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Who are health managers ?

Case studies from three African countries

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Acronyms

BMC	Budget and management centre
GHS	Ghana Health Service
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
HRH	Human resources for health management
HRM	Human resource management
MDG	Millennium Development Goals
MOH	Ministry of Health
MPH	Master of Public Health
WHO	World Health Organization
WHO-AFRO	World Health Organization - Regional Office for Africa

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Executive summary

Health managers are considered essential at both the strategic and operational levels of health systems. Health sector managers at central or national levels oversee the strategic direction of the sector as policy makers, managing overall resource allocation and monitoring policy targets and outcomes. At operational levels, managers are responsible for converting health systems input and resources such as finance, staff, supplies, equipment and infrastructure, into effective services that produce health results. A continuing emphasis on decentralization in developing countries makes the need for managers with the right skills even more essential. However, health systems in developing countries lack data and information regarding health service managers. While most health workforce statistics record the availability of various cadres of health professionals, as currently structured, they do not provide information on the actual roles played by health professionals, many of whom play management and other roles in addition to their professional tasks. The managerial function is rarely a part of human resources for health management (HRH) development plans.

A rapid descriptive assessment was undertaken in three African countries, namely Ethiopia, Ghana, the United Republic of Tanzania (mainland and Zanzibar) to gain an initial understanding of the management workforce for service delivery in these countries and to test selected criteria for assessing managers as part of the health workforce. The study was approached using the WHO framework on leadership and management of health services that identifies four essential conditions for effective management in health systems. The framework proposes that effective management requires an adequate number of managers with appropriate competencies, working with effective support systems in an enabling organizational environment. The study focused on the first two conditions and was intended to help provide better knowledge and data on who the managers of health services are, what their main characteristics are and how they are deployed and utilized to achieve service delivery goals. This initial study focused on persons leading health units such as districts, hospitals, provinces/regions and national directorates. Other managerial staff such as accountants, logisticians and general administrators were not included.

A team consisting of WHO headquarters, WHO Regional Office for Africa and country staff designed the study. Local researchers in each country carried out the study which included desk reviews of each country's information and statistics related to managerst in the health sector. The information sources included policies, strategic plans, organizational structures, regulations, job descriptions and guides. In addition, key informants were interviewed, based on a sample of senior health managers at national and service delivery levels especially the department in charge of human resources for health at national level.

The term "manager" was not specifically defined in the countries reviewed, and key informants in each country were asked to provide some consensus definitions. In general, health managers were defined by the roles they play, for example as a district director, programme manager or as a hospital director. The combined data from Ghana, the United Republic of Tanzania shows managers ranged in age from 27 to 72 years, with most (46.4%) clustered in the 41 to 50 age group. However, another 40% were aged between 51 and 60 years. As official retirement ages ranged from 55 to 60 years, this has implications for upcoming retirements and the need for succession planning. The pre-retirement group accounts for approximately 30% of the total management workforce in Ghana, and 38% in the United Republic of Tanzania (mainland). There was a general male dominance in managerial posts with females accounting for less than 10% managers in the United Republic of Tanzania and approximately 25% in Ghana.

The backgrounds of managers in the three countries are quite varied. It is well known that managers in developing countries are usually clinicians with management as an additional role. The studies showed that health managers include professionals such as doctors, nurses, assistant medical officers, health administrators, pharmacists, health officers and clinical officers. Doctors formed the bulk of managers at national and provincial levels though there was considerable variation between the countries. For example, 68% of managers in the United Republic of Tanzania (mainland) are physicians. In Ghana, 62% of district directors are doctors but this ranges from 100% in urban districts to 33% in the rural north of the country. In Zanzibar, 83% of managers are doctors or assistant medical officers and only 6.6% are nurses. At district levels, assistant medical officers account for the majority of managers.

Every health system desires managers who are competent and have the knowledge, skills and demeanour to be effective. The definition of a "qualified manager" varies between the countries and what was accepted as a valid qualification does not necessarily include management. Indeed, many hospital managers for example were considered qualified on the basis of their clinical qualifications[1]. The United Republic of Tanzania (mainland) requires district managers to have a health professional qualification and an additional qualification in public health. Ethiopia has much the same requirement but the additional qualification can be in management. Ghana classifies managers into two categories, namely administrative and technical, both being health professionals with additional qualifications. Administrative managers such as district directors require a public health or management degree, while technical managers such as hospital directors simply require a clinical specialty qualification. In Ethiopia, 31% of all health sector managers are considered qualified but this drops to 10% at district (woreda) level, and to 32% at zonal level, vs. 88% and 83% at regional and federal levels, respectively. In the United Republic of Tanzania (mainland) 49% of all health sector managers are considered to have the requisite qualifications and in Ghana 54% of district directors and 36% of hospital heads are considered qualified.

While the study focused on who managers are and their qualifications, it also briefly examined other limiting factors in the working environment of managers, such as the lack of incentives and inadequate authority to perform their duties. The study looked more specifically at human resources management (HRM) support systems. Each country has national human resources directorates within the Ministry of Health (MOH), however, most of these are not considered to be adequately staffed and are not well represented at decentralized levels. At the district level, human resources (HR) systems are said to be weak in all the countries with a low level of HR information and HR decision-making occurring at this level. Decentralization of HR management has been initiated in all three countries. For example, some HR management functions have been decentralized to the regional level in Ghana and Ethiopia, but payroll management is still centralized in both countries. Managerial authority over staff is generally weak with ineffective discipline and performance management systems. In Ethiopia, the use of unqualified and poorly performing staff for personnel management at district level was identified as an issue.

The information from the study suggests a major lack of appreciation of this component of the health workforce and the catalytic role it can play in scaling up service delivery. More clarity is needed about the management workforce and closer attention should be paid to health managers in order to improve the performance of health systems. Country health systems need to identify critical management posts and generate information that will assist with planning for this essential cadre.

[1] The study accepted each country's own criteria for the definition of "qualified manager".

Introduction

Despite recent increases in development assistance for health, most low income countries are not progressing well towards achieving the health-related Millennium Development Goals (MDGs).(1) Weaknesses in general managerial capacity at all levels of health systems have been cited as one of the contributory factors to this failure in scaling up health services and achieving health goals.(2)

Improved availability of resources for scaling up health interventions cannot on its own achieve expected outcomes without effective and efficient management. Thus, managers at all levels of health systems are essential to a country's capacity to absorb and utilize resources efficiently and effectively.

During the 1990s many African countries undertook health sector reforms which addressed areas such as financing, cost effectiveness, decentralization and privatization. However, many of the reforms and resulting strategic plans do not appear to have adequately addressed operational management issues. Management and leadership issues also need to be addressed with planned strategies. Managers need to be ready to lead services towards attaining sector goals.

The WHO definition of a health services manager is someone who spends a substantial proportion of his/her time managing:

- the volume and coverage of services including planning, implementation and evaluation;
- resources such as staff, budgets, drugs, equipment, buildings and information;
- external relations and partners, including service users.(1)

However, very little information seems to exist in developing countries on who the health service managers are, what competencies they require and what roles and results are expected of them in service delivery. Often what exists tends to be about specific project management linked to specific disease programmes that neglect the generic management role.

This study was therefore initiated in order to get more field information on the above issues and aims to provide an overview of managers as part of the health workforce.

Case studies were undertaken in three countries in Africa, namely Ethiopia, Ghana and the United Republic of Tanzania, to explore the availability and training of health service managers, especially those at operational levels. In the United Republic of Tanzania, the study was carried out separately in both the mainland and Zanzibar. For the ease of reference, hereafter, mainland data is referred to as for the United Republic of Tanzania (mainland) and the parts specific to Zanzibar mentioned as such. This report presents a summary of the findings from the three country case studies.

The first part of the paper covers the objectives and rationale for the studies and discusses a WHO conceptual framework on which the analysis is based. The second part examines the context and background of the study countries and the factors that influenced their approach to health services management. The third part describes the study's methodology and the fourth part presents and discusses the key findings. The report concludes with a discussion of the practical implications of the management situation for the countries and makes recommendations.

1
Objectives and rationale

The case studies were aimed at eliciting broad information and knowledge on managers of health services, their location and main characteristics, as a means of helping to improve the planning processes for the management workforce in developing countries.

The broad objective was to assess the current status of the management workforce in the health sector of these countries, to provide a basis for comparative analysis and determine essential information types that can help in planning the training, recruitment, selection and deployment of managers.

For ease of comparison between countries, the case studies focused on managers that play specific roles as heads of certain levels of health services, in particular, heads of hospitals and health districts. Although multiple management and supervisory levels and personnel are found in health systems, it was decided to keep the focus of the case studies on the levels of management considered critical to overall service delivery.

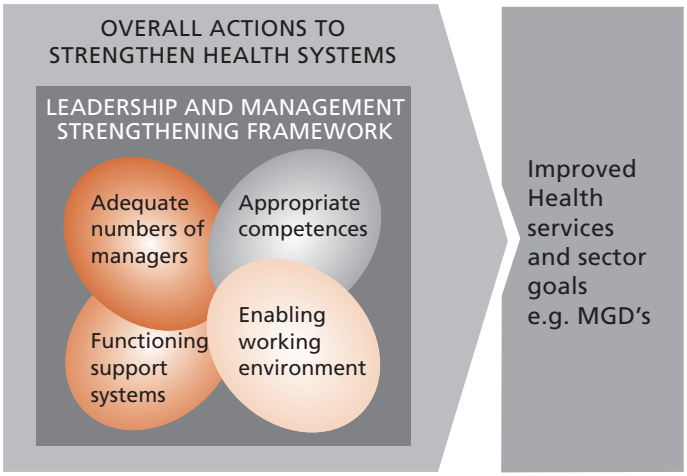
A conceptual framework

For the design and analysis of the studies, the WHO framework for strengthening leadership and management capacity was used.[2,3] This framework addresses the question of what conditions are necessary for good leadership and management, and asserts that good leadership and management requires a balance of four generic factors:

- an adequate number of managers are available at all levels of the health system
- managers have the appropriate competences
- critical management support systems are functional and effective
- the working environment enhances managers' performance.

The four conditions are closely inter-linked and have various areas of overlap, so management interventions need to be implemented in a coordinated way to get effective results. Assessing the extent to which these four conditions are fulfilled in any particular health system helps to expose gaps in management systems and to determine the kinds of interventions needed to improve management of services. The framework recognizes that activities to strengthen leadership and management are a means to the end of effective health services and should be integral to health systems. For the purposes of this study, the relevant aspects of the WHO framework were used to map the current situation of managers and to determine key issues that need to be considered in planning for an effective management cadre (Figure 1).

Fig. 1 LEADERSHIP AND MANAGEMENT IN HEALTH SYSTEMS



Source: Making Health Systems Work Series. Geneva, World Health Organization, 2007.

The case studies obtained basic essential information on the first two components of the framework which represents availability of management capacity. The primary concerns were to gather information on the availability and deployment of managers. This included data on the number and type of managers and their characteristics such as age, gender, and professional background, and information on the training and competencies of managers, including health manager qualifications accepted in each country and how these are acquired.

The other two components of the framework, namely support systems and working environment were not dealt with in detail but were touched upon where they relate to issues concerning the first two components.

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[2] Towards better leadership and management in health. *Making Health Systems Work Series, Working Paper No. 10*. Geneva World Health Organization 2007. Available from: http://www.who.int/management/working_paper_10_en_opt.pdf

[3] *Building Leadership and Management Capacity in Health*. Geneva, World Health Organization, 2007. (WHO/HSS/OMH unpublished brochure).

2

Context and background in study countries

Much effort has been expended on improving health management capacity in developing countries but this activity appears not to have met expectations. Health systems performance is still considered very poor in many developing countries with poor management considered as a critical factor. The study countries, Ethiopia, Ghana, and the United Republic of Tanzania, are all developing countries in sub-Saharan Africa, which despite their similarities have many differences and variations in terms of how their health sectors operate. However, they have in common health sector reforms aimed at improving the coverage and quality of health services.

The health sectors in the three countries have a similar structure with a central/national headquarters level that works through provinces/regions, districts and sub-district levels to deliver health services (Table 1)[4].

Table 1. ORGANIZATION OF THE HEALTH SECTOR

COUNTRY	MANAGEMENT LEVELS	COMMENTS
Ethiopia	• Federal Ministry of Health (MOH) • Regional health bureaux • Zonal health offices • District (woreda) health offices • Health facilities (health centres, district, zonal and referral hospitals.	The federal MOH and regional bureaux are responsible for policies and guidelines. Senior managers heading federal level directorates oversee strategic direction of the sector, manage resource allocation and monitor policy implemen-tation. The sector aims to devolve more power to health facilities. However, the sector strategic plan lacks specific policies on management.
Ghana	• MOH • Ghana Health Service (GHS), other auto-nomous agencies and national hospitals • Regional health directorates with regional hospitals • District health directorates and district hospitals • Sub-district units, e.g., health centres, clinics.	The GHS and Teaching Hospitals (TH) Act 525(1996), focused MOH on policy formulation, sector monitoring and evaluation, resource mobilization/allocation and regulation of services. Authority for core service delivery was devolved to semi-autonomous MOH agencies created by the Act. Budget management centres (BMCs) are the basic management unit which have a budget and render defined services. BMCs at each level have a management team. The recent five-year sector strategy did not directly address management issues.
The United Republic of Tanzania (mainland)	• MOH and semi-autonomous national and regional hospitals • Regional local government health directorates • District council health units and district hospitals • Sub-district units, e.g., health centres, clinics.	The national MOH has responsibility for policy, regulation and standardization of health services. Service provision is decentralized to local government and regional and district health departments are under the Ministry of Regional Administration and Local Government. Autonomous regional and national hospitals are managed through boards of trustees.
Zanzibar	• National level (MOH) • Regional level • District level • Health facilities (hospitals, health centres etc.)	The MOH is responsible for policy making but may have a more centralized system possibly due to the smaller size of this territory.

Sources : (i) Esser tial Health Services for Ethiopia, 2005, FMOH unpublished document (ii) Organizational manual, Ministry of Health, Ghana, 2001, (unpublished document) (iii) Decentralization in the United Republic of Tanzania, a concept paper, 2001 (unpublished document)

All the case study countries have similar pyramidal structures with centralized policy-making and monitoring at the national level and with service delivery devolved to decentralized MOH units or to local government. With the exception of Ghana where managed units are clearly defined as budget management centres (BMCs), it was not clear in the other countries what defined a unit of management in the sector. This lack of a definition creates difficulties in collecting information about managers and being able to identify shortages, mal-distribution and other issues. Generally, national health sector policies and strategic plans have paid little attention to designing management strategy and planning for its implementation.

[4] The health sectors in the three countries have similar structure with a central/national headquarters level that works through provinces/regions, districts and sub-district levels to deliver health services. Table 1 summarizes each country's structure.

3
Study methods

Case studies were carried out in the three countries based on a rapid assessment methodology that scanned for key essential information from existing sources. The studies were coordinated by a WHO team from both WHO headquarters and the Regional Office for Africa. The case studies were carried out with assistance of the WHO's country offices, the Ministries of Health (MOHs) and selected researchers in the target countries.

The process used included:

- Desk reviews of various national documents pertaining to health sector management in each country and retrieval of information, where available, on the availability and characteristics of managers. Types of documents reviewed included MOH policies, strategic plans, administrative manuals, legislation, regulations, research reports, job descriptions, and HR policies etc. related to the work of managers.

- Key informant interviews were also held in each country, at national, provincial, district and sub-district levels where relevant. These sought insights into management issues and how these have been dealt with in each country. Key informants were senior health managers and policy makers at national and provincial levels as well as experienced managers from districts and hospitals.

- In some cases, in-depth data was collected from selected provinces and districts to build a picture of the country's situation especially where national figures were not available. However, the case studies relied extensively on the secondary data found in the countries' information systems and the reports reviewed.

A basic generic protocol was used from which a semi-structured questionnaire or guide was developed for key informant interviews. The questionnaire was used to collect data and information related to the numbers, personal characteristics, professional background and training of health managers. Detailed statistics on managers were universally very limited or outdated and often not summarized and used nationally. The study also supplemented the available data with qualitative information that elicited managers' perceptions on their working conditions and organizational environment. In some cases samples of managers selected on a convenience sampling basis from districts visited provided a sampling where statistics were not readily available.

Therefore the case studies are not an accurate statistical representation of the status of each country's managers but an attempt to have the best possible mapping of the management workforce and issues related to it. In the area of management support systems, the case studies focused exclusively on HRM structures as an example of such support systems.

4
Findings and discussion

The findings are provided in three sections. The first section focuses on the personal characteristics and types of managers and their deployment issues. The second section explores qualifications accepted by each country for managers and examines the proportions of managers considered qualified for the job in each country. The final section focuses on other conditions and qualitative issues arising from the studies, including perceptions of factors that enable better function and performance as managers.

4.1
Country definitions of a health services manager

The term "manager" is not specifically defined in any of the country documents reviewed. However, key informants from the MOH headquarters in each country were asked to provide some consensus definitions. Generally health managers were identifiable in documents by the roles they were assigned such as district director, programme manager or hospital director. It is recognized however that within each hospital or district unit, other staff play managerial and supervisory roles for which formal definitions are not always available. The definitions of managers derived from key informants included:

- Anybody in charge of administration or overall running of hospitals, programmes, departments and units. (Zanzibar)
- Those who set the strategic direction of the health sector, formulating policies, mobilizing resources, developing and disbursing budgets. (Ghana)
- Those who manage staff and resources for health service delivery and coordinate health programmes. (Ethiopia)
- Anyone in charge of a group of people jointly charged with attainment of specific objectives through delivery of specified outputs. (The United Republic of Tanzania (mainland))

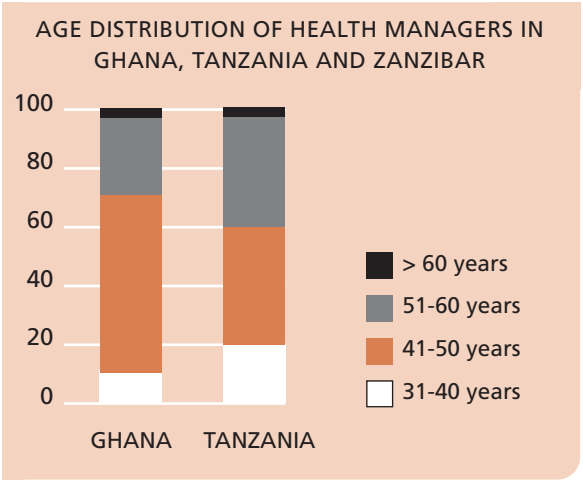
These definitions are broad and non-specific and so in addition respondents also tended to list a hierarchy of public sector management titles ranging from the very senior policy levels (chief director, permanent secretary) to operational functions (in-charge, supervisors, administrators, unit heads). The heads of a health district and a hospital are fairly well-defined, though other managers working under these groups are still less recognized by the system. The term "manager" is used quite liberally. For example, certain posts in one country were designated material manager but were actually occupied by junior auxiliary and non-professional staff who had no actual managerial responsibilities. Clearly defining managers and management posts should help policy makers to identify critical management staff needs and determine whether they are effectively deployed. It also makes it easier to determine recruitment and training needs of managers.

The study estimated that there are a total of 1105 health managers, based on the study's definition[5] in all three countries, with 805 in Ethiopia, 160 in Ghana, 30 in Zanzibar and 110 in the United Republic of Tanzania (mainland). The large Ethiopian figure includes a large number of woreda and sub-district heads, probably a reflection of the lack of clarity as to who was a manager. In the other countries, data was focused on district, regional and national level managers.

Characteristics of health services managers

Combined data from Ghana, the United Republic of Tanzania[6] shows managers range in age between 27 and 72 years, with most (46.4%) clustered in the 41 to 50 age group. The second largest group, comprising approximately 40% of all managers, are those between 51 and 60 years. This has implications for retirement and succession planning as the official retirement age is 55 in the United Republic of Tanzania and 60 in Ghana. In Ghana this pre-retirement group constituted 30% of managers, and it also accounted for 38% in the United Republic of Tanzania (mainland). While there is no benchmark for an ideal age distribution of managers, the absence of any replacement plans and the lack of awareness of its implications among decision makers is cause for some concern.

Fig. 2 AGE PROFILE OF MANAGERS



Gender distribution of managers was skewed in favour of males in the two countries providing gender information (Ghana and the United Republic of Tanzania). In Ghana, 16.3% of managers are female. This figure is only 7.6% in the United Republic of Tanzania (mainland). Only three of 34 formally appointed hospital managers (medical superintendents) in Ghana were female and at the national MOH headquarters, four of 28 directors and deputy directors (14%) were female. This level rises to approximately 19% among district managers even though other studies show about 59% of the total health workforce in Ghana is female.(3)

Table 2. MANAGERS' AGE AND GENDER DISTRIBUTION: GHANA, THE UNITED REPUBLIC OF TANZANIA (MAINLAND)

AGE INTERVAL	FEMALE	MALE	TOTAL	%
31 - 40	2	11	13	10.00
41 - 50	13	64	77	59.70
51 - 60	6	32	38	29.50
60 +	0	1	1	0.8
GRAND TOTAL	21	108	129	
%	16.3	83		

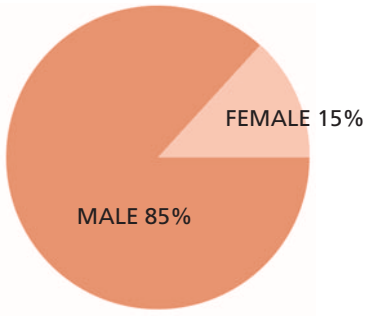
The United Republic of Tanzania (mainland)

Managers sampled / all levels

AGE INTERVAL	FEMALE	MALE	TOTAL	%
31-40	2	19	21	20
41-50	5	39	44	41.9
51-60	1	39	40	38.1
GRAND TOTAL	8	97	105	
%	7.6	92.4		

Opportunities for female managers may be related to their proportion in the physician workforce that often dominates senior managerial positions and also other factors that may delay their rise into senior positions such as family obligations and child rearing. It is also likely that if the sample of management positions had included in-charges of ward and other hospital and programme units, the gender proportion may well be higher for these levels where the managers may tend to be nurses.

Fig. 3 GENDER DISTRIBUTION OF HEALTH MANAGERS, GHANA AND THE UNITED REPUBLIC OF TANZANIA



[5] For purposes of the study countries were asked to focus on heads/ managers of national directorates, provincial/regional and districts, as well as heads of all non-tertiary hospitals

[6] No age data available from Ethiopia

The professional background of health services managers
Managers in developing countries are often health professionals who have also taken up managerial roles. The managers in the case studies came from various backgrounds and include doctors, nurses, assistant medical officers, health administrators, pharmacists and health or clinical officers. Doctors usually form the bulk of managers at national and provincial levels but there is still considerable variation among the countries. For example only 7% of district health directors in Ethiopia are doctors, while 34% are health officers and 47% are nurses. Overall, almost all managers at woreda level have some health qualifications but this proportion drops to 26% at regional level and 39% at federal level. This is possibly due to the policy, planning, budgeting and financial management roles performed by senior civil service managers seconded from other sector ministries such as finance and public service.

In Ghana, available data from 2004 indicates that 62% of district directors are doctors but this ranges from 100% in urban districts to 33% in the rural north of the country. All regional directors and heads of hospitals (including persons in acting positions) are doctors. A human resources update presented during the annual sector review in 2005 estimated that the MOH headquarters alone employs 2% of all doctors in the country.

In Zanzibar, most managers at national level (83%) were doctors or assistant medical officers and only a few (6.6%) were nurses. All district level heads were assistant medical officers. The United Republic of Tanzania (mainland) had a similar range of professional types but overall 64% of all managers in the group were doctors, 27% were assistant medical officers and the remaining 9% included a mix of other cadres such as clinical officers and health officers.

Managers, service providers or both?
Many health managers are not full-time managers but play dual roles in performing both their usual clinical tasks as doctors, nurses or pharmacists and also management tasks. The extent and the share of time each role takes is not well delineated but this dual role appears to be fairly common in the case-study countries. In Ghana however, 82% of district managers interviewed considered themselves to be in full-time management and spent less than 10% of their time on clinical tasks. Hospital directors in general indicated that they spent over 60% of their time on clinical tasks.

The managers in the United Republic of Tanzania (mainland) at national, regional and district level are all considered to be in full-time management and to have no clinical responsibilities though as we found in Ghana, many hospital heads were in reality part-time managers with major clinical tasks.

In Zanzibar, managers generally had both managerial and clinical responsibilities though 60% of district managers claimed to be in full-time management while 40% indicated that between 25% and 40% of time was spent on clinical work. Among hospital directors, 67% indicated they spent between 10% and 30% of their time on clinical duties with the rest claiming full-time management responsibilities. Managers at MOH headquarters with medical specialist qualifications often consulted at the referral hospital and could not calculate the actual amount of time spent on each role, but they estimated most of their time was spent on management. Zanzibar's district medical officers specifically reported that they did not have any guidelines on how to apportion their time between the two roles, but responded to the situation if, for example, a shortage of doctors existed at that location.

The study did not explore the possibility of full-time management roles in the public sector being supplemented with clinical practice in the private sector, possibly after hours. While having the right experience is likely to be beneficial to being a manager, about a third of managers in the three countries are between 51 and 60 years of age and approaching retirement. The lack of turnover data on managers especially in critical service delivery posts remains a constraint to planning.

4.2 Qualifications of managers: a proxy for competence?

What makes a qualified manager?
Every health system desires managers who are competent, who have the knowledge, skills and behaviour needed to be effective in their jobs. A manager's competence derives from a combination of experience, training and coaching. However, determining the competence of health managers in the countries studied was well beyond the scope of these studies. Therefore the case studies simply tried to determine the approved qualifications required of people appointed into managerial positions for each country. Thus, who was considered a qualified manager and what was accepted as a valid qualification varied between the countries. The approved qualification often did not include management subjects and indeed in many cases hospital managers were selected on the basis of their clinical qualifications.

The United Republic of Tanzania (mainland) requires managers to have a health professional qualification and additional qualification in public health. Ethiopia has similar requirements but the additional qualification can be in management. Ghana classifies managers into two categories, administrative and technical. Both are health professionals with additional qualifications in public health or management (e.g., district directors) for administrative managers and simply a clinical specialty qualification for technical managers (e.g., hospital directors). Based on each country's criteria the case studies

sought to establish the availability of managers considered as qualified. The definition of managers, which was the head of a specific health unit (province, district, hospital) may have precluded non-health professionals who are managers but in support roles at these levels. However, in the United Republic of Tanzania (mainland) there are a few instances of managers with only a first degree in public administration.

Are management posts filled by people considered to be qualified?
In Ethiopia, some 31% of all sector managers are considered qualified, though this proportion is only 10% at woreda and hospital level, rising to 32% at zonal level, 88% at regional level and 83% at federal level. In the United Republic of Tanzania (mainland), 49% of sector managers are considered qualified though this rises to 61% among doctor managers and is only 10% among assistant medical officer managers. According to the data from Ghana, 54% of district directors and 36% of hospital directors are considered qualified.

Zanzibar does not have clear qualification criteria for managers though an HRM situational analysis in 2004 recommended the deployment of personnel with a diploma in management to strengthen district management teams. This recommendation led to about 60% of all district managers receiving on-the-job management training.

In general, there are very few purpose-trained managers, i.e., managers who are not health professionals. All the countries studied, with the possible exception of Ethiopia, require district medical officers in particular to have only a Master of Public Health (MPH) degree. Other WHO studies found the same with Uganda (2) and Togo (4) While public health skills are no doubt essential for primary health care management, it is not clear whether management is required as a component of public health degrees in each country.

Are qualifications synonymous with competence?
The countries surveyed generally used formal university training received from both local and foreign universities as the basis for management qualifications. In some cases university courses are said to be tailor-made for specific local needs and others had practical field training components. The courses are accredited by local bodies and generally recognized by the MOH. None of the four MOHs maintained a list of acceptable institutions and qualifications or tried to influence how graduates were produced. Indeed, none appeared to have a standard competency framework for health managers to guide curricula development and the influence of MOH on the content and methods of the courses was unclear. No document reviewed in countries provided in-depth assessments of managers' competencies, though managers do seem to receive a large variety of either generic or programme specific management short courses and workshops. Job descriptions for managers were available in variable detail in each country but mostly lacked documentation on competency requirements and expected performance standards.

Are there purpose-trained managers?
Purpose-trained managers are defined in the studies as those whose primary training and qualifications are in management rather than the health professions. Ethiopia has some, mainly said to be at the federal level and mostly engaged in management support areas such as human resources administration or supplies management. Ghana also has health service administrators who are purpose-trained for the health sector and 124 persons are listed as such in staff statistics. They usually form part of the management team in hospitals and at regional level but rarely head units themselves, except at a few national directorates. In the United Republic of Tanzania (mainland), administrative functions in regional and district hospitals are led by hospital secretaries with diplomas in public administration with a specific hospital administration component.

4.3 Other conditions for effective management

Management support systems are critical for managers to be effective
The performance of health services managers will depend in part on how certain standard support systems function. Even good managers will have problems if procedures for running finances, staff, etc., are not working well. Functional systems should have clear rules and regulations, good guides and forms, effective monitoring and supervision and appropriate support staff, e.g. account staff, supplies and information staff and secretarial support.(6) Examples of critical management support systems include:

- planning, budgeting and financial management systems
- personnel management systems, including performance management
- procurement and distribution systems for drugs and other commodities
- information management and monitoring systems
- systems for managing assets and other logistics, infrastructure and transport.

Support systems help to ensure uniformity in management practices and ensure that management and administrative systems function and get results. The case studies examined some support systems in relation to their effect on management practices but have not dealt with them in depth.

In terms of HRM systems in the countries studied, there are national human resources directorates within the MOH. However, most of the directorates were not considered to be adequately staffed and furthermore did not have much

representation at decentralized levels. At the district levels HR systems were said to be weak in all the countries, with a significant lack of HR information and HR decision-making. Aspects of HRM have been decentralized in all three countries but payroll management is still centralized in Ghana and Ethiopia. Managerial authority over staff appears to be generally weak and discipline and performance management are ineffective. The use of unqualified and poorly performing staff for personnel management functions at woreda level in Ethiopia was identified as one of the constraints to effective management.

However, there were some examples of good practices in financial management in the countries surveyed. Ghana's fiscal decentralization policy has created budget management centres (BMCs)[7] that are required to prepare plans and budgets with significant authority over local fees and funds which are 100% retained by each unit. Despite quite significant time spent on plans and budgets preparation in each country, there were complaints about centralized budgets that did not reflect local realities as well as sudden budget cuts and disbursement delays. In Zanzibar, facility managers complained of a lack of participation in determining the budget. Non-hospital facility managers said that planning and budgeting was done from the regional hospital level and did not offer an opportunity to reflect their own specific needs. However, there is evidence that financial management regulations, guidelines and periodic audit checks exist and are used.

Weakened support systems like HR information and supervision support have probably contributed to factors like poor supervision and inadequate data on HRH in the countries surveyed. These systems inevitably inform policy initiation and formulation and the need to rapidly expand and improve health support systems cannot be overemphasized.

Is there an enabling working environment for managers?
Even when managers have good skills, the organizational environment must be conducive to motivating good performance. Factors that can influence managers' work environment include (6):

- the degree of autonomy they have for decision making;
- a clear definition and communication of their roles and responsibilities within the organization;
- existence and use of national management standards, rules and procedures;
- effective support and supervision, performance monitoring with regular meetings, from the headquarters and other supervisory levels;
- financial and non-financial incentives to motivate or improve performance and systems to hold managers accountable for service delivery results.

The study tried to sketch the situation of health managers' work environment and very briefly explored the autonomy and authority of managers, job descriptions, standard administrative protocols, incentives and motivators for managers and assessing managers' performance.

Autonomy and authority of managers
In all countries surveyed, district managers have some control over staff discipline, promotions of some staff categories, conduct of staff appraisals, and nominations for in-service training.

In some countries studied, staff management functions have not been decentralized and district managers do not usually have authority to hire and fire, or can do so only with the approval of regional or provincial directors. In Ethiopia, district managers prepare plans and budgets and spend based on approved ceilings. Woreda managers have the formal authority to hire, fire, and manage personnel, although their decisions must be approved by the regional health boards and must adhere to generic civil service contractual terms and conditions. Ghana's district and regional managers can hire and fire only casual staff and can only spend up to approved budget ceilings. However, they have total control over any funds generated from local fees. Hiring and firing authority in Zanzibar lies with the MOH permanent secretary. In the United Republic of Tanzania (mainland) district managers cannot hire and fire. In the public sector of all these countries, district managers can take disciplinary measures against their staff but the effect of this is limited by the lack of the ultimate sanction to back this up.

In general, the degree of autonomy for operational managers is limited to certain functions like budgeting, staff discipline, promotions and training selection but not hiring and firing and they have very limited flexibility to reallocate budget resources. Though decentralization has been a significant component of health sector reforms in each of these countries, delegation of service delivery responsibilities may have occurred without commensurate delegation of financial and administrative authority. (5)

Job descriptions
Though managers have some awareness what they are supposed to do, many do not have formal written job descriptions. In Ghana, in the sample of district, regional, referral hospital and national level managers interviewed, 71% do not have written job descriptions. In some areas they simply have a brief description of the role as part of the appointment letter.

[7] BMC's are independently managed units such as districts and hospitals that have their own budgets, bank accounts and accounting staff and must have unit specific plans. Certain system requirements are needed to qualify as a BMC.

In the United Republic of Tanzania (mainland), 58% of district and regional managers do have formal job descriptions that clearly describe their roles and responsibilities. Zanzibar indicated that job descriptions for senior national level managers are part of appointment letters but as these letters are confidential, their job descriptions are not in the public domain. It is not clear if hospital managers have written job descriptions as there is no documentary evidence to support this.

Standard administrative protocols

In general there are clear guidelines in each country for planning, procurement, drug logistics and supplies management. Ghana and the United Republic of Tanzania (mainland) have clear guidelines for financial management, working with local government, health sector priorities and public procurement but this is less evident in Ethiopia and Zanzibar. Ethiopia has technical guidelines for various specific programmes or with instructions communicated as a memo, but guidelines with standards were generally unavailable to managers.

Incentives and motivators for managers

Some countries described incentive packages for managers but others indicated that incentives are inadequate or absent altogether. In Ghana, public sector sponsorship of further training for managers is seen as a good incentive, along with the provision of car and housing loans. Zanzibar's managers do not have specific incentives for managers and some said verbal praise is all that a performing manager can expect. While some were of the view that performing managers stand a better chance of getting promoted, others felt that promotions are not linked to performance and that often people are promoted without formal appraisals being done.

In Ghana, managers appeared more satisfied with their incentives which may possibly account for a relatively low annual turnover of managers (14%) compared to Ethiopia's higher rates (20% to 30%). In the United Republic of Tanzania (mainland) and Zanzibar the retention issue is probably expressed by the high acting rates among managers at 37% and 50%, respectively.

Assessing managers' performance

Poor supervision was reported as a common concern in the studies. Even when supervisory visits take place, they are described as casual and do not provide adequate support. Generally, there was little information as to the form supervisions took and what results and feedback occurred.

Performance assessments for managers occurs in all the countries studied but are not considered vigorous and results-oriented, but as routine checks without any significance, performed by immediate supervisors and line managers. An open performance review and appraisal system is used in the United Republic of Tanzania (mainland) which, according to district managers, is not effective. Zanzibar has no criteria for assessing managers' performance and none of the managers interviewed could themselves describe how subordinate staff performance is assessed.

Ethiopia has a performance appraisal system which is used for all staff and has components evaluating ethics, customer service, leadership and innovations. The system is used to assess managers' performance. This is required twice a year but most respondents do not consider the appraisal systems to be effective and said that there was little follow-up from the civil service when the appraisals concluded. In addition, the methods and approaches may differ in different regions. Ghana has a combination of assessments including performance checklists, appraisal reports, quarterly and annual reports, but again the results of assessment are not utilized. The Eastern region of Ghana is piloting a new performance system that has been developed to use weighted indicators to assess and compare the performance of various districts and sub-districts and build a performance league table.

5 Conclusions

The studies were conducted as a rapid assessment to find and analyze what qualitative and quantitative information might be available in countries and what knowledge can be obtained on the management workforce in health. The estimation by the 2006 World Health Report (5) that fully a third of the health workforce is made up of management and support workers reveals a largely unknown cadre of whom there is little understanding and for whom almost no planning occurs.

The studies reveal that a general lack of attention is being paid to management cadres. This is illustrated by an almost universal absence of data on managers, and the lack of management development strategies as part of sector policy documents. It would appear that the skills and competencies of managers, unlike that of other professionals, are not regulated by clear job descriptions and clear performance results and there are no national training plans for them.

A formal definition of health managers' posts was lacking in many cases and recruitment and selection of managers into posts appear unplanned, with clinicians often moving into management by virtue of length of service and without preparation. While it is recognized that technical staff also have to play management roles, management and clinical tasks are often in conflict and it seems that there are no policies to guide

managers on the best mix of this dual roles. It is also not clear in any of the study countries how persons interested in management may be developed towards this role.

The study used country-approved qualifications as the basic proxy of managerial competence and even then a significant proportion of managers in each country were unqualified, with many in acting positions. The absence of national management competency frameworks means that the frequent short courses provided by donors and priority disease programmes may not be meeting the actual needs of managers.
While human resources information systems capture the clinical professionals (doctors, nurses, midwives and pharmacists) fairly well, they are generally unable to assess critical functions like management, which may not be related to basic professional qualifications. The true availability of cadres such as doctors for service delivery maybe less than estimated from professional statistics, if significant members are managers.

Hospital, district and sub-district health service leadership is critical to improving the performance of health systems and countries such as those studied need to take a more strategic look at how to mobilize managers and influence the effectiveness and efficiency of service delivery. Managers, like any other health cadre, need to be planned for, retained and motivated. Efforts should be made to understand their dynamics as a workforce in terms of availability, deployment, skills and competencies, retention and turnover, with a strong emphasis on monitoring their performance and on building the available managerial capacity to achieve results. Managers also need to be supervised in a structured and well-organized way, and aided by better clarity and formalization of roles.

Large numbers of management training programmes have targeted every type of supervisor and manager but these programmes need to be harmonized into a national framework to minimize duplication and expand the coverage of basic management education according to needs at each management level.

The starting hypothesis was that having effective and efficient managers in health systems will facilitate the scaling up of key health interventions. There is little solid information at this stage to support this. However conventional wisdom and the role of managers play in other sectors and industries compels us to believe that a strong management cadre is important for scaling up services. Further investigation and improvement of this cadre will help resource poor settings to reach their health goals.

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Health managers are considered essential at both the strategic and operational levels of health systems. To gain an initial understanding of the management workforce for service delivery, a rapid descriptive assessment was undertaken in three African countries, namely Ethiopia, Ghana and the United Republic of Tanzania. The study looked at who the managers are and what their backgrounds are as well as whether they have effective support systems in an enabling organizational environment. The information from the study suggests a major lack of appreciation of this component of the health workforce and the catalytic role it can play in scaling up service delivery. This publication summarizes the findings of the study.

This publication is available on the Internet at:
http://www.who.int/hrh/documents/country-profiles

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