STRENGTHENING MANAGEMENT IN LOW-INCOME COUNTRIES

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STRENGTHENING MANAGEMENT IN LOW-INCOME COUNTRIES

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1. BACKGROUND AND CHALLENGES

Currently, a great deal of attention is being placed on scaling up service delivery to achieve the Millennium Development Goals (MDGs). Scaling up depends on having some key resources but it also depends to a large degree on how those resources are managed. Lack of 'managerial capacity' at all levels of the health system is increasingly cited as a 'binding constraint' to scaling up services and achieving the MDGs [1] [2] [3] [4] and this rather non-specific diagnosis is being coupled with exhortations that 'something must be done' about management. This call for action needs to be teased out, so that what needs to be done and by whom becomes clearer. Action also needs to build on past experience of what works and what does not, as national and international efforts to improve management capacity have been going on for years[5].

This brief note focuses on the management of sub-national systems and services. It provides a simple framework for analysing current managerial challenges; it summarises what is known about effective approaches to improve management and what returns from investing in these can be expected, and it outlines some directions for action by the international community. It is a revised version of the draft 'core technical framework' presented at the Montreux meeting[6].

What are the current challenges?
Many managers are operating in unstable and changing conditions. In countries engaged in some form of decentralization, roles and relationships between the centre and other levels are shifting. For example, districts may now have much more direct responsibility for services and resources. Central ministries of health (MOHs) may be moving from direct line management towards commissioning of services from local authorities and facilities. Strategies such as contracting and accreditation are being tried. In addition there is more awareness of the proportion of care provided by the private sector.

Common concerns of central policy makers include: We don't have enough managers; we can't keep those we have. How can we make them perform better? What types of support really make a difference? What will make the biggest difference to improving service delivery? Do we need a professional cadre of managers? How long would that take? How much would it cost? How do we recognize/measure good management? What type of management training will help us get there?

Concerns of local health services managers include: What exactly am I supposed to do as a manager? Will this month's salaries / supplies be on time? How can I get more staff? How free am I to use the money, staff etc that I do have? How can I make better use of them? How can I better balance my own managerial and clinical duties? How can I reduce time spent doing reports? Are there tools and techniques which could help me do my job?

The overall challenge is that those managers and their teams attempting to scale up services in somewhat unstable conditions are also struggling with some very basic problems: limited skills in basic accounting; managing drug stocks and stores and in basic personnel management, to name but a few. Managers also work within a wider set up that can either facilitate or disrupt good management. Over-centralization of authority, unhelpful procedures or procedures not

followed, lack of transparency coupled with insufficient monitoring and support systems can make the jobs of local managers even more difficult.

2. FRAMEWORK FOR MAPPING CHALLENGES AND RESPONSES

The term 'management' broadly encompasses three types or levels of management: management of the national and sub-national health system, of health care services and clinical case management. This note focuses on sub-national health systems and services.

There are four questions to ask whenever mapping out management challenges and possible responses: a) what needs to be managed? b) who are the managers? c) what conditions are needed to help them do their jobs better? d) how will one tell if management has improved?

a. What needs to be managed?

When managing health systems and services, the nature of what has to be managed is remarkably similar across many different settings. All programmes, projects, facilities and area health authorities, whether public or private, have to manage to different degrees the three things outlined in Box 1.

Box 1. What needs to be managed?

- Volume and coverage of services (planning, implementation and evaluation)
- Resources(e.g. staff, budgets, drugs, equipment, buildings, information)
- External relations and partners - including users of services
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b. Who are the key health service managers in low income countries?

Health service managers are those with primary responsibility for services, resources, and partnerships. Box 2 gives some examples of managers in low income countries. Many are clinicians that are also working as managers, often without proper management training. There are few formally trained managers placed in dedicated management posts.

Box 2. Who are the key health service managers in low income countries?

- Heads of sub-national health services[7] (e.g. district medical officers; those in charge of health sub-districts)
- Programme managers
- Hospital and facility managers

The first question to ask when starting to think about health service 'management capacity' is *are there adequate numbers of managers*? Those listed in Box 2 are the people who should be counted as managers in a country's health service personnel statistics as they are key to scaling up service delivery. There are many other staff that have more limited management responsibilities, but their management skills are probably less critical for scaling up services. Administrative staff who carry out tasks at the instruction of managers are also important but not counted as managers. There is often said to be a big gap in the availability of managers, but there is little real information in many countries on the management posts that exist, and even less on the number of staff in the posts and what qualifications they possess. As a proxy, one

can assess posts known to have management responsibilities. For example, in Malawi, 50% of District Medical Officer (DMO) posts are currently vacant.

c. What conditions are needed to help managers do their jobs better?

The fact is that whilst many health systems are becoming more complex and health managers may be required to change what, who and how they manage, the conditions to achieve better management are essentially the same. There are four things to consider, summarized in Box 3. There need to be enough managers, appropriately deployed. These managers need the knowledge, skills and behaviours (collectively called 'competencies') to organize themselves and their immediate work environment. They need effective management support systems to manage money, staff, information, supplies etc. And they need an enabling environment i.e. to know what is expected; the rules under which they work; supervision and incentives for better performance.

Box 3. What conditions facilitate good management?
▪ Sufficient managers, properly deployed
▪ Managers with the necessary competencies
▪ Well functioning management support systems
▪ An enabling work environment

d. How will one tell if management has improved? What is one aiming for?

While the ultimate test of good management is better health services being used by those that need them, if resources are to be invested in improving management, there needs to be some 'vision' of what good management is i.e. what one is striving for. How can one recognize a 'good' manager? Well-functioning management systems? An enabling work environment?

The definition of a good manager used here is that it is someone who *provides direction to and gains commitment from partners and staff, facilitates change and achieves better health services through efficient, creative and responsible deployment of people and other resources.* How to track progress in the different dimensions of management capacity is discussed further in Section 5.

3. TACKLING SOME OF THE TRACTABLE PROBLEMS IN COUNTRIES

a. The current profile of support being provided to managers

This section's notes are derived from interviews with nationals, with agencies working in management in low-income countries, and from agency web-sites. Though incomplete they give a sense of the range of support types currently being provided. Five types of support are identified:

i.   Time-limited efforts to develop management competencies of ***individual and teams***

ii. Efforts to provide ***continuing learning support*** to local managers

iii. Efforts to develop more ***robust and appropriate management support systems***

iv. Changes in ***incentives, regulations, guidelines*** etc, to create a more enabling environment for good management

v.   ***Comprehensive programmes*** and those using ***combined approaches***

i. *Development of individual or team competencies*

Training courses remain the most prevalent approach to management development. Universities and other institutions offer generic short courses, diploma and longer post-graduate programmes. These may be classroom-based or in the form of distance learning courses offered both by local and overseas training institutions. The disease specific health programmes (eg funded by the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), the Global Alliance for Vaccines and Immunizations (GAVI)) also offer training courses for managers of their projects.

A wealth of management training tools / modules have been developed by international technical agencies, donors and nongovernmental organizations (NGOs). Some are specific to particular programmes and others are topic specific e.g. 'district' management, or competency specific e.g. 'leadership'. An internal survey by WHO[8] counted 120 such tools developed in the last 15 years within WHO alone. There is however little information on their application and utility in resource poor settings.

On-the job training programmes are also popular. These often use problem solving approaches. Some have a specific focus on quality e.g. the Total Quality Management (TQM) approach used by the TB programme in Malawi. Others start from the day-to day operational problems managers face or from selected priority health problems[9][10] . There are also efforts to strengthen local management training institutions [11], and local government management development programmes that include local health managers (e.g. World Bank in Uganda).

ii. *Continuing support to local managers*

A variety of mechanisms have been developed to provide longer-term support and learning opportunities to local managers. The most important are captured in Box 4.

Box 4. Modalities of continuing support for managers

- Regular supportive supervision by higher level managers
- Periodic management meetings e.g., organized by Ministers of Health, church groups etc. for DMOs; intercountry meetings of programme managers e.g. Expanded Programme on Immunization (EPI), reproductive health, integrated management of childhood illnesses (IMCI), malaria, and TB
- Medium-term direct technical support from resident staff of external agencies
- Initiatives to encourage action learning e.g. using the learning approach[12] (South Africa, Namibia)
- The establishment of Health Care Managers Institutes or associations (e.g. South Africa)
- Within- or inter-country electronic 'networks'. These are increasing and are designed for different purposes and audiences; there is limited information on their operations and effectiveness
- Twinning between similar organizations in developed and developing countries (e.g. South Africa/UK)
- Web sites and other electronic resources (e.g. CD-ROMs) for health service managers: Few exist; it is hard to find information relevant to low-income settings; connectivity, though improving, is still a challenge. Others are non electronic learning resources such as management newsletters (e.g. MSH's "The Manager") and others with specific technical focus e.g. management of Family Planning services.

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iii. *Management systems development*

There appears to be significant activity here, usually related to specific systems e.g. information systems, drug procurement and management, financial management etc. Within the health sector, management systems development may be programme specific or system-wide. An example of a system-wide effort is the development of district financial management systems in Ghana in the 1990's. Some public sector reform programmes give attention to strengthening planning, personnel and financial management systems while disease specific programmes may provide information and financial systems specific to their needs. Other systems include audits and clear monitoring and reporting systems.

iv. *Changes in incentives, guidelines, regulations etc*

Efforts to influence the behaviour of managers include a variety of performance management strategies and systems including greater clarity in roles, expected performance standards, transparency in procedures, and measures for accountability. For example, in Malawi, the hospital autonomy reform involved new legislation, hospital management strengthening and the development of performance indicators[13]. In Uganda manuals have been developed that clearly define the roles, responsibilities and qualifications needed for each level of the health system. Another strategy is to publish and require adherence to national procedures (say for disbursement and financial reporting). There are often few clear benefits for managers to become better managers, and few direct incentives to encourage them to be more 'pro-active'. Ghana provides one example: for management units to access donor pooled funds, they needed to demonstrate efficient structures and processes based on agreed criteria. In some countries (for example Namibia, India, South Africa), acquiring certificates from management training have been seen by potential managers as an important incentive to going into management. Lastly, the Introduction of a Patients Charter, as in South Africa, can be seen as a type of incentive - by raising expectations and therefore demand for better managed services.

v. *Comprehensive / combined approaches*

There are examples of district management capacity building projects which take a more comprehensive approach to the problem, and address skills, hardware and resource management systems. These vary in scale from a few districts to nation-wide efforts. The Tanzania Essential Health Interventions (TEHIP) provides an example of such efforts:

Box 5. TEHIP project[14]

In Tanzania, responsibility for health care planning was devolved in the 1990's to District Health Management Teams (DHMTs). Officials initially thought the teams would need only two planning tools: to measure burden of disease, and to help select cost-effective interventions. But in 1997, the first year the districts had access to $2 extra per capita through TEHIP, they could only spend 57 cents. 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.

In two districts, a suite of strategies was developed, comprising the building of local managers' skills; introduction of new tools; strengthening of financial management; improvement of communication and supervision; involvement of communities. These actions collectively allowed the two districts to better target their new resources. One of the many dramatic results has been a decline in child mortality in those districts of more than 40% over just three years.

b.   What is known about 'good practice' in building management capacity?

Many approaches exist for individual and team management capacity development but there is relatively little documentation of their effectiveness. Most focus on developing management skills though it must be recognized that dealing with wider organizational systems and the work environment can promote better management performance. A review of what competency development that does exist points to some fairly consistent and generic lessons which are summarized in Box 6:

Box 6. Current lessons on 'good practice' in management competencies development

- Management development strategies need to address knowledge, skills and behaviours (collectively referred to as their 'competencies').
- While knowledge needs may differ for different types of managers, a number of basic skills and behaviours are common to all managers.
- Learning-by-doing and action learning techniques are more effective in changing behaviour than formal classroom based courses - especially "one-off" courses.
- One off courses may exacerbate poor management by increasing absence from the workplace.
- Simple, problem-based approaches combined with continuing on-the-job support can quickly improve the performance of existing managers even in resource-poor settings.
- Certificates, however simple, are valued by learners. Professional institutes can also help create professional recognition. However, these take time and money to establish.
- Building competencies alone is not enough to achieve sustained improvements in management functioning. Other strategies may also be needed to strengthen key national management systems and to tackle some of the organizational obstacles that reduce managers' effectiveness.
- Whilst a diversity local approaches and ownership of strategies can be encouraged, fragmentation can waste scarce resources.
- Utilizing peer learning approaches encourages learning and experience sharing among managers.
- From the start, good management development must be committed for the 'long haul' to sustain improvements and evolve with changing systems and management roles.

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c.   Apparent weaknesses in the current management development repertoire

i.   *Managers still lack access to some key information*

Experience suggests they lack two sorts of information. At a very basic level, many managers lack clarity about their roles and responsibilities in their particular job and have no agreed objectives and this is especially so when organizational reforms are under way. Managers lack access to useful national or international guidelines and tools. WHO's 'The Blue Trunk Library' for district health centres includes some material on management and some other agencies have recently developed electronic resource centers for managers. Whilst these are useful they are not always easy to find, and documents can be difficult to download in areas with poor connections. Furthermore such materials may not always be relevant to the local context.

ii. *Little synthesis / dissemination of successful approaches*

As mentioned above, documentation of programs are scarce, and their dissemination more so. Often course evaluations are limited to providing numbers of trainees and pre /post-test scores. Impact on participants' daily work has been evaluated in few cases[15] and many assessments are anecdotal, with a few exceptions such as in The Gambia[16], Tanzania[17], CIDA (Canadian International Development Agency) experience[9] and a recent set in Latin America[18]. There may be a need to develop institutional capacity for skills and culture of documentation of experiences in resource poor settings.

iii. *Multiple, fragmented and small-scale interventions within one country*

Multiple varied interventions may either be seen as a problem of duplication and fragmentation or otherwise as opportunities for experimentation and innovation. Attempts to streamline and coordinate local management capacity building programmes do exist. In Kenya, for example, the World Bank, DFID (United Kingdom Department for International Development), SIDA (Swedish International Development Cooperation), HLSP and MSH, are supporting the improvement of management systems and capacities of 15 districts, (referred to as 'Phase I Districts'), as part of a broader initiative aimed at improving district performance under decentralization. However, there is still a tendency for countries to have multiple small-scale interventions from a variety of sources that are not always linked with a common central level framework.

Box 7. Are multiple projects more effective than coordinated action? Management strengthening activities in Tanzania

Promoting Essential Health Interventions in 11 Districts (TEHIP):	District Health Support Project in 7 Districts:
▪ Using Evidence based planning ▪ With IDRC (International Development Research Centre), UNICEF, WHO support	▪ Through improving HMIS (health management information systems) and Quality Management in hospitals ▪ Supported by GTZ (German Technical Cooperation)
Strengthen district health Systems in 2 districts:	Performance and Quality Improvement (PQI) in 16 Districts:
▪ Based on assessing the operationality of districts ▪ Supported by NORAD (Norwegian Agency for Development Cooperation) and WHO	▪ Focusing on maternal and child health ▪ Supported by John Hopkins University

iv. *Little emphasis on management competencies in pre-service training curricula of health professionals*

Clinical staff when they qualify are soon given some management responsibility. There is a need to have basic concepts of management included in the training programmes of nursing and medical schools. For example, communication, negotiation, conflict management, problem-solving, information analysis and work planning should be available in such programmes. Detailed and specific management skills are likely to be needed at post-basic and specialist training levels from where graduates tend to assume leadership and managerial roles.

v. *Little emphasis on helping managers to manage themselves*

Managers need to be well organized themselves in order to do their job. Skills include leadership, priority setting and time management, personal workload planning, delegation, and use of new technology. Such topics should be part of building management competency.

vi. *Efforts to strengthen management systems not documented*

There are many efforts to strengthen personnel, financial and other management systems, which have not been comprehensively reviewed. The table in Annex 1 provides a crude and partial overview of efforts by external agencies in countries. The key questions to reflect upon are: what are the most critical management systems to address when scaling up or attempting to improve performance of services? To what extent are existing management systems able to meet the most basic needs of local management teams for effective service delivery.

4. ADDRESSING THE GAPS: HOW CAN THE INTERNATIONAL COMMUNITY HELP?

Four main areas are proposed, involving short, medium and longer term actions. Some activities are already under way, but many are not receiving sufficient attention and merit more action and collaboration between the many interested parties in this field.

a. Improve knowledge base on effective approaches to building management capacity

In the short term, this will entail:

- More systematic review of the current management development repertoire by external agencies, NGOs, global initiatives, national governments and institutions, to identify any critical gaps given old and new needs of health service managers.

- Quick case studies to stimulate efforts to better document approaches to management development and their results. Another line of work is to identify 'well-performing' managers / teams (overall, or in specific management systems) and document 'how they do it'.

- Encouraging and supporting managers and training providers to write up and discuss their experiences - even informally.

- Linking with the post-Mexico health system research agenda to promote evidence in this area.

- Defining benchmarks and outcomes of good management.

b. Improve managers' access to knowledge, guidance, tools etc.

Ministries of Health, WHO, and other agencies' web sites could provide easier access to existing tools and materials designed for managers and include reports from the field of how useful they were[19]. Depending on the setting, CDs and hard copy toolkits may also be helpful resources.

c. Provide country support

Short to medium term types of support could include the following:

- *Help develop country specific management development strategies*
  This needs to build on any existing efforts and address practical problems. Questions to ask in the development of a strategy include: what aspect needs to be tackled most - knowledge, skills, management systems or work environment? Which managers should be the initial target? Where multiple interventions are needed, which are the most important ones to begin with? Who should be involved? What are the resource implications?

- *Identify ways to help managers better do their job in the current circumstances.*
  For example, by helping national authorities to: (i) Clarify responsibilities and roles at different levels of the system (ii) produce a simple handbook for managers and a managers help line to respond to queries on rules and procedures, identifying delegated functions, managing relations with new partners etc (iii) identify critical aspects of managers' knowledge and skills that need urgent attention, and the sort of training that would help.

- *Develop more operational management support systems*
  These cut across all aspects of service delivery. For example: financial; personnel, drugs, equipment, vehicle maintenance systems etc. The Montreux meeting flagged financial, workforce and information management systems as key sub-systems to address.

- *Revise rules, regulations and incentives*
  Changes to these may need to be developed as part of wider overall organizational and financing changes within the system and are likely to constitute medium to long term efforts.

- *Identify ways to encourage more coherent support to countries, by international agencies*
  Are there some common international standards and guides that could be developed - such as generic competency frameworks, or performance standards? A resource pack could be developed of known, effective interventions, costed for different situations, to serve as a reference point when commissioning management development activities and guide curricula of training programmes. It will also be important to integrate management strengthening activities into development instruments such as SWAPs and PRSPs.

- *Encourage local management training providers within countries to include good principles and methods based on what works.*

d. Advocacy for greater investment in management and management capacity development

More and more persuasive advocacy is needed to communicate that management strengthening makes a difference and is a core responsibility of all health sector partners. This will entail both short and longer term action:
- Producing a clear, concise and convincing (one page) summary on why management matters.
- Making the arguments for integrating management development principles into overall health sector strategic processes such as sector-wide approaches (SWAPs), poverty reduction papers (PRSPs).

- Providing evidence on the value of 'good' managers for the World Health Report 2006 and linking this to well known goals such as the MDGs and facilitating poverty reduction.
- 'Mapping the gap' between the need for and the availability of managers. This will involve:
    o reviews of existing survey data
    o revising occupational classifications in consultation with the International Labour Organization (ILO)
    o improving survey tools on health managers, integrating them into workforce surveys
    o developing tools for inventories and rapid assessments

5. ARE THINGS GETTING BETTER OR WORSE? HOW TO TRACK PROGRESS?

At present, there is little documented experience on how to track improvements in management capacity on a regular basis in low-income settings[20], though many exhaustive lists of possible indicators for specific management dimensions can be found[21].

In terms of *what to monitor*, the key domains that need to be addressed would seem to be:
- Changes in recruitment and retention of managers
- Changes in their competencies / performance / accountability: proxy measures will probably have to be used[22] [23]
- Changes in critical management systems: staff management; financial management; information systems; logistics management
- Changes in their immediate work environment
- Changes in service outputs

Box 8. Monitoring improvements in management capacity

Domain	Example of indicator	Performance			
Changes in:	(Direct or proxy)	Not adequate at all	Partially adequate	Adequate	Highly adequate
Availability of managers	% of designated posts filled				
Competencies / performance of managers	% with accredited management training % that have met with private providers in the last year % financial reports submitted on time				
Key management support systems	% disbursement of funds on time % districts w. no stock outs % salaries received on time				
Work environment	% job descriptions available % supervisory visits				
Service outputs	e.g. DPT, attended deliveries				

Measuring changes in the performance of management systems is likely to be more straightforward - for some of them at least - than capturing changes in competencies and performance of managers themselves. However, as noted above, even these data are rarely captured on a routine basis. New approaches to measurement, and benchmarking of management development and performance impact are needed. Finally, the challenge remains of how to make this kind of monitoring simple enough to be useful and feasible in a low-resource setting.

ANNEX 1. ROUGH AND RAPID OVERVIEW OF MANAGEMENT STRENGTHENING ACTIVITIES BY EXTERNAL AGENCIES IN SIX COUNTRIES

	USAID	MSH	FRA	CIDA	DAN	In WEnt Germny	GTZ	JICA	DFID	NOR.	Sida	Options	Irel.	WB	UNICEF	AFDB	EU	CDC
Management areas																		
Resources (drugs, money, staff, info, equip)	D, I, F	D		■		D,F	I			F	F			■		■		
Volume and quality of services				■			■		■					■			■	■
Ext. relatiosnhips and collaboration				■														
Constituencies																		
National policy makers, leadership etc	■	■	■		■				■	■	■	■		■	■	??		
Hospital managers			■						■									
Programme managers	■	■		Imms			■	■			HIV; RH			■	HIV			■
Area (region/district) managers	■																	
Local support system staff							■										■	■
Private sector managers	■		■															
Dimensions																		
Individual skills/competencies	■					■	■										■	
Institutional capacity											■			■		■	■	■
Support systems		■					■	■								■		
Enabling environment	■		■				■		■							■		
Comments	Often programmatic; contractors eg QAP, BASICS, MSH, Abt	Focus varies from RH / HIV to overall management of health services	admin co-op' - not health spec	non health in Nic; RATN in E&S Africa; Uganda	SWAP and budget support	Focus on HMIS, but shifting more and more towards	Cambodia - SWiM; Tanzania DED - 1 region; Uganda;	Focus on MCH and Tb		public fin mx						7 districts in K;		
Countries	Cambodia: Kenya; Nicaragua; Uganda; Zambia	Kenya; Nicaragua; Tanzania; Uganda; Zambia		Cambodia; Kenya; Nicaragua; Tanzania; Zambia	Kenya, Tanzania, Uganda Zambia	Tanzania; Uganda	Cambodia; Kenya; Tanzania	Cambodia	Cambodia; Kenya; Tanzania; Uganda; Zambia	Tanzania; Uganda	Kenya; Nicaragua; Zambia	Cambodoa	Uganda; Zambia	Cambodia, Kenya, Nicaragua, Tanzania	Cambodia	Kenya; Tanzania; Uganda	Kenya (20 districts)	Cambodia; Nicaragua; Uganda; Zambia

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[7] In different countries this might be provinces, regions, districts, sub-districts

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[12] A learning set is a way of utilising the experience, expertise and knowledge of the people who make up the group, so that they can learn from and with each other.

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