What sort of stewardship and health system management is needed to tackle health inequity, and how can it be developed and sustained?

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Work in Progress:

Please note that this is a work in progress. It has not yet been possible to address all the comments already received on the paper: and further comments are welcome.

Background to the Health Systems Knowledge Network

The Health Systems Knowledge Network was appointed by the WHO Commission on the Social Determinants of Health from September 2005 to March 2007. It was made up of 14 policy-makers, academics and members of civil society from all around the world, each with his or her own area of expertise.   The network engaged with other components of the Commission (see http://www.who.int/social_determinants/map/en) and also commissioned a number of systematic reviews and case studies (see www.wits.ac.za/chp/).

The Centre for Health Policy led the consortium appointed as the organisational hub of the network. The other consortium partners were EQUINET, a Southern and Eastern African network devoted to promoting health equity (www.equinetafrica.org), and the Health Policy Unit of the London School of Hygiene in the United Kingdom (www.lshtm.ac.uk/hpu). The Commission itself is a global strategic mechanism to improve equity in health and health care through action on the social of determinants of health at global, regional and country level.

Summary

This paper argues that stronger and values-based public sector management and leadership is essential in building health systems that better address health inequities. By considering evidence on the existing weaknesses of health system action to redress inequity it identifies a complex and inter-locking set of problems involving individuals, organisational culture and the ways in which wider political, economic and socio-cultural forces influence public sector organisations. From this base it then, first, examines the particular features of organisational culture in organisations judged to be better performing, and considers how change in organisational culture can be brought about. Second, it identifies the particular competencies of public sector managers and reviews evidence on how these competencies can be developed. Renewing the values base of public health system managers and professionals is an important requirement. Overall, the paper's four key conclusions are that:

1. managerial action cannot be separated from the context in which it occurs;
2. strengthening public sector management will require efforts to generate organisational cultures that support and enable relevant managerial actions;
3. changing organisational culture involves multi-level actions focussed on individuals within organisations, the organisation and the wider system in which the organisation is embedded;
4. leadership training for senior and middle level public sector managers is an essential element of strengthening health system management.

Management development initiatives cannot, therefore, simply be taken from sets of existing management strengthening tools and approaches. Instead they require careful, country-specific reflection to identify: appropriate entry points, how to link training programmes with health system developments that themselves build capacity, the package of personal, organisational, professional and systemic-level interventions to adopt, and the flexible approaches to monitoring and evaluation that sustained these complex interventions.

1.   Introduction: paper premises and terrain

This paper has three basic premises. First, as widely accepted internationally, that the public sector is the legitimate steward of the public interest and population health (Global Health Watch, 2005). Second, that macro-level structural and financing change within health systems will not by itself build health systems that address health inequity. Third, that the additional action needed must be led by the public sector and will require innovative and risk-taking management founded on a strong ethical basis.

From these starting points the action challenge, then, is how to strengthen values-based management within the public health system in order to enable it to take the actions necessary to tackle health inequities.

This paper seeks to provide some ideas about how to address this challenge. It does this by, first, considering in more detail the second and third premises outlined above, as well as, second, by reviewing available evidence about relevant public sector managerial and management-support interventions.

It must be noted that the evidence basis for the paper is relatively limited, particularly in relation to the actions proposed. Special efforts were made to identify empirical evidence, as well as evidence and experience pointing to interventions relevant in strengthening health management. Within a particular focus on the needs of low and middle income countries, there was nonetheless some limited review of high income country experience. Yet despite wide ranging and systematic, as well as opportunistic, knowledge search strategies (see Annex 1), it is clear that the existing body of relevant health (and perhaps even development) research is patchy, small and dispersed across disciplines and sectors, and that the focus of investigation is itself complex and contested. Much of the available evidence base is linked to the existing problems of health systems rather than how to address them; many of the studies are quite topic or country specific. Nonetheless, several relevant and strong reviews of empirical experience and literature were identified and are used here (see Annex 1). In addition, four particularly rich case studies from low and middle income countries (Brazil, Laos, Nepal and Tanzania) were identified through these searches, as outlined in Annex 2, and are used throughout the paper.

However, a basic foundation for the paper is the understanding that evidence gaps should not constrain action, and that evidence is anyway not itself enough to bring about policy change to tackle health inequity. As Exworthy et al. (2003) note, based on the UK experience,

whatever the evidence base there is a need for policy entrepreneurs within the health system who work to tackle health inequalities and have the motivation, competencies and policy space to make a difference. This paper seeks to support such entrepreneurs by encouraging reflection on the environments in which they work and the ways in which those environments can be re-oriented better to support their efforts.

2.   Making the case: the need to strengthen practices of management within public health sectors

The limits of macro-level financing and structural changes in bringing about performance improvements, and the importance of the 'soft' capabilities of management within strong public sectors, are increasingly acknowledged internationally (Blaauw et al., 2003; Grindle, 1997; Scott et al., 2003). Such capabilities include, for example, those that enable organisations to transfer or internalise core values over time, adapt to change, reach out to other organisations and networks, and to learn (Morgan et al., 2005). In terms of the health system action required to support redistribution in particular, the UN Millennium Project Task Force on Child Health and Maternal Health, for example, argues that

'Successful implementation of policies to promote equity and inclusion requires a focus on human interactions at the micro level, as well, as the development of supportive institutional systems for financing, information and regulation. Development of a rights-based health system that increasingly addresses the systematic barriers to care experienced by poor and vulnerable groups requires managers who are more than administrators, managers who understand a given context and are able to take appropriate action' (Freedman et al., 2005:117).

The need to strengthen the approach and practices of health management is specifically demonstrated by five critical failures in how health systems currently function and are managed, failures that themselves exacerbate health inequity. The Nepal case study (Annex 2) provides good examples of many of these problems.

First, across country contexts, there is clear evidence that, in addition to the geographic and financial access barriers they face, marginalised and vulnerable population groups commonly **experience health care as demeaning and exclusionary** (Gilson, 2007). The way in which they are treated by health providers and by the wider health system (for example, in terms of its organisational arrangements), may cause delays, or even deter, health care use, as well as undermining aspects of the process quality of care and its effectiveness. In high income

countries (HICs), these problems are experienced more among low income population groups, ethnic minorities, immigrants, indigenous people and women within these groups, than higher income and higher status groups (Barr, 2005; Jacobs et al., 2006; O'Malley and Forest, 2002; Moxley Rouse, 2005; Tamsma and Berman, 2004; Wloff et al., 2003). In low and middle income countries (LMICs), the available evidence indicates that these problems are particularly borne by women, low income population groups, especially those living in rural or peri-urban areas, people living with stigmatizing diseases and indigenous people (Johannsson and Winkvist, 2002; Gilson et al., 2005; Golooba-Mutebi and Tollman, no date; Govender and Penn-Kekana, 2007; Greene, 2004; Russell, 2005; Lonnroth et al., 2001; Shaikh and Hatcher, 2004; Tibandebage and Mackintosh, 2005; Watkins and Plant, 2004).

Second, for marginal and vulnerable groups the consequences of the combined set of access problems include the very real **possibility of worse health outcomes**, compared to higher socio-economic groups. In some cases, health care may not even be sought and instead self-treatment and alternative providers may be used. The health outcomes will depend on the nature of the illness or condition, as well as on the appropriateness and quality of the alternative treatment practices. Even if health care is used, rude and abusive treatment by health providers, for example, may make patients from these groups more unwilling to reveal details of their past medical history and less likely to adhere to advice or treatment received, with the probability of worse outcomes (Gilson, 2007). One large scale US study has even linked dis-trust in health care providers, resulting from such experiences, with poor health outcomes (Armstrong et al., 2006). In any event, the cost burdens of the resulting ill-health, arising from inability to work as well as the need to try and access additional care, may then particularly weaken the asset base and livelihood status of poor households, whereas comparison with higher income households have more stable incomes and may have greater access to protection from health care costs (Xu et al. 2003; McIntyre et al., 2006; Russell, 2004). Even in the United Kingdom, for example, the transport costs of seeking health care have been found to be an important burden for low income groups, and deterrent to seeking care, whilst evidence of the potentially catastrophic impact of such costs on poor households in LMICs is growing (Dixon et al, 2003). Finally, and as importantly, poor treatment by health providers is experienced by marginalised and vulnerable groups, including women (Govender and Penn-Kekana, 2007) as the denial of personal dignity and respect, itself a denial of their human rights that adds a lived social element to their material experience of poverty (Freedman, 2002; Gilson et al., 2005; Tibandebage and Mackintosh, 2005; Houston, 2003; Kabeer, 2000; Williams, 1999).

Third, health workers' rude and abusive behaviour towards patients may itself likely to reflect **poor managerial practices**. Although the evidence base on human resource management in LMIC health sectors is particularly limited (Rowe et al., 2005; WHO, 2006), evidence from other sectors as well as broader theory suggests that employee commitment to the organisation, and their performance, results from motivation, that motivation is driven by the combination of intrinsic and extrinsic factors and that it is responsive to both financial and non-financial incentives (Franco et al., 2002). The Brazilian case study (Annex 2) provides some evidence on these points and, very interestingly, offers a positive experience of management and health worker behaviour. Other empirical evidence for LMICs, however, suggests that rude and abusive behaviour by public health providers to patients results not simply from the concern that they do not have the facilities (space, equipment, supplies) and training to respond adequately to patient needs, but also from the sense that they are not cared for by their superiors and employers. This lack of care is, in turn, reflected in a combination of factors such as low salary levels, poor working and housing conditions, poor training opportunities - and abusive and disempowering management.

Reflecting a range of empirical evidence (Geogre, 2007), an important study, from Pakistan, for example, shows how gender discrimination in the workplace reflects societal norms and, ultimately, impacts on provider behaviours towards patients. The existing practices of hierarchical management within the public sector are infused with gender biases and act to undermine and oppress lower status women health workers, with negative consequences for the availability and manner of treatment they provide to poor rural women and men (Mumtaz et al., 2003; Shaikh et al. 2006). Studies from South Africa also demonstrate how managerial practices that are perceived as unfair and disrespectful are themselves seen by health workers as one cause of poor behaviours towards patients (Gilson et al., 2004; Gilson et al., 2005). This finding also reflects broader assessments of provider opinions from South Africa and elsewhere (Fonn et al. 2001; Mathauer and Imhoff, 2006), which sometimes lead to the conclusion that 'dignity and recognition of work was more important for providers than a raise in salary or income' (Shaikh et al. 2006: 337). The Nepalese case study (Annex 2) also provides evidence of the negative interconnections between poor managerial practices and low health worker morale.

Fourth, weak public sector management is also a factor **limiting the capacity of the public sector to implement the innovative practices necessary to address inequity**. Such innovations include facility-based interventions that improve the quality and acceptability of services in general as well as specifically for vulnerable and marginalised groups, organising targeted and culturally appropriate outreach services for particular vulnerable groups,

developing collaborative relationships with private, non-government and alternative providers serving those groups, the demand-side interventions that seek to empower vulnerable groups, and the other forms of inter-sectoral action necessary to address health inequalities (Exworthy et al., 2002; Ferlie and Shortell, 2001; Mackian, 2002; Simmons and Shiffman, 2006). The relevance and importance of this range of actions is clearly demonstrated by the Nepal case study (Annex 2). All of these actions require managerial practices that are currently rarely seen within public sector environments. Such practices include respectful and non-hierarchical modes of communication with clients, participatory management strategies that actively engage target groups of beneficiaries, collaboration and team working within the public sector and with private and non-government providers, partnership working between sectors and agencies within local areas, developing shared meanings and understandings among implementing actors, and the ability to learn, and adapt innovations, through implementation (Greenhalgh et al., 2004; Mackian, 2002; Simmons and Shiffman, 2006).

Fifth, and critically important, the apparently personal failings of health workers and managers are themselves **founded in broader public sector practices**. For example, the hierarchical nature of the public health sector is commonly identified as encouraging the authoritarian style of management that, as in the Pakistan and South African studies cited above, is experienced by health workers as uncaring (Grindle, 1997; Fonn et al., 2001; Mathauer and Imhoff, 2006). The hierarchical, rigid and rule-bound culture of the public sector also represents a critical obstacle to implementing the wider innovative action necessary to tackle health inequities (Mackian, 2002; Simmons and Shiffman, 2006). Specifically, it drives the usually centrally-controlled and top-down approach to managing policy implementation within public sectors. Yet this approach to managing policy change is recognised as undermining the motivation of local level managers to implement central initiatives as well as generating resistance to change from those responsible for implementing them. The result may be unintended and unwanted outcomes that exacerbate inequities - such as a worsening of provider attitudes towards patients, or the failure to take action to protect equity (Gilson, 2005; Walker and Gilson, 2004). Not surprisingly, therefore, the UK government has concluded that this approach to policy implementation only works under limited conditions which rarely exist in practice, particularly within health sectors where power is widely dispersed (Performance and Innovation Unit, 2001). Other cultural barriers to effective management within the UK's public sector, that are likely to be replicated elsewhere, include: an aversion to risk-taking; a blame culture, given fear that the media, parliament or groups will penalise failure rather than reward success; the limited space given to leaders to lead, given an unclear division of labour between ministers and civil servants, the

tight control exercised over senior officials and a general undervaluing of leadership (Performance and Innovation Unit, no date; Bullock et al., 2001).

An additional and very influential element of organisational culture within public health systems is, moreover, the dominance of medical expertise and bio-medical notions of health. At one level, this gives power to the provider over the patient, providing opportunities for poor provider treatment of patients. In the UK, at least, it has also been identified as a factor inhibiting managerial change and the inter-sectoral action that requires collaboration across professional groupings (Crilly and Le Grand, 2004; Ferlie and Shortell, 2001; Mackian, 2002). More generally, it is identified as underpinning the cultural divide between bio-medical systems of care and other understandings of health and illness, deterring or delaying use of relevant services and heightening the dis-empowerment experienced by indigenous peoples when using bio-medical care (Anderson et al., 2006; DOH, Govt of Western Australia, no date; Houston, 2003)

However, in moving towards thinking about the actions necessary to tackle these five elements of experience with and within health systems, it is also necessary to recognise that the public sector is itself **infused with wider systemic and societal influences** that, in turn, shape management practices. The range of influences and challenges faced by public sectors worldwide include: rapid technological change, increased consumer expectations, growing pressures for continuous improvement, and the growing complexity of governance structures (Performance and Innovation Unit, no date).

Three LMIC examples show how political and governance structures influence public sector organisational capacity. For example, the Tanzanian context is one of limited political conflict and a high level of policy continuity, given a common language, few regional differences in economic and political power and a political system structured along the lines of non-competitive pluralism. In contrast, ethnic and geographic fragmentation characterises both Pakistan and Papua New Guinea, and political struggles have influenced public administration structures (Morgan et al., 2005). In the latter cases, public sector organisational capacity to tackle inequity is particularly weak.

Economic forces are another important influence over public sector practices. The emergence of abusive provider behaviour in many African countries, for example, has been the strongly influenced by the commercialisation of the health system in recent decades. Macro-economic circumstances and policies led to drastic reductions in real salary levels in many countries and were also associated with the introduction of fee for service systems. Some argue that the

resulting diversification of income sources by health workers, whether in terms of bribery or additional employment, not only influenced the availability and nature of care provided to poorer groups, but also encouraged abusive practices by undermining the ethical and values base that had previously shaped provider practices (Owusu, 2005; Segall, 2000; Basu, 2005). There is also evidence to show that in various country contexts, not only in Africa, fee for service systems are often a cause of patient dis-trust of provider as they are seen to encourage providers to act against patient interest (Gilson, 2005).

Socio-cultural norms are, moreover, also embedded in the public sector. Reflecting wider experience (Standing, 1997; Woodford-Berger, 1998), the Pakistan health provider study already cited, for example, shows how societal gender norms underpin weak managerial practices. The Nepalese case study (Annex 2) identifies the prevailing *ke garne* mindset (a sense of dis-empowerment and apathy where the individual feels no responsibility to work hard or change things) as an important barrier to organisational and managerial change, whilst an earlier and very detailed Nepalese study clearly outlines the parallel universes that can exist within health systems (Aitken, 1994). The official system emphasises the improvement of population health, the quality and number of services delivered and the purpose of the staff as providers of these services. However, for the staff themselves the services are not very important, and service improvements are primarily seen as a way of generating additional income. Training interventions are, thus, not understood as service improvement interventions nor used to those ends. Similarly, the influence of *wantokism* undermines public sector administration practice in Papua New Guinea by emphasising the responsibility of the individual to use all available opportunities for resource access to the benefit of one's family and tribe, in conflict with widely-accepted civil service standards (Bolger et al., 2005; Nicholson, 1997).

3. Addressing the action challenge: how can health system management be strengthened in order to better address inequity?

Despite the general weaknesses of public sector organisations there are pockets of positive experiences in every setting: better management is possible. Key organisations within the health sector are local authorities, such as district health management teams or local government authorities, and hospitals; but other organisations include higher level managerial tiers such as state or provincial authorities and the national ministry of health offices.

Reflecting on the positive examples she found among twenty nine LMIC organisational cases, Merilee Grindle has specifically called for public sector reform initiatives that focus on

'social and moral reward systems that make it possible for government agencies to tap the creativity, sense of duty and public spiritedness of their workers' (Grindle, 1997 quoting DeIulio, 1994: 315), subsequently calling for the development of positive organisational cultures (Grindle, 2002).

According to two leading theorists in the field, the term organisational culture refers to 'the collective programming of the mind which distinguishes the members of one organisation from another' (Hofstede, 1997: 180) and 'a pattern of basic assumptions that the group learned as it solved the problems of external adaptation and internal integration' (Schein, 1992: 12). The second theorist (Schein, 1992) also conceives of organisational culture as comprised of three layers: artefacts (what one feels, hears and see as routines and rituals within it), values (notions of how things should be) and basic assumptions (taken for granted assumptions that shape people's behaviour).

In considering how to strengthen health system management, therefore, this section considers theory and evidence on, first, the features of high performance public sector organisational cultures and second, bringing about change in organisational culture. As part of this latter discussion it specifically discusses examples of multi-level cultural change initiatives and evidence around strengthening public sector leadership.

3.1 What are the features of high performance public sector organisational cultures?
Although a very limited field of investigation within the health sector there is growing interest in whether and how organisational culture influences performance. Two key health studies (Gerowitz et al., 1996; Mannion et al., 2005), one implemented in the US and one in the UK, have clearly demonstrated that organisational culture is linked to organisational performance, and wider empirical work in health and the public sector more generally allows identification of the key organisational facets influencing better performance..

Comparison of good and bad performers across a range of performance outcomes (Gilson and Erasmus, 2004; Grindle, 1997; Mannion et al., 2005), thus, highlights the discriminating influence of:
▪ employees' sense of organisational mission and purpose;
▪ leadership style;
▪ the role of the middle management tier;
▪ human resource management practices;

- some degree of decision-making autonomy, particularly in human resource management (HRM) matters but also in operational and financial matters, working within central guidance and frameworks;
- the functionality of information systems in relation to internal and external accountability frameworks;
- inter-relationships with other local organisations.

Leaders are particularly important because they establish organisational values and purpose, the shared norms that act as an implicit, or psychological, contract with their staff and that, in better performing organisations fosters positive performance. Effective leaders, thus, set the tone of the organisation, role model its values and, by giving meaning to their work, motivate their staff to follow suit (Couper and Hugo, 2005). Different styles of leadership may, however, be relevant for different purposes. Mannion and colleagues' study of organisational culture in UK hospitals, finds that transactional leadership, emphasising strong central direction, clear lines of accountability and internal performance management, is important in meeting the sorts of performance targets currently driving UK health policy. Yet they also note that the current organisational high performers may want, in the future, to apply a more transformational style (involving more devolved and participatory management, and focussed on renewal of values and assumptions within organisations) given that there are limits on what can be achieved by central control, and that they have the systems in place to monitor performance at lower levels (Mannion et al., 2005). In a different paper they also argue that transformational leadership processes may be particularly important in supporting patient-centred care, given that this will require changes in the dominant understandings driving clinical practice (Mannion et al., 2003). Similarly, from experience in the UK and US, Ferlie and Shortell (2001) argue that transformational leadership is necessary to develop the organisational culture of learning required for effective implementation of quality improvement programmes.

Grindle (1997), meanwhile, argues that the better performing public sector organisations among her 29 cases were those where leaders had open and non-hierarchical management styles, consulted widely and encouraged employee participation in decision-making and problem-solving. These experiences reflect trust-based management models which are rooted in caring and empowering managerial practices, based on strong personal communication and ethical behaviour, and encouraging team work. Indeed, Nyhan (2002) specifically argues that trust-based management is particularly appropriate for public sector organisations because the front line provider is the primary service deliverer and the organisation is concerned with client responsiveness (see also Brazil case study, Annex 2). Greenhalgh et al. (2004) and

Simmons and Shiffman (2006), meanwhile, argue that the sustained implementation of innovation within organisations requires supportive leadership, devolved decision-making, allowing early employee participation in planning, and clear intra-organisational communication practices through which the advantages of innovation are made visible and shared meanings are developed that support implementation and learning processes. All

Leaders are also needed in the **middle management** tier: see Brazilian case study, Annex 2. Middle managers are critical within higher performing organisations as they act as the ears and voice of senior managers and mediate the organisation's psychological contract with its employees (Ruppel and Harrington, 2000; Watson and Papamarcos, 2002). Their communication practices and roles in human resource management are particularly important. This seems likely to explain why supportive supervision is one of the few HRM interventions where the existing health sector knowledge base demonstrates clear evidence of the intervention's potential to improve job performance, satisfaction and motivation (Rowe et al., 2005; WHO, 2006).

However, other **HRM practices** are also likely to be important in establishing and sustaining organisational culture. HRM theory and some empirical evidence (Gould-Williams, 2003; Whitener, 1997) thus, points to the importance to empowering and high-trust management practices of merit recruitment practices, through which people are hired because of their competencies for the jobs available, induction periods in which to build shared understanding of organisational norms, job descriptions that clearly lay out performance expectations, probationary periods to assess performance, promotion and incentives systems that reward organisationally-defined good performance (considering both financial and non-financial incentives) and disciplinary procedures that respond to poor performance. Comparison of good and bad organisational performers certainly demonstrates that an active HRM function is important in ensuring and maintaining better organisational performance (Grindle 1997; Mannion et al., 2005; Matthauer and Imhoff, 2006; Performance Innovation Unit, 2001).

Given the wider influences over public sector organisations in LMICs, leaders are also likely to be more effective when they have some degree of **organisational autonomy**, particularly in relation to HRM practices (Grindle 1997; Morgan et al., 2005). Decision-making autonomy is important in, for example, allowing leaders some flexibility in their ability to reward good performance, their ability to invest in the capacity development initiatives and the fairness with which they can apply HRM procedures. Wider decentralisation of at least some decision-making power within the public sector is, moreover, also important in giving organisational units the flexibility necessary to develop innovative responses to, or adapt innovations to,

local needs and circumstances (Performance Innovation Unit, 2001; Simmonds and Shiffman, 2006). Decentralisation is, therefore, also one key element within the primary health care approach to health system organization and operation, and one vital in allowing such systems to be responsive to people's health needs (PAHO, 2006).

Within the public sector, decentralisation and centralisation generally occur at the same time: decentralisation of some authority over some decisions goes hand in hand with centralisation over other decisions (Mills, 1994). Some central direction and control is always necessary because the public sector serves the public interest, using taxpayers money, and must respond to public concerns. A UK government document on public sector leadership suggests, for example, that central direction is important where there would be 'legitimate public concern about variation in services, or where there is clearly established evidence that one approach is the best means of achieving certain ends' (Performance and Innovation Unit, no date: 31). Its specific concern for variation in clinical practices points to the importance, within the health sector, for example, of centrally-developed and uniform clinical guidelines. Other relevant examples of centralised decision-making are transparent, national resource allocation procedures that promote equity in budget allocations whilst allowing local decision-making about resource use (McIntyre et al., 2005). The Brazilian case study (Annex 2) also provides evidence of how centralised authority can be used to encourage local level innovation and flexibility. Ultimately, moreover, and unlike their private sector counterparts, public managers answer to elected politicians and their organisations are held accountable to other tiers of government as well as the parliament. Accountability to central officials must, thus, be retained even as some decision-making power is decentralised.

As discussed, however, public sector frameworks allowing **accountability upwards** generally remain rigid and controlling, and so constrain local decision-making. Although resource allocation, budgeting and planning procedures provide opportunities for innovation in this field there remains little empirical evidence about large-scale practice. The TEHIP and Lao case studies (Annex 2) provide two such examples from the health sector, clearly demonstrating that strengthened district level decision-making can generate substantive health gains. The TEHIP experience, in particular, also provides ideas about the types of informational tools that could empower local level health managers. Yet neither study offers much insight into the wider performance management systems within which such tools can be embedded to ensure upward accountability without too tightly constraining local level decision-making.

Yet in both Lao and Tanzania, although not discussed in detail, it seems that the receipt of annual budgets may be dependent on submitting, and getting approved, locally developed annual plans. Similarly, in Ghana, health management units' access to donor-pooled funds has been dependent on demonstrating efficient structures and procedures based on criteria set and agreed with central level managers, and in Malawi hospital management autonomy has been linked to the development of agreed performance indicators (Janovsky and Peters, 2006). With the development of stronger information systems it might even be possible to link such processes to output or outcome achievement. Recognising that the achievements of the UK performance management experience is a subject of some debate (Mannion et al., 2005), this experience nonetheless highlights managerial principles of relevance to other settings. These include: the importance of focussing on outcome targets, rather than defining how to carry out tasks; ensuring such targets stretch organisations but are achievable; embedding these targets within job descriptions and employee agreements; developing monitoring systems that generate relevant information speedily; and using the information judiciously in making judgements about performance, with a good sense of on the ground realities, and determining appropriate responses (Performance and Innovation Unit, 2001; Performance and Innovation Unit, no date). Mannion et al. (2005) also emphasise the importance of high quality information systems in underpinning performance-focussed hospital organisational cultures. Analysts examining innovation, however, suggest that the critical ingredient to performance success is developing an organisational culture that uses information to learn (Greenhalgh et al., 2004; Simmonds and Shiffman, 2006).

Particularly in addressing inequities, health sector organisations also need to **look outwards** to ensure high performance, as particularly emphasised by the primary health care approach (PAHO, 2006). Referral networks among health facilities are important in ensuring comprehensive care, and may require collaboration between government layers (e.g. between central/provincial (or state) and local government). Tackling access barriers and wider health inequalities will require inter-sectoral action. Public sector managers also have responsibility for establishing partnerships with private and non-government providers. Finally, collective empowerment strategies that reach the most vulnerable groups must be built on community dialogue and engagement. Such engagements outside particular organisations and the public health system itself are both necessary in addressing health inequity and provide channels of influence (both positive and negative) over organisational cutlure.

Public managers need new skills to manage these relationships. Studies of social entrepreneurs, for example, identify as their key leadership characteristics: the capacity to work with and build bridges among diverse stakeholders; the ability to articulate a clear

vision and generate commitment to it, the credibility to mobilise resources, the capacity to catalyze adaptation, relevant technical skills and the abilities to train others, and a long-term commitment to initiative (Alvord et al., 2003; Simmonds and Shiffman, 2006). Others talk of the skills needed to establish the organisational stories and narratives that create a vision within which the full range of partners can work (Performance and Innovation Unit, no date). None of these skills are common in the public sector, and existing ways of working are likely to pose challenges to the development of such relationships. One example of a health system intervention intended to strengthen health services' accountability to the community clearly demonstrates these challenges. The implementation of the Patient's Rights Charter in South Africa is intended fundamentally to alter the existing power relationships between providers and patients, creating a more patient-oriented culture in which stronger patient-provider relationships are possible. Implementation has, however, been challenged by the ways in which the charter is understood differently by actors and so destabilises existing relationships, especially in an environment where multiple new policies are being implemented simultaneously and given the top down manner of its implementation. In practice, therefore, the main consequence of the Charter has been continued decline in provider morale with little apparent change in organisational culture concerning provider-patient relationships (London et al., 2007).

Finally, as noted, public sector organisational culture is itself infused with **broader influences**. Some derive from wider national policy frameworks. Decentralising authority, for example, will require consideration of civil service employment frameworks or resource allocation procedures and budgeting guidelines. National and local policy frameworks must also be supportive of each other (Mannion et al., 2005). In the UK, however, the local level inter-sectoral action necessary to address health inequalities has been undermined by the establishment of harder health sector performance targets focussed on other goals (such as reducing waiting lists) that then shape local actors' behaviours (Exworthy et al., 2003). The wider political influences over organisational culture must also be managed. Public sector managers must, specifically, manage their interface with the political system wisely, insulating their organisation as much as possible from political interference or instability, and building the wider trust and legitimacy that enables access to resources and opportunities within the system (Berwick, 2004; Grindle, 1997; Performance and Innovation Unit, no date). 'Managing up' effectively is, moreover, not simply an issue in LMICs, but is one of the peculiar features of public sector management anywhere in the world (Moore, 1995). However, in LMICs, as discussed, organisational culture is often a combination of formal organisational structures and pre-existing socio-cultural norms, with power and legitimacy derived strongly from the latter. A wide-ranging study on organisational capacity, change and

performance in LMICs, thus, concludes that effective capacity development strategies must work at both levels rather than, as is common with donor interventions, only targeting formal structures and technical management skills (Morgan et al., 2005). The Nepalese case study (Annex 2) provides one example of an attempt at such dual level working.

3.2 How can change in organisational culture be brought about?

The two detailed health sector studies that have clearly demonstrated that organisational culture is linked to performance both show that those aspects of performance valued in the dominant culture of the organisation are those where performance is high. There is, however, considerable **dispute about whether it is really possible to direct change in organisational culture**, and recognition that there are always likely to be problematic consequences (Gilson and Erasmus, 2005). Four negative impacts of existing UK efforts at organisational cultural change in the hospital sector, for example, are: the resulting focus on identified performance targets rather than broader clinical needs; the potential for bullying and intimidation of staff not contributing to performance achievements; the erosion of staff morale and public trust resulting from poor performance in terms of stated targets; and polarisation between hospitals, with poor performers losing staff (Mannion et al., 2005).

However, assuming there is some possibility of bringing about cultural change with positive outcomes, Scott et al. (2003), in one of the few health sector papers on the topic, suggest that **the starting point is to clarify both the performance outcomes desired and the facets of organisational culture that will be supportive of these outcomes**. Then the nature of the existing culture and its degree of fit with the broader context must be assessed, before considering if and how to bring about change that moves the existing culture towards the desired features (Mannion et al., 2003; Mannion et al., 2005).

For example, if cultural change is already occurring in ways that are likely to support desired performance outcomes, it might just need to be encouraged. Caroll and Quijada (2004), thus, argue that strategies for bringing about organisational culture change must start from the existing elements of culture that can be retained, strengthened, reframed and linked to new desired values and behaviour. They specifically suggest that the approach of Appreciative Inquiry (AI), which has roots in action research and organisational development, is helpful in this task because it encourages the positive elements of current cultures to be identified and adapted as the basis for new cultures and ways of working, by creating opportunities for people within organisations to work together on real problems in their environments. AI was also used in this way within the Nepalese case study (Annex 2).

However, as AI may gloss over problems and conflicts that are likely to prevent or constrain change, and does not address issues of power (Reed et al., 2001), **active intervention in the process of change is likely to be necessary where there is resistance** to planned cultural change (Scott et al., 2003). Such resistance might result from: a lack of ownership of the change among staff, and a fear of loss; the differences of sub-cultures within any organisation; the very complexity of the process and its necessarily long time frames; the influence of external stakeholders, such as professional associations, or wider public values; an inappropriate style of leadership and evidence of negative consequences. Relevant actions might include: managing the meaning of proposed changes by providing a clear vision and narrative that builds support for them; changing leadership approaches; tackling external influences or monitoring for negative consequences and taking necessarily remedial action.

The literature on policy analysis also offers guidance on how to tackle resistance as it takes power seriously (see also Brazilian case study, Annex 2). Summarising both theory and experience, Hardee et al. (2004), for example, identify the six key tasks of policy implementation as:

- legitimization, getting a new policy accepted as important, desirable and worth achieving;
- constituency building, gaining active support from groups that see the policy as desirable and beneficial;
- securing resources and ensuring that present and future budgets and HR allocations are sufficient to support implementation;
- adapt organizational structure, adjusting objectives, procedures, systems and structure of agencies responsible for implementation;
- mobilizing action or marshalling committed constituencies to develop action strategies to translate intent into results;
- monitoring impact to assess progress and alter policy makers of problems and unintended consequences.

In addition, **the interventions needed to bring about cultural change may vary depending on the life-cycle of the organisation** (Schein, 1992). In young organisations it might be possible to build positive visions of desired forms of organisational and work towards them, perhaps drawing on the experience of employees who have particular experiences of other organisations. In midlife organisations, cultural change might rather come about through promoting people from particular sub-cultures within the organisation or by establishing new systems (or technologies, structures) working alongside old systems, with the new systems (technologies, structures) slowing becoming more dominant. Finally, in mature organisations more radical strategies may be needed, such as bringing in new people, or challenging

organisational members by demonstrating how the difference between the values they think they hold and the basic assumptions actually driving their behaviour influence performance outcomes, before re-defining features of organisational culture.

The inter-connectedness of the health system problems (section 2) and the various dimensions of organisational culture (section 3), suggest, moreover, that changing organisational culture within the health system will require **multi-faceted and multi-level action**. Developing the values based management needed to sustain action on health inequity requires the development of supportive cultures within which managers work, as well as the development of managerial attitudes and skills.

Thus, the experiences reviewed so far, as well as the specific case studies (Annex 2), show that performance-oriented organisational cultures will require an appropriate balance of hard and soft organisational elements, and that efforts to change culture must also pay attention to both. For example, although effective leadership is clearly vital, its effectiveness is enhanced in settings where some decision-making power is decentralised, and information systems provide the necessary strong foundation for accountability mechanisms that enable and sustain decentralised authority. At the same time, neither of these latter interventions is adequate without leadership to bring about change in decision-making practices. One particular intervention commonly identified as having the potential to strengthen the cultural competence of health organisations (and so their acceptability) is to hire new staff that better reflect the diversity of the community served (Gilson, 2007). However, as the Pakistan example of female health workers clearly shows (Mumtaz et al., 2003), such staff will only be able to perform well if leaders support new employees and manage the workplace tensions that may result, including offsetting wider socio-cultural influences.

The gender mainstreaming experience, however, amply demonstrates that multi-level intervention strategies are required to have any chance of brining about change in organisational culture (Women and Gender Knowledge Network, 2007). Two recent and rich reviews of experience also highlight the range of actions required.

The first review was undertaken by the National Health and Medical Research Council of the Australian government, and resulted in a set of policy guidelines about how to develop cultural competence in health care and so address the significant inequities in health between indigenous and other Australians. The review was based on a wide-ranging literature search, specially commissioned qualitative research, and national consultations and focus group discussions. Focussing on developing the capacity of the health system to improve health and

well-being by integrating culture into the delivery of health services, they establish four principles to guide action and four dimensions of action (Box 1). The guiding principles provide important reminders of the role of agents outside the health system in securing necessary changes in organisational culture. In addition to accountability upwards public health systems need to be accountable outwards to the public and in particular, to the socially marginalised groups whose interests they specifically seek to protect (Murthy et al., 2005). The first two dimensions of action, meanwhile, are vital in directing, supporting and acknowledging improved practice at the professional and individual level. At the organisational level, reflecting the earlier discussion, relevant actions include establishing performance agreements that include achieving an organisation with the capacity and commitment to work effectively in cross-cultural environments.

Box 1: Developing culturally competent health care systems (NHMRC 2005)

Four guiding principles:
- engaging consumers and communities and sustaining reciprocal relationships;
- using leadership and accountability for sustained change;
- building on the strengths of the system by engaging the community;
- shared responsibility through partnerships.

Four dimensions of action:
1. *systemic*: involving effective policies and procedures;
2. *organisational*: including putting the necessary skills and resources in place, creating a culture in which cultural competence is valued as integral to core business and there is management committed to diversity at all levels;
3. *professional*: recognising the influence of professional organisations over professional development;
4. *individual*: so that knowledge, attitudes and behaviours are strengthened within a supportive environment and health professionals feels supported to work with communities.

The second review assesses the current experience of quality improvement initiatives in the US and the UK, presenting the case for strengthening quality of care by working at a similar set of levels to those highlighted in Box 1 (Ferlie and Shortell, 2001):

1. *individual level*: involving education, academic detailing, leadership development;

2. *group/team level*: involving team development;

3. *organisational level*: strengthening organisational culture to allow learning and improved knowledge management;

4. *system/environment level*: considering national bodies, payment policies, accountability mechanisms and legal systems.

This review emphasises the importance of the organisation as a lever of change precisely because organisational culture can support or impede necessary action, and developing a learning culture is identified as being of particular importance in implementing quality improvement strategies. However, the authors also argue that the greatest changes are possible if action at any level is taken with awareness of the other levels, so that possible barriers to change at those other levels can be identified and managed. They argue that organisational level change must, thus, be supported by macro-policy changes in financing, payment and regulatory policies and must build new skills among individuals. Implementation strategies should also be implemented in ways that take account of the national context. The hierarchical nature of the UK health system, for example, suggests a need to focus particularly on action at the individual, group and organisational levels whilst the plural nature of the US system requires careful thought about how to spread good practice.

The importance of flexible, multi-level change efforts underlies, moreover, the concern expressed in a report on a multi-country study on organisational capacity and capacity development (Morgan et al., 2005), that **donor-supported capacity development initiatives in LMICs tend to ignore the complexity of bringing about change within organizations**. The report's authors comment that such initiatives tend to push specific pre-packaged approaches to change (such as formal results-based management/logical frameworks), ignoring the need to understand the dynamics of the complex process of change in any setting as a basis for strategic planning needed to support effective change. The UK government similarly argues that improving public sector leadership requires an environment that gives leaders the freedom to lead and opens them to challenge from within and beyond their organisation, as well as an improved supply of good leaders (Performance and Innovation Unit, no date).

Finally, however, even within multi-faceted capacity development strategies, the experiences presented here (section 2 and 3) demonstrate that there is particular importance in thinking about how to **strengthen public sector leadership**. Such leadership is particularly provided by the senior managers of health organisations, but must also be encouraged throughout the system – including, for example among the middle level managers that link senior managers and employees. It is essential in encouraging the teamwork among employees likely to be required to bring about and sustain change in organisational culture.

Many of the particular demands on public sector leader have already been identified within the earlier discussion (section 2). In his seminal work on strategic management in government, Moore (1995) has summarised three core aspects of every public manager's job:

- establishing the value of their purpose and vision;
- managing upwards, toward the interface with politics, to invest their purpose with legitimacy and support
- managing downwards, towards their staff, to improve the organisation's capabilities to achieve the desired purpose.

These job aspects reflect the particular features of public sector environments already outlined, such as the political context, funding arrangements and accountability patterns, the pressure to collaborate with other government structures at similar levels, the distinctive ethos of the public sector and the lack of market competition (Performance and Innovation Unit, no date). They demand very different competencies to those of private sector leaders, yet there remains very little investigation that allows these competencies to be delineated. Brinkerhoff and Klauss, for example, argued in 1985 that there were four managerial roles for social development managers working in LMICs: technical roles (technical review and problem solving), information roles (monitor, disseminate, spokesperson), interpersonal roles (figurehead, leader, liasion) and decision roles (entrepreneur, disturbance handler, resource allocator, negotiator) (Brinkerhoff and Klauss, 1985).

A more recent compelling account of the nature of these competencies has also been laid out in a UK government document (Box 2), based on a review of relevant literature and experience. On the basis of these competencies, the document then considers how to strengthen the supply of public sector leaders, providing ideas that seem useful elsewhere. It cautions against seeing recruitment from the private sector as a magic bullet, given the peculiar demands of public sector management. It discusses ways of improving salary levels to make public sector positions more attractive, whilst also acknowledging that the public sector will never be able to compete on pay with the private sector. Instead, therefore, it argues that it is important to build up the features of the public sector that attract people to it. Reporting a recent study of 400 senior UK managers from different sectors, the document emphasises that public managers are motivated by a desire to make a difference in society, to produce public value. It, therefore, proposes that leaders could be attracted into the UK public service by making its values clear and open, offering greater recognition for higher performers, perhaps through award systems, and improving non-financial rewards, such as encouraging their greater involvement in the development of policies, improving working conditions and offering opportunities to develop the skills and experiences needed in any other job, and, specifically, by valuing management skills in addition to professional disciplines such a medicine. Strengthening these public service employment conditions and opportunities would then provide a basis for active recruitment strategies.

Turning to programmes for leadership development, the UK government document notes that the literature on these programmes and their link to public sector performance is generally weak, mirroring the conclusion of a recent WHO review of management strengthening activities in low income countries (Egger et al., 2005). The stronger evidence base on the features of effective learning programmes does however allow some common conclusions:

▪ adopt approaches to learning that are most suited to particular leadership qualities (such as self-directed learning and assessment, observation and supported experimentation, coaching and performance management systems to develop leadership style and behaviours, and taught programmes on the job training to develop relevant technical skills);

▪ balance taught courses with opportunities for experiential learning (such as through secondments and work exchanges);

▪ structure taught programmes to allow for action-oriented, hands-on learning, with time to reflect and absorb new ideas;

▪ establish informal peer support networks to support continuing personal development, as well as encouraging it through performance management agreements, for example.

Many existing LMIC health management activities focus on the technical and operational skills of planning and budgeting (see for example TEHIP and Lao case studies, Annex 2).

However, the WHO review highlights the need to strengthen personal skills, such as those of priority setting and time management, and the UK government document stresses the need to include more focus on soft managerial skills, such as leadership theory, how to motivate others, leading organisational and cultural change and mentoring others. Complementary needs are likely to include communication and negotiation skills.

The top down nature of existing public sector leadership practices may, as discussed earlier, suggest that there is a particular need to challenge and strengthen the values base of leaders. Some LMIC leadership development activities thus seek specifically to develop transformational leadership styles. Sanders and Timsina (2004), for example, outline one programme within a wider UNDP leadership development programme. The programme responds to the opportunities and needs created by decentralisation within the Nepalese public sector, seeking to build a group of resource people who can train others conducting HIV/AIDS work. The programme combines frameworks for understanding HIV/AIDS issues with those allowing personal reflection to build self-confidence and, finally, opportunities to apply the Appreciative Inquiry approach and learn how to use it in facilitating strategic planning processes. Overall, the goal of the programme is 'to create leaders who envisage possibilities and see opportunities previously unimagined, and bring voice to the previously unheard' (p.762). The AI approach has also been used to generate leadership transformation in the Nepalese case study discussed in Annex 2.

A similar approach has also been implemented within a training programme supporting implementation of the Cairo reproductive health rights agenda in Latin America (Diaz and Cabral, 2006). Based on Freirean principles of conscientisation, this programme seeks both to empower participants and to create an enabling environment in which they can become agents of change. The programme not only provides opportunities for personal reflection and empowerment, but also provides technical knowledge relevant to new clinical practices, develops the capacity to conduct organisational development activities and provides insights into the socio-cultural factors and power relations that shape policies. It is, moreover, supplemented by efforts to build an enabling environment that include training an inter-sectoral team from each municipality that includes managers, getting political commitment through formal agreements for the training programme and continuing support through coaching and electronic networking. It has also adopted a training of trainers approach, involving locally-based mentoring for participants backed up by the training organisation.

The potential of these types of approaches to renew the values base of professional practices is, finally, shown by a training intervention aimed primarily at health facility staff teams. The

Health Workers for Change (Fonn et al., 2001) training intervention is also a workshop series based on Freirean principles, providing participants with opportunities for critical reflection on their practices, their patients, the obstacles to providing good quality of care in their facilities and ways of addressing these obstacles. An evaluation of the impacts of the workshop package was conducted using a common protocol across seven countries (6 in Africa and 1 in Latin America). It judged that it had a 'positive impact on the relationship between providers and clients, creating teamwork within a facility, creating a supportive environment for health facility staff to take more initiative and to some extent, demand more responsiveness from system level' (Onyango-Ouma et al., 2001: 30). Subsequent application of the package in Pakistan also showed that the process was able to generate a renewed commitment to work among participants, with greater willingness to examine their own practices and improve quality of care (Shaikh et al., 2006). However, reflecting wider experience, the multiple country evaluation as well as the Pakistan study noted that although application of the workshop package can be a step towards initiating behavioural change, it is vital to establish an enabling environment that supports the changes initiated at local level. Indeed, higher-level commitment for the programme was identified as a key influence over its potential for positive impacts, as well as an environment of communication and participatory management practices (Vlassoff and Fonn, 2001).

The WHO review of LMIC management strengthening activities (Egger et al., 2005) highlights, moreover, that current, mostly donor-supported, training activities are often fragmented, small scale and duplicatory, precluding the coordinated development of skills and systems that allow coherent learning. The review calls, therefore, for the international community to:

- improve the knowledge base on effective approaches to building management capacity;
- improve managers access to knowledge, guidance and tools (for example, extending existing web-based learning opportunities);
- provide country support to develop context specific management development strategies that support managers to do their jobs better in existing circumstances, strengthen operational systems, revise rules, regulations and incentives, facilitate coordinated external support and strengthen nationally-based training providers;
- advocate for greater investments in management and capacity development.

Importantly, however, a multi-country study of organisational capacity and capacity suggests that that 'there is persuasive evidence of the value and effectiveness – in contributing to organisational capacity building – of endogenous M&E (monitoring and evaluation) approaches that: are based upon participation through self-assessment by key players;

encourage feedback, reflection and learning on the basis of experience; and promote internal and external dialogue between stakeholders' (Watson, 2002: viii). Rather than pushing particular approaches to capacity development within limited timeframes and linked to the measurement of outcomes, international agencies are encouraged to develop M&E approaches to capacity development that themselves contribute to the enhancement of key capacities within the participating organisations.

4.   Conclusions

The TEHIP study has proved conclusively that system level interventions generate health gains. However, we still know very little about why and how TEHIP or other similar management strengthening initiatives achieve such gains, and so we know little about how to implement them in ways that secure the gains.

The argument presented in this paper is that the provision of evidence, additional funds or the decentralisation of some authority (all important TEHIP components) are ultimately unlikely to be enough by themselves to sustain better managerial practice. Instead, such 'hard' interventions must be complemented by initiatives that strengthen 'softer' managerial skills and prompt or provoke wider cultural change in public sector organisations. Such initiatives are particularly important in implementing the innovative and challenging interventions required to address health inequity.

Such initiatives cannot, however, be taken off the shelf from sets of existing management strengthening tools and approaches. Instead, the paper argues that:
1. managerial action cannot be separated from the context in which it occurs;
2. strengthening public sector management will require efforts to generate organisational cultures that support and enable relevant managerial actions;
3. changing organisational culture involves multi-level actions focussed on individuals within organisations, the organisation and the wider system in which the organisation is embedded;
4. leadership training for senior and middle level public sector managers is an essential element of strengthening health system management.

Country-specific reflection will always be necessary to identify: appropriate entry points; how to link training programmes with health system developments that themselves build capacity; the package of personal, organisational, professional and systemic-level interventions to

adopt; and the flexible approaches to monitoring and evaluation that sustained these complex interventions.

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<u>Annex 1: Knowledge search strategies</u>

A wide range of searches were undertaken using health and social science academic data bases (Pubmed, IBSS (social sciences), and Ingenta select), internet tools (Google and Google Scholar), data bases of specific organisations and web sites (specifically, that of Institute for Development Studies, the UNDP, and the European Centre for Development Policy Management, the UK government's Policy Hub), hand searches and consultation with professionals working in the field. The data base searches were conducted for the last *ten* years, focussing exclusively on English language literature, with a particular but not exclusive concern for low and middle income countries. The main search terms used in combination with health were: appreciative inquiry, capacity development, innovation, management, management strengthening, organisational capacity, and organisational culture.

Specific, but relatively unsuccessful, efforts were made to identify evidence on management development and organisational capacity development interventions.

Among the literature used in the paper are several wide-ranging and strong reviews of experience, including:

- Greenhlagh et al., 2004: a well-documented and systematic narrative review of a wide body of literature relevant to innovation in health care organisations;
- Morgan et al., 2005: a synthesis of experience from a set of empirical studies undertaken using the same theoretical framework of capacity and across a wide range of organisations and sectors within low and middle income countries;
- Simmonds et al., 2006: a synthesis of theory and experience on scaling up innovations in health systems in low and middle income countries, based on a range of empirical work as processes of reflection between academics and practitioners.

In addition, a number of pre-existing reviews conducted by the author in related fields were also directly used in this paper (specifically, reviews on organisational culture, trust and human resource management, and acceptability, access and health seeking behaviour).

<u>**Annex 2: Detailed case studies**</u>

Case study 1: Strengthening district health management in Tanzania

The widely publicised Tanzania Essential Health Intervention Project (TEHIP) was a demonstration project specifically implemented to test the proposition that a system level intervention can, even in a low resource settings, have positive mortality and morbidity impacts. Implemented in two Tanzanian districts from 1997 onwards, TEHIP developed and implemented several tools for strengthening district health planning within a process that provided support to district managers who already had considerable decision-making power, increased their funding level by $1 per population head and generated district-specific data on prevailing health needs as well as other issues of relevance to planners (e.g. health seeking behaviour). The intervention essentially enabled district health planners to target health resources (budgets and human resource activities) towards local health needs. Ultimately child mortality fell by over 40% in the two districts in the 5 years following the introduction of new planning approaches, and in one, the death rate for those aged 15-60 years fell by 18%. TEHIP managers argue that the improved efficiencies that led to these overall health gains also supported equity gains, as the poor were likely to benefit most from improvements in services addressing the districts' main health problems. They also acknowledge, however, that additional investment and action would be required to meet the needs of those who are most marginalised.

The range of TEHIP managerial support approaches developed over time, partly in response to challenges faced within the districts, and some activities were only implemented in parts of the districts (e.g. facility ownership transfer). The full set of approaches developed and implemented across the TEHIP lifetime were:

- participatory action research conducted within local communities by locally based facilitators to strengthen community engagement with and leadership of local development activities
- transferring ownership of primary care facilities to local communities (under agreements which make the government responsible for covering all recurrent costs) in to encourage community investment in infrastructure rehabilitation and development
- strengthening the supervision of primary level facilities by improving transportation and communication equipment and ?strengthening skills
- the generation of annual information on the district population's burden of disease profile (based on district level census data), provided in a user-friendly format

- participation in management development programmes run within Tanzania, building managerial teams and skills, supplemented by more specific training
- the generation of annual analyses of budget allocations and sources of funding, provided in a user-friendly format
- the production of computerised maps of each district, locating health facilities, other local facilities, and key geographical features.

These were supplemented by, for example, skills training for health workers, funded through their own budget when identified by the district managers as necessary, regular and frequent interaction between district health managers and TEHIP technical support officers, as well as between TEHIP officers and other district and national level stakeholders.

A widely publicised feature of the TEHIP experience is the use of information for planning, but the full range of activities listed above makes clear that these activities extended way beyond the simple provision and use of information. The available project evaluations do not not, however, allow a comprehensive assessment of how TEHIP was able to generate its achievements. In particular, no judgement is possible on whether and how the diverse TEHIP activities themselves influenced leadership practices and organisational culture, nor of whether such intermediate changes may themselves have been important in generating the mortality gains achieved. Yet such changes seem possible, and may have had a catalysing effect in relation to the mortality reductions achieved. The focus on information and systems for using it may, for example, have encouraged the emergence of a learning culture, supporting the continued and effective use of information. Similarly, the emphasis on developing integrated solutions to strengthen planning, management and service delivery, runs directly counter to the dominant Tanzanian (and LIC) culture of focussing on strengthening specific disease programmes.

Working initially in only two districts, it also remains unclear if and how the TEHIP experience can be scaled up nationally, or what impacts may still achievable when implemented entirely through routine systems.

Source:

de Savigny, D., Kasale, H., Mbuya, C., and Reid G. (2004). *Fixing Health Systems*. Ottawa: International Development Research Centre.

Case study 2: Strengthening district health management in Laos

Experience of strengthening district health programmes over 12 years in one province of Laos confirms the potential of such activities to generate health and access gains for poor populations at low cost. The maternal mortality rate was, for example, halved over a 5 year period (1998-2003) whilst there was a three fold increase in utilisation and a more than double increase in ante-natal care utilisation between 1997 and 2003.

The intervention activities included in-service training for managers and staff system strengthening activities such as annual and six monthly planning, development of the information system, developing job descriptions for staff, regular supervision of dispensaries and community health workers; problem-solving support visits and career development opportunities for district staff. The investment costs were US$1 per person served per year, with US$0.13 per person per year recurrent costs. Again, however, it is unclear how these interventions impacted on leadership practices, whether and how they influenced organisational culture or whether they enabled the project successes. Yet such catalytic effects seem likely given the nature of the interventions - which include wide-ranging efforts to strengthen management development as well as other HRM interventions.

Source:

Perks C., Toole MJ and Phouthonsy K (2006) District health programmes and health sector reform: case study in the Lao People's Democratic Republic. *Bulletin of the World Health Organisation* 84(2): 132-138

Case study 3: Strengthening a community health worker programme, Ceara State, Brazil

Introduced in 1997 within a broader programme of public management strengthening in the period 1987-1994, during the tenure in office of two reformist governors of a centre left party, this programme contributed to a 36% reduction in infant deaths by 1992, tripled vaccine coverage for measles and polio (from 25% to 90%), expanded its operations from 30% of the state's counties to nearly all within five years and by 1993 was visiting around 65% of the state's populations in their homes. Programme costs averaged US$2 per capita served, around US$7-8 million per year, largely (80%) supporting employment of health agents who visited every household offering preventive and promotive health advice, and who were, in turn, managed by nurse-supervisors.

In examining the reasons for success in this programme, the analysts suggest, first, that much of what occurred was unintentional but that four sets of issues help explain the successes:

1. a combination of centralised and decentralised control was noted: for example, whilst the state (or rather a dedicated group of state officials) was responsible for hiring and paying all health agents, these agents nonetheless worked for nurse supervisors hired by local municipalities and were only employed once the local mayor had agreed to join the programme – this balance of control prevented the use of the programme as a source of patronage by mayors, and yet developed sufficient popular for the programme that mayors were encouraged to accept it;

2. the creation of a sense of mission and status for the programme despite a lack of job security (health agents were employed on a contract basis): was achieved through a state-led and rigorous process of meritocratic selection and training, wide publicity efforts and repeated public prizes for good performance – generating a sense of collective responsibility for the programme among agents, supervisors and clients, and empowering all three groups;

3. the voluntary enlargement of work tasks by health agents, watched over by supervisors but balanced by monitoring by community members (newly informed by public information campaigns about health agents jobs) and the creation of relations of trust with their clients – generated job satisfaction among both supervisors and agents, allowing the supervisors to exercise considerable discretion in their control of the programme and enabling agents to respond to client preferences by taking on additional tasks (both curative and community level action to tackle public health hazards), building relationships of trust with them that sustained their motivation and job satisfaction;

4. and as a result of the above sets of actions, the state was also able to offset the resistance to the programme, first, of mayors (who gained no patronage opportunities from the programme but instead came to see it as something from which they could get credit as well as being subject to popular pressure to implement it); and second, of nurses and doctors (nurses were offered professional opportunities through the programme without threatening the accepted territory of doctors).

Sources:
Tendler J (1997). *Good Government in the Tropics*. Baltimore, The Johns Hopkins Press
Tendler J. and Freedheim S. (1994) Trust in a rent-seeking world: Health and government transformed in Northeast Brazil. *World Development* **22**(12): 1771-91.

Case study 4: The Nepal Safe Motherhood Programme

The Nepalese government's safe motherhood programme was launched in 1997 along with the introduction of the DFID-funded safe motherhood project which sought to improve maternal health initially in three, and after 2000 in nine, of the Kingdom's 75 districts. The project was phased out in 2004, but DFID has continued to provide direct support to the government's programme under a new agreement after this time.

The 1997-2004 project goal was to contribute to mortality reduction by generating sustained increases in the utilisation of quality midwifery and obstetric services through action to support policy and programme development, strengthen the provision of good quality services and address the social context for and access to midwifery and obstetric services within NSMP supported districts. No data are so far available on project impacts, but some data are available on utilisation and quality of care improvements. Although overall coverage remains low, national data show that the proportion of deliveries attend by health care providers had increased from 7.4% in 1991, to 10.8% in 2001 and, using routine health information system data (HMIS), to 16.1% in 2002/3. Moreover, in the project districts the average annual increase in met need for emergency obstetric care (EOC) was 1.3% for phase 1 districts over 7 years, and 1.2% for phase 2 districts over 4 years, although the proportion of all births occurring in a facility remained well below the UN recommended level of 15%. At the same time, national HMIS data show an increase in deliveries at home attended by health workers rising from 4.3% in 2001/2 to 5.7% in 2002/3 nationally. Assessment of the project's impact on quality of care also shows improvements over time in structure and process including, specifically, in staff confidence and motivation. Overall, however, project evaluations also report continuing implementation challenges and constraints associated particularly with the broader weaknesses of the health system, prevailing power structures within communities and the broader context of conflict within the country.

Yet despite these challenges, the NSMP applied innovative approaches in its efforts to strengthen maternal care, which offer particularly important insights for equity-promoting health system strengthening efforts. The change process applied within NSMP and its current challenges are summarised below and then discussed in more detail.

Using participatory approaches, NSMP developed a clear, easy to articulate and shared vision of the project outcomes. Project appointed Human Resource Development Officers acted as change agents and helped ensure an effective communication strategy within and outside the project. An appropriate overall strategy – changing 'hearts and minds' – was adopted, and key

elements were implemented using tried and tested approaches, such as CQI/COPE and FFC. The project identified and strategically addressed critical points of resistance, including the prevailing *ke garne* mindset. The project also fostered ownership and involvement of key stakeholders using the 'whole hospital approach', and by training entire teams of staff ensured that there was a body of people committed to making the change sustainable. However, the changes brought by NSMP are still dependent on appropriate political support and the maintenance of an enabling policy environment. Human resource allocation remains a precarious area, and inappropriate transfer of staff still has the potential to undermine some of the positive changes brought about by the project. Addressing these critical issues will be part of the challenge of the next phase. (Model for Change Report, quoted in Aitken and Thomas p. 31)

NSMP activities were founded on recognition of the diverse social barriers to health care access and differences in these barriers between areas of the country. Working within a newly decentralised system (the Local Self-Governance Act of 1999 devolved decision-making power to district development committees, municipalities and village development committees), the NSMP sought to address barriers within the community by adopting a district partnership approach, involving work with local structures and:

1. social mobilisation efforts to strengthen community awareness around safe motherhood practices,
2. the development of community based emergency funds and transport schemes to offset the financial and transport barriers to accessing care,
3. efforts to reduce the social and cultural distance that included staff training activities to strengthen their confidence and motivation so that they would offer better treatment to patients;
4. district level advocacy to build political and institutional support within districts.

The parallel actions taken to strengthen quality of care combined a range of hardware and software interventions, to strengthen equipment and infrastructure as well as staff skills, behaviours and motivation levels, and those of hospital managers. Together the synergies resulting from this combination are judged to have been particularly important in supporting QOC improvements; for example allowing effective use of newly acquired skills by ensuring supplies and equipment, as well as enhancing provider confidence and motivation.

In the initial phase of implementation, intensive support for an iterative learning and quality improvement process was provided by NMSP human resource development officers, but in phase two these officers then worked with and through locally identified change agents (a

staff member expected to lead change from within the facility). The QOC improvement process also applied two specific capacity strengthening approaches. First, an adapted version of the COPE tool (client oriented provider efficiency) was used to initiate and support quality of care change. Second, the Appreciative Inquiry approach to generating change was used within a training programme called Foundations for Change (FFC), with participants from hospitals, district stakeholders and village development committees. The FFC programme aimed to bring about changes in motivation and attitudes of people towards each other, changes in the way they take responsibility and increases in their skills to organize, manage and lead. Indeed, Clapham et al. (2004: 92) specifically comment that an integral element of QOC improvements efforts 'was the adoption of methods to encourage accountability, respect and desire to provide service among staff members that will result in both a greater self-respect and a respect for clients'. An evaluation of the FFC process found, based on respondents perceptions of the experience and their subsequent work, that the training had enabled hospital staff to develop positive and committed attitudes to life and work, strong team work, better management of their tasks and positive client relations. It also helped district stakeholders work together, and across political lines, to promote safe motherhood awareness among village development committees.

Overall, however, these QOC improvement approaches are judged both to have enabled improvements by challenging existing organisational culture, and yet to have been constrained by other cultural factors. The FFC approach specifically tackled the culture of *'ke garne'*, characterised by a sense of disempowerment and apathy where the individual feels no responsibility to work hard or change things, by empowering service providers to improve service quality. It fostered a team approach to address gender dynamics and the social exclusion of certain groups within health organisations. The synergies resulting from a multi-faceted intervention package were also important in sustaining this motivation. However, these gains are challenged by the continued frequent and inappropriate transfer of staff within the public sector, and the failure to institutionalise the FFC approach, to train new staff and renew the motivation of remaining staff. Quality of care is also undermined by the continuing expectations and practices of patronage (service providers treating their own family and friends better than others) and the continuing lack of power experienced by poor patients, so that the relationship is still provider dominated. Wider cultural change will be required to offset these barriers.

Wider action will also be needed to tackle the low productivity of maternal and child health care workers, which is judged as linked to low community support for them, as well as to strengthen the skills of staff to offer better delivery care, strengthen referral linkages, improve

the use of information, and the quality of reporting. Broader health system reforms are also needed to address the range of health system weaknesses undermining safe motherhood activities, including frequent staff transfer and shortages, the management of drugs and supplies, the quality of laboratory services, and general resource constraints.

Review of experience also specifically suggests the extension of services to the most marginal groups (ultra-poor, dalits and janajatis) will require stronger action to offset the influence of local power structures over their access to available transport and cost subsidies, for example, and community-based empowerment programmes. Recognising that household decision-making continues to account for the longest delay in accessing services, the end of project report calls for approaches targeted to the specific social and cultural context of different groups, requiring flexible planning at district level rather than standardised national strategies.

Finally, the challenges to programme sustainability include sustaining improvements in staff motivation and changes in organisational culture, national and district level political commitment for the integrated package of QOC improvement activities of the improvements, in turn generating financial support for the activities, deepening and sustaining the newly initiated organisational and socio-cultural changes underpinning improved access as well as finding ways of working within the larger context of health system weakness and political conflict.

Sources:
Aitken, J.M. and Thomas, D. (2004) Synthesis of Final Evaluation Findings from the Nepal Safe Motherhood Project. Report to HMGN, DfiD, Options. Accessed at http://www.nsmp.org/publications_reports/index.html, 19 July 2006.
Clapham, S.M., Basnet I., Pathal L.R., and McCall, M. (2004) The evolution of a quality of care approach for improving emergency obstetric care in rural hospital in Nepal. *International Journal of Gynaecoolgy and Obstetrics* 84, 86-97
Hodgson, R., Badu, K., Kati, C. and Parajuli, M. (2003). Artistry of the invisible. Evaluation of 'Foundation for Change' – a change management process. Report prepared for Report to His Majesty's Government of Nepal, DfID, Options. Accessed at http://www.nsmp.org/publications_reports/index.html, 19 July 2006.
ODC (2004) Study on Quality of Care approach in selected health facilities of Nepal. Prepared for Nepal Safe Motherhood Project, Nepal. Accessed at http://www.nsmp.org/publications_reports/index.html, 19 July 2006.