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Research Article

District Health Leadership Capacity Development in Uganda: Challenges and Way Forward

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Abstract

Background: Although good leadership is necessary for effective functioning of the health system, developing countries such as Uganda do not adequately prepare health workers for the leadership tasks ahead. Donor funding has been used to try and fill the gap in leadership capacity development under "capacity building" projects. But these projects have not helped either. In many cases, health systems, including health leadership and governance have increasingly got worse. This study sought to understand the root causes of the leadership capacity challenges and suggest some solutions.

Methods: The concept of root cause analysis for planning, implementing and monitoring was used to design the study. Selected documents were reviewed to elaborate on key concepts and definitions of leadership, capacity building and sustainability. Selected government and project documents were also reviewed. Key informant interviews were conducted targeting district-level leaders, central government officials administering leadership development activities in the health sector, and officials of donor organizations as well as of donor-funded projects. Analysis was done against the key elements in the conceptual framework.

Findings: Leadership at the district level has huge gaps in all aspects. Most leaders in the health sector were found to be academically well educated and technically competent. And the government has put in place leadership development policies and institutions. But these were not fully functional or operational due largely to under-funding. There was relatively good gender balance in leadership positions at the district level, with women occupying 38% of key health leadership positions. There was no local budget or initiative for leadership capacity building. The work environment was not conducive for productive work, as there was rampant nepotism, corruption and bureaucracy. Even the private health sector organizations were faced with similar leadership challenges. None of the capacity building initiatives was found to be sustainable. Key donor funded projects did not provide the kind of support to effectively develop leadership capacity at the district level.

Discussion and Conclusion: Four main root causes of the dismal performance of leadership capacity development initiatives are: 1) gross underfunding of leadership development, 2) problematic donor funds, 3) disjointed government and donor planning and funding, and 4) poor work environment. Systematic leadership needs assessment should be done. Gaps in all aspects of leadership need to be characterized and quantified. A desired level of leadership capacity should be defined and interventions packaged to address them. Leadership courses should be introduced in schools and at higher institutions of learning. Selected civil servants and health workers should be trained on leadership regularly. There should also be specialized and tailor-made leadership training for certain categories of public workers. The government and donors need to harmonize their planning and funding of leadership development. Regular monitoring of leadership capacity should be done and the information fed into periodic situation assessment, planning and implementation of leadership capacity development.

Keywords: Donor; Leadership; Health Sector

Introduction

Good leadership is a key component of an effective health system. But most health sector personnel in developing countries are not adequately prepared to provide effective leadership in the sector [1]. Yet, the health sector, which is rapidly changing and becoming more complex, requires competent leaders with foresight, commitment, inspiration, and impeccable skills in initiating and managing change [2]. In developing countries, leadership development is not often given the priority it deserves. It is often just haphazardly incorporated into donor-supported programs.

In Uganda, although the government has policies and institutions for leadership development, it is often underfunded and not a priority. Leadership enhancement initiatives are therefore usually part of "capacity building" components of donor-funded projects. After two decades, leadership capacity at the district level for health service delivery has remained unsatisfactory [3-5].

This study a follow-up of a two-decade evaluation of health sector reforms in Uganda [6-8]. The purpose of this particular study was to assess district level leadership capacity development in the Uganda health sector over the past two decades 2000-2020), specifically: 1) to assess the strengths and weaknesses of leadership capacity development in Uganda; 2) to gain insight of the root causes of the dismal leadership capacity building over the two decades; and 3) to propose a way forward.

Methods

Conceptual framework

The conceptual framework for this study is based on root-cause analysis framework. From a situation analysis, which in this case is leadership capacity in the health sector, a vision is conceived. Based on this vision, the desired targets in service delivery and corresponding leadership capacity are determined. The gap between the desired and actual levels of leadership capacity is determined. The root causes of the gap in leadership capacity are identified. A number of interventions are then selected and packaged into a plan for implementation. This is monitored and the information is fed back into a new situation analysis. And the cycle is repeated. The figure 1 below diagrammatically presents the conceptual framework. The study is designed on this framework.

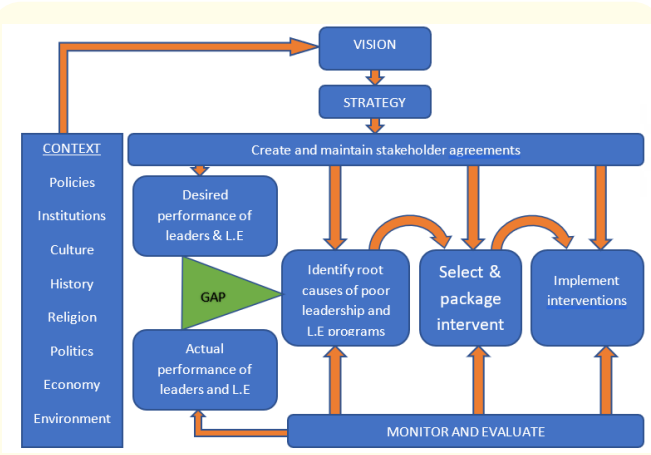

Figure 1: Root-cause analysis based planning cycle.

Source: Adopted from RCQHC 2006: Manual on root cause analysis [9].

Documents review

Review of locally relevant documents and general literature was done under four categories: a) leadership, b) donor aid c) capacity building, and d) leadership enhancement.

Key informant interviews

A total of 21 district officials (16 male and 5 females) were interviewed in six districts of Bududa, Jinja, Mbale, Namutumba in the East; and Gulu and Oyam in the north, and Mpigi in the central region region. The districts were selected based on where leadership enhancement projects were being or had been implemented. It was also based on providing a national representation as much as possible.

Three key district officials were interviewed per district in Mpigi, Oyam, Namutumba, Mbale and Bududa. District personnel interviewed in each of the five districts were the Chief Administrative Officer (CAO) or a representative, District Health Officer (DHO) and a Human Resource Officer (HRO). Officials of key donor-funded projects supporting leadership enhancement initiatives were interviewed.

Key informants from donor organizations were also interviewed. These were from USAID, World Bank, Italian Embassy, Belgium Technical Cooperation (BTC) and DANIDA. Central government

staff interviewed included staff of the Ministry of Health (MoH), Ministry of Education and Sports, Ministry of Finance, and Ministry of Local Government. Questionnaires and checklists were made to carry out interviews.

Data analysis

Data was analyzed against the objectives and related as well as emerging themes.

Results

Understanding key concepts

A review of selected and relevant literature was done to have a common understanding of some key concepts and issues in leadership development**.**

The meaning of capacity building

Ultimately development or progress is associated with independence or freedom from being controlled by others [10]. Donor aid establishes a dependency relation. Capacity building denotes a move towards independence or freedom. However, most development workers or institutions do not have a common understanding or definition of capacity. Capacity building is often used synonymously with institutional strengthening or development management. Emphasis is often put on program/ project execution, independent of the permanency of systemic and structural capacity (Potter C and Brough R 2004).

A useful attempt at the definition of capacity building is the "the creation, expansion or upgrading of a stock of desired qualities and features called capabilities, that can be continually drawn up on overtime". However, the focus here tends to be improving the stock of capacity rather than managing what capacity is available. The Concise Oxford English dictionary offers several definitions of the word capacity, inter alia: Power of containing, reviewing or experiencing or producing; the maximum amount that can be contained or produced; the volume; mental power; faculty or talent; and a position or function.

These definitions indicate how and why the term capacity is nebulous and confusing. Thus, if a district or an institution does not have sufficient capacity, we could mean: The staff do not have the knowledge or skills; the staff are inadequate in number; the staff do not have tools (computers, vehicles etc); the staff do not have a clear role in the system of decision-making, resource allocation, supervision etc.; or the staff are not supported by appropriate organizational management such as times of accountability, forums for decision-making etc.

It is suggested that management is to do with systems capacity [2]. An organizational is defined as a system to comprise of a package of services, staff, facilities, structures and processes. The authors suggest nine component of systematic capacity building: Table 1 below summarizes the hierarchy of capacity in a social service system.

Components	Requirements
1. Performance capacity	Tools, money etc.
2. Personal capacity	Knowledge Skills Confidence
3. Workload capacity	Staff numbers Staff mix Appropriate job description
4. Supervisory capacity	Reporting and monitoring systems Lines of accountability Incentives and sanctions
5. Facility capacity	Are training centers adequate, service outlets big enough?
6. Support service capacity	e.g. laboratory services training institutions supporting organizations
7. Systems capacity	The flow of information, funds and decisions
8. Structural capacity	Decision-making forums
9. Role capacity	Authority and responsibilities given to individuals, teams and structures.

Table 1: Hierarchy of components of a social service capacity.

These components can be collapsed into four categories: 1) Tools, 2) Skills, 3) Staff and infrastructure, and 4) Structures and Systems. Potter and Brough (2004) assert that tools are easier and technical in nature, and take a short time to accomplish. But as one moves from (1) to (4) it gets more difficult. The structures and systems are harder, require socio-cultural interventions, and take far longer to achieve.

Leadership and governance

There are three interlinked concepts: leadership, stewardship and governance. Leadership has been defined as the ability to scan the environment and to create an alternative vision and strategy, and to inspire and align actors and interests for action to achieve an agreed goal. Leadership development refers to any activity that enhances the quality of leadership of an individual or an organization.

Leadership capacity in Uganda's health sector at national and district levels has been found to be unsatisfactory [11-13]. Successful leadership in the health sector appears to be linked to an individual's characteristics rather than to their exposure to training [14]. Many health sector organizations and institutions continue to operate with no clarity of vision, to live in uncertainty, and their programs continue to be driven by the dynamics of donor funding.

Stewardship is the upholding and protection of public interest and trust and ultimately being responsible for ensuring conditions that allow people to attain the highest possible welfare are available. Thus, governments are stewards or protectors of public interest and trust [15]. Stewardship functions include providing a vision, oversight, regulation, incentives, institutions, partnership, accountability and monitoring. Governance is the alignment of multiple actors and interests to promote collective actors towards an agreed goal.

Donor-funded capacity building

Donor aid is supposedly given to recipient countries to finance "gaps" in capacity and service delivery. But the way in which aid is given and the actual reasons are far more complicated. Donors or development partners give aid to poor countries to 1) contribute to global public goods 2) provide global security 3) show solidarity, and 4) support their own domestic policy and interests [16]. Aid has become increasingly problematic not just for capacity building, but in all its portfolios. There is no global mechanism to ensure proper administration and management of aid. Aid is short-lived, volatile, unpredictable and often mal-aligned with recipient country priorities. There are too many aid management instruments. Social sectors such as health are complex, which requires long-term funding, where short- term funding from donor aid is unsuitable, and may even be disruptive to the development of a social service.

The term "capacity building" is nebulous. A report has described "capacity building" as "risky, murky, unpredictable, unquantifiable, having questionable methodologies, with contestable objectives, and with unintended and undesired consequences" [14]. The report further notes that capacity building efforts in Uganda "[have] not necessarily strengthen[d] the analytical capacity, adaptability, change management, adoption of initiatives and risk taking, all critical to sustainability".

Poor quality aid has been characterized as: 1) being tied to ideology and profit, 2) having huge administration costs, 3) a situation where potential beneficiaries are not often being informed or do not participate, and 4) being a situation where aid comes in short periods, in form of narrowly focused projects, and in numerous disjointed grants [17]. Because of such problems, a group of 6 donors and 56 poor countries signed the Paris Framework on Aid Effectiveness [18]. The framework consists of five components 1) ownership by recipient countries; 2) alignment of donor projects to recipient country needs, priorities and systems; 3) harmony among donors in management and information flow, 4) managing for results; and 5) mutual accountability.

Seven key challenges have been identified with donor aid, all related to capacity building [19]: a) uncontrolled proliferation of donor funded projects and the hopelessness of coordination; b) overemphasis on new players (UN organizations, bilateral agencies, international NGOs, private foundations) rather than reforming and strengthening existing institutions and capacities; c) donor influence on priority setting and their lack of accountability for decisions they make; d) the rhetoric of "health systems" as donor projects are focused narrowly on vertical programs such as HIV/AIDS and TB; e) going around the government: it has become the culture for donor aid to go increasingly to non-state actors, thus disempowering government efforts and capacity; f) channeling funds through northern organizations, thereby denying capacity development of indigenous institutions.

There is a concerted effort by development partners to eliminate or reduce the role of government and local organizations in aid management: "in this debate, the US government and the Gates Foundation are united in largely bypassing government health programs"; and linking health to national security foreign policy interests. Three main ways forward have been suggested

regarding international aid [19]: a) to strengthen mechanisms to hold donors to account using the Paris and Accra agreements b) develop national plans to support national leadership development in the health sector, and c) study and learn from south-to-south collaboration e.g. Sino-Africa, Africa-India collaborations, which have been instructive.

Review of donor-funded projects in general

A review of donor-funded project report [11-13, 20-31] has shown that donor-funded projects implemented in Uganda mostly covered HIV/AIDS, health, education, poverty alleviation and support to orphans. Most projects had a component of leadership enhancement.

However, overall, most project objectives were found to be too ambitious, with limited overall achievement, and the projects always faced enormous implementation challenges. Of particular relevance is that there was no common understanding of or systematic approach to leadership capacity development [14]. Many organizations and institutions still operate with no clear vision, live in uncertainty, and their programs are driven by the dynamics of donor funding which are often erratic, responding to short-term needs. Table 2 below summarizes key findings of capacity building projects in Uganda.

Project	Objectives	Achievements	Evaluation	Relevance to leadership capacity building
District Health Services Project (DHSP)/ World Bank	Mobilize resources to finance health Reallocate to preventive care. Promote collaboration with private sector. Strengthen planning management and coordination Promote community participation.	Development of National Health Policy sector decentralization reform Restrictions of MOH Policy reform Quality assurance Introduced Sector wide approaches (SWAPs) Leadership training	Most objectives were not achieved but the project laid ground for policy reform	This project supported infrastructure development and little financial support for leadership enhancement.
AIDS competence Enhancement (ACE)/ USAID	Strengthen Uganda Aids Commission Strengthen Ministry of Health Resource Centre. Strengthen few NGOs Support HIV/AIDS Policy and Planning	No concrete capacity recorded. Generated interest in capacity building	No attention on leadership. Training was narrow and for few staff. Implementation was out of context of institutional set-up. No sustainable.	Capacity building focused on entire organizations rather than on individuals
Capacity Project/ USAID	Enhance Human Resources (HR) for Health policy and planning Strengthen performance-based workforce planning Promote practices for improved performance and retention.	Increase in filled staff positions. Improvement in service delivery reflected in league table.	Improved HR info systems, audits and planning. Trained leaders and managers Developed tools for planning and management	No focus on leadership. Too narrow to address HR issues

Program for Human and Holistic Development (UPHOLD)/USAID	Improve human resource capacity. Increase service delivery capacity. Promote enabling environment	Staff was trained Planning improved Family Planning (FP) commodity distribution was done FP use increased. Promotion of TB DOTS (directly observed treatments) Increased HIV testing and counseling.	Fell short of original aim of integration. Instead of district support, large funding was channeled HIV/AIDS support. Implementation was open ended, with no clear deliverables.	Too wide, too complex, too ambitious. No mid-term review was done NGOs took over 70% of funds. Districts used only 16% of the funds.
Joint Clinical Research Centre (JCRC)/Treat Program/USAID	Expand access to HIV /AIDS treatment. Expand access to quality lab monitoring Expand community outreach. Build capacity of local organizations.	Client number rose from 864 in 2003 to 29,700 in 2007. Treatment sites from 6 in 2003 to 51 in 2008.	Achieved most targets and objectives	Sustainability was found to be questionable. No effort on eldership and general management. Differential salary top-up disrupted services, as those who did not get them neglected patients.
AIDS Integrated Model District program (AIM)/USAID	Strengthen capacity Integrate HIV/AIDS services Increase access to services	Trained DAC Plans were prepared. Monitoring carried out. Improved HIV services Improved referral network.	Evaluation by objective or target not available. Many Mgt issues were discovered and remained unattended to but as obstacles to the overall performance of the project.	This was capacity building project limited to training, planning, monitoring and referrals. Some leadership training was carried out but related to HIV/AIDS management

Table 2: Evaluation of key capacity building projects.

Results from key informant interviews

Level of education of leaders

Without exception, all leaders, both at central and district levels interviewed had university education with a bachelor's degree and a good number had master's degrees. A few had formal training in leadership, but most had had short courses (including workshops and seminars) on leadership. All leaders demonstrated a sound grasp of their roles and the contextual challenges in leadership that they faced. In two districts, Bududa and Namutumba, concern was expressed about the level of education of district political leaders especially district and sub-county councilors who are not required to have any formal education.

Key district leaders by gender

A total of 21 respondents were interviewed. Of these 13 were male and 8 were female. The female proportion of the key district leaders is 38%. The constitution requires that at least one-third of all public leadership positions be held by women.

Understanding of leadership

While most respondents could not give a definition of leadership straight away, they listed several components. Examples include:

- "Leadership entails communication, striving for results, innovation, strategic planning, effective decision-making, being knowledgeable, showing direction to others, and being flexible" official from Mpigi.
- "Leadership includes mentoring, resource mobilization, staff motivation…" official of Numat project, Gulu.

- "The ultimate test of leadership is whether the organization's objectives and goals have been achieved or are on course to be achieved…" an official of the Health Service Commission.

Leadership capacity gaps

Respondents were asked about each of the eleven aspects of leadership. Here (in Table 3 below) is a summary of their responses with regard to issues and gaps in what is expected of them as leaders.

Leadership aspects	Gaps/Issues in Uganda
1. Leading for results	Leaders not accountable for results. Low public demand for accountability
2. Enabling teams to face challenges	Leaders expect challenges to be addressed from outside. Low level of ownership by leaders.
3. Improving work climate	Poor work climate appears to be getting worse
4. Moving up leadership ladder	Most leaders at different levels have remained at the levels for too long for as long as 10-15 years.
5. Reorient roles to manage change	Much of civil service practices remained unchanged in the face of new public management orientation.
6. Initiate changes based on needs assessment for better results	Little or no local initiative to address local challenges
7. Leaders' ability to provide a vision	Most leaders have no vision for their organizations.
8. Focusing on the goal	Leaders are pre-occupied with donor inspired outputs but not the ultimate goal.
9. Aligning interests to the goal	There are too many conflicting and competing interests that come with resources especially from donor aid.
10. Mobilizing resources	Leaders tend not to be proactive in resource mobilization. Resources pushed on them from above with severe restrictions.
11. Inspiring staff	Most staff are unmotivated, but where leaders are inspirational their staff have better attitude towards work.

Table 3: Gaps in the different aspects of leadership at district level.

Initiatives by leaders

Most respondents hesitated answering this question. Some confessed that most initiatives originated from the centre or were tied to donor-grants they received. Some central level staff mentioned initiatives made collectively by their organizations (notably ministries for health, local government and public service) to develop capacity and leadership.

A senior Ministry of Health (MOH) official gave examples of leadership orientation Uganda Management Institute (UMI) and training in management at Health Manpower Development Centre (HMDC). Some local government leaders enumerated initiatives that they originated themselves and mobilized funds for. These include establishing maternity units in health centre IIs (against MOH policy) in Oyam district. Other initiatives include empowering junior staff such as nursing aides to be appointed as heads of health centre IIs.

A senior administrator in Oyam district listed the following local initiatives for capacity building: the use of private firms for induction courses, overseen/witnessed by government officials; induction of staff in procurement procedures; induction in team-building and how to relate with politicians; tailor-made courses; liaised with partners to support locally-designed, in-house trainings; study tour to learn from other districts; and regular training of top managers.

Work environment

The questions about whether and how the general environment affects capacity building and leadership development elicited two main responses. Some respondents were of the view that the political environment, culture and religion did not affect their work in general and in particular in capacity building. Others cited political interference, nepotism and corruption as major constraints impeding the performance of district leaders. However, a few respondents (notably from HSC, LGC and UMI) were of the view that there is a culture in civil service where taking initiative and working proactively is not possible. An official from UMI said:

"We train leaders and managers in new public management concepts based on market principles. But when they get back to their posts in civil service, the environment does not allow them to apply what they have learnt. To apply new public management principles, the current civil service may have to be overhauled…."

Respondents mentioned old rules, hierarchy, the culture of "what the boss says is final" as making it difficult for the staff to participate in decision-making.

The private sector

Officials from three private sector organizations were interviewed. The organizations were Uganda Nurses and Midwives Union, (UMNU), Uganda Medical Association, Uganda Protestant Medical Bureau (UPMB). Generally, these organizations have received some support from the government or donors for capacity building, mainly for training; tools development; infrastructure; and development of plans, policies and manuals. They expressed the need for support in professional development and improvement of performance. In particular, they required support for mentorship, internship, placements, and supervision of the staff.

UNMU which aims to advance the professional growth and welfare of its members suggests that more training of lower-level staff be done. Leadership should be part of the training curriculum. As nursing professionals, they were of the view that leadership capacity within the nursing field would be useful when nurses rise to occupy high leadership positions in the health sector.

UPMB had developed an elaborate capacity building and leadership development strategy with institutional mechanisms in place. They however faced problems of resource gaps and sustainability. Their biggest capacity constraint was with human resource, which is facing serious shortages and high turnover. They recommended a needs assessment, mentoring, and support to their governance structures to improve performance.

Uganda Medical Association (UMA) is currently weak and has no regular revenue. It obtained small grants from a couple of donors but was not able to do much. It needs support for capacity building in its entire scope including leadership development. The members have been involved in the supervision of doctors and public education. They require legislation and a predicable revenue source to become viable and relevant.

Sustainability

Most respondents were of the view that no donor-funded project in capacity building, including leadership enhancement, could be sustained. Sustainability was interpreted to mean the continuation of project activities and benefits after the end of the projects. Some respondents, notably from Mpigi and Oyam, said sustainability in this definition was not possible in the context of Uganda, and that sustainability should be seen as "the ability of a country to attract donor funding perpetually to support gaps in capacity development and service delivery".

Views about donor funded programs

Perhaps the following view from an official of the MoH best summarizes the general view of government officials. He said: "…donor-funded projects are usually parallel, disjointed, unsustainable, not replicable, unsystematic, changed in design before the project ends, generally of poor design and poorly implemented" (an official MOH).

Officials of the donor organizations interviewed showed how much they had provided for capacity building, including training in leadership. They maintained that the funds available to them was from tax-payers of their countries and had certain rules of governance. These rules would not make it easy to use such funds using Uganda's national systems. They acknowledged the poor performance of leadership capacity initiatives to the lack of Uganda government's planning and sustainability measures.

Gaps, weaknesses and issues

Respondents listed a number of problems that were classified as gaps, weaknesses or issues. Gaps were identified in resources especially financing, tools (such as office space, stores, health/school buildings, equipment, housing etc.). Weaknesses were identified in overall governance in the country, in information flow, in the functioning of government departments and structures. Poor incentives for leadership development, inappropriate budget structures, and weak team spirit were mentioned. The lack of incentives for hard and honest work, many vacant sub-district positions of key cadres such as chiefs, accounts assistants. Key leadership positions were vacant at the district level. Other problems mentioned were the wrong attitude to training, where staff seek for allowances rather than seek to learn.

Other problems included lack of assessment as a basis for planning and donor-funded projects. Concerns were raised about donor-funded initiatives that do not support district health plans as the leadership initiatives were often introduced outside these plans. As a result, "We do not now plan according to what we need,

but according to what the donors expect and tell us because the money comes from them" (a district official).

Leadership development was noted by some respondents not to be currently a priority of the government, based on the level of funding and planning.

Leadership capacity development experiences

Respondents were asked about their experiences with leadership training, elements of good leadership, indicators of leadership performance and selection of leaders.

- **Training**: Most respondents said leadership training had not been part of their main/technical training. But some got leadership training on the job. However, they are unable to practice good leadership because of resource and institutional constraints. They cited political interference and nepotism as key constraints in the exercise of leadership.
- **Elements of good leadership:** Variously respondents listed some or most of the following elements of a good leadership: That is, the ability to: achieve overall goal of the organization; scan the environment for opportunities; come up with an attractive vision; create a strategy for the vision; inspire, motivate and incentivize; align interests and resources to strategic objectives; build teams; do strategic planning; negotiate; collaborate; coordinate; communicate; and manage change
- **Indicators of leadership performance:** Respondents listed some or all of the following: the extent to which strategic objectives have been met; the presence of a vision and strategic plan; the extent to which a leader can display the attributes the above; and the extent to which a leader is viewed well within the organization.
- **Selection of leaders:** Respondents suggested that for a person to be selected as a leader, they should have the following characteristics: they are strategic, analytic thinkers, fast thinking, have wide multi-disciplinary knowledge, are confident, listen to people and act/respond to address problems.

The national leadership development system

Respondents described the national system as attempting to address national capacity and leadership development. Mention was made of the constitutional requirement to have at least a third of all political and high-level leaders to be women, and this is expected to reflected across all sectors. The attempts mentioned include national institutions of management and leadership training. They also mentioned different government programs and projects under Ministry of Local Government (MOLG) and Ministry of Public Health (MOPS) aimed at both leadership development and capacity building as a whole. Respondents cited the MOPS's elaborate human resource strategic plan, procedures and manuals. The result-oriented management, performance-based funding and service code of conduct, reward and sanctions protocols, among others, which they said were in place.

But some respondents observed that the institutions and policies were not adequate to address leadership and capacity challenges. An official at UMI said: "We train leaders and managers in new public management concepts based on market principles. But when they get back to their posts in civil service, the environment does not allow them to apply what they have learnt. To apply new public management principles, the current civil service may have to be overhauled….".

Respondents recommended for better operational funding, incentives to staff, stronger public demand for accountability, logistical improvement, and for an enabling work environment. They were generally satisfied that Uganda had adequate policies for leadership and capacity development. They, however, conceded that big funding, work environment and institutional difficulties and gaps exist in the implementation of national leadership and capacity building efforts.

Discussion

Current situation and desired capacity

Uganda is in the category of least developed countries and it cannot adequately finance its critical social services. Because of competing priorities, leadership capacity is often left out of the government budget. However, the government is aware of the importance of effective leadership and has put in place certain policies and institutions, which are underfunded. Dependence on donor funding of social services is still high at about 50%. There are concerns about rampant corruption and nepotism in the civil service which deter planned leadership development. Pervasive dependence attitude and poor work ethic deter self-drive and local

vision for the future. There is lack of a coherent and comprehensive strategy for leadership development in the health sector. As a result, many public servants make private arrangements to enroll for leadership training in local and foreign institutions. Health sector facilities and institutions continues to operate with no clarity of vision, to live in uncertainty, and their programs continue to be driven by the dynamics of donor funding.

Vision and strategy for leadership

Government owned and planned leadership development programs have been implemented too. [28-32]). Commendable attempts have been made by develop leadership capacity. There are plans to set up new institutions (e.g. the Civil Service College). The recent effort to popularize patriotism nationwide will hopefully contribute to improving an overall enabling environment for better leadership and the demand for accountability in the country. An attempt to provide special incentives to attract qualified health personnel, including those to lead health institutions, to rural areas has been made [33]. The National Development Plan 2020-2025 envisages visionary sector leaders at all levels who are analytical, easily adaptable and flexible, who expect and manage changes, who adopt initiatives to their situations and who can take risk. The health sector requires competent leaders with foresight, commitment, inspiration, and impeccable skills in initiating and managing change.

Gaps in leadership capacity

Assessment of gaps

Leadership development in the health sector is ad hoc. There is little or no exposure to leadership skills and principles at pre-service training. No or little in-service training is done. Universities and other higher institutions do not provide leadership training as course. There is need for specialized leadership training for the health sector. This kind of training program or institute does not currently exist.

The lack of systematic needs-assessment for the planning of leadership development has come out clearly as a major issue. Gaps in capacity building efforts in general include: funds, human resources, equipment, physical structures (e.g. offices, residences, and health facilities), institutions, systems for management, and supplies (e.g. drugs). Gaps in leadership enhancement include gaps in incentives for leaders, work climate, appointments and promotions of leaders, orientation to the role of leaders, and the preparedness to face challenges of change. Issues that recur commonly throughout the assessment of leadership capacity include: corruption in state and non-state institutions, poor attitude of staff and leaders to change and to learn, the problems of donor aid, and poor governance.

Proposed interventions for leadership development

A number of approaches and institutions have been proposed to improve leadership in the country. First, pre-service training in leadership is necessary. This would be in schools, universities and other tertiary institutions. It would have to be deliberate and systematic and taken seriously as an examinable module or subject. Second, in-service leadership training in government departments, NGOs and private sector must be encouraged and systematically developed. Third, universities and tertiary institutions should provide comprehensive leadership courses (up to one year) on leadership for students intending to devote much time in leadership as a profession. Finally, specialized institutions such as UMI and others that are to be created should be able to address specific needs in finance, local governance, health services, education/schools etc. Such institutions should be able to develop tailored courses to address special needs of leaders or potential leaders.

The table 4 below presents leadership enhancement approaches and institutional development.

Proposed approaches to leadership training	Institutions involved	New approaches/ Institutions required
Pre-service training	Schools, universities and other tertiary institutions	Mandatory for high school and tertiary institutions.
In-service training	Ministries, local governments, NGOs private sectors	Mandatory/encouraged systematic and routine orientation and identification of potential leaders.
Formal specialized leadership training	Universities, specialized institutions, private firms/ institutes	Develop curricula for general leadership and specialized leadership to take up to 1 year.
Tailored leadership courses	Specialized institutions	Short courses on different aspects of leadership and management.

Table 4: Leadership training approaches and institutional development.

Sustainability

Sustainable capacity development means freedom external support towards self-reliance. So sustainability must embody taking responsibility and ownership to ensure that project activities and benefits continue after the external support has ended. This entails generating more internal revenue, as well as attitude transformation that supports systems thinking. This is a slow and gradual process. But progress should be seen to be made in this direction.

Packaging of leadership capacity development

From the study, emerge six key principles that could be used to package a leadership enhancement program. These are:

- Comprehensiveness of capacity building to include leadership, leadership enhancement activities, leadership skills development and management skills.
- The development, publication and circulation of leadership strategic plans for organizations.
- Assessment of resources from all sources (i.e. from the government, donors, fundraising etc) and to identify gross gaps, under-funded and over-funded areas.
- Assessment of possibilities to reallocate according to identified priorities.
- Phasing and sequencing of the package for maximum benefit, for efficient management within affordable resources.

In designing capacity development strategies and plans the following principles are recommended [34]:

- Capacity building is long-term and never-ending process.
- Respect for and use of local values, and fostering of self-esteem of the local people.
- Scanning near and far; but reinvent locally to suit local circumstances.
- Capacity building should be for sustainable outcomes.
- Incentives should be aligned with capacity development.
- Fixed mindset and vested interests must be challenged in working out effective capacity building strategies. Frank dialogue and a collective culture of transparency are essential
- External aid must be integrated into national priorities, processes and systems.
- Capacity building efforts must build on existing capacities rather than create new ones.
- If institutions are not functional, or national officials are not cooperative or interested, promoters of capacity building interventions should stay engaged; they should not withdraw or work outside or parallel to the existing systems.
- Capacity building programs, decision-makers and implementers must ultimately remain accountable to the people who are the beneficiaries of the programs.

Proposed health sector leadership development package

The table 5 below summarizes the broad content of leadership development package that emerges from the study.

Key Areas	Components
1. Capacity building in general	Funding Human Resource Equipment Infrastructure Institution Systems
2.Leadership enhancement programs	Incentives Work climate Appointments and promotions Procedures for identification, selection and placement of leaders Training/orientation Tooling/retooling Governance/Governance structures
3. Leadership skills development	Vision and strategy development Scanning for opportunities Aligning resources Mobilizing resources Inspiring staff Improving work climate Creating team spirit Preparing for challenges Initiate or prepare for changes to achieve better results.
4. Management	Planning Organizing Implementing Coordinating Control Monitoring and Evaluation Resource mobilization

Table 5: Suggested content of leadership development.

Leadership capacity monitoring

Leadership functions and components

Leadership has six tasks and five functions. The six tasks which can be converted into leadership objectives: leading for results, enabling teams to face challenges, improving work climate, enabling staff to move up the leadership ladder, reorienting roles to manage change and initiating change for better results. The five functions of leadership are: providing a vision, scanning for opportunities, focusing on goals, aligning interests toward the goal, mobilizing resources, and inspiring the staff.

The study has shown that leadership enhancement initiatives have hardly paid attention to any of these 11 components. The 11 items can be used as a basis for a framework for leadership capacity development as well as for its assessment. Table 6 below summarizes the ideas for this framework.

Leadership components	Gaps/Issues in Uganda	Proposed interventions	Possible indicators
1. Leading for results	Leaders not accountable for results. Low public demand for accountability	Results be made contractual obligation. Leaders to be changed if poor results. Initiatives to promote public demand for accountability.	Extent of achievement of annual results. Number of public complaints/actions to demand accountability.
2. Enabling teams to face challenges	Leaders tend to expect challenges to be addressed from outside. Low level of ownership by leaders.	Local solutions to address challenges. Widen stake holder consultations at all levels.	Number of local solutions to key challenges. Extent to which challenges are addressed.
3. Improving work climate	Poor work climate a major challenge in all districts and appears not to have improved.	Systematic approach to poor climate elements	% of staff satisfied with work climate. Extent to which each key element addressed e.g. staff residence, staff salary
4. Moving up leadership ladder	Most leaders at different levels have remained at the levels for too long for as long as 10-15 years.	Need for systematic upward mobility of staff through appointments and promotions. Emoluments commensurate with length of service where no promotion is feasible.	% leaders/managers at same level for 5 years. % leaders promoted/ appointed.
5. Reorient roles to manage change	Much of civil service has remained unchanged/traditional in the face of new public management orientation.	Effective public service reform to be through legislation. Develop roles to address changes and new challenges.	Extent of civil service not consistent with new public management principles. Percentage of staff able to face changes and challenges.
6. Initiate changes based on needs assessment for better results	Most changes introduced have not brought about better results.	Changes to be based on needs assessment and principles of implementation.	% of changes arising from an objective needs assessment. % changes based on principles of implementation.
7. Leaders' ability to provide a vision	Many leaders cannot provide convincing visions for their organizations. Convincing visions are not implemented due to many factors beyond the control of leaders.	Leaders to be given freedom to develop visions within broad national policy framework.	% districts with clear visions. Extent to which the visions are achieved over 5 years.

8. Focusing on the goal	Leaders tend to be pre-occupied with donor inspired outputs but not the ultimate goal.	The aid policy in Uganda to be restructured so as to support national leaders …on goals not just short-term outputs.	Extent to which goals are achieved. Extent to which all resources are focused on the goal.
9. Aligning interests to the goal	There are too many conflicting and competing interests that come with resources especially from donor aid.	The restructuring of aid policy in Uganda could address this problem. Empowering local leaders to be in control of resources will also help.	% of resources for service delivery under control of local/district leaders. % resources channeled through the district budget.
10. Mobilizing resources	Leaders tend not to be proactive in resource mobilization but get resources pushed on them from above with severe restrictions.	Local leaders to be empowered and encouraged to lobby for resources locally and at national level. Locally generated taxes were requested.	% of resources from leaders initiative. Extent to which resources grow annually.
11. Inspiring staff	Most staff are demotivated, but where leaders are inspiring staff have better attitude towards work.	Leaders need to inspire staff inspite of resource constraints. Capacity building inspiring staff to be done.	% staff working on schedule. Rate of staff turnover. % staff with positive attitude.

Table 6: Leadership components, current gaps and indicators of progress.

Monitoring capacity development

Since both the general capacity building and leadership enhancement augment each other and are ultimately aimed at achieving health-sector goal, the measurement of their success will be judged by the extent to which that goal has been attained. Other monitoring measurements should therefore address the extent to which specific gaps and issues have reduced. Suggested indicators are included in the table 7 below.

Gaps/Issues	Indicators	Comments
Capacity in general		
Funds	Extent to which gaps in funds from all sources address national/district priorities.	All funds from: The public Development partners NGOs Private sector
Human Resources	Human resources gaps in: Numbers Skills Distribution Mix Motivation	For planning Human resources include all those available in the country.
Equipment	Availability/adequacy of office logistical and technical equipment relative to assessed needs.	Equipment include office (e.g. computers) logistical (e.g. cars) or technical (e.g. microscope).
Institutions	Availability and functionality of institutions of management and leadership (e.g. committees, boards, guidelines, plans etc)	Institutions include management structures and procedures (e.g. committees and manuals)

Systems	Extent to which management systems meet the assessed needs.	Systems are the inter-related and coordinated activities to achieve a specific task (e.g. information systems).
Supplies	Availability of essential drugs and supplies	Availability in stores and to users. It also includes consistency and predictability.
Assessment of leadership enhancement programs		
Incentives	Rewards for good performance. Disincentives for bad performance	The incentives may be at unit, local, government or national level
Work climate	The key conditions for work: Reasonable salary Residence Water and other amenities School	These may include issues of corruption, discrimination and favoritism
Appointment, appraisal and promotions	Whether formally appointed Whether promoted since appointment How long on same post?	These are controlled by the Public Service or District Service.
Selection/identification of leaders	What criteria are used to identify and select leaders	Are the criteria applied, if not, why not?
Training/Orientation	Orientation/Internship of leaders Formal/Short trainings	What are the training needs assessed.
Tooling	What technical, logistical and office tools are needed? Availability and adequacy	These must be assessed within the context of existing resources constraints.
Assessment of leadership performance		
Goal of the sector/ organization	Extent to which the goal/objectives of the sector/ organization have been attained.	Consider time scale, resources and other contextual factors.
Creation of an attractive/convincing vision	The presence of a vision and strategy to achieve it. The credibility and acceptance of vision by stakeholders	The attractiveness of a vision and strategy is the hallmark of good leadership
Ability to inspire/ motivate	The rate of turnover of staff Dedication to work (hours spent usefully at work) Proportion of staff who view a leader well Proportion of (outsiders) Proportion of public members who view a leader well	Many factors such as working environment confound the inspiration and motivation of staff. But comparison with organizations with similar conditions can indicate the ability of leadership to inspire/motivate.
Ability to coordinate and align different interest and resources to strategic objectives	Proportion of resources to national/organizational priorities Proportion priorities not funded Resource gap Extent of over-funding and under-funding of priorities	These also measure abilities to negotiate, collaborate, communicate and manage change.

Table 7: Suggested leadership enhancement indicators.

Conclusion

Uganda has sound foundations of well-educated technical leaders, enabling policies and structures that can be built upon to develop effective leadership capacity in the health sector. But the political, social and cultural environment presents challenges for leadership capacity development as well as for proper exercise of leadership. These include political interference with technical work, nepotism and corruption. The gap in resources is a major constraint to the performance of leaders. Uganda will in the

foreseeable future continue to depend on external donor support, which unfortunately is inherently problematic. This should be taken into account in designing leadership capacity development. Sustainability of interventions funded by donors will therefore need careful attention in the design of the interventions.

Closer integration and stakeholder involvement in the design and implementation of capacity building projects is mandatory. Regular and formal stakeholder consultation at appropriate intervals in the project cycle is necessary. Leadership capacity development efforts should take into consideration the culture, politics and institutions which not bypassed. Systematic, comprehensive and consultative needs assessments should precede all interventions for leadership capacity planning and implementation. Implementation of the plans should be accompanied by close monitoring. Lessons learned should inform future actions.

Author

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Declaration of Interests

None.

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