Building Management Capacity to Rapidly Scale up
Health Services and Health Outcomes

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Executive Summary

Many approaches and tools to develop management capacities have been attempted. Approaches based on 'problem-solving' and/or incentive-based performance principles are becoming more and more popular. However, little is known about the effectiveness and sustainability of these approaches. More significantly, even less is known on how to expand and sustain capacity building approaches throughout the health system. As many countries are undergoing major reforms and are currently faced with multiple initiatives, the question is: what are the best ways for building and sustaining the necessary management capacities to rapidly scale up health services and health outcomes at district and facility levels?

This paper has reviewed selected country experiences that represent the most effective approaches to management development in decentralized health services of developing countries. These experiences confirm that action learning is the most effective learning approach to develop individual and team competencies in management in the workplace. Action Learning is a combination of formal training sessions with on-the-job problem solving. However, country experience also confirms that management training cannot be separated from the work and activities being managed; that the different elements of management (such as human resources, finance or information) are best developed together and, that the organizational context has to be taken into account in management training. For this reason a systems approach to management development can address the multidimensional nature of the change process initiated by action learning in the workplace. In this regard leadership and management training must be considered jointly as essential elements of any effort to develop management capacity at all levels of the health system. A country project in Tanzania demonstrated that this approach to developing management capacity of District Health Teams, when linked to evidence based district health planning results in improvements of health outcomes.

Country experiences report that the real challenge in management development is sustaining and replicating successful approaches beyond the project level. Experiences point to the lack of leadership and capacity of the central level to scale up and manage the change process in the institution. This paper argues that beyond these points there is a systemic problem that needs to be explored. It raises the question: Why does the central level of the health system consistently invite donors (regardless of change in leadership) to explore, initiate or otherwise experiment with different approaches in selected areas and at the same time devotes energy to maintaining and ensuring the status quo in the system? The slow implementation of decentralization policies is another example. There is a need to understand this paradoxical behaviour, possibly by starting to identify with governments the implicit assumptions that dictate the central task of the ministry of health and govern the dynamics and behaviour of the system at the central level.

Ownership by national health authorities of any effort to develop managerial capacity in the health system is a key to success. The choice for decision makers and donors is whether to continue attempting to fix the system or whether to engage in transforming it
so that it begins to respond to the local needs of the people it serves. A successful transformation of the health system can be measured by the extent to which the system has developed the capacity to scale up an action learning response to local health needs.

Based on country experiences, this paper concludes that the best ways for building and sustaining the necessary management capacities to rapidly scale up health services and health outcomes at district and facility levels, is to institutionalize management and the capacity for management development in the health system. A ten point action plan is proposed.

1. Background

In many cases, countries that are trying to achieve the largest expansion in access to care are also the countries where current facility and district management practices are weakest. Examples abound of equipment failures, drug stock outs, fragmented and unreliable information systems, unmotivated staff.

Many approaches and tools to develop management capacities have been attempted. Efforts by WHO tend to concentrate on clinical and programme management, versus generic skills and resource management across services. Approaches based on 'problem-solving' and/or incentive-based performance principles are becoming more and more popular. However, little is known about the effectiveness and sustainability of these approaches. More significantly, even less is known on how to expand and sustain capacity building approaches throughout the health system.

As many countries are undergoing major reforms and are currently faced with multiple initiatives, the question is: what are the best ways for building and sustaining the necessary management capacities to rapidly scale up health services and health outcomes at district and facility levels?

On one side, most developing countries are in a process of decentralizing their health system with some degree of changing authority to the district/local level, particularly with regard to priority setting, resource allocation and other key decisions. This calls for a better integration (horizontal approach) of a number of functions, such as planning of services and interventions, management of resources, including HRH, monitoring and evaluation, and hence improved management capacity. Decentralization requires improved management capacities across services, including public and private health providers.

At the same time, many developing countries with the highest burden of diseases like HIV-AIDS, TB, malaria and high maternal and child mortality, etc. are faced with a rapidly growing number of global initiatives which have a tendency of being centralized and work through parallel channels (outside of the other health services) in order to achieve quicker results.
Purpose and scope of the paper:

The overall purpose of the paper is primarily to provide analysis of country experiences, drawing lessons from these experiences to help WHO to develop an effective approach to management development at district and facility levels. More specifically the paper will focus on:

- lower income and developing countries with a minimum of macro-economic stability
- management development across services, versus clinical or programme management
- approaches to effective and sustainable management rather than content
- district and facility levels

2. Health Management and its policy determinants

Management is a social discipline that deals with the behaviour of people and human institutions. (Adapted from Drucker Management in the 21st Century.) The management of any institution or organization is determined by the policies, structures, processes and cultural values in which it is practiced and adapted to the context in which it seeks to achieve results. The single most important purpose of management is to make effective and efficient use of institutional and organizational resources to achieve results outside the organization. More precisely in the health sector, results relate to and are measured in terms of health of populations. Management and managers must therefore be externally focused while all other internal managerial processes and structures are means to fulfil this purpose.

It is with this understanding of the purpose of management that this paper focuses on identifying management development approaches adopted by countries that have demonstrated a contribution to improving health outcomes of health service organizations at district and facility levels.

Currently, national health systems are engaged on two fronts simultaneously in what some describe as an ambitious attempt to improve the health status of the population with specific targets i.e. HIV/AIDS, malaria and TB, while at the same time, improving the efficiency of the institutions and organizations that provide the services. Health policies driving these changes determine the role and purpose of management in the health system.

The Health Sector Reform movement initiated in the late 1980’s and early 1990’s gave impetus to the development and implementation of national health reform programmes. These programmes have highlighted the need to improve efficiency, access and quality of care as a means to achieve better results or health outcomes. In principle this would imply a shift in organization and management of the health system. From one which is
centralized, hierarchically structured and supply oriented institution and where management is rule driven. To one which is decentralized, where power is shared and management is driven by the need to acquire information and knowledge while being accountable for results. In practice however, the reform process has been slow and the results difficult to assess.²

**Health Sector Reform**
Support for reform has been most successful where project strategy, entry points and methods used have been informed by a thorough appraisal of the situation on the ground, rather than by preconceived ideas about the effectiveness of different forms of intervention. 2 Cassels A. Watson J, 2001.

During the decade of the 90’s important shifts in global health policy directions set the stage for establishing the Millennium Development Goals (MDGs) which in turn gave new urgency for implementing national health sector reform programmes and further elaborating the dimensions of health management in service provision. In 1993 the World Bank Report on Investing in Health proposed a new approach to measurement of the burden of disease and identified packages of effective interventions which provided an economically affordable set of solutions to address the priority public health problems in developing countries. In 2001, WHO’s Commission on Macroeconomics and Health asserted that health was a critical investment for economic development and that there was an urgent need to adopt a “bottom up” approach to scale up affordable and effective health interventions. The term “scaling up” is used variously to indicate:
- advancing a successful pilot project from local to national application
- maximizing the capacity of service provision within the current level of physical access
- extending physical access of services to achieve complete coverage of the population
- increasing financial protection so that more people can afford to use available services
- broadening the range of services to a more comprehensive package³

The notion of scaling up effective interventions was incorporated in the MDGs strategies as a means to achieve specific health targets such as reduction of HIV/AIDS, TB and malaria and child mortality, thereby contributing to significant reductions in poverty and priority health problems by 2015.

There is a growing consensus that attainment of these goals by countries has been constrained by services that are too fragile and fragmented to deliver the quality and volume of services to those in need. A high level forum on achieving the MDGs
identified major shortfalls in the workforce, lack of donor coordination, and weak information systems as critical challenges. 

Concurrently, UNDP identified the need to develop capacities at local levels that could improve implementation and move beyond the questions of efficiency and resource generation that are being addressed by the reform programmes. The term capacity is defined as the ability to perform functions, solve problems, and set and achieve objectives. It is in this overall context that health authorities have over the past 10-15 years, have attempted in various degrees to implement the process of decentralization or transfer of power to local or provincial and district levels. As part of the health sector reform programme, decentralization aims to allow more autonomy at the local level on decisions regarding management of the health systems, with the expectation of increasing thus the efficiency, equity and community participation in the health service delivery process. However, the actual achievement of the proposed objectives of decentralization has proved to be elusive and there is no evidence that decentralization contributes to improved health services or health outcomes.

3. What is Needed

Management with a strong leadership role

The implementation of these health and health systems policies, in resource poor and changing health context, calls for both leadership and managerial competencies at all levels and particularly at the decentralized level of the health system. Leadership is an important managerial role with complementary competencies vital to the achievement of organizational results. Leadership training is considered part of management development. The role of a leader is to guide, facilitate and enable others to take action. This is an important role for all managers. Leadership is not a hierarchical position. Heads of institutions or organizations may be good managers but not necessarily good leaders. The difference is usually felt throughout the organization. Alternatively, health workers such as a midwife or nurse with no managerial position or authority can and do lead and motivate others to improve services and contribute to results. A recent review of leadership programmes provides lessons learned and highlights the interrelationship between leadership and management and the need for an institutional approach to sustain its development.

For the purposes of this paper, the conditions of the health services and policy requirements for achieving results are such that leadership is subsumed as part of management. Therefore health managers need to have both managerial and leadership competencies some of which include those listed below.
Managerial and Leadership Competencies

*Managers:*
Follow Vision
Use rules
Look at the job
Process oriented
Concentrate on content of work
Know details/tasks of the organization
Do things right (be efficient)

*Managers in a leadership role:*
Shape and share the vision
Use broad concepts
Look at the big picture
Concentrate on the context
Know peoples’ and organization’s strengths and weakness
Do the right thing (be effective)

*With the ability to perform specific tasks*
Management competency is the knowledge, skills and behaviour needed to perform a specified task. Historically, leadership and management competencies have not been identified or linked to organizational performance or to management development programmes.9

The implications are that managers at all levels and especially those responsible for health service delivery must be held accountable for achieving results while focusing on three specific tasks:

1. Preparing strategies and implementing plans based on assessment of local needs and context and adapting or aligning organizational structures and processes and resources to ensure wider access to services and continuous improvement of efficiency and service quality;
2. Creating and managing partnerships where needed (with communities and others sectors) to ensure that desired results are achieved.
3. Building and maintaining the capacity of health resources-particularly human resources in the organization.

*Which require specific competencies*
These tasks call for a set of specific competencies that enable health managers and their teams to confront the challenges of the changing health care system. In the context of health sector reform and decentralization policies, a recent survey10, of health sector managers in European countries identified these top six competencies required at
different levels of the health system: Leadership; Communication; Resource
management; Results based management; Problem solving skills and;
Consumer/community responsiveness. It is important to note that these are not the
same as public health competencies necessary for programme planning and evaluation or
for good clinical practice in the community. Management and public health competencies
are both complementary and essential to produce successful results.

…acquired through a learning approach
Identification of these priority areas of management competencies focus very clearly on
the need to develop the capacity to adapt to implement changes in resource allocation,
organization of work, management processes and community and intersectoral
relationships. These competencies emphasise not only the ability to use management
concepts and tools but also to be able to adapt their application to their working
environment. This calls for changes in the approach to learning. One that develops not
only knowledge and skills but also develops effective managerial behaviours.

In this context the question is what methods and approaches to training and learning work
effectively particularly at district and facility levels in developing countries. The
following section provides a brief profile of the district manager in a developing country
to provide some perspective of the current managerial capacities and context in which
they operate, then a review of approaches to management development to identify the
most effective approach as a basis to select country experiences and lessons learned.

4. Who is “the local health manager”
The literature provides few indications what District Health Officers and others who are
responsible for health facilities actually do as part of their managerial functions. Yet it is
possible, however, to draw a profile of these managers and the context in which they
operate from the lessons learned from interventions implemented to improve the
management of those services.

Mid Career Medical Officer
In general, most of these managers are mid career in the public health system. The great
majority are medically trained and some have public health certificates or degrees. It
should be noted that training in public health is not equivalent to training in management.
In most cases the District Health Officer is also the director of the hospital. He/she is
usually a surgeon, internist or a nurse who earns a monthly salary of $100-200 per month,
compelling most to engage in private practice or commercial activities. For this reason
and other family concerns such as opportunities for children’s education, most doctors try
to avoid being assigned to rural areas especially remote parts of the country resulting in
high turnovers every two or three years in these positions.  

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8
With little training in management and much responsibility
Few have formal management training or education. Yet they are responsible for the operation and maintenance of established health facilities providing curative and public services to a population of between 50,000 to 250,000 representing approximately the equivalent of $500,000 to $1,000,000 in resources. The facilities they run usually include a 50 to 80 bed hospital and a network of urban and rural health centres and sub centres. Their staff complement is approximately 80 to 100 including all categories serving in different facilities.

...with little authority
Their scope of decision making mostly concerns the operations of both clinical and public health services. Managerial decisions about the allocation and use of both financial and human resources are usually decided at the central level. Beyond this, these managers are responsible for compliance with administrative directives and standard procedures and to respond to numerous requests/directives of hierarchical levels authorities in the health system. Administrative and technical accountability is often to multiple authorities, at provincial or regional levels.

Who see themselves as doctors not managers
In this risk avoidance and centrally controlled environment, there is little incentive or support for managerial initiatives that would improve performance. Rather, value is placed on professionalism expressed through technical achievements particularly in terms of outputs, productivity and efficiency which are measured mostly in terms of targets achieved and rates of service utilization.

Working in a professionally disabling environment
Even achieving this is a major feat in a health system whose major constraints to service delivery have been identified as: insufficient resources (staff, equipment, facilities, transportation, drugs and disposables); lack of health team management skills; rapid staff turnover and vacant posts; low staff morale and motivation; lack of control over resources and planning; limited policy guidelines; and poor information systems, communication and coordination.\textsuperscript{14}

5. Approaches to Management Development
The most common approach to management development programmes are education and training which aim to improve and/or maintain management knowledge and skills of individuals and teams working in a specific organizational context. Management development is often an integral part of an institution’s overall Human Resource programme and is linked to job descriptions, recruitment, and career development, continuing education and performance appraisal. It is also used as a means to support the implementation of institutional changes thereby ensuring that managers are equipped to implement new strategies or services, or meet new challenges in achieving the desired
results. This paper is mostly concerned with using management development approaches as a means to improve the performance of the health services. There are a number of entry points that have been used for this purpose.

Human resource development programmes are often the most common vehicle for management development activities. HRD or training departments offer the resources i.e. training facilities, equipment and staff, and institutional framework for in service training and continuing education. In most developing countries, training capacities at sub national level are usually very poor in terms of materials and equipment and shortage of overcommitted and poorly motivated staff.  

Projects introducing new systems and tools such as the introduction of individual performance management systems; development of management information systems, tools for planning, health assessment, monitoring, financial management, supervision etc…must all be accompanied by some management training activities to develop the knowledge and skills required to use and even further adapt the systems or tools to local needs.

Health authorities are relying increasingly on training to ensure that managers have the management competencies needed to meet their new roles and responsibilities. However, ensuring managerial competence of health workers through the turbulence of decentralization is a major challenge. Peripheral managers may have received sufficient training in management but the control of resources remains centralized. The decentralization process in many developing countries is itself implemented without the benefit of providing managers with job descriptions, clear decision making guidelines and procedures or the tools needed for effective management of their district or facilities.

Country experiences reviewed in this paper focus principally on these entry points.

There are however other management development interventions in the health system which are mostly related to clinical services or implementation of vertical programmes and not for management development across services. For example in a programmes such as IMCI or TB or malaria and HIV/AIDS- management training to develop knowledge and skills in planning, supervision, drug supply management is introduced as one element to strengthen the implementation and capacity for scaling up the programme. Training health workers in quality management techniques is increasingly used as a management development intervention for improving the quality of clinical services or vertical programme interventions.

For each of the entry points described above there is a range or mix of approaches for management development that can be considered. The following outlines the most common approaches used, compares them and identifies the approach which is
considered to be the most effective for managers and teams working at district or facility levels. Descriptions adapted from Rojas PhD\textsuperscript{15}

### 5.1 Formal training

This is the most common approach adopted in management education. It consists primarily of classroom training usually provided by Universities or institutes of management. Teaching methods are predominantly lectures or case study approach. It is “usually designed to transmit knowledge and information efficiently through a variety of methods and most often presupposes a model of the ideal or desired managerial behaviour” (Kerrigan and Luke, 1987:40).

### 5.2 On-the job training

This method ranges from informal and even unintentional learning, such as that which occurs whenever a junior manager works with a senior manager, to a more formal program of indoctrination used to prepare administrators for higher posts in an organisation.

In the health sector this approach is closest to the practice of internships for doctors or nurses. Internships or on the job training is widely used in the private commercial sector to develop young professionals for future management positions. It is usually considered to be an integral component of supervision, tutoring or mentoring. It is not widely used in the health sector certainly not for training prospective managers.

### 5.3 Action Learning

Action Learning (AL) is a more recent approach to management training. It is a “combination of formal training sessions with on-the-job problem solving” (Kerrigan and Luke, 1987). It is also known as “action training and research”, “capacity building”, “joint development activities”, and so on. According to Pedler (1991), action learning (AL) is an approach to the development of people within organisations that uses real-life tasks as the vehicle for learning. “It is based on the premise that there is no learning without action and no sober and deliberate action without learning”\textsuperscript{18}.

Kerrigan and Luke described AL as organisational research integrated with managerial self-development. AL generally involves the trainees or participants with action by getting them “to tackle real-life problems, rather than allowing them to be passive recipients of someone else’s wisdom and knowledge”\textsuperscript{19}. AL has three main components: people who accept responsibility for taking action on a particular issue; problems, or the particular tasks that people set themselves; and a set of around six to eight participants who support each other in making progress on problems.
AL presents itself as a tool that any group can apply to facilitate its learning, and thus to identify, address and solve its problems more effectively. It is primarily a developmental activity. Development applied to managers involves the whole person in a continuous and conscious learning process that takes place progressively over time and, indeed, their complete life cycle.

5.4 Non-formal training
This is essentially self-directed learning through peers. It can be described as a learning situation where a group of peers share expertise, exchange practical ideas, and inform each other of emerging trends, issues or theories. Although it is typically neglected as a viable management training approach for developing countries, it does occur spontaneously in a variety of organisational forms from highly structured clubs or associations to loosely structured networks or support groups.

More common examples of this approach used in developing countries are the annual meetings of medical or nursing associations which provide fora for such exchange. Another promising but little used example are partnership programmes which are focused on solutions to health care delivery problems that are technologically and economically sustainable in the host country and concern various aspects of healthcare, from technical “disease-oriented” programs to management education partnerships. Partnership programmes are intended to make a system-wide impact through success stories and approaches dissemination and application to areas where it might be applicable. The main objectives of most partnership programs are to establish sustainability of results and disseminate the results broadly and improve the quality, efficiency and sustainability of health services. Joint planning of partnership programmes helps assure the sense of ownership, when involvement of regional and national health administrations and ministries assures that the partnership is firmly anchored in national priorities.

Lasting 4 to 5 years in average, partnership programs may include different activities, such as professional exchange visits (2 to 3 months in average), technical assistance (equipment, study materials etc.) workshops and training programs delivery.

Partnership programs may include complementary activities usually funded by donor agency, such as establishment of learning and information centres, management and administration training programs delivery. Partnership programmes reviewed were held mainly between the US and a limited numbers of developing countries of Eastern and Central Europe.

As pointed out above, of the four training approaches, formal training continues to be the most common management training approach used in developing countries. Yet it
seems to have less potential than the others for achieving immediate management training objectives. Table 1 summarises the relative advantages of each approach. Of the four, AL would appear to offer most, because it combines the benefits of formal training with those of on-the-job training.

<table>
<thead>
<tr>
<th>Training Approach</th>
<th>Formal</th>
<th>On-the-job</th>
<th>Action Learning</th>
<th>Non-formal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acquire knowledge</td>
<td>⬜</td>
<td>⬜</td>
<td>⬜</td>
<td>⬜</td>
</tr>
<tr>
<td>2. Understand concepts</td>
<td>⬜</td>
<td>⬜</td>
<td>⬜</td>
<td>⬜</td>
</tr>
<tr>
<td>3. Understand techniques</td>
<td>⬜</td>
<td>⬜</td>
<td>⬜</td>
<td>⬜</td>
</tr>
<tr>
<td>4. Acquire skills in use of techniques</td>
<td>⬜</td>
<td>⬜</td>
<td>⬜</td>
<td>⬜</td>
</tr>
<tr>
<td>5. Acquire skills in analysis of organisation problem</td>
<td>⬜</td>
<td>⬜</td>
<td>⬜</td>
<td>⬜</td>
</tr>
<tr>
<td>6. Acquire skills in developing and implementing action plans</td>
<td>⬜</td>
<td>⬜</td>
<td>⬜</td>
<td>⬜</td>
</tr>
</tbody>
</table>


Key: ⬜ High potential ⬜ Medium potential ⬜ Low to no potential

From this it is clear that formal training has great potential with all packaged knowledge (on teaching the known), but not with the development and use of management skills. On-the-job training shows good potential for two immediate objectives related to skills development, but less in one of them and also in the three related to knowledge acquisition. Non-formal training appears to be the weakest of the four. AL has high potential across the board and therefore merits further consideration as a strategy for management development in developing countries.

Country experiences reflect this wide range of training approaches for improving management capacities at district and facility levels. However, training and development is often implemented as an integral part of a broader approach for improving access, efficiency and quality of health services or to improve performance of managers in the context of a decentralized health system. Selected country experiences with action learning are reviewed below.

6. Country experiences
The evidence in the literature supporting the success of interventions based on management strengthening consists mostly of descriptive studies which are methodologically weak. A recent review of the literature on improving the management
of service delivery provides some indication of what has been found to work in country
experiences.24

For the purposes of this working paper three country studies were selected as
representative of the different management development initiatives across services.
Namely The Gambia, Tanzania: Tanzanian Essential Health Intervention Project (TEHIP)
and thirdly a combined study of three Latin American Countries: Mexico, El Salvador
and Colombia.
   o all three adopted an AL approach to improving management capacity;
   o two of the three were research projects; and,
   o each one provides a different focus for expected results for improving
     management capacity i.e. individual manager performance and health team
     management.

6.1 Common Features and differences of projects reviewed

The common aim of all three projects was to demonstrate that by strengthening some
aspects of management in selected health districts, improvements would result in terms
of individual performance (Mexico, El Salvador and Columbia) or team effectiveness
(The Gambia), service quality and efficiency (The Gambia and Tanzania) and where
possible health outcomes (Tanzania).

Each adopted an action learning approach to improve management capacities of
individuals or teams in the district. In Latin America this was in the form of a series of
management courses delivered intermittently over 18 months with follow up practical
applications of management tools known to improve management performance. In The
Gambia and in Tanzania the process for Strengthening Health Management developed by
WHO was used to develop district health teams References are provided below with each
case study. This process of assessment, problem identification, strategy and action
planning, implementation and monitoring and monitoring progress was also implemented in the
workplace over a period of 18 months. All the projects recognized that different elements
of management such as human resources, finance, information systems, and facilities
maintenance were needed to be developed together as part of any effort to realize
sustainable management capacities in the health services. Consequently the
implementation of the approaches used especially in Tanzania and The Gambia were
multidimensional, including separate elements such as resource management for The
Gambia, and for Tanzania, a wide variety of tools to support planning, mechanisms for
supplementary financing, community participation, project coordination and feedback to
managers on the effectiveness and efficiency of their services. All projects recognized
the challenges and issues related to going to scale. Some recommended measures to be
taken but little effort in this direction was reported in the studies. Finally all projects were
supported by external facilitators either from the country such as in The Gambia or from
external donor agencies/institutions such as IDRC in Tanzania and by National NGO’s
and the EU in Mexico, Columbia and El Salvador in Latin America.
There were some important differences among the projects reviewed. Two were published reports on research projects and the third was a published review of a project to develop management capacity at district level. The differences among these initiatives are best captured by comparing the underlying assumptions or hypotheses implicit in the approaches used to achieve their stated aim and objectives.

The Gambia
If health teams would function as decentralized management units in the districts, team management skills would improve (particularly planning, supervision, teamwork, provision of in-service training, and coordination); and if there would be more efficient and effective resource management and more awareness of district health management problems at national level, there would be improved implementation of PHC.

Tanzania
If essential effective health interventions are planned on the basis of an analysis of the local burden of disease and resource are allocated according to priority interventions supported with a small amount of additional funds, there would be a measurable improvement in health.

México, El Salvador and Colombia
If health managers were trained using modified adult learning methodologies with content associated with “best practice” in performance management and that powerful reinforcement was provided to the training programme by senior health authorities, they would demonstrate significant improvements in their performance.

Essentially the driving concept of each project differs considerably depending on what type of results are sought. In The Gambia the concept is that effective health management teams (with a sense of self confidence and capacity to make changes) at the district level can plan and make improvements in the efficiency of service delivery. Whereas in Mexico, El Salvador and Columbia, the notion is that individual district health managers with the knowledge and skills to use concepts and tools associated with management performance in the workplace will be better managers. Finally in Tanzania, the concept is that the capacity of a district health team to identify and prioritize effective health interventions based on local assessment produces the best results in terms of health outcomes.

To put it more succinctly: better managers and management teams provide more efficient and better quality of services; effective health interventions supported by better managers and teams provide better health outcomes. These are not mutually exclusive guiding concepts but they indicate the different entry points and emphasis given to the interventions developed and implemented to produce an improvement in service delivery.
6.2 Results achieved

The Gambia

There was no baseline data obtained prior to the interventions; the results reflect third party observations, review of project documents and reports and interviews of individuals involved in the project.

The project resulted in some improvements in the management of district health services, particularly in the quality of team planning and coordination, and the management of the limited available resources. Specifically in terms of The performance of District Health Management Teams:

- Better coordination for supervision and training support to district health staff rather than fragmented individual actions.
- Greater self confidence and assertiveness of team members in coordinating activities with NGO’s which informed national authorities on management in the district.
- Establishment of regularly scheduled meetings with action oriented format and reviews of planned actions taken.
- More effective use of service delivery data that was usually sent directly to the national level led to further identification of gaps in service delivery. e.g. such as the need for greater supervision and training in the diagnosis and treatment of malaria and fevers.
- Problem analysis skills were improved. Underlying causes of problems of service delivery were identified rather than simply the lack of resources.

<table>
<thead>
<tr>
<th>The Gambia:</th>
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<tr>
<td>o Increase in staff motivation as a result of empowerment.</td>
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<tr>
<td>o Team leadership shown to be an important factor in success</td>
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<tr>
<td>o Action based and Problem solving “learning by doing” was observed to be appropriate in facilitating change in management practice and learning for district health managers.</td>
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<tr>
<td>o More interest in continuing learning and better access to information on programmes, professional literature.</td>
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In terms of the placement of a trained health administrator for capital resource management

- There was improvement in the management of facility and transportation. Information provided to central level facilitated planning for additional and replacement transportation.

Mexico, El Salvador and Columbia

Final assessment compared to baseline data confirmed that district health officers who receive the training successfully increased knowledge of management tools and concepts; improved their skills and demonstrated competency to apply management tools in the workplace in relation to the key management functions associated with performance.
management. However, the long-term effects in terms of maintaining newly acquired management practices in the workplace are unknown.

Going to scale was attempted by replicating the training programme but was not part of the study. An in-direct measure of the success of the program was the number of replication workshops to district health teams carried out by the work-shop participants. Mexico: 147 replicated work-shops for a total of 2,048 participants (on aver-age 13.9 participants per workshop); Colombia: 62 replicated workshops for a total of 918 participants 14.8 participants per workshop) and El Salvador: no replicated workshops, as this was not yet a program element. These differences were attributed to the strong leadership role played by central level of Ministry of Health particularly in Mexico and Colombia.

This experience with in-service management training confirms the assumption that management training cannot be separated from the work and activities being managed; that the different elements of management (such as human resources, finance or information) are best developed together and, that the organizational background has to be taken into account in management training.

Tanzania, Evaluation of this research confirmed the underlying assumption that a well planned and implemented essential package of health interventions did have an impact on health outcomes in the districts where it was implemented. In Morogoro, child mortality between the late 1990s and early 2000s has declined over 40% -- from about 35:1000 to around 20:1000 annual deaths in children under 5 years of age. An important share of this reduction has been shown to be the direct result of the IMCI system.

Other related areas of documented improvements included:

**Quality of care**, were the result of two factors. One was how district managers chose to use the planning tools to decide what health interventions to fund and prioritize in response to the portrait of burden of disease produced by the tools. The second was how District health management teams (DHMTs) used these tools to: overhaul the way they planned; revise distribution of funds; and promote integrated solutions that offered multiple benefits from single health interventions.

**District health management teams (DHMT)**, acquired essential planning and management tools and skills over time. Trust and cooperation between members was fostered, specialties combined in ways that complemented each other, and teams learned how to delegate responsibility. In addition to team and problem solving approaches to management development, DHMTs requested and received training for: (a) computer skills; (b) upgrading in the use of prevailing government administrative and financial procedures; (c) upgrading the HMT office management; (d) addressing routine maintenance activities for health facilities; and health equipment (e.g. cold chain equipment, solar, vehicles, and radio equipments). As the team approach moved outward

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to encompass facility staff and, indeed, whole communities (which participated in health reforms by helping to renovate health centres) so too did the list of partners needing training and capacity building expand.

By following the processes outlined in the WHO course on Strengthening Health Management which was translated into Kiswahili, the teams began to work together to assess problems and propose solutions. In doing so, the teams “found that almost 60% of the problems — ranging from low immunization rates to poor vehicle maintenance — were within their capacity to solve,” says Dr Kasale. They also learned that problem solving involved delegating and sharing responsibilities, essential elements of team building.

Communications: an approach called the Management Cascade was established as a vital communication link between the HMT and front line health workers in health centres and sub centres. Some positive results included:

- Actual supervision of peripheral facilities with time for supervisors to directly observe patient care;
- More coherent laboratory specimen collection and diagnostic laboratory reporting functions;
- Timely delivery of drugs, equipment, and supplies;
- Coordination of referrals of patients to the district hospital;
- Emergency epidemic support, such as during cholera outbreaks;
- Routine collection of health information and data;
- Notification of arrival of staff salaries (resulting in reduced closure of health facilities as health workers travel to collect salaries too soon and have to wait before returning);
- Improved maintenance of facilities and equipment, and replenishment of stationary, registers, etc.;
- Improved linkages and communication with communities;
- Locally conducted capacity-building workshops, technical training, and refresher courses; and
- Posting of replacement health staff when regular personnel are ill or have died.

In the Cascade System, selected “mother” health centres are responsible for supervising groups of “daughter” dispensaries with the aid of two-way radios and reliable transportation. Supervisors use motorbikes — and a boat in the case of coastal Rufiji district — to cover their territories, while dispensaries are supplied with bicycles. (Jokes Dr Machibya of Morogoro: “I could use a helicopter.”). The cascade system is also used for delivering drug kits and bednets, collecting reports, and implementing national campaigns, such as immunization programs.

The benefits of the cascade system have spread to sectors outside of health. For example, it is used to distribute examinations to remote schools. The Rufiji DHMT has also installed a satellite connection that links all members of the district authority — not just the health team — to the Internet.
Rehabilitation of health facilities
Approximately 40 communities were involved in building of health centres that they would own. Renovation projects cost between 31% and 48% less than they would have cost under normal subcontracting practices. In some cases, the momentum from health facility rehabilitation has spurred other changes, with community members initiating new upgrading projects for mosques, schools, health workers' houses, and other local amenities.

Supplementary Funding
The project first offered additional funding of up to US $2 per capita to the districts of Morogoro Rural and Rufiji in 1997. Both districts soon discovered that they were unable to absorb and spend this amount of extra funding. The average fund consumption over the first 4 years of the project was US $0.92 annual per capita supplementary contribution for the two districts.

7. Lessons Learned in developing health management capacities at local levels
Analysis of the few documented country experiences provides examples and insights as to what has worked in districts where attempts to improve the health services by developing management capacity have been evaluated.

The lessons learned are described in such a way as to highlight the importance of the systemic relationships among the various components of the multidimensional approaches used for capacity building and management development in the health services thus providing some insight as to the nature of potentially successful future initiatives.

7.1 Approaches to Education and Training in Management
Countries such as South Africa\(^29\), Chile, and Argentina\(^26\) have relied mostly on formal training methods delivered either through universities or institutes or through donor supported fellowships or country workshops. This approach to teaching vs. learning is the one most commonly used in countries. However, evaluations of these training activities found that health managers could understand the concepts but had little opportunity or skills to apply them in a workplace environment that did not welcome, seek or appreciate the benefits of innovation in management practices. On the other hand country experiences such as the ones highlighted above which have emphasized the use of an action learning approach to management development, found that action learning, also referred to problem solving or “learning by doing”, was appropriate in facilitating change in management practice and learning for district health managers and district health teams (The Gambia). This approach to learning also resulted in increase in staff motivation and empowerment as a consequence of having built on successes in improving services. Trust and cooperation between members of the health management
team was fostered, specialties combined in ways that complemented each other, and
teams learned how to delegate responsibility. As the team approach moved outward to
encompass facility staff and, indeed, whole communities (which participated in health
reforms by helping to renovate health centres) so too did the list of partners needing
training and capacity building expand. In addition to team and problem solving
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rates to poor vehicle maintenance — were within their capacity to solve,” says Dr Kasale
MOH Tanzania. They also learned that problem solving involved delegating and sharing
responsibilities, essential elements of team building. “It consolidated teamwork,” says Dr
Harun Machibya, the District Medical Officer for Morogoro of the Strengthening Health
Management process. “It was a real eye-opener.”
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The unique aspect of an action learning which makes it such an effective approach can be
found in the cycle of learning which is adopted. The cycle starts with an assessment of
the problem, an examination of underlying causes, followed by the development of
strategies for solutions, a plan for implementation and the development of indicators for
monitoring progress towards achievement of desired outcomes. This problem solving
method is common in many development and improvements approaches such as quality
assurance and quality management. Nevertheless it is important to note the initial step of
“self assessment” goes beyond data collection and engages managers and their teams in
defining the nature of the problems and the context in which they must be addressed.
This initial step develops the capacity of individuals, teams and organizations to learn
from their experiences and to seek and rely on information as a basis to initiate
improvements. This contributes to management's ability to develop strategic thinking and
to later have the ability to implement changes in their organizations. In the end
however, change in the services comes as a result of the implementation and monitoring
of action plans to address the weaknesses in the services. As a process, the application of
an action learning as part of a continuous change process improves managerial
competence and increases organizational capacities to implement policies and adapt to
changing needs and demands of its stakeholders. It also reinforces the sense of
ownership which teams develop because it grounds their solutions in a better
understanding of the realities and needs of their stakeholders, the context which impacts
on their approach and the limits and potential of their own work environment.
Involvement of stakeholders in such a process stimulates a sense of ownership on their
part and use of information and data in future work.

In conclusion, action learning contributes to creating self reliant individuals and teams
with the capacity, motivation and commitment to continuously improve the way they

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organize, manage, support and deliver services that provide results in terms of improved health outcomes for the people they serve. Consequently, these individuals and teams express greater demand and make better use of health service data, reports and documents which would help them better understand and manage the services they deliver. Greater need for information leads to greater need for knowledge and skills. Demand for continuing education in the workplace for specific management and technical subjects, increases with the use of an action learning approach. Maintaining this new culture and heightened sense of professionalism among the service providers and their managers draws attention to the important role of leadership at the district and facility levels of the services. Without effective leadership the positive cycle of development and improvements in efficacy and effectiveness of services and their outcomes cannot be sustained in changing health contexts.

Action learning in the workplace is what works in a developing country context. It is the basis for changing managerial behaviour and organizational culture in the health services which are oriented to achieving results with efficiency and quality services. Action learning provides the basis for developing management development programme for managers who are in a position to specify their needs and use the knowledge skills offered to them through training and facilitation and mentoring support.

7.2 Planning
Country experiences have shown that while AL is the most effective workplace method to train and develop management competencies of individuals and teams, it is usually part of a multidimensional strategy to improve health service delivery. Other elements of such strategies for improvements usually include health planning, resource management (facilities, equipment, and transportation) and financing. Among these, to plan and prioritize health services and interventions was also seen as having raised the level of confidence of district planners and health managers in producing acceptable health plans.

District health planning (DHP) is considered one of the most useful tool and intervention by health managers. What is known is that most district health plans are based on facility generated information on service utilization, donor priorities and other factors not necessarily related to the health or service conditions of the population in the district. As confirmed in country experiences, strengthened management capacity in this case emphasises improvement of internal efficiency in delivery rather than improved results in health outcomes.

In Tanzania under the TEHIP project the DHMT adapted district health planning tools to include: a tool to measure burden of disease another to help select cost-effective interventions and tools that the DHMTs could use to allocate resources more effectively. The use of these tools established an evidence based approach to district health planning as a way of identifying and prioritizing effective health interventions, and produced some important findings. The project conducted research into three distinct areas — health systems, health behaviour, and health impacts — provided critical insights that aided health care reforms in Rufiji and Morogoro Districts. One of the most striking findings of
the inquiries into health-seeking behaviours, for example, was that most deaths (close to 80%) occurred at home rather than at a health facility. This statistic underscored earlier doubts about the use of attendance and cause-of-death statistics — compiled by the government on the basis of health facility data only — as an aid for planning health budgets. Surely, this form of planning could not be reliable since it was based on only 20% of deaths. Since Demographic Surveillance System (DSS) information, by contrast, captures all deaths — those that occur in health facilities, in households, and elsewhere — it can be counted upon to give a more accurate and complete portrait of the burden of disease as experienced by the community. Another surprising revelation arising from research into health-seeking behaviour was that the people who had sought modern health care prior to their deaths greatly outnumbered those who had not. For malaria, 78.7% used modern care, only 9.4% used traditional care, and 11.9% used no care at all. These figures prove that the death rates in Rufiji and Morogoro Districts were not primarily an outgrowth of a preference for traditional healers over modern health care (as some observers had speculated), but are more reasonably seen as related to problems of access, delay, or the apparent inability of modern health facilities to prevent these patients from dying. Formative research into the health systems planning process confirmed that planning was not being conducted as a response to the burden of disease, but instead was driven by a wide range of factors including donor agencies' agendas, bureaucratic inertia, and simple guesswork. As a result of this assessment, the DHMTs were able to reorient their budgets to place greater emphasis on major causes of mortality, namely malaria and a cluster of childhood illnesses. The result was an impact on reduction of child mortality in the districts.

7.3 Financing

Modest amounts of funding are needed by district health managers to implement improvements in the management and health services. Country experiences have shown that there is both limited capacity to absorb new money or in some cases to spend the moneys provided. In the Gambia, before problem analysis skills were improved, some managers mentioned that they would not know what to do if more resources were made available.

The TEHIP project offers another example. The project offered additional funding of up to US $2 per capita to the districts of Morogoro Rural and Rufiji in 1997. The districts' initial lack of capacity to absorb the additional US $2 in funding was at first baffling to the DHMTs. Why were the new funds sitting unused in a bank account? The answer was that health systems in Rufiji and Morogoro lacked the administrative and management capacity to put the funds to work. To absorb the top-up funding would have required the skill base to transform financial resources into program spending. Staff would have needed the skills enabling them to draw up contracts, hold structured meetings, issue cheques, procure supplies, interact with accountants, etc. -- to do all the little things that are crucial to the functioning of a health system. With the training however these funds allowed districts to achieve new efficiencies in the daily operations of health systems and to increase spending where needed on interventions aimed at the most significant contributors to the local burden of disease.
To channel more money into health services, the district health teams first had to improve their ability to plan, to manage, to administer, and to implement.

The important lesson is that channelling more money into health services, requires first that the district health teams improve their ability to plan, to manage, to administer, and to implement.

### 7.4 Replication and sustainability

*At this stage, little is known on how to introduce a system wide change in the management processes of the health system of a country.* Initiating and sustaining improvements in health services requires leadership, motivation, facilitation, a minimum of financial support and an approach or mechanism for going to scale. Country experiences have demonstrated that action learning is a training process that requires leadership support from the central level, and external initiation and facilitation at the local level to be effective. It is also been demonstrated that it is a learning process that generates interest and builds motivation in the health team. Country experiences in management development are not clear as to what will work to sustain motivation of health managers and their teams in the long run. Different approaches to this issue will have to be developed according to the specific requirements for management in each health system. Whereas the lessons for financial support are clear. Sustaining improvements in the health services requires that health management teams have access to a small basket of funds to implement these improvements but that this must be linked to management development and in particular to the development of specific skills required to allocate and manage finances. Finally the issues related to going to scale are often mentioned but unresolved in most country experiences. The most typical strategy for replication is to generate echo or cascade workshops. Experience shows that the effects of this approach quickly dilute both the process and content of the training provided with no evidence as to the results obtained. Again the TEHIP project demonstrated another approach to building the management and technical capacity and support to front line health workers. This approach focuses more on establishing communication between managers and supervisors and the front line workers. Communication in terms of technical and material support, facilitation, mentoring and training. It is a more holistic approach to building bottom up capacity to sustain efficiency and quality of services provided and maintaining the active participation and contribution of the community while implicating front line workers in the managerial processes of services delivery.

In conclusion, lessons learned through country experiences provide good evidence on what works in management development at the district level. As a method of training, the action learning approach or its adaptations provide the needed link between concepts, tools and their application in the reality of the work environment. This approach has demonstrated its effectiveness in helping managers and their teams take action to plan, implement and monitor improvements or changes in their services. AL is both a learning
process which creates information and knowledge-seeking behaviour. It is also an engine which gives impetus to an action and result-oriented managerial process in the services. By participating in an action learning approach to training, managers and their teams have been able to be more precise about their training requirements in both managerial and technical fields. Action learning not only applies to management but provides the basis to link management as an integral part of the technical aspects of service delivery. This provides the opportunity to develop more relevant and effective continuing education programmes to support district health teams and their health workers.

The decision to improve manager performance or service efficiency or improve health outcomes is important to determining the scope and content of management development. Country experiences have shown that most efforts to improve management are embedded in a broader approach to health service improvement. These multidimensional approaches usually include: planning; management training of health teams and resource management i.e. building maintenance construction, logistics and drugs etc. Each element implemented separately with the intention of achieving some internal improvements in efficiency and quality of the services provided. Implicitly, there is a broad consensus that the purpose of management is to focus on internal results not necessarily related to the main purpose of the health services which is to improve health.

The research project TEHIP offers a different perspective to management development. Using the same AL approach for strengthening health management, the district health management team adapts tools to conduct an evidence based district health planning process which becomes the basis for selecting effective health interventions. The management team then introduces internal changes in the services on the basis of the interventions selected for addressing the assessed health problem in the communities. In this example, management is used as a means to ensure that any improvements made in the services are directly related to improving health outcomes. Confirming what Peter Drucker said, the purpose of management is to affect a change outside the organization.

Leadership of the central level is recognized in all cases as key to project success at the district level. Equal importance is given to the capacity to facilitate management development processes at district level. Without central level support and active involvement, and without facilitative capacities at sub national levels, the effects of any investment in management development quickly evaporate and return to the status quo. Replicating and sustaining such initiatives constitute another major challenge. By definition documented projects on management development are time limited and none have effectively addressed this issue. There is only one area of real agreement: namely, that it is a long term complex process, requiring sustained leadership at the central level, and a willingness to create the enabling environment for management.
8. Constraints to implementing what works in management development at local levels

It is perhaps not surprising that different country experiences encounter very similar constraints to sustaining and expanding the implementation of what works in terms of management development and capacity building in general. That these constraints persist in an institutional context committed to improving health sector performance through structural and financial reforms and decentralization of authority and responsibility simply indicates that the enabling environment for results based management has not yet been developed in the health system.

Country experiences point to the following as major challenges to management development:

8.1 Leadership

Leadership or lack of it is a major issue for initiating and sustaining change in managerial practice and behaviour in the health system. The impact of effective leadership at the central level, committed to and involved in developing managerial and leadership capacities at local levels, is an issue in all projects and is well illustrated by comparing the results obtained in the health management training programme conducted in Mexico, Columbia and El Salvador. The sense of ownership and direct involvement of top managers in the Ministry of Health in Mexico and the Minister of Health in Columbia in the outcomes of the training programme were important determining factors contributing to the results obtained. Yet beyond the leadership of one or a few at the central level, country experiences confirm that decentralization and management reform need a critical mass of skilled managers at national level with the time and capacity to design and implement changes in structures, procedures and develop tools to support management at local levels.\textsuperscript{27,32}\textsuperscript{27,32}. A review of experiences in decentralization in developing countries highlights the total absence of any coherent programme for achieving the objectives of this policy.\textsuperscript{14}

8.2 Human resource management

Current approaches for managing human resources and developing their capacities present another significant challenge to improving management in local health services. Where management development projects are initiated, countries experience high turnover rates of district health officers, hospital directors and other facility managers making it very difficult to train a critical mass of management cadre who with time can lead their teams to improve health outcomes. Other bottlenecks to the management development process include the constant request for management team members to attend specific training activities motivated by “topping up” low salaries. Staff time is also consumed by national level requests for data collection not used or relevant to
service providers. Then there is the problem of staff pilferage by donors who recruit capable staff members to coordinate their projects in the country. Viewed from the national level however, the problem of human resources for health presents a serious crisis for maintaining a viable public health service in developing countries. Migration contributes significantly to the loss of health workers from many countries. For example, approximately 50% of medical school graduates from Ghana emigrate within 4.5 years and 75% within 9.5 years. There is also a maldistribution of staff with predominance of the health workers in urban areas where opportunities for them and their families are greater. Absenteeism, low morale and work related stress reduce productivity related to understaffing, fear of infection and caring for an overwhelming number of dying patients with AIDS. Example in 2003 80% of hospital beds in Uganda were occupied with people with HIV/AIDS. Most importantly vacancy rates are rising in all public sector organizations while the pool of skilled workers is shrinking. Apart from the challenges this presents to any effort in management development in the health services, these human resource issues raise a far more fundamental question of a viable public health service having the capacity to obtain results while providing efficient and quality care.

8.3 Training capacity at local levels

Resources for management development are heavily reliant on donor funds to support workshops or courses, external facilitation support and materials development. With some exceptions such as South Africa, Ghana and Uganda, few countries have institutional capacities for leadership and management development to support management development at sub national level. Most training supported by donor agencies is for specific disease or health interventions such as HIV/AIDS, TB Malaria etc…Only recently have donors started providing support for leadership training and a variety of management workshops on management techniques related to performance management This presents health authorities with two problems: first is that funding is usually limited to two years, insufficient to demonstrate impact of the training on the management of health services; and second, is that a number of donors in any one country provide their own array of management tools and techniques and approaches. To move away from the use of “external consultants” there is an attempt to build a network based on local expertise capable of facilitating management development in countries. See http://www.msh.org. Management institutes specializing in health management in developing countries are very few such as the Indian Institute for Health Management Research. They usually conduct formal courses or short seminars for health managers and provide consulting services in management development on contractual basis within their country and with neighbouring countries. Such contracts are also funded or financed through external donor agencies or World Bank.
8.4 Institutionalizing Small Scale Approaches

Even with successfully implemented donor supported projects such as the TEHIP which has influenced national policy the question remains how to expand externally funded, district-level projects to a national scale? A major constraint identified was the lack of coordination among the various players working in the health sector. Without more effective coordination and cooperation among donors, health care workers and training centres, “confusion and competition will exist”. Different donors support different districts, which are developing their own approaches to planning. This posits the question: which tools do we use? “What we need now is a coordinated roll-out of existing, proven initiatives”. Expansion of district level projects has system-wide implications which are, of course, larger than coordination issues. Often, projects such as TEHIP introduce new methods of work which have implications on management structures and processes at all levels of the health system as well as changes in roles and responsibilities of managers and health workers. New methods of work often require data processing and information and communication support technology.

9. Discussion

Countries have demonstrated the contribution of management development to the strengthening of health services in time limited projects with external donors’ technical and financial support. At the same time these experiences have shown what the effective approaches to management development are and that management development cannot be separated from health systems development. Management development is not simply an HR function. These experiences provide some important insights and implications and at the same time raise important questions about how to go to scale.

The action learning and research approach has proved to be highly effective in developing both leadership and managerial competencies of individuals or teams in any health systems context. It is a result based learning process that has the potential for initiating a dynamic of continuous learning and improvement in the management and delivery of the health services. It is by definition, a systems approach to management development. By integrating action learning into an evidence based planning process at district level, TEHIP demonstrated the potential for its integration in the managerial and technical processes of the health system at any level. In health systems that are resource poor, fragmented and operating in an environment of constant change, learning from experiences, and the capacity to lead and manage change, are essential for better use of available resource to obtain improvements in health. For health managers this represents a significant departure from the routine administrative tasks of complying with standard operating rules and procedures. For the health system, it underscores the need to develop institutional capacity to support effective management development approaches at the local level.
9.1 Implications for the work environment

The implications however of creating such a “movement” towards learning and change in the workplace are many. Management tools have to be developed or adapted for use at local levels. Information systems and supporting technologies are essential for data processing, access to databases, graphic presentations and communications. Two way communications systems between managers and health workers and between managers, higher level health authorities and other partners are essential for feedback and support or whenever problems or bottlenecks prevent or constrain improvements. Authority and responsibility over financial, capital and human resources have to be delegated with commensurate accountability to local level managers. A working environment that engenders trust and cooperation and mutual support rather than competition within and between levels of the health system is needed to maintain flow of information across a network of health teams operating at different levels. A full complement of qualified health staff that have available to them essential equipments, facilities and supplies and to carry out their functions.

9.2 Implications for Human Resources

The human resource implications are no less numerous: clarity of roles and functions of different levels of management are essential; a system of incentives that rewards personal and management development and achievement of results; a management career path in the health system. Open access to continuing education programmes that are designed to meet the expressed needs of managers and health workers reflecting the priorities in their areas of work as these emerge. Support by facilitators and mentors are required for initiating and sustaining leadership and management development in the workplace.

9.3 Implications for health systems research

Health systems research would have a significant role to play in developing management tools, systems and processes that would support a result based management approach in service delivery within the context of decentralization. Action research involving health managers and their teams in developing or adapting solutions to meet their needs would be essential to their needs and use. This approach to research and development has the potential for creating networks for distributed learning and knowledge development throughout the health system. Such networks would provide a mechanism for rapid development, deployment, application and feedback of solutions designed to address emerging issues of health service as they arise at any level in the health system. Some of the preliminary areas for R&D would include: development of indicators at district and systems levels for monitoring key organizational processes such as drug inventories; utilization of services etc…; development of management tools for planning, supervision, reporting and feedback; financial monitoring and control, priority setting, and assessment of management and organizational performance.

The implications outlined above underscore the need for a multidimensional and multilevel systems approach to management development in countries. Indirectly they give substance to the difficulties of going to scale or as health authorities in Tanzania said
at the end of the TEHIP project “we need a good roll out plan but the energy required to coordinate and sustain this effort over a long period of time can’t be done”.

9.4 Fixing versus Transforming the Health System
Like most development projects, TEHIP set out to demonstrate that it could fix a problem namely by developing local plans that prioritized effective health interventions that would reduce the burden of disease. There is good evidence that it worked in two pilot districts. The success of this project was that it adopted a multidimensional systems approach to developing a solution over a period of 7 years. However in examining its impact on policy at the national level little attention was given to presenting policymakers with the system implications of expanding this research project to other districts in the health system. In the case of training district health managers in performance management in Latin America, providing managers tools and training in performance management, works when they apply it in their district. Again there is good evidence for this claim. But again the systems implications of these successes are not drawn for policy makers who might be interested in expanding these successes throughout their health system.

Health authorities and donor agencies carve out a segment of a larger health system problem to demonstrate on a small scale, that it can be fixed. There is little if any systems analysis made by donors or countries of the changes or improvements that the projects propose neither before nor after implementation. Unfortunately, the systemic problems related to decentralization, reallocation of resources, clarification of roles and functions at all levels of the system, and changes in support systems remain and the “solution” to build the capacity of the health system invariably fails to contribute to the wider effort to improve the capacity of the whole system.

Countervailing forces in and outside the health system ensure that equilibrium is maintained as this is one of the basic laws of homeostatic system process. For every effort to change or improve a system there is an equal and opposite force that resists the change.

As long as the problem of management of health organizations or service provision is viewed and treated as a mechanical problem that needs to be “fixed” efforts to go to scale with a solution will fail. The spare parts replacement mentality for fixing the problems of the health system has not had a successful track record of success in the past 30 years. The problems of the basic health services identified by the WHO EB in 1973 are little different from the ones identifies in connection with attainment of the MDG’s.

The question is no longer how do we fix the health system to make it achieve our goals, but rather how do we transform it so that it responds to and adapts to the changing needs of those it is intended to serve and the environment or context in which it operates. Looking at the health system as a living organism that adapts, based on internal and external relationships and context, provides a very different perspective than the more static mechanistic view currently held. Reframing the question opens up different
possibilities or options for rethinking, redesigning and managing a health system. It also provides more effective leverage for addressing such chronic problems as sustainability and building management capacity for rapid scaling up effective health interventions.

The invitation to shift the paradigm of health systems development has been there for more than two decades starting with the HFA/PHC movement followed by the Health Sector Reform movement and now the MDG. The question with all such fundamental shifts in thinking is the readiness to be open to another perception of reality. The chronic and universal problems of health systems have up to now successfully resisted efforts to make them more affordable, more result oriented, more responsive to patient and community needs, and more accessible to the poor.

There is currently a growing number of training projects in leadership and management in developing countries designed and supported by donors. Each of these is an attempt to improve the implementation of services in one or several dimensions: quality, efficiency, coverage, utilization. Consistently however, the problem of expanding these “successful” approaches to other facilities or organizations in the health system is identified without resolving the issue Sustained leadership or lack thereof from the central level is usually identified as the reason for “failure” to expand. The reality however, is that there is a rapid turnover of leadership in Government Health Ministries in developing countries, with each successive Minister introducing his/her agenda for improvements which can be and usually is divergent with the views of the predecessor. Another problem identified is lack of capacity at central levels to manage the reforms and decentralization. Undoubtedly, these are important contributors to the problem of scaling up. The problem however needs to be explored at a systems level. Why does the central level of the health system consistently invite donors (regardless of change in leadership) to explore, initiate or otherwise experiment with different approaches in selected areas and at the same time devotes energy to maintaining and ensuring the status quo in the system? The slow implementation of decentralization policies is another example. There is a need to understand this paradoxical behaviour, possibly by starting to identify with governments the implicit assumptions that dictate the central task of the ministry of health and govern the dynamics and behaviour of the system at the central level. Success in scaling up can only be achieved if the cause for the resistance to change at the central level can be identified and addressed. Only then will it be possible to scale up an action learning response to local health needs. Only then can a transformation of the system take place.

The donor community could play an important role in strengthening health leadership and management, given the almost total absence of institutional capacity for management development in developing countries. However donors must also carefully consider the implications of adopting a systems approach to management development on their own institutional capacities to sustain effective long term systems development support to health authorities. Donors currently promote, design and support the implementation of leadership and management training courses both at home and in developing countries. There is a wide variety of materials using various approaches to learning that reflect the particular philosophy and priority of each donor about what can work and needs to be done. This is further compounded by competition among donors selling their ideas to
government. The proliferation of experiments and initiatives in health leadership and management will undoubtedly expand in the next few years. There is a risk that countries will be or may already be overwhelmed and confused about what approach to management development to adopt in their systems. This presents a number of challenges to the donor community that will need to be addressed.

First, what can the donor community do to get out of the vicious cycle of investing time, money and energy in demonstrating successful evidence based projects in management development which the health system ultimately rejects? One possible avenue to consider is for donors to jointly plan management development programmes with national health authorities to include detailed proposals for scaling up, monitoring progress and providing feedback on systems constraints during the implementation. This would also address the important issue of national ownership of the process, the materials, the tools and the outcomes;

Second, what can the donor community do to make its array of leadership and management materials and available technical training and facilitative support easily accessible to national programmes for continuing education in management? For management training materials and tools, an electronically accessible international clearinghouse on health management development could be considered. For professional technical support in management training and organization development a network of existing management development institutions specializing in health management could be explored; and,

Third, how can the donor community help countries accelerate learning from experiences both within and across national boundaries? Helping governments develop a national strategy for management development in the health sector would provide a framework for action learning across the system and for sharing experiences with other countries. The UK Government recently appointed a Council for Excellence in Management & Leadership to develop a strategy to ensure that the UK has the managers and leaders of the future to match the best in the world-in all sectors including public and private. This of course goes beyond health as it should in all countries. The work and products of this Council may provide useful guidance and experiences for similar initiatives in developing countries. Please see http://www.managementandleadershipcouncil.org/

Finally, the reality is that the health services in developing countries are increasingly under stress of rapid changes both from within and from the context in which they operate. Pressures arising from migration, ageing populations, natural and man made disasters, viral epidemics and more, demand that the health services develop the capacity to become more adaptable and flexible in their response. Health services in the very near future will have to have the capacity to learn rapidly from their experiences and anticipate health problems and needs before they become overwhelmed. There is an urgent need to take action!
10. Looking towards the Future

In light of these experiences and their implications, the best way for building and sustaining the necessary management capacities in the health system is to focus on building the institutional capacity for health leadership and management. This requires a systems approach which engages all levels of the health system in developing leadership and management capacities while realigning the structures and processes to support service delivery. Rapid scaling up of health services will occur through synergistic effect of simultaneous action at all levels. To this end, sustained effective action will depend on leadership and commitment of national health authorities to role model and promote the changes needed in the system and management culture of the institution.

10.1 A Proposed Action Plan
The following is a proposed action plan or elements of a national strategy to institutionalize the continuous development of health leadership and management in the national health system.

1. Elevate management to a recognized career position in the health system with all its implications for selection, recruitment, rotation, promotion, continuing education, performance appraisals and conditions of employment.
2. Assess the management development needs in relation to achieving results and scaling up services at local levels; and inventory the actual and potential resources available in the country for an effective response.
3. Develop sub national training and learning infrastructure and curriculum for management to develop leadership and managerial capacities for health service.
4. Use evidence based local health plans for health service as a means for introducing managerial accountability. Identify key process indicators to jointly monitor progress with local health managers and teams as basis for feedback on systemic constraints to further improvements.
5. Develop incentive system to reward/encourage good leadership and management of health services as reflected in continuous improvement of services and attainment of results.
6. Establish basket of funds to be used by health managers and teams at local levels to support their project to improve services at local levels.
7. Reinforce programme of decentralization to work with local health managers to realign existing structures, administrative procedures and processes and develop managerial tools that will support decentralized management of services.
8. Progressively align provincial and central level roles, structures, functions, systems and procedures to ensure effective support and guidance to decentralized management of health services.
9. Establish coordination mechanism to harmonize systems and management development activities (including donor contributions) to ensure sustainability and rapid scaling up of health services.
10. Promote the development of associations and networks at all levels which support sharing and dissemination of knowledge and experience on health leadership and management; contribute to the development of health management as a career and to improvements of its practices in the health system.

Understandably, implementing the proposed plan of action represents a challenging and long-term institution wide engagement. It is not expected that all national health systems are prepared to undertake such a comprehensive approach. Most developing countries have limited capacities and resources available for such initiatives. However with determination, country experiences such as the one in Tanzania have demonstrated the potential for harnessing external donors with the technical resources to be active partners in building management capacity in the health system. The important point is that national health authorities set the agenda for capacity building in management and not the donors. The alternative is to continue an incremental or “fix it” approach selecting one or several items on the action plan as a way to begin the process of building management capacity.

The proposals for building management capacity to rapidly scale up health services are based on the evidence provided by country experiences. Efforts to rapidly scale up are attempts to introduce large scale systems changes in a complex health institution. Past and current efforts to introduce change or improvements in health services have continued to rely on rational approaches such as planning and training and health care financing, restructuring and privatization as change levers. The more recent introduction of action learning in management development interventions has added the dimension of behaviour change to the more common acquisition of knowledge and skills. This has provided new insights as to the dynamic and systemic nature of changes required in large bureaucratic institutions.

In conclusion, change is not a strictly "rational" or controllable phenomenon. In complex institutions and organizations such as the health services, large scale change is also political and deals with deeply imbedded assumptions, beliefs and values as well as strongly held perceptions based on ancient human archetypes that govern social and personal behaviour. Any effort to scale up health services must go beyond simple "rational" or “linear” approaches and recognize the deeper well hidden barriers to large scale systems change. Country experience shows us the deeper and complex dimensions of change that are rarely analyzed and infrequently understood and recognized in health systems reform. A final question, will the proliferation of leadership training in health produce national leaders with the vision, the competence and the courage to guide efforts for large scale changes needed in their national health system?
References


5. Note. Specifically the UNDP identified what are essentially leadership and managerial capacities required by national institutions which include the capacity to set objectives; develop strategies, draw up action plans; develop and implement appropriate policies; develop regulatory and legal frameworks; build and manage partnerships; foster an enabling environment for civil society; mobilize and manage resources; implement action plans; monitor progress


9. Fitzpatrick S. A Process Model for Management Capacity Interventions Within Health Systems of Developing Countries PhD, University of South Australia International Graduate School of Management, 2003

10. WHO EURO and WHO Collaborating Centre for Health Care Systems Research and Development, Identifying Competencies Required at the Different Levels of Health Care Systems Andrea Hilchie-Pye, MHSA and Thomas Rathwell, PhD

10 Note. Leadership - Defines a vision and guides individuals and groups towards the vision, while maintaining group cohesiveness, motivation, commitment and effectiveness.

• Communication - Communicates effectively such that messages are understood in both written and oral form. Effective listening skills by understanding the essence and subtle meanings of what is said.

• Resources Management - Manages human, capital, financial and information resources so that organizational objectives are achieved.

• Results Oriented Management – Plans, implements, monitors and evaluates courses of action for self and others in order to achieve results
• Conceptual Skills - Identifies and analyzes situations and problems such that viable solutions are found; approaches tasks and problems such that total systems and strategies are taken into account.
• Consumer/ Community Responsiveness and Public Relations - Responds to consumer/community needs; actively promotes positive relations with the community and consumer groups.


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26. Note. Key management functions: Use monitoring; Involve communities; Have technical meetings; Do a plan; Use maps; Send information; Implement the plan; Identify risk groups; Use indicators; Priorities; Coordinate with other sectors and produce minutes.

27. Neilson S, Smutylo T. Planning and Managing Health Resources at the District Level. *A report on Tanzanian Essential Health Intervention Project (TEHIP) and its influence on Public Policy*. Final Report Evaluation Unit IDRC, Ottawa, Canada, 1 April 2004


31. Health Systems Trust Internet Website: [www.hst.org.za](http://www.hst.org.za)


34. Nakaweesi, D. “*AIDS patients Take up to 80% of the Hospital Beds*.” Monitor (Uganda), June 8, 2003