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Research Paper

Challenges faced by Health Unit Management Committees in rendering Health Services to Communities in East-central Uganda

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ABSTRACT: Like other countries, Uganda implements programs that help to enhance health services delivery in communities. One of the strategies to ensure this is by facilitating the construction of health centres and equipping them with adequate staff including doctors, nurses and Health Unit Management Committees (HUMCs), who are the basis for this study. However, it has been established that much as HUMCs monitor the general administration of the HCIII on behalf of the Local Council and the Ministry of Local Government, done within the policy and guidelines of Ministry of Health, the environment under which they work is characterized by a number of challenges which affect the effectiveness of HUMCs services. The study was largely qualitative and only interviews were used to obtain responses from HUMCs and a few administrators. Purposive sampling technique was largely used to select the sample size of 288 respondents who were predominantly HUMcs. The challenges are multiple. Results were analyzed qualitatively. Where necessary and to a small extent, verbatim forms were used to report the original voices of HUMCs. First, HUMCs do not participate in most of the meetings even those concerning events at health centres. This limits endeavors for transparency and accountability. In addition, rewards system at health centres rarely caters for the HUMCs who are tasked with the duty to monitor all activities. This reduces the morale of HUMCs to work hard because they do not feel part of the working team at HUMCs. Another great challenge was on the lack of proper coordination between HUMCs at health centres and district health teams (DHTs) which has resulted in the design of rewards systems not catering for HUMCs. Conclusively, a number of challenges including lack of adequate training, low participation in meetings and lack of seminars as well as workshops to intimate them with various tasks of their work characterized delivery of health services to communities by HUMCs. At the moment, the HUMCs are tasked to oversee many responsibilities but are rarely appreciated, salaries come late, and the chances to have a say in the vertical planning system are minimal. Therefore, the HUMCs are not as effective as expected due to the numerous challenges they face. The key recommendation was that members of HUMCs should be trained for at least 2 weeks by a group of well-drilled mentors and the training should be hands-on (mentorship). This will enable them to appreciate the role, tasks and challenges and participate in improving services. It is also recommended that MoH trains a pool of mentors at least 10 per district to be able to train all the members of HUMC in each district.

Keywords: Challenges, delivery of services health unit management committees, health centers

INTRODUCTION

According to the World Health Organization report (WHO, 2019), countries in the world are working hard to enhance the delivery of health services to communities. This is because Goal 3 of the Sustainable Development Goals (SDGs) calls for ensuring of healthy lives and promoting well-being for all at all ages. Dizon-Ross et al. (2016) noticed that in order to meet SDG3, countries have to come up with interventions to reduce Child Mortality, Maternal Mortality, and Human Immuno-Virus/Acquired Immuno-Deficiency Syndrome (HIV/AIDS), Tuberculosis and Malaria. Tanner (2018) established that unlike in countries like Uganda, Cameroon, Kenya, Libya, among others, where H the developed world is doing well in implementing SDG3 successfully given the fact that they have even resource distribution, gender equality is to an acceptable level and government systems are considerably favorable. By 2012, Mukasa et al. (2012) reported that the health system in Uganda is so much

worrying that Maternal Mortality Ratio (MMR) was estimated in 2006 at 435 maternal deaths per 100 000 live births, showing little progress towards the government's own goal of reducing maternal mortality from 500 to 300 between 2001 and 2008.

Anokbonggo et al. (2017) note that policy-makers have been seeking alternative ways to provide services that are responsive to communities; especially at the local level, thus opting to train HUMCs. The fact that health is a discipline that handles people's lives directly, deployment of Health Unit Management Committees (HUMCs) is always given maximum attention to ensure that that they are fully-fledged with ideas of how to manage communities especially when it comes to delivery of health services (Abor, 2015). The function of the committee is to monitor the general administration of the HCIII on behalf of the Local Council and the Ministry of Local Government (Ministry of Health, 2019).

However, due to different reasons which keep making updates here and there, HUMCs keep experiencing problems in delivering health services to communities. A study about functionality of HUMCs using a sample of 126 HUMCs in 18 Health Centres in Manafwa District identified a number of challenges facing HUMCs in rendering services. According to DSpace (2019), during planning HUMCs in Manafwa District neither conducts needs assessment, collect and commend work plans, nor makes regular follow-up for effective implementation of planned activities. Besides, HUMCs neither make monitoring and evaluation plans, evaluate planned activities nor give feedback of the two to community and health workers. Therefore, the objective of this study was to describe the challenges faced by HUMCs in rendering health services to communities.

METHODOLOGY

Research design

This study employed a mixed methods approach within a pre-post randomized community trial study design to explain how training of HUMCs triggers improved performance of health centres. The unit of analysis in the study was the members of HUMC, managers and clinical staff in relation to prerequisites for health centre performance improvement. Most importantly, the study was qualitative all through in that no use of tables was adopted anywhere in findings of the study.

Rational for pre-post community trial study design

The randomized community trial study methodology was considered suitable for addressing the study objectives and satisfactorily enabled achievement of the objectives. The study objectives sought to understand a social phenomenon "system reaction to training of members of HUMCs" at an organic entity (the health centre) that can be referred to as a social system. Health centre has a number of actors, a culture for interactions, rules and professionals and personal interpretation of experience. As such, when the health centre system was subjected to the training of its HUMC as a structural intervention, the experience and interpretation of the actors provided the basis for understanding the impact that training had on the performance of health centre as compared to a matched control whose members of HUMC were not trained. The strength of the community trial borrowing from the case-control study methodology was the depth of study it enabled for the phenomenon to be better understood. Machin's definition of community trial illustrates its appropriateness to this study. 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. Prominence (in pre-post experimental study) is given to understanding the actions of participants on the basis of their active experience of the world and the ways in which their actions arise from and reflect back on experience before and after the intervention.

Selection criteria for study health centres

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. The study covered health facilities at the level of sub-hospital and general hospital. The study questions in this research were indeed best addressed at hospital or sub-hospital-level (HC IV) as opposed to smaller health facilities. Hospitals represented higher costs of resource inputs (finance, personnel and technology) in the health system. The social benefits accruing from improved performance of hospitals was therefore considered to be of higher importance to policy of training HUMCs. 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 HUMC members in the intervention arm with limited skills and knowledge were subjected to intensive seminar type training for period of two weeks. Each health centre had a trainer from Ministry of Health of Uganda and one Research Assistant. After the initial two weeks training which ended with in the first month of intervention period,

then six HCs in the intervention arm were followed up with close mentorship and coaching sessions while the other six remained with knowledge gained at the seminar type training level, Follow up was done three months after the initial training in all twelve intervention sites 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.

Study area

The study was conducted in randomly sampled health facilities in the East Central Region of Uganda. Uganda is a low developed country in Africa. It is boardered by Kenya in the East, South Sudan in the North, Democratic Republic of Congo in the West, Rwanda and Tanzania in the south. Uganda is land locked country. The East-Central Region of Uganda shares borders with Kenya and Part of Southern Sudan and Northern Tanzania. The East Central Uganda is a composition of 16 districts (UBOS, 2016). It sits on an area of 15,242.8 square metres with a population of 9,042,422 people (UBOS, 2016). The people in the villages and towns have options between farming and producing food for consumption or doing some petty trading and or working in public offices. The proportion of the population in Uganda that lives within 5kms of a health facility is 78% up from 49% in 2000 and in Eastern Central Region of Uganda; it is 72% (MOH, 2012).

Study population

The study population included general hospitals (thus health centres at level of HC IV and HC V) in all the districts of East Central Uganda from which a sample was randomly drawn. The subjects of the study included sampled participants selected from the Members of HUMCs, Managers of District Health Services, Managers of Hospitals, Managers of Health Centres IVs (Sub Hospitals), and the Health Care Workers.

Inclusion criteria for participants

(i) Participants for the study included purposively sampled respondents from the District Health Teams, the District Administrators for the baseline in both the intervention and control arms.
(ii) Participant also included members of the HUMC and must have served for at least one year from the time of the study.
(iii) It also included sampled health workers and the managers in those selected health centres who were willing to participate.

Exclusion criteria for participants

(i) Member of the HUMC who had served for less than one year was excluded in the study.
(ii) Any member of HUMC in the region who did not belong to any of the selected health centre HUMC was excluded in the study.

Sampling procedure

Health centres that were selected for the study were those at the level of health centre IV and health centre V that carry out admission of patients. Therefore a sampling frame of 67 health centres was drawn from all health facilities in the East-Central Region of Uganda that offer in-patient services and were found to be at level of sub hospital/hospital. Selection of the 24 health centres to participate in the study was done after all the 67 hospitals in the sampling frame had been coded with three digit numerals beginning from 001. The selection was made using the random number to draw the first coded health centre and continuing until all 24 required health centres had been drawn. The coding followed alphabetical nomenclature taking into account the first letter for the name of the health centre. This excluded selection bias since the naming of these centres was done randomly and independently of each other. Hospitals coded with odd numbers were placed in intervention arm and those coded with even numbers were placed in the control arm of the study.

Sample size determination for the qualitative stream

Taking the study in phenomenological context, we considered each study site as being heterogonous because of their social cultural diversity. There were 12 intervention study sites and 12 control study sites. There were 288 respondents from HUMC that were interviewed, 64 KII respondents from DHT members (four members of DHMT from each of the 16 East Central Districts of Uganda) 72 KI respondents from hospital management (3 hospital leaders per from each of the 24 health centres) and 20 Community leaders (5 from each of the 4 randomly selected districts in the region). A ration of 1:1 was used in both control and intervention centres
Using the formula

$n= (1+1/C) P1 Q1 (Zά + Zß) 2 / (P1 – P0)^2$
$P1 = (P1 + CP0)/ (1 + C)$, but $Q1= 1- P1$
$P1 = P0 R/ [1 + P0 (R – 1)]$
$C= 1$ (the number of controls per case)
$P0 = 46.3\%$ (Carl May, 2006: A rational model for assessing and evaluating complex interventions in health care, UK).
$P1 = 79\%$ (Carl May, 2006: A rational model for assessing

and evaluating complex interventions in health care, UK)

By substituting the figures into the equation;

$n = 1 \times 1 \times 0.79 \times 0.21 (1.96 + 0.84)^2 / (0.79\text{-}0.463)^2 =$
$n = 1 \times 0.79 \times 0.21 \times 7.84 / 0.107 =$
$n = 1.300656 / 0.107 =$
$n = 12$

Therefore we used 12 intervention health centres and 12 control health centres for this study.

Study procedures

Screening procedure

(i) Members of the health Unit management Committee (HUMCs) were identified by the study team from the study health centres by either direct contact with them or review of performance indicators for the selected health facilities.
(ii) The research teams then notified the training team about the readiness to undertake a baseline to identify the specific capacity needs for each HUMC member.
(iii) The research assistant visited the HUMC member and screened them in their respective facilities for eligibility.

Enrolment procedure

(i) Consent for the HUMC to participate in the study was taken by Research Assistant (this was tested in during the end point evaluation).
(ii) In addition, eligible respondents were given their informed consent for the study.
(iii) Those that declined were exited and their data was not captured or included.
(iv) Once included, the HUMC members, the leaders and health care workers remained in the study until 6 Months of the intervention and participated in post intervention assessment

Follow-up procedure

(i) Participating HUMCs were followed up and their capacity was continuously built through mentorship, coaching support supervision and training sessions.
(ii) Once a health centre HUMC had chosen an intervention to improve a performance theme or areas, the Research team endeavored to check progress on the performance indicator during the intervention and at post intervention test.
(iii) The research team also conducted a formal end-of study assessment of the performance at the end of 6 months of the intervention within the health centre where the HUMC existed.

Construction of interview guides

Interview Guides were employed to get information from district managers Health centre manager and sampled leaders of health facilities and from all sampled members of HUMCs. The DHMTs and 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/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.

Training of research assistants

Research assistant were required to know details of the study in order to be confident especially in probing the respondents and filling answers in the questionnaires. The RAs received two weeks intensive training on the contents of the questionnaires and techniques for achieving scientific validity and trustworthiness of the data. They were drilled on how to establish a rapport with the respondents while maintaining the neutrality essential to obtaining the most accurate data possible. Specific topics covered included introduction to research, background and aims of the study, basic communication skills, how to introduce the work, informed consent, giving constructive feedback, data collection, mapping, expected problems and their solutions, how to complete the questionnaire and other basic field work information plus the required ethical considerations. The training was participatory, consisting of role-playing and practice sessions aimed at ensuring that the RAs fully understood their roles and ensured that they were able to complete the data collection tools without any difficulties. The researcher not only supervised the RAs throughout the research period but also carried out a substantial number of interviews as a quality control mechanism.

Pre-testing of research instruments

Tools were pre-tested in the nearby health centres in one of the district in East Central Region of Uganda which did

not have it facilities in the study sample (Luuka-District). From the health centres in the District of Luuka this was done to pretest the research instruments for both the intervention and control. The pretest sample size was predetermined by investigator to be 90 respondents detailed as follows: 18 HUMC members, member for the district health Teams (5), middle level managers were 22, health centre staff were 18, staff from non-government facilities were 6 and health centre administration staff 3. 4 hospitals were purposevely selected tobe able to pretest the tools and these were Kiyunga Health Centre IV, Bukova Health Centre III, Ikumbya HC IV and Bukanga HC III. The objective of this was to ensure that the questionnaires could bring out the exact information required by the researcher.

Protections of participants

In order to minimize access to sensitive information about the participants, the study materials had limited access on all study participants information. In the consent forms, it was ensured that only raw individual participants' data was captured using code numbers rather than direct identifiers. The study procedures restricted access to the raw individual participant's data. This reduced the overall sensitivity of the file. However, participants' files still contained indirect identifiers (e.g., age, sex, health centre, cadre of respondent) and other identifying characteristics that would be used to re-identify specific individuals if need arose.

Field editing of data

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.

Missing data

The RAs checked data carefully to make sure all respondents answered the questions; efforts were made to make sure that there was no missing data.
After each day of data collection, filled in questionnaires were collected, edited, and checked for completeness.

Data analysis

Data were analyzed 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.

Logistical and ethical considerations

The following ethical considerations were followed during this research; A letter introducing the researcher to subjects of the research was obtained from the Department of Health Services Management and Informatics of Kenyatta University. Permission was sought from the Managers of the districts and the managers of the respective Health Centres before commencing the research and before serving participants with any questionnaires. Informed consent was on all occasions obtained from the respondents and the study only proceeded with those that endorsed the consent form in the affirmative. All information collected was handled with utmost confidentiality using only codes mostly rather than names of individuals. Ethical approval was obtained from the Kenyatta University Ethics Review Committee (KUERC) before proceeding to Uganda for further clearances. After obtaining clearance from Nsambya Hospital IRB and the Uganda National Council for Science and Technology, the researcher then proceeded to data collection. Permission was first granted from the individual Health Facilities Research Ethics Committees before participants could be engaged into the study process.

RESULTS AND DISCUSSION

This section consists of the data analysis of findings expressed according to specific objectives and research questions. These results were purely qualitative hence no use of tables but description using verbatim for purposes of authenticity. The study was intended to describe and document the performance framework in the Uganda Health system as a whole but with more focus on health centres in East central Uganda. In this particular journal, the intentions to explore, and document challenge faced by HUMCs in delivering health services was given attention. The researcher deduced the results that the above multiple players in command each had an approach to ensure that there was achievement of the desired performance in their own realms of authority which could ultimately be acquired through good performance of the health centres at the lowest level of authority.

Rewards and sanctions for performance as stimuli

According to findings, each of the districts in East-Central Uganda has a rewards and sanctions committee that is

responsible for setting parameters 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. Unfortunately, besides complaining about unfair salary scales HUMCs receive, Abor (2015) stated that helath workers including HUMCs do not receive bonueses and as a result, lose morale for work and this explains increase in infant and maternal mortality rates. In this case, some HUMCs in some health centres work passed 5.00 pm the hour of departure even when they are into some other person's shift. However, their efforts are not compensated, which interferes with efficiency of delivering health services. In the words of one of the HUMC;

…to the extent that we do work which is not supposed to be our tasks. Sometimes, we end up making supervisory roles over nurses, other times we even move as far as to monitor what is going on in wards and this is done on regular bases. Management could include something like that but still there is this spirit of empathy…you feel someone who is admitted must be treated well….but surely no financial compensation from anywhere…

Besides, the objectives of HUMCs sets out in the frame work are not those ones used to rank districts in the national Performance League 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. 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. In the words of a HUMC;

…but again sometimes, we may not very much blame government or any other authority. Sometimes everything is dying from the district. Much as we would like to receive our shares, a lot of people also want their families to be well at the expense and loss of their friends. I wish there could be a bottom-up approach to planning rewards systems…

The lack of the parameter for rewarding performance has led to a challenge of the unpredictability of resources to support occurrences that would follow decisions whether to sanction or reward performance. If it requires suspension of an 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 reward and setting criteria to reward or sanction and this could account for performance improvements in those health centres. In relation to this, Acker (2013) noticed that many occupations and all professions offer their recruits the opportunity of pursuing a career, in the sense that individuals receive promotion through a clearly delineated promotions hierarchy. This is done as a way of rewarding workers. Unfortunately, HUMCs do not have such benefits; rather, there is a whole lot of regrets being pronounced in most of the health centres. Work-based bonuses are one of the extrinsic rewards that explain the morale of health workers to provide effective services as per the work place. In the works of Williams (2011), work places where employees receive bonuses in terms of extra finances for excelling or for working overtime register excellence in service delivery.

The District Health Team (DHT) and Health Centre Meetings

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, we 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. This was not pleasing to the members of HUMCs so that one of the HUMCs stated;

…actually I am also confused when it comes to the issue of meetings. At first, I thought we would either be the people to organize the meetings or even be a center of

this meetings since we have a lot to explain regarding many of the operations at the health centres, that is what happens, sometimes we even get to know about the meeting when it is a day after it took place.

Basing on the above quotation, the lack of participation by HUMCs in meetings makes them feel isolated and meaningless at health centres. The core values of motivation are to make someone feel part of the organization and if HUMCs are not called to participate in the meetings, they do not render services as effectively as expected. This is one of the challenges faced by HUMCs in

Inadequate number of health teams

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. Some of the complaints from HUMCs about the state of environment under which they work are;

…can you imagine apart from having to receive low salaries from the sweat we exhibit, the nature of environment under which we operate is not conducive enough to render services from…we really..

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).

Degree of perception on governance

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. Individuals/bodies from outside the health centres that were also discovered to be driving the performance of health centres in the study area included the district political and technical leaders, the Ministry of Health, the Ministry of Finance, the Ministry of Security, the Ministry of Education amongst others and several Non-Government Organization that were partnering with government in the implementation of their programmes sometimes performance enhancement of the health centres being accrued as a side effect. The information on performance of health centres and the driving influences was obtained from the following data collection activities:

(i) Review of available reports and other vital documents.
(ii) Observing participants during DHMT, TPC and HUMC meetings discussing performance of health centres.

In-depth interviews with stakeholders responsible for management and running of the health sector that included the District Health Officer (DHO) and District Health Team (DHT), and members of the Health Centre Management Team (HCMT). Private clinics and hospitals in urban areas have grown rapidly over the last decade. The supply of health professionals remains seriously below the required number, although the government has increased the number of training places. 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 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.

Other challenges

Whereas Uganda delivers services in a decentralized framework, most health interventions, though often successful, are vertical in nature, and rarely get integrated into District Health Systems letting alone their success being hard to sustain. Health Interventions remain stand-alone, vertically planned and executed, with the district leadership being passive recipients of external support. The functional involvement and participation of district level leadership (including HUMCs) in assimilating the above vertical support into existing and on-going programmes for sustainability of immunization outcomes is not documented. Despite a marked improvement in service delivery indicators, East-Central Uganda still has leadership gaps, and the current vertical implementation framework poses a risk of failing to fully integrate and make the improvements sustainable. The United Nation's International Children's emergency fund (UNICEF),

through the Community and District Empowerment for Scale (CODES) project, has been supporting the scaling up of childhood interventions, including immunization, thus explaining a wide coverage.

A study by Jennifer et al. (2014) shows that the key issue of concern in this project is the limited engagement of district political and other leaders outside the health team, and community leaders. We hypothesize that using different leadership engagement strategies including making use of HUMCs could lead to integration and sustainability of immunization programs. However, at the moment, the various leadership approaches applied to rectify these gaps have not been documented and obstacles to full integration of HUMCs views into other vertical programmes have also not yet been determined in these settings. Given the fact that most vertically implemented programs have many influential external actors, are heavily funded thus, have adequate logistics during implementation, they often times have success but when their support ends, it is difficult to sustain results. This seriously affects HUMCs because in the first place, they are not heavily involved in decision making.

Conclusion

Much as the government saw a need to introduce and train HUMCs at health centres, the benefits still remain almost unseen. This is because of a number of challenges including lack of adequate training, low participation in meetings and lack of seminars as well as workshops to intimate them with various tasks of their work. At the moment, the HUMCs are tasked to oversee many responsibilities but are rarely appreciated, salaries come late, and the chances to have a say in the vertical planning system are minimal. Therefore, the HUMCs are not as effective as expected due to numerous challenges they face.

Recommendations

The study recommends that all the members of HUMCs should be trained for at least 2 weeks by a group of well drilled mentors and the training should be hands-on (mentorship). This will enable them to appreciate the role, tasks and challenges and participate in improving services. The study therefore recommends that MoH trains a pool of mentors at least 10 per district to be able to train all the members of HUMC in each district. This study applied data from hospital and sub-hospitals but did not capture data from lower level HCs and from bigger regional referral hospitals and national referrals. Therefore, the study did not take into consideration issues such as size of HC/hospital and regulatory requirements. Therefore the study recommends that further research should be conducted with a view of performing inter-HC comparison across various market segments.

Declaration

I declare that the content and structure of this journal is my original work. It is a qualitative study intended to describe the challenges facing Health Unit Management Committees. I also declare that no part of the work is offensive since any document from literature sources was clearly referenced both in-text and in references.

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