSC members by the Local Governments Act. Subsequently the PSC was asking the Parliament to raise the minimum
.qualifications of members of the DSCs to a University degree so as to meet the demands for high
calibre personnel currently required at districts.
CHAPTER THREE - METHODOLOGY

3.1 Introduction

This chapter describes the methods used in the collection, presentation and interpretation of data. The chapter covers the following sub-topics: study design, area of study, study population, and sample selection, methods of data collection, processing and analysis of data.

3.1 Study design

This research used a descriptive case study design. This design “describes in-depth the characteristics of one or a limited number of cases” (Varkevisser, Pathmanathan & Brownlee, 1991, p.121). This design was therefore, selected to enable the in-depth description of the effect of decentralisation on personnel performance in Uganda with focus on the Health Directorate of Tororo district using qualitative and quantitative techniques.

3.3 Area of study

The study was carried out in June 2003 in Tororo district of Eastern Uganda. Tororo district was chosen because it was one of the first twenty-seven districts to be decentralised by 1994, thereby presenting longer exposure to the decentralisation policy. According to the 30 January 2002 Monitor Newspaper Tororo supplement, the district had 24 sub-counties including two divisions in the Municipality. It has a total population of 559,528 as per the 2002 Uganda Population and Housing Census results; the population is made of mainly the Badama, Banyole and Iteso ethnic groups. Tororo district Health Directorate is made up of the health headquarters, 5 sub-districts
(health centre IV) at Constituency/County level, 17 health centre III at sub-county level and 31 health centre II at parish (Tororo HMIS, 2002).

3.4 The study population

The population targeted for this study included: personnel and politicians at district, municipality, sub-county and parish levels. It also targeted NGOs and the private sector, and the consumers of health services. Table 1 below summarizes the study population; outlining the various sources of information sought; and the data collection techniques or tools used to collect the information needed.
Table 1: Study population, information and data collection techniques used

<table>
<thead>
<tr>
<th>Population/source</th>
<th>Type of information</th>
<th>Technique/tool</th>
</tr>
</thead>
</table>
| Personnel from Health headquarters at the District, health centre IV, III and II | -District performance definition  
-Performance facilitation  
-Performance encouragement  
-Consumer perceptions | -Key Informant Interviews  
-Questionnaire  
-Documents, records, minutes review |
| District Politicians, policy makers and administrators  | -District performance definition (long term plans)  
-Performance facilitation (staff planning and supervisory)  
-Performance encouragement | -Key Informant Interviews  
-Documents, records, minutes review |
| Consumers (citizens)                                  | -Service accessibility, satisfaction, quantity, quality, timeliness, and fairness. | -Key Informant Interviews  
-Observation and exit interviews of patients/caretakers at health units  
-Focus Group Discussion  
-Documents review |
| Non Governmental Organisations                        | -Performance facilitation through relationship with district personnel.             | -Key Informant Interviews  
-Documents review |
| Private Sector                                        | -Performance facilitation through relationship with the district, the personnel and contracting out. | -Key Informant Interviews  
-Documents review |
| Documents, records, district plans and minutes        | District personnel performance trends in Health sector, personnel quality           | -Documents review |

3.5 Sample size

The sample was composed of 10 key informant interviews including a politician at the district and sub-county level, 3 from the top administrators of the Directorate of Health and representatives of women, NGO health unit and the private health unit and 3 from Health Management Committees at district, sub-county and parish.

Focus Group Discussions (FGDs) were carried out targeting female and male youth, adult men and women and Local Council leaders. Each group comprised of 10 homogeneous groups of women, youth, men and community leaders. A total of 10 FGDs were held with the community groups identified above to represent consumers of health services.

As for the quantitative data, for purposes of minimising the error and taking into account the limitation of resources in terms of time, personnel and finances, a sample of 150 district health staff out of about 660 from all health units were used for the administration of the survey questionnaire. The Kish and Leslie’s formula (1965) was used allowing for an error of 8%.

Exit interviews were administered to 30 patients or their caretakers in government and 30 in non-governmental health units (10 from each of Health centre II, III and IV respectively) from sampled health units.

3.6 Sampling procedure

The qualitative part of the study required purposive sampling targeting the various key informants with experience of the performance of Tororo district decentralised personnel. With the
quantitative sample, the 150 district Health staff and 60 patients/caretakers were selected by proportionate representation using the stratified random sampling method to ensure that all health facilities (at district, sub-county and parish levels) were represented.

3.7 Data collection

3.7.1 Qualitative data collection
Key Informant Interviews were carried out to generate information on perceptions and experiences from senior Local Government officials and politicians regarding the personnel policies and other aspects of personnel performance such as plans, facilitation, encouragement and output. Specifically targeted were: politicians, the Health Directorate administrators, representatives of women, NGOs and the private sector, and sub-county officials. Data was also collected from users of health services through focus group discussions. The qualitative data was used to strengthen the quantitative data derived from the survey.

3.7.2 Quantitative data collection
With quantitative data, a questionnaire was administered to find out issues on personnel definition of performance, how they are facilitated and encouraged, and skills available and needed by staff and politicians. The survey was conducted with sampled staff at district, county and sub-county levels (health centre IV, III and II) for quantifiable data on available personnel. The structured and semi-structured questionnaires were administered to sampled staff to collect data on numbers, qualifications, staffing gaps, demographic data, perceptions and motivation of Health staff of Tororo district. Documents were also used in supplementing the above tools. In addition, exit interviews and observations at health units were carried out with patients/caretakers to generate data on consumers’ perceptions of the current personnel performance levels.
The information collected by the above two methods was supplemented by a review of available relevant documents (for secondary data) on personnel issues in Tororo district before and after the Local Governments Act, 1997. Documents targeted include district budgets, development plans, staff structures, outputs and studies related to personnel issues. A checklist of issues to guide the researcher in collecting the secondary data was used. The collected data was cleaned up and made ready for data analysis. Prior to the main study, a pre-test of the tools and training research assistants was carried out to ensure the validity and reliability of the research instruments.

3.7.3 Ethical considerations
As by the Laws of Uganda, final ethical clearance was sought and given by the Uganda National Council for Science and Technology (UNCST). Introductory letters were secured from the UNCST and Makerere University Department of Political Sciences and Public Administration to the authorities in the district. During data collection, the respondents were assured that the study will be purely for academic purposes and the respondents’ responses were to be kept strictly confidential and anonymous.

3.8 Data analysis

3.8.1 Qualitative data analysis
Analysis of the qualitative data from key informant interviews and FGDs was transcribed from field recordings, then data was entered into computer and coded (identifying the relevant themes) using Ask Sam version 3.0 for Windows computer package. The coding categories were the sub-items (indicated under each of the main themes in the conceptual framework).
3.8.2 Quantitative data analysis
The administered questionnaires were edited to ensure that all the required information was properly recorded. A coding frame was developed to capture all structured and semi-structured questionnaire responses; the primary unit of analysis was the Local Government staff who included unit in-charges and at least one staff from each health unit randomly selected. The data was entered in the computer using Epi-Info 6.04 and analysed using SPSS (Statistical Package for Social Sciences) 10.0 for Windows. For quality assurance, double data entry was used and validation done to ensure accuracy. From the computer entries, data was summarised as frequencies, means and percentages.
CHAPTER FOUR - STUDY FINDINGS, INTERPRETATION AND DISCUSSION

4.1 Introduction

Chapter four presents and discusses the results of the study. Information was handled in the order of respondents’ background characteristics, job expectations/performance definition, performance facilitation, performance encouragement and quality of service. This arrangement was picked because it presents the systematic flow of personnel performance as earlier supported by Cascio (1986, p. 423) and outlined in chapters 1 and 2 above.

Objectives of the study will mainly be answered as follows: The objective of assessing quality of personnel will be answered by job expectation and knowledge and skills of personnel presentation; quantity of personnel will be answered by the staffing measure, while performance facilitation (including feedback, equipment, supplies, workspace and organisational support) and performance encouragement will cater for the objectives of identifying key constraints to effectiveness and personnel accessibility; and finally client satisfaction will be catered for by the quality of service presentation.

4.2 Background characteristics of respondents

A total of 150 Tororo District Health personnel and 60 exiting patients/caretakers were interviewed by questionnaire from four out of the five Health Sub-districts of Tororo district. Additionally, 10 focus group discussions were held in Bunyole and Tororo Health Sub-districts (the furthest and nearest to the district headquarters) targeting female and male adolescents (10-19 years), female and male adults (20 years and above) and community leaders. Key informant interviews were administered to 10 respondents who were associated with the Tororo District Health Directorate.
work, including politicians and bureaucrats from the government and non-government health sector of the district. Documents at the Central Government and the Local Government were also reviewed for supplementary data.

4.2.1 Personnel respondents’ distribution by Health Sub-district (HSD), unit ownership and unit level

Table 2 below shows the distribution of personnel respondents by HSD, health units’ ownership and health unit levels. Tororo Municipality HSD, which has the biggest, and the largest number of health units contributed the highest number of personnel respondents (46%). Tororo Municipality was followed by Bunyole (29%), while Tororo County contributed (15%) and West Budama North (11%).

71% of personnel interviewed were from Government units, 22% personnel came from NGO health units, while 7% were interviewed from private units. Personnel interviewed as by health unit level were 38% at hospital level, 37% at HCII, 19% at HCIII and 6% from HCIV.
Table 2: Distribution of personnel respondents by HSD, unit ownership and unit level (N=150)

<table>
<thead>
<tr>
<th>Health sub-district</th>
<th>No. of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tororo Municipality</td>
<td>69</td>
<td>46.0</td>
</tr>
<tr>
<td>Bunyole County</td>
<td>43</td>
<td>28.7</td>
</tr>
<tr>
<td>Tororo County</td>
<td>22</td>
<td>14.7</td>
</tr>
<tr>
<td>West Budama North</td>
<td>16</td>
<td>10.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>150</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Unit ownership</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Government</td>
<td>107</td>
<td>71.3</td>
</tr>
<tr>
<td>Non Government Organisation</td>
<td>33</td>
<td>22.0</td>
</tr>
<tr>
<td>Private</td>
<td>10</td>
<td>6.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>150</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health unit level</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>57</td>
<td>38.0</td>
</tr>
<tr>
<td>HC II</td>
<td>55</td>
<td>36.7</td>
</tr>
<tr>
<td>HC III</td>
<td>29</td>
<td>19.3</td>
</tr>
<tr>
<td>HCIV</td>
<td>9</td>
<td>6.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>150</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

4.2.2 Background characteristics of personnel respondents

Table 3 below shows the summary of background characteristics of personnel respondents. Starting with the age and sex of personnel respondents, the table shows that age range of 20 to 29 years (31%) had the largest number of respondents and age range 60 to 69 (3%) had the smallest number. The female constituted the largest number with 51% while the male were at 49%.

The majority of health personnel interviewed had attained Secondary education (62%), post-secondary (25%) and University (3%). Primary leavers were (9%). Only (1%) reported that they had never gone to school. As for duration in service, over half of the respondents had worked for a
duration of 1 to 10 years (57%) a possible indication of new staff recruited during years of decentralisation, they were followed by (21%) for 11 to 20 years service range, (19%) for 21 to 30 years, (3%) for 31 to 40 years and lastly (1%) for 41 to 50 years of service.

Positions held by personnel respondents constituted nursing assistants forming the biggest proportion of the respondents interviewed (20%), followed by nurses/midwives (19%), support staff (17%) and unit in-charges (15%) who included nursing assistants, nurses, midwives and clinical officers. Other officers (10%) (comprising of dispensers, dental, radiography and orthopaedic officers), vaccinators (9%), clinical officers (5%), laboratory (5%) and medical officers (1%).
Table 3: Background characteristics of personnel respondents (N=150)

<table>
<thead>
<tr>
<th>Sex</th>
<th>No. of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>77</td>
<td>51.3</td>
</tr>
<tr>
<td>Male</td>
<td>73</td>
<td>48.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>150</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>No. of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 to 29</td>
<td>46</td>
<td>30.7</td>
</tr>
<tr>
<td>30 to 39</td>
<td>38</td>
<td>25.3</td>
</tr>
<tr>
<td>40 to 49</td>
<td>45</td>
<td>30.0</td>
</tr>
<tr>
<td>50 to 59</td>
<td>17</td>
<td>11.3</td>
</tr>
<tr>
<td>60 to 69</td>
<td>4</td>
<td>2.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>150</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level of education</th>
<th>No. of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>14</td>
<td>9.3</td>
</tr>
<tr>
<td>Secondary</td>
<td>93</td>
<td>62</td>
</tr>
<tr>
<td>Post secondary</td>
<td>38</td>
<td>25.3</td>
</tr>
<tr>
<td>University</td>
<td>4</td>
<td>2.7</td>
</tr>
<tr>
<td>Others</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>150</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Years of service</th>
<th>No. of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to 10</td>
<td>85</td>
<td>56.7</td>
</tr>
<tr>
<td>11 to 20</td>
<td>32</td>
<td>21.3</td>
</tr>
<tr>
<td>21 to 30</td>
<td>28</td>
<td>18.7</td>
</tr>
<tr>
<td>31 to 40</td>
<td>4</td>
<td>2.7</td>
</tr>
<tr>
<td>41 to 50</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>150</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Position held</th>
<th>No. of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing assistant</td>
<td>30</td>
<td>20.0</td>
</tr>
<tr>
<td>Nurse/Midwife</td>
<td>29</td>
<td>19.3</td>
</tr>
<tr>
<td>Support staff</td>
<td>25</td>
<td>16.7</td>
</tr>
<tr>
<td>In-charge</td>
<td>22</td>
<td>14.7</td>
</tr>
<tr>
<td>Other officers</td>
<td>15</td>
<td>10.0</td>
</tr>
<tr>
<td>Vaccinator</td>
<td>13</td>
<td>9.0</td>
</tr>
<tr>
<td>Clinical officer</td>
<td>7</td>
<td>4.7</td>
</tr>
<tr>
<td>Laboratory</td>
<td>7</td>
<td>4.7</td>
</tr>
<tr>
<td>Medical officer</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>150</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
4.3 Respondents’ perceptions of key terms

4.3.1 Decentralisation
95% (142/150) of the personnel reported to have heard of the term Decentralisation during the course of their activities. On the meaning of Decentralisation, 55/145 respondents defined it as transfer of powers from the Central Government to the district, 47/145 as bringing services nearer to the people, 12/145 saw it as making the district independent of Central Government in terms of provision of services. Other definitions included services and decision-making by the people and working within one district, while 5/145 could not precisely define it, these included nurses, nursing assistants and a clinical officer.

As for participants in the 10 FGDs conducted in Butaleja and Osukuru sub-counties’ perception of the term decentralisation in relation to health, almost all respondents viewed decentralisation as a process of helping in bringing services nearer to the people through construction and renovation of health units, improving health staffing and empowering the people to supervise the services. Below are some FGD participants’ definitions:

Improvement of the staffing at the rural health units – I mean that we used to have only two health workers but we now have ten in the health unit (FGD - male youth, Butaleja).

Decentralisation means bringing health units nearer to the people and makes people happy. But these health centres are not well facilitated, for example, sometimes there are no drugs and people are still referred to drug shops in Tororo town (FGD - leader Osukuru).

In-depth interviews with district key informants also defined decentralisation as a policy transferring powers from the Central Government to Local Governments to manage delivery of services to the
district people. One DHT official said: “Decentralisation means the transfer of budgeting, staffing and monitoring powers from the Centre to the district and then transferring the same powers from the district to lower levels to enable delivery of services to citizens” (KI, DHT).

It was observed that a good number of people had sufficient knowledge of understanding of decentralisation; that it operates within the framework of transfer of political, legal, financial and administrative powers from Central to Local Government to promote service provision to the residents as elaborated by Nsibambi (1998, p.6).

### 4.3.2 Job performance
The personnel that were interviewed gave various ways as to how they understood the term job performance. Of the total 148 responses, the biggest proportion (40%) understood it as a way in which one carries out his/her duties, 32% presented it as an achievement of job descriptions/set targets, 16% reported performance to be a measure of how one fulfils one’s duties. However, 4% could not precisely define job performance, these included five nursing assistants and one support staff.

The study revealed that there is agreement that job performance is a conscious effort to achieve planned future desired results. A key informant (DHT official) said: “Job performance means what you do and how you do it and you do it with the aim of achieving goals as they are set” (KI, DHT).

### 4.3.3 Personnel decentralisation
On the question of what the respondents understood by the term personnel decentralisation, a total of 140 personnel responded. A quarter (25%) could not precisely tell what they understood by the term, these included a medical officer, a clinical officer and some in-charges. Nursing assistants
formed the biggest proportion of 49% (17/35) of those who said they did not understand the term. 19% (20/105) of those who said they understood the term perceived it as the district getting powers to decide and employ people where it deems necessary, 14% called it bringing personnel services closer to the people and another 14% were for an employee working in his/her own district of origin. Other responses were staff being employed in a district without transfer (3%) and limited number of people working in a district (3%). This shows that with time there has been some improvement in understanding the term when compared to the 1998 Tororo and Busia districts’ study findings by Kyaddondo (2002, p.11) where he reported: “Majority of health unit workers had not conceptualised the decentralisation policy and its implication to their terms and conditions of service. … A few could only give very abstract information, many of them not certain if what they were saying was right.”

In-depth interviews further revealed that even some high-ranking district officials understood personnel decentralisation as recruitment of district personnel from within the district as opposed to open national recruitment. For example a DHC official said: “Unlike before, now all cadres of personnel are recruited locally” (KI, DHC). A member of the HUMC also pointed out: “Personnel Decentralisation is the recruitment of workers from the district where they work. All this was transferred from the Centre and carried to the district” (KI, HUMC).

From the above presentation, there was a misconception of personnel decentralisation, while the law demands for open national staff recruitment for the district, some Health Directorate staff and politicians interviewed conceived it as closed recruitment from within the district. This is likely to influence their decisions in rejecting applications of candidates from other districts especially as high-ranking officers also hold the misconception.
4.4 Job expectations: the quality of a personnel able to explain what is expected of them and focus on performance goals

This section presents results on the personnel’s ability to explain what is expected of them on their jobs and issues of their job descriptions that enable them to focus their performance. Issues handled were: personnel perception of their job expectations, setting of goals, reminders of performance goals, job descriptions and the effect of decentralisation on job expectation.

4.4.1. Personnel perception of their job expectations

Almost all personnel were capable of describing their current jobs at the health units where they were working, hence they knew what they were expected to do. It was reported that decentralisation of the personnel officer to the District Health Directorate had enhanced personnel exposure to knowing what they are supposed to do. A DHT official pointed out: “The introduction of the personnel officer at the DDHS as a result of Decentralisation has been of great help, because when we go for supervision, she explains job descriptions of different workers and who is supposed to do what” (KI, DHT).

But the study also revealed that there were weaknesses in the way the district Health Directorate was creating awareness of the activities of the health office among the different stakeholders, hence weakening the holistic approach to health services. A private health unit manager observed: “Previously, this organization used to sit in the District Health Management Team meetings but these days, we are not invited and I don’t know why. These meetings would let us know what is required of health” (KI, Private unit manager).
However, it was noted that through supervision, the Health Directorate helped in updating the stakeholders on what they were supposed to do. A private health unit manager also said: “Meanwhile, the district health office helps us in our activities because it sends a Medical Team to supervise us, to know what is going on and advise on what we are supposed to do” (KI, Private unit manager).

### 4.4.2 Setting of goals

As regards to who sets job goals for Health personnel, 26% reported that it was the District Director of Health Services (DDHS) as the one who sets their job goals, followed by the Ministry of Health at 22%, health units in-charges at 20%, followed by heads of NGOs 14%, and 11% saw themselves as setting their goals. Others reported as setting personnel goals - 7% (included HSD, Nursing Council members and politicians). On cross-tabulating goal setters with health units’ ownership, personnel responses from government units indicated the DDHS as setting their job goals (92%), while very few (4%) for NGO personnel and (4%) for private units personnel reported DDHS setting their goals. Heads of units were reported as playing greater role in setting goals for personnel of NGOs and private units. This indicates that the DDHS’ role, as head of Health in the district, was less felt in NGO and private health units than in Government units in terms of personnel performance direction.

It was observed that there is coordination between Central and Local Governments in setting of goals for health personnel, the Ministry of Health is still playing a big role as supported by a DHT official below. “Goals setting follows the national standards during the planning process, after prescribing a problem, we look for the goal to target, followed by designing objectives by the District Health Team which is supported by similar committees at Health Sub-district levels” (KI DHT).
4.4.3 Reminders of performance goals

On regularity of reminding personnel of their performance goals, the biggest proportion (47%) said they were reminded on a monthly basis, 15% quarterly, 15% on daily basis and 13% annually, while others (7%) included weekly and when problems arose. Those that have never been reminded were (3%) of all interviewed. This means that the majority of health personnel were getting timely reminders of performance goals.

The respondents reported that most of the reminders of their performance goals were oral (47%), and written (11%). However, 39% of the respondents were getting reminders both in verbal and written form, while 3% reported that they were not reminded.

4.4.4 Measurability of performance goals

95% of the respondents reported that performance goals were measurable while 5% reported that their goals were not measurable. Of those who said that their performance goals were measurable, 66% said that they were measured according to number of persons attended to, 21% basing on the activities/targets covered, 8% were for amount of drugs given out and 5% relied on feedback from patients.

4.4.5 Job descriptions

About being given job descriptions, 88% reported that they were issued with job descriptions. But 12% reported that they were not given, these included an in-charge, a dispenser, a dental officer, three nurses, two laboratory officers, seven nursing assistants and three support staff. Giving job
descriptions to the majority is a good indicator of focused performance of personnel, while it is the reverse for staff that had not received theirs.

4.4.6 Effect of decentralization on job expectation

On whether the current system of decentralisation is helping health personnel to clearly know what they are expected to do on their jobs, according to table 4 below, the majority of the personnel (72%) answered that it had helped them, 17% reported that it had no effect and 11% could not tell. Of the personnel who had worked for more than 10 years in service (44% - 65/148) or joined service before decentralisation, 71% (46/65) reported that decentralisation had helped improve personnel's knowing what they are expected to do, 25% reported that there was no improvement and only 5% could not tell. When asked to give ways through which decentralisation had helped them to clearly know what they were expected to do, of those respondents who reported decentralisation had helped them, the biggest proportion of 45% (48/106) reported it was through support supervision, 19% (20/106) by organising short term trainings, while 11% (12/106) reported having powers to plan and budget in relation to job descriptions. Others included knowing whom to report to, easy communication with supervisors and administrative units at lower levels.
Table 4: Respondents’ perception of how decentralisation has improved their job expectation knowledge

<table>
<thead>
<tr>
<th>Duration years in service</th>
<th>Personnel reported effect of decentralisation on job expectation</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Improved</td>
<td>Not improved</td>
</tr>
<tr>
<td>1 to 10</td>
<td>72.3%</td>
<td>10.8%</td>
</tr>
<tr>
<td></td>
<td>(60)</td>
<td>(9)</td>
</tr>
<tr>
<td>11+</td>
<td>70.8%</td>
<td>24.6%</td>
</tr>
<tr>
<td></td>
<td>(46)</td>
<td>(16)</td>
</tr>
<tr>
<td>Total</td>
<td>71.6%</td>
<td>16.9%</td>
</tr>
<tr>
<td></td>
<td>(106)</td>
<td>(25)</td>
</tr>
</tbody>
</table>

From the above results presented on personnel job expectation, it is clear that decentralisation in Tororo had improved majority of the Health personnel’s ability to know what is expected of them on their jobs thereby improving their quality and job performance.

4.5 Performance facilitation: the constraints to effectiveness and the quality, quantity and accessibility of personnel

Performance facilitation section presents results on the staffing status, action on elimination of roadblocks to performance and provision of adequate resources for making easy personnel tasks. It includes subsections on staffing, knowledge and skills, performance feedback, equipment, supplies and workspace and organisational support.
4.5.1 Staffing, knowledge and skills of personnel: the quantity and quality of the health-workers

This section presents and discusses results on staffing of the Health Directorate, adequacy of pre-service training for personnel, staff on-the-job training, and training needs and the effect of decentralisation on improving personnel job knowledge and skills.

4.5.1.1 Staffing of the Health Directorate

As a result of decentralisation, new health units have been opened to serve the created health administrative structures at county (HCIV), sub-county (HCIII) and parish (HCII) levels without proportionate increase in personnel. This has led to staff shortage per unit and consequently personnel doing work that is not on their job descriptions especially at many health centre II units where nursing assistants are in charge of tasks that would have been the responsibility of enrolled nurses.

Appendix 1 shows staffing gaps at Tororo government HCII, III and IV health units, revealing that 73% of recommended staff in the health units were not filled leaving the remaining 27% available staff heavily overloaded. Over 50% (14/27) staff categories had 100% staffing gaps, while another 19% (5/27) staff categories had staff gaps above 50%. Examples of key positions that were understaffed were medical officers, clinical officers, nurses and laboratory staff whose absence negatively affects personnel performance in health services delivery because their services are vitally needed. This situation led to all 13 government HCII and 17 HCIII not being headed by the approved staff cadres. Consequently, all HCII units were headed by nursing assistants, clinical officers grade II or health assistants headed HCIII, respectively.
According to appendix 2, the study further revealed that the hospitals both governmental and non-governmental suffered from the problem of understaffing. The nurses and midwives, though badly needed in all sectors, were the most understaffed. For instance, the Enrolled nurses filled positions were 33/64 (52%) at Tororo hospital, 10/32 (31%) at Busolwe hospital and 12/32 (38%) at St. Anthony hospital. In an effort to compensate for the nurses’/midwives’ understaffing, the nursing assistants (who train locally for only three months) were overstaffed (49/30 – 163% at Tororo, 23/15 – 153% at Busolwe and 18/15 – 120% at St. Anthony hospitals). This understaffing is likely to compromise the quality of services at these health facilities, for instance, understaffing could be one of the reasons why the waiting hours were long with some clients waiting for as long as five hours before seeing a health care provider as reported in both patient exit interviews and FGDs.

Similarly, Kyaddondo (2002, p.10) from his study of Busolwe hospital in Tororo district reported that by 1998 “the hospital did not have its staff establishment filled.” While studying five districts, Asiimwe et al (2000, p.14) found out that the average staffing strength of four districts of Arua, Mbale, Mbarara and Rakai stood at 77% with a shortfall of 23%. It is worth noting that they reported that the shortfall in staffing was more pronounced in the Directorates of Health and Education, among others. They also noted that staff in the middle management level, generally lacked minimum required qualifications like was the case for Tororo as highlighted above especially in the case of nursing assistants being in-charges of health units that are meant for enrolled nurses. A similar situation was reported by Batega (2003, p.57) who observed that “both districts (Bugiri and Tororo) were understaffed with critical staff but overstaffed with supportive staff such as nursing aides.” While in Kumi the DDHS noted: “We are operating at about 40% of our staffing needs yet currently there is a ban on recruitment of medical staff” (New Vision, 2003, July 27, p.4.).
Some key informants revealed that there was integration of activities as a coping method to the understaffing problem as one DHT reported: “Because of shortage of staff, there is integration of work whereby, for example, a midwife can also work as a vaccinator, a nursing assistant as an in-charge and as well as a vaccinator” (KI, DHT).

It was noted from in-depth interviews at the district that personnel performance under decentralization was having problems. The health workers were becoming fewer and fewer per unit because of the introduction of new health centres. Subsequently, health personnel who have been working in small health units are picked on to manage more challenging facilities like health centre IV without orientation.

It was also reported that some health workers resisted transfers to some units especially of rural areas and this further compounded the staffing problem and challenged the decentralised powers to improve on personnel performance. “The power of the DDHS to transfer any health worker from one unit to another is not clear. This is because some health centres are better staffed but when some are transferred to other units, they refuse” (KI, DHT). Another KI, DHT official had this to say:

People come expecting to work in hospitals, in towns or in units near the roadside. When they are posted to rural areas after recruitment, they do not turn up. They are not encouraged by low salary, which sometimes comes late, and the lack of effective demand for private practice in such places to complement their incomes (KI, DHT).

As regards the role of the Directorate of Health on staffing in private and non-governmental health facilities, it was reported that it only ensures that qualified staff are recruited to particular posts but
not on numbers because this has financial implications. They recruit as and when they have the financial ability to support the staff. The district also helps in organising induction courses for some of their staff.

Generally, there are deliberate efforts to put in place the right personnel and distribute them geographically so as take services nearer to the people. But this is hampered by lack of enough funding. The staffing problems were further exacerbated by the delays in putting up a District Service Commission (DSC) charged with the top management of district personnel matters in accordance with the 1995 Constitution and Local Governments Act, 1997. Even at the time of this study, the district had not had an operational DSC for a year, which vacuum constrains the personnel performance. Kyaddondo and Whyte (2003, p.334) also reported the absence of a DSC in Tororo in the 1998 study, when they observed: “The DSC of Tororo had been disbanded for unclear political reasons;” this is not healthy. The same problem was experienced in other districts, for instance, in Mayuge district; political bickering was reported to have led to inaction towards recruitment of health workers (New Vision, 2004, February 2, p.9). Jitta et al (2002, p.vi) in their study of health service delivery in Gulu, also noted that the staff were generally few and untrained.

4.5.1.2 Adequacy of pre-service training for personnel

Three quarters (75%) of the interviewed health personnel viewed their training before service as adequate for the tasks they were engaged in, 18% considered theirs as inadequate, these included three clinical officers – it is worth noting that these made up 43% of all clinical officers interviewed, others were a dental officer, five nurses, two laboratory officers, five nursing assistants and two unit in-charges. 7% had no training before their current jobs; they were seven support staff and four nursing assistants. Therefore, the reporting by the majority of personnel that they had the required
pre-service training indicates a good start for staff performance, as this is crucial for delivery of health services.

Responding to the question whether the health units had qualified personnel, the majority (7/10) of the members of 10 FGDs believed they had both qualified and unqualified staff at their health units; however, 2/10 said the staff are qualified and 1/10 were not sure about staff qualifications. One of the community leaders of Butaleja that participated in FGDs made the following observation on staff qualification: “The trained health workers here are not adequate, for instance; instead of posting a doctor, the Government just gave us a clinical officer. This is very bad for us” (FGD – Leader Butaleja).

4.5.1.3 On-the-job training

Ninety four percent of the personnel interviewed reported that on-the-job training would improve their performance because of the new challenges that keep coming up as a result of changes in health problems and technology. Only 6% (9/150) said they did not need the on-job-training, these included 8/9 support staff and a nursing assistant.

Concerning on-the-job training attendance, 29% of personnel interviewed said they had never attended any on-the-job training; these included among others, 15 nursing assistants, six nurses, two laboratory officers and two in-charges; this inhibits better performance. Over a-quarter of the respondents (31%) reported that their last on-the-job training was within 0-6 months back, 23% had been trained 7-12 months back and 12% had trained 13-24 months back. Though the majority of the personnel interviewed had had on-the-job training within the last two years, the nearly one-third that had not, were as a result not performing to required levels and negatively influenced the overall results.
Reports from in-depth interviews also showed that there was need for induction and refresher training to strengthen personnel performance in the district. A DHT official made the following observation:

If the newly recruited health workers could have induction courses, it would help them so much. Then the old ones also need orientation courses like refresher courses, workshops, seminars and short courses because people forget. For example, people work in the same unit but do not know how to operate certain machines (KI, DHT).

4.5.1.4 Training needs

It should be noted that the majority of the respondents interviewed (54%) were nursing assistants, nurses and unit in-charges (mainly nursing assistants/nurses), this is why most of the training needs were reported within their area as indicated below. The most needed training areas in descending order were: registered nursing, administration, clinical medical care, family planning, midwifery and counselling. Others needed training as nursing assistants, training in public health, community health care and computer knowledge.

4.5.1.5 Effect of decentralisation on improving personnel job knowledge and skills

Personnel explanation of how the system of decentralization had helped to improve their job knowledge and skills were summarised in table 5 below. The table illustrates the views of personnel respondents on the effect of decentralisation on job knowledge and skills. In general, the majority (74%) of all personnel interviewed reported that decentralisation had helped to improve their job knowledge and skills while the rest (26%) reported that they had not improved their job knowledge and skills under the decentralisation system. Of the personnel who had worked for more than 10 years in service (65/140) or joined service before decentralisation, 75% (49/65) reported that
decentralisation had improved their job knowledge and skills and 25% said they had not had their job knowledge and skills improved under decentralisation. On how decentralisation had improved personnel job knowledge and skills, of those respondents who reported improvement (104/140), 40% answered that it was through attending seminars and workshops organised by the DDHS office, 26% was for training received, 14% through support supervision and others included sharing knowledge with personnel from other units and information passed on through grand rounds and radio. From the staff that gave reasons for why they had had no improvement, the majority, 72% (15/28) argued that they had not gone for any other training, seminar or workshop during decentralisation.

**Table 5: Effect of decentralisation on improving job knowledge and skills**

<table>
<thead>
<tr>
<th>Duration years in service</th>
<th>Personnel reported decentralisation effect on job knowledge and skills</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Improved</td>
<td>Not improved</td>
</tr>
<tr>
<td>1 to 10</td>
<td>73.3% (55)</td>
<td>26.7% (20)</td>
</tr>
<tr>
<td>11+</td>
<td>75.4% (49)</td>
<td>24.6% (16)</td>
</tr>
<tr>
<td>Total</td>
<td>74.3% (104)</td>
<td>25.7% (36)</td>
</tr>
</tbody>
</table>

Information from qualitative interviews below confirms that the commonest training to personnel is very short on-the-job type through Grand Rounds and Continuing Medical Education (CME), whose attendance is also limited by work overload due to understaffing and lack of transport money
for staff to attend. In support of the above, key informant DHT officials made the following observations:

We usually hold Grand Rounds, which are shared by selected health workers at the health sub-district level. For example, this week we have given a topic for presentation and discussion to Tororo hospital and Mukuluju health centre, this will also rotate to other health centres. This helps health workers to update and improve on their knowledge (KI, DHT).

Here in our district, there is CME and we also have Grand Rounds, which take place at health sub-districts and hospitals. However, not all health workers go for such training because of distance and lack of transport. Worse still, these health workers are always too busy with patients and when such time for training comes, they leave behind nursing aides who do not know much (KI, DHT).

Kyaddondo & Whyte (2003, p.335) also found out in the 1998 study of Tororo and Busia that “the opportunities that did exist for skills training mainly took the form of seminars and workshops that were donor funded under specific programmes… organised by government or NGOs.” The difference now is that more on-the-job-training is now organised and executed by the Health Directorate, an indication of progressive maturity under decentralisation.

In-depth interview information indicates that apart from the money allocated for staff training being little, it was also diverted to improve on workspace as pointed out by a District Councillor below.

Some little money for training comes from the Central Government although the district has decided to use this money for construction. The reason given for this diversion of funds is
that we cannot have trained personnel who will not have where to work. And we have to get the structures in place i.e. Health Centre IIIIs and IIIs (KI, DHC).

Jitta et al, (2002, p.vi) also found out in Gulu that diversion of funds meant for health activities was a factor in making the Government health unit services poor. This means that decentralisation had not solved the problems of meagre funding to the health sector, thereby negatively affecting programmes like the training of staff for better performance.

4.5.2 Performance Feedback: re-focusing personnel for better quality

Performance feedback addresses the continuous orientation of personnel towards what they are expected to do to achieve total performance by regular removal of obstacles to a clear focus on performance goals. Good performance feedback enhances personnel quality.

4.5.2.1 Nature of job performance feedback

The study revealed that the majority of the interviewed health personnel were getting some form of job performance feedback. 45% of the respondents reported that they were getting job performance feedback (reorientation to knowing they are doing what they are expected to do) through verbal means, 37% reported that it was both verbal and written and 11% said it was by written means only. 7% reported that they were not getting any feedback; these included a dental officer, nurse, laboratory officer, an in-charge and a radiographer.

As regards the frequency of performance feedback, 49% indicated receiving feedback on monthly basis, 17% quarterly, and 16% daily. However, only 8% reported receiving it annually. Respondents under the category of “others” (11%) said that they either received feedback weekly, rarely or did not get any feedback. When cross-tabulated with unit ownership, it was noted that the
majority of the personnel in government, NGO and private health units, reported receiving feedback on monthly basis. From the above presentation, clearly, a big proportion of personnel received feedback on a monthly basis, which is good for enhancing good performance.

On the question of who assesses the personnel performance, 37% reported that they were normally assessed by unit in-charges, 32% by Heads of Department, 18% said they were assessed by health sub-district (HCIV) and 11% by the DDHS officials and 2% said by the Parish Development Committee (PDC).

4.5.2.2 Perceived effect of decentralization on performance feedback

Personnel were asked to explain how the system of decentralization had helped to improve their performance feedback, their responses were summarised in table 6 below. According to the table, the majority (67%) of the personnel respondents reported that decentralisation had helped to improve on performance feedback, 17% said it had not improved on feedback and 17% could not tell, these included a clinical officer, a dispenser, with the biggest proportion of 36% (9/25) being nursing assistants. Of the personnel who had worked for more than 10 years in service (65/150) or joined service before decentralisation, 69% (45/65) reported that decentralisation had improved on performance feedback, 20% reported that there was no improvement while 11% could not tell whether there was improvement or not. On ways in which decentralisation had improved on feedback, of the respondents who reported improvement (100/150), 37% answered that it was through supervisors being nearer hence regular supervision was ensured, 19% was for information on guidelines and mistakes being given immediately and 16% said it was because of easy access to information on performance from DDHS and HSD. Respondents that reported that decentralisation had not improved on feedback (22/150), 32% contended it was because the policy
is not followed, 23% said that there was little effect to NGO and private units and 18% that there is no change because the situation was as it was before decentralisation.

### Table 6: Reported effect of decentralisation on personnel performance feedback

<table>
<thead>
<tr>
<th>Duration years in service</th>
<th>Personnel perception of the decentralisation effect on performance feedback</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Improved</td>
<td>Not improved</td>
</tr>
<tr>
<td>1 to 10</td>
<td>64.7%</td>
<td>14.1%</td>
</tr>
<tr>
<td></td>
<td>(55)</td>
<td>(12)</td>
</tr>
<tr>
<td>11+</td>
<td>69.2%</td>
<td>20.0%</td>
</tr>
<tr>
<td></td>
<td>(45)</td>
<td>(13)</td>
</tr>
<tr>
<td>Total</td>
<td>66.7%</td>
<td>16.7%</td>
</tr>
<tr>
<td></td>
<td>(100)</td>
<td>(25)</td>
</tr>
</tbody>
</table>

Decentralisation as a way of improving job performance feedback is further supported by reports from key informant interviews below: A DHT official said: “Under decentralization, it is easier to provide feedback because of the new structure introduced with it” (KI, DHT).

The in-depth interviews also revealed the weaknesses that constrain decentralisation as a way of improving on job performance feedback. A DHT member pointed out: “The problem persisting under decentralisation is that there is still a shortage of stationery, functional communication means and allowances” (KI, DHT).
On the other hand, a former member of the DHT noted: “Most districts do not ask for the monthly plans and monthly reports to enhance feedback. If the DHT officials insist, they can be realized, but most times they are absorbed in attending to the councillors' wishes” (KI, DHT).

Based on results presented above, performance feedback in Tororo Health Directorate had been largely improved upon as a result of decentralisation thereby further improving on the competence and performance of health personnel. However, meagre funds were still a hindrance to better results.

4.5.3 Equipment

4.5.3.1 Availability of equipment and its maintenance

It was indicated that the majority (72%) of the personnel did not have all the essential equipment needed to do their work, while only 28% had all of them. One of the Councillors for health at Tororo District Health Council (DHC) observed: “We have a shortage of equipment. The theatres and laboratories are not equipped, and it is worse for the HSD theatres. We also do not have enough delivery beds at the hospital” (KI, DHC).

On the maintenance of equipments, only 24% of the respondents reported that not all were maintained in working state, while 76% said they were maintained. They reported that equipments not maintained in working state included: weighing scales, examination, delivery and admission beds, and blood pressure machines. Others were suction, X-ray and sterilizer machines, operating tables, bicycles and motorcycles. Kyaddondo (2002, p.19) noted in his study of Tororo and Busia in 1998, that since decentralisation was failing to meet staff remuneration, it could do little to improve equipment and supplies as exhibited by the situation on the ground at the time of the study. Indeed
this study found out that the majority of personnel in the Health Directorate were still not provided with enabling equipment six years after the Kyaddondo study reported a similar situation.

As for equipment requested for but not received, 68% of the respondents reported that they had never received any. Some of the most needed equipment requested by personnel but not received included: forceps/dressing equipment, refrigerators, beds, weighing scales, bicycles and X-ray machines. The rest were blood pressure machines, stethoscopes, microscopes, vaccine carriers and dental and laboratory equipment.

The study revealed that the inability to procure and maintain equipment and other facilities partly stemmed from the low revenue as compared to the many activities that have to be accomplished by the district. Maintenance of equipment in particular was noted as a big problem even for equipment purchased through donors. A DHT official noted: “Although donors buy and give us bicycles and motorcycles, maintenance is a big problem, we even lack fuel. We have budget ceilings, which affect the programmes because you try to fit very many activities within the ceiling.” Similarly a District Councillor pointed out:

We cannot do everything not even buying important equipments, the revenue collection like graduated tax is poor and these people who pay expect better services especially from the health sector. On the other hand, the Centre is still controlling us and LGDP funding has strings attached (KI, DHC).

It is evident from these quotations and earlier presentations that, a large proportion of the district personnel from the Health Directorate lacked the necessary equipment and many requests for equipment were not honoured. Yet for some, their equipment was not well maintained thereby
constraining the personnel’s efforts to perform and consequently reducing on their quality of performance in the eyes of clients.

4.5.4 Supplies

4.5.4.1 Availability of supplies

A big proportion (66%) of staff did not have all supplies needed to enable them do their work, while 34% reported that they had all supplies needed for their work. 60% of the personnel had requested for supplies but never received them.

Lack of supplies particularly drugs was also confirmed in all the FGDs that were conducted in the sub-counties of Butaleja and Osukuru. All participants reported that they were not given the prescribed drugs all the time they visited the health centres. The supply of drugs at health units was reported to be irregular as observed below in an FGD by a community leader from Osukuru: “At times when the drugs have just been brought, you get. However, when you come a month after the supply you get only tablets or nothing because the drugs are inadequate” (FGD – Leader Osukuru).

A community leader from Butaleja argued: “I wonder when drugs come they sometimes allocate us only six vials of X-pen, we see them when the health provider is opening the boxes. But are we in Butaleja HCIII supposed to get only six x-pens per quarter?” (FGD – Leader Butaleja).

And another community leader from Osukuru noted: “Decentralization meant bringing health units nearer to the people which was very good. But these health centres built are not well facilitated, for example there are no drugs and people are still referred to drug shops in Tororo town” (FGD – Leader Osukuru).
Due to the irregularity of drugs at health facilities, sometimes clients were not appreciative of the personnel performance because the staff were blamed by clients for the shortages. A member of the HUMC pointed out: “The delivery of drugs from the district is poor and this has caused problems for the staff and people suspect that the staff sell the drugs” (KI, HUMC)

Some respondents from private health facilities also observed that the district’s effort to supplement non-government health units was declining. A private health unit manager noted: “We used to receive drugs from the district but that one dried up for the last one year” (KI, Private unit manager).

4.5.4.2 Request of supplies

Drugs and protective wear were the supplies that had been mostly requested for by personnel in the district but were not received in sufficient quantities; drugs requested and not yet received included mainly antibiotics, intravenous fluids and related syringes and needles. While protective wear requested but not sufficiently supplied included gloves and gumboots. Other supplies regularly requested for and not received were cleaning supplies/antiseptics, operating supplies, office supplies (like patient cards and files), uniforms and laboratory supplies. The staff had done their work to put in requisitions but the system failed them.

In line with the failed requisitions, the Councillor of the DHC below also had the following to say:

‘There has been improvement in taking health services closer to the people. But the services’ quality is not really good because of logistics. For example, one health centre II is given Uganda Shillings 150,000 only for purchase of drugs in a whole month. This is very little money for drugs (KI, DHC).
Under normal circumstances HC II provides health services for a parish comprising of about 5,000 persons, meaning that with the monthly release of Shs 150,000, every citizen is entitled to Shs 30 only every month for drugs, but in Tororo with only 31 registered HC II units for a total population of 559,528 or 112 parishes, the demand far outstretches the monthly Shillings 150,000 allocated for drugs. This negatively affects the performance of personnel in the HC II units. Similarly, Jitta et al (2002, p.v) found out that the drugs in Moroto district were inadequate due to the unfavourable funding culminating in some people getting discouraged to seek health services from health units. Angura in New Vision (2003, April 29, p.5) also reported that Members of Parliament (MPs) were stunned by lack of medical equipment and supplies at Jinja regional referral hospital. The medical superintendent of Jinja informed the MPs that the hospital receives Shillings 20 million for drugs monthly, but the drugs purchased lasted for only 14 days.

The above-described situation of inadequate drugs supplied due to unavailability of funds leaves the performance of health personnel in a poor rating and constitutes a major constraint to satisfying the local people.

**4.5.5 Working space**

**4.5.5.1 State of working space**

48% of the respondents reported that they did not have enough working space. Of those who reported that they did not have enough space, 11/72 lacked enough room for delivery/maternity wards, 10/72 for examination rooms, 9/72 needed injection/treatment room and 9/72 immunisation rooms, 6 were for out-patient waiting room and 5 lacked counselling/family planning space. The other space needed was for offices, storage, dispensary, antenatal, laboratory, cold chain and monitoring of very sick patients.
In-depth interviews with health officials at the district further confirmed the problem of lack of enough working space. A DHT official said: “There is lack of working space in most health centres. Plans for construction of health centres are on paper and a few are completed. Space is provided for as and when money is received from the Centre” (KI, DHT).

4.5.5.2 Effect of decentralization on improving workspace at health facilities

Personnel explanations on how the system of decentralization had helped to improve workspace were summarised in table 7 below. The table illustrated that the majority (57%) of all interviewed personnel reported that decentralisation had not helped to improve workspace mainly due to lack of funds for developmental purposes, 29% reported improvement, while 14% could not tell (these included 10 support staff, eight nursing assistants, a nurse and a clinical officer). Of the personnel who had worked for more than 10 years in service (65/148) or joined service before decentralisation, 71% (46/65) reported that decentralisation had not improved on workspace, 26% reported that there was improvement and only 3% could not tell. On ways how decentralisation had improved work space, 28% (11/43) answered that it was through new units built and completed, 15% was for ongoing construction, 10% were for a maternity unit built, 10% a theatre built and 10% for increase on existing space and others included partitioning existing space, renovation and planning support for NGO units.
Table 7: Effect of decentralisation on improving workspace at health facilities

<table>
<thead>
<tr>
<th>Duration in service</th>
<th>Personnel perception of the decentralisation effect on work space status</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Improved</td>
<td>Not improved</td>
</tr>
<tr>
<td>1 to 10</td>
<td>31.3%</td>
<td>47.0%</td>
</tr>
<tr>
<td></td>
<td>(26)</td>
<td>(39)</td>
</tr>
<tr>
<td>11+</td>
<td>26.2%</td>
<td>70.8%</td>
</tr>
<tr>
<td></td>
<td>(17)</td>
<td>(46)</td>
</tr>
<tr>
<td>Total</td>
<td>29.1%</td>
<td>57.4%</td>
</tr>
<tr>
<td></td>
<td>(43)</td>
<td>(85)</td>
</tr>
</tbody>
</table>

The construction of new buildings for workspace improvement is very slow as reported in one of the in-depth interviews. A former member of the DHT said: “I left in 1998 a building which was being constructed at the district head office for Health courtesy of DED but it has just been completed in 2003” (KI, ex-DHT).

Photographs of health facilities buildings below and observations done by the study team during the survey revealed some of the buildings constructed under decentralisation, those in a sorry state and ones that had taken long (close to five years) to complete. Results from observations and interviews further support the slow pace of improving workspace. The slow speed of constructing workspace was exhibited in the uncompleted units by time of study (June 2003), for example Bunawale HCII started in 1999 was found operational by the time of the study but incomplete, Budumba HCIII started in 1999 was also incomplete, while Kangalaba HCIII started in 1997 was completed in 2001. Some of the health units reported lack of essential facilities like latrines.
Photograph 1: Above are photographs of Bunawale HCII building, in Bunyole HSD; in the middle is the foundation stone showing start of construction in 1999. The right-hand side shows clients in front of the health provider's table in an incomplete structure at the time of study June 2003.

Photograph 2: Morikatipe HCII building in Tororo county HSD is an example of a health unit illustrating lack of workspace maintenance for a long time even under decentralisation.
Photograph 3: Nakasanga HCII building in Bunyole HSD is an example of a health unit that has been constructed under decentralisation. Staff in such units still complain of inadequate space because the buildings are relatively smaller than their needs.

The lack of enough space for health personnel’s operations coupled with the slow pace of completing space under construction during the decentralisation era, impacts negatively on the performance of personnel in service delivery. It is partially responsible for the delays and lack of confidentiality while attending to patients.

4.5.6 Organisational support

This section deals with the structure of Tororo district resulting from decentralisation and how it facilitates or de-facilitates the health personnel performance. For that matter, results will be presented on the structure, personnel supervision and the relationship between politicians and personnel vis-à-vis service delivery.
4.5.6.1 Decentralised structure of Tororo district Health Directorate

The study revealed that the DDHS heads the Directorate of Health. DDHS coordinates and supervises all the health personnel performance and health related activities in the district. The DDHS is assisted by medical officers (Medical Doctors) who head the five Health Sub-districts (HSD/HCIV) at county level, that are supposed to supervise and coordinate the lower level health units known as HCIII and HCII. Subsequently, HCIII at sub-county or LCIII level supervise HCII units at parish or LCII level. This organisational structure (also see its diagrammatic expression below in figure 1) was established in all districts of Uganda in 1998 by the Central Government to guide the implementation of the decentralisation of health services as per the 1995 Constitution and 1997 Local Governments Act.
Figure 1: DISTRICT STRUCTURE FOR HEALTH CARE DELIVERY

KEY:
CAO = Chief Administrative Officer
DDHS = Director of District Health Services
DHMT = District Health Management Team
DHC = District Health Committee
HSD = Health Sub-District
HC = Health Care
LC = Local Council

Source: Ministry of Health- Health Sector Strategic Plan 2000/01-2004/05
The study revealed that there is general agreement that the structure had extended better health management to the lower communities through creation of closer administrative centres at HCIV, HCIII and HCII, construction of new units and posting there some staff. One of the key informants (DHT official) agrees as follows: “Decentralization has helped in service delivery because of the establishment of more structures of health centres, which have helped in getting health staff and services nearer to the community” (KI, DHT).

With regard to how the district structure of Tororo Health Directorate was helping personnel to improve their performance, 25% of the personnel reported that decentralisation had brought supervisors closer to them, 14% reported that by opening up health centres at different levels it had brought their services closer to the community, 14% said it provides enabling services and drugs, while 10% could not tell (including mainly support staff and nursing assistants) and only 5% said it had not helped (these included mainly support staff and nurses). Others said it helped through easy communication and improved procurement.

On how the decentralisation structure was making it difficult for health staff to perform effectively, 23% reported that by delaying to respond to requisitions like in the case of drugs, 20% because of delays in release of funds and attending to problems, 12% were for delay in appointing and confirming staff, 8% staff were overworked as a result of failure to recruit staff and 8% could not tell (they included mainly support staff and nurses).

From the in-depth interviews, it was reported that the structure had not been fully utilised to bolster personnel performance due to poor facilitation. A DHT member observed:
The structure would be of greater use to health workers’ performance, but the problem is that we are not regularly in touch with them. Instead, the structure helps the health workers less because the staff to do the supervision is not enough and sometimes there is no transport due to lack of enough funding (KI, DHT).

It was also noted by Child Health and Development Centre (1999, p.61) that in Uganda: “Decentralisation had not been matched by increase of resources and capacity to enable Local Governments to perform their roles effectively.” In agreement with this observation, Okunzi (2002) argued: “good policies tend to conflict with other (bad) policies of the Government. For example, increasing the coverage of health services, is contradicted by the arbitrary imposition of budget ceiling on health care expenditure as a measure of macro-economic policy.” The structure created by decentralisation to carry personnel services closer to the local people has been watered down by the limited funding from the Central Government and directives to the Local Governments limiting revenue collection.

4.5.6.2 Supervision.

On getting enough help and guidance from supervisors, 90% of respondents said they were getting enough supervision. 10% (15/150) reported that they did not get enough help, of whom four were support staff, three nursing assistants, two unit in-charges, two nurses and two laboratory officers.

But some key informants at the district reported that they were not giving enough guidance to lower health unit cadres to supplement lower administrators efforts due to lack of funds, this hampered the support supervision visits to HCIV, HCIII and HCII personnel. This means that the satisfaction with supervision reported above mainly comes from the services of the newly created
lower structures at HCIV, HClIII and HCII as a result of decentralisation. However, the personnel still miss the more advanced technical supervision support from higher structures. This was confirmed further from reports that even technical supervision from the DDHS and Ministry of Health to the district had become irregular as reported by members of the DHT below:

“The health workers do not get enough guidance from us. We are supposed to go to the health sub-district quarterly and to lower units monthly, but this does not take place due to lack of funds” (KI, DHT).

We used to have technical supervision from the Ministry of Health; he/she would be a specialist and would make genuine comments and finally produce a report. This technical supervision was carried out together with our own supervision but is now rare (KI, DHT).

4.5.6.3 Relationship between politicians and health personnel

The study revealed that 40% of the respondents observed that the relationship between health personnel and politicians was not supportive to the delivery of services. However, 45% of the respondents said that their relationship with politicians was good and that it helped to speed up service delivery, while 14% (21/150) could not tell, with 13/21 working in NGO health units of whom one was a medical officer and four were nurses. Of the 67 who praised the relationship, 57% said the politicians help in mobilising people, 15% reported that they increased supervision, 9% said that they participate in meetings for collective agreements and 8% said politicians mobilise for drugs and equipment. From the 59 personnel that did not praise the politician-personnel relationship for service delivery, 45 gave different reasons, of whom 29% observed that politicians do not care about improving their relationship, 27% said that politicians did not understand the personnel’s work but just harass them, 13% said that they take health workers as being corrupt yet they are not, 9% said
that they take long to make decisions and another 9% said politicians only mind about their allowances.

In support of the good relationship between politicians and personnel, the following was reported from in-depth interviews at the district: A DHT official reported:

The relationship between politicians and health workers is very useful because if there is a politician who is interested in health, he/she can speed up health delivery by mobilizing people and facilities to assist personnel in health services delivery. And if he/she is interested in mistakes that take place at a unit, he/she labours hard for solutions (KI, DHT).

Information from qualitative interviews also indicated that under decentralisation, the politicians feel they are empowered to monitor personnel activities and assist in eliminating hindrances to delivery of services. Two Councillors, one from the district and another from the sub-county demonstrated how they were able to use their powers effectively:

Under decentralisation, we now have powers in the district, hence, the public servants feel answerable to the district. It is now possible to sensitise the sub-county chief to go and monitor the activities done at the health centres, even the LC1 Chairman has powers to monitor what is happening (KI, DHC).

I went and reported to the DDHS so that we can use the vacant house on compound of our health centre III to accommodate our staff. The suggestion was first rejected but I kept on pestering the office until they accepted. Now the midwife and a nurse stay in the house nearer to the health centre (KI, LCIII Councillor).

However, some respondents reported that some politicians are ill equipped technically in health matters and with that background, their efforts were reported not to be very helpful for the delivery
of services to citizens and are seen to be protecting their votes instead. A DHT official observed:

These politicians are not technically conversant in health issues but make strong demands bordering on technical decisions. For example, for them, they want many health centres in their constituencies but they do not think about who will work there, where the equipment and supplies to those units will come from; but they just dictate and want to see structures constructed so that they can get votes (KI, DHT).

Kasadhakawo & Buyungo (2002, p.311) also reported that in Bududa hospital, “there was a general outcry of outside unnecessary interference in affairs of the hospital as reported by 82.4% health workers, and of these 50% reported it was political interference.”

However, it was also reported from qualitative interviews that there is growing improvement of the relationship between the politicians and personnel as time goes by. This trend promises improvement in the performance of personnel. An LCIII Councillor said:

At the beginning of decentralisation, our relationship was not so good but now we have identified areas of specialization – we, as politicians, monitor and supervise. We work as a team and where there is a problem we identify it and also encourage the health workers to tell us their problems (KI, LCIII Councillor).

A former DHT member of Tororo district also pointed out:

Decentralisation is a great idea as long as it is embraced positively and will be greater as the politicians mature and know they are facilitators not ‘frustrators’, they are support supervisors not inspectors, and the civil servants also look at politicians as partners, when the two realize they are working as a team (KI, ex-DHT).
Results show that the decentralised structure has been broken down to provide support at lower levels of administration, hence making personnel more available to offer service nearer to centres of need. To an extent it has helped, despite the inadequate funds to facilitate officials at higher levels to reach out to the personnel and patients. The closer relationship between politicians and personnel is still bogged down by selfish interests, but there are signs of improvement for better health service delivery.

4.6 Performance encouragement: facilitating or constraining personnel effectiveness and accessibility

This section presents results for job rewards; promotions and other opportunities that the district gives health workers to encourage them to perform and even perform better.

4.6.1 Job rewards

The biggest proportion (68%) of the personnel respondents indicated that they were receiving rewards in form of salary and allowances. They reported that these allowances included lunch, outreach, housing, transport and medical benefits. 21% reported that they were receiving salary only as a job reward, 9% received allowances only while 2% said they were getting no rewards at all. All three staff that said they were receiving no rewards and the 13 receiving allowances only were mainly nursing assistants, and others were three support staff working in Government units. This meant that some personnel in Government health units go without enough encouragement to continue with good performance.
4.6.2 Value and amount of job rewards

The majority (80%) of the health personnel interviewed reported that they were not happy with the value and rates of their job rewards. Reasons advanced by those that were not happy said that the salary was meagre (63%), that personnel did a lot of work but received little or no allowance (13%), others were unhappy due to the fact that they were not receiving a salary, salary increment, housing and transport allowances. Only 20% were happy about the value and amount of their job rewards, some of the reasons given by the happy personnel were: 67% (20/30) said it sustained them and their families, and 19% because they had a job and salary.

4.6.3 Timing of the rewards

Generally, there was disagreement on the timing of rewards, whereas the majority (57%) indicated that they were happy with the timing of the rewards in that it came in time, a big proportion (43%) expressed unhappiness of the timing of rewards, noting that it came late. It seems late coming of rewards had been persistent and is still a problem in Tororo, even at the time of the study, some personnel did not receive their salary on time which caused loss of hours at work as personnel checked on their pay status. A similar situation was reported by Kyaddondo & Whyte (2003, p.335) from their 1998 study, “some health unit staff had spent as many as 36 months without receiving their salaries, starting around 1994 when Tororo got decentralised.” Kasadhakawo & Buyungo (2002, p.310) also found out from staff interviewed in Bududa hospital, Mbale district, that 97% reported they did not receive salary on time. In Masaka, the District Chief Finance Officer was reported to have said that 80 staff had not been paid for three months (New Vision, 2003, October 18, p.4).
Though the majority of personnel complained of little pay, information from key informant interviews with the district policy-makers indicate that the health workers were better paid than those in other Directorates, a District Councillor affirmed: “When you compare Health workers with workers in other Directorates, our Health workers are okay and better off because they get lunch allowance on top of salary” (KI, DHC).

4.6.4 Realization of promised job rewards

57% of the respondents reported that they were getting all job rewards as promised by the employer. On the other hand, 43% said they were not getting all promised job rewards, reasons for this were that they were not paid allowances, no salary increment and promotion and some had not received their accumulated salary arrears.

4.6.5 Decisions on promotions, training and other opportunities

55% viewed their units’ administration as playing a major role in making decisions on promotions, training and other opportunities, 35% gave the district administration as major players, 9% could not tell (included mainly nursing assistants and support staff), while only 1% was for the Ministry of Health. From the above, it is noted that personnel already believe that the power for making decisions affecting them lies with their district institutions.

The study revealed that the promotion of personnel is not satisfying and is inhibited by scarcity of funds for increase in salaries. A DHT official pointed out: “You know promotions have financial implications like salary increments. Therefore, they do not even promote anyone because money for the salary increments is not available.” Not much has been done on improving the above state of affairs as this was the same situation in Tororo and Busia in 1998 where Kyaddondo (2002, p.15)
reports: “District authorities I talked to acknowledged the districts’ inability to pay salaries after health staff have been confirmed or promoted.”

It was also noted that decentralisation has an inbuilt problem of limited positions for promotion of staff leading to discrimination in promotion of personnel. This was found to have a negative impact on the performance of personnel. A DHT official observed: “The problem with decentralization is that there is more malice and sectarianism, because if you do not have informal connections to the high offices like the CAO, you may never be promoted” (KI, DHT).

The problem of limited promotional opportunities is further compounded by nepotism and tribalism as noted by a District Councillor below:

Decentralization when handled well can improve the whole situation of health service delivery by personnel. The problem is that decentralization is promoting tribalism and nepotism because if the chairman of the recruiting committee is a Mudama or Munyole, then he will influence committee members to recruit only the Badama or Banyole. Secondly, there are no transfers made for people to work in different districts hence only one tribe works in a particular district (KI, DHC).

Osike in New Vision (2003, November 3, p.22) also noted the issue of nepotism and tribalism affecting personnel negatively: He reported: “Tororo district is in crisis. There is no money to run it and ethnic and religious differences are tearing it apart. Civil servants are not certain of their future.” Meanwhile, in an earlier report, Odeke in New Vision (2002, January 11, p.9) also reported that, there were calls from the citizens to split Tororo into three districts along tribal boundaries to reduce tensions among ethnic groups.
4.6.6 Suggestions on improving recognition for good performance

Responding to how their employer could improve recognition for good performance, 34% of personnel said they wanted salary increment and promotions, 21% for further training, 19% wanted prizes/bonuses and 8% were for being given allowances.

Qualitative interviews revealed that recognition for good performance lacks enough supporting finances as revealed by a DHT official and a former DHT member respectively below:

Sometimes if funds allow, we organize ourselves at the end of the year and hold a meeting that is called ‘End of year get-together’. People who have performed well are given gifts for example coming early for work is recognized as keeping time, smartness and other various ways of recognition. This system was introduced during the time of Dr. Mudusu and after his succession it had a lapse but is being revived under Dr. Okumu (KI, DHT).

Concerning revenue generated at the district, the Health Directorate was supposed to receive 20% from which we would pay some allowances, but it was a struggle getting it. I used to fight hard for it and that could have been one of the reasons why I lost my job at the district, they levelled accusations against me that were cleared in court of law in my favour (KI, ex-DHT).

A member of the DHC, was pessimistic about improving recognition of personnel performance basing on locally generated revenue at the district, the member said:

Performance of health workers under decentralization is not encouraged because of little money. We are planning to put recognition for good performance in our work plans so that funds can be allocated for that activity. However, with the low tax revenue collected (that is 3,000/=), and even some do not pay but evade, then it may take long to be implemented. It will encourage health workers to work hard if implemented.
This means that financing is a big factor in improving recognition of good performance under decentralisation. However, the scarcity of funds in Tororo district had not helped in this important area so as to improve personnel performance.

4.6.7 Effect of decentralization in improving job incentives

Personnel were asked to explain how the system of decentralization had helped to improve their job incentives, their responses were summarised in table 8 below. The table shows that 48% of all personnel reported that decentralisation had not helped to improve job incentives, 35% reported improvement while 17% could not tell, they included mainly nursing assistants, nurses and support staff. Of the personnel who had worked for more than 10 years in service (65/147) or joined service before decentralisation, 54% (35/65) reported that decentralisation had not improved job incentives, 41% said there was improvement and only 5% could not tell. On ways through which decentralisation has improved job incentives, of the respondents who reported improvement, 42% answered that it was through provision of incentives in form of physical and monetary allowances, 38% was for assured rewards every month and others included contribution to NGO staff allowances.
**Table 8: Effect of decentralisation in improving job incentives**

<table>
<thead>
<tr>
<th>Duration years in service</th>
<th>Personnel reported decentralisation effect on job incentives</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Improved</td>
<td>Not improved</td>
</tr>
<tr>
<td>1 to 10</td>
<td>30.5%</td>
<td>42.7%</td>
</tr>
<tr>
<td>(25)</td>
<td>(35)</td>
<td>(22)</td>
</tr>
<tr>
<td>11+</td>
<td>41.5%</td>
<td>53.8%</td>
</tr>
<tr>
<td>(27)</td>
<td>(35)</td>
<td>(3)</td>
</tr>
<tr>
<td>Total</td>
<td>35.4%</td>
<td>47.6%</td>
</tr>
<tr>
<td>(52)</td>
<td>(70)</td>
<td>(25)</td>
</tr>
</tbody>
</table>

Most key informants reported that personnel motivation is not good, leading to lower performance than would be desired; this is because of low revenue to the District. For example, a DHT official said: “Personnel motivation is poor, nothing much given apart from the salaries. No money from district local revenues that can be used to assist the personnel. The few staff recruited go away for other jobs because of lack of incentives.”

A member of the HUMC also pointed out: “Because of lack of motivation from rewards, the staff do not deliver as they are expected to do and engage in other jobs” (KI, HUMC)

Meanwhile, the chairperson of the Uganda Medical Association was reported to have said: “If the Government wants to enforce the law barring doctors from working in more than one place, it should provide better remuneration” (New Vision, 2003, April 17, p.9.).
The majority of health personnel interviewed were not happy with their job rewards because of their low value, sometimes they came late and not receiving all rewards promised to them during decentralisation. Efforts to improve on rewards and recognition of good performance are inhibited by meagre funds. Such a situation does not encourage the personnel to perform and even perform better than before.

4.7 Quality of service: expressing satisfaction or dissatisfaction with performance of personnel

This section presents results on how the performance of personnel under decentralisation is affecting the quality of service delivered and subsequently the client satisfaction. Areas investigated included: waiting time to see health care providers, manner of handling clients’ complaints, information provision by health workers, clients’ satisfaction with treatment, peoples’ perception of personnel performance and personnel’s overall view of the effect of decentralisation to their job output.

4.7.1 Waiting time to see health care provider

It was observed that patients took a long time of waiting at health facilities to access health services. Exit interviews revealed that on average, patients spent 1hr. 15min at health facilities before being attended to by a health worker, while the highest waiting time reported was 5hrs and the lowest was 05min. The above findings are supported by the responses from the 10 FGDs where 3/10 reported usual waiting time range of 30min to 3hrs, 3/10 wait for 3min to 5hrs, then 2/10 said they were waiting for 1 to 3hrs and another 2/10 for 3 to 5hrs. Below are some complaints on time recorded from FGD participants:
A community leader from Osukuru pointed out: “Staff come late at 10.00am and also close early. When they go for lunch, some of them do not turn up for work in the afternoon” (FGD – Leader Osukuru). Similarly, a male youth from Butaleja said: “Most health units have set time for opening at 8.00am. You find a health centre still closed by 9.00am. So when you come you stay on the veranda, there is no health worker until 10.00am. If you are very sick and you approach her, she says I had personal work to do, just wait, then she ends up cleaning the unit” (FGD – Youth Butaleja)

The clients were generally not satisfied with the long time they had to wait before getting attention of health workers; consequently the staff were not always available to patients. Six years back in 1998 the above situation was also noted by Kyaddondo (2002, p.17) who pointed out: “though the official starting time is 8.00am, many staff were not reporting on duty until after 10.00am. … Despite starting late health workers were leaving early, by 1.00pm”. Related to this, the World Development Report, 2004 (as cited in New Vision, 2003, September 29, p.6) revealed that in Uganda, “36% government health workers and 26% primary school teachers were found absent during spot checks carried out in 2002 and 2003 in all districts.”

4.7.2 Manner of handling clients’ complaints

As asked to comment on the way health providers handled the clients, 97% of the respondents during exit interviews indicated that they had been handled well, and had got the treatment that they had come for. This corresponds with information collected from focus group discussions, whereby most participants from 8/10 FGDs reported that some health providers handled them well despite the general lack of drugs experienced most times in the health units. However, some respondents observed that some health workers were at times rude, careless and money minded. Other providers were reported to have no knowledge of the local language and thus could not communicate properly
with clients. These were seen as major handicaps in the provision of health services to the community as reported below.

A female adult from Butaleja reported: “There are some of them who talk to the patients carefully others don’t, for example, they prescribed for me ‘Fansider’, the dispenser barked at me ‘you are also here to waste drugs’ and gave me only two tablets instead of the three” (FGD – Adult Butaleja).

From Osukuru, a female youth observed: “Health workers are different and it depends on who is attending to you. If it is a kind staff treating you he/she talks to you kindly and advises you on how to avoid such a disease in the future” (FGD – Youth Osukuru).

During an FGD, a leader from Osukuru complained: “You take a sick child to the hospital, nurses look at the child, then you, and they begin shouting at you. ‘You people don’t care about your children’s health, but only want to drink waragi (an alcohol). This belittles us’” (FGD – Leader Osukuru)

### 4.7.3 Information provision by health workers to clients

Almost all the respondents in the exit interview (95%) reported that they had been satisfied with the type of information they had got from the health providers. This was supported by FGDs whereby most participants in 8/10 FGDs reported that health staff gave clients the information, which answered their needs. For those who said that they were not satisfied, they reported that this was due to the large numbers of patients being handled by the providers, lack of knowledge of the local language for easy communication and rudeness of some of the personnel as supported by extracts from FGDs below. For instance, a female adult from Butaleja reported:
Here in Butaleja we have a problem of language between us the patients and the health care providers. … . I came here with my child who was having diarrhoea and when I was trying to explain, he shouted and said you speak English so I failed and he left for lunch without attending to me I had to go away (FGD – Adult Butaleja).

In-depth interviews with district health officials also revealed that there was a problem in communication between providers and clients and that could count for the rudeness of some of the providers. For example, one DHT official said:

We have a problem of health workers that cannot communicate with patients because of language barrier. And actually this could be the reason for rudeness. Therefore, decentralization has still not helped us on the problem of communication of health workers to patients as far as language barrier is concerned (KI, DHT).

4.7.4 Treatment satisfaction

Table 9 below shows how the respondents had got the prescribed drugs at health units during two visits. On the last visit (visit to health unit by respondents before the date of interview), 60% of the respondents indicated that they got all the drugs as prescribed, while 70% reported to have received all the prescribed drugs on the current visit (at the time of the survey). It was, however, noted that all government health units had just received new supplies of drugs from the district and this could partly explain the increase in the number of patients who received drugs at the time of the study time early June 2003.
Table 9: Exit clients’ prescribed drugs received from health unit

<table>
<thead>
<tr>
<th>Prescribed drugs received</th>
<th>Last visit</th>
<th>Day of survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>36 (60.0%)</td>
<td>42 (70.0%)</td>
</tr>
<tr>
<td>Some</td>
<td>16 (26.7%)</td>
<td>9  (15.0%)</td>
</tr>
<tr>
<td>None</td>
<td>4  (6.7%)</td>
<td>9  (15.0%)</td>
</tr>
<tr>
<td>Follow up (No drugs required)</td>
<td>4  (6.7%)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>60 (100.0%)</strong></td>
<td><strong>60 (100.0%)</strong></td>
</tr>
</tbody>
</table>

On whether the patients were satisfied with the way they had been treated, 90% said they were satisfied only 10% were not satisfied. Those satisfied reported that they had got treatment and received drugs (35%), had been examined (16%), were well received and the providers were polite (12%), that they had not waited for long before being treated (9%) and other reasons included immunisation of children, others were because of thorough explanation, workers were available and because they received prescriptions for buying the missing drugs. Information from qualitative interviewees also concurred with reasons given by exit respondents, but they added the construction of new health units and posting their staff as helping in bringing health services closer to the people.

The reported relatively high satisfaction of treatment (90%) by exit patients could be partly explained by the abundance of drugs at the time of study and as one of the reasons given above. This was also the case as reported by Kasadhakawo & Buyungo (2002, p.310) reported that clients at Bududa hospital “derived much satisfaction when they got all the drugs prescribed without telling them to buy from outside the facility.” This could also partly explain why the majority of the exit respondents (75%) rated personnel performance as generally good at the time of this study in Tororo.
Reasons given by the dissatisfied exit respondents were: they did not receive all drugs (26%), waited for too long (22%), few health workers (22%), not being examined, staff did not explain well, and paid for treatment where they should not have paid. On the other hand, the dissatisfied FGD participants gave more reasons that make them dissatisfied by the way they were treated as: untrained health workers attending to them, few health workers, language barrier of some health workers, being required to come with candles for admission, midwives were harsh to mothers in labour, little explanation received, uncooperative health workers, and unwelcoming health workers. They also were not happy with health workers coming late and leaving early, health workers lacking equipment like stethoscopes at the unit, rudeness of health workers, health staff apportioning working time to private clinics, lack of electricity to open at night, no running water and lack of laboratory services.

4.7.5 People’s perception of personnel performance

On the rating of the performance of health workers, 75% of exit respondents reported that it was generally good, 17% said it was fairly good, while only 8% rated the performance as poor.

The study revealed that the relatively lower personnel job output was largely blamed on poor facilitation that affects the job quality and staff morale. A former DHT member noted: “The results are embarrassing because of the new challenges facing personnel that are not proportionately facilitated (that is inadequate funding, supplies and equipment to meet the extended services). Decentralisation came with benefits and liabilities” (KI, ex-DHT).
An LCIII Councillor/HCIII HUMC member also said: “Personnel output has been a bit slow. Some workers feel sidelined. They are not very friendly because of frustration due to the fact that they cannot effectively sustain themselves on the small salary plus allowance” (KI, HUMC).

This was also supported by the FGD participants in the sub-counties of Butaleja and Osukuru who noted that health workers were under-facilitated, understaffed, some were untrained, received low salary, lacked enough drugs and the majority did not have electricity to enable them work at night.

4.7.6 Effect of decentralisation to personnel output

Personnel explanation of how the system of decentralisation had affected their output were summarised in table 10 below. The table illustrates personnel respondents’ views on the effect of decentralization to their job output. The majority (76%) of personnel interviewed reported that decentralisation had helped to improve their job output while the rest (24%) said that their job output had not been improved under the decentralisation system. Of the personnel who had worked for more than 10 years in service (65/144) or joined service before decentralisation, 71% (46/65) reported that decentralisation had improved their job output and 29% said they had not had their job output improved upon under decentralisation. This means that though decentralisation had helped the majority improve performance, the other lot still needed to be uplifted for better results.

Table 10: Personnel views on the effect of decentralization to their job output

<table>
<thead>
<tr>
<th>Duration years in service</th>
<th>Effect on personnel job output</th>
<th>Total</th>
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</thead>
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<tr>
<td></td>
<td><strong>Improved</strong></td>
<td><strong>Not improved</strong></td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>1 to 10</td>
<td>81.0% (64)</td>
<td>19.0% (15)</td>
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<tr>
<td>11+</td>
<td>70.8% (46)</td>
<td>29.2% (19)</td>
</tr>
<tr>
<td>Total</td>
<td>76.4% (110)</td>
<td>23.6% (34)</td>
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</tbody>
</table>
5.1 Introduction

This chapter presents the conclusions and recommendations drawn from the findings. This study examined the effect of decentralisation on the performance of Tororo District Health Directorate personnel; it assessed the personnel performance in terms of their quantity and quality, personnel accessibility to local people, the clients’ satisfaction of personnel services and constraints to personnel performance under decentralisation. In the process, it followed up the personnel performance factors; that is performance definition or job expectation, performance facilitation and encouragement, and the quality of service. Conclusions are therefore, presented on the personnel performance factors of job expectations, staffing, knowledge and skills of personnel, equipment, supplies and workspace, organisational support, job rewards and quality of service. Through these, conclusions based on the study objectives are drawn.

5.1.1 Job expectations

Decentralisation was found to have improved upon the ability of health personnel in Tororo to know their job expectations and consequently improve on their quality. Performance goals were set within preset national standards. Reminders of performance goals were clear (written and oral), and were both regular and timely. Personnel were able to describe their performance goals in measurable terms, and the majority of them said they had been given job descriptions. Both staff recruited before and after decentralisation reported improvement on knowing their job expectations as a result of decentralisation, they reported that this improvement was mainly through support supervision, short term trainings, having more powers to plan and budget in relation to their job
descriptions. Other improvements were knowing whom to report to, easy communication with supervisors and administrative units at lower levels.

5.1.2 Staffing, knowledge and skills of personnel

In an effort to take health services closer to the Tororo communities, decentralisation created more health units in categories of HCII, HCIII and HCIV; however, this was not followed by a proportionate increase in the numbers of relevant manpower, subsequently overloading the available personnel. This led to many health units especially those falling under HCII and HCIII category to be headed by under-qualified staff who did not measure up to the required performance demands of planning, implementing and evaluation of activities as managers of Health in the district. Even at hospitals, various categories of staff were understaffed among these were the nurses while nursing assistants were overstaffed to cope with the shortage of nurses. The staff resisted posting to rural areas where new units were being created, this challenges the decentralisation powers to improve on service delivery. The Health Directorate had little influence on numbers of staff in NGO and private health units, while it has direct influence on their staff qualifications. But results showed that many personnel in NGO and private units were under qualified for the posts they occupied. Lack of funds was found to be the biggest roadblock to eliminating staffing gaps; the DSC that was sometimes nonexistent probably due to political reasons made the staffing problems worse.

The majority of staff interviewed felt that their pre-service training was adequate for their jobs. However, most clients expressed dissatisfaction with the recruitment of personnel they deemed to be unqualified. The majority (94%) of personnel expressed the need for on-the-job-training to improve on their performance, but almost one-third (29%) had never attended any on-the-job-training while 54% had attended within the last one year. The majority of interviewed staff (about
¾) that had worked before and after the introduction of decentralisation in the district reported
improvement on their job knowledge and skills; this was mainly through training received, support
supervision, sharing knowledge with personnel from other units and information passed on through
Grand Rounds and radio.

The type of staff training mainly given was of a very short-term nature, but this was also hampered
by inadequacy of funds for organising the trainings and transporting participants and facilitators.
Worse still, the training funds were diverted to construction of new health units. The understaffing
that leaves some staff unable to attend because they do not have partners to delegate their duties to
during their absence, also blocks personnel from attending training.

5.1.3 Performance Feedback

Regular verbal and written performance feedback on monthly, quarterly and daily basis received by
the majority of personnel, helped to remind them to properly focus their performance to the right
services. In-charges, Heads of Department, HSD and DDHS, in that order, were reported to be
playing a big role in performance feedback. This is an indication that managers under
decentralisation are active in guiding personnel to stick to the right performance goals.

The majority of the personnel recruited both before decentralisation (69%) and after (65%),
reported improvement on performance feedback during the decentralisation era. Reasons given for
the improvement included supervisors being nearer hence regular supervision was ensured,
information on guidelines and mistakes being given immediately and easy access to information on
performance from DDHS and HSD. However, meagre funds were still a hindrance to achieving
better results.
5.1.4 Equipment

Availability of equipment to personnel was very poor with almost three quarters of interviewed personnel reporting not having the equipment needed for their work. The majority of the requests for equipments were not honoured. Equipment maintenance, on the other hand, was very good with over three quarters of personnel saying that all their equipments were well maintained. The relatively low amount of revenue collected by the district and that remitted by the Central Government was largely blamed for the unavailability of equipments and its poor maintenance in some cases.

5.1.5 Supplies

The study revealed that the majority of the personnel did not have all supplies needed for their work, neither were all their supplies’ requests honoured. Supplies most requested but not received were drugs and protective wears. This led to demoralisation of patients and personnel. The low funding situation in the district was mainly blamed on lack of supplies especially the scarcity and irregularity of drugs in health units.

5.1.6 Working Space

About half of the personnel interviewed did not have enough working space like rooms for maternity services, patients’ examination, injection and counselling. A large proportion of both staff recruited before and after decentralisation introduction in Tororo, reported that decentralisation had not improved on their workspace status. Construction of new buildings for workspace improvement was very slow due to inadequate funding which was given as a major reason for diverting money meant for staff training to workspace construction. The inadequate workspace
makes staff inaccessible to all clients due to lack of rooms to conduct their duties in confidence leading to client dissatisfaction of personnel services.

5.1.7 Organisational support

There was general agreement that the structure for decentralisation of health services in Tororo had extended better health management to the lower communities especially through creation of lower administrative centres. This had helped personnel to improve on their performance through taking supervisors closer to them, by opening up health centres at different levels it had brought their services closer to the community, and a little more quantity of drugs than before. On the other hand, the structure was also making it difficult for health staff to perform effectively because of delays in responding to requisitions like for drugs, delays in release of funds and attending to problems, delay in appointing and confirming staff leading to personnel getting overworked and collectively become less effective. The structure had not been fully utilised to bolster personnel performance due to poor facilitation mainly because of inadequate staff and funds to support supervisory work and provide logistics.

The relationship between politicians and health personnel was found to be both supportive and unsupportive to service delivery. It was supportive because politicians helped in mobilising the people, supplies and equipment for health service, supplementing supervision and participation in meetings. While on the other hand, it was not supportive because some politicians did not care about improving the relationship, politicians did not understand the personnel’s work but just harassed them, politicians took all health workers to be corrupt yet this did not apply to all of them, politicians were taking long to make decisions and only cared about securing future votes and getting allowances. It was noted that the gap between politicians and personnel under
decentralisation was narrowing, leading to better service delivery, whereby the two increasingly work as a team as time goes by.

5.1.8 Performance encouragement

The biggest proportion of personnel respondents indicated that they were receiving salary and allowances as job rewards. The majority were not happy with the value and amount of their job rewards, because the rewards could not meet all their basic needs. Just over half of the interviewed personnel were happy with the timing of their job rewards while about a-half were not happy as they received them late. Similarly, just over half of the personnel were getting job rewards as promised by employers, while the rest were not happy because they had not received accumulated salary arrears, no allowances paid, lacked salary increment and promotion. Personnel promotions were generally inhibited by scarcity of funds, limited positions for promotion in the district and further compounded by nepotism and tribalism. Generally, just over a half of the personnel interviewed reported improvement of job incentives during decentralisation. The majority of the personnel were not encouraged by their job rewards to sustain good performance.

5.1.9 Quality of service

Most patients were taking long to see health workers; the waiting time was at an average of 1hr 15min. Some clients were also not able to see health staff in the afternoons as the staff were leaving early before end of working hours. This made staff unavailable and the clients dissatisfied. Generally, most health workers were reported to be handling patients well despite the lack of drugs at times, and for that the clients were satisfied. But some health workers were at times rude, careless and money minded thereby not satisfying the patients with their service. Most health workers gave clients the information that answered their needs for which the clients were satisfied. On the other
hand, some staff were reported to be overloaded by large numbers of patients, not free with the local languages and some were rude hence not giving the needed information and making the patients dissatisfied. Most patients were receiving all prescribed drugs from the health units at which they were prescribed. However, about two fifths of patients were either receiving some or no drugs at all which made them dissatisfied with the treatment they were receiving from health workers. Other common reasons given by citizens dissatisfied with treatment included unavailability of staff, rudeness of staff, lack of comprehensive explanation from staff, poor or partial examination and staff coming to health units late and leaving before end of working day. The people perceived the health personnel performance as generally good. They further noted that the relatively lower personnel job output was mainly due to under-facilitation of staff, which negatively affects the quality of output and staff morale. The majority of the personnel reported that decentralisation had helped to increase their job output.
5.1.10 Final conclusions

In conclusion, the study achieved its general objective of assessing the effect of decentralisation on the performance of district personnel in Uganda and Tororo District Health Directorate in particular. It further attempted to answer the specific objectives of assessing the nature of personnel performance in terms of their quantity and quality; the extent to which personnel were accessible to their clients; the consumers’ satisfaction of personnel services. The study also identified key constraints affecting effectiveness of the personnel performance under decentralisation in Tororo District as specifically laid out below:

The improvement of personnel’s ability to know what they are expected to do on their jobs under decentralisation led to improvement in personnel quality as being focused in their performance.

The quantity of the Health Directorate personnel in Tororo district was found to be lacking leading to overloading of personnel to serve the increasing numbers of clients and increasing numbers of health units, it also led to understaffing hence constraining service delivery. The personnel performance was also constrained by absence of the DSC that is the top legal body in the district that overseas the smooth functioning of personnel. Personnel quality was also found wanting especially in lower cadres of Government, NGOs and private units where personnel were serving in positions for which they were under-qualified. The above coupled with the lack of funds to recruit personnel were constraints to Tororo personnel performance under decentralisation.

Personnel quality was partially enhanced under decentralisation by improvement of job knowledge and skills through mainly very short-term training. Long-term courses were limited and non-participation to available training of some personnel were caused by lack of funding and
understaffing that left no time for training to improve staff quality and subsequently their performance.

The quality of personnel was in part improved by the regular verbal and written performance feedback from the Health Directorate managers at lower levels created under decentralisation. But meagre funds were again a constraint to the smooth flow of feedback in terms of transport and stationery.

Personnel quality and accessibility were negatively affected by the general lack of equipment. Staff without the essential equipment are viewed by the local people as inferior; and staff are also forced not to attend to clients when they lack the necessary equipment. The lack of equipment and the funds that would purchase equipment were therefore major constraints to personnel performance and contributed to some of the clients’ dissatisfaction.

Necessary supplies, especially drugs were scarce and irregular as a result of the poor financial capacity of Tororo district. Little amounts of drugs were purchased as and when funds became available, this was a constraint to personnel performance leading to the dissatisfaction of the local people who sometimes blamed staff for the situation based on mere allegations. Lack of drugs is a major source of dissatisfaction among service users.

Workspace as venue for confidential personnel-client interaction was lacking to many personnel, thereby constraining health workers and making them not easy to access ending into dissatisfaction of clients. On the other hand it is worth noting that an almost equal number of personnel had their
workspace made better under decentralisation. The lack of enough funds was blamed for the inadequate and slow pace of workspace improvement.

Accessibility of health workers was improved upon through the creation of the health services decentralisation structure that brought nearer more qualified cadre of personnel form hospitals to lower health units, the same also partly improved health management at lower levels thus enhancing personnel quality. But the structure was also found to be unhelpful when it came to its inability to do away with the personnel constraints of poor staff appointment and confirmation, and delayed in responding to calls for staff facilitation. The politicians were, on the one hand, helpful to health workers in improving performance where they mobilised people and resources, while on the other hand they constrained personnel performance especially the selfish ones, but they were found to be progressing for better as time went by.

Personnel performance was constrained by poor job rewards, this made personnel less accessible whenever they sought supplementary income activities (like gardening in the mornings) as an alternative survival strategy and consequently dissatisfied the citizens. Personnel were not happy with the value and amounts of job rewards that were not meeting their basic needs; the rewards were sometimes received late, while promotions were inhibited by scarcity of funds, limited positions in the district, nepotism and tribalism.

The clients expressed dissatisfaction with the way some personnel delivered services; clients took long to see health workers, the personnel were sometimes unavailable, staff were overloaded and could not avail enough time with patients, some were rude and others were not conversant with the local languages. Sometimes, dissatisfaction was also directed to personnel whenever patients did not
receive the prescribed drugs. However, clients were satisfied with some personnel labouring to handle patients carefully and giving thorough explanations concerning patients’ ailments despite poor facilitation in terms supplies (drugs) and equipment.

All in all, the study revealed that decentralisation has helped to improve on personnel performance and is still beneficial to service delivery, but there is urgent need for proportionate facilitation of the system to appropriately deliver the decentralised services.

5.2 Recommendations

In order to improve the quality of personnel, there is need to strengthen the lower administrative units at the HCIV, HCIII and HCII to increase the reminders to personnel of performance goals in written and oral form at timely and regular intervals. This will enhance the personnel’s ability to know their job expectations or performance definitions thereby improving their service delivery.

To enhance the personnel quantity, quality and accessibility, urgent action is required to proportionately recruit personnel to fill the current 70% health personnel gap in Tororo. Similarly, there is urgent need to allocate personnel to perform duties for which they are qualified to give citizens the quality of service for which they pay taxes. In particular, urgent action should be directed towards recruitment of enrolled comprehensive nurses and clinical officers Grade I who are needed across all health facilities to head HCII and HCIII respectively and to provide lead and supportive treatment elsewhere. Enrolled comprehensive nurses gap was 100%, while that of clinical officers Grade I was 85%.
Personnel quantity, quality and accessibility improvement requires to have a functional DSC, which is operational at all times. This will allow it to perform its duties of ensuring adequate and satisfied personnel for the district to fulfil its service delivery to the citizens. The Tororo District Council should be made to realise the importance of the existence of the DSC in personnel performance and go out to ensure its existence.

The need to regularly update the quality of personnel requires that the personnel office should ensure that all personnel get equal chances of attending timely and regular on-the-job-training to keep up with changes for better performance. In addition, more funds should be mobilised to enable staff to attend longer-term training sessions. Health workers should also be encouraged to expeditiously learn local languages of their areas of operation to communicate fully with their clients.

Performance feedback should target all personnel to help them focus their performance to the right goals. There is need to invest more in performance feedback activities like regular meetings with staff, supervisory visits and confidential discussion of individual appraisal forms.

To supplement personnel quality, availability and raise client satisfaction, more funds should be mobilised for procurement of equipment and its maintenance, for regular and adequate purchase of supplies of drugs, protective wears and others like stationery. Under the current decentralisation system, the Central Government takes biggest responsibility of securing funding to districts as it retained the most lucrative revenue generation sources.

For better accessibility of personnel, extra funds should be mobilised to expedite construction of new rooms and maintenance of existing workspace. The workspace status should always ensure
upholding of the principle of confidentiality for areas like the examination of patients, injection, counselling and maternity services.

To reduce constraints resulting from poor relationships between politicians and personnel, continuous team building between the two factions should be organised and most especially with every new batch of politicians to cement the working relationship towards better performance for service delivery. Roles for politicians and bureaucrats need to be clearly understood during these team-building sessions for them to avoid confusion in the process of working alongside each other as is required under decentralisation.

To minimise constraints to performance of personnel due to poor job rewards, there should be a deliberate effort to significantly improve the job rewards given to personnel so as to encourage them to continuously aim at better performance. The improvement should address the value and amount of job rewards, timely release of all promised rewards, salary increment and promotion of personnel. Putting in place and implementing a system that ensures availability of personnel at the work place for all the time they are supposed to be there should complement the improved rewards.
BIBLIOGRAPHY


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APPENDIX 1: HCII, HCIII AND HCIV STAFFING GAPS BY CADRE, TORORO DISTRICT AS OF MAY 2003

<table>
<thead>
<tr>
<th>Staff Cadre</th>
<th>Staff Norms Per Unit</th>
<th>Approved Staff Numbers</th>
<th>Total Staff Approved</th>
<th>Available Staff</th>
<th>Staffing Gap (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HC II</td>
<td>HC III</td>
<td>HC IV</td>
<td>HC II (13)</td>
<td>HC III (17)</td>
</tr>
<tr>
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<td>-</td>
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<td>Askari</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>13</td>
<td>34</td>
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<tr>
<td>Support staff</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>26</td>
<td>28</td>
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<tr>
<td>Total</td>
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<td>17</td>
<td>42</td>
<td>91</td>
<td>283</td>
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</table>

Source: Tororo DDHS Personnel Department
### APPENDIX 2: DISTRICT HOSPITALS STAFFING GAPS BY CADRE, TORORO DISTRICT AS OF MAY 2003

<table>
<thead>
<tr>
<th>Staff Cadre</th>
<th>Tororo Hospital officially 100 beds but is at 200 beds (Govt owned)</th>
<th>Busolwe Hospital 100 beds (Govt owned)</th>
<th>St. Anthony Hospital 100 beds (NGO owned)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Approved</td>
<td>Available</td>
<td>Gap</td>
</tr>
<tr>
<td>1. Senior Medical Officer</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>2. Medical Officer</td>
<td>6</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>3. Dental Surgeon</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>4. Pub. Health Dental Assistant</td>
<td>2</td>
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<td>-1</td>
</tr>
<tr>
<td>5. Pharmacist</td>
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<td>2</td>
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<tr>
<td>6. Dispenser</td>
<td>4</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>7. Senior Nursing Officer</td>
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<td>2</td>
<td>0</td>
</tr>
<tr>
<td>8. Registered Nurse Midwife</td>
<td>6</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>9. Registered Nurse</td>
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<td>0</td>
</tr>
<tr>
<td>10. Registered Midwife</td>
<td>6</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>11. Reg. Public Health Nurse</td>
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<td>0</td>
<td>2</td>
</tr>
<tr>
<td>12. Psychiatric Nurse</td>
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<td>5</td>
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<tr>
<td>13. Enrolled Nurse</td>
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<td>14. Enrolled Midwife</td>
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<td>-3</td>
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<td>15. Assistant health Visitor</td>
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<td>-1</td>
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<td>17. Psychiatric Clinical Officer</td>
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<td>18. Ophthalmic Clinical Officer</td>
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<tr>
<td>19. Health Inspector</td>
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<td>2</td>
</tr>
<tr>
<td>20. Medical Entomological Off.</td>
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<td>0</td>
<td>2</td>
</tr>
<tr>
<td>21. Radiographer</td>
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<td>2</td>
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</tr>
<tr>
<td>22. Physiotherapist</td>
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<td>1</td>
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<tr>
<td>23. Occupation Therapist</td>
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<td>24. Orthopaedic Officer</td>
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<td>-2</td>
</tr>
<tr>
<td>25. Health Educator</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>26. Anaesthetist Officer</td>
<td>4</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>27. LaboratoryTechnologist</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>28. Laboratory Technician</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Staff Cadre</td>
<td>Tororo Hospital officially 100 beds but is at 200 beds (Govt owned)</td>
<td>Busolwe Hospital 100 beds (Govt owned)</td>
<td>St. Anthony Hospital 100 beds (NGO owned)</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---------------------------------------------------------------</td>
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<td>Gap</td>
</tr>
<tr>
<td>Laboratory Assistant</td>
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</tr>
<tr>
<td>Clinical Officer</td>
<td>8</td>
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<tr>
<td>Hospital Administrator</td>
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</tr>
<tr>
<td>Medical Social Worker</td>
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<tr>
<td>Nutritionist</td>
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<td>0</td>
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</tr>
<tr>
<td>Supplies Officer</td>
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<tr>
<td>Stores Assistant</td>
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<td>3</td>
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<tr>
<td>Stenograph Secretary</td>
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<td>1</td>
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<tr>
<td>Records Assistant</td>
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<tr>
<td>Senior Accounts Assistant</td>
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<tr>
<td>Accounts Assistant</td>
<td>4</td>
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</tr>
<tr>
<td>Dark Room Attendant</td>
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<tr>
<td>Mortuary attendant</td>
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<tr>
<td>Driver</td>
<td>4</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Cook</td>
<td>6</td>
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<tr>
<td>Guard</td>
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<td>Support Staff</td>
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<tr>
<td>Senior Clerical Officer</td>
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<tr>
<td>Clerical Officer</td>
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</tr>
<tr>
<td>Copy Typist</td>
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<td>Telephone Operator</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>264</strong></td>
<td><strong>266</strong></td>
<td><strong>-2</strong></td>
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*Source: Tororo DDHS Personnel Department*
THE EFFECT OF DECENTRALISATION ON THE PERFORMANCE OF DISTRICT PERSONNEL IN UGANDA: A CASE-STUDY OF TORORO DISTRICT

Questionnaire for Personnel from DDHS office, Health Centre IV, III and II (Govt & Non Govt)

This questionnaire seeks to obtain information on the above very important topic of national importance. You have been randomly chosen as a respondent from amongst the Tororo district health personnel. Be informed that the information you give will be strictly for research purposes and will be treated with utmost confidentiality.

Date:…………………..(dd mm yyyy) Name of interviewer:……………………………..
Name of Health Sub-District (HSD) …………………………………………………………
Name of health unit: ………………………………. Health Unit Level: …………(I, II, III, IV or Hospital)
Start time: ………….. End time: …………..
Please circle the number preceding the right answer for closed questions below.

SECTION A
Characteristics of Respondent
Q1. Sex
   1. Male
   2. Female
Q2. Age: ...........Years (Completed)
Q3. Position held at unit: .................................................................
Q4. Level of education:
   1. Primary
   2. Secondary
   3. Post-secondary
   4. University
   5. Post graduate
   6. Others (Specify) .................................................................
Q5. What is your qualification / specialization? ........................................
Q6. For how long have you been in service ............ Year(s)......................

SECTION B
Definitional Issues
Q7 a. Have you heard about decentralisation?
   1. Yes
   2. No
Q7 b. If yes, what does decentralization mean? ........................................

SECTION C
Job expectations/Performance definition:
Q8. Can you explain briefly what is expected of you on your current job in this health unit?
........................................................................................................
Q9. Who sets your job goals? (Multiple choices)
1. Ministry of Health
2. District health directorate heads
3. Myself
4. Head office NGO/Private
5. Others (specify)........................................................................................................

Q10. How often do you get a reminder of your performance goals? (Multiple choices)
1. Annually
2. Quarterly
3. Monthly
4. Daily
5. Other (specify)........................................................................................................

Q11. In what form do you get the reminder of your performance goals?
1. Orally
2. Written
3. Both orally and written
4. Other (specify)........................................................................................................

Q12 a. Are your performance goals measurable?
1. Yes
2. No (If no, skip to 13)

Q12 b. If yes, give three examples to back your answer in 12(a) above
........................................................................................................

Q13. Have you been given a job description?
1. Yes
2. No

Q14 a. Has the current system of decentralization helped you to clearly know what you are expected to do?
1. Yes
2. No (If no, skip to 14(c)
3. Do not know
4. Others (specify)........................................................................................................
Q14 b. If yes, in what ways has decentralization helped you to clearly know what you are expected to do? .................................................................
Q14 c. If no, why? ..............................................................................

SECTION D
Performance facilitation and encouragement (eliminating road blocks to perform)
Feedback
Q15. What do you understand by the term job performance? ......................
Q16 a. How do you get job performance feedback (know you are doing what you are expected to do)?
   1. Orally
   2. Written
   3. Both orally and written
   4. Other (specify) .................................................................
Q16 b. How often? (Multiple choices)
   1. Annually
   2. Quarterly
   3. Monthly
   4. Daily
   5. Other (specify) .................................................................
Q17. Who normally assesses you? (Answer giving positions of officials) ...........
Q18 a. Has the current system of decentralization helped to improve feedback from your superiors and juniors?
   1. Yes
   2. No (If no, skip to 18c)
   3. Do not know
   4. Other (specify) .................................................................
Q18 b. If yes, in what ways has decentralization improved on your job feedback?......................................................................................
Q18 c. If no, why?..................................................................................
Equipment, supplies and workspace:

Q19. Do you have all the equipment you need to do your work?
   1. Yes
   2. No

Q20 a. Is there any equipment that you have requested for but not received?
   1. Yes
   2. No (If no, skip to 21)

Q20 b. If yes, please mention three top most equipment requested for but not received
   1. .......................................................... ...........................................................
   2. ............................................................................................................................
   3. ............................................................................................................................

Q21 a. Is all the equipment at your work place maintained in working state?
   1. Yes (If yes, skip to 22)
   2. No

Q21 b. If no, please mention three top most equipment not maintained in working state
   1. ............................................................................................................................
   2. ............................................................................................................................
   3. ............................................................................................................................

Q22. Do you have all the supplies you need to do your work?
   1. Yes
   2. No

Q23 a. Are there any supplies that you have requested for but not received?
   1. Yes
   2. No (If no, skip to 24)

Q23 b. If yes, please mention three top most supplies requested for but not received
   1. ............................................................................................................................
   2. ............................................................................................................................
   3. ............................................................................................................................

Q24 a. Do you have enough working space?
   1. Yes (If yes, skip to 25)
   2. No

Q24 b. If no, state which working space you do not have.................................
Q25 a. Has the current system of decentralization helped improve the workspace
   1. Yes
   2. No
   3. Do not know
   4. Other specify .................................................................

Q25 b. If yes, in what ways has decentralization helped improve the workspace............................

**Incentives:**

Q26. Name the job rewards you get from your current employment *(probe for: salary, transport, housing allowances and others).* ...............................................................

Q27 a. Are you happy with the value and amount of your job rewards?
   1. Yes
   2. No *(If no, skip to 27c)*

Q27 b. If yes, why? .................................................................

Q27 c. If no, why? .................................................................

Q28 a. Are you happy with the timing of the rewards?
   1. Yes
   2. No *(If no, skip to 28c)*

Q28 b. If yes, why? .................................................................

Q28 c. If no, why? .................................................................

Q29 a. Are the rewards you get for your job fair compared to fellow workers in the health directorate?
   1. Yes
   2. No
   3. Do not know

Q29 b. If yes, why? .................................................................

Q29 c. If no, why? .................................................................

Q30 a. Are the rewards you get for your job fair compared to Ugandan workers’ outside the health directorate?
   1. Yes
   2. No *(If no, skip to 30c)*
   3. Do not know
Q30  b. If yes, why? ...........................................................................................................
Q30  c. If no, why?........................................................................................................

Q31  a. Do you get all the job rewards as promised by the organization/district?
   1. Yes  (If yes, skip to 32)
   2. No

Q31  b. If no, why? ........................................................................................................

Q32. In your section, how are decisions made about promotions, invitations to external training, or other opportunities? .................................................................

Q33. How can the district/organisation improve recognition for good performance?
..............................................................................................................................

Q34  a. Has the current system of decentralization helped improve the job incentives?
   1. Yes
   2. No  (If no, skip to 34c)
   3. Do not know
   4. Other (specify).....................................................................................................

Q34  b. If yes, in what ways has decentralization helped improve the job incentives?
..............................................................................................................................

Q34  c. If no, why?........................................................................................................

Organisational support / structure:
Q35  a. How does the structure of Tororo district health directorate under the decentralized system help you to work? .................................................................

35 b. How does the structure make it difficult for you to do your work? .................

Q36. How are the goals and strategies of the Tororo district health directorate communicated to you? .................................................................

Q37. How are important decisions made? .................................................................

Q38. How are the decisions communicated to you? ..........................................................

Q39. Are you getting enough help and guidance from your supervisor?
   1. Yes
   2. No
Q40  a. Does the relationship between the politicians and personnel help to speed up the service delivery?
     
     1. Yes
     2. No (If no, skip to 40c)
     3. Do not know
     4. Other (specify) .................................................................

Q40  b. If yes, why?.................................................................

Q40  c. If no, why?.................................................................

Knowledge and skills:

Q41. Was the training you received before service adequate for the tasks you are performing now?
     
     1. Yes
     2. No
     3. Do not know
     4. Other (specify) .................................................................

Q42  a. Would on-the-job reminders/training help you with certain tasks?
     
     1. Yes
     2. No (If no, skip to 43)

Q42  b. If yes, mention three most needed training areas in your case ..............
     
     1. ..............................................................................................
     2. ..............................................................................................
     3. ..............................................................................................

Q43. When did you last go for on-the-job training?
     
     1. 0 - 6 months back
     2. 7 - 12 months back
     3. 13 - 24 months back
     4. Other (specify) .................................................................

Q44. What do you understand by the term personnel decentralisation?............... 

Q45  a. Has the current system of decentralization improved your job knowledge and skills?
     
     1. Yes
     2. No (If no skip to 45c)
Q45 b. If yes, in what ways has decentralization helped improve your job knowledge and skills?

Q45 c. If no, why?

SECTION E
Output

Q46. How would you rate your health unit output?

1. Excellent
2. Very good
3. Good
4. Average
5. Poor

Q47 a. Has the current system of decentralization helped you to increase your job output?

1. Yes
2. No (If no, skip to 47c)

Q47 b. If yes, in what ways has decentralization helped you increase your job output? (Describe 3 areas of output)

1. 
2. 
3. 

Q47 c. If no, in what ways? (Describe 3 areas of output affected negatively)

1. 
2. 
3. 

Any other comments related to performance of personnel under decentralisation

Thank you.
THE EFFECT OF DECENTRALISATION ON THE PERFORMANCE OF DISTRICT PERSONNEL IN UGANDA: A CASE-STUDY OF TORORO DISTRICT

Exit interview questionnaire for patients/caretakers

This interview seeks to understand the performance of personnel at health units. Help me by telling me how you liked your visit today to this health center by answering the questions below. Be informed that the information you give will be strictly for research purposes and will be treated with utmost confidentiality.

Date: ……………………………….  Name of Interviewer:………………………………………………
Name of Health Sub-District: ………………………………………………………………………
Name of health unit: ……………………………… Health Unit Level: ………… (II, III, IV or Hospital) Start time: …………..    End time: …………..

Please circle the number preceding the right answer for closed questions below.

Q1. At what time did you arrive at the health unit? …………………………………………………

Q2. At what time did you see the health care provider? ………………………………………………….

Q3. Did the health care provider handle your complaints in a polite manner?
   1. Yes
   2. Fair
   3. No

Q4. Did the health care provider give you information that answers your questions or needs?
   1. Yes
   2. Some
   3. No
Q5. Did you get all the prescribed drugs today?
   1. Yes
   2. Some
   3. No
   4. Follow-up

Q6. Did you get all the prescribed drugs at the last visit?
   1. Yes
   2. Some
   3. No
   4. Follow-up

Q7. Are you satisfied with the way you have been treated?
   1. Yes
   2. No

Q8a. In what ways are you satisfied? .................................................................

Q8b. In what ways are you dissatisfied? ............................................................

Q9. Would you like to tell us more information about performance of health workers in this health unit? .................................................................

Thank you.
THE EFFECT OF DECENTRALISATION ON THE PERFORMANCE OF DISTRICT PERSONNEL IN UGANDA: A CASE-STUDY OF TORORO DISTRICT

Focus Group Discussion guide (For adult women 20yrs++, female youth 10-19yrs, male youth 10-19yrs, adult men 20yrs++ and community leaders)

This interview seeks to obtain information on the above very important topic of national importance. You have been purposively chosen as a respondent because you fall within the group of possible consumers of health services and the information you could possibly have regarding the said topic. Be informed that the information you give will be strictly for research purposes and will be treated with utmost confidentiality.

Date: ……………………. (dd mm yyyy)  Group: …………………………………………
Moderator……………………………………………… Recorder: ………………………………
Names of participants …………………………… Venue of discussion …………………
Start time ……………………………………… End time ………………………………………

Q1. What do you understand by the term decentralization? (Especially in provision of health services.)
Q2. Which is the nearest health unit to this area?
Q3. What is the distance to the nearest health unit?
Q4. When at the health unit how long does it take to see the health care provider?
Q5. Are there qualified staff, equipment, supplies and workspace at the above health unit?
Q6. When you visit the health unit, does the health care provider handle your complaints in a polite manner?
Q7. Do all health care providers give you information that answers your questions or needs?
Q8. Do you normally get all the prescribed drugs at the health unit?
Q9. Are you satisfied with the way you are treated? (Probe for:
   In what ways are you satisfied?
   In what ways are you dissatisfied?)
Q10. Would you like to tell us more information about performance of health workers in the health unit? _____________________________.

Thank you.
THE EFFECT OF DECENTRALISATION ON THE PERFORMANCE OF DISTRICT PERSONNEL IN UGANDA: A CASE-STUDY OF TORORO DISTRICT

Key Informant Interview Guide: District Politicians, Administrators and District Service Commission

This interview seeks to obtain information on the above very important topic of national importance. You have been purposively chosen as a respondent because of the position you hold and the information you could possibly have regarding the said topic. Be informed that the information you give will be strictly for research purposes and will be treated with utmost confidentiality.

Date: …………………(dd mm yyyy)          Interviewee Title. ..................................................
Location: ..................................................
Start time: .............................................        End time: .............................................

Definitional Issues

1. What do you understand by the term decentralization?...............  
2. What do you understand by the term personnel decentralization? ..... 
3. What do you understand by the term performance?....................

Job expectations

4.0 How are district health personnel Job expectations / tasks arrived at and passed on to the personnel  Probe for:
4.1 Who sets the goals?
4.2 Are the goals measurable? Give examples
4.3 How and when are reminders made?
4.4 Are job descriptions given to all employees?
4.5 How do you compare the situation now with that before decentralization?
4.6 Has the current system of decentralization made a difference in informing personnel about their job expectations? How?
Performance facilitation and encouragement (eliminating road blocks to perform)

5.0 How is personnel performance feedback in comparison with the expectations of their job handled? Probe for:

5.1 Do they know they are meeting job expectations? (Performance appraisal)
5.2 Feedback orally and/or writing or both?
5.3 How often?
5.4 From whom? (Positions of officials)
5.5 Has the current system of decentralization had an effect on personnel performance feedback? How?

6.0 What is the district health staffing situation like? Probe for:

6.1 Staff qualifications?
6.2 Staffing trends since 1996
6.3 How has the current system of decentralization affected the: Human resource planning, recruitment, selection, induction and orientation, transfer, demotion, and separation.

7.0 What is the status of the health directorate workspace, equipment and supplies? Probe for:

7.1 Equipment and supplies for work?
7.2 Requested material and supplies not realised?
7.3 Financial (budgeted Vs Actual), Central Government ceilings, financial diversions.
7.4 All the space needed, particularly private space?
7.5 Is equipment maintained in working state?
7.6 Funding sources and proportions
7.7 What was the status of the health directorate workspace, equipment and supplies before decentralization?

8.0 What is the health directorate personnel incentives situation like? Probe for:

8.1 What happens if a worker does an outstanding job on a particular day/other period of time?
8.2 Types of current job rewards given to district personnel
8.3 Are you happy with the value and amount of personnel job rewards?
8.4 Are you happy with the timing and likelihood of rewards?
8.5 Are the rewards for the jobs fair compared to all workers in the health directorate?
8.6 Are the workers' rewards fair compared to workers outside the health directorate?
8.7 Are the job rewards given as promised by the organization?
8.8 How are decisions made about promotions, invitations to external training, or other opportunities?
8.9 Has the current system of decentralization helped improve the job incentives?
8.10 How can recognition for good performance be improved?

9.0 Organizational support: How has the district management helped in putting up supportive organizational structure, strategies and work processes for personnel performance? Probe for:
9.1 Does the structure of the organization/Tororo district/health directorate help workers to perform or make it more difficult?
9.2 Are the goals and strategies of the organization/Tororo district/health directorate communicated to workers?
9.3 How are important decisions made and communicated to workers?
9.4 Are workers getting enough help and guidance from their supervisors?
9.5 Does the relationship between the district/sub-county politicians and personnel help expedite service delivery?
9.6 In what ways has the current system of decentralization improved or not improved the organizational structure support for better performance?

10.0 Knowledge and skills: How does the district management ensure that the health personnel have the required pre-service education and in-service training? Probe for:
10.1 How much of the health personnel pre-service training is used on the job?
10.2 Would on-the-job reminders help workers with certain tasks?
10.3 Has the current system of decentralization improved personnel job knowledge and skills?

11.0 What is your comment on the health directorate personnel output? Probe for:
11.1 Trends since 1996
11.2 Quantity, quality, timing, fairness(equity), likelihood, accessibility.
11.3 Friendliness, privacy, confidentiality, communication and problem solving

Would you like to tell us more information_____________________________.

Thank you.
THE EFFECT OF DECENTRALISATION ON THE PERFORMANCE OF DISTRICT PERSONNEL IN UGANDA: A CASE-STUDY OF TORORO DISTRICT

Key Informant Interview for Non Governmental Organizations and private sector

This interview seeks to obtain information on the above very important topic of national importance. You have been purposively chosen as a respondent because of the position you hold and the information you could possibly have regarding the said topic. Be informed that the information you give will be strictly for research purposes and will be treated with utmost confidentiality.

Date: ………………(dd mm yyyy) Interviewee Title: …………………………………………
Location: ……………………………………………
Start time: ……………………………………… End time: ………………………………………

Definitional Issues

1. What do you understand by the term decentralization? .................
2. What do you understand by the term personnel decentralization? ..... 
3. What do you understand by the term performance? .....................

Job expectations / performance definition

4.0 What role does the district health directorate play in your personnel Job expectations?

Probe for:
4.1 Does it help explain what is expected of them?
4.2 Does it help with setting your personnel goals on the job?
4.3 Does it help with continuous reminder of performance goals
4.4 Are the performance goals measurable?
4.5 Are your personnel job descriptions influenced by the health directorate?
Performance facilitation and encouragement (eliminating road blocks to perform)

5.0 What relationship do you have with the district health directorate in ensuring feedback on your personnel performance? Probe for:

5.1 Does the health directorate influence your personnel knowing whether they are meeting their job expectations? (Performance appraisal)
5.2 Do they supervise personnel performance

6.0 Does the district health directorate have influence on your staffing policy? Probe for:

6.1 Qualifications
6.2 Numbers of staff
6.3 Established positions
6.4 Filled positions
6.5 Trends since 1996
6.6 Human resource planning, recruitment, selection, induction and orientation.

7.0 Does the district health directorate have influence on your Workspace, equipment and supplies? Probe for:

7.1 Equipment or supplies needed to do your work?
7.2 Space needed, particularly private space?
7.3 Equipment maintenance?
7.4 Funding sources, proportions

8.0 Does the district health directorate have influence on your personnel incentives? Probe for:

8.1 Value and amount of personnel job rewards?
8.2 Timing and likelihood of rewards?
8.3 Fairness compared to other workers in the health directorate?
8.4 Fairness compared to workers outside the health directorate?
8.5 Ensuring that the job rewards are given as promised by the organization?
8.6 Decisions made about promotions, invitations to external training, or other opportunities?
8.7 How can recognition for good personnel performance be improved under the current decentralized system of governance?
9.0 Organisational support: Probe for:
9.1 How does the structure of Tororo district /health directorate help your personnel to perform or make it more difficult?
9.2 Are the goals and strategies of the Tororo district/health directorate communicated to you?
9.3 How are important health directorate decisions made and communicated to you?
9.4 Are you getting enough help and guidance from the health directorate as a supervisor?

10.0 Does the district health directorate influence the knowledge and skills of your personnel?
Probe for:
10.1 On health personnel pre-service training?
10.2 On-the-job reminders to personnel?
10.3 Has the current system of decentralization improved personnel job knowledge and skills?

11.0 Has the health directorate had influence on your personnel output? Probe for:
11.1 Trends since 1996
11.2 Quantity, quality, timing, fairness(equity), likelihood, accessibility.
11.3 Friendliness, privacy, confidentiality, communication and problem solving.

12.0 Does the district health directorate support/contract you to provide health services? What effect is the support to your personnel service provision?

13.0 Would you like to tell us more information about performance of health workers in this health unit? ________________________________.

Thank you.
THE EFFECT OF DECENTRALISATION ON THE PERFORMANCE OF DISTRICT PERSONNEL IN UGANDA: A CASE-STUDY OF TORORO DISTRICT

Documents, records, district plans and minutes review guide

**Job expectations** - communications to personnel on health directorate goals and objectives, personnel job descriptions, goal reminders

**Performance facilitation and encouragement (eliminating road blocks to perform)**

Feedback policy/guidelines for personnel performance

**Staffing policy/guidelines**
- Skills
- Qualifications - Technical, - Administrative
- Numbers of staff
- Established positions
- Filled positions
- Trends since 1996
- Human resource planning, recruitment, selection, induction and orientation, training and development, performance appraisal, transfer, promotion and demotion, and separation.

Status on workspace, equipment, supplies (what should be and what is present)
- Inventory of workspace, equipment and supplies.
- Requested materials and supplies that you have not received? -Financial (budgeted Vs Actual), Central Government ceilings, financial diversions.
- Funding sources, proportions

Incentives structure, guidelines
Organisational support
- Recommended structure and the present status
- The structure of Tororo district /health directorate
- Goals and strategies of the organization/Tororo district/health directorate

Knowledge and skills
- Staff qualifications against positions held and the recommended qualifications
- Health personnel training held and the participants

The Output trends
- Trends since 1996
- Quantity, quality, timing, fairness (equity), likelihood, accessibility.
- Friendliness, privacy, confidentiality, communication and problem solving

Thank you.