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Better management for better health services

Poor management has been a significant limiting factor in the development of Papua New Guinea’s health services, particularly since their decentralization increased the responsibilities of provincial staff. A programme designed to strengthen management at this level has been proceeding since 1986.

At the outset of Papua New Guinea’s national health plan for 1974–78 it was clearly understood that unless significant advances in management skills were to occur there would be only limited improvements in the people’s health (1). A decade later the need to develop strong management capabilities was still a major concern and in 1986 the second national health plan identified poor management as one of the main factors hindering improvement of the health services at all levels (2).

The decentralization of the health services in 1983 substantially increased the responsibilities of staff at the provincial (i.e., district) level. Although a few of the senior staff at provincial level were given further training in management, most had to accept greater responsibilities without adequate preparatory training and experience. The national Department of Health recognized that the development and enhancement of provincial management capabilities had to be given special attention (3).

National and regional workshops were held and some staff received overseas training. Soon after decentralization a new postgraduate course in community health was developed at the University of Papua New Guinea (4). Unfortunately, these measures did not meet the needs of the 19 provincial divisions of health. A more extensive and sustained approach to management training was clearly required.

Management support for the provinces

In 1986 a management consultant, a systems analyst and a management officer were appointed to engage in management strengthening activities at provincial level, and the Department of Health formed a coordinating group to help with this work. In addition to the consultants, staff members of an Asian Development Bank health services project, the Department of Health
and the World Health Organization collaborated in programme development and implementation.

This group reviewed the planning and management of health services in the provincial divisions of health. The purposes were to determine what was needed in order to develop and strengthen management capabilities, and to identify ways of achieving this goal. The areas selected for immediate attention were information system development, planning and supervision. Other areas, such as financial control and quality assurance, were to be addressed later. The review team recommended the development of appropriate training materials for distance learning and the regular provision of technical personnel “on site” to support provincial staff in areas where management problems had been identified.

Training modules for distance learning were duly developed in the areas of greatest need for management development, and trained facilitators visited each province three times a year to meet technical managers. During each visit, progress was reviewed, problems were discussed and new objectives were set. In-service training sessions were held if required.

After each visit the facilitators reported on what they had found. In addition an annual programme review was instituted to deal with the achievement of the objectives of the programme. Indicators were specifically selected for assessing the performance of provincial staff in the identified areas rather than the performance of the health services.

### Health workers trained by facilitators, 1987–1990

<table>
<thead>
<tr>
<th>Category</th>
<th>Number trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistant secretary for health</td>
<td>8</td>
</tr>
<tr>
<td>Health extension officer</td>
<td>72</td>
</tr>
<tr>
<td>Nursing officer</td>
<td>52</td>
</tr>
<tr>
<td>Dental worker</td>
<td>3</td>
</tr>
<tr>
<td>Health inspector</td>
<td>8</td>
</tr>
<tr>
<td>Nutritionist</td>
<td>5</td>
</tr>
<tr>
<td>Administrative officer</td>
<td>3</td>
</tr>
<tr>
<td>In-service training coordinator</td>
<td>10</td>
</tr>
<tr>
<td>Disease control officer</td>
<td>9</td>
</tr>
<tr>
<td>Health information officer</td>
<td>9</td>
</tr>
<tr>
<td>Hospital secretary</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>184</strong></td>
</tr>
</tbody>
</table>

**Achievements**

So far, in-service training courses have been provided for 184 provincial and health centre staff (see table). On average a training workshop involved 15 participants and lasted five days. The average cost was approximately US$2500, which covered travel, accommodation, food and training materials. The training modules developed by the end of 1990 are indicated in the box on page 163.

Efforts directed at improving the information system have been more successful than those aimed at strengthening planning and supervision. One reason for this was that the programme coincided with computerization of the information system, which generated enthusiasm and interest in this area (5). Prior to decentralization, provincial staff had not been required to formulate medium-term plans. Consequently they
found it easier at first to develop annual programme objectives and indicators than longer-range plans. Examples of annual objectives for family health are indicated on page 165. Having become accustomed to the concept of objectives and indicators and having recently collaborated in the preparation of the national health plan for 1991–1995, many provinces have expressed an interest in developing their own five-year plans using the national plan as a guide. This growing awareness of the importance of planning reflects the long-term nature of management development. People cannot be taught the value of planning but can learn about it through a process of participation.

The attempts to strengthen supervision have given the least cause for satisfaction. The main impediments to the development of a supervisory system have been:

— resource constraints;
— an organizational structure with no focus for supervisory activities;
— cultural factors limiting the willingness of staff to supervise and discipline others.

Economic constraints have had their most serious effects on non-salary operating expenditure, including transportation, making it difficult for staff to fulfil supervisory duties.

The health services are provided in an integrated manner but most provincial divisions of health are structured vertically. Senior staff plan their supervisory activity only for their own programme areas. The concept of a team approach to supervision has been difficult to introduce, requiring organizational reorientation.

As a rule, people in Papua New Guinea are disinclined to confront others with their shortcomings, and this contributes to the difficulties faced in establishing regular supportive supervision.

Changing direction

After three years of operation it became clear that the programme could not be

In-service training modules, 1986–90

Unit A: Using health information to plan, manage and monitor health services
- Basic mathematical skills for using health data
- Calculating target populations and indicators
- Graphing health information: making, using and interpreting graphs
- Developing goals, objectives and action plans to manage health services
- Reference manual for planning, managing and monitoring health services
- Guidelines for developing provincial health plans
- Workbook for developing provincial health plans

Unit B: Support and supervision of health workers and facilities
- Health centre support and supervision by provincial health division
- Health centre support and supervisory check-list
- Health centre and aid post support and supervision by health centre staff

Unit C: Management tools for health services
- Use of cost analysis for provincial health planning and management
- Programme budgeting
- Management indicators for interpreting health information
sustained in its original form because of:
— undue reliance on donor support;
— a dearth of skilled national facilitators;
— poor motivation of some national and provincial staff;
— the high cost of regularly visiting the provinces.

The extension of improved management from the provincial level to the health centres is particularly important in provinces where a parallel decentralization of the health services is scheduled.

Donor support

The initiation of the programme and its early development depended heavily on the work of consultants. In 1987 a national coordinator was appointed but implementation continued to be largely in the hands of expatriate personnel. Their technical expertise was essential but there was undue reliance on them for implementation.

Externally funded projects are by nature short-term exercises. The reliance on external assistance to generate programme activities was to some extent incompatible with the long-term character of management development. The termination of the Asian Development Bank’s financial and personnel inputs in 1988 left the programme in a resource vacuum. WHO assistance has continued but it cannot fully support the programme. Although efforts to secure other external aid are being made, uncertainty about this hinders planning for the future.

Facilitators

When the programme was initiated there was no national counterpart to the consultants and little involvement of senior national staff from the Department of Health. However, in 1987 a national counterpart was appointed and efforts were intensified to involve senior departmental staff and to improve their performance in planning and management. To this end, annual objectives were set and quarterly monitoring meetings were held.

At the provincial level it had been intended that the management materials should be used as self-instructional distance learning tools. However, after some time it became evident that this was not possible. Although the content of the training modules was very relevant and geared to active learning principles, the provincial health staff were unable to use it for distance learning. This was partly because the materials were not sufficiently user-friendly and partly because there was a general unfamiliarity and lack of confidence among provincial staff in respect of the use of self-instructional materials without guidance.

The programme has therefore been modified by using a national facilitator who specifically trains provincial in-service coordinators or training officers to prepare other provincial staff for the use of the training materials. This approach has recently been extended to the training of regional staff as trainers of provincial staff. In several provinces, provincial staff have conducted training for health centre managers.

In essence the programme is now functioning as a scheme for the training of trainers. Given the limited resources, this approach makes sense and has the added advantage of strengthening the technical support relationships between the different levels of the health system.
Morobe Division of Health: family health objectives, 1987

Antenatal
- to increase new antenatal attenders from 49% to 54% of expected pregnancies
- to increase the proportion of mothers making four or more visits during pregnancy from 25% to 30%
- to give all women in first pregnancy a full course of tetanus toxoid
- to increase the proportion of supervised deliveries from 25% to 30%

Family planning
- to increase the proportion of women between the ages of 15 and 45 accepting contraception from 3% to 5%

Child health
- to increase new enrolment of children aged under one year from 55% to 60%
- to improve average monthly attendance at clinics from 16% to 20%

Immunization
- to increase immunization with third dose tetanus toxoid from 30% to 35%
- to increase immunization with third dose Sabin polio vaccine from 30% to 35%
- to increase BCG immunization from 60% to 65%
- to increase measles vaccination from 41% to 45%

Poor motivation
The decentralization of responsibilities necessitated major organizational change and the creation of new provincial public service departments and, within them, divisions of health. This process took some years in most provinces; in the interim, senior staff held only temporary or acting appointments.

Some provincial staff, aware of the temporary nature of their positions, lacked the motivation to make a commitment to the programme. In the national Department of Health it was very difficult to motivate most programme managers to participate in the programme because of their heavy workloads.

Visiting the provinces
The high cost of travel and the large number of facilitators required to provide support to all 19 provinces have made it difficult to provide uniform coverage. Indeed, by the second year of the programme it was obvious that all the provinces could not be given the same attention. It was therefore decided that provinces evincing little interest in participation would be visited only once in order to assess development and likely future attitudes.

Prospects
If the gains made by the programme are to be consolidated and if the management development process is to continue, the following issues will have to be tackled:
- institutionalization;
- extension of management improvements to other levels of the health system;
- provision of leadership support;
- recurrent financing;
- training of facilitators.
Health Systems

Institutionalization

Initially it was intended to integrate senior staff of the Department of Health into the management development process so that the provision of technical support to the provinces became a regular part of their responsibility. This plan was revised because difficulties were experienced in eliciting involvement in the programme due to heavy workloads and because schemes to provide technical support for the provinces through units based in each of the country’s four geographical regions were being introduced. Activities such as curriculum writing and the production of training materials will continue to be centred in the Department of Health.

The technical support function is being moved to regional support units, which will provide the provinces with backup in management and other technical areas. It is intended that regional staff should become increasingly involved in the training of provincial staff, who in turn will acquire heightened responsibilities for the training of health centre managers.

Because several agencies are involved in management development, the Department of Health has strengthened its coordinating role by establishing a management support programme coordinating committee.

Other levels of the health system

Organizational change and development cannot be effective if they occur at only one level. This is why the programme is turning to management support for all levels of the health system. If the benefits of improved management are to endure, an extension of skills from the provincial level to the national Department of Health and the health centres is essential.

One reason why national staff have given little support has been that they have lacked confidence. An effort should be made to build on their strengths and make them more confident about travelling to the provinces to provide technical support. Only with the development of a core of capable managers in the health centres can the overall performance of the system improve. The extension of improved management from the provincial level to the health centres is particularly important in the small number of provinces where a parallel decentralization of the health services is scheduled.

Leadership support

Strong committed leadership is critical to the continued success of the programme. Leadership support should be available at the national and provincial levels. There should be participation in the process and special attention should be given to the implementation of improvements in management.

In order to obtain commitment it is necessary to ensure that the relevance and importance of the programme’s activities are understood and accepted by key officials and managers at all levels.
Recurrent financing

Adequate resources have to be provided to support the management development effort on a continuing basis. The World Health Organization and the Asian Development Bank have provided technical and financial assistance allowing the process to proceed to date. The costs for the first three years amounted to over US$154,000, and it is estimated that US$30,000 will be required annually to support the programme, excluding payment for consultants (6). As the programme is assimilated into the regular operations of the Department of Health, it is important that the government assume responsibility for financing and staffing. The Department appointed a full-time national coordinator for the programme in 1987. Additional resources are required to sustain the programme, for instance to cover transport costs and developmental work.

Training of facilitators

The training of national and provincial staff to facilitate management training must continue. Efforts to train as wide a range of health personnel from the national, regional, provincial and local levels need to be intensified. This will diminish reliance on external facilitators, increase the self-esteem of national staff and contribute to the institutionalization of the programme.

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Management development is a long-term process and, if sustained improvements are to occur, it must evolve in a responsive way. Since the programme began, changes have been made in response to needs. Thus staff of the national Division of Primary Health Services have been included in management strengthening activities, the programme has been extended to the health centre level, and regional support units have been established.

The changing nature of the programme and the management of donor inputs over an extended period necessitate strong and constant national coordination. The maintenance of a full-time national coordinator and the continuing support of the Secretary for Health and other departmental executives will be essential for the evolution of the programme.

So far the programme has focused on the improvement of management functions with a view to improving health care delivery. In the long term the focus will need to change to service outcomes if meaningful evaluation is to be performed.

Acknowledgements

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References