Health workers' experiences of professional regulation on the 'frontline' of service delivery in Ugandan hospitals

Gerry McGivern, Catherine Nakidde, Frank Wafula, Anita Musiega, Dosila Ogira, Tina Kiefer, Mike Gill Mike English, and Gloria Seruwagi

Introduction

How do health workers perceive, experience, and respond to regulation in health systems in Low- and Middle-Income Countries (LMICs)? This chapter describes experiences of professional regulation among doctors and nurses/midwives in Ugandan hospitals. The chapter takes a 'frontline' [1-4] perspective, examining how these health professionals interpret, engage with, and are affected by regulation in the settings where they work.

Professional regulation refers to a system of rules, standards and oversight mechanisms governing professional practices. These are typically established by governmental bodies and professional associations to ensure professionals practise ethically, safely, competently, and thereby to protect both professional legitimacy and the public. Professional regulation usually encompasses several elements; mechanisms for registering and licencing professionals to ensure they have the education and training they need and engage in continuing professional development; ethical codes and practice standards guiding conduct; processes for monitoring and evaluating ethics and practice standards; and procedures for investigating and disciplining unprofessional behaviour [5].

However, regulation may fail in health systems due to poor 'contextual fit' between how regulation is designed and written 'on paper' and the lived circumstances in which it is enacted [6]. Indeed, alongside regulatory standards and rules, other professional, moral and practical norms [7, 8], and local relationships [3, 9] influence health workers' practices and behaviours. Therefore understanding health workers' lived experiences of regulation on the 'frontline' of service delivery in health care facilities can elucidate influences supporting or undermining regulatory goals and implementation, and hence help develop more effective regulation in practice. This is particularly important in LMIC health systems, where research [1, 2, 10-13] shows regulation is often weakly implemented and enacted.

Analysing qualitative data from interviews with doctors and nurses/midwives in two Ugandan districts and focus groups involving a wider group of doctors and nurses, we describe general experiences of remote and weak regulation having little impact on frontline clinical practice. However, in one district nurses were far more positive about professional regulation. Here there was a regional nursing regulation coordinating centre, run by the head nurse in a regional referral

hospital. Our findings show that while regulation, per se, may have little impact on health workers' practices, local regulatory offices and leaders can enact regulatory processes in way that improve compliance and the quality of health workers' practice and professionalism.

Research context

Uganda is a low income East African country, with a resource-constrained health system, in which poor general regulation has historically compromised health care quality [14]. In 2021, Uganda had 7,742 medical and dental practitioners but only 4,417 renewed their annual medical licenses[1], and 81,435 registered nurses and midwives, of whom just 52,335 nurses have active practice licenses[2]. This equates to 1.238 nurses per 1000 population (2018 figures)[3].

Doctors are regulated by the Uganda Medical and Dental Practitioners Council (UMDPC) and nurses/midwives by the Uganda Nurses and Midwifes Council (UNMC), which are statutory governmental bodies respectively responsible for oversight of practice and training for medicine and nursing/midwifery. Professional associations, including the Uganda Medical Association and Uganda Nurses and Midwives Union, work with these regulators to develop standards that professional regulation is based on. Doctors should renew their medical licences annually by providing a copy of a previous medical licence, registration certification or certificate of good standard from a regulator in another country, evidence of continuing professional development, and paying a licencing fee. Nurses/midwives renew nursing licences every three year by providing a copy of a previous nursing licence, certificates demonstrating appropriate education and training, and paying a licence fee.

Research methods

This chapter draws upon qualitative data from a wider study of health professional regulation in Kenya and Uganda [15, 16]. In 2020, we interviewed 27 health workers in hospitals in two Ugandan districts, and two further doctors respectively working for a national military hospital and an international non-governmental organization (NGO) in Uganda. We asked semi-structured interview questions about views and experiences of professional regulation.

We purposefully sampled doctors and nurses/midwives in two Ugandan districts (See Table 1) to explore variations and generalisability in experiences of health care regulation. Medicine and nursing represent two main professions working in Ugandan district hospitals. One district was rural and remote, in which there was a district hospital. The other district was more central, urban and in

[1] https://umdpc.com/Resources/Brochures/Brochure%202021.pdf
[2] https://unmc.ug
[3] https://data.worldbank.org/indicator/SH.MED.NUMW.P3?locations=UG-KE

which there was a regional referral hospital. Thus, the overall case study contained professional and geographical sub-cases, which we compare.

We also draw upon data collected in 2021 during two online/in-person focus groups containing separate groups of 9 Ugandan nurses/midwives and 12 Ugandan doctors, including doctors and nurses representing professional associations and unions. We presented our research findings from Ugandan districts to these focus groups to validate whether they reflected doctors' and nurses/midwives' general experiences and discuss ideas for regulatory improvement. Focus group discussions elicited further data describing participants' views and experiences of professional regulation. Interviews and focus groups were digitally recorded and transcribed verbatim and data thematically coded [17] comparing themes by professions and districts.

Table 1: Research participants

Profession	**Remote District interviews**	**Central District interviews**	**National interviews**	**Focus groups**	**Total**
Doctors	4	3	2	12	21
Nurses/midwives	12	8		9	29
Total	**16**	**11**	**2**	**21**	**50**

Findings

General experiences of professional regulation

Ugandan health regulators have a large regulatory responsibility but limited staff and resources. They therefore focused on ensuring health workers paid licence fees, held valid licences, and were listed on professional registers, rather than regulating health workers' practice, as Senior Doctor 3 (Military hospital) noted:

"Regulators simply collect revenue… the only time you interface with the registration body is when they need the fee… If a patient complains of malpractice, nobody is interested… Regulatory bodies are not functional, they are not looking at professionalism or quality of service."

Interviewees also complained about the time it took for the UNMC to register *"nurses who finished their internship two years back but don't have the licences yet."* (Graduate nurse intern 24, Central District). During this time, nurses were unable to work, earn money or gain clinical experience, and even forgot what they had learned at nursing school, as Nurse 14 (Remote District) described: *"Seated [waiting] for two years… A person who relaxes for a long time tends to forget things."*

Ugandan doctors and nurses then had little contact with regulators in day-to-day practice. Nurse 2b (Remote District) commented: *"Since I started working here, I have never seen [UNMC] in more than ten years."* Likewise, a doctor (focus group discussion) commented: *"Leaving medical school, I was required to pay my provisional licence fees at the UMDPC… I've never heard from them again."*

Lack of engagement between professionals and regulators is problematic; it undermines professionals' perceptions of regulatory legitimacy and means regulators are unaware of the challenges health workers face: *"Councils never get time to come and visit "up-country", the challenges we are getting as health workers, they are not aware."* (Medical Director 7, Remote District); *"We're here suffering… professionalism is dying because those guys [UNMC] are not coming out of their offices."* (Nurse 2c, Remote District). Health workers also consequently lacked understanding of what regulation meant and how it could enhance clinical practice: *"We don't have any guidance… We need to see [regulators] helping [health care] facilities. Let them come down to this earth."* (Nurse 2a, Remote District)

"My personal experience is of cracked engagement on the part of health workers because the opportunities to interface with [regulators] are not usually frequent, especially for us who are upcountry… we remain highly out of the picture. We haven't had any direct engagement [with regulators]… Health workers don't see how they are relevant… What does it mean to be regulated by these people?" (Senior Doctor 4, Central District)

Thus, Ugandan doctors and nurses suggested regulation had little impact on professional practice, which depended more on health workers' professionalism inculcated during medical and nursing school, as Senior Doctor 3 (Military hospital) described:

"No regulatory body, nobody monitors. There is no consequence for doing wrong. Most of us [doctors] are driven by the oath and medical training that tends to train you to care, look after patients, and do the right thing. But even if you don't do the right thing, the consequences are not there… that engrains that feeling among health workers that nothing will happen to them even if [patients] complain."

Similarly, Nurse 11 (Remote District) commented: *"Regulations governing the public hospitals… are not enough… People are not doing what they are supposed to do… We nurses lose our manners when we are in practice… [In] nursing school [tutors] are very strict… but after qualifying, I think [nurses] lack follow up."* Interviews described cases of minor malpractice, including *"absenteeism or late coming"* (Medical Director 7, Remote District) and treating patients poorly being addressed by senior health workers or hospital 'disciplinary committee' meetings. More serious malpractice, like *"extorting money"* (Senior Doctor 25, Central District) from patients, was reported to senior hospital

managers. Thus, malpractice was usually addressed at local level and rarely by regulators, as Nurse 9 (Principal Nursing Officer, Remote District) noted: *"In case someone misbehaves, we have a disciplinary committee, it sits whenever there is a problem. We also talk to them… about what is right… We also refer to higher powers, if necessary, but most of the time we just handle it."*

Similarly, Nurse 20 (Assistant DHO, Central District) commented: *"We had people with fake certificates in the district… The DHO [District Health Officer] went to the Nursing Council, who didn't help us in any way, they left the district to deal with it… Ideally, that was the work of the [Nursing] Council… I wonder what they [UNMC] do. To me, they're not so helpful."*

However, Doctor 26 (NGO) suggested that sometimes hospitals handled professional malpractice and negligence internally to avoid bringing negative attention: *"Facilities don't want to be in the limelight for that negligence, so usually find a way of dealing with it internally."* Similarly, Doctor 3 (Military hospital), suggested that health workers often protected one another, even where malpractice had occurred: *"Your own fraternity will defend you because of the image of the profession… nobody is held accountable… we are locked into protecting each other even when wrong has been done."*

Yet many interviewees indicated a desire to interface with and be guided by professional regulators. For example, Doctor 10 (Remote District) contrasted their experience of their professional regulator [UMDPC) with the Health Monitoring Unit, a national regulator responsible for monitoring health care and investigating malpractice, which had visited the district where the doctor worked:

"[Health Monitoring Unit] are doing a good job, at least they come… monitor… you feel they have guided… They are rough … [but] they are helpful. If you compare it with the Medical Council [UMDPC], at least we have interfaced with them at work. But for the other one [UMDPC], no."
(Doctor 10, Remote District)

Similarly, Doctor 15 (Remote District) commented that being regulated by an effective regulator led health workers to be 'more careful': *"Health workers… know in case of any neglect it can backfire and get repercussions; it has actually helped to maintain health in Uganda… [Health Monitoring Unit] have done more good; at least health workers are more careful about their work."*

Overall, however, Ugandan doctors and nurses/midwives generally described weak professional regulation having little impact on health workers in Ugandan hospitals.

Registering and renewing clinical licences

Historically, registering, and renewing nursing and medical licences involved travelling to Uganda's capital city, Kampala, where the main regulatory offices are based. For health workers, particularly

those “up country”, far from Kampala, this involved taking time off work and travel and accommodation expenses, as Medical Director 7 (Remote District) described: *“Regulators are not easily accessible to the health workers… Being in Kampala, that distance is cumbersome and leaving “up country” to Kampala to have your practicing license renewed, it is not simple… it means you are giving that person time off [work] for two days.”*

However, Ugandan regulatory councils have now introduced online relicensing to address this problem. In 2020, when we conducted interviews, online licencing was newly established for doctors and being developed for nurses (started in 2023). Online licencing was seen as a significant improvement. Doctor 10 (Remote District) commented: *“Now that we register online it doesn’t even take ten minutes, scan, send mobile money, and you download the [licence] hard copy … [Relicensing] used to involve transport.”*

In summary, Ugandan health workers historically found registering and renewing their licences difficult. However, the introduction of online licencing is addressing this problem.

Positive experiences of local nursing regulation

While Ugandan doctors and nurses were generally negative about professional regulation, in the central district nurses were more positive. Here, a UNMC ‘Coordination Centre’ had been established, which integrated the regulation and management of nurses in the district and wider region. The Centre was based in a regional referral hospital and run by the hospital’s head nurse (Assistant Commissioner, Nursing; ACN), who combined responsibilities for hospital management and the regulation of local nurses in a single role. The ACN had significant nursing and administration experience and a master’s degree in public administration, so was knowledgeable about nursing, regulation, and management.

Nurses in Central District described the Coordination Centre having improved regulation in several ways. First, it enabled renewal of licences locally. Head Nurse 5 (Central District) noted: “*instead of nurses and midwives moving to Kampala to the centre, they bring their documents here, and then I take them to… the Council to renew their licenses.*” This resolved nurses’ difficulties renewing their licences. As Nurse in Charge 22 (Central District) noted: *“Once registration was brought to this hospital, there’s now no problem.”*

Second, the regulation coordinator, and district hospital nurse managers working under them, actively supervised, mentored, counselled, and trained local nurses to follow regulatory codes of conduct, ethics, and professionalism. Head Nurse 5 (Central District) noted they: *“Supervise and*

mentor, or even remind them [nurses] about professionalism, because others [nurses] will look at it [nursing] as just getting a salary… they've not really embraced professionalism."

Third, since the Coordination Centre had been established, Central District was better connected to UNMC: "*Lately they [UNMC] are coming so frequently; this year they came twice. They just talk to us; they gather all the nurses… tell them what they do as our regulatory body."* (Nurse In Charge 6, Central District). Thus, through more frequent interactions with regulators, nurses in the central district enhanced their understanding of how and why they should comply with regulations. Connection between UNMC and the local regulation coordinator also helped address local problems: *"Here the ACN is connected to the [Nursing] Council… So, the ACN can forward [problems] to [UNMC], then [UNMC] come to the ground… come up with solutions."* (Nurse In Charge 22, Central District)

Finally, by integrating professional regulation and district hospital management, with local regulatory leadership, nurses were more mindful and likely to comply with rules and regulation: *"I really don't have a lot of information about [UNMC], but we have the ACN who is in charge of all the nurses. So, anything goes wrong, you go to ACN… [Nurses don't comply with regulations when] leaders are not there, that's human nature, but having such leaders in place helps to ensure they have complied."* (Graduate Nurse Intern 24, Central District)

Concluding discussion

Returning to the chapter's original question, how does regulation affect health workers on the 'frontline' in LMICs? Wider research literature suggests that regulation is often weakly implemented and enforced in LMIC health systems, with relatively little impact on health workers' practice [1, 2, 10-13]. Similarly Ugandan doctors in both districts, and nurses in one district, generally saw regulators as remote, unaware of problems affecting health workers, and focused on collecting licencing fees rather than regulating professionalism, quality, and preventing malpractice.

Nurses also described cumbersome and time-consuming registration and relicensing process, historically involving travel to the Ugandan capital. However, licensing and registering qualified health workers is necessary to maintain the standards of professional practice and the introduction of online licencing in Uganda (https://www.ehealthlicense.go.ug) was seen positively and should address this problem.

Our data suggest that where poor professional practice is addressed, it is usually by health workers and managers. Hence, professionalism, inculcated during clinical training, has significant bearing on

health workers' practices and behaviours. Yet our wider study [15, 16], and other research [12], also raise questions about whether and how professionalism and ethics are being adequately taught to new health workers in LMICs.

Nevertheless, the example of the Coordinating Centre for nursing regulation in Central District shows that local regulatory offices and leadership can improve regulation. Here, nurse relicensing functioned well, nurses were supervised and mentored to maintain professionalism, and problems were reported to and addressed by the nursing regulator. Other research [8, 18, 19] similarly highlights the importance of local clinical leadership in implementing governmental policies in ways improving practice. Elsewhere, the Ugandan Allied Health Professionals Council have established ten regional regulatory offices (https://www.ahpc.ug/region.php), which our interviewees reported were working well. So, while the general view of professional regulation in Uganda is gloomy, there are brighter examples that we can learn lessons from.

However, developing regional regulatory offices and leadership requires resources, which are scarce in the constrained Uganda health system. Yet regional regulatory offices could be based in existing health care facilities, so not costly, and our research suggests that investing in local regulatory offices and leadership may significantly improve the quality of health workers' practice.

Our study has limitations that provide opportunities for further research. We examined professional regulation for just two professional groups in one country (Uganda, and Kenya in our wider study [15, 16]). More research on experiences of regulation on the frontline of health service delivery is therefore needed in other LMICs and for other health professional groups. Moreover, researching other cases where regulation potentially works well, like the regional nursing regulation office in our case, or potentially regulation of Ugandan allied health professionals, would be valuable, providing learning beneficial to other regulators.

To conclude, our research highlights several key opportunities to improve health professional regulation and practice in Uganda and other similar resource constrained LMICs:

1. Introducing online professional licensing to significantly reduce the administrative burden involved for regulators and regulated professionals. Online professional training and webinars might also be useful to support health workers' continuing professional development, particularly where travelling for in-person training is difficult.
2. Developing local regulatory offices and leadership to increase regulators' awareness of and ability to address problems affecting professionals in health care facilities and enhance local professionals' understanding of regulation.

3. Enhancing and ensuring training in professionalism and ethics during health workers' pre-service education and training to increase support professional and ethical clinical practice.
4. Finally, enhancing relations between professional regulators and associations, so that both encourage professionalism, self-regulation, and ethics in complementary ways. More research is needed to explore whether and how this might happen.

References

1. Akhtar, A., *Health care regulation in low & middle-income countries: a review of the literature*. Health policy & health finance knowledge hub working paper, 2011. **14**.
2. Wafula, F., et al., *Protecting the public or setting the bar too high? Understanding the causes & consequences of regulatory actions of front-line regulators & specialized drug shop operators in Kenya*. Social Science & Medicine, 2013. **97**: p. 220-27.
3. Nxumalo, N., et al., *Accountability mechanisms and the value of relationships: experiences of front-line managers at subnational level in Kenya and South Africa*. BMJ global health, 2018. **3**(4): p. .e000842.
4. McGivern, G. and M.D. Fischer, *Reactivity and reactions to regulatory transparency in medicine, psychotherapy and counselling*. Social Science & Medicine, 2012. **74**(3): p. 286-296.
5. McGivern, G., et al., *Exploring and Explaining the Dynamics of Osteopathic Regulation, Professionalism and Compliance with Standards in Practice: Report for the General Osteopathic Council*. 2015, Warwick Business School.
6. Soderlund, N. and V. Tangcharoensathien, *Health sector regulation— understanding the range of responses from government*. Health Policy and Planning, 2000. **15**: p. 347–8.
7. De Herdt, T. and J. Oliver de Sardan, *Real Governance and Practical Norms in Sub-Saharan Africa: The game of the rules*. 2015, Routledge: Abingdon.
8. Nzinga, J., G. McGivern, and M. English, *Hybrid clinical-managers in Kenyan hospitals: Navigating between professional, official and practical norms*. Journal of Health Organization & Management, 2019. **33**(2): p. 173-187.
9. Cleary, S., C. Molyneux, and L. Gilson, *Resources, attitudes and culture: an understanding of the factors that influence the functioning of accountability mechanisms in primary health care settings*. BMC Health Services Research, 2013. **13**(320).
10. Dejene, D., T. Yigzaw, and S. Mengistu, *Exploring health workforce regulation practices and gaps in Ethiopia: a national cross-sectional study*. Glob Health Res Policy, 2019. **4**(36).
11. Clarke, D., et al., *Strengthening health professions regulation in Cambodia: a rapid assessment*. Human resources for health, 2016. **14**(1): p. 1-9.
12. Keshri, V.R., V. Sriram, and R. Baru, *Reforming the regulation of medical education, professionals and practice in India*. BMJ Global Health, 2020.
13. Mayra, K., S. Padmadas, and Z. Matthews, *Challenges and needed reforms in midwifery and nursing regulatory systems in India: Implications for education and practice*. PLoS ONE, 2021. **16**(5): p. e0251331.

14. WHO, *Primary Health Care Systems (PRIMSYS): Case study from Uganda*. 2017, World Health Organization: Geneva.
15. McGivern, G., et al., *Strengthening Health Professional Regulation in Kenya and Uganda: Research Findings Policy Brief*. 2021.
16. McGivern, G., et al., *Deconcentrating regulation in low- and middle-income country health systems: A proposed ambidextrous solution to problems with professional regulation for doctors and nurses in Kenya and Uganda*. Human Resource for Health, 2024. **Forthcoming**.
17. Braun, V. and V. Clark, *Using thematic analysis in psychology*. Qualitative Research in Psychology, 2006. **3**(2): p. 77-101.
18. Nzinga, J., G. McGivern, and E. English, *Examining clinical leadership in Kenyan public hospitals through the distributed leadership lens*. Health Policy and Planning, 2018. **33**(Supply 2): p. ii27-34.
19. McGivern, G., J. Nzinga, and M. English, *Pastoral practices' for quality improvement in a Kenyan clinical network*. Social Science & Medicine, 2017. **195**: p. 115-122.