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Conflict Situation for Health Care Workers: A Case Study of the Occupational Challenges in Kasangati Health Centre IV and Their Implications for Patient Care.

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A Case Study of the Occupational Challenges in Kasangati Health Centre IV and Their Implications for Patient Care

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Dedication

I *dedicate this work in loving memory of Rosalie McDowell, whose encouragement, selflessness, and joy have continuously been a shining example in my life. Her immense strength and faith over the past several years have had a profound impact on me, and have helped to shape me as the young woman I am today. Her overwhelming support has opened my eyes to the richness of learning and shown me that anything is possible through the power of God.*

I love you, Grandma. This one's for you.

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Acronyms

HCII	Health Centre II
HCIII	Health Centre III
HCIV	Health Centre IV
HCWs	Health Care Workers
HSD	Health Sub-District
HSSP II	Health Sector Strategic Plan II (2005/2006 – 2009/2010)
KHC IV	Kasangati Health Centre IV
NGO	Non Governmental Organization
NMS	National Medical Stores
OPD	Outpatient Department
RRH	Regional Referral Hospital
SAP	Structural Adjustment Program
VHT	Village Health Team
WHO	World Health Organization

Abstract

Many factors influence a country's ability to provide quality health services for its people. Particularly, quality health care hinges upon the availability of properly trained and equipped health care workers (HCWs) to deliver effective care. Resource-strained countries committed to the Millennium Development Goals are confronting the reality that shortages and uneven distribution of HCWs threaten their capacities to encourage and establish healthy communities. A scarcity in HCWs is one challenge of public health initiatives and places stress on existing HCWs. Other challenges faced by HCWs severely affect performance, motivation, and overall care-giving ability.

This study aims to examine the particular occupational challenges facing health care workers at Kasangati Health Centre IV in order to analyze their impacts on patient care and understand how the general quality of health care fits into the development of a country. A large component of this study consisted of the researcher partaking in participant observation at Kasangati Health Centre IV in order to gain a more accurate perspective of the issues. Individual interviews were also obtained and supplemented with secondary sources in order to gain a more holistic view of the current situation.

From this study, the researcher determined that the challenges to health care workers are exceptionally prevalent and their impacts have the capacity to severely affect the quality of care patients receive. The physical, social, and psychological challenges confronting health care workers stem from a plethora of sources including lack of adequate governmental support, mismanagement at the local and district levels, and loss of internal motivation over time. The results of this study are intended to initiate a preliminary examination in order to further explore the linkages of health care workers, public health, and development.

Introduction

If development is a final goal to be achieved in Uganda, then attention to the healthcare system must constitute a top priority in the country's agenda. Good health and quality health care are central to the well being of the human person. Healthy people are more likely to be in a proper position to contribute positively to society and take part in the economy, leading to the foundations and persistence of personal, local, and national development. Many factors influence health status and a country's ability to provide quality health services for its people. Particularly, quality health care hinges upon the availability of properly trained and equipped health care workers (HCWs) to deliver effective care. The number and distribution of HCWs employed in a country is one indicator of that country's ability to meet the health care needs of its people. Resource-strained countries committed to the Millennium Development Goals are confronting the reality that shortages and uneven distribution of HCWs threaten their capacities to encourage and establish healthy communities. A scarcity in HCWs is one challenge of public health initiatives and places stress on existing HCWs. Other challenges faced by HCWs severely affect performance, motivation, and overall care-giving ability.

The research in this study is intended to further explore the occupational challenges faced by HCWs in a level IV health centre near Kampala, Uganda, in order to gain a specific and enhanced understanding of the linkages between public health and development. It strives to identify local challenges experienced at this health centre in order to identify gaps in the giving and receiving of government healthcare and find where improvements can be made. Because it can be difficult to truly understand the implications of challenges faced by government HCWs, a large part of the research has been realized through participant observation and active integration into the daily agenda of the health centre. Similarly, the research includes an examination of local opinion from the HCWs themselves as well as a supplementary look at existing academic literature pertaining to the subject.

Background of the Study

Uganda's Public Health System

Before the upheavals of the 1970's and 1980's, Uganda had the best health indices in East Africa.[1] Under the rule of President Idi Amin, Uganda's health system experienced a collapse, creating serious gaps within health targets and achievements. In July 1994, under the power of President Yoweri Museveni and the National Resistance Movement, Uganda began implementing a Structural Adjustment Program (SAP) as a method of critical reform in the health sector, which resulted in the decentralization of health services to the district level.[2] This program was intended to improve the quality of health services and pharmaceutical supplies in hospitals, but the result was a large increase in health service utilization throughout the country that led to supply and human resource shortages and a general trend of inadequate health care coverage throughout Uganda.[3] This produced a considerable and distinct gap between the technically rational policies in the books and those actually in place on the ground in the health care centres of Uganda. Unfortunately, this trend is noted consistently in many developing countries.[4] Although significan reforms had been undertaken, in 2000 acessibility to basic health services, or the percentage of the population living within 5 km of a health facility, was still estimated to be only 49% nationwide.[5] Another study from 2000 conducted by the World Health Organization (WHO) analyzing overall health system performance ranked Uganda's health care system efficiency at 149 out of all 191 WHO member states.[6] Such a number shows that there is room for improvement and encourages exploration into some of the challenges in health care provision in the field.

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[1] Ministry of Health, Health Sector Strategic Plan I, 2000/01-2004/05, (Kampala, Uganda: 1999) iv.

[2] Ogwal-Okeng JW. et al. (2004). The Impact of Decentralization on Health Services in Uganda: A Look at Facility Utilization, Prescribing, and Availability of Essential Drugs. PPT. International Conference on Improving Use of Medicines. 2-3, 11.

[3] *ibid*.

[4] Van Kerkhoff, L. , & Lebel, L. (2006). Linking Knowledge and Action for Sustainable Development. *Annual Review of Environment & Resources*, *31*(1), 451.

[5] Ministry of Health, Health Facilities Inventory, (Kampala, Uganda, 2000).

[6] Tandan, A. et al. (2000). *Measuring Overall Health System Performance for 191 Countries*. GPE Discussion Paper Series No. 30. World Health Organization. 20.

The structure of Uganda's healthcare system aims to achieve and sustain good health for its people. As mentioned above, health care delivery is conducted through a decentralized district framework. The structure of Uganda's public health system is detailed as follows.

Facility	Coverage	Staffing Levels	Services	Targeted Population
Village Health Team (VHT)	Village	Volunteers	-Link to primary care -Drug Distribution	25-30 households
Health Centre II	Parish	6 Staff: -Enrolled Nurse -Midwife -2 Nursing Assistants -Health Assistant	-Outpatient Clinic -Antenatal Care -Treatment for common diseases	5,000 people
Health Centre III	Sub-County	18 Staff led by Senior Clinical Officer	-General Outpatient Clinic -Maternity Ward -Laboratory	20,000 people
Health Centre IV	County	48 including a Senior Medical Officer and a Doctor	-Wards for men, women, and children -Theatre for emergency operations	100,000 people
Regional Referral Hospital	District	-Doctors -Consultants	-Specialized clinics -Consultant physicians	500,000 people
National Referral Hospital	Country	-Doctors -Consultants	-Emergency care -Outpatient care -Specialist treatment	31,000,000 people

Table 1: Uganda's Public Health Care Setup[7]

The first tier consists of the village health team (VHT) or community medicine distributor. This is usually the first contact for someone living in a rural area, and each village is supposed to have these volunteers available to assist their neighbors of the community. A VHT is supposed to serve a targeted population of 25-30 households, and the function of the VHT is to sensitize the people of the community on topics like sanitation and the fundamentals of health. They also should have the capacity to dispense basic drugs, advise patients, and refer them to health centres when necessary.[8]

[7] Adopted from: Foundation for Human Rights Initiative. (2010). *The Right to Healthcare in Uganda January-June 2010,*. Available: <http://216.172.176.118/~fhri/index.php/publication/thematic-reports.html>.

[8] Kamwesiga, Julius. (2011). Uganda Health Care System. Powerpoint presented at Makerere University, Kampala, Uganda. Available: <http://docs.mak.ac.ug/document-categories/presentations?page=13>.

Health Centre II (HCII) makes up the next tier and provides coverage at the parish level. Each parish is supposed to have one HCII, and each HCII should have the capacity to treat common diseases like malaria as well as provide antenatal care and contain an outpatient clinic. The staff should consist of an enrolled nurse, a midwife, two nursing assistants, and a health assistant that serve a targeted population of 5,000 people.[9]

Health Centre III (HCIII) is the next tier that provides coverage at the sub-county level. Each HCIII should contain a general outpatient clinic, a maternity ward, and a laboratory run by a staff of 18 HCWs led by a senior clinical officer. Each HCIII should serve a targeted population of 20,000 people.[10]

Health Centre IV (HCIV) makes up the next tier that serves at the county level. In addition to services found at HCIII, an HCIV should contain wards for men, women, and children and a theatre for emergency operations. The HCIV should contain a staff of 48 including a senior medical officer and a doctor. The targeted population for each HCIV is 100,000 people. The research in this study was conducted at Kasangati Health Centre IV and will focus on the results collected from this particular HCIV.[11]

The next tier is composed of the Regional Referral Hospital facility, which is situated at the district level. Each hospital should have all the services found at HCIV, as well as specialized clinics (such as those for mental health and dentistry) and consultant physicians. There are 12 RRHs, which are each supposed to serve a targeted population of 500,000 people.[12]

At the top of the healthcare chain are the three National Referral Hospitals (Butabika, Mbarara, and Mulago hospitals) that serve at the country level. These hospitals provide the services offered at HCIV level, but specialize in emergency, outpatient, and specialist treatments that are not found at the other tiers.[13]

This healthcare structure has a strong theoretical framework, but the Uganda healthcare sector faces several challenges; most of which are directly related to under-funding. Uganda's Health Sector Strategic Plan II (HSSP II) of the 2005/2006 – 2009/2010 fiscal years aimed at

[9] *ibid*.
[10] *ibid*.
[11] *ibid*.
[12] *ibid*.
[13] *ibid*.

granting $28 per capita to health care funding. However, funding was as low as $8 per capita.[14] In the 2009/2010 fiscal year, the MOH budget was 734 billion shillings, equivalent to 10.3% of the national budget. This falls short of the 15% minimum government commitment stated in the Abuja Declaration,[15] and it has greatly hampered the provision of healthcare services in the country.[16]

Uganda's theoretical healthcare framework consequently often falls short of providing adequate care for its citizens. In order to explore this more thoroughly, the researcher focused on one particular health centre, KHC IV.

Kasangati Health Centre IV

Kasangati Health Centre IV is located 14 km northeast of Kampala in the Wakiso District and Kyadondo East Health Sub-District (HSD). The HSD consists of Nangabo Sub-County and Kira Town Council. It has 8 townships and 15 parishes, which have peri-urban/rural populations. The total HSD population is made up of approximately 271,700 people and contains four HC III and three HC II units.[17]

KHC IV's mandate is as follows: To reduce morbidity and mortality from major causes of ill health in the district as a contribution to poverty eradication and socio-economic development of the people.[18] In order to uphold this, some of the KHC IV provides include outpatient services, inpatient services, maternity services, referral services, immunization, health education, and teaching. KHC IV was established in 1959 and now operates with the Makerere University School

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[14] Foundation for Human Rights Initiative. (2010). *The Right to Healthcare in Uganda January-June 2010*, 2. Available: <http://216.172.176.118/~fhri/index.php/publication/thematic-reports.html>.

[15] *In the Abuja Declaration of 2001, many of the countries of Africa came together to assert that the containment of the HIV/AIDS epidemic, tuberculosis, and other communicable diseases should be an integral part of the continental Agenda for promoting poverty reduction, sustainable development, and ensuring durable peace and political security and stability.*

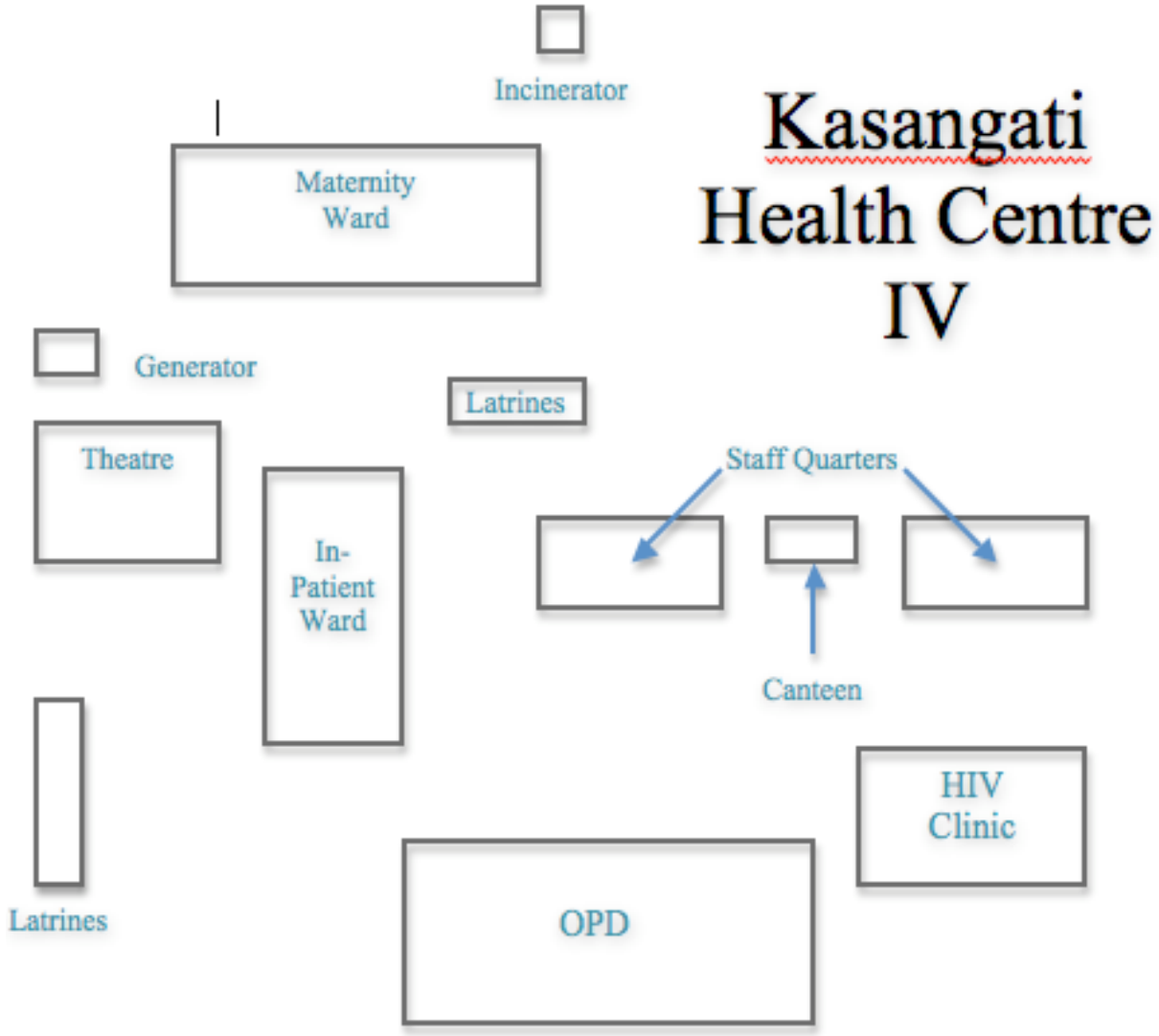
[16] WHO. (2001). *Abuja Declaration*. Available: http://www.who.int/healthsystems/publications/abuja_declaration/en/index.html

[17] Health Care Worker 2, interview by researcher. Kasangati, Uganda. (2 May 2012).

[18] Health Care Worker 1, interview by researcher. Kasangati, Uganda. (2 May 2012).

of Public Health as a Model Health Centre that serves three main purposes: to teach public health to medical students and other allied staff, to serve as a resource centre in community medicine, and to provide basic health services to the community.[19]

Table 2: Bird's Eye View



KHC IV contains an Outpatient Department (OPD), HIV Clinic, Maternity Ward, Theater, and Inpatient Ward where services are offered. Infectious diseases constitute the bulk of the morbidity

[19] Health Care Worker 5, interview by researcher. Kasangati, Uganda. (4 May 2012).

within the HSD. Some of the most common causes of morbidity include malaria, respiratory infections, HIV/AIDS, diarrhea, pneumonia, skin diseases, and road traffic injuries.[20]

The researcher conducted participant observation primarily in the OPD, the Maternity Ward, and the HIV Clinic of KHC IV (See appendix for photos). In these areas the researcher was allowed the chance to observe the daily interactions of HCWs in order to explore their trials and tribulations in their typical daily settings and situations.

Significance of the Study

The significance of the study lies in the fact that, despite efforts to improve the coverage and quality of care in Uganda, it still remains an issue in the lives of many Ugandan citizens. If the capacity for healthcare depends upon the availability of properly trained and equipped HCWs, then a scarcity of adequately trained and equipped HCWs hinders improvements in health care initiatives. This study is intended to explore the challenges faced by HCWs in order to gain an enhanced understanding of the linkages between HCWs, public health, and development in order to assess the current situation and understand where some of the problems arise.

Objectives of the Study

The objectives of this research are to:

1.1. Identify the key challenges facing Health Care Workers (HCWs) at KHC IV.

1.2. Analyze the reasons and root causes for these challenges in order to further understand their impact on HCWs and the quality of their work, especially the impacts on patient care.

1.3. To identify perceptions of HCWs concerning Uganda's decentralized health care system and their attitudes towards their role in this system.

1.4. Gain an understanding of how health care in Uganda factors into the larger picture of development.

[20] Health Care Worker 1, Interview by researcher. Kasangati, Uganda (2 May 2012).

Scope of the Study

The researcher conducted a research practicum based outside of Kampala for the restricted six-week period from March to May of 2012. The focus of this study is concentrated on one particular health centre in Uganda. Much of the data collected from this research is restricted to a fairly small-scale study. The researcher is unable to generalize the findings of this study because the presented information was gathered at one level IV health centre in one health sub-district of Uganda over the course of only a few weeks. The results of this study are neither intended to imply homogeneity in all government health centres nor to impose assumptions of other HCWs in other sectors, centres, or situations. However, when supplemented with information collected from secondary sources, it is the belief of the researcher that a better idea of how health care in Uganda factors into the larger picture of development can be better understood.

Discussion of Methodology and Procedure

The research for this study was primarily conducted utilizing participant observation, formal, and informal individual interviews at KHC IV. A transect walk was employed in order to obtain information concerning the location surrounding KHC IV which provided insight into the socio-economic make-up of the area as well as possible challenges in the accessibility of the health facility. Finally, secondary sources were utilized in order to provide a historical, political, and sociological framework concerning healthcare in Uganda, challenges facing HCWs in the developing world, the consequences for patients and the care they receive, and implications for development. Secondary sources were gathered through online academic database searches and from documents and books at the SIT Resource Centre. Collectively, the research was qualitative in nature, but employed empirical data from secondary sources for reinforcement, justification, and support. Each method of research provided valuable information, but was also accompanied by explicit challenges confronting the researcher. The following sections will take an in-depth look each research method and procedure as well as its challenges and implications for the study.

Participant Observation

Participant observation was selected as the primary source of information gathering by the researcher. This method was chosen in order to allow the researcher to understand the social world of KHC IV from the HCWs' point of view. It permitted the researcher to openly participate in the daily activities of the health centre in an attempt to experience events in the way that HCWs experience them. This allowed the researcher to draw upon the particular challenges, setbacks, and frustrations regularly encountered by the HCWs. This also permitted the researcher to gain a more holistic and empathetic understanding of the particular issues facing the HCWs at KHC IV.

One general strength of using participant observation for this study proved to be its flexibility as a research method. It gave the researcher the opportunity to react to particular events and ideas, follow leads, and pursue avenues of research that had not occurred before involvement at KHC IV. In this respect, the researcher was able to test hypotheses and redefine pre-conceptions about particular challenges in the light of the experience at the health centre. Participant observation also allowed the researcher to generate a depth of detailed information about the habits and perceptions of HCWs and their impacts on the quality of care delivered to patients. Finally, this study method created a greater opportunity for understanding. The researcher began to recognize the social pressures, group norms, general protocol, and historical context that influenced particular forms of behavior among HCWs and their reactions to the challenges presented.

Although overall this method was implemented successfully, a varying number of challenges were faced and particular limitations to this method of study emerged. Participant observation required a great deal of skill and commitment from the researcher. Much of the success of this research hinged upon such factors as the ability to fit-in and communicate with the HCWs and their patients in a way that was conducive to their own norms and standards. This meant learning basic medical terminology, understanding the general logistics of the centre, recognizing the hierarchical structure of the HCWs at the centre, and utilizing the local language, Luganda, when necessary.

It also required an intentional establishment of rapport from the beginning. KHC IV is a place of study and variable research initiatives, but the HCWs themselves are unused to being the subject of such research. Consequently, the researcher was required to work to garner the trust of the HCWs at the centre in order to become an accepted member of the group, which proved to be necessary, but quite time-consuming within the already meager time constraints of the practicum period. The researcher was compelled to learn the culture of the group in order to begin to participate fully in their behavior. This in itself was a great challenge for many reasons. The fact that the researcher was a foreigner with a very limited background in medicine and healthcare caused confusion and curiosity among some of the HCWs, which sometimes created an observer effect that altered the patterns of their work agendas and behaviors. These challenges, however, were greatly reduce over time.

Taking part in overt participant observation allowed the researcher the opportunity for note taking and data recording while on the job, but in the interest of group integration, the researcher often delayed in note-taking until away from the HCWs and the health centre, which created a possible loss of data and information. Finding the balance between becoming a well-integrated member of the group and retaining objective distance from the group was a challenge, but necessary for unbiased and valid observation and data collection. It required the ability to separate the role of the participant from that of the observer through clear conscious effort.

Participant observation also created demands on the researcher, not only in terms of observing and recording behavior accurately, but also in terms of interpreting data. Deciding which observations were significant was subjective in nature, and the researcher was confronted with the fact that behavior and observations that seemed significant to the judgment of the researcher may not have seemed very significant to the subjects, the HCWs themselves and vice versa. To combat this, the researcher followed-up with interviews in order to interpret the findings in the most accurate and culturally considered manner.

Formal and Informal Interviewing

The Researcher strategically chose participants for interview that demonstrated variation in goals, methods, and work locations at KHC IV. In total, ten individual interviews were conducted. Formal interviews lasted a duration of approximately thirty minutes. There was no single questionnaire posed to participants, but the researcher used some consistent questions throughout and all interviews followed a similar format. The intention was to gather qualitative data, and obtain as much specific information regarding the various challenges facing the different HCWs at the health centre as possible in the limited time provided.

The researcher informed each interviewee regarding the details of the research. No interviewee was pressured to respond to any question with which he or she felt uncomfortable. The setting of most of the interviews was generally formal in nature, though the researcher made a concentrated effort to establish a friendly and comfortable rapport with the interviewee before the interview began. This was further aided by the fact that each interview took place in familiar surroundings for the interviewee. See the primary sources section of the works cited page for a detailed list of the interviewees.

Transect Walk

A transect walk was conducted in order to allow the researcher to gain an understanding of the location and distribution of resources, infrastructure, land usage, and the general landscape of the area surrounding KHC IV. This allowed the researcher to understand the socioeconomic characteristics of the population directly surrounding the health centre and the scope of the physical accessibility of the health centre to the HCWs and the people they serve.

The researcher observed the section of Gayaza-Kampala Road slightly north (0.3 km) and south (0.3 km) of KHC IV and the stretches of land respective to these areas. The researcher also traced the area west of the health centre grounds in order to observe the population situated away from the main road. All of the information gathered allowed the researcher to triangulate data collected through other methods (participant observation, individual interviews, and secondary sources) in order to gain a more holistic representation of the population supported by KHC IV.

Although the two hour-long transect walk was not completely inclusive, it allowed the researcher to identify some major problems and possibilities perceived by the local people in relation to areas along the transect. It also allowed the researcher the opportunity to understand how the physical location of the health centre fits into the local community as a tangible entity.

Secondary Sources

Secondary sources were utilized in order to provide a historical, political, and sociological framework for this study. Secondary sources were gathered through online academic database searches and from resources collected at the SIT Resource Centre. These secondary sources allowed the researcher to contextualize the situation for HCWs in Uganda and develop a sense of what issues to be aware of at the onset of research on-site.

Ethical Considerations

Conducting research in which individuals share personal information required the utmost attention to the rights of the participants and interviewees. While encountering another culture, the researcher made conscious efforts to account for the social norms and expectations of the participants. The research aim for this study was to discover the challenges of HCWs in a health care centre and to gain insight into this topic through the voluntary participation of interviewees and participants. Informed verbal or written consent was required at the start of every interview. A participant consent form is located in the appendix. No interviewees will be referred to by name or title, but instead in more generic terms. The safety and confidentiality of research participants was foremost, and measures have been taken seriously by the researcher to uphold them.

Research Findings and Discussion

The HCWs at KHC IV face a plethora of challenges. Such challenges can arise as a result of an external stimulus failing to meet a particular tangible, social, or practical need. Similarly, challenges emerge in both the physical and psychological spheres.

Challenges to HCWs: Personal Logistics

Two of the most significant and frequently observed challenges to HCWs concerned the meager amount of compensation and the overwhelming level of short staffing at the health centre. Nine out of ten participants interviewed cited dissatisfaction with their current salary package, stating a particular want or need for an increment in salary. One HCW noted that some of the workers at the health centre were forced to find multiple sources of employment in order to make ends meet.[21] This participant provided the example of doctors that were previously employed by KHC IV. Insufficient salary obligated them to take up additional practice in private health centres in order to supplement their income, which resulted in neglect to their responsibilities at KHC IV and general absence with seldom appearance until they eventually resign from their position.

Studies show that HCWs are often willing to leave their posts for higher pay elsewhere. A pattern has emerged in which workers in developing countries are seeking better-paid jobs in other regions and countries of the world. In one particular study, salary outranked all other factors when health care professionals were asked what would make them remain in their home country. In fact, 84% of HCWs interviewed in Uganda in this study implied that improvement in salary structures would be a good reason to stay.[22]

As a result, many of the HCWs spoke of the frustrations and apprehension caused by the linkages of salary, subsequent short staffing, and the anxieties that arise from these two things. KHC IV contains 48 recommended HCW positions. As of February 2012, only 37 of these positions were filled. This means with 11 gaps, only 77% of recommended positions are occupied.[23] This puts a tremendous amount of pressure on the remaining HCWs to adequately serve the population. Consequently, HCWs cited the tremendous amount of stress and strain as basis for loss of motivation, depression, and ensuing absence or late arrival at work. This trend seems to stir a sort of domino effect that has the capacity to severely limit the care-giving abilities of HCWs at KHC IV.

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[21] Health Care Worker 1, interview by researcher. Kasangati, Uganda. (2 May 2012).
[22] Yumkella, F. (2006). Retention of Health Care Workers in Low-Resource Settings: Challenges and Responses. *Capacity Project Technical Brief.* 1:1-4. Available: http://www.hrhresourcecenter.org/node/337.
[23] Health Care Worker 1, interview by researcher. Kasangati, Uganda (2 May, 2012).

These things are only made worse by the related dissatisfactions connected to ideas of compensation and reasonable employment. One HCW emphasized an immediate need for better options for staff accommodation at KHC IV. Currently only a few HCWs reside on the KHC IV compound in residences that are small and in need of infrastructural attention. Although KHC IV is located on Kampala-Gayaza Road and is accessible by bus, taxi, or boda boda (passenger motorcycle), several HCWs mentioned having only fair or poor access to transportation from their current places of residence and many expressed dissatisfaction with an extensive daily commute to the health centre.

A transect walk conducted by the researcher depicted the problem of transportation accessibility. Only a short distance away from the main road presented landscapes that were difficult to maneuver and contained uneven ground levels, poor drainage patterns, and conditions that were virtually inaccessible by large motor vehicles. These locations proved to be maneuvered exclusively by boda boda or bicycle, means of transportation that were noted to be too costly, dangerous, or inconvenient by the HCWs interviewed. Similarly, the researcher herself experienced a daily 2-3 hour round-trip commute to KHC IV that put into perspective the exhaustion and tension that can also influence punctuality, outlook, and work ethic among HCWs even outside of the workplace.

All of these facets hold a strong influence on HCWs at KHC IV. However, if these problems in themselves are not enough, other challenges also arise that have the capacity to severely affect the ability to provide quality care to patients.

Challenges with Funding and Resource Allocations

Another serious challenge facing HCWs concerns problems that are seemingly out of their control: shortages of drugs, supplies, equipment, and financial capital to adequately sustain the functions of the health centre and the population it serves. All of the participants expressed concern and frustration about drug shortages, an issue that the researcher observed first-hand.

Drugs are supplied to KHC IV through the National Medical Stores (NMS) at regular time intervals, but sometimes the drugs run out before the next supply arrives. Even worse, sometimes the supply is delayed by days or even weeks for reasons unknown to the HCWs.[24] As a result, patients are instructed to purchase their prescribed drugs from pharmacies or medical stores, as opposed to receiving them for free from the health centre. Many patients cannot afford to purchase these drugs or do not understand their importance, so they go home with partial or no treatment. One HCW explained that some patients become suspicious, distrusting the HCWs and the health centre for seemingly withholding drugs[25]. These tensions create a barrier between HCWs and their patients and forge misunderstandings and frustrations between both parties, which makes it difficult for HCWs to effectively administer care and patients open to receiving it.

Resource shortages can be detrimental to the care HCWs can offer. The researcher observed one HCW test over 10 patients for HIV while wearing the same pair of gloves. Similarly, over 20 diabetes patients' blood sugar levels were taken without the use of any gloves by another HCW. Pregnant women in Uganda are required to bring their own "MAMA Kits" when they deliver in a public health centre[26]. These kits contain essential materials the HCWs use right before, during, and after delivery such as cotton, polythene sheet, string, gloves, and a razor blade. When a mother has not gathered the necessary items for delivery, HCWs are forced to either improvise or send her away.[27] This can be extremely detrimental and dangerous to the mother, and it also takes an emotional toll on the HCW assigned to deal with the situation.[28] Physical barriers quickly become emotional struggles that cause some to even question their profession.[29]

Similar to these things, the HCWs at KHC IV struggle with under-funding, especially when it comes to issues of infrastructure, water, and fuel.[30] The crumbling infrastructure of some of the buildings of KHC IV, the crowded waiting areas, and the shortage of beds in the ward were all items of concern noted by the participants. NGOs have joined with KHC IV over the past several

[24] Health Care Worker 5, interview by researcher. Kasangati, Uganda (4 May, 2012).
[25] Health Care Worker 4, interview by researcher. Kasangati, Uganda (4 May, 2012).
[26] Health Care Worker 3, interview by researcher. Kasangati, Uganda (2 May, 2012).
[27] Health Care Worker 1, interview by researcher. Kasangati, Uganda (2 May, 2012).
[28] Health Care Worker 10, interview by researcher. Kasangati, Uganda (9 May, 2012).
[29] Health Care Worker 8, interview by researcher. Kasangati, Uganda (9 May, 2012).
[30] Health Care Worker 2, interview by researcher. Kasangati, Uganda (2 May, 2012).

years to build a covering over the outdoor reception area, latrines, and even a new HIV clinic to be opened later in 2012, but still more work is needed. Sick patients are crowded into tiny waiting areas, and sometimes not enough beds are available for inpatients. These are problems the HCWs are noticing and want to do something about.

Similarly, KHC IV faces challenges with rights to water and obtaining enough to sustain its own functions. All of the water collection tanks on the premises are empty and in need of repair.[31] Sometimes HCWs must go without washing their hands because of water shortages. In another vein, funds are insufficient to provide for fuel to supply both the generator and local ambulance. Some buildings contain solar panels for times when the power is out, but some, like the Maternity Ward, must rely on candlelight.[32] The district contains an ambulance for KHC IV, but funding often does not suffice to fill the tank. In most emergency cases, another ambulance must be summoned from an external location such as Mulago in order to transport a patient.[33] This adds a great deal of time and inefficiency to a situation that may not be able to afford it.

These challenges often seem beyond the control of the HCWs. The effects of these problems are felt tangibly, but their blame is oftentimes a bit more vague. The next set of challenges stem from the people the HCWs work with every day: the patients.

Challenges With Patients

KHC IV is the only public HCIV among a population of 270,700 in its HSD. This creates intense population pressures that prompt many of the challenges already mentioned. According to one HCW, the large population size compromises the quality and functionality of the entire centre.[34] This is something that has an immense influence on patient waiting time, drug supplies, inpatient bed availability, and overall efficiency. As the researcher observed, it also determines when the HCWs are allowed to finish work and go back home. This seems to have an interesting impact on quality care. HCWs at KHC IV do not receive a lunch break. Shifts begin at 8:00 am and usually end when all the patients have been seen, usually around 3:00 pm, with only a break for

[31] Health Care Worker 1, interview by researcher. Kasangati, Uganda (2 May, 2012).
[32] Health Care Worker 10, interview by researcher. Kasangati, Uganda (9 May, 2012).
[33] Health Care Worker 3, interview by researcher. Kasangati, Uganda (2 May, 2012).
[34] Health Care Worker 1, interview by researcher. Kasangati, Uganda (2 May, 2012).

tea in between. As the researcher observed, toward the end of the day, HCWs are exhausted and generally ready to go home. Consequently, patients are shuffled through as quickly as possible and much less attention is paid to detail. With such a long day and so many patients to see, the quality of care certainly has the capacity to be compromised

One HCW indicated that population pressures have only gotten worse as a result of the global financial crisis of recent years.[35] This HCW explained how some patients used to go to private clinics for treatment, but can no longer afford to pay for health care and are seeking treatment at public health centres instead.

Another challenge HCWs indicated about some of the patients included low levels of literacy, specifically health literacy. Health literacy is a term used to describe and explain the relationship between patient literacy levels and their ability to comply with prescribed therapeutic regiments. This infers that adequate functional health literacy means being able to apply literacy skills to health related material such as prescriptions, appointment cards, medicine labels, and directions for home health care. This is specifically important when dealing with patients who suffer from chronic diseases and research shows that lacking health literacy may represent a major cost to the health care industry through inadequate or inappropriate use of medicines.[36]

Finally, HCWs expressed low motivation as a product of many factors including feelings of under appreciation from employers and specifically patients. Studies have indicated that a major challenge to the human resource crisis of HCWs in sub-Saharan Africa stems from their low motivation.[37] Thus, HCWs that are poorly motivated and under-appreciated find it very difficult to provide the best care for their patients.[38]

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[35] Health Care Worker 3, interview by researcher. Kasangati, Uganda (2 May, 2012).
[36] Nutbeam, D. (2000). Health literacy as a public health goal: A challenge for contemporary health education and communication strategies into the 21st century.*Health Promotion International*,*15*(3), 259-267.
[37] Mathauer, Inke, and Ingo Imhoff. "Health Worker Motivation in Africa: The Role of Non-financial Incentives and Human Resource Management Tools." *Human Resources for Healt* 4.24 (2006). Web. <http://www.biomedcentral.com/1478-4491/4/24#>.
[38] Health Care Worker 6, interview by researcher. Kasangati, Uganda (9 May, 2012).

Challenges with Organization and Administration

Finally, HCWs at KHC IV have experienced challenges with the administration and overall organization of the health centre. One HCW expressed particular frustration with the administrative inefficiencies stemming from the decentralized system of health care. This participant explained that most problems faced at KHC IV must be taken up at the district level, where there is much time inefficiency and very little accountability, seldom resulting in a suitable solution.[39]

Another participant struggled with the lack of information available to HCWs at KHC IV concerning things like new drugs and clinical studies. This participant wished the information were made available in order for the HCWs to have access to the latest updates from the rest of the medical world.[40] This participant also expressed the importance of information made available to HCWs concerning important details about the drugs administered, common conditions diagnosed, and possible side affects and reactions of medicines. This participant conveyed often feeling cut-off from the rest of the medical world and articulated the importance of feeling more inclusive.

Another concern for HCWs centered upon careless record keeping within the health centre. As the researcher observed, both diabetes patient files and HIV patient files were stored in their respective cabinets sans any order or organization. HCWs were required to sort through each file to find the one they were searching for, which proved to be time consuming and quite frustrating at times. Patient information was recorded in patient record books, but at times diagnoses or prescriptions were recorded incorrectly. Similarly, recorded data could be difficult to relocate and much of the responsibility often lay with the patient to bring or remember certain information concerning medical records.

Finally, the researcher observed issues of communication within the context of KHC IV itself that led to its own combination of challenges. One HCW explained the issue of "polypharmacy" at KHC IV. Polypharmacy refers to problems that can occur when a patient is

[39] Health Care Worker 1, interview by researcher. Kasangati, Uganda (2 May, 2012).
[40] Health Care Worker 4, interview by researcher. Kasangati, Uganda (4 May, 2012).

taking more medications than are actually needed.[41] This HCW expressed worry concerning misuse of antibiotics by unskilled practitioners and their impact on the drug supply of the health centre and consequent or eventual antibiotic resistance of a person or entire population. However, this is a controversial issue because beliefs of necessary medications are often subjective or open to debate. The challenge arises when there is no opportunity or venue for such conferring or debate. This has often led to internal disagreements and divide that go unsettled.

Conclusions

Despite the noticeable shortcomings at KHC IV, there still remains a great deal of hope. As previously mentioned, at one point in history, Uganda had the best health services delivery system in East Africa. Although the problems in the 1970's and 1980's can be blamed to a certain extent for many of the failures of the health system, the current Ugandan government should be doing more to improve the existing system. The theoretical framework of the health care system is feasibly sound, but it is unable to be fully implemented due to mismanagement of resources, poor attitudes and motivation, and a lack of good governance.

There are very many challenges to public HCWs specifically working at KHC IV, and these challenges greatly sacrifice the quality of care patients receive. Changes need to be made on the government level to alleviate some of the burden, but that is only the beginning on a long road to change. Attitudes need to change. Leaders at health care centres need to find fresh new ways to motivate their HCWs and fill those vacancies. HCWs must embrace needed changes and advocate for something more, something better for themselves and their patients.

One piece of information that the researcher found was the change in attitude HCWs experienced between the time when they were just beginning their career in health care to the time after they had been in the practice for a few years. HCWs that had been employed for longer periods of time reported feeling more jaded and methodical in their work. They explained that this was a sort of coping mechanism: if every patient was granted bouts of sympathy, compassion, and untarnished individuality every single day, the HCWs would quickly and easily exhaust themselves, become depressed, or feel the need to seek

[41] Health Care Worker 1, interview by researcher. Kasangati, Uganda (2 May, 2012).

employment elsewhere. Consequently, HCWs resorted to performing the duties of their job and leaving their emotions at the door. They tend not to see themselves in the greater picture of Ugandan healthcare, but rather as men and women simply doing their jobs. As a result, the researcher observed a purely drug-based form of medical care, one that seeks to alleviate the symptoms purely through medical or chemical means. There is little though for non-prescriptive measures or consideration for the circumstances surrounding the situation that may be causing the patient to feel unwell. The dilemma confronting these HCWs is how to adhere to the basic principles of medical care and ethics in an atmosphere of deprivation and ever-shrinking and often non-existent resources. Thus the dilemma arises: the principle of greater good must be carefully interpreted and applied in the context of KHC IV and all health centres of Uganda. While health promotion and disease prevention must be the primary focus, health planners should avoid pushing prevention at the expense of those currently sick. Health care reform in Uganda must respond to societal needs and be relevant to the community in question in order make progress in the direction of development.

Recommendations

Recommendations for Kasangati Health Centre IV

Government change is at times very slow, but that does not mean that other improvements cannot be attempted at the health centre level. One recommendation for the HCWs at KHC IV is to hold employee information-sharing meetings at regular intervals in which HCWs can share information concerning issues with patient care at the centre, updates concerning health studies or medications, points of contention, or any other concerns they might have. The HCWs need to be on the same page working together and supporting one another. Similarly, it might be useful to host employee refresher sessions once or twice a year to ensure that all HCWs are following the same protocol in their ways of dealing with situations. An incentive program might be helpful to boost general morale and motivation, and the capacity for career advancement might encourage HCWs to more actively take advantage of the opportunities offered at the centre.

KHC IV currently holds partnerships with NGOs and other private organizations, but the centre might try to make even more of an effort to strengthen partnerships with these and others in order to increase the flow of information, resources, and assistance. As an extension of this, KHC IV should look into telemedicine. Telemedicine is the use of telecommunication and information technologies in order to provide clinical health care at a distance. It helps eliminate distance barriers and can improve access to

medical services that would often not be consistently available in distant rural communities.[42] It can be used for clinical electronic consultation, and might be particularly useful in the Theatre of the KHC IV in order to consult other physicians who might be more familiar with the work or obtain a second opinion.

[42] Zanaboni, P. , & Wootton, R. (2012). Adoption of telemedicine: From pilot stage to routine delivery. *BMC Medical Informatics & Decision Making*, *12*(1), 1-9.

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Appendix

Consent Form

Participant Written Consent

Principal Investigator: Shannon McDowell

Title of Study: Conflict Situation for Health Care Workers: A Case Study of the Occupational Challenges in Kasangati Health Centre IV

You are invited to participate in this focus group/interview on the topic: "Conflict Situation for Health Care Workers: A Case Study of the Occupational Challenges in Kasangati Health Centre IV" conducted by Shannon McDowell from the School for International Training (SIT).

Your participation in this study will require participation in a focus group/interview and possible completion of a questionnaire. This should take approximately 1.5 hours of your time. Your participation will be confidential/anonymous and you may be contacted again in the near future for further research.

You will not be paid for participating in this study. This focus group/interview does not involve any foreseeable risk to you and there are no direct benefits. However, the benefits of your participation may impact your community by providing insight into some of the challenges facing health care workers in Uganda.

The project will be completed on 5th May, 2012. All interview recordings will be stored in a secure workspace.

I understand the procedures described above. My questions have been answered to my satisfaction, and I agree to participate in this study.

Please check any or all that apply

☐ I give permission for this interview to be recorded on a tape recorder.

☐ I give permission for this interview to be recorded in written format.

☐ I give permission for the following information to be included in publications resulting from this study:

☐ My name ☐ My title ☐ Direct quotes from this interview

Name of Subject _____

Signature of Subject _____ Date _____

Signature of Investigator _____ Date _____

At any time during this study you have the right to withhold information and to terminate your participation completely. I will be happy to answer any questions you have about this study. If you have further questions about this project or if you have a research-related problem, you may contact me, Shannon McDowell, at 0774383524. Thank you in advance for your participation in this study.

General Interview Questions

Logistical Questions

- How many HCWs work at this clinic?
    - What types of HCWs?
    - What is the ratio of HCWs to patients?
- How many patients are treated each day?
    - What types of treatment are available at this health centre?
- What services does this health centre provide?
    - What services are supposed to be provided but cannot be?
- What happens when needed/prescribed services cannot be performed at this health centre?
- Are there enough beds for the patients at this health centre?
- Is someone in charge of administrative and organizational work at this health centre?
    - What responsibilities does this person have?
- Does this health center ever experience a shortage of needed supplies/drugs?
- How often does this health centre receive supplies/drugs?
- Does this health centre have someone to contact when supplies/drugs have run out?
- What happens when supplies/drugs run out?

Communicable Disease Questions

- How does this health centre dispose of used supplies/contaminated waste?
- What are the responsibilities of the person/people who handle this?
- What measures are taken at this health centre to avoid disease transmission between patients and HCWs?
- Has there been any incidence of disease transmission between patients and HCWs at this health centre?

Sanitation Questions

- Does this health centre have running water?
    - If not, where does the water come from/how is it gathered?
    - How is the water sterilized/treated?
- Do HCWs wash their hands before treating patients?
- What measures does this health centre take to sterilize equipment before/after use?
    - How are the beds/facilities sterilized?
- What do you feel are some of the challenges of HCWs at this health centre?
    - What do you think is the biggest challenge?
- Does this health centre provide housing for HCWs?
- How far do you travel to reach this health centre?
- How do you commute to this health centre?
- What motivates you to work hard?

- Do you feel the salary you receive is adequate for the work you do?
- How do you feel about the quality of leadership and management at this health centre?
- Are there opportunities for career development and enhancement at this health centre?
- What is the turnover rate of HCWs at this health centre?
    - Why do you think HCWs decide to leave?
    - Where do they go?

Photographs

Table 3: KHC IV OPD

Table 4: KHC IV Maternity Ward

Table 5: KHC IV HIV Clinic