



Ministry of Health

**HUMAN RESOURCES FOR HEALTH
BI-ANNUAL REPORT**

“Improving HRH Evidence for Decision Making”

OCTOBER 2014 – MARCH 2015

April 2015

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Ministry of Health,
P.O Box 7272,
Kampala.

CHAPTER 1: INTRODUCTION

1.1 Background

Health workers are the most important component of any health system: They design it, manage it, and deliver preventive and curative services. They are also the largest component covering 60% or more of the total health budget in well designed and facilitated health systems in form of salaries, wages and allowances. Sufficient, competent, equitably distributed, motivated and facilitated health workers have to be available at all levels of the health system in order to achieve a good standard of health by all people in Uganda.

Uganda has been carrying out annual human resource audits since 2009 in order to improve HRH evidence for decision making. This is in line with the Health Sector Strategic and Investment Plan 2010/11-2014/15 which has been focusing on achieving Universal coverage with quality health, and health related services. However, following the expiry of this plan period at the end of 2015, new strategic decisions will be made for the coming plan period. More importantly, this has necessitated gathering new HRH evidence to make critical decisions for addressing both technical and adaptive challenges facing the health system development in the country.

Administratively, Uganda is divided into districts which are further sub-divided into lower administrative units namely counties, sub-counties and parishes. In the course of time, the number of districts and the lower level administrative units have been increasing with the aim of making administration and delivery of social services easier and closer to the people. This has increased pressure on the need for more health facilities and expansion of the existing infrastructure. The demand for health workers to manage the newly established health facilities and expansion of local governments also increased over time.

Focus Areas

This bi-annual report focuses on HRH staffing, human resource trends over the HSSIP period, training and financing. This is because the HSSIP is ending in 2015 and the new plan period (2016-2020) requires adequate HRH information for decision making. Over this period, GoU also made reasonable investment in health worker recruitment and payment salaries to enhance functionality of HCIII and IV. The percentage of approved positions filled by health workers (public facilities) continued to improve over this period details of which are discussed in chapter 3. The public sector staffing did not reach optimum level of the HSSIP period due to financing and retention challenges. Details are also discussed in the subsequent chapters.

1.1.1 Objective

The general objective of this bi-annual is to provide data required for HRH planning at all levels. The long term objective of the bi-annual data is to avail key stakeholders with synthesized HRH country information for use in planning, making decisions based on evidence, policy formulation and programming.

1.2 Methods

The Ministry of Health with support from USAID funded Strengthening Human Resources for Health, collected data using standard reporting forms from 2 national hospitals, 3 central specialized institutions, 14 Regional Referral Hospitals (RRH), 42 General Hospitals (GH), 179 HC IVs, 936 HC IIIs and 1,619 HC IIs. Data were entered, processed and analyzed using MS Excel 2013.

In addition, the Workload Indicators of Staffing Needs (WISN) methodology was employed utilizing ART data by facility level in each of the 112 districts to calculate workload created in the provision of HIV/AIDS services for doctors, enrolled nurses, registered nurses, clinical officers, and dispensers (See Appendices 3 and 4). WISN was used with district-level data to calculate workload for laboratory technologists and technicians.

Furthermore, this analysis utilized information earlier provided. In 2013, the USAID-Supported Uganda Capacity program completed a costed analysis of accommodation needs for the health workforce throughout Uganda. Housing gaps by district and health unit level were calculated. The analysis showed that overall in Uganda there is an 85% gap in appropriate housing for health workers – a significant barrier to the retention of health workers. The team prioritized staff accommodation in our high-burden and hard to reach districts, and also prioritized the retention of medical officers and health workers at HCIII and above (*Bi-annual Report 2013*).

Additional information was elicited from reviewing UBOS and DHIS2 data as of April 2015. This was particularly the health facilities in Uganda and administrative units in public and PNFP institutions.

Finally, a desk review of the key previously prepared HR and financial documents from MoH and Strengthening Human Resources for Health project were reviewed and key issues analyzed. These provided great information that was used to produce this bianaul report.

1.3 Local Governments and Administrative units

The country is divided into 111 districts and the Kampala Capital City Authority. The districts are further sub-divided into Counties, Sub-counties, Parishes and Villages (LC Is). The number of

local governments and administrative units has been increasing overtime. On July 1, 2010 the country created 22 municipalities, 7,138 parishes, and 66,036 villages as shown in table 1.3 below.

Table 1.3 Uganda’s Local Governments and administrative units

Category	No
1. City	1
2. Districts	111
3. Municipalities	22
4. Counties	162
5. City Divisions	5
6. Municipal Divisions	56
7. Sub-County	1,116
8. Town Councils	144
9. Town Boards	207
10. Parishes/Wards	7,138
11. Villages/Cells	66,036

Source: UBOS Data, 2012

From 2010 districts, counties and sub-counties have increased further as shown in table 1.4. Article 179(4) of the Constitution provides for the creation of districts and/or Administrative Units based on the necessity for effective administration; the need to bring services closer to the people; to take account of the means of communication, geographical features, population density, economic viability; and as a response to the wishes of the people concerned. After considering a number of requests from Local Government Councils across the country, Government, found it necessary to create 25 new districts, effective FY 2010/2011.

Besides, in a bid to ensure that fast growing centers are properly guided in terms of orderly physical planning, organized settlement and development, Government elevated a number of Urban Councils to a higher status. In this regard, nine Town Councils were elevated to Municipal status and 23 Trading Centers to Town Councils during the same period.

Table 1.4: Number of administrative units in Uganda, 1969-2014

Level of Administrative units	1969	1980	1991	2002	2014
Districts	21	33	38	56	112
Counties	111	142	163	163	181
Sub-counties	594	668	809	958	1,381
Parishes	-	-	-	-	7,138
Villages	-	-	-	-	66,036

Source: National Population and Housing Census Nov.2014

1.4 Health Service levels

A comparative analysis was done to assess the changes in health service levels as a result of changes in the local governments and administrative units in the country in April 2015. A summary of health facilities by region is as indicated in table 1.4 below.

Table 1.4: Health facilities by region (Public and PNFP) in 2015

Organisation unit	Administrative Unit	Clinic	General Hospital	HC II	HC III	HC IV	Nat.Ref Hosp.	Reg.Ref Hosp.
Central Region	263	645	53	1,065	318	51	2	3
Eastern Region	428	34	30	618	324	48	0	3
Northern Region	332	32	27	484	271	31	0	4
Western Region	407	120	34	774	376	67	0	4
Total	1,430	831	144	2,941	1,289	197	2	14

Source: DHIS2 2015

It was noted from DHIS2 data, that in 2015 there was an increase in administrative units from 1,381 to 1,430. The data also shows that there is an increase of health centres at various levels for both government and PNFP. Health Centre IV increased from 166 in 2012 to 197 in 2015, HCIIIs from 962 in 2012 to 1,289 while HCIIIs increased from 1,321 in 2013 to 2,941 over the same period.

The importance of these service levels cannot be over emphasized. Prevailing cultural beliefs, attitudes and practices constitute some of the major determinants of health seeking behavior in most African countries including Uganda. In Uganda, about 60% of the people first seek care from traditional and complementary medical practitioners before resorting to modern health facilities. The major thrust in health promotion and disease prevention has been the establishment of VHTs at community levels to facilitate creation of awareness, community participation and delivery of efficient and effective health services. Thus, understanding administrative units and how they link with the health service levels helps in planning interventions that are both effective and efficient.

HSSIP targets for promotion of individual and community responsibility for better health by 2015 included the following.

- Standards and guidelines (including criteria for gender sensitivity) for production of delivery of IEC materials developed and disseminated among institutions by 2011/2012
- The proportion of districts with trained VHTs increased from 31% to 100% by 2014/2015
- The proportion of health facilities with IEC materials maintained at 100%

Most of these targets were achieved. Where the targets were not achieved, it was due to the budget shortfall as discussed in chapter 4.

1.5 Outline of the report

The first chapter is an introduction and provides the background for the bi-annual report. Chapter two provides information on the staffing situation based on the analysis made on the current HR data as of April 2015. The chapter provides staffing level by type of cadre and information on the available frontline health workers for quality health care. Chapter three provides information on the human resource trends over the HSSIP period between 2009 and 2015. Information on staffing and production of health workers is provided. Chapter four provides information on financing human resources for health. It is an analysis of investments made to support training, recruitment and retention of health workforce. The appendices provide detail on performance of different system components in support of human resources for health.

CHAPTER 2: STAFFING SITUATION ANALYSIS

This chapter provides an overview of the staffing situation based on secondary analysis of the available HR data from various sources including the HRH audit, HMIS, DHIS2 and HRIS reports. Improvements in staff recruitment and deployment have contributed to improved access, quality and safety of health services in the country. Uganda's MDG progress report of 2013 shows commendable progress in the health-related indicators. This is partly due to the presence of appropriately trained health workers in the right places.

2.1 Uganda Public Sector staffing situation

Human Resource data were aggregated to form the national staffing levels for public health facilities in 2 national hospitals, 3 central specialized institutions, 14 Regional Referral Hospitals (RRH), of 42 General Hospitals (GH), 164 HC IVs, 803 HC IIIs and 1,321 HC IIs. Analysis was done for each of these levels. A summary of this analysis is presented in table 2.1 below.

Table 2.1: National Level Public Sector Staffing Summary as of April 2015

NAME	No. of Units	Total Approved Norm	Positions Filled	Vacant	Filled %	Vacant %
Butabika NRH	1	424	359	63	85%	15%
Mulago NRH	1	2,801	1,880	581	67%	24%
UBTS	1	242	215	27	89%	11%
UCI	1	213	122	91	57%	43%
Uganda Heart Institute	1	190	134	56	71%	29%
RRH	14	4,744	3,820	924	81%	19%
Sub-Total Central Level	19	8,272	6,530	1,742	79%	21%
Total district staffing	111	46,851	31,357	15,494	67%	43%
Health facilities in KCCA	17	3,933	2,792	1,141	71%	29%
Municipal Councils	22	176	111	65	63%	35%
Sub-Total Local Government	150	50,960	34,260	16,700	67%	33%
Total National Level	169	59,232	40,790	18,442	69%	31%

Uganda had overall staffing of 69% of the approved staffing positions in public health facilities as at April 2015. The combined staffing level at central-level institutions (national referral hospitals, specialized health institutions and regional referral hospitals) was 81%; while the combined staffing at health facilities and management offices at the district local government and Municipal Council levels was 67%. The staffing for municipal health councils stood at 63%.

The general administration cadres and Clinical Officers are in sufficient numbers (101% capacity). Nurses and midwives are staffed to 83% and 76% capacity respectively. The following health cadres are severely in short supply: Pharmacists (8%), Anaesthetic staff (30%), Health administrators (33%), and Cold chain technicians (40%). Overall, staffing is skewed in favour of specialized health institutions and larger health facilities (RRH 81%; GH 69%; HC IV 85%; HC III 75%; HC II 49%).

2.2 Staffing level by type of cadre

Staffing in the health facilities was also analyzed by type of cadre. The analysis of health workers was grouped into 15 broad categories shown in Table 2.2. The table shows total staff in the public health sector facilities providing health care at health facility level to the population of Uganda. These were considered health workers that provide direct health services based at health facilities.

Table 2.2 Total filled positions by cadre of staff in public health institutions, April 2015

Cadre category	Norm	Filled position	Percent Filled
Doctors	1,296	936	72%
Nurses	19,946	16,584	83%
Midwives	6,061	4,607	76%
Clinical Officers	2,758	2,780	101%
Laboratory staff	2,737	2,379	87%
Anaesthetic cadre	725	215	30%
Pharmacists	370	31	8%
Dispensers	420	232	55%
Other Allied Health Staff ¹	1,177	820	70%
Cold Chain Technicians	284	115	40%
Consultants	305	107	35%
General administrative cadres	1,337	1,356	101%
Health Administrative cadres	374	124	33%
Support Staff	8,622	4,573	53%
Others	6,055	3,330	55%
Total	52,467	38,189	73%

Note: The figures indicate health facility staff excluding staff in KCCA, MoH headquarters and central level institutions such as UBTS and prisons. Staffing for these cadres was found to be at 73%.

The categories of Nurses and Midwives consist of both enrolled and registered staff, of all grades. Similarly, doctors consist of Medical officers (MOs) at different levels of seniority, including MO special grades; but excluding Consultants. Health administration cadres comprise

of staff with health-related qualifications/skills, and are serving in substantive administrative positions. This category includes hospital directors, health planners and health economists, and DHOs. On the other hand, staff classified in the category of “general administration” consist of all those with generic management qualifications (e.g. hospital administrators, stores assistants and the like). The category for “others” includes nursing assistants and environmental health staff found at health facility level.

Service outputs

Since the general administration and clinical cadres were in sufficient numbers particularly in hospitals and high volume health facilities of many districts in the country, there has been tremendous improvements in addressing HIV/AIDs for instance (see HSPR Oct 2014 p.98).

- The proportion of people who are on ARVs increased from 72% in 2012 to 83% in 2013 among adults and from 35% to 41% in children less than 15 years of age over the same period.
- The trend of new HIV infections (incidence) has been declining over the HSSIP period from 162,294 in 2011, 154,589 in 2012 to 140,908 in 2013. With more inputs, this trend is expected to drop further.
- HCT services are available in all health facilities up to HCIII and to about 30% of HCII (38% of health facilities with HCT services). All districts are implementing community level HCT with financial and technical support from health development partners.
- All hospitals, HCIVs, over 80% HCIIIs and 30% HCII were providing PITC by March 2014. The proportion of those enrolled on ARVs for eMTCT increased from 52% in 2011 to 72% in 2013.
- A total of 1.4 million Ugandan men have been circumcised since the launch of safe male circumcision as an HIV prevention strategy; an achievement way above the mid-target of 1.25 million men (aged 14-49) to be circumcised the end of 2013.

Challenges

- There is limited funding for HIV prevention and implementation which also affects supplies such as condoms.
- There is still poor linkage between services provided such as PMCTC, Paediatric HIV services and ART.

The next chapter presents the human resource trends over the HSSIP period to show improvements in staffing and retention both of which are linked to the above achievements.

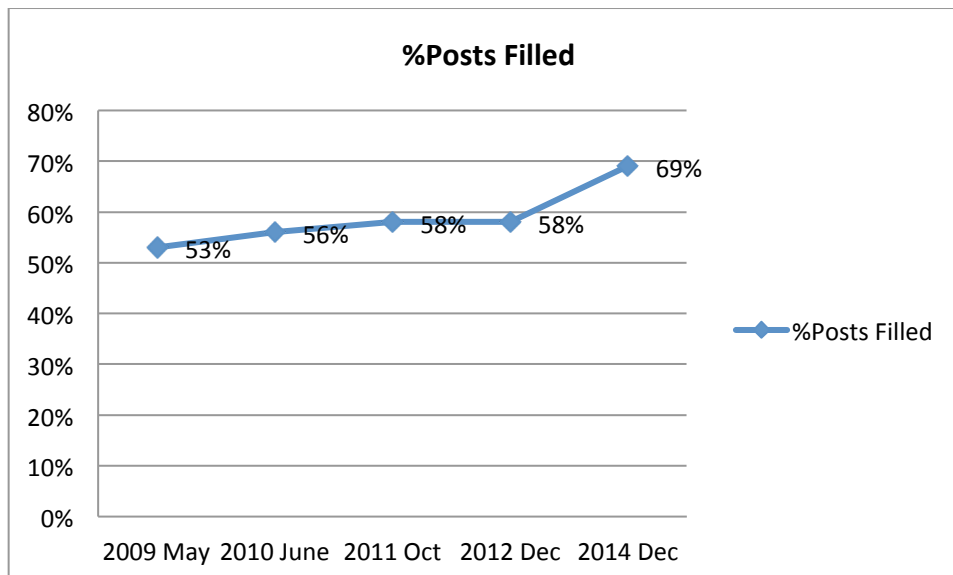
CHAPTER 3: HUMAN RESOURCE TRENDS OVER THE HSSIP PERIOD

This chapter provides information on the human resource trends over the HSSIP period (2010-2014) and the gains the health sector has experienced over this period. The main objective is to assess whether the indicator of the percentage of approved posts filled by health workers has been achieved during the period under review. Improved staffing together with other health inputs contributes to good health outcomes.

3.1 Improvement in staffing

During the period 2009-2014, the health sector staffing has tremendously improved from 48% to 67% in local governments and 53% to 69% nationally (Fig 3.1).

Figure 3.1 Percent of approved posts filled by health workers (2009-2014)



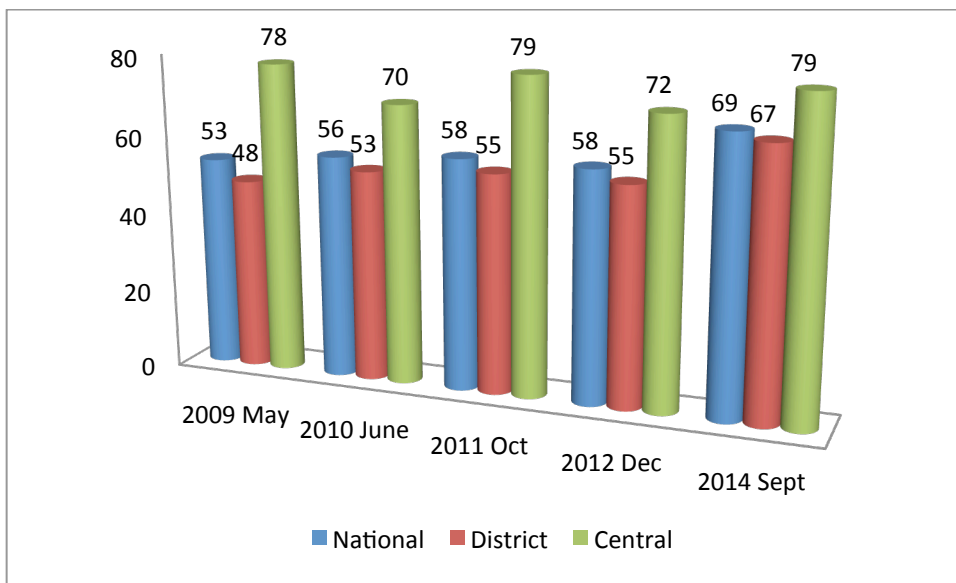
Source: MOH Annual HRH Staff Audit, selected years

The graph also shows stagnation of staffing nationally during FY2011/12 at 58% partly due to limited funding for additional recruitment and salaries for health workers. In 2012, there was massive recruitment of health workers by GoU and the proportion of approved posts filled rose to 69% in 2014 from 58% in 2012.

The staffing for central level institutions (MoH headquarters, NRH, RRH, UBTS, UVRI, Uganda Heart Institute and UCI) has marginally improved from 78% in 2009 to 79% in 2014. At this

level, the staffing tends to be stable because of proximity to Kampala city and social amenities that are associated with the city. Health centre II staffing has improved from 36% in 2009 to 49% in 2014. Staffing at HCII has remained low due to challenges associated with attraction and retention of health workers in rural areas. There are also limited social amenities at this level because of the location. Analysis of approved positions filled by various health professionals is as shown in figure 3.2 below.

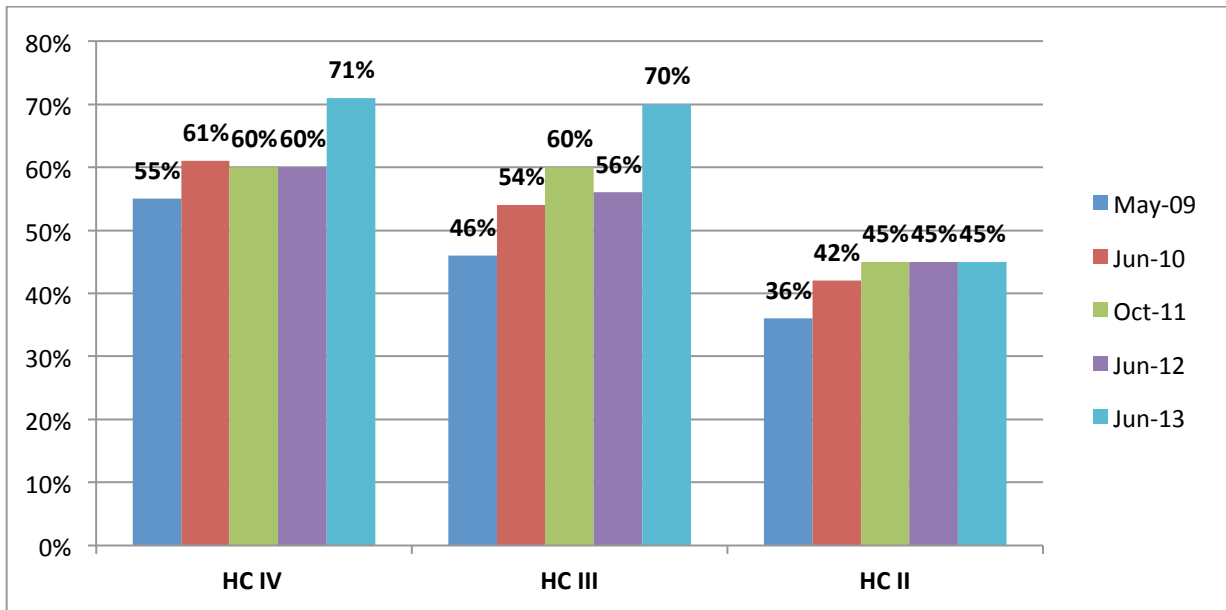
Figure 3.2: Trend analysis of approved posts filled by health workers by level 2009-2014 (in percentages)



Source: MOH Annual HRH Staff Audit, selected years

The greatest gains in the proportion of posts filled are at HCIII and HCIV following the government massive recruitment to improve staffing at these levels. The percent of positions filled in HCIV increased to 71% and HCIIIs to 70% following this intervention (fig 3.3).

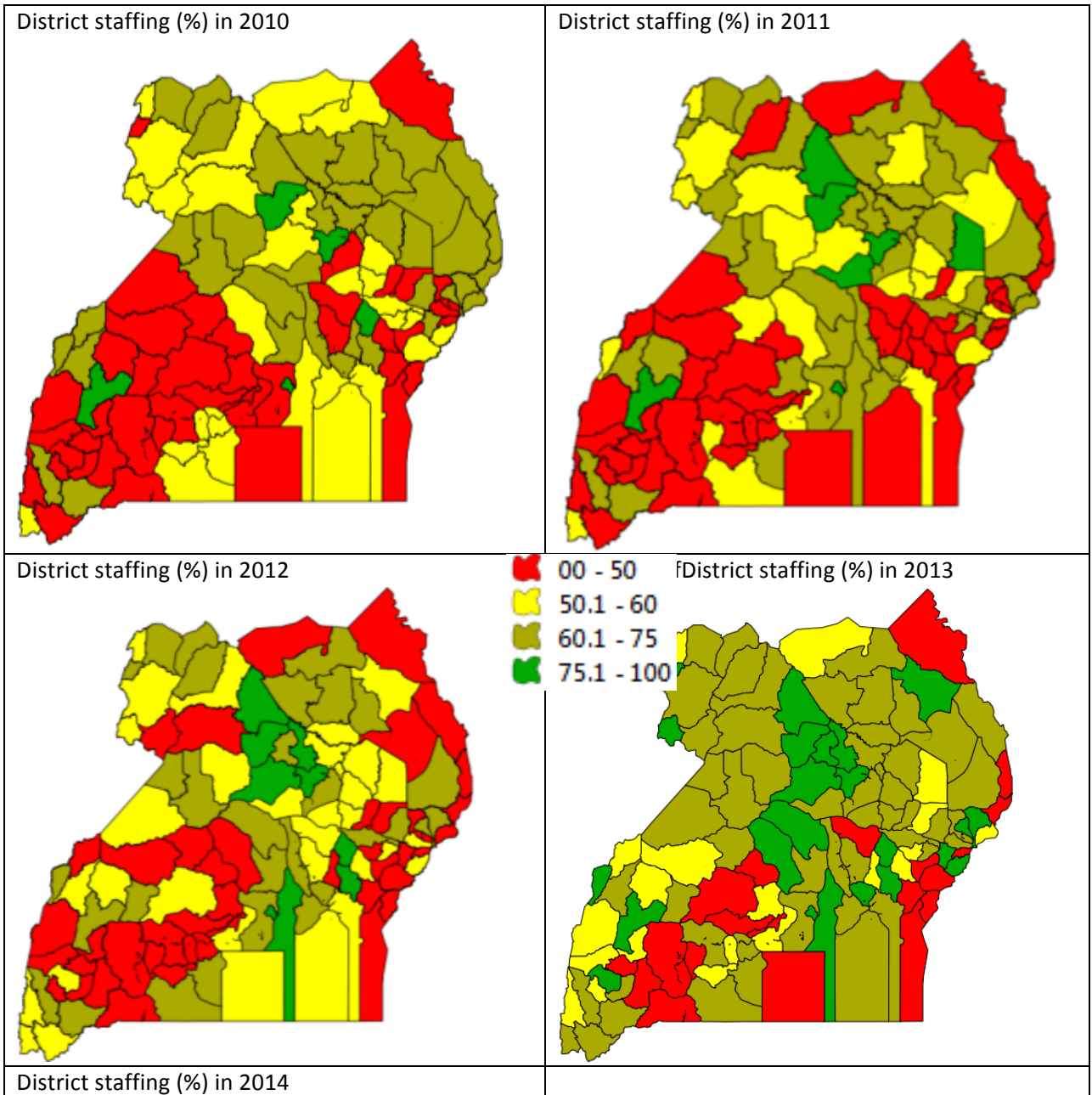
Figure 3.3 Percent of approved posts filled by health workers in lower level health facilities (2009-2014)

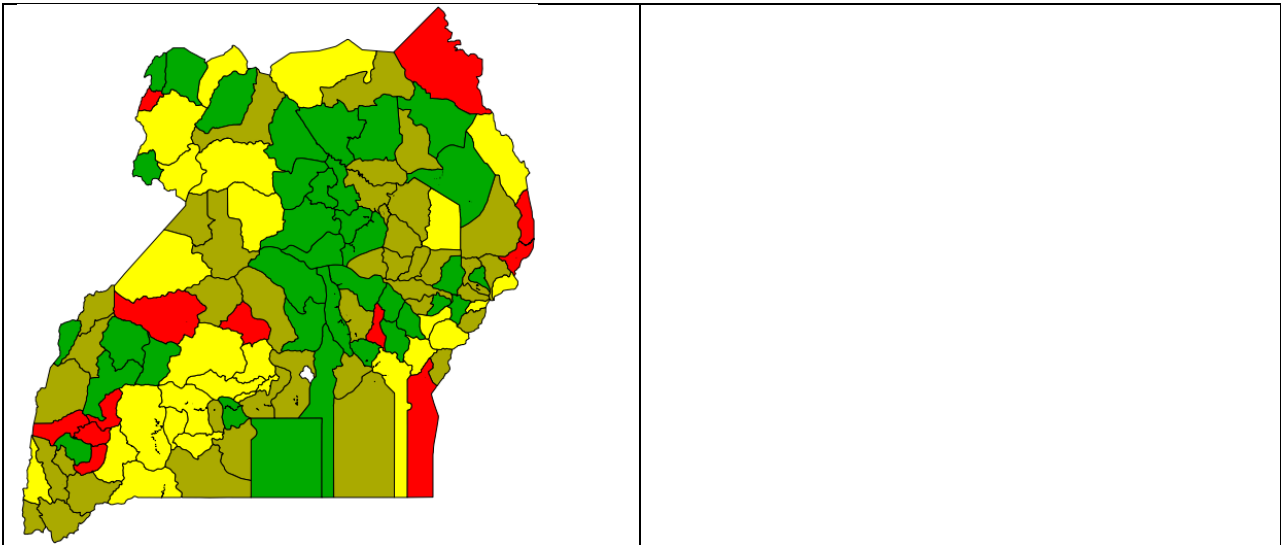


HRH mapping

HRH analysis was done for all the districts to establish the number and type of districts with staffing below 60% of the approved positions. The main objective of HR mapping was to assess as to whether the Ugandan health system is able to fill the vacant posts to scale up HIV/AIDS activities for improved quality of life among the people of Uganda. Analysis out of this assessment is as indicated in figure 3.4 below.

Figure 3.4: Districts with approved positions filled up to 60% 2010 to 2014





Source: HRIS data 2014

The districts in red have staffing below 50% which means it is difficult for them to implement the minimum health care package with the size of health workforce they have. The figure shows that in 2010, the number of districts falling under this category was almost one half of the total districts. The situation has since changed with increased recruitment of health workers. In 2014, the figure shows more green (more than 75% staffing) in most parts of the country including Karamoja region.

3.2 Training of Health Workers during HSSIP period

The World Health Report of 2006 identified Uganda among the 57 Countries Worldwide and 36 of them in Africa with a critical shortage of health workers. According to WHO a country with less than 2.28 health workers (doctors, nurses and midwives) per 1000 population is regarded to be in severe shortage of health workers to meet its health needs. For Uganda, this ratio was 1.22 in 2006 and about 1.50 in 2013. Uganda therefore needs to continue producing and recruiting health workers necessary to meet WHO minimum human resource standards. Further, the recruited health workers need to be retained in service through various retention strategies.

Accredited health training institutions are owned by the GoU, others by faith based organizations (or PNFPs) and others by private owners (or PFP). There are about 149 accredited health training institutions engaged in pre-service training to produce the country's human resources for health. The breakdown of these training institutions by ownership is as shown in table 3.1.

Table 3.1: Health Training Institutions by ownership and registration April 2015

Type of HTI	Status	Public	PNFP	PFP	Total
Nursing/Midwifery	Registered	14	6	6	26
	Licensed	0	19	29	48
	Not registered, not licensed	0	0	3	3
Sub-total		14	26	38	77
Allied Health Professions	Registered	21	2	6	29
	Licensed	0	7	19	26
	Not registered, not licensed	0	0	3	3
Sub total		21	9	28	58
University Medical schools	Registered/ Licensed	4	0	1	5
Total		39	35	75	149

Allied Health Professionals

Training analysis for health workers was made to establish the trends of annual production of Allied Health Professionals in the last five years. The output figures were summarized as shown in table 3.1 below.

Table 3.1: Summary outputs for allied health professionals from 2010- 2014

Training Program	2010	2011	2012	2013	2014
Higher Diploma in Anaesthesia	33	23	18	26	15
Diploma in Pharmacy	32	29	26	42	38
Advanced Diploma in Health Promotion and Education	12	13	11	9	15
Higher Diploma in Psychiatric Clinical Medicine (Mental Health)	19	22	7	12	2
Higher Diploma in ENT surgery	-	-	4	2	5
Higher Diploma in Ophthalmology	12	10	12	19	18

Diploma in Public Health Dentistry	29	40	30	37	57
Diploma in Medical Radiography	26	30	27	13	35
Diploma in Occupational Therapy	17	11	17	13	13
Diploma in Orthopedic Medicine	83	62	37	41	58
Diploma in Orthopedic Technology	23	52	59	57	57
Diploma in dental technology	-	-	-	4	-
Diploma in Physiotherapy	3	25	17	11	16
Diploma in Environ Health Sciences.	50	40	82	38	118
Diploma in Medical Laboratory Technology	164	156	178	284	278
Diploma in Clinical medicine &Community Health	-	396	506	430	412
Certificate in Environ Health Sciences	222	218	150	204	181
Certificate in Medical laboratory Techniques	836	518	872	1458	868
Total	1,561	1,645	2,053	2,700	2,186

The output figures indicate that production of health workers in most of the Allied Health programs has remained almost at the same level except programs for medical laboratory personnel, clinical officers, environmental health officers that steadily increased over time. Diploma in dentistry, orthopaedic medicine and anaesthesia registered negative growth in the last five years. In order to meet the future needs of health service delivery, there is need to scale up production of theatre assistants and anaesthetic staff.

Nurses and Midwives

The analysis of training output figures for nursing cadres from 2010 to 2014 reveals interesting trends. There has been a steady increase in production of nurses and midwives in the last five years except the psychiatric nurses where production increased slightly, public health nurses and paediatric nurses where production significantly reduced and eventually stopped. The detailed analysis is as shown in table 3.2.

Table 3.2: Summary annual output of nurses and midwives from 2010 to 2014

Training programs	2010	2011	2012	2013	2014	Total
Diploma Comprehensive Nursing	246	314	277	229	268	1334
Diploma Nursing	356	349	302	401	467	1875
Diploma Midwifery	271	239	254	268	429	1461
Diploma Mental Health Nursing	46	40	39	45	56	226

Diploma in Paediatric Nursing	-	-	-	2	-	2
Diploma in Public Health Nursing	-	-	-	2	0	2
Certificate in Comprehensive Nursing	1534	2966	1072	2256	2315	10143
Certificate Nursing	83	271	393	763	1618	3128
Certificate midwifery	140	228	229	546	1214	2357
Total	2676	4407	2566	4510	6367	20526

The steady growth in production of nurses and midwives in the last five year can be attributed to the rapid growth of private sector in training of health workers in the country and increased support by government and development partners to government of Uganda and PNFP HTI s that offer programs in midwifery. In addition, training for nurses and midwives in Uganda has adopted a range of innovative training approaches to increase production on new health workers such as; extension programs for health workers in the service, e-learning - a distance learning program which only requires limited expansion of physical infrastructure and staffing.

Average output per annum

The capacity of training health workers to meet HIV/AIDS and other health demands in Uganda for both public and private training institutions is summarized in table 3.3.

Table 3.3: Average output per annum by training program March 2015

Health Cadre	Average output per annum (absolute numbers)
Medical Doctors	250
Dentist (Dental Surgeon)	35
Pharmacist	60
Pharmacy Technician	55
Lab Biomedical Scientist	196
Med Lab Technician	292
Medical Laboratory Assist	676
Clinical Officers	531
Anaesthetic Officer	26
Environ Health Officer	185
Theatre Assistant	15
BSc Nurse	164
Registered Comprehensive Nurse	233
Registered Midwife	403
Registeres Nurse	720
Enrolled Midwife	1,531
Enrolled Nurse	1,561

Enrolled comprehensive Nurse	1,190
Total	8,123

From the table above, the data suggests that Uganda has enough training institutions and programs for health workers to meet the current and future demands of the health system. On average, a total of 8,123 health workers come out of the country's health institutions both public and private. It is estimated that 4,230 health workers (52.0%) graduate from the private sector institutions contributed by 2,086 (25.6%) from PFP and 2,144 (26.4%) from PNFP health training institutions.

These findings imply that if the health system in Uganda could absorb all the health workers produced by the health institutions annually, the current public sector vacancies of 18,442 would be filled within a period of about 2 years and 6 months. This is an indication that the country has adequate capacity to produce its own health workforce but it would require additional inputs to address gaps in human resources and infrastructure to make it happen. What is required now is improved quality of training, adequate infrastructure, modern training equipment and funding to lubricate the system.

Further more, the numbers for certain cadres produced annually, such as public health nurses, pharmacy technicians, anaesthetic officers and theatre assistants have remained low. One option available to planners and policy makers is to reduce on training of other cadres such as enrolled comprehensive nurses and medical laboratory assistants and instead mobilize and align resources to scale up training of those cadres that are in short supply.

Achievements on health worker training

- 1) Stakeholders in Uganda have generally agreed to adopt competence based training to improve health worker performance
- 2) More partnerships and collaborations have been formed to strengthen education and training in Uganda
- 3) Education programs at all levels are being standardized and accredited

Training Challenges

- 1) Due to high demand for health training, there is over enrollment of trainees in HTI s beyond the design capacity of training institutions. The quality of training is negatively affected by shortage of qualified tutors and clinical instructors in the pre-service training schools.
- 2) Tutor establishment in government HTI s for nurses and midwives is less than 60% and this has an effect on the quality of training resulting from high teacher student ratio. Due

to the shortage of tutors and qualified clinical instructors, most GoU and PNFP, health training institutions have had to rely on health workers in the neighboring hospitals who have passion of teaching but are not trained in pedagogical methods. It is recommended that more investments be put in health tutor training to meet the country's training demand.

- 3) The quality of skills training in pre- service health training institutions across all cadres is affected by the shortage of trained clinical instructors and mentors as well as inadequate space and equipment in the skills laboratories. Little investment has been made in improving infrastructure and purchase of learning material and equipment in PFP institutions but majority of training institutions do not meet the required minimum education standards.
- 4) Training sites in most of the schools especially in the rural areas are poorly equipped to provide the necessary training skills. It is recommended that requisite equipment be procured for improved skill development.
- 5) There is limited supervision of students on practicum training resulting in production of less competent health workers. It is recommended that supervision be improved at all the training schools.

3.3 Status of contracting health workers

Following extensive consultations between the Parliament and Executive arms of government, it was agreed that the recruitment and enhancement of health workers' pay be done in a phased manner beginning with recruitment of staff for health centre level III (HCIII) and health centre level IV, and enhancement of the pay of the medical officers at HCIV.

To implement the strategy, the Government provided Ushs 49.5 billion (USD 29 million) for the recruitment of 6, 172 new Health Workers for HCIVs and HCIIIs in September 2012, including approximately Ushs3 billion for recruitment costs. The government recruitment efforts were intended to achieve 100% staffing level at HC III and HCIV, and would raise staffing number from 23,321 to 33,552, and overall national level staffing from 58% staffing to about 70%.

Simultaneously USG/PEPFAR and partners also supported recruitment of selected cadres of staff critical for the provision of HIV/AIDS services (chapter 4). The government recruitment covered some of the cadres prioritized by the USG partners, although it was limited to HCIII and HCIV in the public sector. The recruited staff by various partners is detailed out in appendix 4.

Health worker absorption challenges

- Changes in government policies and procedures for the public sector have caused some delays in timely absorption of health workers recruited by partners. For instance the process of filling vacant positions in districts requires authorization from the Ministry of Finance, Planning and Economic Development unlike in the past when local governments were only dealing with the Ministry of Public Service.
- Many districts particularly in northern Uganda indicated inadequacy of the GoU wage bill as a factor that would hamper their efforts to absorb the health workers recruited by partners.
- Many district local authorities deployed health workers to HCIII and HCIV contrary to what was provided for in the PEPFAR guidelines because of the actual unmet need in those health facilities.

Solutions to these challenges (how the challenges would be handled in future)

- District leaders have agreed in various meetings to engage the Ministry of Finance, Planning and Economic Development and the Ministry of Public Service on how best they can address HR absorption challenges. First they need to seek clearance before absorbing each health worker and also to lobby for wage increment to enable their local governments absorb staff on contract into Public Service main stream.
- Health partners supporting northern Uganda together with local governments agreed to develop mechanisms for motivating and retaining health workers once attracted to their local governments to minimise labour movement.

Lessons learned

- Majority of local governments indicated that PEPFAR programme has made a significant contribution to their institutions at a time when they could not handle the situation themselves.
- The financing mechanisms together with health worker absorption scenarios are discussed in chapter 4.

Recommendation

- Over 50% of the local governments benefiting from contracted staff requested that the contracts of the health workers be extended for at least one more year to enable them work on the absorption mechanism into the mainstream public sector employment.

3.4 Trends in registration of health workers

This section presents data on the registration status of health workers. The purpose is to establish how many health professionals have a valid practicing licence for year in question during the HSSIP period. The analysis for 201 to 2014 was done and a summary of the number by category of health staff is as shown in table 3.4 below.

Table 3.4: Trends in registration of health professionals 2011-2014

Cadre	Registered 2011	Registered 2012	Registered 2013	Registered 2014
Pharmacists	364		578	
Doctors and Dentists	3,841	4,093	4,361	223
Allied Health Professionals	11,026	13,319	16,017	1,666
Nurses and Midwives	29,847	33,417	36,641	3,581
All Categories	45,078	50,829	57,597	5,470

The table shows that a total of 57,597 health workers had practicing licences by December 2013. We note that some health workers are practicing without registration licences. Data available indicates that at that time of this analysis, government health facilities had a total of 40,790 health workers in employment. This implies that a total of 10,387 health workers are working without practicing licences.

3.5 Human Resources in the private sector

The HSSIP indicates that overall 60% of the health workforce is in the public sector health facilities and 40% are working for the private sector. The total health workforce in the health sector (GoU + Private) therefore is about 67,984. Out of the total 40,790 are working in the public sector and about 27,194 are working with the private sector.

Secondary analysis to establish the staffing norms and percentages of posts filled by staff in PNFP and PFP health facilities was not done. This was because the exercise did not collect the detailed information from the private sector.

Challenges

- This bi-annual report was written using secondary data that was collected by a team of key stakeholders who elicited information from public health sector facilities (national and local governments). PNFP and PFP health facilities were not covered during this exercise. To obtain this information would require collecting data from PNFP and PFP health facilities in all the local governments.

Lesson learned

- The next bi-annual should have the total health workforce in Uganda including detailed GoU facilities, PNFP and PFP to provide a total picture.

Recommendation

- There is need to enforce regulations to ensure that all practicing health workers are registered with their respective health professional councils.

CHAPTER 4: FINANCING HUMAN RESOURCES FOR HEALTH

This chapter provides information on financing human resources for health. It is an analysis of investments made to support training; recruitment and retention of health workforce. As discussed in earlier chapters, local governments and administrative structures have been increasing annually. The new local governments need direct support from the central ministries to enable them effectively take on their mandates. Besides, the increase in the number of LGs in the country comes in with an added responsibility to the ministry of health in terms of inspection, support supervision, mentoring and policy guidance. In turn, this calls for additional resources (financial, human, materials and time).

4.1 Background

Health service delivery together with health systems strengthening is financed by the government of Uganda, private sources and health development partners. Government of Uganda capital budget excluding donor for FY2013/2014 accounted for 15% of health sector public expenditure while the recurrent expenditure including salaries and wages, utilities and other operational costs accounted for 85%.

During the FY 2012/2013 health facilities in Uganda were grossly understaffed. The staffing situation was worse in lower level health facilities located in remote rural areas, while the hospitals located in relatively urban areas were comparatively better staffed. On average only 58% of all approved staffing positions in government health facilities were filled. The staffing situation also varied for various cadres. The shortage of the higher level cadres such as doctors was more severe in the remote rural areas than in large urban facilities. There were also some cadres like laboratory staff, midwives and pharmaceutical cadres that were generally in short supply in the country.

The recurrent budget outturn was US\$592.4bn (93%), while the outturn for the development budget was US\$451bn (92%).

The FY2013/14, the per capita public health expenditure increased from \$9 to \$12 due to additional funding from government projects of Global Fund and GAVI as indicated in table 4.1. However, the health sector needed more funding to support production and management of its human resources (Tables 4.2 & 4.3).

Table 4.1 Government Allocation to the Health Sector 2010/11-2013/14

FY	GoU Funding	Donor projects and GHI (Ush billions)	Total (Ugsh billions)	Per Capita Public health Expenditure (Ush)	Per Capita Public health Expenditure US\$)	GoU health expenditure as % of total government expenditure
2010/11	569.6	90.44	660	20,765	9.4	8.9
2011/12	593.02	206.1	799.11	25,142	10.29	8.3
2012/13	630.77	221.43	852.2	23,756	9	7.8
2013/14	710.82	416.67	1127.48	32,214	12	8.7

The table above shows that GoU health expenditure as a percent of total government expenditure has remained low. This creates a challenge for the health sector as it does not attract the require quality and number of the key health workers. This has caused a persistent service delivery gap in health facilitiea across all local governments. According to the ministerial policy statement (2014/15), no funds have been provided for wage enhancement for other health workers, except for medical officers at health centre IVs. This creates dissatisfaction among the other health cadres who are members of the same health care team. Health worker salaries have also remained low during the entire HSSIP period. Anecdotal evidence shows that low salaries lead to increased absenteeism and reduced productivity as workers are forced to consider supplementary sources of income. Table 4.2 shows PHC grants by year FY2010/11-2013/14.

Table 4.2 Primary Health Care Grants FY 2010/11-2013/14 in billions of Shillings

FY	PHC WAGES	PHC (Non-Wage)	PHC NGOs (PNFP)	General Hospitals	PHC Dev't Grant	Total
2010/11	124.5	17.4	17.7	5.9	15.3	180.8
2011/12	143.43	18.5	17.19	5.94	44.43	229.49
2012/13	169.38	15.84	17.19	5.94	34.81	243.16
2013/14	228.69	18.05	17.19	5.94	30.08	299.95

Source: Annual Health Sector Performance Report, 2014

Assessing the wage short fall

The resource allocation has not moved at the same speed with increase in local government and administrative structures highlighted in Chapter 1. The resultant effect has been a short fall in the wages allocations in addition to inadequate equipment and materials in the health facilities.

About 57 of 111 districts and 9 of 22 municipalities had a wage shortfall during FY 2014/2015. This resulted from the fact that government allocation for health as a percentage of the total GoU budget has averaged about 8% from 2010/2011 to 2013/14 which is 1.8% short of the HSSIP target of 9.8%. This translates into a government contribution of US\$12 per capita expenditure on health (AHPR 2014). The calculated amounts of money required together with the wage shortfalls for municipalities and districts are illustrated in a few examples as indicated in table 4.3 and Appendix 2.

A total of Ushs 129bn is required for salary enhancement for all staff in the sector annually. In addition, there is need to revise a non wage recurrent budget to enhance health service delivery in the local governments. The sector requires Ushs 39.5bn to make health facilities operational without considering the proposed recruitment. Examples of wage allocation shortfalls for local governments are as indicated in table 4.3 and appendix 2.

Table 4.3: Wage allocation and shortfall to health workers in Municipalities FY 2014/15

No	Municipality	Total wage allocated 2014/2015	Projected wage to 30/6/2015	Projected wage balance/gap by 30/6/2015
1	Arua-MC	433,425,969	378,304,296	55,121,673
2	Bushenyi-MC	416,474,000	378,060,000	38,414,000
3	Busia-MC	338,605,675	361,187,508	(22,581,833)
4	Entebbe-MC	1,215,125,337	619,470,960	595,654,377
5	Fort-Portal-MC	537,720,061	624,593,256	(86,873,195)
6	Gulu-MC	530,166,000	530,166,000	-
7	Hoima-MC	299,569,000	301,139,760	(1,570,760)
8	Iganga-MC	269,182,000	229,942,292	39,239,708
9	Jinja-MC	1,244,201,963	1,218,547,577	25,654,386
10	Kabale-MC	427,734,000	436,582,000	(8,848,000)
11	Kasese-MC	2,033,576,000	2,160,706,263	(127,130,263)
12	Lira-MC	283,630,020	239,351,534	44,278,486
13	Masaka-MC	242,906,000	243,185,120	(279,120)
14	Masindi-MC	307,432,004	345,964,397	(38,532,393)
15	Mbale-MC	912,755,185	915,552,053	(2,796,868)
16	Mbarara-MC	-	-	-
17	Moroto-MC	-	-	-
18	Mukono-MC	731,880,540	347,675,034	384,205,506
19	Ntungamo-MC	-	-	-
20	Rukungiri-MC	514,310,832	494,159,668	20,151,164
21	Soroti-MC	703,695,021	688,043,164	15,651,857
22	Tororo-MC	430,682,173	463,117,418	(32,435,245)

4.2 Government response

With regard to inadequate staffing levels, Government of Uganda responded by mass recruitment of the priority health cadres to serve at HCIV and HCIII levels mainly to fight HIV/AIDS, Malaria and other communicable diseases. There was also enhancement of salaries for medical officers serving at HCIV through a government pronouncement by the leader of government business in parliament to improve attraction and retention of health workers at this level.

4.3 Response by the health development partners

Following the mass recruitment by the GoU, there was unprecedented glaring staffing gap left at HCII and hospital levels since government recruitment had only covered HCIII and IV. Health Development partners through health program initiatives such Global Fund and USG/PEPFAR supported recruitment and eventually paid salaries for prioritized cadres that were critical for HIV/AIDS services, including doctors, clinical officers, midwives, nurses, dispensers and laboratory staff to address critical shortage of staff in hospitals and HCII.

PEPFAR support for Health Workers

The current PEPFAR-support of health workers totals \$9,330,000 USD. It is envisaged that the Government of Uganda would successfully absorb at least 30% of the current PEPFAR-supported health workforce by the end of FY15, leaving approximately \$2,799,000 USD in savings. Several scenarios were developed to utilize these funds to further improve the health workforce both in continued staffing-up and in the retention of current health workers through the construction of institutional housing, the lack of which is a demonstrated barrier to retention of health workers especially in hard to reach areas.

4.4 Application of WISN Methodology

As earlier indicated in the introduction, the Workload Indicators of Staffing Needs (WISN) methodology was employed utilizing ART data by facility level in each of the 112 districts to calculate workload created in the provision of HIV/AIDS services for doctors, enrolled nurses, registered nurses, clinical officers, and dispensers. WISN was used with district-level data to calculate workload for laboratory technologists and technicians. However, WISN was not applied to district health offices, so priority ADHO and biostatistician vacancies were identified and prioritized for the purpose of supporting disease control functions at the district health team level. A 15% increment increase in workload over past years was assumed overall.

The WISN Method is based on the work which is actually undertaken by health staff. Every health facility has its own pattern of workload which may include inpatients, surgical operations, deliveries, outpatients, clinics of various types, health education, home visits, outreach activities, inspection visits, etc. Each type of workload calls for effort (i.e. time) from specific health staff

Cadre. For example, a patient Active on ART requires time from a Registered nurse (preparation and recording), a doctor or Clinical Officer (examination), a laboratory technician (performing tests), a dispenser (filling a prescription), and so on, depending on the medical practices and procedures which are followed. Sometimes treating a case requires time from several different staff categories working together as a team.

For each type of workload in the ART clinic, we can set an **Activity Standard**. This is a unit time for each staff cadre - how much time on average a case, a prescription, etc. should take each staff category which is involved in it, working to acceptable professional standards. Alternatively we can set a standard rate - how many patients, laboratory tests, etc. can be dealt with to an acceptable standard of performance per hour or per day. This unit time or rate will differ, depending on the type of work, on the category of staff dealing with the clients (on average ward nurses spend longer per day with hospital patients than doctors do) and also on the type of facility (more complex cases are referred to the higher level hospitals where on average they take more staff time per case).

This Activity Standard, an activity time or a rate of working (either can be used), can now be converted into the equivalent **annual workload**, that is, how much of this type of work could be done by one person in a year working to these professional standards and also making due **allowance** for time spent on vacation, holidays, training, sickness absence, etc. This equivalent annual workload is called the **Standard Workload**.

The amount of each type of work done in a health facility in a year is reported in its annual statistics. Thus applying the Standard Workloads (annual work rates) to these annual statistics will show how many staff in each category are required in order to accomplish this workload to acceptable professional standards. This figure is the staffing requirement of the facility calculated according to the WISN Method.

The formula is: **Workload in the facility (service statistics) / Standard workload (for one staff) = Staffing requirement**

Results

The results are presented according to the following structure; Total staffing requirements per district, and total staffing HRH requirements in the 44 HIV “high burden” districts. Out of 112 districts targeted for the assessment, 108 (96%) have final results as four did not have complete HIV/AIDS statistics to enable complete analysis (appendix 3). Findings of WISN analysis and the associated annual costs are as indicated in table 4.4.

Table 4.4: Results of WISN and Priority Analysis, by Cadre

Results Summary by Cadre	Number of Health Workers			COST - Annual		
	High Burden Districts	Low Burden Districts	TOTAL Need	Subtotal High Burden	Subtotal Low Burden	Total Annual Cost USD
Doctor	24	21	45	281,774	246,552	528,326
Enrolled Nurse	452	584	1036	1,626,319	2,101,261	3,727,580
Registered Nurse	276	404	680	1,504,608	2,202,398	3,707,006
Clinical Medical Officer	20	74	94	116,071	429,461	545,532
Dispenser	66	63	129	366,814	350,141	716,955
Lab Technologist	61	74	135	618,036	749,748	1,367,784
Lab Technician	96	100	196	550,967	573,924	1,124,891
ADHO	5	0	5	75,053	-	75,053
Biostatistician	13	0	13	108,714	-	108,714
TOTAL	1013	1320	2333	5,248,355	6,653,485	11,901,840

Costs are based on a loaded salary per health worker per year which includes base salary, 10% NSSF, and an assumed 25% NICRA levied by implementing partners. (Also see appendix 3 for detailed analysis).

Overall a total of 2,195 additional health workers are required to manage the existing HIV/AIDS workload in the 108 districts (see appendix 3) for detailed analysis. Kampala and Wakiso require the most number of additional health workers with Kampala requiring 188 health workers and Wakiso 105. This is explained by the fact that the 2 districts have the highest volume of HIV/AIDS clients compared to other districts according to USAID HIV statistics. It is important to note that the two districts also fall in the regions that have high HIV prevalence rates according to AIS 2011 i.e Kampala 7.1% and Wakiso 10.6%.

The five districts from Mid-east, North East and West Nile (Bukwa, Kween, Kaabong & Moyo) require the least number of additional health workers due to low HIV/AIDS workload currently experienced. It is also not surprising that these districts fall in the regions with the lowest HIV/AIDS prevalence rates according to UAIS 2011 i.e. at 4.1%, 5.3% and 4.9% respectively.

Analysis of staffing requirements by cadre indicate that, nurses account for the biggest proportion of staff required 52% (1,130), followed lab staff at 15% (331). A total of 133 doctors are required. It is also not surprising that the majority of additional staff required are nurses as it is widely acknowledged that nurses perform the most number of tasks in provision of HIV/AIDS services in health facilities.

High Burden Districts

The PEPFAR 2015 HRH strategy is to recast the HRH investment towards health service delivery sites with moderate and high yield of patients and geographic areas with high burden of

HIV. In line with the above strategy, the HRH staffing requirements were further analyzed for the districts with highest HIV/AIDS burden according prevalence rates from MEEPP 2013 annual performance report. Given that there is no universally agreed standard definition for “HIV high burden districts”, the districts that have HIV prevalence rates above the national average of 7.3 were considered to fit the “high burden” category.

Brief description of Scenarios and suggested options for decision making

Scenario 1: Maintain the unabsorbed PEPFAR staff, recruit priority staff to target HIV/AIDS service delivery especially in high burden districts. The table below shows the new recruitment analysis by cadre, and what percent of the need determined by WISN it fulfills in high burden districts.

Table 4.5: Priority Recruitment Summary

Priority Recruitment	No of Health Workers	% High Burden district determination filled	Cost USD (2,800 UGX to USD)
Medical Officer	11	46%	129,146
Enrolled Nurse	243	54%	874,326
Registered Nurse	159	58%	866,785
Clinical Medical Officer	20	100%	116,071
Dispenser	30	45%	166,734
Lab Technologist	22	36%	222,898
Lab Technician	41	43%	235,309
ADHO	5	100%	75,053
Biostatistician	13	100%	108,714
Total	544	54%	2,795,036

Scenario 1 Summary	# of Health Workers	USD Cost
Unabsorbed	910	6,531,000
Priority Recruitment	544	2,795,036
Total	1,454	9,326,036

Scenario 2: Utilize cost savings from absorbed health workers to construct staff housing for priority cadres in high burden and hard to reach districts. Priority housing was for doctors in HCIV and GH (the 3 bedroom houses) and the rest for all other staff in HC II and HC IV (2 Bedroom Houses).

Scenario 2 Summary	No of Units	Cost	Notes
2 Bedroom	68	1,906,720	For staff at priority HC III-HC IV
3 Bedroom	11	904,475	For retention of doctors in high-burden districts
Health Worker Salari	910	6,531,000	Unabsorbed Health Workers
TOTAL		9,342,195	

Scenario 3: Recruit priority health workers as in Scenario 1, provide increased support of housing units to encourage retention in high burden districts.

Scenario 3 Summary	No of Units	Cost	Notes
2 Bedroom	122	3,420,880	For staff at priority HC III-HC IV
3 bedroom HCIV, GH	20	1,644,500	For retention of doctors in high-burden districts
3 bedroom RRH	4	621,400	For Retention of doctors at RRH
Unabsorbed Health Workers	910	6,531,000	
Priority Recruitment	544	2,795,036	As in Scenario 1
TOTAL		15,012,816	

Scenario 4: Recruit priority health workers as in Scenario 1, provide further increased support of housing units to encourage retention in high burden districts, especially targeting HCIIIs, HCIVs, and doctors in High Burden Districts.

Scenario 4 Summary	No of Units	Cost	Notes
2 Bedroom	382	10,711,280	For staff at priority HC III-HC IV
3 bedroom HCIV, GH	37	3,042,325	For retention of doctors in high-burden districts
3 bedroom RRH	8	1,242,800	For Retention of doctors at RRH
Unabsorbed Health W	910	6,531,000	
Priority Recruitment	544	2,795,036	As in Scenario 1
TOTAL		24,322,441	

Table 3: Scenario Summary

Scenario	Unabsorbed PEPFAR Staff	New Priority Recruitment	Housing Units	TOTAL COST
Scenario 1	910	544	0	9,326,036
Scenario 2	910	-	79	9,342,195
Scenario 3	910	544	145	15,012,816
Scenario 4	910	544	427	24,322,441

Key assumptions used in determining staffing requirements

- Health facilities are generally understaffed with percent of approved positions filled by health workers in all districts at 67% and health worker to population ratio estimated at **1.29** health workers per **1,000** people.
- The few existing health workers are already working under a lot of pressure to provide health services to the population including HIV/AIDS
- HIV/AIDS services create an additional burden to the few existing staff already working under pressure
- The additional numbers of health workers by WISN are required to take care of the work pressure created by HIV/AIDS services to provide quality HIV/AIDS services
- These additional numbers of health workers should actually relieve existing staff work pressure created by HIV/AIDS services and give an extra hand in provision of other health services.

Recommendations

- There is need to review the current staffing standards. This implies, recruiting the numbers as shown by the WISN analysis in the tables above to cover the HIV/AIDS workload in all the districts.
- There is need to use the WISN methodology in estimating the actual health worker requirements. If the budget does not allow for recruitment of all required health workers in all districts, deliberate actions should be done to prioritize recruitment in the districts with high client volume/workload.
- If there are no funds at all to recruit, redistribute staff within each district i.e. from health facilities with low client volume/workload to health facilities with high client volume.
- There is need to increase the level of GoU per capita expenditure on health in line with WHO recommendation of US\$ 34 for countries like Uganda.

Limitations of the assessment

- The assessment did not consider contribution of the existing health workers in provision of HIV/AIDS services. However, the urgent need is to reduce the work pressure created by provision of HIV/AIDS services.

Notes on the WISN method:

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

The bi-annual report indicates that, presently, health institutions are well staffed with clinical officers (101%) and nurses (83%). However, there is severe shortage of anesthetic staff (30%), cold-chain technicians (40%), dispensers (55%) and pharmacists (8%). In any case most of these cadres are in the majority of cases concentrated at the large health facilities. Future recruitment plans need to prioritize these rare cadres and lower-level health facilities. Further, future HRH interventions need to focus on achieving equitable distribution and promoting accountability and productivity of health workers.

Further, with regard to training, tutor establishment in government HTIs for nurses and midwives is less than 60% and this has an effect on the quality of training resulting from high teacher student ratio. Moreover, due to the shortage of tutors and qualified clinical instructors, most GoU and PNFP, health training institutions have had to rely on health workers in the neighboring hospitals who have passion of teaching but are not trained in pedagogical methods. It is recommended that more investments be put in health tutor training to meet the country's training demand.

Analysis of staffing requirements by cadre indicates that, nurses' account for the biggest proportion of staff required i.e 52% (1,130), followed lab staff at 15% (331). A total of 133 doctors are required. It is also not surprising that the majority of additional staff required are nurses as it is widely acknowledged that nurses perform the most number of tasks in provision of HIV/AIDS services in health facilities.

It is recommended that recruitment of the HRH numbers gets effected as shown by the WISN analysis in tables 4.4, 4.5 and appendix 3 to cover the HIV/AIDS workload in all the districts. If the budget does not allow for recruitment of all required health workers in all districts, prioritize recruitment in the districts with high client volume/workload. If there are no funds at all to recruit, redistribute staff within each district i.e. from health facilities with low client volume/workload to health facilities with high client volume.

The GoU per capita health expenditure is way below the HSSIP target of US\$17. It is recommended that government works towards increasing the per capita health expenditure to US\$34 as recommended by WHO Commission of macro economics in order for the country to effectively tackle her human resource adaptive and technical challenges.

APPENDICES

Appendix 1: District staffing categorized by total positions filled as at April 2015

No.	District	Approved Norm	Total Filled	Total vacant	% Filled	% Vacant
1	Gulu	468	594	-126	127%	-27%
2	Luuka	372	471	-99	127%	-27%
3	Koboko	198	242	-44	122%	-22%
4	Rukungiri	657	778	-121	118%	-18%
5	Otuke	190	186	4	98%	2%
6	Kabale	710	685	25	96%	4%
7	Bundibugyo	480	458	22	95%	5%
8	Jinja	531	503	28	95%	5%
9	Mbale	455	429	26	94%	6%
10	Alebtong	153	140	13	92%	8%
11	Lira	294	266	28	90%	10%
12	Kumi	280	248	32	89%	11%
13	Kaberamaido	251	222	29	88%	12%
14	Agago	334	294	40	88%	12%
15	Iganga	703	612	91	87%	13%
16	Kabarole	470	408	62	87%	13%
17	Bududa	262	227	35	87%	13%
18	Moroto	177	153	24	86%	14%
19	Sironko	454	387	67	85%	15%
20	Apac	626	518	108	83%	17%
21	Adjumani	576	476	100	83%	17%
22	Wakiso	907	744	163	82%	18%
23	Kyegegwa	227	185	42	81%	19%
24	Nakasongola	396	322	74	81%	19%
25	Isingiro	506	408	98	81%	19%
26	Nwoya	355	285	70	80%	20%
27	Oyam	284	228	56	80%	20%
28	Amuru	346	276	70	80%	20%
29	Mukono	440	348	92	79%	21%
30	Kalangala	235	184	51	78%	22%
31	Bushenyi	318	248	70	78%	22%
32	Kayunga	526	410	116	78%	22%
33	Luwero	647	497	150	77%	23%
34	Kaliro	176	133	43	76%	24%

No.	District	Approved Norm	Total Filled	Total vacant	% Filled	% Vacant
35	Amolatar	179	135	44	75%	25%
36	Kamwenge	417	313	104	75%	25%
37	Ntoroko	124	93	31	75%	25%
38	Ntungamo	752	564	188	75%	25%
39	Buyende	180	134	46	74%	26%
40	Budaka	262	191	71	73%	27%
41	Pader	352	256	96	73%	27%
42	Yumbe	523	374	149	72%	28%
43	Napak	170	121	49	71%	29%
44	Mpigi	336	238	98	71%	29%
45	Manafwa	460	325	135	71%	29%
46	Hoima	470	331	139	70%	30%
47	Kamuli	692	486	206	70%	30%
48	Kasese	1091	766	325	70%	30%
49	Abim	348	237	111	68%	32%
50	Masindi	544	370	174	68%	32%
51	Kisoro	768	514	254	67%	33%
52	Nakaseke	511	339	172	66%	34%
53	Bullisa	148	98	50	66%	34%
54	Masaka	293	194	99	66%	34%
55	Mitooma	255	167	88	65%	35%
56	Amuria	425	278	147	65%	35%
57	Kotido	231	150	81	65%	35%
58	Kapchorwa	429	276	153	64%	36%
59	Kyankwanzi	257	165	92	64%	36%
60	Buikwe	526	337	189	64%	36%
61	Kween	346	221	125	64%	36%
62	Kyenjojo	475	302	173	64%	36%
63	Kanungu	599	380	219	63%	37%
64	Namutumba	293	185	108	63%	37%
65	Bukedea	168	106	62	63%	37%
66	Kiruhura	506	318	188	63%	37%
67	Buvuma	161	101	60	63%	37%
68	Serere	302	188	114	62%	38%
69	Soroti	254	157	97	62%	38%
70	Tororo	789	478	311	61%	39%
71	Nakapiripirit	261	158	103	61%	39%
72	Mayuge	423	255	168	60%	40%

No.	District	Approved Norm	Total Filled	Total vacant	% Filled	% Vacant
73	Pallisa	573	344	229	60%	40%
74	Rakai	1320	791	529	60%	40%
75	Sembabule	309	184	125	60%	40%
76	Moyo	751	443	308	59%	41%
77	Bukomansimbi	143	82	61	57%	43%
78	Bulambuli	350	200	150	57%	43%
79	Mityana	781	446	335	57%	43%
80	Gomba	234	133	101	57%	43%
81	Lwengo	312	177	135	57%	43%
82	Dokolo	239	135	104	56%	44%
83	Bukwo	409	226	183	55%	45%
84	Butambala	358	195	163	54%	46%
85	Mubende	609	331	278	54%	46%
86	Kalungu	219	119	100	54%	46%
87	Kibuku	228	122	106	54%	46%
88	Kiryandongo	432	230	202	53%	47%
89	Butaleja	486	254	232	52%	48%
90	Ibanda	407	212	195	52%	48%
91	Zombo	322	167	155	52%	48%
92	Katakwi	447	229	218	51%	49%
93	Maracha	408	208	200	51%	49%
94	Arua	849	423	426	50%	50%
95	Buhweju	140	69	71	49%	51%
96	Sheema	544	262	282	48%	52%
97	Bugiri	635	301	334	47%	53%
98	Rubirizi	224	106	118	47%	53%
99	Lyantonde	447	211	236	47%	53%
100	Kiboga	498	235	263	47%	53%
101	Busia	424	199	225	47%	53%
102	Kaabong	483	223	260	46%	54%
103	Lamwo	319	144	175	45%	55%
104	Mbarara	597	238	359	40%	60%
105	Kole	379	140	239	37%	63%
106	Namayingo	279	98	181	35%	65%
107	Ngora	390	127	263	33%	67%
108	Kibaale	680	220	460	32%	68%
109	Amudat	125	38	87	30%	70%
110	Kitgum	478	120	358	25%	75%

No.	District	Approved Norm	Total Filled	Total vacant	% Filled	% Vacant
111	Nebbi	699	109	590	16%	84%
Total		46,851	31,357	15,494	67%	33%

NB: These figures are without municipalities and RRH staffing. A total of 75 districts (68%) have their approved positions filled up to 60% following massive recruitment by government.

Staffing for all Municipal councils

	Approved Norm	Total Filled	Total vacant	% Filled	% Vacant
Municipal Authorities	176	111	65	63%	37%

Overall Local Government staffing

	Approved Norm	Total Filled	Total vacant	% Filled	% Vacant
Grand Total	47,027	31,468	15,559	67%	33%

Appendix 2: Government of Uganda Wage Budget by district FY 2014/2015

No	District	Total wage allocated 2014/2015	Projected wage to 30/6/2015	Projected wage balance/gap by 30/6/2015	Projected Wage bal 30/6/2015
1	Abim	748,418,000	742,018,000	6,400,000	6,400,000
2	Adjumani	1,724,684,000	749,952,300	974,731,700	974,731,700
3	Agago	743,215,000	760,539,797	(17,324,797)	(17,324,797)
4	Alebtong	1,178,841,000	897,841,000	281,000,000	281,000,000
5	Amolatar	1,992,908,000	995,893,572	997,014,428	997,014,428
6	Amudat	1,562,392,000	1,402,364,886	160,027,114	160,027,114
7	Amuria	1,436,730,240	1,514,131,968	(77,401,728)	(77,401,728)
8	Amuru	1,597,529,796	1,553,861,868	43,667,928	43,667,928
9	Apac	1,443,190,034	1,612,170,996	(168,980,962)	(168,980,962)
10	Arua	2,585,857,008	2,714,927,979	(129,070,971)	(129,070,971)
11	Budaka	3,016,785,000	2,919,999,924	96,785,076	96,785,076
12	Bududa	6,075,410,000	7,166,777,667	(1,091,367,667)	(1,091,367,667)
13	Bugiri	5,470,298,000	5,334,298,000	136,000,000	136,000,000
14	Buhweju	5,251,054,410	3,923,544,000	1,327,510,410	1,327,510,410
15	Buikwe	4,018,828,000	4,268,797,198	(249,969,198)	(249,969,198)
16	Bukedea	2,639,164,000		2,639,164,000	-
17	Bukomansimbi	2,784,197,952	2,625,717,137	158,480,815	158,480,815
18	Bukwo	2,412,956,352	1,936,704,502	476,251,850	476,251,850
19	Bulambuli	2,079,656,000	1,852,554,459	227,101,541	227,101,541
20	Bullisa	1,148,544,191		1,148,544,191	-
21	Bundibugyo	-		-	-

No	District	Total wage allocated 2014/2015	Projected wage to 30/6/2015	Projected wage balance/gap by 30/6/2015	Projected Wage bal 30/6/2015
22	Bushenyi	1,876,200,000	938,200,000	938,000,000	938,000,000
23	Busia	1,042,006,000	962,000,000	80,006,000	80,006,000
24	Butaleja	1,159,945,000	988,326,956	171,618,044	171,618,044
25	Butambala	908,424,850	1,016,750,672	(108,325,822)	(108,325,822)
26	Buvuma	1,078,920,000	1,082,388,465	(3,468,465)	(3,468,465)
27	Buyende	1,014,359,763	1,091,415,885	(77,056,122)	(77,056,122)
28	Dokolo	1,676,662,000	1,155,621,078	521,040,922	521,040,922
29	Gomba	1,012,798,000	1,155,684,324	(142,886,324)	(142,886,324)
30	Gulu	1,183,288,000	1,298,944,000	(115,656,000)	(115,656,000)
31	Hoima	1,319,213,905	1,302,234,060	16,979,845	16,979,845
32	Ibanda	1,231,103,000	1,351,639,892	(120,536,892)	(120,536,892)
33	Iganga	1,220,675,650	1,373,410,308	(152,734,658)	(152,734,658)
34	Isingiro	1,590,407,000	1,446,560,138	143,846,862	143,846,862
35	Jinja	1,451,405,744	1,451,405,742	2	2
36	Kaabong	2,089,138,000	1,467,621,350	621,516,650	621,516,650
37	Kabale	1,617,987,000	1,469,974,692	148,012,308	148,012,308
38	Kabarole	1,462,079,151	1,594,316,520	(132,237,369)	(132,237,369)
39	Kaberamaido	1,745,511,133	1,672,378,508	73,132,625	73,132,625
40	Kalangala	1,679,482,000	1,713,686,676	(34,204,676)	(34,204,676)
41	Kaliro	1,548,031,699	1,887,198,253	(339,166,554)	(339,166,554)
42	Kalungu	2,250,795,188	2,165,623,161	85,172,027	85,172,027
43	Kamuli	2,412,600,000	2,251,128,846	161,471,154	161,471,154

No	District	Total wage allocated 2014/2015	Projected wage to 30/6/2015	Projected wage balance/gap by 30/6/2015	Projected Wage bal 30/6/2015
44	Kamwenge	2,229,172,100	2,351,307,564	(122,135,464)	(122,135,464)
45	Kanungu	2,488,484,348	2,474,050,956	14,433,392	14,433,392
46	Kapchorwa	2,898,305,789	2,979,447,461	(81,141,672)	(81,141,672)
47	Kasese	3,248,916,654	3,366,436,092	(117,519,438)	(117,519,438)
48	Katakwi	5,612,917,974	3,392,887,500	2,220,030,474	2,220,030,474
49	Kayunga	3,420,980,000	3,720,672,587	(299,692,587)	(299,692,587)
50	Kibaale	3,363,635,000	3,857,728,684	(494,093,684)	(494,093,684)
51	Kiboga	6,051,666,000	4,186,944,803	1,864,721,197	1,864,721,197
52	Kibuku	2,606,719,993	2,528,019,438	78,700,555	78,700,555
53	Kiruhura	1,328,236,209	1,609,224,648	(280,988,439)	(280,988,439)
54	Kiryandongo	409,424,000	196,653,486	212,770,514	212,770,514
55	Kisoro	633,557,000	1,218,910,224	(585,353,224)	(585,353,224)
56	Kitgum	1,325,422,413	1,325,422,413	-	-
57	Koboko	1,272,242,000	1,519,017,668	(246,775,668)	(246,775,668)
58	Kole	1,176,000,000	1,533,035,688	(357,035,688)	(357,035,688)
59	Kotido	1,594,032,660	1,576,617,792	17,414,868	17,414,868
60	Kumi	-	-	-	484,695,810
61	Kween	1,525,245,461	1,266,423,468	258,821,993	258,821,993
62	Kyankwanzi	911,958,927	1,002,847,554	(90,888,627)	(90,888,627)
63	Kyegegwa	939,068,816	1,008,544,360	(69,475,544)	(69,475,544)
64	Kyenjojo	965,017,855	1,150,574,704	(185,556,849)	(185,556,849)
65	Lamwo	1,319,019,216	1,369,046,988	(50,027,772)	(50,027,772)

No	District	Total wage allocated 2014/2015	Projected wage to 30/6/2015	Projected wage balance/gap by 30/6/2015	Projected Wage bal 30/6/2015
66	Lira	1,334,318,000	1,383,788,472	(49,470,472)	(49,470,472)
67	Luuka	987,856,598	1,500,000,000	(512,143,402)	(512,143,402)
68	Luwero	1,821,835,000	1,859,910,916	(38,075,916)	(38,075,916)
69	Lwengo	1,254,045,000	1,955,935,632	(701,890,632)	(701,890,632)
70	Lyantonde	2,026,605,996	1,997,398,003	29,207,993	29,207,993
71	Manafwa	1,885,559,000	2,300,188,757	(414,629,757)	(414,629,757)
72	Maracha	2,000,661,700	3,058,418,876	(1,057,757,176)	(1,057,757,176)
73	Masaka	3,374,901,416	3,074,570,572	300,330,844	300,330,844
74	Masindi	1,143,416,153	3,365,725,416	(2,222,309,263)	(2,222,309,263)
75	Mayuge	3,529,090,376	3,649,101,476	(120,011,100)	(120,011,100)
76	Mbale	800,237,129	810,586,580	(10,349,451)	(10,349,451)
77	Mbarara	1,028,264,698	1,062,861,349	(34,596,651)	(34,596,651)
78	Mitooma	1,140,750,600	1,131,428,459	9,322,141	9,322,141
79	Mityana	1,616,292,316	1,229,292,316	387,000,000	387,000,000
80	Moroto	1,929,327,000	2,205,430,674	(276,103,674)	(276,103,674)
81	Moyo	2,215,598,423	2,892,262,512	(676,664,089)	(676,664,089)
82	Mpigi	1,978,657,000	2,338,547,880	(359,890,880)	(359,890,880)
83	Mubende	2,136,922,000	2,364,719,000	(227,797,000)	(227,797,000)
84	Mukono	2,364,735,913	2,496,278,328	(131,542,415)	(131,542,415)
85	Nakapiripirit	3,502,547,000	2,712,470,106	790,076,894	790,076,894
86	Nakaseke	2,468,187,493	2,778,628,323	(310,440,830)	(310,440,830)
87	Nakasongola	4,565,919,000	4,032,095,831	533,823,169	533,823,169

No	District	Total wage allocated 2014/2015	Projected wage to 30/6/2015	Projected wage balance/gap by 30/6/2015	Projected Wage bal 30/6/2015
88	Namayingo	4,074,703,516	4,161,198,265	(86,494,749)	(86,494,749)
89	Namutumba	2,222,214,891	2,503,346,783	(281,131,892)	(281,131,892)
90	Napak	1,018,027,000	1,142,119,457	(124,092,457)	(124,092,457)
91	Nebbi	1,561,681,800	1,280,352,000	281,329,200	281,329,200
92	Ngora	1,468,028,003	1,468,028,004	(1)	(1)
93	Ntoroko	2,660,269,000	2,796,684,469	(136,415,469)	(136,415,469)
94	Ntungamo	1,443,803,083	2,887,606,166	(131,310,166)	(131,310,166)
95	Nwoya	2,756,296,000	2,950,849,316	(194,553,316)	(194,553,316)
96	Otuke	3,325,057,979	3,171,213,528	153,844,431	153,844,431
97	Oyam	4,282,782,000	3,576,045,907	706,736,093	706,736,093
98	Pader	952,593,060	427,682,834	524,910,226	524,910,226
99	Pallisa	611,461,000	493,275,732	118,185,268	118,185,268
100	Rakai	1,159,324,000	1,091,324,000	68,000,000	68,000,000
101	Rubirizi	1,626,852,000	1,556,274,225	70,577,775	70,577,775
102	Rukungiri	1,351,353,000	2,024,896,856	(673,543,856)	(673,543,856)
103	Sembabule	2,089,304,230	2,074,655,184	14,649,046	14,649,046
104	Serere	2,535,042,000	2,556,489,627	(21,447,627)	(21,447,627)
105	Sheema	2,689,874,000	2,607,283,195	82,590,805	82,590,805
106	Sironko	2,698,786,000	2,698,786,000	-	-
107	Soroti	2,809,627,000	3,164,830,093	(355,203,093)	(355,203,093)
108	Tororo	3,441,571,000	3,358,504,600	83,066,400	83,066,400
109	Wakiso	2,091,439,000	3,798,318,000	(1,706,879,000)	(1,706,879,000)

No	District	Total wage allocated 2014/2015	Projected wage to 30/6/2015	Projected wage balance/gap by 30/6/2015	Projected Wage bal 30/6/2015
110	Yumbe	5,432,926,000	6,724,711,559	(1,292,685,559)	(1,292,685,559)
111	Zombo	1,432,456,000	1,288,237,348	144,218,652	144,218,652
	TOTAL	228,642,913,854	227,444,771,483	2,509,734,668	(793,277,713)

Appendix 3: Total calculated staffing requirements by district

NO	District	Cadre								Total Staff Per District	
		Medical Officer	Laboratory Technologists	Laboratory Technicians	Clinical Officers	Midwives	Registered Nurses	Enrolled Nurses	Dispenser		Counselors
1	Abim										No data
2	Adjumani	0	1	1	0	1	2	3	0	0	8
3	Agago	1	1	1	1	2	3	6	1	1	17
4	Alebtong	1	1	1	1	1	3	4	1	1	14
5	Amolatar	1	1	1	1	1	3	5	1	1	15
6	Amudat										No data
7	Amuria	1	1	1	1	1	3	5	1	1	15
8	Amuru	0	1	1	0	1	2	3	1	0	9
9	Apac	1	2	2	1	2	3	7	1	1	20
10	Arua	2	1	2	1	2	4	10	1	1	24
11	Budaka	1	1	1	0	1	2	4	1	0	11
12	Bududa	0	1	1	2	1	5	4	1	0	15
13	Bugiri	1	1	1	3	1	4	5	1	1	18
14	Buhweju	0	0	1	2	1	2	2	1	0	9

NO	District	Cadre									Total Staff Per District
		Medical Officer	Laboratory Technologists	Laboratory Technicians	Clinical Officers	Midwives	Registered Nurses	Enrolled Nurses	Dispenser	Counselors	
15	Buikwe	2	2	2	1	3	4	11	1	3	29
16	Bukedea	0	1	1	0	1	2	3	1	3	12
17	Bukomansimbi	1	1	1	0	1	2	3	1	1	11
18	Bukwa	0	0	1	0	1	2	2	1	0	7
19	Bulambuli	0	0	1	0	1	2	3	1	0	8
20	Buliisa	0	1	1	0	1	2	3	1	0	9
21	Bundibugyo	1	1	1	0	1	2	4	1	0	11
22	Bushenyi	2	2	3	1	2	5	13	2	2	32
23	Busia	1	2	2	1	1	3	7	1	1	19
24	Butaleja	0	1	1	0	1	2	4	1	0	10
25	Butambala	1	1	1	0	1	3	4	1	1	13
26	Buvuma	0	1	1	0	1	2	3	1	1	10
27	Buyende	1	1	1	1	1	3	4	1	1	14
28	Dokolo	0	1	1	0	1	2	3	1	1	10
29	Gomba	1	1	1	0	1	2	4	1	1	12
30	Gulu	4	3	4	4	3	7	22	2	4	53
31	Hoima	2	2	2	1	2	4	10	1	2	26
32	Ibanda	1	1	1	1	2	3	6	1	1	17
33	Iganga	1	1	2	1	2	3	7	1	1	19
34	Isingiro	1	2	3	1	2	4	8	2	2	25
35	Jinja	3	2	3	2	2	5	16	2	2	37

NO	District	Cadre									Total Staff Per District
		Medical Officer	Laboratory Technologists	Laboratory Technicians	Clinical Officers	Midwives	Registered Nurses	Enrolled Nurses	Dispenser	Counselors	
36	Kaabong	0	0	0	0	1	2	2	1	0	6
37	Kabale	2	2	2	1	2	4	11	2	1	27
38	Kabarole	4	3	3	2	2	7	21	2	4	48
39	Kaberamaido	1	1	1	0	1	3	5	1	1	14
40	Kalangala	1	1	1	1	1	3	5	1	1	15
41	Kaliro	0	1	1	0	1	2	4	1	0	10
42	Kalungu	1	1	1	0	2	3	7	1	1	17
43	Kampala	17	10	13	9	11	22	85	6	15	188
44	Kamuli	1	1	1	1	2	3	7	1	1	18
45	Kamwenge	1	1	2	1	2	3	7	1	2	20
46	Kanungu	1	1	2	1	2	3	7	1	1	19
47	Kapchorwa	0	1	1	0	1	2	3	1	0	9
48	Kasese	2	1	2	1	2	4	4	1	2	19
49	Katakwi	1	1	1	0	1	3	3	1	2	13
50	Kayunga	1	1	2	1	2	4	8	1	1	21
51	Kibaale	2	2	2	1	3	4	9	1	2	26
52	Kiboga	1	1	1	1	1	3	6	1	1	16
53	Kibuku	0	1	1	0	1	2	3	1	0	9
54	Kiruhura	1	1	2	1	2	3	7	1	1	19
55	Kiryandongo	1	1	1	0	1	3	3	1	1	12
56	Kisoro	1	1	1	0	1	2	4	1	0	11

NO	District	Cadre									Total Staff Per District
		Medical Officer	Laboratory Technologists	Laboratory Technicians	Clinical Officers	Midwives	Registered Nurses	Enrolled Nurses	Dispenser	Counselors	
57	Kitgum	1	1	2	1	2	3	8	1	1	20
58	Koboko	0	1	1	0	1	2	4	1	0	10
59	Kole	1	1	1	1	1	3	5	1	1	15
60	Kotido	0	0	1	0	1	2	3	1	0	8
61	Kumi	1	1	1	0	1	3	4	1	0	12
62	Kween	0	0	0	0	1	2	3	1	0	7
63	Kyankwanzi	0	1	1	0	1	2	3	1	0	9
64	Kyegegwa	1	1	1	1	1	3	4	1	1	14
65	Kyenjojo	2	1	2	1	2	4	4	1	1	18
66	Lamwo	1	1	1	0	1	3	3	1	1	12
67	Lira	3	2	3	2	3	5	5	2	3	28
68	Luuka	0	1	1	0	1	2	3	1	0	9
69	Luweero	1	1	1	1	2	4	4	1	1	16
70	Lwengo	1	1	1	1	2	3	5	1	1	16
71	Lyantonde	0	1	1	1	1	2	3	1	1	11
72	Manafwa	1	1	1	1	1	2	4	1	1	13
73	Maracha	0	1	1	1	1	2	4	1	1	12
74	Masaka	2	1	3	2	2	4	10	3	2	29
75	Masindi	1	1	2	1	2	3	7	2	1	20
76	Mayuge	1	2	3	2	1	4	8	2	1	24
77	Mbale	2	1	3	2	2	4	11	4	2	31

NO	District	Cadre									Total Staff Per District
		Medical Officer	Laboratory Technologists	Laboratory Technicians	Clinical Officers	Midwives	Registered Nurses	Enrolled Nurses	Dispenser	Counselors	
78	Mbarara	5	2	5	5	4	7	25	9	3	65
79	Mitooma	1	1	1	1	1	3	4	1	0	13
80	Mityana	1	2	4	1	8	3	4	1	4	28
81	Moroto	0	1	1	1	1	2	3	1	0	10
82	Moyo	0	0	1	0	1	2	3	0	0	7
83	Mpigi	1	1	2	2	2	3	7	2	2	22
84	Mubende	2	2	4	3	3	5	12	4	2	37
85	Mukono	2	2	5	3	3	4	11	4	3	37
86	Nakapiripirit										No data
87	Nakaseke	1	1	2	1	2	3	5	1	1	17
88	Nakasongola	1	1	2	1	1	3	5	1	1	16
89	Namayingo	1	1	3	2	1	3	6	2	2	21
90	Namutumba	0	1	1	1	1	2	4	1	0	11
91	Napak										No data
92	Nebbi	1	1	2	2	2	3	7	2	1	21
93	Ngora	0	1	1	0	1	2	3	1	0	9
94	Ntoroko	0	1	1	0	1	2	3	0	0	8
95	Ntungamo	2	1	2	2	2	4	9	3	2	27
96	Nwoya	1	1	1	1	1	3	4	1	0	13
97	Otuke	1	1	1	1	1	3	4	0	1	13
98	Oyam	1	2	3	2	2	4	8	2	1	25

NO	District	Cadre									Total Staff Per District
		Medical Officer	Laboratory Technologists	Laboratory Technicians	Clinical Officers	Midwives	Registered Nurses	Enrolled Nurses	Dispenser	Counselors	
99	Pader	1	1	2	1	2	3	6	1	1	18
100	Pallisa	1	1	1	1	1	3	4	1	1	14
101	Rakai	3	2	5	4	3	5	16	5	4	47
102	Rubirizi	0	1	1	0	1	2	3	0	1	9
103	Rukungiri	2	2	3	3	2	4	12	4	2	34
104	Serere	1	1	1	1	1	3	5	1	1	15
105	Sheema	1	1	2	1	1	3	7	2	1	19
106	Sironko	1	1	1	1	1	3	4	1	0	13
107	Soroti	1	1	2	2	2	3	8	2	1	22
108	Ssembabule	1	1	1	1	1	3	3	1	1	13
109	Tororo	2	1	3	3	2	4	13	4	2	34
110	Wakiso	8	4	10	10	6	11	41	15	0	105
111	Yumbe	0	1	1	0	1	2	3	0	0	8
112	Zombo	1	1	1	1	1	3	4	1	1	14
	Total	133	135	196	124	181	360	770	167	129	2,195

Appendix 4: Health workers on contract by support agencies by district April 2015

District	Approved Norm	Total Filled	Total vacant	Contract - MOH	MOH contract Bonded	Contract - PEPFAR	Contract - GF	Total Contract HWs
Abim	378	237	141		5	11		16
Adjumani	443	476	-33	1	6	5	20	32
Agago	379	294	85			10		10
Alebtong	166	140	26			9		9
Amolatar	342	135	207			5		5
Amudat	142	38	104			12		12
Amuria	754	278	476			18		18
Amuru	402	276	126			6		6
Apac	596	518	78			0	41	41
Arua	668	423	245	1	3	1	2	7
Budaka	258	191	67			6		6
Bududa	397	227	170	1		11		12
Bugiri	581	301	280	2		1	26	29
Buhweju	188	69	119			11		11
Buikwe	383	337	46	1	3	10		14
Bukedea	163	106	57			20		20
Bukomansimbi	145	82	63			3		3
Bukwo	409	226	183			12		12
Bulambuli	306	200	106			3		3
Bullisa	310	98	212			12		12
Bundibugyo	535	458	77		10	19		29
Bushenyi	315	248	67			4		4
Busia	512	199	313		2	14		16
Butaleja	539	254	285			14		14
Butambala	368	195	173		6	9		15
Buvuma	161	101	60			4		4
Buyende	192	134	58			19		19
Dokolo	231	135	96			8		8
Gomba	253	133	120			6		6
Gulu	669	594	75		4	8		12
Hoima	603	331	272			6		6
Ibanda	491	212	279			12		12
Iganga	723	612	111		1	13		14
Isingiro	804	408	396			3		3
Jinja	603	503	100			1		1

District	Approved Norm	Total Filled	Total vacant	Contract - MOH	MOH contract Bonded	Contract - PEPFAR	Contract - GF	Total Contract HWs
Kaabong	479	223	256			0	50	50
Kabale	1125	685	440			2		2
Kabarole	594	408	186			18	25	43
Kaberamaido	261	222	39	1		9		10
Kalangala	280	184	96		1	1		2
Kaliro	177	133	44			19		19
Kalungu	219	119	100			4		4
Kamuli	700	486	214			2	47	49
Kamwenge	420	313	107			10		10
Kanungu	599	380	219	1	8	8		17
Kapchorwa	387	276	111		3	11		14
Kasese	1628	766	862	1	10	22		33
Katakwi	452	229	223			14		14
Kayunga	512	410	102	1	4	15		20
Kibaale	565	220	345	1	6	0	29	36
Kiboga	440	235	205	1		10		11
Kibuku	248	122	126			8		8
Kiruhura	465	318	147			9		9
Kiryandongo	432	230	202		5	8		13
Kisoro	787	514	273	2	7	8		17
Kitgum	220	120	100		5	8		13
Koboko	454	242	212			3		3
Kole	162	140	22			9		9
Kotido	244	150	94			0		0
Kumi	639	248	391	1	5	13		19
Kween	361	221	140			5		5
Kyankwanzi	262	165	97			12		12
Kyegegwa	227	185	42			17		17
Kyenjojo	455	302	153			0		0
Lamwo	289	144	145			11		11
Lira	292	266	26			7		7
Luuka	765	471	294	1		10		11
Luwero	681	497	184	2		8		10
Lwengo	272	177	95			12		12
Lyantonde	387	211	176	2	5	4		11
Manafwa	458	325	133			8		8
Maracha	297	208	89	1		2		3
Masaka	288	194	94	1		8		9
Masindi	475	370	105			9		9
Mayuge	419	255	164			2		2
Mbale	563	429	134			6		6

District	Approved Norm	Total Filled	Total vacant	Contract - MOH	MOH contract Bonded	Contract - PEPFAR	Contract - GF	Total Contract HWs
Mbarara	570	238	332	11		0	33	44
Mitooma	245	167	78			5		5
Mityana	774	446	328		1	9		10
Moroto	271	153	118			0	34	34
Moyo	676	443	233			3	35	38
Mpigi	390	238	152		1	3		4
Mubende	657	331	326	1		4		5
Mukono	440	348	92		1	0		1
Nakapiripirit	275	158	117			0		0
Nakaseke	500	339	161	3		3	43	49
Nakasongola	430	322	108			2		2
Namayingo	307	98	209			11		11
Namutumba	324	185	139			3		3
Napak	202	121	81			2		2
Nebbi	190	109	81	1	6	7	28	42
Ngora	201	127	74			13		13
Ntoroko	150	93	57			13		13
Ntungamo	789	564	225		10	7		17
Nwoya	331	285	46			15		15
Otuke	298	186	112			7		7
Oyam	283	228	55			5		5
Pader	231	256	-25			2		2
Pallisa	568	344	224		8	3		11
Rakai	1310	791	519	3		0	65	68
Rubirizi	213	106	107			7		7
Rukungiri	910	778	132			4		4
Sembabule	317	184	133			10		10
Serere	293	188	105			14		14
Sheema	544	262	282		8	12		20
Sironko	576	387	189			2		2
Soroti	264	157	107			3		3
Tororo	906	478	428	1		10		11
Wakiso	1148	744	404	2	6	6	30	44
Yumbe	407	374	33	1	15	4	33	53
Zombo	322	167	155			12		12