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WORKING PAPER No. 10

TOWARDS BETTER LEADERSHIP AND MANAGEMENT IN HEALTH:

REPORT ON AN INTERNATIONAL CONSULTATION ON STRENGTHENING LEADERSHIP AND MANAGEMENT IN LOW-INCOME COUNTRIES

29 January - 1 February 2007
Accra, Ghana

World Health Organization

Making health systems work

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Department for Health Policy, Development and Services
Health Systems and Services
WHO, Geneva

ABOUT THE "MAKING HEALTH SYSTEMS WORK" WORKING PAPER SERIES

The "Making Health System Work" working paper series is designed to make current thinking and actual experience on different aspects of health systems available in a simple and concise format for busy decision makers. The papers are available in hard copy and on the WHO health systems website.

Working paper 10:
Towards Better Leadership and Management in Health: Report on an International Consultation on Strengthening Leadership and Management in Low-Income Countries

This report is based on deliberations from an international consultation on strengthening leadership and management as an essential component to scaling health services to reach the Millennium Development Goals. The consultation took place in Accra, Ghana in January 2007. The focus was on low-income countries though the principles discussed concerned leadership and management in other settings as well. The report describes a technical framework adopted by the consultation for approaching management development and sets out key principles for sustained and effective capacity building. The consultation and discussions resulting in this report involved some 80 participants from 26 countries, 20 international, regional and national management and development organizations, and 5 WHO Regional and 5 Country Offices. The draft report was circulated to all participants of the meeting. Their comments have been incorporated in the final version.

The paper was prepared by Catriona Waddington (HLSP UK) with contributions from Dominique Egger, Phyllida Travis, Laura Hawken and Delanyo Dovlo (all of WHO/HQ).

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Further comments and information
Those wishing to give comments, or interested in finding out more about the international consultation and its background papers, please visit http://www.who.int/management/ghana/en/index.html or contact Dominique Egger (eggerd@who.int) or Delanyo Dovlo (dovlod@who.int).

For more information on the work of WHO on health systems, please go to:
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TABLE OF CONTENTS

A. RATIONALE

To achieve the health-related Millennium Development Goals, many low-income countries need to significantly scale up coverage of priority health services. This will generally require additional national and international resources, but better leadership and management are key to using these resources effectively to achieve measurable results. Good leadership and management are about providing direction to, and gaining commitment from, partners and staff, facilitating change and achieving better health services through efficient, creative and responsible deployment of people and other resources *(1)*. While leaders set the strategic vision and mobilize the efforts towards its realization, good managers ensure effective organization and utilization of resources to achieve results and meet the aims.

Ministries of Finance and international donors are increasingly insisting on evidence of measurable results in health. Better leadership and management are thus critical to achieving the MDGs: they are required to demonstrate results from existing resources – and these results, in turn, make it more feasible for additional resources to be made available to the health sector. (We could call this the "virtuous circle of leadership and management strengthening".) In many low-income countries, what is really needed is managers who can lead, and leaders who can manage.

At present, a lack of leadership and management capacity is a constraint, especially at operational levels of both the private and public health sectors. This is sobering, considering the time and money spent by governments and development partners to strengthen capacity in leadership and management. Thus it is clear that these efforts have to be improved. The competencies, roles and responsibilities should be clearly defined and performance changes measured. Progress requires systematic work to determine needs and identify effective interventions; countries to implement an overall plan for developing leadership and management capacity; and international aid to be coherent in support of country plans.[1]

B. THE INTERNATIONAL CONSULTATION

Given the above context, WHO convened an international consultation on strengthening health leadership and management in low-income countries *(2)*. The overall *purpose* of the meeting was to consult in detail on actions required and how these might be achieved. Specifically, the objectives of the consultation were:

- to agree on the key leadership and management issues in scaling up service delivery;
- to share countries' experiences and lessons learnt;
- to bring the above together into a practical framework, with specific strategies for supporting leadership and management capacity-building (especially in low-income countries);
- to propose a follow-up programme of work – for WHO and others.

The consultation took the form of a highly participatory four-day meeting, consisting of presentations, plenary and group discussions and poster and video presentations. All proceedings were held in English and French.

Participants included: a) Ministry of health and private sector managers; b) staff from institutions involved in leadership and management development; c) staff from development agencies; d) WHO staff from headquarters and regional and country offices. A full list of participants is given in Annex 2.

[1] Documents in the WHO series *Making Health Systems Work* tackle many of these issues. http://www.who.int/management/mgswork/en/

The consultation produced four outputs:

- a **framework** for strengthening health leadership and management in scaling up health services;
- agreement on key leadership and management **issues** in scaling up health services delivery;
- a set of **good practice principles** for strengthening health leadership and management in low-income countries;
- **recommendations** on actions (for WHO and others) to further strengthen health leadership and management in low-income countries.

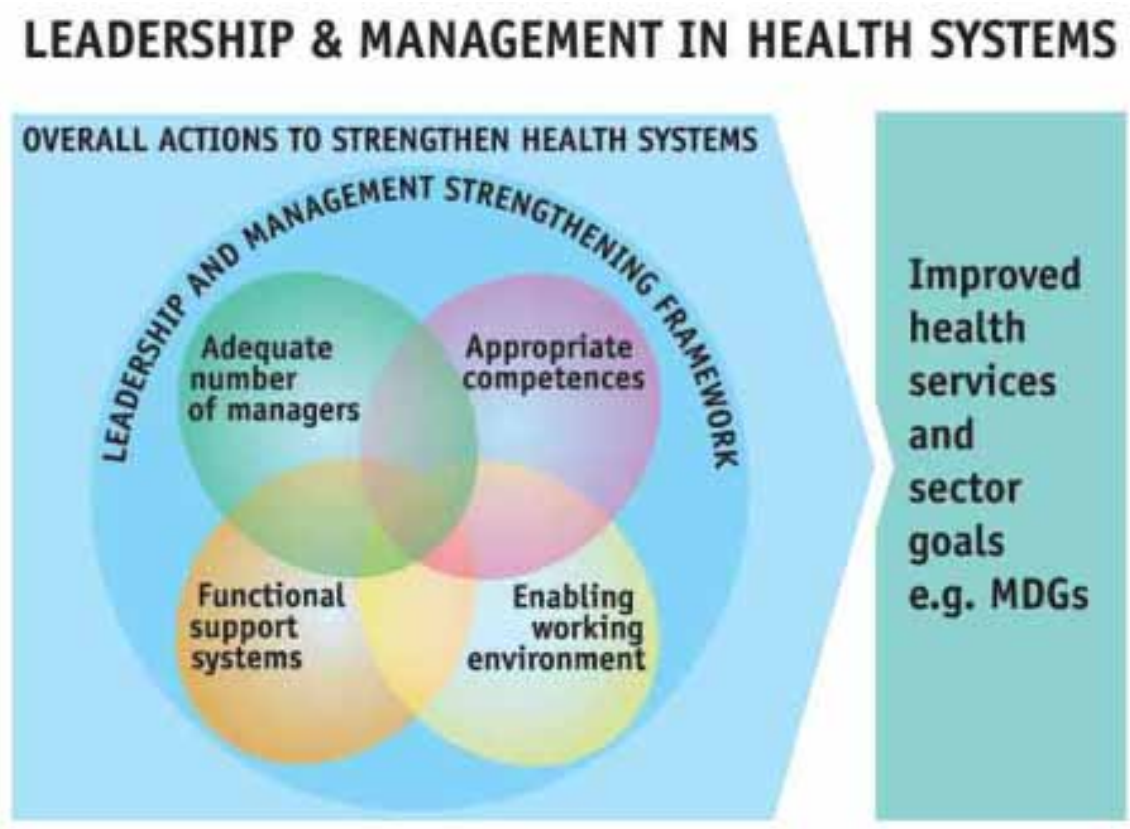
Although the specific focus was on low-income countries, the consultation concluded that the framework and many of the other points summarized in this report are also relevant to other countries.

The rest of this report is structured around these four outputs, which essentially summarize current thinking on, and future action points for, strengthening leadership and management in low-income countries.

Output 1. A leadership and management framework

Leadership and management are complex concepts which are relevant to many different parts of the health system, including the private and public sectors; health facilities, district health offices and central ministries; and support systems related to pharmaceutical, finances and information. Leadership and management are also human resource issues – specifically, the skilled and motivated managers and leaders needed to work throughout a health system.

To structure work on these complex issues, WHO devised a draft framework which addresses the question, “What conditions are necessary for good leadership and management?” This draft was discussed and ultimately endorsed by the consultative meeting – the revised framework is described below.



The framework proposes that for good leadership and management, there has to be a balance between four dimensions:

1. ensuring adequate **numbers** and deployment of managers throughout the health system;

2. ensuring managers have appropriate competences (knowledge, skills, attitudes and behaviours);

3. the existence of functional critical support systems (to manage money, staff, information, supplies, etc.)

4. creating an enabling **working environment** (roles and responsibilities, organizational context and rules, supervision and incentives, relationships with other actors).

These four conditions are closely interrelated. Strengthening one without the others is not likely to work.

The framework makes the point that leadership and management strengthening activities are a means to an end – more effective health systems and services, and an integral part of health system strengthening.[2] Better-functioning systems will, in turn, contribute to achieving the MDGs.

The framework provides a simple but coherent approach to leadership and management strengthening within health systems and in each specific context, can be adapted or modified for use in local situations.

Examples of the issues included in each of the dimensions are provided (see box on p. 4).

The framework has a variety of uses, including:

- Mapping current activities – which of the four dimensions are covered by current leadership and management strengthening activities?

- Needs assessment – what are the leadership and management development needs in a given health system?

- Planning – does a country's leadership and management development plan deal with issues in all four dimensions of the framework?

- Problem solving – why are some leadership and management problems so persistent in a particular country, given the amount of investment in strengthening leadership and management?

- Monitoring and evaluation – what are the effects of existing leadership and management strengthening activities on the four dimensions of the framework?

[2] Health systems strengthening is defined as building capacity (in critical building blocks) to achieve more equitable and sustained improvements across health services and health outcomes.

The four conditions which facilitate good leadership and management

1. Ensuring adequate **numbers** of managers
   - How many health service managers are employed? Do we know this?
   - How many of these have "manager" in their job title? How many combine the role with clinical work?
   - How are the managers distributed throughout the country? At what levels of the health service?
   - What efforts to increase and maintain the pool of available managers have been employed?

2. Ensuring managers have appropriate **competences**
   - Is there a practical competency framework for the knowledge, skills, attitudes and behaviour required for various managerial posts?
   - How are competencies enhanced? Through off-site or on-the-job training, coaching or action learning?
   - Is there a national system for competency development?
   - What qualifications and experience do managers have?
   - What are the principal limitations of current managers in terms of their own competencies?
   - Which managerial competencies have been targeted for development?
   - Have approaches been piloted and later scaled up? What is known about their costs and effectiveness? Are the activities and the achievements sustainable?

3. Creating better critical management **support systems**
   - How well do critical support systems function?
   - What are these critical systems? (The list could include budget and financial management; personnel management, including performance management; procurement and distribution for drugs and other commodities; information management and knowledge sharing.)
   - How successful (or not) are efforts to improve one or more of these support systems? Have any improvements been sustained?
   - How important were changes in these managerial support systems in terms of improving the performance of managers themselves?
   - Who are the management professionals running specific support systems and how qualified are they (e.g. accountants, logisticians, IT specialists)?

4. Creating an enabling **working environment**
   - Do organizational arrangements within the health system encourage managers to perform well? (These include degree of autonomy, clear definition and communication of roles and responsibilities, fit between roles and structures, existence of national standards, rules and procedures, availability of help lines, regular meetings, etc.)
   - Do incentives and supervision encourage managers to perform well?
   - How do the various disciplines in the health sector work together in the context of leadership and management?
   - Have there been recent changes to organizational arrangements, incentives or supervision? (e.g. job descriptions, written guidelines, benchmarks, changes in remuneration packages, etc.)
   - How important were these changes in improving managerial performance?

Output 2. Key leadership and management experiences and issues in scaling up health services delivery

The consultation explored the four dimensions of the framework in relation to a variety of contexts. Through presentations, posters, videos and discussions, a large number of examples were explored. These included case studies from Benin, Egypt, Guinea, Kenya, Myanmar, Nigeria, Papua New Guinea, South Africa, United Republic of Tanzania, Togo, Uganda and the United Kingdom, as well as from institutions including the African Medical and Research Foundation (AMREF), Centers for Disease Control and Prevention (CDC) and WHO AMRO/PAHO *(3)*. Details of the posters are given in Annexes 3A & 3B.

A number of issues emerged as recurring themes critical to leadership and management development in low-income countries. These are grouped below according to the four dimensions of the framework.

In general:

- There are more activities related to aspects 2 and 3 (competences and support systems) of the framework than to 1 and 4 (numbers and working environment). Traditional training and strengthening individual support systems are more common than activities such as mentoring, developing incentives for improved leadership and management or innovative ideas for retaining experienced managers.

- Many leadership and management strengthening activities are relatively small-scale. There is a need to think about scaling up to a country-wide level.

Dimension 1. Ensuring adequate numbers and deployment of managers throughout the health system

Low-income countries generally face a shortage of health sector managers. However, it seems that few, if any, low-income countries are tackling this shortage systematically.

Defining "manager"

Countries need to adopt a practical definition of "manager". Few Low-income countries have a designated health management cadre – staff often become managers after working in a technical job. Indeed, many health workers combine management with clinical or other technical work.

Each country can define "health manager" differently. However, a useful starting point is the following definition:

A health manager is someone who spends a substantial proportion of his/her time managing:
- volume and coverage of services (planning, implementation and evaluation);
- resources (e.g. staff, budgets, drugs, equipment, buildings, information);
- external relations and partners, including service users *(1)*.

The term "manager" should in the first instance be used for staff who have a major management role with the significant proportion of their time spent on this role. If the term is applied to anyone who has only partial managerial responsibilities, its importance is diluted and it is difficult to prioritize leadership and management strengthening activities. It is also useful to distinguish between managers who have overall responsibility for service coverage and quality (such as district health officers) and staff who manage only one specific support system, such as logistics.

> "When we talk about managers, it is like a hat which fits all the heads."
>
> *Conference delegate, reflecting on the over-use of the designation "manager"*

Information about managers

Few low-income countries have a human resource information system which can identify health sector managers and where they are posted. This is often because managers are classified in the database according to their basic (often clinical) qualification.

An information system which records information about health managers has many potential uses:

- Providing basic information about vacant and filled management posts;
- Informing employment decisions - what managers are available, their length of service, performance record, qualifications, competences, etc.;
- Enabling operational research on key issues such as the retention of experienced managers;
- Storing information on the qualifications and training record of individual managers.

In addition to information on the current situation, countries also need to think about the supply of managers in the short, medium and long term. In the future, how many management posts will need to be filled?

Formalizing management posts

Management posts need to be properly described and formalized. This requires:

- clarity about their roles and degree of authority (what kind of decisions they are entitled to make) at all levels of the health system;
- clarity about the competences they need to have at each level of the health system;
- job descriptions based on the above. These should make clear how much authority a particular post has, and the competences required.

Ideally, as the range of management posts become clearer, career pathways for managers can also be developed.

In some countries, formalizing these issues is an important step in raising the status of managers through official recognition. It can be hard to be effective as a manager without the official designation.

In general, few leadership and management strengthening activities were identified which tackled the issue of numbers systematically. This is an important area for future work. A good starting point is to identify a limited number of high-priority management positions and to work out how these posts can be filled appropriately. For example, a country may decide to prioritize the heads of district health management teams, on the ground that good district managers can significantly improve local service coverage and quality.

Dimension 2. Ensuring managers have appropriate competences (knowledge, skills, attitudes and behaviours)

> "We've learned the expensive way that training on its own does not solve management problems."
>
> *Conference delegate*

In contrast to the "numbers" dimension discussed above, there is a great deal of activity related to managerial competences. There are, however, some common problems:

- Much of the activity is in the form of short, one-off training. There are many ad hoc workshops and other events, which are not coordinated in terms of content, timing or participants. These workshops may be initiated, inter alia, by vertical disease programs, senior managers of support systems, or donors. Without overall direction from the ministry of health, there can be significant duplication.

- Training often concentrates on the knowledge of individuals, rather than on skills, attitudes and behaviours of management teams. The knowledge is often specific to the management of a particular disease program.

- The opportunity costs of this training are high in terms of managers being absent from their jobs. Managers often do not have the opportunity to plan or choose what trainings they join; per diems are often a strong incentive which distort decisions to participate in training events.

In summary, competency development is often driven by short-term, narrowly-focused need, rather than aimed at providing adaptable generic competences which will have long-term and broader cross-cutting benefits.

Most low-income countries do not use competency frameworks for health managers and thus do not have a national plan for managers to acquire these competences. A competency framework specifies some common values, attributes and skills for all health managers and identifies specific competences for different types of managers. Similar frameworks can be developed for leadership.

There are many existing competency frameworks to use as reference documents.[3] Care must be taken to ensure that "new" competences are included – for example, managers are increasingly expected to develop and manage partnerships with the private sector. Teamwork, advocacy and negotiation skills and a variety of "soft skills" all need to be included. Competences should be related to an analysis of the local working environment (dimension 4 - see below).

The above implies a logical set of steps related to leadership and management competency development:

- Realistic roles and tasks and hence, competences need to be defined for each management position.
- Information on the required managerial competences should be used to develop operational plans for competency development.

[3] Examples were given by (a) Management Sciences for Health and (b) the UK National Health Service.
(a) *Managers Who Lead: A Handbook for Improving Health Services,* MSH Leadership and Management Program, 2005 (page 12). http://www.msh.org/projects/lms/Programs/MWL.htm
(b) *NHS Leadership Qualities Framework,* NHS Institute for Innovation and Improvement, 2006. http://www.nhsleadershipqualities.nhs.uk/portals/0/the_framework.pdf

- Competences need to be acquired through a variety of means, including coaching, mentoring and action learning. Traditional classroom-based learning is rarely adequate for acquiring competences. Some activities should be organized for management teams, and some for individuals.

Dimension 3. The existence of functional critical support systems (to manage money, staff, information, supplies, etc.)

Managers require well-functioning support systems in order for them to do their jobs effectively. The main support systems are:

- planning
- financial management
- information/monitoring
- human resource management
- management of stocks and assets – particularly, drugs, buildings, vehicles and equipment.

Support systems rarely work perfectly in low-income countries – there may be communication gaps, for instance, or inadequate staffing or unnecessary bureaucratic procedures. Managers need to learn how to navigate real-world systems so that they can get the best possible information out of them. This requires country-specific learning materials and resource people who know the on-the-ground realities.

The support system of financial management can provide an example of "support system navigation" competence. In theory, a district health office might be expected to receive its quarterly financial allocation close to the start of the quarter and an amount of money the same as the agreed budget for that quarter. In practice, this may never happen. In theory, it may not be the formal responsibility of the district manager to contact the district and regional accounts offices, but in practice, he may receive more money sooner if he is seen as a manager who lobbies hard for his money *(4)*.

> One practical problem is the *volume* of information required. Health centres in one country had to record 11 full sheets of data every working day. This took one staff member, who had other clinical tasks, up to eight hours a day.
>
> From *Managing the Health Millennium Development Goals - The Challenge of Management Strengthening. Lessons from Three Countries.* WHO, 2007

In the longer term, however, it is clearly desirable to have well-functioning support systems. In the extreme, a support system can be so dysfunctional that it needs to be reformed. But whose responsibility is it to ensure that support systems in a health system function adequately? This is clearly a matter of leadership – senior managers at the central level need to see this as their responsibility. Even when reforming a particular support system lies beyond their remit – for example, human resource management procedures are often government-wide – senior managers need to ensure a practical balance between developing managerial skills and the existence of functioning support systems.

A great deal of attention has been paid to some aspects of support systems. For example, many health managers spend a lot of time learning about planning and then, formulating the plans. Many countries have also made major efforts to improve the management of drugs and information. Many health managers have been trained in at least some aspects of financial management, often for particular sources of money. In contrast, human resource management and maintenance systems for buildings and equipment seem to be relatively neglected, compared with other support systems. All support systems have a

role to play and management suffers when any one of the support systems functions poorly. It is thus important to have a balanced approach that avoids concentrating too heavily on one or two support systems.

Reforms to support systems need to keep a balance between national and local needs. Local managers should be able to use information locally and to adapt systems to some extent to reflect local conditions. Reforms to the health planning system in Uganda, for example, aimed to streamline planning and improve prioritization. However, the system became so centralized and prescriptive that local managers were frustrated because they felt they could not include local priorities in their plans.

More work needs to be done that looks at support systems together – most existing work concentrates on individual support systems. Can too many support systems be strengthened or reformed at the same time? Can reforms happen too frequently? If several support systems function poorly, where is the best place to start? What do district- and facility-level managers think are the priorities for change? Moreover, vital connections between support systems need to be established - for example, practical links between information on achievements and on expenditure.

Dimension 4. Creating an enabling working environment (roles and responsibilities, organizational context and rules, supervision and incentives, relationships with other actors)

> "It's important to understand the working environment. Indeed, it affects the competences that we need in our managers."
>
> *Conference delegate*

The environment in which managers work clearly influences their effectiveness. Three broad categories of "working environment" were identified:

- The *immediate working environment* within the health sector. Examples included how much authority was delegated (over staff, budgets, etc.); the nature of health management *teams*; the level of tolerance of corruption; how supportive senior management was; the degree of professional, social and geographical isolation felt by managers; incentives - whether good local leadership and management were rewarded; the ability to prioritize locally; and influence, if any, over national decisions. District managers often experience high expectations "from above" about what they should deliver, but little reciprocal appreciation of the importance of responsiveness to local priorities.

- The *wider working environment*, including other public and private sector stakeholders. A variety of stakeholders play a dominant role in a health manager's work – for example, decentralized authorities and local politicians; the private/NGO sector; local communities. Donors/development agencies were identified as a particularly influential part of a manager's environment. On the one hand, donors provided managers with much-needed resources to work with; on the other, donors were often seen to give managers conflicting messages, with little regard to managers' other priorities. Decentralization also potentially poses challenges to managers, who may find they have multiple and conflicting roles and reporting lines.

- The *broad cultural, political and economic context*. Cultural, political and economic realities can limit managers' scope for decision-making. Overall standards of governance, and the degree to which the rule of law is respected, set the wider context in which the health sector operates.

> "We can't wait until we have a perfect world to do something."
>
> *Conference delegate, contemplating how her Ministry might create a more supportive work environment for its managers*

What can a ministry of health do to make the environment as enabling (or "supportive") as possible? While some environmental factors are clearly beyond a ministry's control, there is much that can be done. For example:

- Work with donors at national level on harmonization and environment so that managers further down the system do not have to respond to different donors with different demands, priorities and procedures.
- Ministries of health can demonstrate with words and deeds that managers are important and valued. Incentives for good performance and worthwhile career paths send the message that good leadership and management are valued.
- Good communications help to create an enabling environment. For example, managers should be informed promptly of new rules or policy directions and key documents such as national plans and guidelines should be readily available.
- Encouraging forums, associations and institutes for managers – these can be effective and motivating channels for capacity-building.
- Supportive supervision can provide managers with a sense of belonging to a wider system and can provide practical help in solving problems. Too often, the hierarchy above a manager is seen as a source of problems and anxiety, rather than a resource to help the manager do his job.
- A reasonable degree of local control. Managers who are just messengers to implement national rules and procedures have less job satisfaction than managers who have some control over resources and room for manoeuvre. Ministries should encourage appropriate local initiative.

In short, there is much that the political leadership and senior management in a ministry of health can do to support local managers.

Even when a particular aspect of the environment is beyond a ministry's control, the very act of explicitly recognizing the role of environment and discussing what it means in a particular context can be helpful. A ministry of health can provide better support for its district managers when there is a shared understanding of the environment in which district managers operate. For the broader cultural, political and economic aspects, it is at least helpful for managers to recognize constraints and to explore how to work within them.

In general, little attention is paid to this dimension of the leadership and management framework. Perhaps it is seen as too broad or too vague, or perhaps it is felt that nothing can be done about such far-reaching issues. In practice, the opposite is true – respecting and supporting managers is a vital part of improving their effectiveness.

"Work environment" can also be explored for a particular aspect of a manager's job. One topical example is partnerships for service delivery. District managers are regularly exhorted to "build partnerships for service delivery" as an efficient way of improving health outcomes. These partnerships can be with a variety of actors - private providers, NGOs, other public institutions such as schools or local councils, industry or community leaders.

Through a coordinated range of activities, much can be done to support managers in forging such partnerships. New skills may be required by health managers and their potential partners. There may also need to be changes in support systems or the broader working environment – for example, a legal change so that the public sector can pay private, for-profit providers. In the language of the leadership and management development framework, building partnerships has implications for what is included under issues 2, 3, and 4 (support systems, competences and work environment).

Good management performance can be encouraged by using simple indicators to compare districts or health facilities.

The *Yellow Star Programme* in Uganda rewards good management. The programme monitors health facilities in 47 districts against a set of 35 standards, chosen because they were the best indicators for overall management. 100% compliance against the standards results in the award of a plaque for display at the health facility – this brings with it recognition and good publicity.

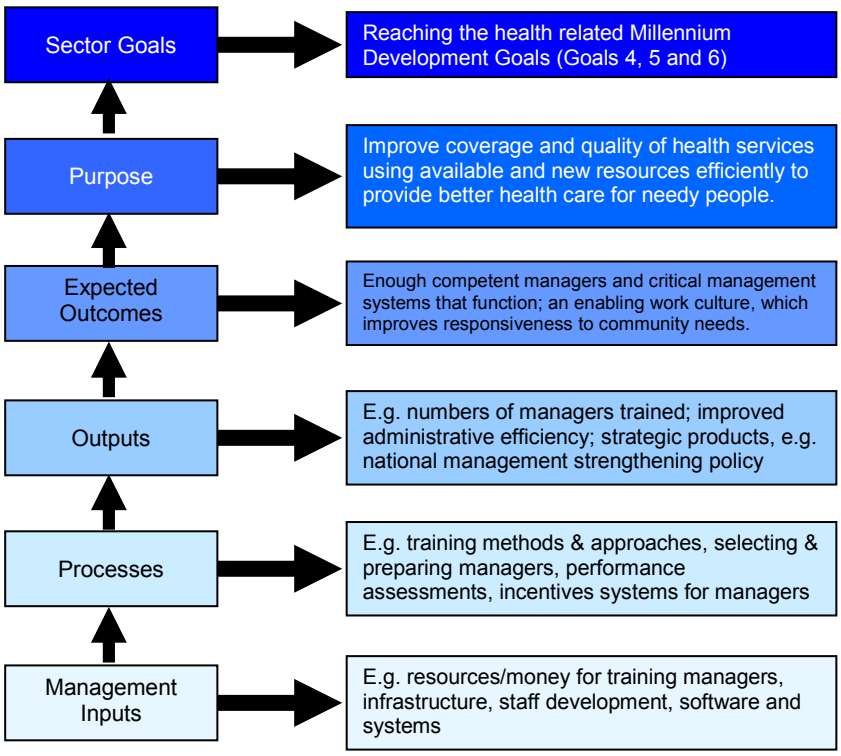
The *District Health Barometer* in South Africa uses carefully selected health indicators to make comparisons among districts. The Barometer contributes to improvements in the quality and utilization of primary health care by identifying problem areas. The Barometer does not provide "new" information however, the information is presented in such a way that it catches the attention of local and national managers. This is something that the same information presented in other reports and tables has not been able to do.

Tracking management performance

For all the issues and dimensions discussed above, monitoring the effectiveness of activities and having an overview of a system's "management well-being" are important. Sound measurement and monitoring are vital for raising the profile of leadership and management strengthening, and for making the case for investing in such activities.

The diagram below illustrates how the inputs, processes and outputs of leadership and management strengthening activities contribute to higher-level health outcomes and goals. The boxes on the right list the kinds of issues which could be measured.

Investment in management improves the health of populations *(5)*



For regular monitoring, the challenge is to find practical measurements of the steps for developing good leadership and management. Annex 4 proposes indicators which assess the inputs, processes and outputs of leadership and management capacity strengthening in terms of the four core components of the framework described above. The indicators are selected to reflect relative simplicity, feasibility of collection and relevance.

It is difficult to directly attribute health service outputs and outcomes to leadership and management strengthening inputs and processes. Nevertheless, there are “leadership and management outputs” which can be benchmarked and linked to health production. For example, one output in Annex 4 is “reduced turnover of managers”. This can be regularly measured and comparisons made – for example, between different regions. The practical consequences of high turnover can also be documented.

The challenge now is to adapt these generic indicators to specific country situations, and to link them to the wider national health objectives.

Output 3. Good practice principles for strengthening health leadership and management in low-income countries

Based on the above identification of issues, the consultative meeting endorsed a set of key principles for strengthening health leadership and management in low-income countries.

Health outcomes	Health leadership and management strengthening is a critical ingredient in achieving the MDGs; leaders and managers need to be held accountable for results.
Evidence based	Leadership and management development should draw on available evidence and national and international good practice; be practical and feasible, and progress in performance be monitored over time.
Aligned	Leadership and management strengthening should not take place in isolation; it has to be part of the broader health sector strategy and reflected in human resource development plans.
Long term	Improvements have to be introduced sequentially, flexibly and incrementally, starting on what can be improved immediately; building on efforts that already exist, and sustaining support over the long term.
Transformational	Addressing leadership and management challenges requires a transformational approach, giving attention to all four dimensions of the framework (numbers; competences; support systems; and working environment) taking account of country goals and aspirations, and overall available resources.
Harmonized	Greater effectiveness in leadership and management development will be achieved through harnessing and harmonizing of all available internal and external resources involved.

Yes … we can do it.

In summary, these principles emphasize:

- Strengthening leadership and management is one part of a range of activities to reach specific health goals. The contribution of leadership and management strengthening activities to broader health goals should always be made clear.

- The importance of using information and building on what already exists. Leadership and management development activities should be designed using existing evidence on what works; monitoring should establish whether the activities produce the desired effects or not.

- Leadership and management strengthening activities need to reflect a balance between the four dimensions of the framework. Activities have to be prioritized to reflect the resources available.

- Leadership and management strengthening should be designed according to the principles of harmonization and alignment described in the Paris Declaration. Most low-income countries and major international agencies have signed this Declaration.

Output 4. Recommendations on actions to further strengthen health leadership and management in low-income countries

Main Messages

In summary, the main messages from the consultative meeting on strengthening health leadership and management were:

General

- Strengthening health leadership and management is not an end in itself – it is done in order to improve progress towards national and global health goals.

- Many examples of leadership and management strengthening are relatively small-scale. There is a need to learn how best to scale up to a country-wide level.

- There are many dimensions to leadership and management. The framework described in this report is a device for bringing together the main dimensions – numbers, competences, support systems and the working environment.

- Concentrating activities within one dimension may not lead to the expected improvements if other dimensions are neglected. In practice, a large proportion of leadership and management development resources are devoted to classroom training, at the expense of work in the other dimensions and on overall competency development.

- While the meeting primarily focused on low-income countries, the issues and approaches discussed were found to be relevant to many middle income countries, too.

Numbers

- Managers are a vital part of the health workforce. The human resource system should have well-defined managerial posts with job descriptions and information on the managerial workforce (numbers, where posted, individual information on competences, etc.).

Competences

- National competency frameworks should be developed and used – these describe the competences required for different managerial posts. Competences should be acquired in a planned manner, using a variety of techniques including mentoring, action learning and classroom learning.

Support systems

- Managers need to develop the skill of negotiating support systems – i.e. getting the best out of real-life support systems, despite their flaws.

- The central ministry of health needs to take the lead in identifying when a support system is in need of substantial reform, rather than incremental strengthening.

Working environment

- Ministries of health can demonstrate in word and deed that managers are important and are valued. Techniques for this include incentives for good performance, worthwhile career paths and supportive supervision.
- Good donor coordination – so that donors are aligned with government priorities and harmonized with government procedures – makes the job of managers easier.

- Managers have to deal with a wide variety of stakeholders – this should be recognized as an important part of their job. Managers need the appropriate competences and enabling environment to forge these partnerships.

Measurement

- Measuring trends in overall management “well-being” and the effectiveness of particular leadership and management development activities is important.

Action points

The consultation concluded with a series of action points for various stakeholders. (A summary of stakeholder roles and actions identified during the meeting can be found in Annex 5.)

- In general, the framework and key principles should be applied to a wide variety of contexts.

- At the country level, the framework should be used to assess nation-wide leadership and management capacity and make a business case for improving it. (A business case is essentially a strong, well-justified funding proposal.) The business case should then be adapted for whatever funding opportunities are available – for example, health sector-wide approaches (SWAp) or the Global Alliance for Vaccines and Immunization (GAVI) health systems strengthening fund.

- Providers and commissioners of training for health workers should ensure that leadership and management subjects are incorporated into more basic and post-basic health worker curricula and that their training reflects all four dimensions of the framework.

- Recommendations for action in five broad areas were made to WHO:

    i) Fine-tuning the framework; supporting the use of the framework in countries and sharing practical experiences and findings;

    ii) Encouraging networks of leadership and management resource institutions and individuals active in the field;

    iii) Creating a clearing house/knowledge centre to review and increase access to simple and effective leadership and management tools and approaches.

    iv) A greater role in catalysing the harmonization and alignment of development partners with country health systems, and assistance to countries in mobilizing resources for strengthening leadership and management. This includes:
    - supporting countries, with a focus on low-income countries, in using the framework and documenting how leadership and management strengthening contributes to improving service delivery;
    - supporting countries to tackle neglected/difficult issues, especially those related to managing the health workforce and improving productivity and performance;
    - linking leadership and management strengthening activities to existing national instruments such as Poverty Reduction Strategy Papers (PRSPs) and health workforce strategies, taking advantage of international vehicles such as the Global Health Workforce Alliance, the Health Metrics Network and the GAVI health system strengthening window.

    v) Further development of tools for leadership and management strengthening, where there are currently gaps, such as:
    - a tool for assessing leadership and management capacities;
    - guidance for developing leadership and management strategies at country level;
    - monitoring and evaluation of leadership and management strengthening activities.

Implementing the above will require leadership:
- from central ministries of health to establish and maintain leadership and management strengthening as a priority;

- from management development/training institutions to support implementation and, where necessary, to lobby about the importance of strengthening leadership and management;

- from international development agencies to provide evidence to countries about the importance and effectiveness of strengthening leadership and management.

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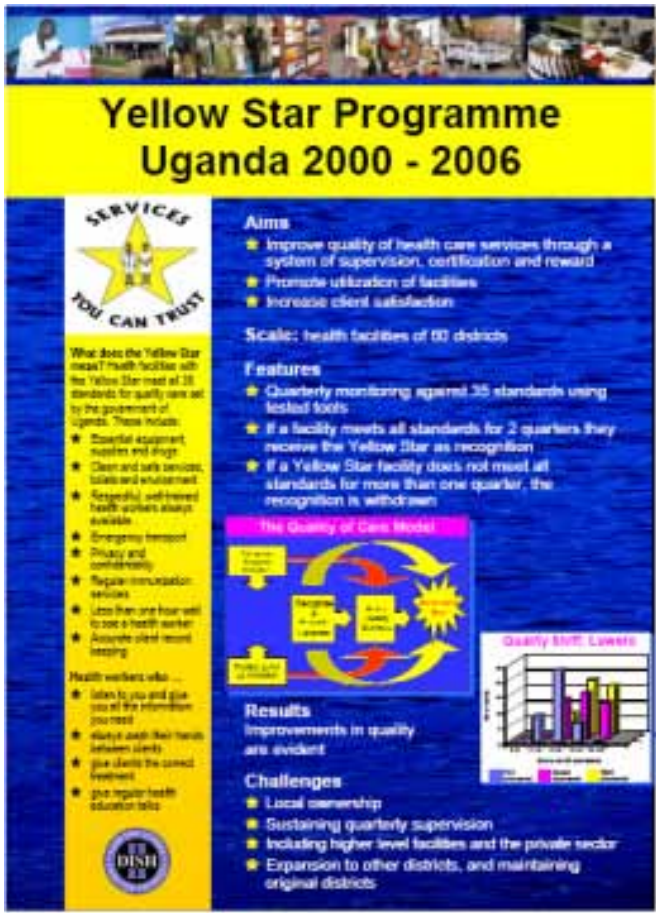
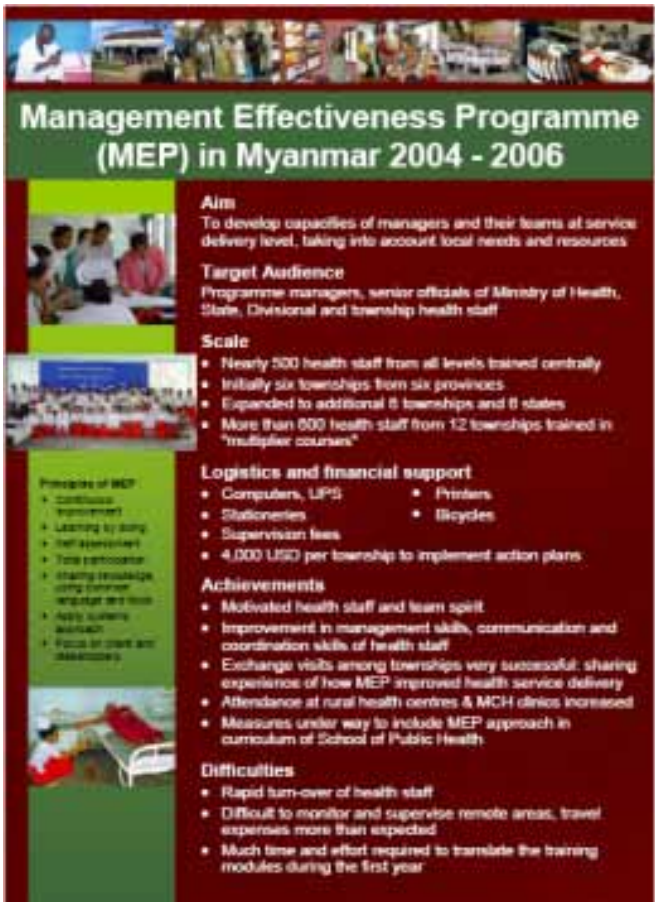
Annex 3 A. List of posters describing country experiences in leadership and management development

POSTER	ACTIVITY PURPOSE AND SCOPE	Numbers of managers	Competences	Support systems	Work environment
African Medical Research Foundation (AMREF) International Training Centre	Outlines management related work of a long established regional NGO running community health development and training programmes and materials for health professionals in Africa		■		
Change Agents Programme, Nigeria	A programme operating in 36 states since 2000 to develop skills of managers, CSOs and the private sector in health reform and policy development		■		
Cost-effective capacity building options in Papua New Guinea: CBSC	Presents a problem-based programme designed to build individual and group managerial capacities, with an emphasis on interactive and distance learning, and communities of practice		■	■	
District Health Barometer, Health Systems Trust, South Africa	Simple PHC monitoring tool used to compare districts' performance and trends; emphasis on presenting data in ways that will communicate well and so enhance use of data			■	
Institut Régional de Santé Publique, Benin	Presentation in French of a range of management related courses for public and NGO managers in the region		■		
Le Concours Qualité, MOH, Guinée	Outlines a recent programme to improve management and health care in 25 of the 34 regions in Guinée		■		
Leadership, Management and Sustainability Programme, Management Sciences for Health (MSH) Egypt	Outlines a team and goal-based approach to developing leadership and management skills with example of one governorate in Egypt (has been implemented in over 30 countries)		■		■
Management Effectiveness Programme, Egypt	Presents a team-based approach to strengthening management in 4 districts in Egypt		■	■	
Management Effectiveness Programme, Myanmar	Presents a team-based approach to strengthening public service management in 12 townships in 6 states in Myanmar		■		■
Martyrs University, Uganda	Outlines range of courses and approaches to training managers provided by the university		■		
National Health System (NHS) Leadership Qualities Framework, UK	Outlines competencies associated with high performing senior managers - designed in 2002, based on evidence from research		■		
Rapid Results Initiative, MOH, Kenya	Nation-wide MOH programme for provincial and district management teams, to accelerate implementation of priority services		■		■
Sustainable Management Development Programme, CDC	Leadership and team-building programme aimed at improving individual and organizational management competencies, with graduates in 63 countries		■		
Tanzania Essential Health Interventions Project (TEHIP), Tanzania	Outline of a project to develop an evidence-based approach to improving service delivery in 2 districts in Tanzania, with an emphasis on building management capacities		■	■	■
WINSIG Management Information System, PAHO	Presents a DRG-based tool designed to improve efficiency and quality of health facilities, used by 300 facilities in 14 countries in Latin America			■	
Yellow Star Programme, MOH, Uganda	Outlines a nation-wide MOH programme of supervision, certification and reward to improve quality of care		■	■	■

Annex 3 B. Posters shared at the consultation

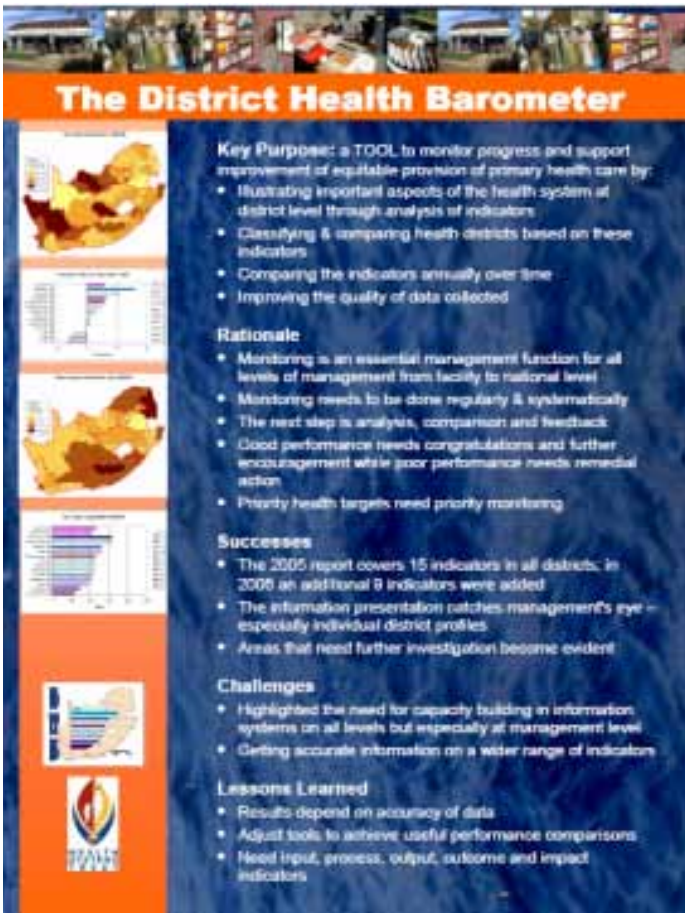


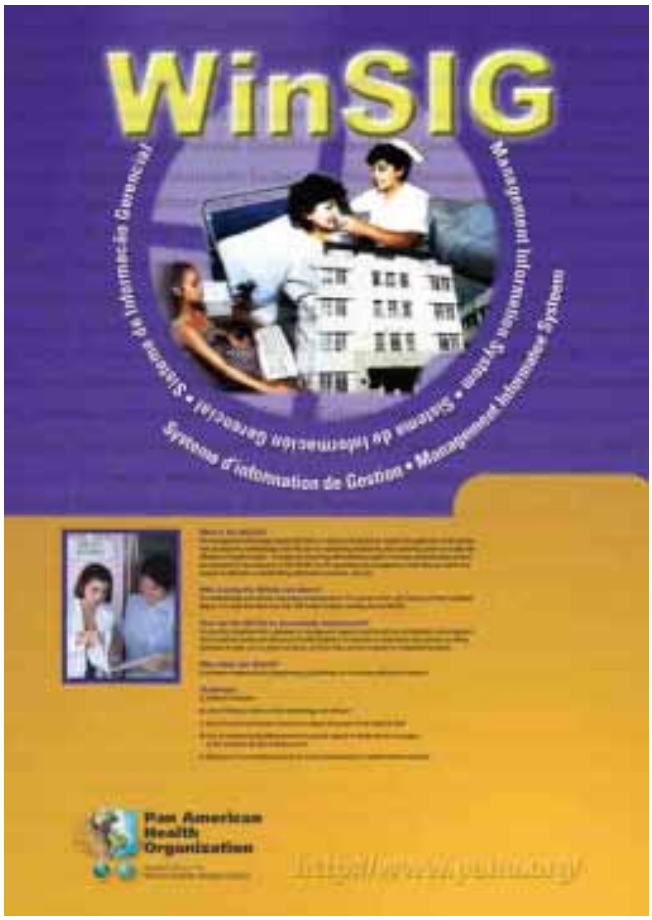

Management Effectiveness Programme (MEP) in Myanmar 2004 - 2006
Aim
To develop capacities of managers and their teams at service delivery level, taking into account local needs and resources
Target Audience
Programme managers, senior officials of Ministry of Health, State, Divisional and township health staff
Scale
Nearly 500 health staff from all levels trained centrally
Initially six townships from six provinces
Expanded to additional 6 townships and 6 states
More than 600 health staff from 12 townships trained in "multiplier courses"
Logistics and financial support
Computers, UPS
Printers
Stationeries
Bicycles
Supervision fees
4,000 USD per township to implement action plans
Achievements
Motivated health staff and team spirit
Improvement in management skills, communication and coordination skills of health staff
Exchange visits among townships very successful: sharing experience of how MEP improved health service delivery
Attendance at rural health centres & MCH clinics increased
Measures under way to include MEP approach in curriculum of School of Public Health
Difficulties
Rapid turn-over of health staff
Difficult to monitor and supervise remote areas, travel expenses more than expected
Much time and effort required to translate the training modules during the first year


Management Effectiveness Programme (MEP) in Egypt 2002 - 2006
Aim
Develop health system management capacity to respond to the needs of clients, adapt to changes in the health context and improve performance in attaining health system objectives
Target Audience
Managers at service delivery level
Scale
Initially in 6 pilot sites, then 4 districts and later 8 housing areas in 3 Governorates
Features
One year of support and continuous capacity building with about 42 days of formal teaching
Annual planning
Monitoring against measurable targets
Emphasis on flexibility
Culture change in values, principles, processes
Improvement in work systems
Principles of efficiency and effectiveness, meeting client needs and improving population health
Mentors support managers
Lessons learnt
1. Integrate within, and make accountable to, an appropriate department in the Ministry of Health
2. Establish a dedicated WEB site for exchanging knowledge and supporting distance learning
3. Enhance recognition through an educational qualification or a credit towards one
4. Management development is a lifelong process – need a clear strategy for continuing improvements in early implementation sites
5. Market WHO/EMRO MEP
6. Develop sufficient tutor mentors for expansion


Exploring Cost Effective Options for Capacity Building in the Papua New Guinea Health Sector
The Capacity Building Service Centre (CBSC) - an Overview:
Capacity Building with the CBSC
The Role of ICTs
Meeting the Challenges
CAPACITY BUILDING SERVICE CENTRE


Change Agents Programme Nigeria 2000-06
Objective: to ensure that skilled and well positioned change agents are actively and effectively developing and defining agendas for health sector reform and policy development in the country
Target audience
Ministries and legislature at federal, state and local levels
Health professionals, health manager's, professional organizations
Civil society and faith-based organizations,
Private sector, traditional healers, women leaders, media
Scale: Has involved 1,500 change agents from 36 States and the Federal Capital Territory
Key features
Study tours
Action learning
Change projects implementation
Networking
Advocacy skill building
Successes
Putting Health High on Political Agenda of Nigeria
Appointment of CAP Director as Minister of Health 2003
Draft and processing of 1st National Health Bill
Revised National Health Policy
Development of Health Sector Reform Agenda 2004-07
Revitalizing Primary Health Care & Routine Immunization
Kick-starting the implementation of Health Insurance Scheme, and Increasing Budgetary Allocation to Health
Establishment of national and state health accounts
Difficulties
Not all Change Agents had their capacity built
Some don't remain in the health system
It is difficult to build a critical mass of change agents using tours that accommodate only very few persons
High cost of US$5,000 per participant


The District Health Barometer
Key Purpose: a TOOL to monitor progress and support improvement of equitable provision of primary health care by:
• Illustrating important aspects of the health system at district level through analysis of indicators
• Classifying & comparing health districts based on these indicators
• Comparing the indicators annually over time
• Improving the quality of data collected
Rationale
• Monitoring is an essential management function for all levels of management from facility to national level
• Monitoring needs to be done regularly & systematically
• The next step is analysis, comparison and feedback
• Good performance needs congratulations and further encouragement while poor performance needs remedial action
• Priority health targets need priority monitoring
Successes
• The 2005 report covers 15 indicators in all districts; in 2006 an additional 9 indicators were added
• The information presentation catches management's eye – especially individual district profiles
• Areas that need further investigation become evident
Challenges
• Highlighted the need for capacity building in information systems on all levels but especially at management level
• Getting accurate information on a wider range of indicators
Lessons Learned
• Results depend on accuracy of data
• Adjust tools to achieve useful performance comparisons
• Need input, process, output, outcome and impact indicators


WinSIG
Management Information System • Sistema de Información Gerencial • Système d'information de Gestion • Management Information Systems
Pan American Health Organization

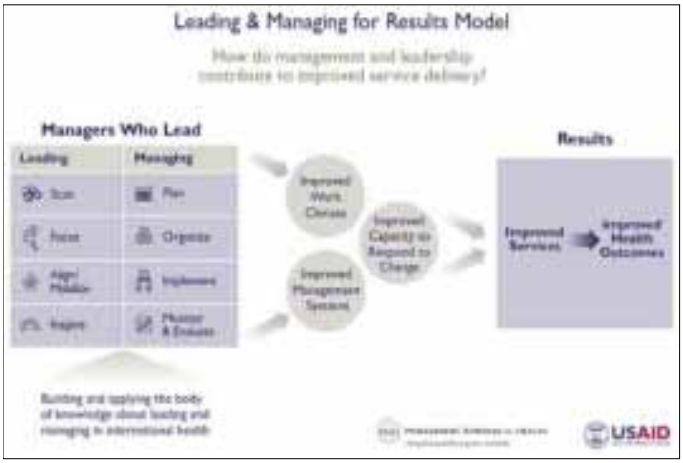

NHS
Institute for Innovation and Improvement
NHS Graduate Management Training Scheme; General, Finance, Human Resources


U.S. Centers for Disease Control and Prevention
SUSTAINABLE MANAGEMENT DEVELOPMENT PROGRAM
"Organizational Excellence in Public Health through Strengthening Leadership and Management Capacity"
Creating Competent Public Health Managers
The Sustainable Management Development Program (SMDP) has developed training content to address public health management competency domains across increasing complex levels of performance (i.e., individual, interpersonal, managerial, organizational and contextual).
Example of Successes:
Hanoi School of Public Health
SMDP's training has led to improved
• Laboratory specimen processing
• Outreach to high risk populations
• Adherence to opportunistic prophylactic treatment among HIV patients
• HIV/AIDS outpatient access to treatment
• Antiretroviral Therapy adherence
• HIV/AIDS counseling services
• Returns for confirmatory test results
Building Capacity
• 525 graduates in 63 countries
• Trained more than 3,000 public health managers
• Enabled thousands more to participate in applied management projects to improve their organizations
SMDP Process
1. Create Strategic Partnerships
2. Develop Capacity
3. Provide Technical Assistance
4. Ensure Sustainability
Challenges
• Leadership commitment
• Suitable local institutional 'home'
• Return on investment in learning
• Quality of trained trainers
CDC
www.cdc.gov/smdp


African Medical Research Foundation (AMREF) International Training Centre
Aim
To provide practical training of the highest quality, ensure effective access to expertise and information for community health development and make effective contribution to health training research in Africa
Scope
• Training health professionals throughout Africa for 45 years
• Since 1987 over 500 students from 37 countries have participated in the one year Diploma in Community Health - which is accredited by Moi University
• In 2006 alone, 1,250 health workers from 30 African countries attended the AMREF 17 courses
• Recognized by the Commission for Higher Education and Ministries of Education and Health in Kenya
• Works in partnership with Tulane University and UCLA in USA and several local Universities
Features
• African designed and African led
• Interactive teaching, learning and assessment
• Competence based programmes
• Distance learning programmes
• Suitable learning materials - AMREF has 60+ published titles
AMREF Library
Over 10,000 book titles, annual subscription to over 50 international journal titles, over 6000 electronic journals, over 7500 e-books, various database on CD-ROM


Martyrs University, Uganda
Faculty of Health Sciences
Mission
To form health managers with the integrity, knowledge, managerial skills, and competences needed to provide good quality health services to the Ugandan population
Scope
• 7 full-time staff members and two visiting staff members
• Number of students in the full-time course has grown from 25 in 2001/02 to 73 in 2005/06
• No. of courses has grown from 2 to 5
Features
• Interactive lectures, problem analysis, case studies
• Practical exercises and guided sessions
• Field attachments
• Mentoring by former graduates
• Extra-mural courses
Success
• Requests for more courses and other collaboration
• Increasing number of applications with requests from the MoH to increase class size
• MoH sponsoring students
• Use of our research findings for decision making
• Provision of tools for management to hospitals
Challenges
• Size of the staff: small compared to the tasks
• Full time structure of courses makes them expensive
• Location of the University: 80 kms from the city, restricts programmes and increases costs
• Fees: not affordable to many
• Need performance assessment of past students in their management roles


Integrated Leading & Managing Process
Face Challenges
Achieve Results


Leading & Managing for Results Model
Managers Who Lead
Leading
Managing
Results
USAID


Institut Régional de Santé Publique, Benin
Main Objectives
• Adapt missions of our institution to the context of globalization and MDGs
• Enhance management development in French speaking African countries
• Be a center of excellence for methodology and expertise in Public Health and Epidemiology
• Avoid brain drain in the health sector
Target Audience in Health
• Health policy makers
• Managers in WHO Country Offices and MOH
• Health project managers in countries (Ministries, international agencies, NGOs)
• Health service managers in districts, hospitals, schools, occupational sector, communities
A Selection of Courses
• Short course Contracting in Health
• Short course Mid Level Management
• Short course Managing Immunization Services
• Master in Public Health
• PhD in Public Health
Methods
• Interactive lectures
• Field work
• Advice at a distance
• Use of ICT for education
• Supervision at work
• Distance learning
• Operational research
Indicators of Success
• Teaching programs are validated by the University
• sponsors give grants for participants
• Country candidates make applications
• Regional Network of expertise

Annex 4. Proposed indicators for measuring management capacity trends

Making Management Capacity Available

1. Ensuring an adequate *number* of managers		
Expected Outcomes: • Adequate numbers of managers in charge of the majority of critical service delivery units (e.g. Health Districts, Hospitals, Health Centres) • Reduced vacancy rates for critical service delivery management posts (DMOH/Hospital)		
Inputs and Processes	**Expected Results/Outputs**	**Possible Indicators**
• Establish human resource information system on managers with data on vacancies, retention, etc. • Establish clear criteria for selection and placement of managers • Establish plans and procedures for filling management posts • Increase the number of qualified and available managers through training/recruitment	• Majority of district and hospital management posts are filled with qualified persons (*as defined by country*) • Majority of management posts are held by full-time and professional managers. • The profiles of managers conform to the health sector's needs. • Appropriate numbers of trainee managers are produced annually.	• %of district manager /hospital director posts that are vacant • Full-time managers as a % of health workforce (*density of manager*s)
2. Ensuring managers have appropriate *competences*		
Expected Outcomes: • Managers and managed units that are able to increase coverage of basic services (e.g. immunization, birth by skilled birth attendants; TB low DOTS drop outs, etc.) • Service delivery plans and budgets prepared and local health targets are reached		
Inputs and Processes	**Expected Results/Outputs**	**Possible Indicators**
• Job descriptions & performance expectations • Establish a national competency framework • Establish training courses/development programs based on national competency standards • Impact assessments of training courses • Establish national accreditation/standards system for management training programs	• A majority of service managers are trained according to national standards. • Better target setting, performance monitoring of service delivery • Improved interactions with clients • Curricula utilizing innovative approaches - problem solving, mentoring, attachments, etc. are used	• % of district and hospital managers with approved management qualifications* • % of graduates from certified (PBL)†/ competency-based courses‡ • Job satisfaction rates of managers

* Qualification as defined by each country.
† PBL: Problem based learning
‡ To be based on country/internationally agreed criteria

Applying Management Capacity Effectively

3. Creating better critical *management support systems*

Expected Outcomes: (*country's system specific indicators/tracers can be applied here)*

- Staff turnover rates at district (or other operational level) reduced or stable
- Stock-outs of essential drugs are avoided in the majority of service delivery units
- Annual accounts and audits of service units completed on schedule

Inputs and Processes	Expected Results/Outputs	Possible Indicators

• National policies established for critical systems
• Operational regulations and forms published
• Annual plans of systems processes established
• Trained system support staff available
• Key operational inputs (e.g. computers) provided
• Some critical management support systems:
  ○ Planning and budgeting
  ○ Financial management
  ○ Personnel management
  ○ Essential drugs and logistics supply
  ○ Information system for decision making
  ○ Monitoring and reporting systems
	• Well functioning critical systems
	• Data-based decisions made by managers
	• Reduced administrative delays, e.g.:
	  ○ Recruitment of staff
	  ○ Stock-outs of essential drugs
	• Specific management products are on time:
	  ○ Annual plans, budgets
	  ○ Reports, e.g. expenditure returns
	  ○ Supervision and monitoring and evaluation schedules
	  ○ Financial returns
	  ○ Personnel returns
	  ○ Information/Statistical returns
		• % of approved budget utilized in financial year
		• % of planned M&E visits undertaken by districts to service units
		• % of managers whose performance were formally appraised in past year
		• % of hospitals with qualified/ trained accountants
		• Staff satisfaction rates/trends
		• Client satisfaction rates/trends

4. Creating an enabling *working environment*

Expected Outcomes:

- Increased innovation by managers to attain results
- Managers are motivated to attain service delivery goals and are recognized for it.
- The focus of service managers is directed to customers and communities' needs.

Inputs and Processes	Expected Results/Outputs	Possible Indicators
• Establish legal authority for service delivery managers' roles • Establish ethical guidelines for managers • Establish clear client and stakeholders rights and responsibilities • Publish national governance guidelines/regulations • Professionalize health management cadres (e.g. institutes, regulators, standards of practice) • Establish incentive schemes for well-performing managers	• Good policy environment allowing effective/confident manager decisions • HR & managers turnover reduced • Establish forums for manager/policy maker interactions • "Professional" status of health managers enhanced • Minimize political/administrative interference in managers' decisions (hire and fire, virement of budgets, etc.)	• % of district managers assessed annually to be performing above average • Coverage rate of MDG targets at local level, e.g. TB cure rate, malaria nets, Anti-retroviral treatment (ART), supervised deliveries, DPT3 coverage • Management turnover: No. of district medical officers or hospital directors leaving the post each year over no. of posts

Annex 5. Summary of stakeholder roles for management capacity development

	Ministry of Health	**Sub national health organizations** (*e.g. in Districts, Provinces, NGOs*)	**National Training Institutions**(*Universities, Research Insts.*)	**International Development Agencies**
Adequate Numbers of managers	Needs and gaps identification & analysis with stakeholders; Prioritization of needs	Participate in needs analysis and gaps assessments	Assist to determine national capacity to produce managers	Assist with needs/gaps assessments and definitions
Appropriate Competencies	Lead the design of national competency frameworks and management standards; Identify the strengths of local training institutions and find ways to assist them deliver appropriate programs	Provide basis for "fit for purpose" competency framework and management strengthening strategies; Foster links with local training institutes & assist with practice sites to deliver appropriate programs	Advocate for and build local trainers capacity; Contribute expertise and research findings to needs assessment	Share technical experiences, knowledge, and evidence of international good practices; Support/facilitate networking between local & external institutions; Avoid donor duplication and coordinate support to MOH
Functional Support systems	Set up M&E systems to follow up on progress; Regular review and evaluation of support systems	M&E partner in collecting data and assessing whether systems are producing results; Sharing experience and good practice	Conduct studies and evaluate effectiveness and impact of management support systems	Share technical experiences, knowledge and evidence of international good practice
Enabling work environment	Identify and access resources needed to strengthen management; Establish incentives and processes to encourage good management	Foster local M&E and accountability to communities for management results; Involve local clinicians in management decision and results	Conduct studies on ways of improving management effectiveness (incentives, rewards, performance assessments, etc.)	Facilitate benchmarking of good management performance and incentives systems
Overall strategy and coordination	Identify and engage with L&M* stakeholders, coordinate strategy and plans formulation for management development with national development and sector plans; Mobilize resources; Facilitate internal sharing of experiences & good practice	Mobilize local resources, training sites, mentors, communities in enabling better management; Sharing experience and good practice	Be engaged in national strategy and policy discussions; Build internal capacity for training, research, technical assistance	Advocate for L&M initiatives by good marketing; Soliciting donors and direct resource mobilization; Work with MOH in support of strategic planning and ensuring long term sustainability

* Leadership and Management