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Strengthening health management: experience of district teams in The Gambia

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The lack of basic management skills of district-level health teams is often described as a major constraint to implementation of primary health care in developing countries. To improve district-level management in The Gambia, a 'management strengthening' project was implemented in two out of the three health regions.

Against a background of health sector decentralization policy the project had two main objectives: to improve health team management skills and to improve resources management under specially-trained administrators. The project used a problem-solving and participatory strategy for planning and implementing activities.

The project resulted in some improvements in the management of district-level health services, particularly in the quality of team planning and coordination, and the management of the limited available resources.

However, the project demonstrated that though health teams had better management skills and systems, their effectiveness was often limited by the policy and practice of the national level government and donor agencies. In particular, they were limited by the degree to which decision making was centralized on issues of staffing, budgeting, and planning, and by the extent to which national level managers have lacked skills and motivation for management change. They were also limited by the extent to which donor-supported programmes were still based on standardized models which did not allow for varying and complex environments at district level. These are common problems despite growing advocacy for more devolution of decision making to the local level.

Introduction

The importance of strengthening district health teams in order to implement the principles of primary health care in developing countries has been recognized for some time (Conyers 1981; Vaughan et al. 1984). WHO states that an essential part of that strengthening process is the provision of appropriate management training and support for management development (WHO 1990). However, governments in developing countries have rarely had sufficient funds or the skilled trainers necessary to tackle basic management development and training.

Donors have tended to support improvements in the technical skills of health workers, and provide capital for vehicles, equipment and buildings, in the context of 'vertical' programmes, rather than provide funds for health system management development. Some donors (often NGOs), due to their perception of governmental services as managerially inefficient or corrupt, have preferred to develop parallel services working outside government structures. These vertical and parallel service approaches have tended to exacerbate management problems for government staff because programme resources are often managed separately from government resources. It is then difficult for district health teams to plan and deliver services in an integrated and efficient way.

A key element of the management development process is decentralization of decision making to district level. This is considered to be an important factor in effective delivery of primary health care services (Mills et al. 1987; WHO 1988). It has been demon-

strated that managers are more effective if they control their own resources and activities. They are in a better position to plan and prioritize taking into consideration the particular needs of the communities they serve, and lobby for additional resources (WHO 1988; Bossert et al. 1991).

A project was set up in The Gambia to strengthen district level health management, against the background of a policy of health sector decentralization. The project emphasized the need to implement improvements with very limited additional funding. It started at the end of 1990 covering two (out of three) Regional Health Services, serving approximately half of the total population of 908,000 (WHO 1993). A health region in The Gambia may be described as equivalent in size and scope to a 'district' in many other countries (Tarimo 1991); here it is considered to be 'district level'.

The paper describes the early stages of the 'management strengthening' project from its conception in 1991[1] *through 18 months of implementation.* Illustrative examples are used to demonstrate project effectiveness as indicators for the purposes of evaluation had not been specified by this time.

Health management in The Gambia

A policy of decentralization of health services had been adopted for some time before the start of the project, but few changes had been made to government procedures. The 'Primary Health Care Action Plan 1980/81' stated that Regional Health Teams (RHTs) should be established to manage service delivery in the three regions (Sanyang 1991). In 1988 the Ministry of Health (MoH) 'National Health Development Programme' (NHDP 1988–1993), supported by the World Bank and other donors, had as an objective decentralization of services to RHTs including management of budgets, personnel and transport. By 1991 health budgets and staff were still managed centrally, and planning remained a centralized function. Whilst policy statements indicated that there was support for reform, little implementation had taken place. A notable exception was the creation of the RHTs in the early 1980s; and in 1988 the post of Regional Health Administrator (RHA) was established by the MoH in recognition of the greater administrative responsibilities of the RHTs.

The role of the RHT was mainly to provide technical support to health staff and to monitor the distribution and use of resources for non-hospital services.[2] The regions were allocated an annual budget which was managed at national level with each RHT applying for its allocated funds on an item-by-item basis. Estimates of the recurrent budget for 1988/89 for regional offices and health facilities vary between 24% and 38% of the total recurrent budget;[3] more than half of this was for drugs and salaries (based on the MoH 1988 budget submission and Sanyang 1991). To access funds from the remaining regional recurrent budget much time was spent in Banjul following the various bureaucratic procedures. As a result of the budget allocation system the scope for increasing RHT access to additional resources and gaining greater budgetary control was limited.

Before the introduction of the project a number of constraints to good management were identified. In addition to insufficient resources, lack of health team management skills, rapid staff turnover and vacant posts, low staff morale and motivation, lack of control over resources and planning, limited policy guidelines, and poor coordination and communications were considered to be major problems.

The regional health management support project

The project aimed to improve the quality of health service delivery through improvements in management practice within a decentralized system. The objectives were that health teams would function as decentralized management units in the regions; that team management skills would improve (particularly planning, supervision, teamwork, provision of inservice training, and coordination); there would be more efficient and effective resources management; and, there would be increased awareness of district health management problems at national level.

The project strategy was not rigidly defined, but was allowed to evolve over time with inputs from local staff. The objectives were useful for setting work priorities and evaluating progress, but at the same time were broad enough to give the teams flexibility in implementation.

The teams were pragmatic when drawing up action plans, in that they tended to include only those activities which they could realistically expect to implement within the available skills, resources and degree of control.

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Project activities

The RHTs were supported to function as decentralized management units. A six-month planning cycle was introduced. This identified health priorities and health service problems (such as lack of supervision). It defined ways to address these priorities and problems within the available resources and in an efficient and integrated way. Teams then made realistic workplans based on this analysis. The planning process involved the national level by inviting integration of health programmes into the six-month plans.

Initiative in planning thus began to shift to the RHTs. Once RHTs could present their own plans at national level meetings (such as the 'Primary Health Care Working Party Meetings'), they were able to challenge NGO providers and the vertical programmes concerning uncoordinated health activities in the regions. An example was the negotiation over training of regional health workers sponsored by some programmes, which was organized to take place during the busy rainy season. In this case RHTs were able to use the regional plans, which indicated that clinic attendance was especially high during the rainy season, to support their argument and guide alternative and more appropriate timetabling.

Also, the effect of RHTs planning as teams was to promote decentralized management and accountability. Instead of relating vertically to cadre heads at national level, individual members of RHTs were encouraged to relate to their peers, discussing and justifying their actions. As a result, the teamwork facilitated more coordinated supervision and training support to regional health staff, rather than fragmented individual actions with little local level accountability.

RHT meetings were held more regularly with a new action-oriented format including distribution of regional health data. This was used as a basis for monthly action plans, and actions agreed at the end of meetings were formally followed up at subsequent meetings. In addition, the introduction of joint-RHTs meetings gave an opportunity for the three teams to share ideas, communicate experiences and provide a stronger lobby to the national level on issues of mutual interest.

As part of the planning process, data on health service delivery came to be analyzed on a monthly basis for local use, rather than being sent directly to national level. Two examples illustrate the benefits of this use of data. Previously most health facilities in the regions were believed to be very busy. By producing accurate information on health facility attendance and workloads, the RHTs were able to lobby the national level to appoint staff to areas of real need. Also, the data helped to identify a number of diagnostic problems. For instance, data on malaria and pyrexia of unknown origin were analyzed for each health facility. Unusually high numbers of cases of the latter were being diagnosed. This information acted as the basis for discussion with health workers which showed that pyrexia of unknown origin was not being treated presumptively as malaria, as recommended by WHO. As a result of this investigation, diagnosis and treatment of malaria and fevers was made a priority issue for supervision and inservice training.

During the six-month planning process, problem analysis skills were improved. This was an important development because early in the project problems identified by the teams centred on lack of resources as such (e.g. lack of trained staff and transport) rather than on the fundamental causes of problems (such as, infrequent and poor quality supervision). Provision of resources had become an end in itself and some team members were not clear about what actions they would need to take if more resources became available. Once a problem was clearly identified it was possible to look for appropriate responses. Taking the case of infrequent and poor quality supervision, the project provided a framework for teams to plan for supervision, discuss supervisory approaches in the more action-oriented monthly meetings and give it a priority status. Teams could then put the better coordinated transport and fuel (resulting from improved management of resources) to good use in implementing supervision workplans.

Improvement in technical support to health workers was identified as a priority area and various initiatives were introduced. A survey was carried out among health workers to solicit their views on the role and value of the RHTs in order to identify ways of improving supervisory relationships; an annual 'training week' for health centre staff was developed; and data distributed at the monthly team meetings provided information for more focused and intensive supervision of health workers.

The recruitment of Regional Health Administrators (RHAs) was a critical step towards improving

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resources management. Initially RHAs introduced tighter systems for the assessment and follow-up of building works and the better utilization and maintenance of transport. RHAs monitored projects involving repair and construction of health facilities and accommodation, and were therefore able to represent the health staff who would use these buildings, helping to ensure that their needs were met.

Mechanisms for better management of transport were: a transport needs assessment and weekly utilization plan, a survey of vehicle mileage logs and fuel utilization survey to compare vehicle and driver performance. The transport needs assessment provided national level planners with information for planning additional and replacement transport; this was especially useful in negotiations with donors on financial support for transport. The weekly transport utilization plan, linked to the RHT work plans, ensured that supervision and other visits were coordinated and prioritized. The fuel utilization survey resulted in greater availability of fuel for supervision; it helped to prevent non-service use of transport; and provided a means for rational distribution of fuel to health facilities.

RHAs had marginal success in speeding up budget disbursement at national level, but as budgets were still managed centrally there was little scope for a greater role in financial management. Before the introduction of RHAs, health-trained RHT staff took time out from providing much needed technical support to do these administrative tasks.

Factors facilitating project effectiveness

A review of activities at this time indicates that various factors contributed to project effectiveness. The first was the growing awareness amongst team members that they could benefit from management change. Consequently they became more motivated and committed to the process, as evidenced by the activities they introduced. Increased motivation has been described in the literature as the factor which 'towers above the rest' in improving staff performance (Fulop 1986). Enhanced motivation was observed to be a function of increased job satisfaction, partly because individuals found that, with some planning and rational use of transport, they could use their professional skills more effectively. Also, satisfaction increased due to the interest, peer recognition and support generated at national level by the regional plans, data and reports. This might have been a result of the 'hawthorne effect' whereby increased interest alone can be an important factor in improved work performance (Cushway and Lodge 1993). Another incentive was the small improvement scheme for staff housing and work environments funded by the project.

Leadership was shown to be an important factor in success and its relevance to management of district health services is increasingly recognized (WHO 1988). Changes in team leadership at the start facilitated meeting project objectives because new leaders were supportive of the process and provided an ideas-oriented environment for teams to discuss the issues of the project. Also, for the first time, staff responsible for resources management joined the teams. The RHAs had the seniority and time to devote to administrative issues and they introduced better control over use of resources, particularly transport, fuel and building works, as well as better coordination and communication.

The problem-solving, 'learning by doing' approach of the project was observed to be appropriate in facilitating change in management practice. In particular, the RHT six-month planning process was a central tool for learning. At each stage of the process new skills were developed in implementing a teamwork approach, in the preparation and analysis of data, in the more indepth problem analysis, in the drawing up of activities and a workplan, and in implementation and evaluation of plans. This finding is in line with the growing number of experiences of using action-based and problem-solving learning for district health managers (Barnett and Ndeki 1992).

Another factor was better access to information in the form of health programme reports, professional literature, and regional health data. The interest in better access to information shown by the teams mirrors the experiences of other countries and is a vital way for rural-based health professionals to continue learning (Patrikios 1989). It was only during project implementation that the real potential for using information became apparent to the teams. As discussed above, aggregated data from health facilities were produced for the first time and became a focus for the discussions of regional problems and needs in the RHTs monthly meetings. This generated considerable interest and created additional demand for data from team members.

Factors limiting project effectiveness

In addition to the constraints identified at the start of the project and despite relative progress, the RHTs

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were limited in how far they could go by the policy and practice of national level government and donors. A key factor at national level was that, although there was a stated policy of decentralization and management reform, government procedures and administrative practices had not changed to make the policy a reality. Resources, especially budgets and staff, were still managed centrally, as was planning and coordination, reducing opportunities for delegated control.

Decentralization and management reform need a critical mass of skilled managers at national level with the time and the skills to design and implement changes. Such managers often need training in broad agenda-setting or policy-making, planning, evaluation and coordination (Godinho 1990). However, a number of problems were observed in relation to managers at national level in The Gambia: 1) they had little time to address the issue of decentralization, partly because of the excessive demands of the decentralized management system; 2) the information they needed for national level management of health services was not being produced; and 3) even if managers had the necessary skills and information, they would be limited in making changes by the actions of donors.

National level managers needed to acquire new skills to meet the challenge of reform: skills which would facilitate delegation of activities, giving them additional time for policy making and coordination; skills to identify the information they needed for planning, and to initiate an integrated information system; and coordination skills for the management of donors. In some instances the national level health managers in The Gambia resisted management reform. This resistance may have been the result of unfamiliarity with the alternatives, lack of incentives, and fear of the consequences of change (Peters 1989).

Donor policy and practice had considerable impact on the way services were delivered in The Gambia. Many donor programmes are based on their own standardized or blueprint models, which may not be appropriate to local circumstances (Hulme 1992). 'Vertical' and 'parallel' programmes, as major components of Gambian regional health services, had an important influence on the way RHTs worked. For example, during the period described an NGO introduced a village-based health care project in one region. This project was managed outside the public sector in parallel to the regional health service. The strategy adopted was one used by the NGO in a number of countries, using its own standardized system. Yet, because of the project's need for local health expertise, it made additional demands on the time and other resources of the regional health staff. Village community expectations were raised and it is unlikely that the government will have the capacity to take over the activities at the end of the project's life.

As well as adopting standardized models, donor-supported programmes in The Gambia tended towards 'top-down' decision making. An example was the AIDS control programme. National-level programme staff set out an ambitious programme of work which the RHTs found difficult to implement without neglecting other important actions like routine supervision and other programme activities. The staff of donor-supported programmes at national level argued that personnel in the regions did not have skills to plan and set priorities: rather that the role of health teams should be mainly to implement programme plans, only allowing them to make marginal changes to those plans.

The preference of donors for top-down decision making and standardized models meant that they were in effect resistant to the process of decentralization. In a decentralized system, implementing managers must have the freedom to prioritize, plan and allocate resources, within the national policy framework. The approach used by donors in The Gambia reflects the dominance of the donor-centred system described by Hulme (1992). He suggests that it is the donor organizational culture which dictates the approach, rather than an active resistance to the ideas of integration and decentralization. It would require a major shift in donor decision-making systems if this situation was to be addressed. There would need to be a change in favour of donors' field managers having more autonomy and being trained to adopt more country-specific approaches to planning (Tarimo 1989).

Team working time was often dominated by programme-centred training and this operated to the detriment of other core functions (such as supervision and planning). Such training was often the only opportunity for team members to 'top up' their low salaries. It was observed that in a typical month health teams had only a few days for routine activities because so much time was allocated to programme workshops.

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Staff time and programme resources in the regions were also often dominated by collection and analysis of data determined at national level. For example, nutritional surveillance was conducted on a frequent basis, yet resources were not available for RHTs to address the problems identified by this reporting. If district level managers had greater control over programme resources, they may have decided to allocate resources to other activities, such as training, supervision and data collection on other health problems, which might be a more efficient and effective way of using those resources.

In The Gambia donors often attracted capable health workers to their programmes, away from government service, by offering better salaries and incentives. This contributed to the shortage of skilled managers at regional and national levels and therefore to the difficulties in implementing management reform.

Finally, one constraint identified in relation to the participatory and problem-solving strategy used by RHTs was that some important issues were neglected in planning. To illustrate this, teams did not give a high priority to involvement of communities in decision making and increased intersectoral collaboration because these approaches had not been included in their training. It is therefore important that such a planning strategy is complimented by additional training.

Conclusions

By the end of its first phase the project had made some gains by assisting RHTs to become more effective management units. Team attitude and staff motivation were improved, and teamwork and planning skills were enhanced. Blunt (1990) describes attitude change as a key to organizational effectiveness, yet this subjective factor is often neglected by health policy makers as they focus on technical problems. More attention needs to be given to management of health personnel if health services are to become more effective, with investment in health workers delivering those services and greater attention to teamwork and leadership skills, and motivation and incentive systems (Simmonds 1989).

The improvement of resources management has been identified as an important factor in upgrading service delivery (WHO 1988). Transport, supplies, maintenance and other support items often absorb a substantial proportion of the district health budget and are vital for successful health service delivery. Yet the need for effective management of support services is often neglected. In some cases poorly-trained clerical staff are responsible for these services or health personnel are required to manage these services in addition to their technical duties. Neither of these options is appropriate and there is a need to address more substantively the issue of resource management support in public sector services in developing countries (Taylor 1992).

Problem-solving and action-oriented approaches to health management development have been tried with some success in a number of developing countries (Barnett and Ndeki 1992). These approaches are valuable because they can be adapted to different situations and they enable district health teams to make their own plans, which are thereby likely to be more realistic and hence easier to implement. This was found to be the case in The Gambia.

However, the project demonstrated that initiatives taken by district health teams are not in themselves sufficient to bring about change. Action to reform systems and structures must also be taken at national level in support of improvements brought about at district level (Cassels and Janovsky 1991). Reform is generally required in government departments which relate to the activities of the health sector (finance, personnel) and often requires attention to civil service reform in general. Nevertheless, it is likely that there is still considerable scope for improvement in RHT management in The Gambia through further health management development initiatives. Such actions might include the following:

- reform to national-level human resources management and planning which would enable district-level teams to function at full strength and staff to remain in post for a reasonable period of time, with implementation of formal handover/induction procedures;
- a training strategy which would include regular and appropriate 'on-the-job' management training (including training in community participation and intersectoral approaches) and supervision of RHTs;
- procedures for policy-making by national level managers;
- formalization of procedures for decentralization of support services and administrative systems and skills introduced at national level;

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- better mechanisms for communication and coordination between national and district levels, and with other sectors relevant to health.

The project also highlighted the danger of donors dominating the health service. It illustrates the general point that donor projects give little scope for health service managers to develop their own skills and plans (Crittenden and Lea 1989; Hulme 1992). Future actions by donors to address this might include:

- integration of projects into national and district planning, avoiding separate planning and budgeting processes;
- conducting 'genuine' consultation with health managers at *all* levels before drawing up programmes;
- developing programmes on a case by case basis and not according to a blueprint model;
- assisting with management inputs to strengthen government and not weaken it, e.g. support to local management training institutions, support for 'on the job' management training to help managers cope with reform;
- reviewing policy on employment of 'key' government officials, and provision of incentives linked to health programmes.

The type of project described in this article appears to meet a need for practical, 'on-the-job' management training, within an environment of management support, helping health teams identify problems and implement actions. Also, it addresses the need for better resource management for effective delivery of primary health care at district level.

Although there are indications of some success in terms of management practice, it is beyond the scope of this paper to analyze the impact of the changes on the quality of regional health services. Evaluation is needed to assess the effects of the project more fully and whether the changes are sustainable, given that they were facilitated by the project. Also, it might be beneficial if future project initiatives incorporated a strategy to address the constraints identified in relation to donors and national level managers.

In a broader sense, the project highlights the opportunities for improvement of district-level health services through an appropriate decentralization and management reform strategy. It also focuses attention on the need for fundamental changes to donor organizations and donor-supported programmes to ensure that district-level changes really make a difference to service delivery and, ultimately, to health status in the community.

Endnotes

[1] The project was an extension of an earlier initiative which had a different focus.

[2] The two hospitals managed centrally receive an estimated 42% of the recurrent budget.

[3] Excluding community health and vector control programme funds.

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