

WHO/HSS/healthsystems/2007.1  
**WORKING PAPER No. 8**

**MANAGING  
THE HEALTH MILLENNIUM  
DEVELOPMENT GOALS -  
THE CHALLENGE OF  
MANAGEMENT  
STRENGTHENING:  
LESSONS FROM THREE COUNTRIES**



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**MANAGING  
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DEVELOPMENT GOALS -  
THE CHALLENGE OF  
MANAGEMENT  
STRENGTHENING:**

**LESSONS FROM THREE COUNTRIES**

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## **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 8:**

#### **Managing the Health Millennium Development Goals - The Challenge of Health Management Strengthening: Lessons from Three Countries**

This study describes various management strengthening activities in three countries - South Africa, Togo and Uganda. Key findings were presented and discussed in a number of fora, including the "International Consultation on Strengthening Health Leadership & Management in Low-Income Countries" held in February 2007 in Accra, Ghana where 20 low-income countries (LICs) were represented. The discussions clearly showed that all LICs are facing and struggling with very similar issues as those coming out of this study.

This paper has been prepared by Dominique Egger (WHO) and Liz Ollier (HLSP Limited, UK). It has been reviewed by the authors of the individual case studies and by Catriona Waddington (HLSP Limited UK) who helped in editing and finalizing it.

#### **Further comments and information**

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## EXECUTIVE SUMMARY

Achieving the health Millennium Development Goals (MDGs) will require a significant scaling up of health service delivery in many countries. The number of competent managers will also have to be scaled up at the same time – managers are an essential resource for ensuring that priority needs are met and resources are used effectively.

A variety of considerations needs to be taken into account when strengthening management, including:

1. ensuring an adequate **number** of managers at all levels of the health system;
2. building existing managers' own **competences**;
3. improving **management support systems** (systems to manage money, staff, information, supplies, etc.);
4. creating a more supportive **work environment** (what is expected from managers; the rules under which managers work; their relationship with local government and other actors; supervision and incentives for improving their performance).

This study describes various management strengthening activities in 3 countries – South Africa, Togo and Uganda. Key findings include:

### *Numbers*

- There are very few professional management cadres: most managers are doctors and nurses who have dual roles.
- Without information on managers, managerial workforce planning cannot be undertaken.

### *Competencies*

- Developing competent managers requires identifying an agreed competence framework.
- There needs to be a balance between time spent in training courses and workshops, and actual application of new competencies within the job supported by reflective practice.
- On-the-job support is perceived by many managers as key to improving their performance – this can include technical assistance, mentoring, coaching and learning networks.
- There is potential to use a broader range of learning techniques, beyond a strong reliance on formal classroom training. Useful techniques include work-based problem-solving and greater use of electronic media.
- The development of learning materials is expensive and needs to be better co-ordinated to avoid duplication.
- Medium- to long-term sector-wide budgets and plans for management strengthening are required if good management is to play its appropriate role in scaling up health services.

### *Management support systems*

- Different sub-systems pose different challenges. Sometimes the system itself is flawed; sometimes district managers lack the skills to use the system effectively.
- Planning, monitoring and reporting systems have been much more developed than other key management systems, such as finance and personnel.
- There is a temptation to make systems too sophisticated and thus, high in transaction costs.
- Planning and budgeting systems tend to be fairly prescriptive and may not bring out local priorities/solutions.
- Countries have appraisal systems for staff, but staff performance is not assessed in any systematic way.

*Working environment*

- There are many ways to help managers do their jobs better. These include clarity about their responsibilities and level of authority; practical reference handbooks; and a regular forum for managers to identify their needs, discuss problems and share ideas.
- Good managers will only be recruited and retained if there is a perception that the incentives and rewards are adequate. This is partially about remuneration, but also relates to status of the post, the degree of autonomy, opportunities for learning and advancement, and recognition of good practice and performance.
- It is important that management is seen as a desirable career option which attracts and retains the most able staff. This needs to be actively managed.

This study aimed to improve the basic information available about what management strengthening activities are taking place and how effective they can be. The study revealed:

- A range of approaches to management development which have been used during the last five to seven years, but countries and external development agencies have concentrated mainly on training and some management systems (planning and monitoring) to the detriment of other key conditions for facilitating good management.
- A lack of national management development plans incorporated in the broader health sector strategy and a paucity of information on the effectiveness of management strengthening activities.

The study also identified a number of practical areas where countries could improve their management development activities.



## A. INTRODUCTION

### 1. COUNTRY CASE STUDIES: RATIONALE AND APPROACH

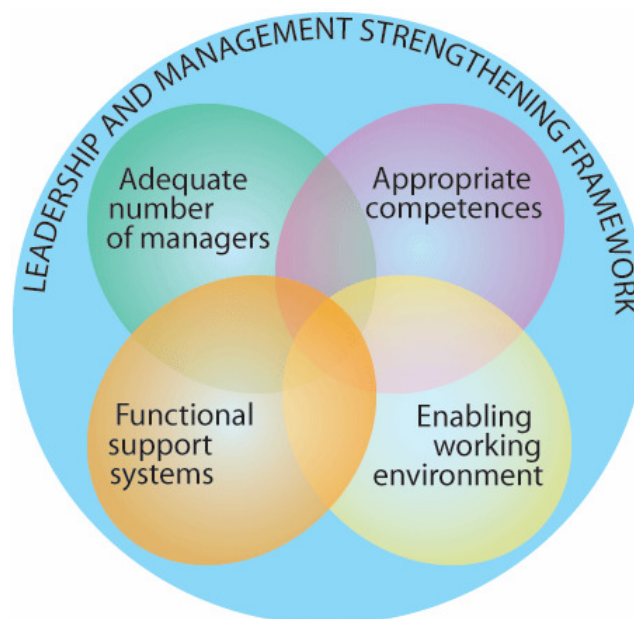
Weaknesses in general managerial capacity at all levels of the health system, but especially at local level, are widely cited as a binding constraint to scaling up health services and achieving the MDGs. Scaling up depends on having some key resources but it also depends to a large degree on how those resources are managed. Health systems are organized in many ways and are continuously changing. Private and community providers are becoming more significant in overall health delivery. Many managers are being required to change what, who and how they manage. Questions are being asked about what to invest in and how, so that services and resources can be managed better.

While there has been considerable investment in this field (much with development partner funding), many of the conditions which are known to facilitate good management are still not fulfilled. These conditions have to do with:

- a. ensuring an adequate **number** of managers at all levels of the health system (staff);
- b. building existing managers' own **competences** (knowledge, skills and behaviours);
- c. creating better functioning critical **management support systems** (systems to manage money, staff, information, supplies, etc.); and,
- d. creating a more supportive or enabling **work environment** (what is expected from managers; how much authority they have; the rules under which managers work; their relationship with local government and other local actors operating in the health sector; supportive supervision and incentives for improving their performance).

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

#### Conditions for good management



Despite broad agreement on the conditions needed for improving management capacity at the operational level (district and sub-district levels), relatively little is known on how countries try to achieve these conditions. As part of a larger programme of work, WHO has started to improve this knowledge base. As a first step, it conducted some quick, largely qualitative case studies in two low-income countries (Uganda and Togo) and low income areas in a middle income country (South Africa) with a high burden of HIV/AIDS, using the above-mentioned framework.

The main purpose of these studies was to explore:

- the range of approaches being used to facilitate good management
- reported changes in managerial performance
- plausible links between the two

The focus was on approaches geared towards developing managerial capacities within the public sector at local and health facility levels.

The study used the framework described above, with its four key dimensions of management strengthening. The study also looked at changes in the national context that might independently affect management performance.

## 2. COUNTRY CASE STUDIES: METHODOLOGY

A combination of desk reviews and key informant surveys at national and sub-national levels in countries visited were used to collect further information, as available, on:

- scope, scale, and duration of the main management development approaches implemented during the last 5-7 years;
- changes in management capacities at district level within the public sector (the four conditions which are known to facilitate good management as mentioned above);
- changes in management performance at district level within the public sector.

The study also explored how these approaches have contributed to improvements in service outputs. Quality and coverage of health services depend, at least partly, on how well health services are organized and managed. It is, however, very difficult to establish linkages between management improvement interventions and health service outputs, as service coverage is influenced by multiple factors. Moreover, the use of standardized district performance indicators is still relatively recent in all three countries. Good, comparable information was not available to show changes in service outputs over time.

At the national level, interviews were held with officials of the Ministries/Departments of Health, development partners and some institutions involved in management development. Short visits were made to districts (all three countries) and sub-districts (South Africa and Uganda).<sup>1</sup> Interviews were held individually and collectively with district management teams. At the end of the country visit, preliminary findings were shared with WHO country offices and some key national stakeholders, where possible.

As with any rapid qualitative study, time and access to relevant documents (particularly evaluations of capacity-building activities) were constraints. Neither the districts visited nor the individuals interviewed were statistically representational - but they did provide a "real life" snapshot and overview of trends. Many of the views collected were based on perception and experience of managers who work within the public sector. The case studies may not have been wholly representational of the country as a whole.

Several themes emerged from the study which appear to have some relevance to other settings.

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<sup>1</sup> See list of districts visited in Annex I.

### 3. NATIONAL CONTEXT

Management performance at district level can be influenced by a number of national contextual factors including the availability of resources (mainly money and staff), the need for health services and the degree of authority granted to local governments.

**Table 1. National context: selected key health and development indicators**

Selected indicators	South Africa	Togo	Uganda
Population (1)	47.4 (2005)	6.1 (2005)	28.8 (2005)
GDP/capita in int. dollars (1)	8,506 (2004)	1,123 (2004)	1,088 (2004)
Economic growth (annual %) (2)	4% (2000) 5% (2005)	-1 % (2000) 3 % (2005)	6 % (2000) 6 % (2005)
Poverty headcount ratio at national poverty line (% of population)	No data	No data	44% (1992/93) 38% (2003)
Under-5 mortality rates (1)	60 (1990) 67 (2004)	152 (1990) 140 (2005)	160 (1990) 138 (2005)
Top five causes of death, all ages, 2002 (3)	1. HIV/AIDS (52%) 2. Cerebrovascular disease (5%) 3. Ischemic heart disease (4%) 4. Lower respiratory infections (4%) 5. Violence (3%)	1. HIV/AIDS (17%) 2. Lower respiratory infections (14%) 3. Malaria (11%) 4. Perinatal conditions (7%) 5. Tuberculosis (5%)	1. HIV/AIDS (25%) 2. Malaria (11%) 3. Lower respiratory infections (11%) 4. Diarrhoeal diseases (8%) 5. Perinatal conditions (4%)
Total health expenditure (THE) as a % of GDP (1)	8.9 (1998) 8.4 (2003)	4.9 (1998) 5.6 (2003)	5.3 (1998) 7.3 (2003)
External resources for health as % of THE (1)	0.2 (1998) 0.5 (2003)	7.2 (1998) 2.3 (2003)	30.9 (1998) 28.5 (2003)
Physicians (density per 1000 population) (1)	0.77 (2004)	0.04 (2004)	0.08 (2004)
Nurses (density per 1000 population) (1)	4.08 (2004)	0.43 (2004)	0.61 (2004)

Sources:

1. WHO Health Statistics 2006
2. World Bank Statistics
3. WHO Health Statistics 2006, based on Death and DALY estimates by cause, 2002 ([www.who.int/entity/healthinfo/statistics/bodgbddeathdalyestimates.xls](http://www.who.int/entity/healthinfo/statistics/bodgbddeathdalyestimates.xls))

As can be seen from Table 1, Uganda and Togo are both low-income countries, whereas South Africa is a middle-income country. The districts visited in South Africa for this study are, however, all considered as suffering from high levels of poverty.

There are considerable differences in health funding in the three countries. Total health expenditure as a percentage of GDP is highest in South Africa (8.4% in 2003) and lowest in Togo (5.6% in 2003). Uganda benefits from a significant amount of external resources for health (28.5% of total health expenditure in 2003). In contrast, Togo receives very little aid (2.3% of total health expenditure in 2003) and suffers from a serious shortage of public funding for its health sector.

The main source of health financing in Togo comes from user fees - 83.2% of total health expenditures.<sup>2</sup> Government funds cover only salary, electricity and water costs of health facilities.

<sup>2</sup> Togo. Comptes nationaux de santé, 2002.

All three countries suffer from a high burden of HIV/AIDS, especially South Africa with 52% of all deaths being attributed to HIV/AIDS. While communicable diseases and peri-natal conditions represent the main causes of death in Togo and Uganda, non-communicable diseases and violence play an increasing role in South Africa.

All three countries have undergone some form of decentralization with the establishment of district health systems, but there is variance in the roles and responsibilities of managers. In the South African and Uganda districts visited, managers have little control over resources. They control only their relatively small operational budget, which pays for little beyond staff allowances (for meetings and supervisory visits); maintenance, fuel, and stationery. Other recurrent items, such as salaries, drugs and supplies (including vaccines) are centrally controlled (provincially in South Africa). Control over capital development funds has only recently been transferred to local governments. In Togo the health regions and districts have considerable control over local revenues, as well as the public funds which are allocated to them by central government. In all three countries hiring and firing of staff is centrally controlled.

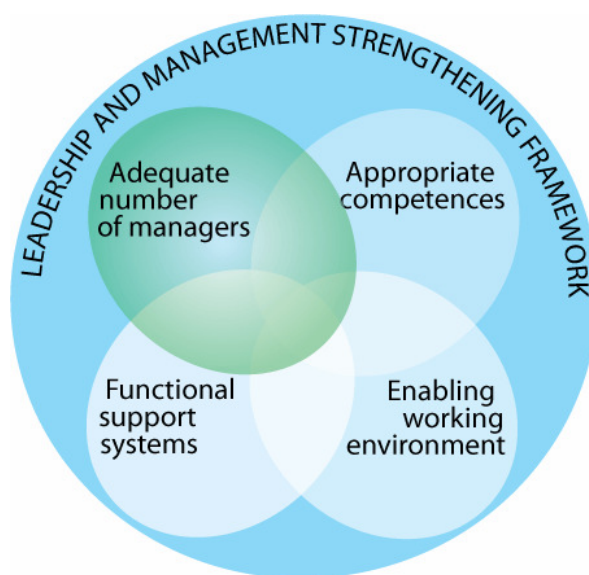
Acute shortages of health personnel were mentioned by all three countries as a major constraint to effective service delivery. On average, South Africa seems to be better off than Togo and Uganda, with a ratio of 0.77 of physicians per thousand population compared to Togo's ratio of 0.04 in 2004. Equally, South Africa has on average 10 times more nurses per thousand population than Togo. In all three countries there are huge variations between rural and urban areas, as well as between better off and poor areas.

## B. MAIN FINDINGS

The findings are grouped according to the four conditions which facilitate good management (see page 1). Throughout the text, relevant examples are described in boxes.

### 1. DISTRICT MANAGERS: NUMBERS AND TURNOVER

Effective management requires an adequate number of managers and a reasonable turnover (giving a span of control which optimizes the management process). Here, "reasonable" means a balance between bringing in new managers with innovative perspectives and retaining sufficient experienced managers with institutional memory.



Exploring the “numbers” aspect of good management involves issues such as:

- how many managers are in post
- how long managers stay in the same post
- how people are chosen to become managers
- strategies for ensuring continuity of supply

### ***How many managers are in post?***

Information about the managerial establishment and posts currently filled is hard to obtain. This is because those who manage the health services at district, sub-district and facility levels are usually doctors and nurses, who are recorded in personnel databases by their professional qualification, rather than by their managerial role.

#### **What defines a manager of health services?**

It is their role to:

- Plan, support implementation and evaluate health activities (volume and coverage of services within their catchments area)
- Manage resources (e.g. staff, budget, drugs, equipment, buildings, information)
- Manage external relations and partners - including users of their services

In practice, managers and management teams can be found in all three countries at district, sub-district (South Africa and Uganda) and facility levels. They often have dual roles, partially technical and partially managerial. In Togo, for example, district management team members spend on average only half of their time on managing their district (see Table 2).

In all three countries, doctors tend to dominate senior management positions.

**Table 2. District Health Management Teams in Togo: team size, turnover, and time management**

Districts	Number of team members	Time spent by the team on managerial tasks versus other responsibilities	Number of years spent by the District Head in this district	Average number of years spent by the team members in this district
Tone	8	50 %	3	4.25 (2 - 10)
Kozah	8	54 %	1	5.75 (1 - 17)
Sotoboua	13	48 %	1	4.15 (0.5 - 15)
Kloto	11	39 %	1.75	5.80 (1.75 - 15)
District des Lacs	9	63 %	2	3.20 (2 - 7)
Distr. Lomé III	9	45 %	7	5.55 (1 - 10)
Average	9.7	49.8 %	2.60	4.80

### ***How long do managers stay in the same post?***

Table 2 shows that turnover is much higher among District Medical Officers (DMOs) than other team members. The studies found significant variations, with stability within the cadre of district health managers in Uganda (with a real danger of stagnation due to limited opportunities for career progression) yet very high turnover in some South African and Togolese districts with managers either leaving to work with the private sector (NGOs and for profit-making clinics) or being promoted to provincial or regional level.

*"A main hurdle in health administration in a rural district like Thabo Mofutsanyanan is the ever changing district leadership. The Provincial Health Department appointed the fourth District manager since... three years ago, all moving to posts at Provincial level."*

Source: Exit report. District Facilitator. Health Systems Trust, South Africa, 2004

### **How are people chosen to become managers?**

Recruitment of managers is based mainly on qualifications; not on potential for being a leader or good manager, or on actual competencies and performance as a manager. In Togo, the members of a DHMT said, "We have been put here; we have not asked to be placed here." In Uganda all health sub-district managers are now required to hold a Masters in public health. In many cases they obtain this after appointment, necessitating up to two years away from their post. This has a major impact on operational service delivery. A similar situation was found in Togo with District Medical Officers undertaking MPHs in Benin post appointment.

### **Strategies for ensuring continuity of supply**

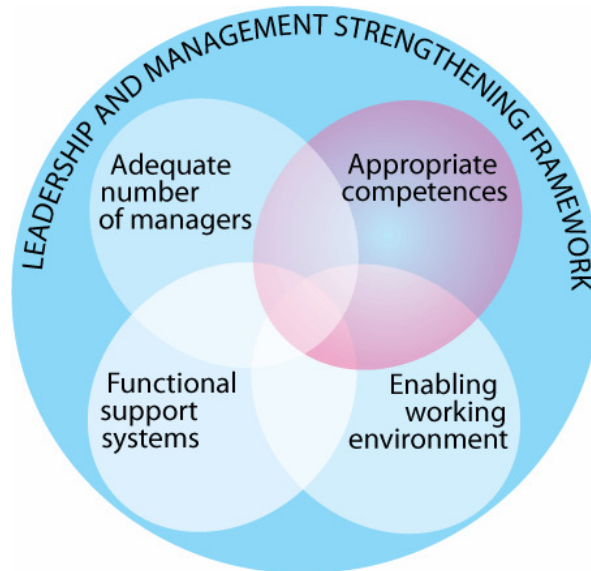
In no country was there an agreed manager/staff ratio. The study also found no national analyses of future demand for managers and no systematic quantification of recruitment rates, retention rates, absence, age profile, gender or qualification/competence profiling of managers.

### **Main lessons:**

1. There are very few professional management cadres at district level: most managers are doctors and nurses who have dual roles, partially technical and partially managerial, with doctors tending to dominate senior management positions.
2. Without information on managers, managerial workforce planning cannot be undertaken. Systematic human resource planning for managers was absent in all three countries.
3. Long term vacancies due to shortages of staff, delayed recruitments or extended study leave are damaging to any organization. This is a common occurrence with many managers "acting" in vacant posts for significant periods of time.

## 2. DEVELOPING MANAGEMENT COMPETENCIES

Effective managers require experience, plus the appropriate knowledge, skills and attitudes/ behaviours (collectively known as competencies).



To explore the “competences” aspect of effective management, the study asked about:

- how management training and development is structured
- the training methods used
- overall planning and coordination of management training and development

### **How is management training and development structured?**

Most district level managers are either doctors or nurses – however, there is generally no managerial content in their basic clinical training. Management development is therefore usually undertaken after appointment to a managerial post.

*"Being a doctor or a nurse does not qualify you to hold a management position."*

*Source: District health management team members, Kloto district, Togo*

In practice, management development activities fell broadly into three categories:

- Academic qualifications
- In-service training courses (in-service)
- On-the-job support and development

Table 3 categorizes these various ways of developing competence according to location and the formality of the activity.

**Table 3. Ways of developing competencies**

<b>Approaches to competency development</b>	<b>Off-site</b>	<b>On-the job</b>
<b>Formal training</b>	Academic courses	Distance learning
<b>Other forms of competency development</b>	Short courses	Technical assistance Mentoring and coaching Learning networks

## **Academic qualifications**

In the countries studied, the majority of personal management development for heads of districts, sub-districts and health facilities was delivered through formal academic courses. A very large number of courses leading to a range of qualifications were identified in all countries. This reflects the desire of participants to obtain a formal qualification.

South Africa and Uganda have a range of training institutions - university and non-university, public and private - which offer masters or diploma courses in public health and, in some cases, management courses. Togo sends their doctors mainly to Bénin to get their academic qualifications. The Masters or Diploma course in Public Health was the most frequent official or informal requirement, although it was recognized that this is not primarily a management qualification. Given that MPHs tend to be modular, it is possible to obtain the qualification without undertaking any management topics. There was a universal perception from managers who had obtained MPHs that the courses tended to be didactic and focused on imparting knowledge, rather than based on personal experience and their own work-based problem-solving.

It is difficult to ascertain the degree of collaboration between the training institutions and central and local governments. Some of the courses were developed in response to an identified request (including by donors) or expressed need, but many were developed purely in response to perceived (but un-assessed) need or on the basis of potential commercial gain.

Recognized effective modern adult teaching methods were, in general, not used. Some academic institutions do not have the infrastructure to support modern teaching techniques such as small group work. Although many of the courses incorporate case studies and students may also undertake an elective, these do not necessarily relate to work-based problems experienced by the student. This may mean that students have a theoretical understanding, but are unable to learn from their own experience through reflective practice.

External accreditation of the courses was variable and it was evident that different levels of courses were being marketed under similar qualifications - i.e., one course at Diploma level appearing very similar to a Certificate course in a neighbouring establishment. South Africa has established a professional Institute of Health Care Managers (<http://www.saihcm.co.za>), but it has no role in course recognition.

Little formal evaluation of most of these programmes and courses was found beyond satisfaction surveys, with the exception of the health management course run by the Centre for Health Research and Development at Bloemfontein (The Free State Goldfields Management Programme in South Africa), which was subject to a 360-degree impact survey. This indicated that managers who had undertaken the programme were perceived by their managers, peers and subordinates as having greater levels of managerial competence than was shown in a baseline survey.

## **Training courses (in-service)**

Disease and programme management is the main focus of in-service training in all three countries. Considerable efforts have been made to train individual programme managers - or sometimes entire management teams – in planning, monitoring and reporting. Much less attention has been paid to other generic managerial skills, badly needed for good management.

**Examples of generic skills needed by managers:**

- decision making and delegation;
- awareness of the political and socio-economic environment;
- consensus building and conflict resolution
- supervisory skills;
- resource management (time, money, staff)
- resource mobilization
- accountability;
- communication, negotiation and interpersonal skills;
- forming useful partnerships and strategic alliances
- time management

Source: Interviews with managers in South Africa, Togo and Uganda, 2005

Ad-hoc training activities accounted for a very high proportion of managerial time. The study found that managers in all three countries spent 65-80% of their time on planning, reporting and related training workshops. There is universally a real problem about unnecessary attendance on courses and training days – much of this stems from an inadequate mechanism for identifying individual development needs. Although there are some appraisal systems (see below), many do not incorporate personal development plans. Ideally, managers should only attend courses which meet their agreed training and development needs but in practice, districts are often told to send X number of participants whether that meets their needs or not.

*"Province told me I had to send four people and there weren't four to send; so, in the end, I went myself."*

Source: District level Programme Manager, South Africa

**On-the-job support and development**

The study identified three main mechanisms for on-the-job support and development:

- support from technical advisors
- mentoring and coaching
- learning networks

*Technical advisors*

Managerial capacity building through support from technical advisers and facilitators to a number of districts was prevalent in all three countries visited. A common model is for different donors each to support a number of districts with either national or international technical assistance.

In South Africa, the support focused on the most deprived districts. In this case, the advisers (known as Facilitators) were contracted through a local NGO (Health Systems Trust) and received support through their organization to obtain examples of good practice and engage in networking.

Experience in Uganda suggested that while some advisers attached to District Health Management Teams (DHMTs) have been able to provide practical on-the-job support and guidance, others have been drawn into the day-to-day operations of the district health office at the expense of higher-level capacity building objectives. In other cases, poorly selected advisers have created more problems than solutions.<sup>3</sup> Technical advisers working in relative isolation appear most likely to shift roles towards operational management and implementation and it appears that this can be avoided by clear expectations, together with support and supervision.

<sup>3</sup> Owarwo, V. et al, "Providing Support to District Health Services under Decentralisation and Sector-Wide Approaches" in 'Experiences in Providing Support to District Health Services'. Paper prepared for a workshop. Uganda, 2003

### *Mentoring and coaching*

A mentor is an individual who works with a manager to act as a role model and sponsor, providing access to opportunities, information and networks. In a classic mentoring role, the mentor should be a more experienced manager in the organization, who has received some orientation in mentoring skills, but should not be in a direct line relationship. Mentors should help managers to reflect on their work situation and to find solutions to their own problems.

Coaches offer knowledge, techniques and skills on a time-limited basis. Coaches should be highly skilled and should be used to focus on specific identified needs.

*"I really benefited from my mentor. He was just retired and he could give me time to think and consider options. He didn't tell me what to do, but he made me think things through."*

Source: District Medical Officer, Uganda, 2005

In each of the country studies, district managers identified mentoring and coaching as highly significant in improving their personal effectiveness. In some cases, this was provided as part of an academic course (such as in the Eastern Cape Health Management and Leadership Programme, the MSc in Health Services Management delivered by the Uganda Martyrs University, Nkozi and the EPIVAC course in Togo), and in other cases, as part of externally funded technical assistance.

### **Coaching services in Togo**

In Togo, long-term international technical expertise (public health advisers) was mainly provided by GTZ until 2002. The districts which used to be supported by GTZ can still access coaching services, as needed, from advisers based in Lomé (the capital city). The DHMT of district No. 3 of the Lomé-Commune Region reported that they found it very useful to have the possibility to draw on these GTZ advisers, mainly to help them solve some of their day-to-day problems. Intensive coaching by GTZ advisers helped them, for example, to improve the quality of the maternal services of their district hospital. The coaching was instrumental in the development of a whole set of strategies:

- Management of change in the attitudes of health personnel and prescription patterns after an initial phase of observation;
- Introduction of a standard cost for a delivery (including antenatal and postnatal care) and a caesarean section service package. This was preceded by a feasibility study and discussions with all those concerned (health personnel and health services users).

As a result of these efforts, the maternity occupation rate appears to have increased from 48.5% in 2002 to 77% in 2005.

### *Learning networks*

Few learning networks for managers were found. The Institute of Health Care Managers was established in 2003 in South Africa. In July 2005, however, the institute had only around 300 individual members, mainly from the private sector. The lack of support from the Department of Health was mentioned as being a major constraint to expanding the network.

The "Ecole Nationale d'Administration" in Togo, whose role is to provide hospital managers with a diploma in hospital management and administration, has established a network of former graduates and new students. The members of this association meet several times a year to discuss issues of common interest, learn from each others' experiences, and review the course curricula for adaptation to evolving needs.

## Training methods

Formal training remains a relatively common approach to competency development in all three countries, but in some cases more modern learning techniques are also being used. These are:

- work-based problem solving
- access to distance learning through the internet

### *Work-based problem solving*

Some courses encompass work-based problem solving exercises – it takes skills to make this an effective learning tool. The selection of the problem for study is critical and managers need to have the confidence to develop the complementary skills and knowledge of their team. There was considerable interest in developing local capacity to undertake problem solving and to “train the trainers” – i.e., to develop the skills of facilitators in problem-solving work. This is potentially a fruitful area for more work and a useful role for Technical Assistance assigned to “strengthen districts.” It only works well in an environment of trust and transparency.

### *Use of technology*

New technology is being used to provide health workers with access to learning materials. In Uganda, the internet is increasingly used by the distance learning programme in health management, organized through the National Staff Training Institution. However, as many districts have poor infrastructure in terms of electricity and access to computers, it must be recognized that it may take some time before the potential of using the internet is fully realized.

Examples of innovative practice are described in the box below. While acknowledging that technology is by no means accessible to all health managers, it, nevertheless, offers excellent opportunities for some management strengthening work.

### Examples of using technology in South Africa

#### Electronic discussion list

The Health Systems Trust in South Africa provides an electronic health information service by hosting over 100 electronic discussion forums and mailing lists with the aim to “facilitate information sharing, communication and networking around broad and strategic public health issues locally and internationally.” Management related issues include:

- District health information system
- District health systems and local Government
- Human resources for health

#### Free State Intranet (ICAM)

ICAM is an interactive video training system which provides training programmes (many delivered by local universities) through more than forty remote classrooms. The system has three channels and is already programmed at nearly full capacity. It is currently largely used for managerial meetings and corporate communication. It was funded from the Skills Development Levy (a national requirement for all employers to devote 1% of payroll to training) and was relatively inexpensive given its coverage. Ongoing costs relate to license costs for the satellite link.

## Overall planning for management training

This study explored whether there was any overall planning related to management development. The short answer is “no.” Specifically:

- None of the three countries had an agreed competency framework for the design or prioritization of training and development initiatives, or for staff selection. In South Africa, a managerial competency framework had been identified, but not agreed on, or used.
- Funding for management development has historically been inadequate and sporadic in many countries. Moreover, it is often an early casualty when there is a budget shortfall. Management

strengthening tends to attract significant programme related funding (often externally funded), but much less funding for core, multi-programme basic management development.

- In both South Africa and Uganda, a ring-fenced training budget is being created through an employment levy, allowing managers in the health sector to undertake strategic training and development planning.
- Many individual courses have been developed with donor funding – and there is considerable overlap in content and methodology. This lack of co-ordination causes duplication and avoidable expenditure. Development costs of new courses are high and could be lessened by ensuring Ministry of Health ownership/right of access to materials. At the moment, many courses appear to flourish only while they are receiving donor support.
- Specific attention needs to be given to sustainability. Two contrasting examples are described in the box below.

#### **Sustainability of training: two examples from South Africa**

##### **The "Management Education Scheme by Open Learning" (MESOL)**

This programme provided over 580 mid-level managers with an internationally recognized, competence-based qualification. Once funding from the Department for International Development (DFID) ceased, it was not picked up by either the National Department of Health or Provincial Health Departments and the license to use the materials eventually lapsed. This may result from inadequate provincial buy-in or it may reflect changes in senior personnel who were not previously involved in the initiative.

##### **Eastern Cape Health Management and Leadership Programme**

Recognizing the need to strengthen the management capability at district and sub-district levels, an initiative was undertaken in collaboration with four local universities to establish a two-year management development programme leading to an advanced diploma. This was initially funded by the United States Agency for International Development (USAID) through the Equity programme and has subsequently been funded by the Provincial Health Department (PHD).

**Main lessons:**

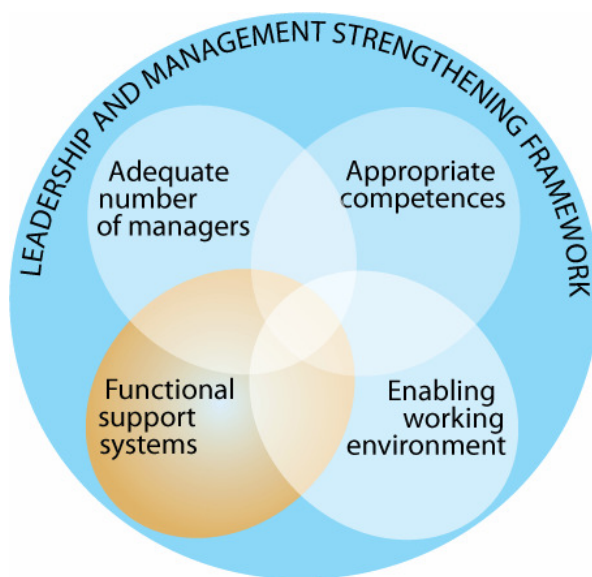
1. Developing competent managers requires identifying what competencies they need (an agreed competence framework) and preparing training and development programmes based on this set of competencies. Competence frameworks must be locally devised and written to ensure relevance and ownership, but most have a lot in common and can be based on international generic materials. When selecting staff for management positions, applicants can be assessed against the framework - this can also form the basis for future personal development.
2. There needs to be a balance between time spent in training courses and workshops, and actual application of new competencies within the job.
3. MPH courses, while having a technical role, are not primarily an effective vehicle for management development. If MPHs are a requirement for management posts, management related modules need to be compulsory.
4. Local training institutions need to develop their courses from assessed, rather than perceived, needs, and ensure that their academic staff understand and use modern adult learning methodologies.
5. On-the-job support is perceived by many managers as key to improving their performance: (i) technical assistance has proved to be useful where it has been able to provide practical hands-on support and guidance; (ii) mentoring and coaching has a significant impact where a more experienced manager in the organization helps less experienced peers think through their problems or transfer their own knowledge and skills; (iii) learning networks can be effective for information and experience-sharing, but are rare.
6. Useful developmental techniques include: (i) work-based problem solving, when there is good facilitation and a degree of trust and transparency; (ii) technology that gives health staff access to learning materials and programmes, provided that districts have the necessary infrastructure in terms of electricity and access to computers.
7. It should be feasible to share proven learning materials, rather than repeatedly developing new materials at a cost to government and development partners. Donor co-ordination bodies within Ministries of Health could assist with this process. The move towards harmonization is key to this.
8. Medium- to long-term sector-wide budgets and plans for management strengthening are required if good management is to play its appropriate role in scaling up health services.

**3. MANAGEMENT SUPPORT SYSTEMS**

The performance of health service managers is dependent in part on how well critical management support systems function. These systems include:

- Planning, budget and financial management systems
- Information management and knowledge sharing
- Personnel management systems, including performance management (objectives/appraisals)
- Procurement and distribution systems for drugs and other commodities

For comparability and consistency, management support systems (notably planning, finance and personnel) have to be developed on a national basis. In principle, systems should be fit for purpose; fully supported by training, procedures manuals and help functions; and regularly evaluated and modified to changing circumstances if necessary.



The “management systems” field of the framework involves identifying both how effectively the system works (centrally and locally) and how well managers are able to use the system.

This study looked in particular at systems for:

- Planning
- Finance
- Information
- Human resources
- Supervision
- Drugs
- Self-management and administration

In all three countries, there has been significant work in developing planning, monitoring and reporting. Systems dealing with finance and personnel received much less attention.

### ***3.1 Planning systems***

All three countries had relatively sophisticated planning processes based on international practice. National guidelines for strategic and operational planning exist in all three countries, including for the district level. Considerable training had taken place and managers at district level were aware of how to undertake the process. In all three countries, planning and budgeting still needed significant central support because there was not always adequate local capacity.

Other major constraints experienced by district managers included:

- The excessive time taken up by planning activities - in Uganda and Togo, this was probably the major time component for district level managers, leaving little time for implementation;
- Access to the data required to complete the prescribed documentation;
- The relatively prescriptive nature of the planning and budgeting process which left little leeway for local prioritization and ownership.

### District health planning and budgeting in Uganda

Since 2000, efforts have been made to streamline the different planning processes and provide guidance to districts and sub-districts. National guidelines have been issued and much training provided through short courses/workshops. Some supervisory visit support takes place and a designated planner from the MOH serves as a link person with a group of Districts for further support. The process is based on a three-year rolling plan with annual workplans – the Medium Term Expenditure Framework. This process has helped to strengthen planning and budgeting – annual workplans are now produced in a common format. However, the documentation used is quite complex and planning activities take a significant amount of a manager's time – often several months. Practical difficulties included annual planning frameworks issued late, changes in budget allocations and delayed support visits about planning and difficulties in obtaining the required information.

In addition, three different formats need to be filled in:

- The budget framework paper for submission to the Local Government;
- The annual estimates of revenues and expenditures, also for submission to the Local Government;
- The annual health plan for submission to the MOH, which is also agreed with the District Health Committee and presented to the Local Government Authority.

In practice, districts appear to draw up plans by taking the previous year's figures and adding a percentage. They are often asked to amend their plans in line with budgetary guidelines and as the planning framework is relatively prescriptive, local priorities may not be reflected adequately. Another major difficulty is the lack of information on funding and timing of activities for centralized disease control programs, NGOs and development partners.

The study also found that while major efforts were made to involve health personnel from health centres to sub-district and districts in the whole planning process, other key actors operating in the health sector seemed to be left out. Local NGOs, for example, were apparently approached by the DHMTs only when they needed some support, such as transport, supplies or money. Community organizations were mainly used to mobilize people for specific public health interventions, such as immunization campaigns or construction of latrines. An example of good, inclusive practice was in South Africa, where there were indications of cross-province collaboration in planning, recognizing the impact of cross boundary flows.

There appears to be some demonstrable improvements as a result of the structured analysis and planning process in districts visited. In all three countries, team work has greatly improved, partly because of joint planning. Resources tend to be better managed because needs are better identified and their use planned for in advance. In South Africa and Uganda, for example, there seems to be less stock-outs of drugs due to assessment-based planning and timely purchasing. This is especially true at the beginning of the fiscal year, when frequent delays have been reported in the release of funds.

### **3.2 Finance systems**

Discussions about budgeting and financing the health system revealed a lot of practical systemic shortcomings from the viewpoint of district managers:

- Control over money was generally very centralized.
- There were often multiple systems for budgeting.

- Approved budgets often did not translate into actual expenditure.
- There was often a lack of communication between those who wrote and implemented the plans and those who managed the finances
- This resulted in changes to allocations without consultation as well as late disbursement, in some cases

### **Control over money**

All three countries have national budgetary guidelines and accounting procedures and rules, but financial decentralization differs between countries. Health districts in South Africa and Uganda have control over very small amounts of money. In Uganda, recurrent items such as salaries, drugs and supplies (including vaccines) are centrally controlled. Authority to re-allocate funds is also very limited. In South Africa, re-allocation of funds is authorized only between cost centres of the same level. In Togo, however, there has been delegation of major financial responsibilities to DMOs. They have the authority to utilize user charge revenue (the only income in most districts apart from external aid), with significant flexibility.

### **Budgeting of district health plans**

In all three countries budget ceilings are given in advance to districts for their plans, with amounts earmarked at the national level for specific activities (national immunization days, for example). In Uganda, district budgets are based on a formula reflecting geographical size, population, poverty and health needs calculated by infant mortality.

#### **Budgeting in Togo**

Togolese health districts usually have three budgets: one for all health centres, one for the hospital (often not shared with the DHMT) and one for the District Health Office. Health activities are budgeted according to the national administrative budgetary line items - mainly inputs. Since costs are related to inputs rather than activities, it is impossible to know, for example, how much has been spent on supervision. Only rarely do budgets mention sources of funds from external aid, even where direct support is provided.

All these caveats and complications about budgeting mean that the budget cannot be used as an effective planning and management tool.

In South Africa, the Department of Health and Treasury at provincial level still have the main power over decisions regarding resource allocation to, and even within, districts. Two main budgeting processes run in parallel. One relates to the operational/recurrent funding and is steered by the provincial health authorities. The other, the Integrated Development Plan (IDP), is very much controlled by the local politicians, and concerns mainly multi-sectoral capital funding. These two budgeting cycles are not aligned and use different financial years.

### **Transfer of funds to the districts for their health plans**

In all the Uganda districts visited, the agreed budgets were not realized because funds were not released in a timely manner.

### **Expenditure tracking and financial control**

In Uganda, each district keeps a bank account (new account opened each year) and financial control is exercised by reconciliation with bank statements, the cash book and the agreed workplan. No financial expenditure outside the workplan can be made. Accounting support is provided by an accountant responsible to the Local Government. These accountants are not always involved in the planning process.

In Togo, follow up and reporting on expenditure is usually left to the district accounts department. Other members of the district health management team, including the district medical officer, have very little information on how the money is actually spent.

South Africa has recently introduced the annual District Health Expenditure Reviews (DHERs) which complement the planning process. Where reviews have been completed, managers have identified the need to shift resources between cost headings and cost centers. Although this usually requires provincial approval, it has been seen to improve services. Although there is currently insufficient capacity to carry out DHERs everywhere, this is still a promising development.

This discussion of finance systems has concentrated more on the practical difficulties encountered with existing systems than on ways of strengthening budgeting and financial management. In practice, management strengthening in this area tends to concentrate on teaching people how to use the formal system, rather than on structural issues such as planning together for all sources of revenue and ensuring that accountants are full members of health management teams. This issue is explored in more detail in WHO's publication, "*Economics and Financial Management – What Do District Managers Need to Know?*"<sup>4</sup>

### **3.3 Information systems**

Information systems in the 3 countries studied seem to have improved in recent years. While there are still some practical difficulties to be ironed out, the main challenge is to encourage the use of the information.

Much development has taken place over a relatively short period of time in information systems, taking advantage of wider access to computers and electronic communication. In all three countries the performance of information systems had improved over the last years, as assessed against timeliness and the completion of monthly reports.

All three countries have defined a list of core indicators for assessing the performance of their districts as part of monitoring the implementation of their sector strategies or plans. The standardization of these indicators allows for comparison of the performance of the districts and will also provide comparisons over time – trend data starts from 2002 or 2003 depending on the country.

There are a number of difficulties in interpreting current data. In Togo, for example, there have been major movements of population since the last census in 1981, which are not taken into account when calculating coverage rates. In Uganda, the number of districts has increased rapidly over the last five years, making comparison over time difficult.

One practical problem is the volume of information required. Ugandan health centers have to record eleven full sheets of data every working day. This took eight hours of work for one member of staff who had another clinical job. One of the reasons why information requirements seem to increase is the demands of the vertical programmes, including the Global Health Initiatives. In South Africa, there has been a policy to have a single integrated system with no parallel programmatic monitoring processes but this has led to a larger core dataset. Only in Togo is the data set of a more manageable size – 26 indicators for the district level are compiled on a regular basis.

To date, in all three countries, information systems are still seen as providing information for "the centre" although the outputs are increasingly being used in planning processes. At national level, there are interesting initiatives in the use of information to monitor and compare performance. South Africa and Togo organize annual review meetings where the performance of districts is analysed and discussed, based on both indicators of performance and narrative reports on successes and failures. Health Systems Trust in South Africa produces a

<sup>4</sup> Making Health Systems Work Series, Working Paper No. 6. WHO, 2006 (<http://www.who.int/management/wp6.pdf>).

comparison on a limited range of indicators both over time and across all districts in the country (the District Health Barometer).

In Uganda, there is regular monitoring against a number of indicators towards the achievement of the national strategic plan (see Annex II). The indicators all have identified targets; some also specify the baseline against which they must improve. Some are output indicators while others are process indicators. These indicators exist at both national and district levels. Progress is benchmarked in league tables which provide information on well-performing districts and those which are struggling to achieve the common objectives. Public service providers and NGOs are monitored, but not the private sector.

The image shows a large, multi-column table titled 'MINISTRY OF HEALTH' with the subtitle 'NATIONAL AND REGIONAL TARGETS PLANNING, SUPERVISORY AND MONITORING INDICATORS FOR 2006'. The table lists numerous health indicators (e.g., malaria, HIV/AIDS, reproductive health) and tracks performance across various districts. Each cell in the table is color-coded: green for 'Excellent performance', yellow for 'Moderate level', orange for 'Low level performance', and red for 'Very low level performance'. A legend at the bottom left explains the shading system. To the right of the table, there are snippets of newspaper text, including 'Court ord...', 'Boards', 'Cops' t...', and 'No ca...', which are partially cut off.

Performance against these indicators is made publicly available in national and local newspapers, which provides a significant motivation and public accountability.

There was less evidence of an information culture among most district managers. Monitoring and evaluation is mainly limited to the use of indicators. There is little documentation and assessment of innovative strategies used at district level to improve service delivery.

Information did seem to be used more for managerial purposes in districts where:

- Staff had computer access including system administration support;
- Staff had received training and support (often one-to-one coaching) on accessing and manipulating data and had, therefore, gained confidence as well as competence;
- District performance was being assessed on the basis of common indicators;
- Staff understood how information could be used to analyse problems and contribute to finding solutions.



### **3.4 Human resources and performance management**

The most important resource for health service delivery is the staff. For this reason, salaries are generally the biggest line item in district health budgets. As with all systems, some human resource (HR) problems require national changes to the system while others are amenable to local solutions. This study revealed several examples of good practice, although none of the three countries had a comprehensive HR system and plan.

All three countries have staffing norms for health districts which are periodically reviewed, especially when new reforms are undertaken within the public sector. In contrast, none of the three countries has a comprehensive manpower development plan for the health sector – this would require better information on health personnel at national and operational levels. In no country was there systematic recording of critical events for operational staff management (training profile, leave, disciplinary events, absence etc).

#### **Control over health personnel at district level**

In all three countries, districts' control over their health staff is mainly limited to:

- Submission of staffing needs;
- Proposing staff re-deployment or promotion;
- Continuing education;
- Supervision, appraisal, and discipline of staff;
- Ensuring an enabling working environment.

In none of the three countries do district managers have control over hiring and firing of government health personnel. In Togo, however, health districts (five out of the six districts visited) have started to hire staff, including professional staff, with funds generated from user fees, so as to overcome some of their most acute shortages.

#### **Conditions for good performance**

For good performance, certain building blocks have repeatedly been found to be important:

- Staff need a job description which specifies their accountability, responsibilities and roles.
- Staff need to know what is expected of them in a given time period to contribute towards organizational goals as expressed in annual plans (personal objectives).

- Staff need training and development to support them in achieving their objectives (personal development plan).
- Staff need feedback on their performance (from supervisors and appraisal), together with recognition of achievement.
- Staff need a minimum of conditions which enable them to do their work.

#### **Recruitment of district health workers in Uganda**

In Uganda, recruitment rests with the District Services Commission which consists mainly of political appointees, but includes representatives of each concerned public sector unit. Recruitments only occur when the districts have the necessary funds to advertise, organize interviews and pay allowances for the Commission members. Since many districts did not have the necessary funds, the recruitment process has been partly re-centralized with the Ministry assigning funds for recruitment to the districts. In any case, the recruitment process is lengthy and while the proportion of approved district posts that are filled by trained health staff is 88% on average (Annual Health Sector Performance Report 2003/2004), there are big variations between rural and urban districts (from 44% to 265%).

Only in South Africa were most of these building blocks in place, with development needs being funded in part from the national training levy.

In Uganda, individual staff members did not necessarily know what they were personally and individually responsible for doing, although the agreed monitoring indicators in the Strategic Plan operated, to some extent, as team objectives.

#### **Incentives for health workers**

Good personnel management provides appropriate incentives.

Continuing education is viewed as one important incentive – though this can be primarily due to substantial per diems provided. Selection of trainees should be based on need and performance, but this is often not the case.

Some of the DHMTs visited in all three countries took the initiative to introduce their own incentive schemes for health workers, such as:

- using some user fee income to top up salaries of all health facility staff, regardless of their performance (Togo);
- personal financial rewards for good performance: bonus/increment based on annual appraisal (South Africa);
- certificates for the best-performing health workers delivered in special end-of-year ceremonies (Togo).

#### **Appraisal systems and use of disciplinary measures**

All three countries have appraisal systems for staff, but staff performance is not determined in any systematic way. Only Uganda's newly introduced system for the public sector is based on a generic framework of critical competencies and a clear process for assessing staff performance.

While comprehensive disciplinary procedures had been developed in each country and managers had received training in them, very few staff were actually being disciplined - even for gross misconduct. The reasons given for this varied from unclear delegated levels of authority and absence of support, to unwillingness to take "unpopular" decisions which is a real issue for district managers living and working in a small community.

**Framework of critical competencies and process  
for staff appraisal in Uganda (2003)**

- Ability to apply professional/technical knowledge and skills
- Knowledge of Job
- Planning and organizing
- Decision making
- Leadership
- Management of financial and other resources
- Communication
- Loyalty
- Integrity
- Ability to achieve desired outputs

The process works through the joint identification of ten annual objectives related to the district workplan and their subsequent appraisal. The annual process includes self-assessments by appraisees, who are involved in documenting their personal work details and in planning future activities and goals. The appraiser is required to rate the appraisees against key competencies.

It remains to be seen to what extent this system will actually be applied.

### ***3.5 Supervision of health services by district managers***

Supervision is an essential link between different levels of the health system. Both quality and quantity of supervision are important. Supervision needs to be regular and of practical help to those being supervised.

All three countries have signed up to the concept of "integrated" supervision, i.e. supervisory visits which are carried out by a multi-disciplinary team and cover all aspects of service delivery. Uganda and Togo have national guidelines for supervision and managers have been trained to use them.

Of the three countries, Uganda seemed to have the most developed and effective supervisory system, with a clearly defined process cascading from central MOH down to districts and sub-districts. This system was originally introduced in 1994 as part of a new Quality Assurance Department (a World Bank/Johns Hopkins project), with quality management processes. The original quality assurance standards focused on priority needs and recognized both internal and external clients. The supervisory process helped to provide support and facilitate exchange of good practices as well as to check on achievements.

The strengths of the system include:

- Supervision is supportive and not punitive, and supervisors are trained to fulfil this role and to establish trust with the units supervised.
- Supervision has been integrated to include priority disease programs and routine services assessments in the single visit.
- Supervision is integral to the annual workplan and both time and budget is allocated for it.
- Certain elements are monitored every six months (finance, planning) and other areas (malaria, child health, etc.) are chosen for each visit and an appropriate technical staff member invited to join the core team.
- The team being supervised receives direct verbal feedback at the end of each visit.
- Summary reports are written after each round of visits which highlight key issues and agreed action plans for local action and national support.

The table below further describes the strengths and challenges of Uganda’s quality assurance supervision.

**Table 4. Strengths and possible weaknesses of the quality assurance supervisory system in Uganda**

Key Strengths	Potential Weaknesses
<ul style="list-style-type: none"> <li>▪ Fully institutionalized, scheduled in annual workplans and funded from the revenue budget</li> <li>▪ Potentially very inclusive – with local government officials and specialists from programmes involved in visits by the area teams</li> <li>▪ Provides information for benchmarking and thus, theoretically, for prioritizing support</li> <li>▪ Reported to be facilitative and not punitive</li> </ul>	<ul style="list-style-type: none"> <li>▪ Not fully implemented at sub district levels, possibly due to staff shortages and high transaction costs</li> <li>▪ Visitors’ books suggest low continuity of supervisory team membership – long-term, trusting relationships cannot be built</li> <li>▪ Despite attempts to integrate supervision, vertical programs still have separate supervision visits</li> <li>▪ Teams report lack of time to sufficiently carry out support activities such as coaching</li> <li>▪ The impact of the Quality Assurance Programme has not yet been systematically assessed</li> </ul>

South Africa and Togo claim to have introduced integrated supervision. In practice, however, there appears to be more supervisory visits by individual programmes than by teams.

### **3.6 Drug management**

Improvements in the overall drug management system itself, or in local management, can lead to tangible developments which are relatively easy to measure.

All three countries have pharmaceutical policies and essential drug lists. In South Africa and Uganda, the sources of financing for essential medicine come essentially from government whereas, in Togo all medicines are paid for from user fees.

South Africa and Togo do not seem to have major problems with stock-outs. Uganda has just introduced a new system to overcome frequent stock-outs. Credit lines have been introduced to allow districts to purchase drugs from the private sector when drugs are not available from the National Medical Store. It seems that stock-outs have decreased, although this system is quite new.

### **3.7 Self-management and administrative systems for managers**

There was little evidence that managers had knowledge of formal personal strategies and techniques for managing themselves. One of the major constraints to managerial effectiveness was identified by managers themselves as adequate time. Despite this recognition, few managers had basic office systems such as brought-forward systems, diary management or systematic filing. Time was, therefore, wasted in tracing misplaced documents and re-scheduling meetings. Well-organized offices often attributed their good organization to mentoring or support in the workplace from Technical Assistants (TAs)/ facilitators.

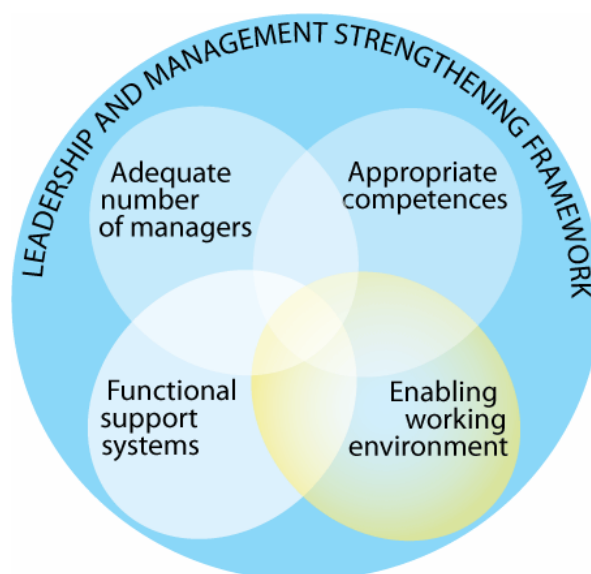
**Main lessons:**

1. Different sub-systems pose different challenges. Sometimes the system itself is flawed. Sometimes district managers lack the skills to use the system effectively.
2. Decentralization brings new relations with Local Government – sectoral systems need to adapt accordingly. This is inevitably expensive, time consuming and disruptive.
3. Planning, monitoring and reporting systems have been much more developed than other key management systems, such as finance and personnel.
4. There is a temptation to make systems too sophisticated and thus, high in transaction costs. This is particularly the case with planning, financial and information systems where there may not be capacity at local level. If there is too strong an emphasis on “filling in the forms,” there is a real risk that the substance will be neglected and that ownership will not be achieved.
5. Planning and budgeting systems tend to be fairly prescriptive and may not bring out local priorities/solutions. People are not told "WHAT to achieve" (and allowed to do it their way), but instead are told "HOW to achieve it." Allowing people to take risks, try new things out (and fail occasionally) is key to improving management performance.
6. Fragmentation causes problems for district managers. For example, districts rarely use the same planning procedures for all of their income – it tends to differ for government revenue, user fees and donor grants.
7. Despite countries having appraisal systems, staff performance is not assessed in any systematic way.

**4. FACILITATIVE WORKING ENVIRONMENT FOR MANAGERS**

The final element identified for effective management is the existence of a supportive working environment. Several factors seem to be critical for good management, including :

- policies, legislation, norms and standards which support the appropriate delegation of authority;
- adequate support for managers;
- incentives to encourage staff to become managers and for good management;
- accountability for performance.



#### **4.1 Policies, legislation, norms and standards**

In all three countries, there was notable progress made towards decentralization. While this has clear benefits, it is important that changes are clear and unambiguous, and that health workers receive sufficient information about decentralization and its implications.

All three countries had legislation and policy documents supporting delegation of authority to the districts. To help managers at district level fulfil their new roles, all three countries had also developed:

- norms and standards for health districts, including on staffing and equipment for teams and facilities;
- national guidelines and procedures for planning, budgeting and accounting, monitoring and evaluation, supervision, staff appraisal and discipline.

The study found that many of these documents intended to guide district managers in their work were not readily available at district level, and sometimes not well known by one or more management team members. Some of these documents were also too general to provide enough guidance on specific roles, functions and responsibilities. Finally, documentation, including job descriptions, could not always keep up with the ongoing reforms.

In South Africa, there were significant provincial variations in achieving re-structuring, with vestiges of the regional tier still in place in Free State. The roles, powers and accountability of the district health management structures are the subject of a long national and provincial debate. In Uganda, the current public service reform is certainly going to result in further changes of roles and responsibilities, as part of the restructuring of local governments. In all three countries, there are a number of areas where roles and responsibilities remain especially unclear, such as the relationships between:

- district local governments, DHMTs and the Provincial Health Department (South Africa);
- district local governments, DHMTs and the Regional Hospitals (Uganda);
- the district hospital and the District Health Department (Togo).

In Uganda and Togo, job descriptions identifying specific roles, functions and responsibilities are still being developed and several district managers expressed concerns about “where they fit.”

#### **4.2 Support to managers**

There are many ways managers can be supported in their work. Access to relevant information and experiences was mentioned repeatedly by district managers as being important, but not often adequate. Supportive supervision also seemed to be highly appreciated by district managers, but only in Uganda has it really been institutionalized.

##### **Access to information and communication**

Managers need to have timely and easy access to a range of information in order to be clear about changes in policy, requirements for action and to know their level of authority. The case study identified a lack of consistent systems which would ensure this was achieved. There were comments at all levels that managers were unaware of policy changes and that required action did not take place, or that notice given was much too short. This was in spite of a very large amount of time being spent in meetings and managers travelling long distances to participate.

There is a need to put in place a national system which ensures that all circulars are classified (policy/information/requests for reports and returns/safety and hazard notices, etc.) and sequentially numbered for easy identification. This could apply to provincially generated

circulars as well. Systems are needed to ensure circulation, in a cascade downwards, to distinguish who is responsible for actions. Likewise, a monitoring system is required to feed upwards stating when action has been completed.

In countries with adequate infrastructure, these systems could be web-based. For example, the intranet installed in the Free State (see page 11) has the potential to support communication, but not all managers have access to it and few have had in-depth training in the use of filing folders, circulation groups and contact lists. In addition, the national Department of Health appears to encounter major internet/e-mail problems with substantial down-time.

Some examples of good practice in the communication field were identified, especially in South Africa (see box). The problem is that some of these initiatives, which sounded rather promising, were not sustained.

#### Examples of good practice in South Africa:

- In Free State: the work undertaken by the Health Systems Trust to increase skills in report writing, presentations and participation in meetings. A newsletter was circulated via the intranet in Free State.
- A simple pocket guide to communication techniques, which could be valuable for all managers. Likewise, *Guidelines for Development of Better Communication in Health Districts* (Health Systems Trust 1998) is a comprehensive guidance document, incorporating practical guidelines and diagnostics.
- Lessons from the national award scheme for districts were published for two years, but this initiative was not continued.
- A national newsletter for hospital managers to disseminate good practice was launched in 2000, but this initiative was also discontinued.
- The electronic learning groups accessed through the HST website appear to be a promising initiative, but it was not possible to identify how much they are used and how significant the shared learning has proved.

### Supervision of managers

Supervision plays a key role in linking DHMTs to the central Ministry of Health, especially as health districts become more and more accountable to local governments. In Uganda, for example, despite major structural changes including the 1997 Local Government Act, this monitoring process has over time remained an integral part of core support systems. Senior MOH staff are members of multi-disciplinary area teams (10 in all), with responsibility for supervising a cluster of districts. The teams must include staff with finance, planning, management and engineering backgrounds in all visits. Technical programmes are also part of the teams.

The districts visited mentioned that supervision has become more supportive over time. National level teams provide help on specific problem areas as part of their scheduled quarterly visits. (see also page 20)

*"They do not only come to control us, but also take the time to listen to us and help us solve some of our problems".*

Source: DHMT member in one of the districts visited in Uganda.

***A car for use by central supervision area teams in Uganda***



In Togo and South Africa, supervisory visits tend to be carried out by each programme, independently from each other, and tend to be too many for the districts to cope with.

***4.3 Incentives for managers***

Good managers will only be recruited and retained if there is a perception that the incentives/rewards are adequate. This is partially about remuneration but also relates to the status of the post, the degree of autonomy and opportunities for advancement.

**Financial incentives**

In general, the financial incentives to take up, and remain in, district management posts are adequate, although not outstanding, as salaries are broadly comparable with similar posts in the public sector. Doctors moving into management may lose opportunities for private practice, although peripheral benefits such as accommodation and transport may be better. In Togo, despite free accommodation and a car are provided, there is such an acute shortage of DMOs that the Ministry of Defence has seconded several army doctors to head health districts. In Togo and Uganda, it is reported that DMOs and medical officers heading the sub-districts maintain medical practices (within the public and/or private sector). In South Africa, many district managers are nurses who find the remuneration attractive. Doctors tend to work in management positions in major hospitals or move on to work for NGOs and donor-funded programmes.

There is little financial recognition of good performance although theoretically, it is possible for South African managers to receive performance-related payments of up to 13% of salary. Such schemes are rare, partly for ideological reasons, but also because they can be inflationary. Progression through salary scales is limited to a given number of increments, so that managers can get stuck at the top of a scale for long periods. This can be disappointing.

**Non financial incentives**

There is a range of non-financial incentives, including status, job satisfaction related to degree of autonomy, opportunities for learning and advancement, and recognition.

*Status*

Managers enjoy a high status within their community but their relative visibility can be a disadvantage if they need to take difficult decisions, particularly if they live and work in the District from where they originate.

*"There are advantages being a "home boy" when you apply for a job, but it makes it quite difficult for the family when times are tough"*

Source: District Manager, Uganda, 2005

*Degree of autonomy*

Encouraging managers to develop their own solutions to address local priority needs can increase job satisfaction. This requires that managers have some flexibility in the use of resources. The study found that managers have very little control over resources (South Africa and Uganda) or very limited financial resources (Togo). Managers at district level have hence, very little freedom in taking risks and trying new things out. In many instances, they are told how to do things rather than what to achieve. Management is more about administration than about leadership.

*Opportunities for learning and advancement*

Access to learning opportunities and training are seen as an important incentive, especially if it is linked to reward for good performance. In Uganda, consolidation of all training budgets within the local government makes it difficult to look for funding. Indeed, many managers self-fund the qualifications needed for promotion, including MPHs. This can amount to nearly one third of their annual take home pay. In addition, some districts remove staff from the payroll if they are absent on long-term training.

In Togo, the selection of managers for training is not always perceived as being fair. In one of the districts visited, a DMO who had been in this position for 14 years, had still not been given a chance to get an MPH (despite it being a condition for appointment), in contrast to other colleagues, who had just graduated from Medical School. In addition, some managers had benefited several times from a similar training or scholarship, due to lack of co-ordination between the ministries of health and education, and the civil service.

Opportunities for identifying and sharing best practice can enhance job satisfaction, but are relatively rare. These are provided to some extent through provincial or regional level meetings (usually on a monthly or quarterly basis), but these meetings are more often used to pass on information or requests rather than for identifying best practices or sharing experiences.

Opportunities for career progression from District posts within the public sector in all three countries are limited. In Uganda, for example, DDHS posts are reasonably well rewarded compared to other public service posts and have significant status in the local community. However, the career path beyond this post is minimal and managers may have to remain until retirement. The only real option is to join the Ministry (jobs are reportedly rarely advertised) or join an NGO or other agency. The higher posts of the local government system (Chief Administrative Officer (CAO) and Assistant CAO) require post-graduate qualifications in Public Administration that DDHSs do not have. This causes some friction as DDHSs feel they should be able to obtain appointments to CAO posts based on their management experience.

**Recognition**

Recognition of good performance is mainly provided through the appraisal system and through various monitoring and supervision league tables. Monitoring systems, particularly those which incorporate benchmarking,<sup>5</sup> provide some recognition for good managers and

<sup>5</sup> Benchmarking can be comparisons with others (e.g. in a league table), or comparisons against a norm.

their teams. In South Africa and Uganda, there are initiatives which either reward the achievement of identified standards (the Yellow Star programme) or acknowledge improvement or consistent good performance. This usually takes the form of trophies, certificates and presentation ceremonies. While there is a degree of cynicism about these, they are generally much appreciated.

#### **The Yellow Star Programme in Uganda**

The Yellow Star Programme is a further development of the quality assurance and supervision system (see page 20). It was designed to provide incentives for improvement and recognition of good management. It is not an accreditation system, but it monitors health facilities against a set of 35 standards. These standards were chosen on the basis that they were the best indicators for overall management. One hundred percent compliance against the standards results in the award of a plaque (displayed at the health facility) with the attendant recognition and publicity. This scheme was originally supported by USAID and has now been introduced to health facilities in 47 districts.

#### **4.4 Accountability**

Accountability to line ministries, local governments and the public is mainly limited to the reporting of specific indicators at the district and sub-district levels. This set of indicators includes service output indicators and some process indicators (see section 3.3.). The study found very little accounting on how well resources are used, especially when it comes to user fees.

One notable example of good practice was found in Kara, one of Togo's regions.

#### **Accountability in Togo: An audit in the Region of Kara**

- Following rumours of mismanagement, the Regional Director for Health (RD) commissioned an audit of financial management in all health centres.
- As a first step, the RD asked the heads of the health centres to have only one pot for revenue collection rather than multiple ones.
- The District Medical Officers were asked to come up with solutions to address the main issues identified by the audit and to discuss them with the RD.

#### **Main lessons:**

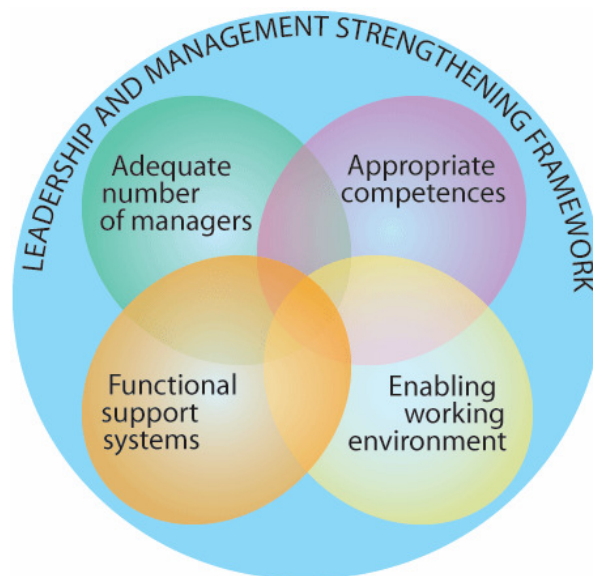
1. There are many ways to help managers do their jobs better. These include:
  - District managers need clarity about their roles and responsibilities, and how they relate to other levels of the organization, especially when new reforms are introduced.
  - Simple handbooks (or a help-line) with information on rules and procedures, delegated functions, relations with new partners, etc. During the study, managers often requested such resources.
  - A system for disseminating new policy in a cascade through the service and a complementary system for reporting upwards on implementing action taken.
  - Providing a regular forum for managers to identify their needs, discuss problems and share ideas.
2. Good managers will only be recruited and retained if there is a perception that the incentives and rewards are adequate. This is partially about remuneration, but also relates to status of the post, the degree of autonomy, opportunities for learning and advancement, and recognition of good practice.
3. It is important that management is seen as a desirable career option which attracts and retains the most able staff. This needs to be actively managed.

## 5. MAIN APPROACHES TO MANAGEMENT DEVELOPMENT

The introduction to this study stated that the main conditions which are known to facilitate good management have to do with:

- ensuring an adequate number of managers at all levels of the health system (staff);
- building existing managers' own competencies (knowledge, skills and attitudes/behaviours);
- creating better functioning critical management support systems (systems to manage money, staff, information, supplies, etc.); and,
- creating a more supportive or enabling work environment (what is expected from managers; the rules under which managers work; their relationship with local government and other local actors operating in the health sector; supervision and incentives for improving their performance).

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



Has a balance between these conditions been achieved in the study countries in the past 5 years or so? Has district management strengthening been comprehensive, or has it concentrated on particular aspects?

The establishment of district and sub-district health systems has been accompanied in all three countries by capacity building - tools, skills and systems have been developed, especially for planning, monitoring, supervision and reporting. None of these efforts took place as part of a clear, country-wide development plan.

Formal in-service training was and is the most common approach to management development. Master degrees in public health or administration are usually a basic requirement for being in charge of district health services or a hospital in all three countries. The Ministry of Health and technical programmes have also provided a lot of in-service training, but often independently from each other. Training programmes in the health sector tend to be frequent and sometimes duplicative, with district officials (especially senior managers) taken out of their work for significant periods of time. Determination of learning "needs" at district level is usually done without involving those directly concerned.

In all three countries, a number of districts have also received significant direct support (financial and technical) through programme/budget support provided by development agencies, mainly bilaterals (see Annex III for Uganda). In Uganda, programme/ project support concentrated on 42 districts out of a total of 77 between 1995 - 2002. Thirty-five districts did not receive any direct

support - 16 received support from more than one agency. District capacity building under these kinds of projects has taken a variety of forms: sponsored participation in long- and short-term training courses targeted workshops for mid-level managers, provision of guidelines and reference materials, distance learning, and on-the-job support and training provided by technical advisers. Most projects have also included significant inputs into infrastructure development. While there are some clear advantages to these focused approaches, there are problems with co-ordination and sustainability.

Togo and South Africa followed a similar pattern, but in some cases, improvements in managerial capacities are being sustained. The box below describes the case of Eastern Cape in South Africa, where a set of strategies has been developed at district and sub-district level.

<b>Eastern Cape Health Management and Leadership Programme</b>
<p>Recognizing the need to strengthen management capability at district and sub-district levels, an initiative was undertaken in collaboration with four local universities to establish a two-year management development programme leading to an advanced diploma. This was initially funded by USAID through the Equity programme and has subsequently been funded by the Provincial Health Department (PHD).</p> <p>The key features of this programme include:</p> <ul style="list-style-type: none"> <li>▪ A modular approach with a requirement to complete one foundation module and a total of four selected from both clinical and managerial topic areas;</li> <li>▪ The course counts as credits towards higher qualifications;</li> <li>▪ Locally developed materials are owned by the PHD and the four universities;</li> <li>▪ Assignments are related to work (in the district visited, the assignment was identified by the entire DHMT, on the basis of it being a local service priority);</li> <li>▪ A quarterly newsletter identifying lessons learnt and good management practice;</li> <li>▪ Participants are supported by mentors and "buddies" (local peers who have already been through the programme);</li> <li>▪ A formal evaluation was carried out involving both participants and their superiors and modifications were made in the light of this.</li> </ul>

Districts that are isolated and experience communication problems are in need of more intensive support than others. In all countries, this was recognized and acted on. For instance, the Initiative for Sub-District Support in South Africa was targeted at the most deprived districts, many of which experienced isolation. (Deprived districts were identified by The National Integrated Sustainable Rural Development Programme).

Overall, during the last five to seven years, there have been multiple initiatives, often not institutionalized, co-ordinated or sustained. There is very little systematic documentation of these initiatives and very little evaluation.

**Main lessons:**

1. A range of approaches to strengthening district management have been used during the last five to seven years, but countries and external development agencies have concentrated mainly on training and some management systems (planning and monitoring) to the detriment of other key conditions for facilitating good management.
2. Multiple, varied interventions can be seen either as a problem of duplication and fragmentation, or as opportunities for experimentation.
3. While there are some clear advantages to small scale or well focused approaches, it is the responsibility of the central Ministry of Health to harmonize, streamline and coordinate local management capacity building.
4. Experience shows that a *package* of interventions is generally needed to improve management, with local ownership to sustain it.

**6. FINALE**

This study aimed to improve the basic information available about what management strengthening activities are taking place and how effective they are. The study revealed a lack of national management development plans in the health sector and a paucity of information on the effectiveness of management strengthening activities. The study has also identified a number of practical areas where countries could improve their management development activities.


There is clearly much to be done in terms of both research and practical actions to develop the management competence to achieve the health MDGs.


**Annex 1. Country case studies: Health provinces/ regions and districts visited in 2005**

<b>Country</b>	<b>Province / Region</b>	<b>Districts</b>
South Africa	Eastern Cape Province	Alfred Nzo
	Free State	Mofutsaruyana
	North West Province	Odi Sub-District
Togo	Savanes	Tone
	Kara	Kozah
	Centrale	Sotoboua
	Plateaux	Kloto
	Maritime	District des Lacs
	Lomé-Commune	District III
Uganda	Central	Mpigi
	Central	Mukono
	Eastern	Busia
	Eastern	Jinja
	Western	Masindi

**Annex II. UGANDA: Monitoring the health sector strategy at the district level**

<p><b>INPUTS</b></p> <ul style="list-style-type: none"> <li>Total public allocation to health per capita</li> <li><b>Health Unit Income</b></li> </ul>	<p><b>FUNCTIONS</b></p> <p><b>Financing</b></p> <p><b>Provision</b></p> <ul style="list-style-type: none"> <li>% of facilities without any stock; out of chloroquine, measles vaccine, ORS and co-trimoxazole</li> <li>% of population residing within 5km of a health facility (public or not for profit NGO) providing the basic package of health services</li> <li><b>% of villages without access to safe water all year</b></li> <li>Total gov't. and NGO OPD utilisation by level and age group (define) (PEAP Indicator)</li> <li><b>Hospital utilization</b></li> </ul> <p><b>Resource Generation</b></p> <ul style="list-style-type: none"> <li>% of health centres with at least the minimum staffing norms by level</li> </ul> <p><b>Stewardship</b></p> <ul style="list-style-type: none"> <li>% of districts submitting completed HMIS monthly returns to MOH on time</li> <li>% of districts displaying current user charge rates</li> <li>% of TB cases notified compared to the expected TB case load</li> <li>% of children under 1 registered (definition needed)</li> <li>Supervision provided to Health Units</li> </ul>	<p><b>INTERMEDIATE GOALS</b></p> <p><b>Effective coverage</b></p> <ul style="list-style-type: none"> <li>% of children under 1 receiving 3 doses of DPT (PEAP indicator)</li> <li><b>% of children fully immunized</b></li> <li><b>(% of 1 yr olds immunized against measles)</b></li> <li>Contraceptive prevalence rate</li> <li><b>Uptake of family planning</b></li> <li><b>Uptake of ANC</b></li> <li>%of deliveries taking place at a facility public or NGO</li> <li><b>Deliveries by trained active CHWs (percentage of births attended by skilled personnel)</b></li> <li><b>Deliveries by trained active traditional birth attendants</b></li> </ul> <p><b>Provider Performance</b></p> <ul style="list-style-type: none"> <li>% of surveyed population expressing satisfaction with the health services</li> <li>Health facilities level number of C-Sec/1000 in the catchment area</li> <li>Total gov't. and NGO OPD utilization per person by level and age group (defin. needed)</li> <li><b>Hospital utilization</b></li> </ul>	<p><b>OUTCOMES</b></p> <p><b>Disaggregated Indicators</b></p> <p><b>Health measures</b></p> <ul style="list-style-type: none"> <li>Proportional morbidity due to malaria expressed as a percentage of malaria cases over the total OPD attendance per year (<b>Prevalence and death rates associated with malaria</b>)</li> <li>Number of Guinea Worm new cases</li> <li>Number of acute flaccid paralysis new cases</li> </ul> <p><b>Health inequalities</b></p> <p><b>Measures of non technical quality</b></p> <p>% of surveyed population expressing satisfaction with the health services</p> <p><b>Fairness in financial contribution</b></p>	<p><b>OUTCOMES</b></p> <p><b>Summary indicators that are possible</b></p> <p><b>Health</b></p> <p>District life expectancy</p> <p><b>Health inequalities</b></p> <p>Inequalities in child survival</p> <p><b>Responsiveness</b></p> <p>If there is data from World Health Survey module</p> <p><b>Fairness in financial contribution</b></p> <p>% of households with catastrophic spending</p>
<p><b>RISK FACTORS</b></p> <p>No indicators reported</p>				

 Indicators used routinely for assessing district performance

 Millennium Development Goal indicator

PEAP = Poverty Eradication Action Plan

**Annex III. Uganda: Direct Support to Strengthening District Health Systems by Development Agencies 1995-2002**

District	EU	EDF	USAID	DANIDA	DFID	GTZ	IRELAND AID	ITALIAN COOPERATION	WHO
Abim									
Adjumani	X								
Amolatar									
Amuria									
Apac									
Arua	X								X
Budaka									
Bugiri									
Bukwa									
Bulisa									
Bundibugyo						X			
Bushenyi		X							
Busia									
Busiki									
Butaleja									
Dokolo									
Gulu									
Hoima									
Ibanda									
Iganga									
Jinja			X						
Kaabong									
Kabale		X	X						
Kabarole						X			
Kaberamaido									
Kabingo									
Kalangala		X							
Kaliro									
Kampala			X						
Kamuli			X						
Kamwenge						X			
Kanungu		X	X						X
Kapchorwa					X				
Kasese		X	X						
Katakwi									
Kayunga									
Kibale							X		
Kiboga							X		
Kilak									

District	EU	EDF	USAID	DANIDA	DFID	GTZ	IRELAND AID	ITALIAN COOPERATION	WHO
Kiruhura									
Kisoro		X	X						
Kitgum				X				X	
Koboko									
Kotido				X					
Kumi					X		X		
Kyenjojo						X			
Lira									X
Luwero			X						X
Manafwa									
Maracha									
Masaka		X	X						
Masindi			X						
Mayuge									
Mbale					X				X
Mbarara		X	X						
Mityana									
Moroto				X					
Moyo	X								
Mpigi									X
Mubende									
Mukono									
Nakapiripirit				X					
Nakaseke									
Nakasongola			X						
Nebbi	X								
Ntungamo		X	X						
Oyam									
Pader				X				X	
Pallisa					X				
Rakai		X	X						X
Rukungiri		X	X						X
Sembabule		X	X						
Sironko					X				
Soroti									X
Tororo									
Wakiso									
Yumbe	X								

26 districts receiving direct assistance from 1 agency  
 16 districts receiving direct assistance from more than 1 agency  
 35 districts not receiving any direct assistance

Source: Owarwo, V. et al, "Providing Support to District Health Services under Decentralisation and Sector-Wide Approaches" in 'Experiences in Providing Support to District Health Services'.



