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Pillars to Effective Performance of Health Unit Management Committees (HUMCs) in Eastern Uganda

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Abstract: *This paper presents the pillars of effective performance of Health Unit Management Committees (HUMCs) in Eastern Uganda. It checks out for the current system through which HUMCs perform their duties, and the kind of support they need to be reinforced. The study population comprised 144 HUMCs in 12 facilities. Data was collected using interview guide with unstructured questions and predominantly structured questionnaire. Were obtained and presented largely using descriptive approach. According to results, the pillars for effective performance of HUMCs include training of HUMCs; meetings with district health leaders to get current information on status of health in the district, having meetings with the District Health Teams especially for purposes of making accountabilities, and sanctioning of rewards especially where products of effective performance are not viewed. The investigation also maintained that quite often, monitoring enhances performance of HUMCs given the fact that they are always at health facilities scarcely expecting their work to be monitored. Recommendations were indicated a need to initiate and maintain a high level of financial inputs to ease facilitation and register good performance of HUMCs, and that the ministry of health is not in direct contact with HUMCs, thus there is no transparency and accountability for all services from HUMCs to MoH or from district to HUMCs as directed by the MoH. It would therefore be recommendable to have an approach that enables HUMCs to deliver information that would otherwise not be handled at the district level.*

Key Words: Pillars, Performance, Health Unit Management Committees.

1. Introduction

Health centres are important structures being close to community they serve. All community benefits in terms of health care spring from health centres. They are the points of reference for prevention of ailments and curing ailments. Health centres are close to the community or rather within the community (Waldman, Sally and Wang 2011). They should therefore be entrenched in community rather than white horses. Community should be having closer feeling and ties to these health centres. There must be a mechanism that brings community in the centre of operations of the health centres. The health sector reforms in Uganda tried to address this through the creation of Health Unit Management Committees (HUMC) (Ssengooba et al, 2007). The Health Sector Reforms prescribed that every health centre must have a Health Facility Management Committee. This was to enable the health centre to be owned and guided by the community.

Despite the Government of Uganda improving on funding levels, improving human resources for health and infrastructure, performance of the Health Centres in East Central Uganda, has been poor yet Health Centres are the main custodians of health. There have been poor health performance measurement indicators in East Central Uganda as a result (Oyaya 2010). For example, the out-patient attendance rates are 80% in East-Central Uganda against 96% for the country average, the immunization coverage in East Central Uganda is 73% well below the national average of 93%. Skilled deliveries are at 50% in East Central Uganda against the 78% national average (MOH 2014). The approaches to managing health services seem not to be working well in many developing nations. There has been a recognized need to improve the quality and utilisation of services provided by primary care facilities in developing countries (Oyaya 2010). The use of the empowered management committees to guide running of health centres and hospitals was expected to foster greater community engagement in health maintenance and care; and have the potential to yield better quality of care and improve the performance of health centres. To increase service delivery and enhance accountability at health facilities, the health sector reforms in Uganda pioneered creation of Health Unit Management Committees (HUMCs) to enable the health centre to be owned and guided by the community. The study took in context the question, why, despite health sector reforms in Uganda, the health indicators remained poor. Community has not been utilizing health services and has not been interested in the health services being provided (Waldman, Sally and Wang 2011). Uganda has been providing health services under Primary Health Care (PHC) policy which calls for community

participation. For community to be driving provision of health services, HUMCs were introduced to provide an eye for the community to monitor and contribute ideas.

HUMCs are the key link mechanism of the health system to the grassroots community. It links the community, the local government and the health facility. HUMCs are established at facilities at the different levels of care, except at Health Center I, which is constituted by Village Health Teams (VHTs). HUMCs consist of representatives of the community within which the health facility is located. Ministry of Health guidelines require that the committee is chaired by "a prominent educated public figure of high integrity and not holding any political position". Other members are chosen by the political leadership; one from each of the major administrative units within the area served by the facility (MOH, 2014). The health workers of the facility are represented by one health worker and the facility in-charge, who serves as the secretary to the committee. The lowest local government unit (Local Council I) is represented by its chairperson. The relevant local government is represented by the secretary for health (MOH, 2014).

2. Literature Review

The government of Uganda established HUMCs in 1998 (McCoy, Hall and Ridge 2012). Prior to this, in some facilities, almost similar community based or NGO supported community participatory mechanisms existed like the Parish Development Committees and Hospital Boards. The committee roles were strengthened through induction trainings provided through the Ministry of Health and Danish International Development Agency (DANIDA) Health Services Project (McCoy et al, 2012). The official roles of the HUMCs are summarized as below:

Table 1: Roles of Health Unit management Committees

	Roles of Health Unit management Committees
1	To oversee the general operations and management of the health centre
2	To advise community on matters related to promotion of health, prevention of diseases, treatments in health centres and rehabilitation
3	To represent and articulate community interests on matters pertaining to health in local development forums
4	To facilitate feedback to community on matters pertaining to health centre
5	To facilitate implementation of community decisions and ideas pertaining to the health of the community
6	To mobilize resources towards development of health in their area
7	To monitor the work-plan and budget and allocate/re-allocate resources

Source: Guidelines of HUMCs, Ministry of Health Uganda, 2014

2.1 Pillars to effective HUMC performance

HUMC empowerment outcomes include community bonding measures – social capital (McCoy, Hall, & Ridge, 2012), neighbourhood cohesion neighbourhood influence community capacities or assets amongst others. Community and national level empowerment variables within the political, economic, legal, and human rights sectors include good governance, institutional performance improvement, and women's empowerment (Goodman, Opwora, et al. 2011). Good governance includes accountability of politicians and managers through an information flow to the public, enhanced civil liberties, lower corruption, and increased responsiveness of an institution to public health needs and problems, and reciprocal relationships with a public empowered with greater access to transparent information and control over resources (Potts, 2009). Civil liberties and community participation, which facilitate transparency, for example, have improved development effectiveness, increased expenditures in schools and shaped health sector services, including increasing health centre attendance (Báez and Barron, 2006).

Performance management relates to the processes that maintain or improve performance during employment. Performance management has attracted research especially in the field of industry, universities and hospitals (McCoy 2012). Given its appeal to the incentive-based approach, Expectancy Theory has been widely embraced in this context. In general expectancy theory explains the links between external incentive and internal (or intrinsic) motivation to undertake or accomplish the required task by a person. Expectancy theory (Molyneux, Atela, Angwenyi, & Goodman, 2012), suggest that individuals can be motivated if they believe that there is a positive correlation between their efforts and required performance outcomes. Favorable performance will result in a desirable reward, the reward will satisfy an important personal need, and the desire to satisfy the personal need is strong enough to make the effort worthwhile.

2.1.1 Psychological Contract

A psychological contract has been advanced as a product of the "will do" and "can do" perceptions reviewed above (Hopkins, 2007). It also attempts to remedy the criticism of the expectancy theory which assumes that individuals are capable of calculating all the odds and always act in accordance with their motivation calculus. Psychological contract has been defined by Rousseau et al as the individual employee's subjective perceptions of the mutual obligations between employer and employee. Given bounded employee rationality, this contract reflects incomplete

and sometimes distorted understanding of the employee-employer relations (Bulut & Culha, 2010). The psychological contract guides the day-to-day employee behavior in ways that cannot necessarily be discerned from a written job contract.

How the psychological contract links back to employee performance is what (Bulut & Culha, 2010) has been identified as causes, content and consequences on the employee. Inputs into the contract or causes include organizational culture, human resource practices, prior experience, expectations, and worker's job-alternatives. The state of the contract or its content has three main affective components: Sense of fairness, trust and fulfillment of workers expectations. Consequences include key attitudes such as job satisfaction, job security, organizational commitment and motivation. If this contract is violated, negative attitudes such as resentment, anger, mistrust and betrayal may arise. These may cause negative work behaviors ranging from low commitment, reduced effort or higher absenteeism, sabotage and worker exit (Jewer & McKay, 2012). In stable contexts, an existing psychological contract is likely to be reaffirmed by positive customs, practices and norms in relation to employer and employee understandings of the basis of the exchange. As such, the psychological contract serves as the internal glue arising from external incentives structures that helps to explain the commitment to relational contractual relations and sustained productivity (Klassen A 2010).

2.1.2 Conferences as a capacity building strategy

As a training and development method, it involves presentations by more than one person to a wide audience. It is more cost effective as a group of employees are trained on a particular topic all at the same time in large audiences. This method is however disadvantageous because it is not easy to ensure that all individual trainees understand the topic at hand as a whole. Not all trainees follow at the same pace during the training sessions. Indeed focus may go to particular trainees who may seem to understand faster than others and thus leading to under training other individuals (Campbell and Coff 2012).

2.1.3 Role playing

Involves training and development techniques that attempt to capture and bring forth decision making situations to the employee being trained. In other words, the method allows employees to act out work scenarios. It involves the presentation of problems and solutions for example in an organization setting for discussion (Kacmar, 2016). Trainees are provided with some information related to the description of the roles, concerns, objectives, responsibilities, emotions, and many more. Following is provision of a general description of the situation and the problem they face. The trainees are there after they are required to act out their roles. This method is more effective when carried out under stress-free or alternatively minimal-stress environments so as to facilitate easier learning. It is a very effective form of training method for a wide range of employees, for example, those in sales or customer service area, management and support employees (Campbell and Coff, 2012).

2.1.4 Formal training courses and development programmes

In formal trainings, courses and programmes carried out are usually defined, widely known and preset. The programmes have been defined whereby the contents, durations and all the details about the training are clear to both the organization and the personnel to be trained. Unlike informal trainings and programmes, formal training and programmes can be planned earlier and also plan for their evaluation. Employees may undertake these courses and programmes while completely off work for a certain duration of time, or alternatively, be present for work on a part-time basis. These programmes can be held within the organization (in-house) or off the job. Off the job is argued to be more effective since employees are away from work place and their concentration is fully at training (Adeniji, 2002). Depending on the knowledge needed, organization's structure and policies, the trainers too may be coming within the corporation or outside the organization.

3. Methodology

3.1 Research Design

A blended experimental approach was used to obtain data on the pillars of effective performance of HUMCs in health centers. The unit of analysis in the study was the response of the performance of health centres to training of the members of HUMC. Clinical out puts like (OPD attendances, deliveries in health facilities, immunization coverage), Perceptions, behaviours, practices and decision processes were the basis for assessing the response. The analysis sub-units embedded in this randomized community trail included the interaction between hospital actors i.e. HUMC members, managers and clinical staff in relation to prerequisites for health centre performance improvement. On one hand, qualitative approaches were used while on the other, quantitative approaches to data collection were used. The experimental study is an empirical enquiry that: investigates a contemporary phenomenon within its real life context; when-the boundaries between phenomenon and context are not clearly evident, and in which multiple sources of evidence are used (Machin, 2010).

3.2 Population and Sampling

Twelve health centres were selected for in-depth intervention study in the experimental arm and twelve health centres were selected in the control arm for this study on training of HUMCs to stimulate productivity of the health centres. The selection of the health centres was random and was guided by the desire of seeking validity of and generalizability in the pre-post community trial study approach.

A baseline to assess health centre performances, skills and knowledge in reviewing and monitoring capacities by HUMCs in the intervention and control arms of the study was conducted. The HUMCs with limited skills and knowledge were subjected to training on

governance for period of two weeks. Each health centre had a trainer from Ministry of Health of Uganda and one Research Assistant. After the training which ended within the first month of intervention period, then follow up was done three months after the training and then six months after the training to ascertain the improvement in performance in the intervention health centres that were compared with those in the control. This enabled explaining the impact and outcomes.

3.3 Research Instruments and research data

3.3.1 Questionnaires
Quantitative Data was collected using questionnaires with the assistance of twenty four research assistants (RAs). Semi-Structured Questionnaire was the main data collection tool targeting the main respondents (members of HUMCs, Managers of Health Centres and users of the services). The questionnaires were divided into sections containing structured and unstructured questions. Questions were structured to cater for the various pillars of effective performance of HUMCs.

3.3.2 Interview Guides
An interview Guide was employed to get information from district managers Health centre manager and sampled leaders of health facilities and from all members of HUMCs.

The District Health Management Teams (DHMTs) and other Health Management Teams (HMTs) were asked how they were relating with HUMCs and how the hospitals were being managed to stimulate performance. Interview questions also dwelt on how the district specific performance targets were selected and what influenced their choices. The interviews with the DHMT and HMT aimed to describe their reactions to performance feedback, rewards and sanctions and to enablers and constraints in achieving the performance targets. At the end of the intervention In-depth interviews were done with members of the HUMC, DHMT and HMTs in the intervention arm health facilities for verification of performance targets. The respondents were asked about the changes they had made as a result of experiences they encountered during training activities and thereafter.

3.4 Data collection and management techniques

The data was collected on daily basis during the period of the study by RAs and the principal researcher from 9 am to 5 pm. The research team checked data carefully to make sure all the filled tools were available and were neatly arranged for filing. After each day of data collection, filled in questionnaires were edited again, and checked for completeness by the principal researcher. Before a respondent left the area of data collection, he/she made sure the data collection tool had been filled. The responses were coded with numbers to ease quantification and analysis. The coded data was entered in the computer using SPSS software, for storage and for analysis later. The file of filled data tools was kept in a locked cupboard for safety

3.4.1 Reliability
Tools were pre-tested in the nearby health centres in Central Region of Uganda since the structures and people in Central Region of Uganda shared similar characteristics with the people of East-Central Region. From the health centres in the District of Mukono this was done to pretest the research instruments for both the intervention and control. The pretest sample size was predetermined by investigator to be 4 HUMC members, and the same number for the district health Teams (4) and health centre administration staff, and local leaders (opinion leaders 4) per selected health facility. 4 hospitals were purposively selected to be able to pretest the tools and these were Naggalama Hospital, Church of Uganda Hospital Mukono, Mukono HC IV and Mukono University Hospital. The objective of this was to ensure that the questionnaires could bring out the exact information required by the researcher.

3.4.2 Validity
The Data collection instruments were designed in such a way that the issues that they were seeking information about were those that had been considered relevant to the study objectives and as such, were able to guarantee their validity. The researcher discussed the interviewer administered questionnaire with the research assistants for clarity before time of interview. The purpose of this was to be able to see whether it would be easy to understand by respondents. According to Teijlingen van et al. (2001), pilot testing is important in the research process because it reveals vague questions and unclear instructions in the instrument. It also captures important comments and suggestions from the respondents and enable the researcher to improve efficiency of the instrument, adjust strategies and approaches to maximize the response rate.

3.5 Data analysis

Data from questionnaires was edited after collecting tools whereas data from interview guides was written concurrently while carrying out interviews with key respondents. Appliances like audio recorders were employed to capture data in details after which it was transcribed and coded for analysis. Most data from this investigation was qualitative and was analysed using a computer based qualitative data analysis software atlas Ti 7. This involved in-depth analysis of each of the main categories of data. The analysis facilitated teams to be able to describe the range of the HUMC member's skills, training and health centre performance. During analysis, each category was considered for further assignment into subcategories. Using these subcategories gave more insight into the details of the mentors' and trainers' activities in each category.

4. Results and Discussion

The main mechanisms for stimulating performance improvement in the intervention arm health centres were the training given to HUMC members. Although there were suggestion boxes and patient rights charters, these

had been available in these health centres, were still available and used in HCs in the control arm and therefore could not explain improvement in performance observed in the intervention arm HCs. Training empowered HUMC members to have significant powers over the management of the health centres. All the respondents in the intervention arm reported that their HUMC members had recently been trained in health facility and management and were reminded on the objectives of the health facilities and performance targets. However, many of them felt that they were greatly lacking skills, especially in the area of community engagement and performance targets prior to the training. Respondents in the intervention arm attributed improvement in attitudes and performance of their health centres to the training of their HUMCs.

4.1 Motivation and Performance of HUMCs

The World Health Organisation has maintained its desire for improved National Health Systems Performances and has continued to provide indicators for assessing National Level Performance of respective health sectors (WHO, 2010). WHO prioritizes three main aims in performance of National Health Systems. The first is improving the health of the population. The second is responding to people's expectations and the third is providing financial protection against the cost of ill health (WHO 2010). From these three main aims, nations draw their policies and plans that guide performance. The National Health Sector Strategic and Development Plan 2015/16 to 2019/20 of Uganda penciled in from the above WHO priorities to set the objectives and indicators for the performance expectations of the Uganda Health Sector (MOH, 2015). This plan set its objectives among others as

- Strengthen Management of National Health systems
- Improve access to quality hospital services (HCs)
- Ensure universal access to Uganda National Minimum Health Care Package
- Review relevant laws and acts
- Ensure adequate and appropriate human resource
- Increase motivation, productivity, performance, integrity and ethical behaviour of the human resource

Health centres and their management are key players in all the above objectives (WHO 2015). To meet these objectives, WHO provided four functional domains whose performance is critical for the objectives attainment. These four included financing, leadership, capacity building and service provision (WHO 2010). World Health Organization continues to monitor progress through assessments of health outcomes such as life expectancy, maternal mortality ratio, and infant mortality among many other measurement of performance at national level. Out of the 32 indicators listed in the Health Service Sector Plan (HSSP) 2015-2020, a short-list of four were identified in this study as the instruments for performance management and assessment at the implementation level (HCs). The four indicators have been assessed annually using a routine data collection system known as the District Health Management Information System II (DHIS-II). The availability of performance data in the routine information systems was important in the selection of the indicators for HSSP monitoring from its very inception (Ssengooba, 2010).

While health centres were required to satisfy several objectives from multiplicity of stakeholders, the health policy put in place a number of indicators to assess the performance of the national health system. Some of the objectives have intrinsic motivating mechanisms for performance and productivity while others, as explained above, would curtail performance of these health centres. This perspective was likely to have both enhancement and constraints to performance of health centres following the training of the HUMCs. Table 2 below, shows performance of the health sector at national level for the five previous financial years.

Table 2: National Health sector performance trends

Indicator	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
OPD Utilization	95%	98%	100%	97%	100%	100%
Immunization coverage (DPT3)	80%	83%	90%	94%	94%	97%
Delivery at Health Facility	38%	41%	54%	58%	65%	70%
Availability of supplies	80%	80%	81%	83%	83%	83%
Degree of perception on governance	88%	90%	90%	87%	92%	90%

Table 3: Performance trends in health sector in East-Central Uganda for the last five years

Indicator	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	Baseline Values
OPD Utilization	75%	68%	75%	78%	80%	80%	81%
Immunization coverage (DPT3)	60%	73%	70%	65%	60%	63%	66%
Delivery at Health Facility	25%	33%	38%	38%	41%	54%	54%
Availability of supplies	60%	60%	64%	63%	63%	63%	63%
Degree of perception on governance	58%	50%	60%	57%	42%	60%	60%

From the Annual Health sector Performance Report of Uganda Ministry of Health for the year 2013, the East Central Uganda was bedeviled with many performance challenges such as health worker shortage, low salaries, sub-optimal functioning of the infrastructure, inadequate drugs budgets and problematic procurement processes of medical goods (MOH, 2014). National level procurement of drugs and other medical products regardless of the needs at the HCs was a prominent issue provided by the respondents as to be causing under-performance.

Overall, the performance expectations at the national health sector level reflected a need to build and strengthen the support systems at local level such as strengthening and empowering the HUMCs, building more capacity of the human resources, improving the medical supplies procurement/delivery, increase financing and expand provision of infrastructure. These were more prominently expressed in the HCs in the study area (East Central Uganda).

4.2 The DHT and Health centre Meetings as pillar for effective performance of HUMCs

Attempts to address performance gaps were traced in the minutes and recordings of meetings of some DHTs and HCs. Meetings at district level were the quarterly and annual performance review meetings where the quarterly or annual performance was shared with stakeholders to inform the planning for the next period in time. As for HCs, the performance review meetings were being held monthly with stakeholders at that level also to inform the next planning period. In these meetings it was observed that members of HUMCs were not being invited and their views were not being captured prior to this study. Also indicators for performance and targets were not being given due attention. No wonder the performance was poor. Frequency of meetings at health centre level was found to be irregular and in some health centres non-existent. After training of members of HUMCs in health centres in the intervention arm, it was observed that the quality and frequency of minutes improved as compared to the HCs in the control arm. Members of HUMCs were being invited at performance review meeting in the intervention arm while they were not in control arm and this could account for improved performance in HCs in the intervention arm. In their study about the strength of meetings, Bulut and Culha (2010) also established that frequent or routine meetings with both juniors and seniors promotes confidence in sharing issues of uncertainty and improves performance mainly by reducing the superior-inferior gap.

4.3 Rewards and Sanctions as pillar for effective performance of HUMCs

The districts in East-Central Uganda have a rewards and sanctions committee each. The committee is responsible for setting parameters on which they base to guide their decisions whether to reward or sanction a public officer. In their work, the rewards and sanctions committees are further guided by rewards and sanctions frame work issued by the Ministry of public service. The objectives set out in the frame work are not those ones used to rank districts in the national Performance League table of the ministry of health. Although the effects of what is done by these committees trickle into products for the improving of performance of the HCs. The rewards and sanctions committee deliberations focus on individual public servants especially focusing on code of conduct. In all districts and in all HCs, the rewards and sanctions committee did not cover members of HUMCs and were not known to the members of the HUMCs. In the same way, Waldman et al., (2011) notice that there exists a tendency in organizations whereby fully trained, committed and competent managers decide or opt to offer rewards to people of their choice, denying others their chance. At the same time, Jewer and Mackay (2012) noticed that sanctions tend to cover more individuals than rewards because administrators find it easier to punish other than to reward for good efforts.

Another challenge was that the rewards and sanctions committees were more focused on sanctions and never at all on rewarding performance. This was in total disregard to the theory of incentives as drivers of performance. It abounded in failure to identify parameter on which to base the rewards and be able to stimulate performance enhancement. It had the complication of separating issues of quantifiable out-puts against issues of quality. The result was failure by all districts in East-Central Uganda to identify parameters for rewarding good performance. These results are in line with Kacmar et al., (2016) whose study about rewards and sanctions found out that much as these benefits are cherished in organizations, in the

health sector, the two are given but no cyclic follow-up is always made to establish whether they make any effect on performance as expected.

In addition to the lack of the parameter for rewarding performance, there was also the challenge of the unpredictability of resources to support the occurrences that would follow the decisions whether to sanction or reward performance. If it required suspension of officer then it would create human resource gap and compromise performance further. If it meant availing a reward then the question of funds to purchase the reward arose. After training of members of the HUMC in the intervention arm, they were participating in decisions of selecting which staff to award and setting criteria to reward or sanction and this could account for performance improvements in those health centtres.

There were observed some common features of HUMCs in the study area. Most notably was their nature, roles and composition. Most HUMCs were reported to have been made-up of community representatives, facility staff, and local administration staff and followed the general guideline provided by the MOH Uganda. Elsewhere in Africa, a close comparison is reported in a study in Zimbabwe, where, health centre committees (HUMCs) consisted of a mix of health personnel, officials, councilors, and traditional leaders, as well as community representatives Machingura (2010) In Uganda, however, membership to the Health Unit Management Committee excluded political representatives MOH (2014).

Comparison of how HUMCs performed their roles within and beyond Uganda is constrained by the limited number of studies reporting the functioning of such committees in their normal setting that is., without external interventions and support. That being said, there is a broader sense that the breadth and depth of HUMC roles are defined in two main *ways* – representing community interests to the facility and overseeing operations and management of the facility Mugisha (2004). While the distinction between the roles is unclear, representing community interests can be seen as an effort to give the community a 'voice' in matters affecting their health McCoy, Hall, & Ridge (2012). In this study, overseeing operations and management of the health facility can be seen to be about performance improvement and accountability aimed at improving service delivery. The driving forces behind the intervention points to the objective – that HUMCs should mobilise the community, raise and control revenue, oversee the management of staff, facilitate outreach and health promotion activities, and help to manage supply essential drugs. These roles are easy to implement if only the committees are trained and empowered as evidenced in results of performance comparing the control arm HCs and the intervention arm HCs.

5. Conclusions and Recommendations

5.1 Conclusions

Generally, this investigation established that cumulatively, the pillars of effective performance of HUMCs are diverse and they do not exclude training of HUMCs, good motivation plans whereby they are fully rewarded for their services, having meetings with the district health teams, especially for purposes of making accountabilities, and sanctioning of rewards especially where products of effective performance are not viewed. The investigation also maintained that quite often, monitoring is a proper way to enhance performance of HUMCs given the fact that they are always at health facilities scarcely expecting their work to be monitored.

5.2 Recommendations

The training of HUMCs must be furthered to enable them improve ways of relating with grassroots individuals to obtain data on health and inadequacies faced by households in a bid to obtain good medical services.

Much as the government of Uganda struggles to improve the health sector through better reforms, it is clear that not much is done to reinforce HUMCs financially. It is common and indeed usual to find a staff of HUMC without transport yet there are some serious health issues they need to handle through sensitization. There is therefore, a need to initiate and maintain a high level of financial inputs to ease facilitation and register good performance of HUMCs.

The ministry of health is not in direct contact with HUMCs, thus there is no transparency and accountability for all services from HUMCs to MoH or from district to HUMCs as directed by the MoH. It would therefore be recommendable to have an approach that enables HUMCs to deliver information that would otherwise not be handled at a level of district.

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