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## Introducing a new cadre into Uganda's health care system: Lessons learnt from the implementation process

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### Abstract

Uganda introduced Registered Comprehensive Nursing (RCN) and Enrolled Comprehensive Nursing (ECN) training programs in 1994 and 2003 respectively, to create certificate and diploma level cadre of nurses with competencies in general nursing, midwifery, public health, psychiatry, paediatrics and management. This paper is based on an evaluation study undertaken to assess how the programs were implemented including stakeholders' perceptions about the graduates. Despite being relevant, the implementation process of both programs failed to meet acceptable standards. We conclude that introducing a new cadre of nurses without proper preparation hinders realization of their full potential including their contribution to the healthcare system.

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### 1. Introduction

The Registered Comprehensive Nursing (RCN) and the Enrolled Comprehensive Nursing (ECN) training programs started in Uganda in 1994 and 2003 respectively (Ministry of Education and Sports, 2004a; Ministry of Education and Sports, 2006; Ministry of Health, 2010). These two new cadres of nurses were introduced into Uganda's Health care system to create a multi-purpose nurse with competencies in general nursing, midwifery, public health, psychiatry, paediatrics and nursing management (Ministry of Education and Sports, 2004b; Ministry of Education and Sports, 2006; United Nations Population Fund, UNFPA 2010). Upon graduation, these graduates were expected to be deployed in primary health care outposts in rural areas of the country where they would provide basic health services to the local communities (Ministry of Health, 2010). This paper reports about findings of a study conducted to evaluate how the new cadre of nurses were introduced and how their curricula were implemented.

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## 2. Methodology

The evaluation study included a series of ten studies using both quantitative and qualitative research approaches. A desk review of national and international documents regarding the competencies of graduates using similar curricula was undertaken. Triangulation was used to validate the data generated during the evaluation process which occurred between June and December 2010. The findings reported on here are based on data obtained from 28 semi-structured qualitative interviews conducted among three categories of key stakeholders at policy level from the Ministries of Health, Public Service and Education and Non-Governmental Organisations and Development Partners; Senior Nursing and Midwifery Tutors; and Managers of Health Institutions where the program graduates worked at the time of data collection. There were 14 policy level key stakeholders, 7 nursing and midwifery tutors and 7 health service managers. All interviews were digitally recorded, transcribed and then thematically analysed.

## 3. Results

The themes that were identified during the data analysis included relevance of the programs; preparations for curriculum implementation; implementation process and professional regulation; resource allocation for the programs; program duration and quality control; preparation of tutors; and provisions for employment into Uganda's health care system upon their graduation. In the direct quotes below the respondent is identified by number only.

### 3.1. Relevance of the programs

The study participants all agreed that the new programs were launched to train a 'generalist nurse' who would support the Primary Health Care (PHC) initiative the country had adopted. The participants reported that the cadres were relevant for this new role as the verbatim expressions below affirm:

*...the Ministry of Health and the stakeholders were concerned with the health of the rural population and needed a person with various skills who could fit at that lower level of health care...to deal with a wide range of issues (7.1).*

*In terms of relevance, it helped us train all round cadres instead of having different single trained cadres like midwife; instead you have a person doing all these.... (4.1)*

### 3.2. Preparations for curriculum implementation

The participants reported that the two training programs were implemented without first piloting their curricula. They also confirmed that most public nursing institutions were asked to implement the programs on full scale with little preparation and follow up resulting in unprecedented challenges, as these participants explain:

*This project needed to have been piloted first but nobody did that to assess [the] impact and even then no evaluation was done to see if things were going the right direction so these loop-holes could have been addressed (10.1)*

*Evaluation needed to have been done to assess progress but this important aspect has been ignored for too long (12.1).*

### 3.3. Implementation process and professional regulation

Findings from the evaluation show that the programs were not implemented as per the requirements of a good nursing educational program. The two programs were implemented with little supervision and regulation from the nursing and midwifery council (the legal and professional body mandated to regulate nursing and midwifery training and practice). This meant that the new programs did not benefit from the checks and balances other nursing programs in the country are subjected to. This culminated into the graduates not being licenced by the regulatory body, until they agreed to undergo a compulsory remedial experiential training to make up for the shortcomings

arising from the inadequate checks during the implementation of their training programs. The following verbatim expressions relate to the curriculum implementation process:

*The content of the curriculum is OK because it has things like psychiatry, community health, etc, but given the period of 2.5 years, can this nurse really be able to master all these? (1.2)*

*The curriculum has too many things to be done within a short time (4.2).*

*The time given for skills is very short and not enough to be able to handle midwifery because from the needs assessment we discovered the time for midwifery is not enough (8.4).*

#### 3.4. Resource allocation for the programs

Almost all the key stake holders and tutors interviewed agreed that both the training facilities and the health care facilities where clinical training was done were generally under-resourced, although a few reported that their training institutions had secured adequate development partner and government funding to support the implementation of the two new programs. The majority of stakeholders reported that the resources available for training of these new cadres, in addition to the existing training programs were inadequate, as herein affirmed:

*The numbers [of students] do not match the resources available like tutors, the equipment both in the schools and the hospitals and even the supervisors are not there in these practicum sites (4.1).*

Many of the clinical training areas were also reported to be overcrowded, with inadequate learning facilities and equipment, thus jeopardizing students learning, as this stakeholder expressed:

*The schools have very many students ...when it comes to [clinical] attachment, they do not know where to put them and even the available facilities have few and worn out equipment (1.2).*

The participants also identified shortages in libraries, clinical laboratories and transport, as this tutor confirms:

*The challenge is that not all schools have been brought up to standard in terms of materials [and supplies] ...there is therefore need for equality in allocation of resources (2.2)*

#### 3.5. Program duration and quality control

With regard to the program duration, we noted that the curriculum was too ambitious for the time allotted and lacked systematic external monitoring for quality. The amount of content to be covered far outweighed the capacity of the students and the training institutions, including time within which to cover the content, as this tutor questions:

*The content of the curriculum has things like psychiatry, community health, etc., but given the period of like 2.5 years, can this nurse really be able to master all these? (1.2)*

In terms of the external regulation for quality control, the evaluators found that the training schools in the early years did not follow the regulations for quality effectively. This was compounded by the fact that the nursing and midwifery council was unable to perform its previously mandated supervisory and regulatory roles due to changes in the legal provisions that governed higher education at that time, as this verbatim transcript reveals:

*Yes, there is the Council that has been mandated to regulate training and practice... [however] ...when we wanted to visit schools to ascertain things, they would say "what are you coming to do here?"... there has been confusion for a long time especially where [nursing and midwifery] council was locked out ... due to changes in legislation (5.3).*

### 3.6. Preparation of tutors

The evaluation study found that some tutors did not clearly conceptualize the ‘comprehensive’ nature of the new programs which required equitable focus on all the five main areas of the curricula, namely general nursing, community health nursing, midwifery, administration and paediatric nursing. It was discovered that because most tutors were not prepared well for this new program, many tended to emphasize their own specialist areas leading to inadequate coverage of other components of the curriculum, as these participants report:

*You find that people...may not have the actual understanding of the program. And you find that there are no orientation programs...you just do [teach] it – as long as you are there. So you are posted and they expect you to run the program the way it is supposed to be (3&4.2).*

*You find some schools do not have specialized tutors in [some] areas ...and you also find people [tutors] have interest in certain areas so you find some areas more emphasized than others... so that can affect the goal of comprehensiveness [in the student’s training] (3&4.3).*

### 3.7. Preparations for employment

The stakeholders reported that the responsible government agencies, the Ministries of Health and Public Service did not make provision in the scheme of service to employ these new nursing cadres in the health care system upon graduation. It was evident that this omission had far reaching effects, including these new cadres failing to be employed by government in primary health care outposts as initially intended by the program implementers:

*The challenge is that [the graduates] have not been utilized because...they do not have any structure in the public service for them and they have not been posted where they were supposed to be and that is health centres (8.1).*

We also found that the health system was never prepared to receive the two new cadres of nurses. The health service managers reported that as a result of this “lack of preparation of the ground” widespread confusion existed about their roles and responsibilities, including how these new group of nurses would best be integrated with existing cadres of health care workers in the country’s health care system, as this respondent argues:

*There are problems with the existing medical [healthcare] team not understanding their [new cadres of nurses] positions especially with the clinical officers [medical assistants] and there is a problem of [clarity] of roles in the medical team (2.4).*

## 4. Discussions and Lessons learnt from the implementation process

Despite the relevance of a study program and the intended graduates, a poorly conceptualized and planned implementation process can result in the failure of an otherwise good training program in achieving its intended goals. It was evident that in the case of the ECN and RCN program, stake holder involvement at the onset of the programs was minimal, yet for effective study program outcomes, their involvement is critical at every stage of the program planning and implementation process. In this regard, Edelenbos and Klijn (2006) argue that adequate involvement of different players during the implementation phases of a program is important for achieving satisfactory outcomes. Similarly, Ritchie and Chappidi (2008) affirm that stakeholder engagement is critical to winning their support in order to secure success for a new program. This success arises from the fact that involving stakeholders creates the opportunity to use their valuable opinions to inform the implementation process at an early stage. Burby (2003) further reiterates that strong plans that result in positive outcomes usually arise out of planning and implementation processes that involve a broad array of key stakeholders. The implementation of the ECN and RCN programs could have been done better if a wider involvement and engagement with educators, regulatory agencies, policy makers and training institutions occurred prior to their full implementation. This would have created an early opportunity to avert challenges that came later on to affect these programs and their graduates.

Another lesson learnt pertains to the value of piloting new study programs before scaling them up for full implementation. Piloting a curriculum is generally undertaken to ensure it is effective, especially after implementers have had the opportunity to make changes before it is distributed or offered widely (UNESCO, 2012). The process of piloting also helps to identify sections which worked well and those that need strengthening (International Training and Education Center for Health, 2008). Piloting is key in that it creates the opportunity to evaluate the likelihood of a program's success including identification of its strengths and weaknesses, thus creating room for early and timely correction. Moreover, when new a curriculum is introduced without piloting, its legitimacy may be challenged, resulting in increased resistance by some stakeholders, thereby jeopardizing its implementation (Operti & Amadio, 2012). Hence by failing to pilot these programs, the Ministries of Education and Health failed to determine their feasibility and relevance as well as identifying possible impediments to their implementation, including failing to build consensus and support for the graduates (Lewy, 1990). The resistance experienced in the implementation of the ECN and RCN programs is consistent with the views of Operti and Amadio (2012) who argue that ignoring piloting often results in the loss of the opportunity to garner the support of key policy makers and educators.

The evaluation team further learnt that the need for supervisory and regulatory support and framework for nursing education cannot be underestimated. Professional regulatory bodies and frameworks exist to guard against training institutions producing graduates who do not have the required competences (Australian Nursing and Midwifery Council, ANMC, 2012). The study found that the Uganda Nurses and Midwives Council (UNMC), the regulatory body, which has hitherto overseen standards in nursing and midwifery education and practice was barred from this oversight role due to a change in the Uganda's legal framework. This absence of oversight from the professional and legal regulatory body resulted in some schools refusing to comply with the usually rigorous standard expected in nursing and midwifery training. Yet in recent times, the need for stronger regulation in health professional's education has been echoed by several organizations including the US Institute of Medicine (Kohn, Corrigan, & Donaldson, 1999; Greiner & Knebel, 2003). These reports and the present findings emphasise the importance of regulatory oversight of health professionals' education programs. As incidences of unsafe practice or unprofessional conduct by health professionals increase, there is need for regulatory councils and other related agencies to implement their mandate without restriction to ensure that standards for training safe and competent practitioners are met (Chisari, et al., 2006).

The evaluation team also found that proper preparation by responsible government agencies, to train and deploy new graduates is critical. The study found that the three line Ministries of Education, Health and Public Service had not done sufficient "ground work" to ensure seamless acceptance and introduction of these new cadre of nurses into the educational and healthcare system, including their deployment into primary health care out posts as initially planned. As Stilwell (2007) noted, to ensure successful introduction process, these government agencies should have created awareness among the program implementers as well as the health workforce regarding this upcoming cadre. Isles and Sutherland (2007) corroborate that awareness creation among existing staff is an important motivator for them to accept new comers into a workforce. Furthermore, Lewy (1990) explains that, part of the ground work requires involvement of implementers in the preliminary work of introducing a new curriculum to enlist their support and ownership. Stilwell (2007) concurs and declares that in addition to creating awareness, effective preparation by the Ministries of Education, Health and Public Service would have helped to ensure their performance is effectively managed through a well-established mechanism for supervision and mentorship, as well as clarifying issues related to their career progression such as career path, reporting systems and motivation as a strategy to ensure they are ready to practice and remain within the workforce (Caffrey & Frelick, 2006; Mathauer & Imhoff, 2006; Capacity Project, 2007). Another critical aspect of the groundwork would have been making considerations for how the ECNs and RCNs would be received and fit within Uganda's complex educational, social cultural, economic and health care environment to prevent resentment among existing workforce and the general public. In fact, Necochea (2006) agrees that successful introduction of a new cadre depends upon the responsible agencies ensuring that the attendant social cultural and economic dynamics and issues related to regulation of their practice and integration into the existing practice frameworks are addressed prior to their deployment. We found that because these steps were not adhered to judiciously, the new cadre are still being resisted by other healthcare professionals, perceiving them as threats. This resistance may have been exacerbated by the failure by implementers



to have clear job specifications, for these new cadre, resulting in many of them undertaking roles and responsibilities for which they have not been prepared, while others have deserted the workforce due to low morale, poor job satisfaction and lack of motivation among other reasons (Bancroft, 2006; Hagopian, Zuyderduin, Kyobutungi, & Yumkella, 2009; UNFPA, 2010).

## 5. Conclusions

Introducing a new cadre of health workforce is a serious undertaking that needs multifaceted and multisectoral approach. The shortcomings reported in this paper serve as an eye opener for other countries and institutions desiring to introduce new cadres into an existing workforce. The findings highlight an established fact that in program implementation, if proper planning is not done it may become a recipe for disaster sometimes spiralling into complex challenges that require a lot more resources to surmount than if better planning occurred at the onset. We conclude that in order to successfully introduce a new cadre of healthcare workforce into an existing system, four critical steps need to be adhered to namely, justifying to stakeholders the need for the new cadre; preparing relevant departments and ministries for their employment; training, recruiting and retaining them at appropriate positions and ensuring the new cadre fits within the socio-economic and regulatory framework of the country.

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