Postgraduate Certificate
in Public Health

# Health Management I
# Module Guide

2008

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Postgraduate Certificate in Public Health – Health Management I by Wendy Venter, Kirstie Rendall-Mkosi, Lucy Alexander, School of Public Health University of the Western Cape, is licensed under a Creative Commons Attribution-NonCommercial-ShareAlike 2.5 South Africa License.

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Value of module: 20 credits
Study time required: 200 notional learning hours

Pre-requisites: None except those in the Rules of Admission
Qualification serviced by this Module:
Postgraduate Certificate in Public Health

Study Materials for this module:
Module Guide & One Reader

**HEALTH MANAGEMENT I**

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***Vision Statement – The School of Public Health, University of the Western Cape***

The vision of the School of Public Health at the University of the Western Cape is to build the capacity of public health workers to transform the health sector from a predominantly curative, hospital-based service to a high quality, comprehensive, community-based, participatory and equitable system.

# CONTENTS

# I MODULE INTRODUCTION

## 1

*School of Public Health*
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*South Africa*

*Dear colleague*

***Welcome to the Health Management I module.***

*This module was created to help prepare individuals in the fields of health and welfare for the challenging role of manager. We hope that you will find the materials relevant to your work situation and useful in developing your skills as a manager.*

***About the Module***

*Health management is considered an important skill area for Public Health professionals. This Health Management module thus forms one of the core modules of the Postgraduate Certificate in Public Health. The module covers three key management areas: people management, planning and resource management. Through exploring these areas, the module aims to provide information and assistance at a practical level, continually referring the student to management issues within their own context. As management is cross-cutting in relation to other Public Health fields, the student is also expected to relate much of the management study material to the contexts of the other Certificate modules.*

*This module is designed for self-study or flexible learning which enables you to work through the study sessions at your own pace. This also allows you to explore the material to whatever depth you prefer, and to skip parts with which you are already familiar. The module invites a range of learning activities including reading, analysis, reflection and application of new concepts, theories and models to your own work context as well as observation and practice.*

***Finding your way around the Module Introduction***

*The introductory pages which follow provide you with an overview of the Module, its outcomes, assignments as well as the sources from which you can expect support and assistance. Take the time to look through this section before you begin studying – taking particular note of the assignments and their requirements.*

***Contact information***

*All the contact information that you may need is contained in section 4 of the introduction. You will find a Student Details Update Form in your SOPH Programme Handbook. If your contact details have changed in any way, please send it to the Student Administrator, School of Public Health straight away.*

***Assessment***

*This module will be assessed through two assignments. Check the due dates with the schedule from the Student Administrator. The assignments will test your understanding of the study materials and your ability to apply this understanding to a work situation.*

***Student evaluation***

*We hope that you will give us some feedback on your experience of these study sessions as this is the first time we have presented them. Your feedback will be valuable to us in improving them. You will be asked to fill in an evaluation form which you will find on the site.*

*We hope you enjoy your studies.*

*Best wishes,*

Module Convenor

**Vision Statement – The School of Public Health, University of the Western Cape**

The **Vision** of the School of Public Health is to contribute to the optimal health of populations living in a healthy and sustainable environment in developing countries, particularly Africa, with access to an appropriate, high quality, comprehensive and equitable health system, based on a human rights approach.

# 2 INFORMATION ABOUT THIS MODULE

## 2.1 Acknowledgements

The writers acknowledge the contribution of the following individuals:

Dr Arthur Heywood of the SOPH, who authored the previous version of this module, the management section of *Management for Health Promotion,* Revised Version, August 2001.

Prof David Sanders and Prof Uta Lehmann of the SOPH, who reviewed sections of this module.

## 2.2 Module aims and rationale

This module was developed in recognition of the fact that health and welfare programmes often fail to perform optimally, not because of technical incompetence, but rather as a result inadequate management expertise. Health care workers are frequently required to carry significant management responsibilities with little or no preparation for the role of manager. The module thus aims to provide students with an understanding of the concepts behind and practices associated with effective management in the field of health. The approach is practical, requiring students to relate information to their own context and reflect on their own experiences as they work through the module.

Three main areas are covered: people management, planning and resource management. Each of these areas is in itself a vast study area, well beyond the scope of this module, but we have attempted to provide insights into some of the key aspects. In keeping with the three management areas covered, the module emphasises three vital management themes: the importance of people, the importance of planning and the importance of systems.

The over-arching theme of the module is captured by the statement:

*Management is: getting things done through people.*

The crux of this definition is that effective management requires focus on both the people doing the work as well as on the work itself.

Thus, in the initial units of the module, you focus on gaining an understanding of yourself, your job and the people you work with: what makes people behave the way they do, what motivates them to work well, and what results in frustration. We look at how to manage episodes of conflict constructively and how to lead your team to optimal performance.

Next we turn our attention to planning as an integral part of management. Here we follow the theme: *Planning is using information from the past and the present to prepare for the future.* Management without planning is impossible.

Three issues underlie the need for planning: activities need to be thought through in detail, decisions need to be made in the face of scarce resources and external influences need to be anticipated. A thorough planning process addresses these issues and becomes an important management tool to help you in understanding your context, making sound decisions and in maintaining control of your responsibilities.

The final broad area we explore is that of resource management. This is closely related to planning. The emphasis here is on the importance of systems to provide clarity in terms of organisation and responsibilities and to ensure optimal use of resources. The establishment and maintenance of well-managed systems links back to issues within leadership, motivation and team work, thus reiterating our theme: *Management is: getting things done through people.*

## 2.3 Module outline

This module consists of 5 Units divided into a total of 17 Study Sessions. Most of the Study Sessions require you to read one or two texts from the Reader. You will be referred to them in the course of the Study Session. In addition, you are expected to work through the Tasks which are integrated across the Study Sessions. Sessions vary in length and could take between one and four hours to complete. The Units in this Module are as follows:

**HEALTH MANAGEMENT I**

**Unit 1 – The Manager**

| | |
|---|---|
| Study Session 1 | What is Management? |
| Study Session 2 | Managing Yourself |

**Unit 2 – Managing People**

| | |
|---|---|
| Study Session 1 | Understanding People |
| Study Session 2 | Managing Conflict |

**Unit 3 – Leading People**

| | |
|---|---|
| Study Session 1 | Motivation |
| Study Session 2 | Leadership |
| Study Session 3 | Building Teams |

**Unit 4 - Planning**

| | |
|---|---|
| Study Session 1 | The District Health System |
| Study Session 2 | Planning: What and Why? |
| Study Session 3 | The Planning Cycle |
| Study Session 4 | Planning a Project |
| Study Session 5 | Information for Planning and Management |

**Unit 5 – Managing Resources**

| | |
|---|---|
| Study Session 1 | Developing and Interpreting Budgets |
| Study Session 2 | Managing Drugs |
| Study Session 3 | Managing Medical Supplies and Equipment |
| Study Session 4 | Managing Transport |
| Study Session 5 | Managing Personnel |

## 2.4 Learning outcomes

The module is intended to lead to the following outcomes:

### Intended Health Management outcomes

*By the end of this module, you are expected to be able to:*

- Identify your own management roles.
- Manage yourself in order to manage others better, through improved stress management, time management and delegation.
- Demonstrate recognition that people's differences will affect the way they behave at work.
- Practise empathic listening.
- Apply conflict management concepts and models to your work situation.
- Describe factors which influence people's motivation to work.
- Describe the theories of leadership and the concept of fitting the leadership approach to the situation.
- Describe the manager's role in leading a team through its stages of development.
- Describe the District Health System and the rationale underpinning it.
- Define planning and discuss reasons for planning, including scarcity of resources and the influence of external factors.
- Describe the stages of the planning cycle and define key planning terms.
- Draw up a plan for a small scale project using a planning tool.
- Describe the role of health information systems in planning and management.
- Demonstrate a basic understanding of how to develop and interpret budgets.
- Summarise the concepts of *essential drugs* and *standard treatment guidelines*, and *inventory control*.
- Describe the concept of *appropriate technology* and the value of standardisation and maintenance in relation to medical equipment.
- Describe the components of a transport management system.
- Describe and the components of a personnel management system.
- Evaluate components of a variety of systems.

### Intended academic outcomes

*By the end of this module, you are expected to be able to:*

- Define, explain and apply a range of concepts, models and theories relevant to the field of health management.
- Collect, select information and analyse information from the field of health management.
- Summarise information using diagrams and interpret diagrams.
- Select, analyse and apply information from academic and procedural texts.
- Evaluate health management practices and systems in terms of criteria.

# 3 ASSESSMENT

## 3.5 Assignment for *Health Management I*

Assignment 1 focuses on people management and Assignment 2 addresses planning and resource management. You are required to submit the assignment on the due date with the Module Evaluation Form (at the back of this Guide).

**Assignment 1 – Managing a Conflict Situation (40% of module result)**

**Analyse a situation of conflict and propose solutions (1 500 words)**

Identify a recent situation of workplace conflict in which you were involved or of which you were aware. Analyse the situation using the following guidelines:

a) Briefly describe the setting in which you work (one paragraph).

b) Summarise the main causes of the conflict, drawing on the terminology of the reading on conflict which you studied.

c) Identify the roles within the jobs of the main individuals involved in the conflict, demonstrating your understanding of the concept of *roles*.

d) Analyse other factors underlying the behaviour of the individuals involved. Refer to the factors and the relevant theories behind the factors affecting human behaviour in the workplace, e.g. Role Theory, needs, motivation, and causes and responses to conflict situations.

e) Describe how you, as a manager, would lead the process of resolving this conflict. Explain the reasons for using the approach you choose, referring to the texts on leadership, conflict management and, if relevant, team building.

Please note: Two thirds of your assignment should focus on sections (d) and (e). Look at how the marks have been weighted below.

**Assessment Criteria for Section 1**
(These criteria show you how you will be assessed)

| Criteria | Marks |
|---|---|
| i) Clear and well-structured answers. (Refers to all sections) | 5 |
| ii) Comprehensive descriptions. (Refers to a, b and c) | 10 |

| | | |
|---|---|---|
| iii) | Use and application of concepts, models and theories. (Refers to b, c, d, and e) | 15 |
| iv) | Critical analysis of conflict situation resulting in problem identification. (Refers to b, c and d) | 10 |
| v) | Appropriate and well substantiated conflict management strategy. (Refers to e) i.e. *Substantiated* means that you give reasons for your choices. | 10 |
| **Total** | | **50** |

**Assignment 2- Evaluation of a Resource Management System (60% of module result)**

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**Describe and evaluate a resource management system in your workplace and propose improvements (1 500 – 2 000 words)**

Describe one resource management system within your workplace, project or programme. The system should be within financial, drug, equipment, transport or personnel management. Use the following guidelines:

a) Briefly describe the activities of different staff members working within the system. Include a diagram to explain the system.
b) Summarise the procedures of the system, how they fit together and explain why these are necessary. Include a description of how supervision takes place and how accountability is assured.
c) Identify an aspect of the system which requires improvement and give reasons for saying this.
d) With a view to improving this aspect of the system, suggest adjustments which would not require additional resources.

**Assessment Criteria for Assignment 2**

| | **Criteria** | **Marks** |
|---|---|---|
| i) | The student is able to identify the components of the system including procedures, accountability procedures and staff roles. | 20 |
| ii) | The diagram is clear and explains the system. | 5 |
| iii) | The description and proposed improvement demonstrate understanding of the rationale underpinning the system. | 20 |
| iv) | The description and rationale demonstrate a sound understanding of the role of supervision. | 5 |
| | **Total** | **50** |

**Pages 9-17 have been removed from this version.**

# Unit 1 - Introduction

# The Manager

In this first unit we focus on the health manager as an individual who has unique roles and challenges and yet shares in the common experience of many other managers and staff members.

Many managers talk about how much they have learned from experience. However, it is easy to have a great deal of experience and learn very little from it.

A useful way to use your experience as a tool for learning is through the process of *reflection*. Reflection involves taking time to look back at the things you have done as a manager and to review how far your actions resulted in successful outcomes. We are using the word *reflect* here to mean more than just thinking about what you have done. Reflecting is about mentally going over what was done, considering other ways of doing things and what the different outcomes could have been. This helps you to learn how you achieved success so that you can repeat it and improve on it in the future.

Throughout this unit, we will be asking you to reflect on aspects of your job, to think about the many different activities you have to perform and the way in which you, as an individual, deal with stress and use your time. The study sessions will present practical ways of approaching some of these challenges. The unit also introduces a principle of management which will be used as a theme throughout the module:

*Management is getting things done through people.*

In this Unit there are two Study Sessions:

Study Session 1: What is Management?

Study Session 2: Managing Yourself.

In the first session, we will examine the meaning of management and explore the nature of a manager's job. In the second session, we will work through some management *survival skills*, including stress management, time management and delegation.

## Intended learning outcomes of Unit 1

| **By the end of Unit 1 you should be able to:** |
| --- |
| ▪ Identify your own management roles.<br>▪ Manage yourself in order to manage others better, through improved stress management, time management and delegation. |

There are also a number of academic skills which have been integrated into the unit. They include learning or revising selected concepts, models and theories which may be useful in developing your understanding of management, as well as practice in the process of clustering or categorising information. This is a useful skill in terms of academic writing and planning as a manager. The skill of time-management which you will develop in the context of your job, will also be very useful in managing your studies. You are probably aware by now that you learn best when you learn actively: this means different things to different people. First of all it suggests that we should use as many of our senses and capacities as possible while we study. Secondly, it can mean making notes in the margins of your study materials, making mind-maps on a notepad as you read, and then evaluating the usefulness of your mind-maps at the end of the session.

Another way to study actively is to read with focus questions in mind. Develop your own questions as you preview the contents of the session e.g. *What management roles do I play and what can I learn from this session to improve my effectiveness?* Then take notes which answer your questions. This forces you to develop your own mental structure for the information you read, which is a good way to internalise new information.

You should also frequently remind yourself of the requirements of the assignment for this module. Be on the alert for ideas and information which might feed into the assignment. Enjoy the unit, and concentrate on reflecting on your own experience: it's an excellent way of developing your management skills!

# Unit 1 - Study Session 1
# What is Management?

## Introduction

Many health professionals are required to perform management tasks, sometimes in addition to their other professional tasks. Even if they are not necessarily called a *manager* in their job descriptions, they co-ordinate, guide, plan and supervise activities, people or processes. They may not think of themselves as managers, but may well be doing the job of a manager.

It is not easy to prepare people for the job of manager. Managers carry out a number of different activities, fulfil a number of different roles, and are faced with a variety of problems. However, one way of helping to prepare managers for their jobs is to help them gain a better understanding of the nature of a manager's job. In this session we examine various definitions of management and then look at the nature of the manager's job in terms of activities and roles.

## Session contents



## Timing of this session

This session has no additional readings, but requires you to do four tasks. It is likely to take you about an hour and a half.

# 1 LEARNING OUTCOMES OF THIS SESSION

| **Intended learning outcomes**<br>By the end of this session, you should be able to: | |
|---|---|
| **Management outcomes:**<br><br>▪ Define management,<br>▪ Use a framework to cluster the roles of a manager.<br>▪ Identify the management activities and roles in your own job.<br>▪ Prioritise the management roles in your job. | **Academic outcomes:**<br><br>▪ Apply key management concepts to your own experience.<br>▪ Categorise work-related activities.<br>▪ Apply a problem-solving approach. |

# 2 REFERENCES

There are no extra readings for this session, but several references are used in the text.

| References | Publication details | Page numbers are in the text |
|---|---|---|
| | Handy, C. (1993). *Understanding Organisations. London*: Penguin Books. | |
| | McMahon R., Barton, E., Piot, M. (1992). *On Being in Charge: A guide to management in primary health care.* Geneva: WHO. | |
| | Pugh, D.S. & Hickson, D.J. (1989). *Writers on Organizations.* London: Penguin Books. In Management Education Scheme by Open Learning (MESOL), The Open University. (2000). *Managing in Health and Social Care*, *Module 1, Book 1.* Milton Keynes: Walton Hall. | |
| | World Health Organisation. (1993). *Training Manual on Management of Human Resources for Health, Section 1, Part A. Geneva*: WHO. | |

# 3 WHAT IS MANAGEMENT?

It is not easy to define management. Many definitions have been suggested, for example:

Management is:

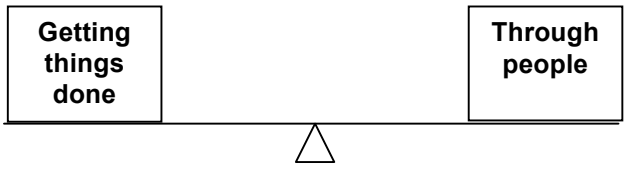
- Getting things done.
- Saying what needs to be done and getting it done.
- Getting people to work harmoniously together and making efficient use of resources to achieve objectives.
- Planning, organising, directing and controlling: the art of getting things done by and through people (WHO, 1993: 5).
- A systematic process of using resources with judgement, to achieve objectives.
- "… Good management is to organisation what health is to the body – the smooth functioning of all its parts …" (McMahon et al, 1992: 3)

**TASK 1 – Defining management**

a) Which definition do you prefer and why do you like it?
b) Write your own definition of management that applies to your situation.
c) Think about your job and identify the things you do which involve management. Use the definitions to guide you.

**FEEDBACK**

The WHO definition, "getting things done through people", is used as a theme throughout this health management module. This definition was chosen because we want to emphasise that management consists of two equally important concepts:




While it is necessary to ensure that things get done, the manager should never forget that without people, nothing will get done!

# 4 WHAT DO MANAGERS DO?

## 4.1 The activities of a health manager

Margaret is the health manager for a non-governmental organisation (NGO) serving two large refugee camps in Tanzania. She has overall responsibility for the provision of health services in these camps. We asked her to write down all the activities that make up her job.

**Margaret's job as a health manager includes:**

"Supervising six programme managers; receiving, checking, interpreting and acting upon health statistical reports; writing reports to donors; managing the health programme budget; preparing the budget for the following year; planning new projects; preparing project proposals; arguing for resources for health; preparing orders for drugs and equipment; finding and contacting suppliers; keeping track of orders; checking the quality of newly arrived stock; approving distribution of drugs and equipment; getting equipment fixed; supervision of the medical stores; organising a transport schedule; getting approval for transport usage by the health team; approving leave requests; arranging referrals; determining staffing needs; recruiting and hiring staff; disciplining and firing staff; sorting out conflict among staff; designing a new medical stores complex and new camp hospital; supervising staff development and training opportunities; establishing a medical library; contingency planning; arranging for transport of bodies; arranging burials; buying shrouds; managing a blood bank; organising work schedules; sweeping the floor; tidying the office; cleaning refrigerators; fixing computer printers; listening to complaints; liaising with donors and other organisations; representing the NGO at community meetings; helping researchers; taking care of visitors; running staff meetings; responding to staff requests and problems."

Margaret's job is challenging. It consists of many varied activities, ranging from large tasks with a high level of responsibility, to duties which are small and uninteresting but nevertheless essential to the smooth functioning of the programme.

**TASK 2 - Examining your activities as a manager**

Using Margaret's job as an example, make a list of all the management activities or tasks that make up your job.

**FEEDBACK**

There will be differences and similarities between your activities and those described by Margaret. Each management job will have its own requirements, but all management jobs will probably have this is common: the job will include a wide variety of activities.

Management jobs also vary greatly in scope, from the management of a hospital with hundreds of employees to the management of a health post with three staff members; or from the management of a health district to the management of a family planning project.

Even within the same job, there may be wide scope: sometimes being a manager involves making difficult decisions, like approving the purchase of an expensive piece of equipment or having to discipline a staff member; but sometimes being a manager means listening patiently to a junior staff member's problem, or trying to fix a printer, or helping to unload a truck, or sweeping the floor if this is what needs to be done!

There are many different kinds of managers in the health care sector, but the purpose of all the different jobs is similar: to provide high quality health services to those who need them. Managers have to carry out a wide range of activities and use a variety of skills and knowledge. Although all management jobs are different, there are skills which are common to many jobs - regardless of the level of the manager or the type of work involved. We will explore some of these important skills as we progress through this module.

## 4.2 The roles of a manager

In order to be effective as a manager, it is first of all necessary to understand exactly what is required of you in your job.

One of the difficulties of a manager's job is that it may seem like a rather large muddle of different activities necessary for simply keeping things up and running. A manager was once described as someone who "… does one damn thing after another!" Sometimes the sheer number of activities required of the manager may seem almost overwhelming.

In the light of this, it is helpful to look for patterns amongst the activities so that similar activities can be grouped together. Each group of activities may be seen as representing a different role within the manager's job. Perhaps because the meaning of management is difficult to pin down, researchers have attempted to understand management work by identifying the different roles that make up a manager's job. Henry Mintzberg (Handy, 1993: 322) studied the jobs of a group of senior managers. He was able to fit all the managers' varied activities into ten quite different roles.

Furthermore, he grouped the ten roles into three key areas:

| Key Areas | Roles |
|---|---|
| **Engaging in interpersonal contact** | 1. Figurehead<br>2. Leader<br>3. Liaison person |
| **Processing information** | 4. Monitor<br>5. Disseminator<br>6. Spokesperson |
| **Making decisions** | 7. Entrepreneur<br>8. Disturbance handler<br>9. Resource allocator<br>10. Negotiator |

"… **Interpersonal** roles cover the relationships that a manager has to have with others. The three roles that a manager has to have within this category are figurehead, leader and liaison. Managers have to act as *figureheads* because of their formal authority and symbolic position, representing their organizations. As *leaders*, managers have to bring together the needs of an organization and those of the individuals under their command. The third interpersonal role, that of *liaison*, deals with the horizontal relationships which work-activity studies have shown to be important for a manager. A manager has to maintain a network of relationships outside the organization.

Managers have to collect, disseminate and transmit information and have three corresponding **informational** roles, namely monitor, disseminator and spokesperson. A manager is an important person in *monitoring* what goes on in the organization, receiving information about both external and internal events, and transmitting it to others. This process of transmission is the *dissemination* role, passing on information of both a factual and value kind. A manager often has to give information concerning the organization to outsiders, taking on the role of *spokesperson* to both the general public and those in positions of influence.

As with so many writers about management, Mintzberg regards the most crucial part of managerial activity as that concerned with **making decisions**. The four roles that he places in this category are based on different classes of decision, namely, entrepreneur, disturbance handler, resource allocator and negotiator. As *entrepreneurs* [an entrepreneur is someone who finds new ways of doing things], managers make decisions about changing what is happening in an organization. They may have to both initiate change and take an active part in deciding exactly what is to be done. In principle, they are acting voluntarily. This is very different from their role as *disturbance handler*, where managers have to make decisions which arise from events beyond their control and unpredicted. The ability to react to events as well as to plan activities is seen as an important managerial skill in Mintzberg's eyes.

The *resource allocation role* of a manager is central to much organizational analysis. Clearly a manager has to make decisions about the allocation of money, people, equipment, time and so on. Mintzberg points out that in doing so a manager is actually scheduling time, programming work and authorizing actions. The *negotiation role* is put in the decisional category by Mintzberg because … a manager has to negotiate with others and in the process make decisions about the commitment of organizational resources …" (Pugh & Hickson, 1989: 12-13)

**TASK 3 – Examining your roles as a manager**

List the ten roles that Mintzberg identifies and then try to group the job activities you listed into these roles. (Not all managers play all roles, so do not worry if you think you only play some of the roles. You may find that some activities fit into more than one role). Have you identified any role which you fulfil but which does not fit into Mintzberg's categories?

**FEEDBACK**

Your answers will be individual, but compare them with the grouping of Margaret's activities into Mintzberg's ten roles:

| | |
|---|---|
| Figurehead: | Representing the NGO at community meetings. |
| Leader: | Supervising the six programme managers; supervising of the medical stores. |
| Liaison: | Liaising with donors and other organisations. |
| Monitor: | Receiving, checking, interpreting and acting upon health statistical reports; keeping track of orders; checking the quality of newly arrived stock. |
| Disseminator: | Writing reports to donors. |
| Spokesperson: | Arguing for health resources in general management meetings. |
| Entrepreneur: | Planning new projects; preparing project proposals; preparing orders for drugs and equipment; finding and contacting suppliers. |
| Disturbance handler: | Sorting out conflict among staff; getting equipment fixed. |
| Resource allocator: | Approving distribution of drugs and equipment; managing the health programme budget; preparing the budget for the following year; determining staffing needs. |
| Negotiator: | Arguing for resources for health; getting approval for transport use by the health team. |

After considering Mintzberg's list and the management activities that make up your own job, it should be clear to you that as a manager you will need to fulfil a wide range of roles and perhaps be expected to have an equally wide range of skills. Every manager will also be faced with deciding how much time and importance to give to the different roles at different times.

# 5 PRIORITISING MANAGEMENT ROLES

We have seen that a manager has to juggle a number of different roles at the same time. Although some people may feel that one role is more important than another, this will vary from job to job and even from time to time in the same job. However, the allocation of time to different roles may be critical to the success of a manager's work. Explore how much time you allocate to your various management roles in the task below.

**TASK 4 – Prioritising your management roles**

a) Refer to the list where you grouped your activities under Mintzberg's roles and estimate what percentage (%) of your time you spend on each role. Write this down in the table below e.g. Monitor: 20%. Remember that the sum of all your roles should be equal to 100%.
b) Now that you have thought about how your time is allocated, think critically about the time and importance you give to the different roles in your job and answer these questions:
    - Which roles receive too much emphasis and which ones receive too little? Mark them + for too much time, and – for too little.
    - How could you improve on the time allocated to the different roles? Would it help if you used your time in a different way, or if you assigned some of the activities or roles to competent people on your staff?

| **Role** | **% of your time spent** |
|---|---|
| Figurehead | |
| Leader | |
| Liaison person | |
| Monitor | |
| Disseminator | |
| Spokesperson | |
| Entrepreneur | |
| Disturbance handler | |
| Resource allocator | |
| Negotiator | |

**FEEDBACK**

There are many ways of changing your allocation of time, but the first step is to become conscious of how you are using it. Simply by doing this exercise, you have taken the first step. This is a very important sort of self-evaluation as a manager and you will return to it in the next session, where we will address the issue of balancing the time you give to the different roles in your job.

# 6 SESSION SUMMARY

In this session, we explored different definitions of management. Hopefully you will have recognised that many of us fulfil managerial roles without being called *the manager*. You should also have developed a possible framework for organising your activities as a manager in terms of roles, and for evaluating how much time you spend on each role. You have also hopefully developed your understanding of the varied roles played by a manager.

Finally, you may have recognised that to do all the things a manager has to do, you will also have to manage yourself!

In the next session we will look at some ways in which you can better manage yourself in order to better manage the people and the tasks for which you are responsible.

# Unit 1 - Study Session 2
# Managing Yourself

## Introduction

In the previous session we looked at the meaning of management and at the nature of a manager's job. We saw that a manager is someone who gets things done through people.

An important aspect of managing people effectively is to make sure that you are managing yourself effectively. Managing yourself is the focus of Study Session 2. We will examine some of the challenges which managers face and suggest some ways of dealing with them, including:

- stress management
- time management
- delegation

These could also be called *management survival skills!*

## Session contents



## Timing of this session

This session contains two readings and fourteen tasks. It is likely to take you three hours. The tasks are short but require engagement and reflection, so try to put aside two study periods to keep the continuity of the session.

# 1 LEARNING OUTCOMES OF THIS SESSION

| **Intended learning outcomes**<br>By the end of this session, you should be able to: | |
|---|---|
| **Management outcomes:**<br><br>▪ Identify signs and impacts of stress.<br>▪ Describe some of the causes of stress.<br>▪ Suggest strategies for managing stress.<br>▪ Analyse your use of time.<br>▪ Implement measures for improving your use of time.<br>▪ Analyse some of the advantages and disadvantages of delegation<br>▪ Describe the types of tasks which can be delegated and the steps of the delegation process. | **Academic outcomes:**<br><br>▪ Learn and apply the concepts of *Role Theory.*<br>▪ Practise time management strategies.<br>▪ Analyse and reflect critically on your own practices. |

# 2 READINGS AND REFERENCES

There are two sources of readings in this session: the four sections of the text by Handy are grouped together in the reader. You will be referred to them in the session as they are needed. There are also a number of references which are a sources of further reading on the topic.

| **Reading** | **Publication details** | **Page numbers** |
|---|---|---|
| 1a-d | Handy, C. (1993). *Understanding Organisations.* London: Penguin Books. | 1a: 60-67<br>1b: 72-74<br>1c: 93-95<br>1d: 334-339 |
| 2 | Management Education Scheme for Open Learning (MESOL), The Open University. (2000). *Managing in Health and Social Care, Module Resource File.* Milton Keynes: Walton Hall. | 25-27 |
| **References** | **Publication details** | **Page numbers are in the text** |
| | Maddux, R.B. (1990). *Delegating for Results.* London: Kogan Page. In Management Education Scheme for Open Learning (MESOL), The Open University. (2000). *Managing in Health and Social Care, Module 1 Book 1.* Milton Keynes: Walton Hall. | |
| | Management Education Scheme for Open Learning (MESOL), The Open University. (2000). *Managing in Health and Social Care, Module 1 Book 1.* Milton Keynes: Walton Hall. | |
| | McMahon R., Barton, E., Piot, M. (1992). *On Being in Charge: A guide to management in primary health care.* Geneva: WHO. | |

# 3 MANAGING PRESSURE AND STRESS

## 3.1 The impact of stress

You will inevitably encounter pressures and stresses in your work. Some people "… find a degree of pressure [to be] positively motivating. They are able to respond to it energetically. Stress, on the other hand, does not produce a positive, energetic response. It is debilitating. It deprives people of their strength, their vitality, and their judgement. Its effects are negative …" (MESOL, 2000: 47) It is important that managers should be able to distinguish between pressure and stress, both in themselves and in their staff, so that they can avoid stress while making the best use of pressure.

The following extract from Handy illustrates the potential effects of stress on a manager:

> "… Stress heightens the dilemmas:
> Stress shortens time-horizons, polarizes issues, exaggerates the importance of the present, makes difficulties into crises and inhibits creativity. Stress in fact is the one thing a person, and especially a senior manager, should be without. And yet, for many a manager, stress is almost a battle honour. To succumb to it is weakness, to be without it is dishonourable. In a way, a heartless way perhaps, it is not the physical and mental outcomes of managerial stress that are the worries. If a man has a heart attack, develops an ulcer, has a nervous breakdown, he is himself a victim, but he is also incapacitated as a manager, prevented from causing hurt to others. It is the less respectable symptoms of stress, the general impairment of judgement and the tendencies listed at the beginning of this paragraph, which can really foul up organizations and the lives of others. Managers, as a social duty, must manage stress, not court it …" (Handy,1994: 334)

Another important point to recognise about stress is that:

"… Under excessive pressure managers are not the only ones to suffer. Managers experiencing stress may have little time to spend with their families and, when they do find time, they may be irritable and unable to relax …" (MESOL, 2000: 47)

We will now look at some signs of stress, then at some of the causes of stress, and finally at ways of managing stress.

## 3.2 Recognising stress

A simple way of differentiating between pressure and stress is to think of pressure as something that comes from outside of yourself, and stress as the response you have when you are subjected to too much pressure.

"… Between these two extremes is a large intermediate area in which pressure merges into stress and this is the danger area. This is where you need constantly to be on the look out for tell-tale signs.

Some of the more obvious signs of stress are irritability and short temper, panic reactions, heavy reliance on tobacco, alcohol and other drugs such as tranquilizers, over-busyness, insecurity, an unwillingness to delegate. People may become difficult to talk to, morose, confused, unable to relax, insomniac. These can all be signs of other problems, but their presence should make you suspect stress, and should suggest the need to find relief before the stress leads to more damaging effects for the individual and the organization …" (MESOL, 2000: 47)

**TASK 1 – Looking for signs of stress**

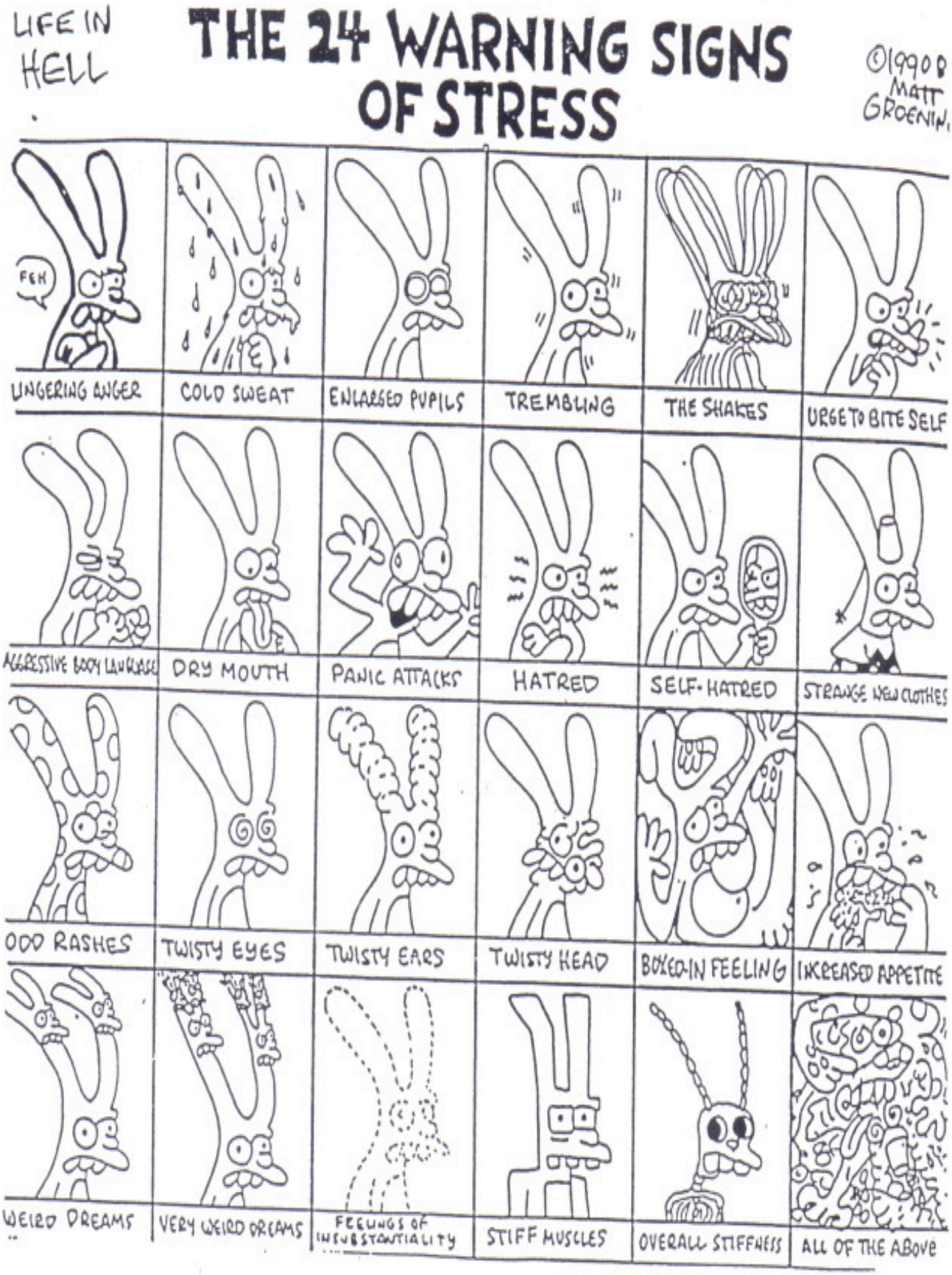
Are you displaying any of the signs of stress above? Now think about two of your colleagues: are they showing any signs of stress?

**FEEDBACK**

Simply by recognising the signs of stress and acknowledging stress as a reality, you have taken the first important step in the management of stress. The next step is to look for the causes of stress

## 3.3 Causes of work-related stress

There are many potential causes of stress in the workplace. We will examine these in two groups: role stress and other sources of stress. Role stress may also be part of other sources of stress, but as it is a very important problem in the workplace we will examine it separately first.


LIFE IN HELL
THE 24 WARNING SIGNS OF STRESS
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FGH
LINGERING ANGER
COLD SWEAT
ENLARGED PUPILS
TREMBLING
THE SHAKES
URGE TO BITE SELF
AGGRESSIVE BODY LANGUAGE
DRY MOUTH
PANIC ATTACKS
HATRED
SELF-HATRED
STRANGE NEW CLOTHES
ODD RASHES
TWISTY EYES
TWISTY EARS
TWISTY HEAD
BOXED-IN FEELING
INCREASED APPETITE
WEIRD DREAMS
VERY WEIRD DREAMS
FEELINGS OF INSUBSTANTIALITY
STIFF MUSCLES
OVERALL STIFFNESS
ALL OF THE ABOVE

### 3.3.1 Role stress

We have already seen that a manager's job involves fulfilling a number of different roles. These roles and the way in which they fit together (or don't fit!) can be a significant cause of stress. This is called *role stress.* Some roles, such as being responsible for the work of others, are obvious causes of pressure, but depending on the capability and motivation of your staff, they may or may not cause stress.

Handy has explored a number of important issues around roles and role stress in the work situation. He points out that role stress increases as one rises in the ranks of an organisation. He uses Role Theory to help understand role stress and find ways to address it. In Reading 1a, Handy explains Role Theory. Make sure that you understand these ideas by doing Task 2 in combination with the reading.

Reading 1a: Handy, C. (1994). *Understanding Organisations*, Chapter 3, Section 1 & 2. London: Penguin Books, pp60-67.

**TASK 2 – Understanding concepts in role theory**

Read Handy's chapter summary and then tick the correct answers.

a) Role strain means:

positive pressure.
negative pressure.

b) Role strain arises from:

- Unclear role expectations.
- Changes in the health system.
- Your expectations of your role being different from those of the organisation.
- Too many roles being expected of you.
- Poor relationships.
- Too few roles being expected of you.
- Being unable to carry out the various roles expected of you in the same situation.

**FEEDBACK**

a) Role strain refers to negative pressure or stress resulting from tensions within or between the role/s we play.

b) Role strain arises from:

- Unclear role expectations (role ambiguity).
- Too many roles being expected of you (role overload).
- Too few roles being expected of you (role under-load).
- Being unable to carry out the various roles which are expected of you in the same situation (role conflict).
- Your expectations of your role being different from the expectations of the organisation (role incompatibility).

The concepts in brackets are some of the key concepts of Role Theory. Changes in the health system and poor relationships are not role stresses - they are situational stresses.

Now that you have clarified the concepts in Role Theory, apply this knowledge to your own situation:

**TASK 3 – Identifying role stress**

Think of some of the roles in your job and those of your two colleagues. Tick those role tensions (stresses) which you experience and those which you think they may experience. Write down an example of each.

| **Role variables which lead to stress** | | | |
|---|---|---|---|
| | Do you experience it? | Does person B experience it? | Does person C experience it? |
| Role ambiguity | | | |
| Role incompatibility | | | |
| Role conflict | | | |
| Role overload | | | |
| Role under-load | | | |

**FEEDBACK**

By considering role stress as a possible source of overall stress, you have taken another constructive step in managing stress. Once you have identified role stress, you would need to try to address it with the individual and within the organisation. This will be discussed further later in the session.

### 3.3.2 Other sources of work-related stress

We have seen that issues surrounding roles are a potential source of stress. There are however other sources of work-related stress.

Handy discusses five of the organisational situations as well as some of the personality variables which can lead to stress for a manager. Read the extract titled "The implications of stress" (Reading 1b) and then do Task 4 to identify the causes of stress you experience in your job situation. Note that role stress may often be part of other sources of stress.

Reading 1b: Handy, C. (1994). *Understanding Organizations,* Chapter 3, section 4 – "The implications of stress". London: Penguin Books, pp72-74.

**TASK 4 – Identifying the causes of your own stress**

Besides the role stresses you have already identified, think about any other stresses that you are experiencing in your job and jot them down. Now compare them to the table below and use the empty rows to add any that are not mentioned here.

Use column A to tick the causes of stress in your job. Again think about the stresses faced by two colleagues and use columns B and C to identify their causes of stress. The categories are explained in the Handy extract which you have just read (Reading 1b). The situations marked with an asterisk are explained below.

| **Some of the situations which lead to stress:** | **A** | **B** | **C** |
|---|---|---|---|
| Responsibility for the work of others | | | |
| Inadequate resources | | | |
| Lack of control over work | | | |
| Innovative functions* | | | |
| Integrative or boundary functions** | | | |
| Relationship problems | | | |
| Career uncertainty | | | |
| Sociability/unsociability | | | |
| Emotional sensitivity | | | |
| Flexibility/rigidity | | | |
| Constant change in the work environment | | | |
| **Fill in any additional causes of stress below:** | | | |
| | | | |
| | | | |
| | | | |
| | | | |

(Adapted from MESOL, 2000: 48)

* Innovative functions are functions where the manager is responsible for new, experimental programmes or functions, which therefore risk not working.

** Integrative or boundary functions are the functions of a manager which have to do with ensuring that the activities or functions of different groups or departments are integrated.

**FEEDBACK**

There are many potential causes of stress, but it will be helpful for you to be aware of some of the common causes of stress in the workplace, so that you can help both yourself and your staff to manage stress.

## 3.4 Dealing with stress

This section focuses on what can be done to assist in reducing stress levels, both in yourself and in those you manage. It also provides opportunities to practise your problem-solving skills. We will first look at Role Theory analysis as a strategy for organisations to use to reduce stress. Then we will examine strategies which individuals can apply to their jobs and lives.

Reading 1c: Handy, C. (1993). *Understanding Organizations,* Chapter 3, section 7.2 - "The implications of role theory". London: Penguin Books, pp93-95.

Addressing stress in organisations

Handy has explored Role Theory as a way of looking at and therefore dealing with strain (harmful stress) as it arises from role tensions. Stress management strategies related to roles often require the co-operation of a broad range of members of the organisation, in particular the top management. Read the extract titled "The implications of role theory" (Reading 1c) and summarise Handy's four strategies for organisations to deal with role tension.

Reading 1d: Handy, C. (1993). *Understanding Organizations,* Chapter 11, section 4.6 - "Dealing with dilemmas". London: Penguin Books. pp334-339.

Addressing stress in individuals

As an individual, there are some strategies which you can engage to manage personal stress. Read Handy's discussion on "Dealing with dilemmas" (Reading 1d) and make sure you understand each of these strategies. Try to relate them to your own experiences of stress and then do the task below.

**TASK 5 – Finding ways of dealing with stress**

Study this list of ways of dealing with stress. It should help you to think about how to help both yourself and others in whom you may have observed signs of stress.

**Managers or staff under stress need to:**

- Understand the value of co-operative solutions.
- Create stability zones for themselves.
- Get a better perspective on their problems.
- Be clear about their roles.
- Be clear about the activities which their roles demand of them.
- Balance the competing demands of their various roles.
- Have a range of responsibilities which matches their competences.

(Adapted from MESOL, 2000: 49)

Now look back at the tables in Tasks 3 and 4. Analyse which of the stresses that you identified in yourself and two colleagues could be reduced by using some of the strategies listed above.

**FEEDBACK**

When we experience pressure that is not excessive, we are left feeling in control; we know that through extra effort we can meet our objectives. When pressure is excessive and we feel under stress, there is a feeling of having lost control: there is too much to deal with, it is too complex and we cannot see our way clear to the goal or we lose sight of the goal.

Addressing the needs listed above can assist a manager to retain control of their situation. It is worth taking the time to consider how to actively address (manage) these issues. If you do not, you may find it extremely difficult to cope with mounting pressures.

As a manager, you can influence the way in which your colleagues and staff deal with stress. Another important strategy for reducing stress is to manage your time more effectively.

## 4 TIME MANAGEMENT

For many managers, it seems that the work to be done just will not fit into the time available. This can lead to considerable stress and may seem almost impossible to change. The only way to deal with a situation like this is to put some time aside to review your time management practices and to find ways to use the time available more effectively.

On the other hand, you may be skilled in managing your time, in which case this section may provide you with a strategy to teach to your staff. Start off by assessing how well you manage your own time.

**TASK 6 – Assessing how well you manage your time**

a) Is time-management a problem for you?
b) Do you feel that you sometimes waste time?
c) Do you feel that other people sometimes waste your time?
d) Write down three examples of problems related to time?

**FEEDBACK**

If time management is a problem for you, you may have noted issues like being called upon to deal with minor issues, or never having enough time to concentrate properly on one important matter. You may have mentioned that even when you do plan the use of your time, you are unable to keep to the plan because of interruptions. You might have difficulty in dealing with things that compete for your time and attention. It is however important to identify the cause of your time management difficulties.

When you cannot see any way of completing what you have to do, you may feel helpless and overwhelmed. You may feel that this signifies a failure on your part: this is not necessarily true. Many managers have similar problems. Once again, identifying the problem and analysing its causes, are the first steps toward a solution.

### 4.1 The long-term tasks versus the immediate

*Things which matter most must never be at the mercy of things which matter least.*
Goethe

Many managers find that they are frequently distracted from work that needs a more long-term view by dealing with people and events that need immediate attention. If you do this often, there will be some important matters that you rarely have time to deal with and that can be neglected. The difficulty is in balancing the immediate matters with the long-term matters to make sure that you give enough time to both. The problem is illustrated by this example:

Nonceba knows that drug distribution in her district could be improved by re-organising the system of ordering and delivery. Doing this would however involve a thorough study of the present system, long discussions with staff, training and follow up. Ultimately, an improved system would result in improved use of resources, increased job satisfaction for staff and improved service to patients. But this process would take several months and would absorb many hours of Nonceba's time.

In addition, during those months she is required to review the budget, write the annual report, conduct several training sessions and attend a conference, in addition to the usual range of meetings and routine issues she is expected to manage. So revising the drug distribution system goes to the bottom of the pile again, and waits for that moment *when there is more time*.

Getting down to long-term activities such as the one described in Nonceba's situation has the potential to really make a difference to your work. Neglecting them could result in a negative long-term impact on your work. Look out for opportunities to streamline systems or speed up procedures, even if the process of putting them in place takes time. This could save time for everyone in the long-term.

**TASK 7 – Separating long term tasks from immediate tasks**

Identify the immediate requirements of your job - the tasks you know you must do within the next two weeks, perhaps because other people are waiting for you to respond. Write down three examples.

Now think of the long-term tasks you want to do, those that always seem to end up at the bottom of the list. Write down three examples. Are any of them systems changes which may save time in the long term? Do you think that you could integrate one of the long-term goals into your immediate plans? If not, why not?

**FEEDBACK**

If you have identified some important things to which you have not given enough time, or if the long-term tasks are neglected because of immediate issues, you need to find ways of improving your time management.

## 4.2 A time-management strategy

There are some practical ways in which you can help yourself to improve your use of time. One way is to start monitoring how long it usually takes you to do typical tasks in your job; then plan to include only the tasks that will fit into the time available. In other words, do not set yourself up for failure by planning to do more than is realistic.

Many managers would say that such planning seems almost impossible because there is no such a thing as a *normal* day: "How ever well you plan, additional things always crop up." Although this will probably always be a problem for managers, it *is* possible to improve your control over your time.

You just need to find a way of managing your time which fits with your personality and your job. Start by trying out some of the well-used strategies described below.

You can develop your own approach to time management by following these steps:

- Analyse your current use of time at work and then reflect on the difference between your current time-usage and how you feel you should be spending your time.
- Decide what you want to change in your time management and how you will go about changing it.
- Implement your new time-management plan.
- Review your progress at intervals to ensure that your approach is still working
- This process of collecting information, planning, implementing (taking action) and reviewing the results is one that managers use for many of their activities.

Another way of looking at these four steps is to ask the questions:

- Where am I now?
- Where do I want to go?
- How will I get there?
- How will I know I have arrived?

This series of steps is often referred to as *The Planning Cycle*.

Because time management is such an important issue, spend some time analysing your use of time and consider the choices you have to improve your management of time.

### 4.2.1 Where am I now? (Analysing and reflecting)

One of the most demanding parts of time-management is clarifying how you presently spend your time. For Task 8, refer to Reading 2 and to try out the strategy of keeping a time-log or register of your time usage. This is part of the process of collecting information.

> Reading 2: Management Education Scheme for Open Learning (MESOL), The Open University. (2000). "Keeping a time-log". *Managing in Health and Social Care, Module 1 Resource File.* Milton Keynes: Walton Hall, pp25-27.

**TASK 8 - Keeping a time-log**

Use Reading 2, "Keeping a time-log" to keep a detailed log or record of how you spend your time on a typical day at work. Do this every day for one week. The process of categorising and clustering the activities in your job is very important. Here are some examples of possible categories: delegating tasks; operational meetings; development planning activities; answering telephone enquiries; having tea and socialising! By grouping activities into categories, you are able to see how you spend chunks of time rather than trying to think about a lot of different, short activities.

**FEEDBACK**

People are often surprised by what they find when they keep a time-log. Have you learnt anything about your time usage? Are there any significant time-wasters in your day?

You have already started to reflect on the way in which you use your time by deciding in which category of your work to record each activity. The next step involves reflecting systematically on your use of time at work.

**TASK 9 – Analysing your use of time**

This task provides guidelines for using your time-log to reflect systematically on your use of time at work. The feedback is integrated into each step of the process, so there is no separate feedback at the end. Take at least 25 minutes on this activity as it could in the end save you time.

"…Stage 1:
On your time-log, highlight all the activities which fit into your roles as a manager.

Stage 2:
Now look at all the activities you have not highlighted and ask yourself why you spent time on them. Do you allow too many interruptions or are you perhaps doing work that others could do if you delegated more?

Stage 3:
In relation to the main focus of your job, what things should you be doing more of?

To help you to think about this systematically, look back at the areas of work priority that you identified in Session 1. Compare your time-log with these priorities in your work. If you spend every day carrying out mainly activities like those recorded in your time-log, will you be doing your job adequately, or will important things have been left out? If some important things have been left out, you need to adjust the balance of your working day to put more emphasis on the work you should be doing.

One way to do this is to use your diary as a planning tool, shaping the way you

Stage 4:
Are you spending too much time on anything? If you think that you are spending too much time on some activities, think about why this is so.

If it is because you do not do them as well as you should and this causes delays, you may have identified a training need for yourself. If it is because you under-estimate the time needed for the activity, this is something you could learn from and improve your planning in the future.

Stage 5:
How much of your time was spent in responding to demands from others?

If you spend a great deal of your time making decisions on routine matters, consider whether you could delegate some tasks.

Stage 6:
How much of your time was spent dealing with unexpected urgent issues? All managers find that they have to attend to unexpected priorities from time to time, but even in a job in which much of your time is spent responding to demands, you can still plan your time. For example, you might be able to divide your plan for the day into things that must be completed today and things that must be done within the week. The things that do not have to be done today can be the ones that you replace with the unexpected tasks. However, you will have to review the weekly items carefully to make sure that they are not squeezed out completely by unexpected tasks.

Stage 7:
Look at one particular day. Did you complete the things you intended to do on that day?

Many managers find it useful to make a list of priorities for each day. This can help you to use your time to achieve your work objectives and is useful for reviewing your own progress. It also helps you not to forget anything important. Towards the end of the day, you can review the list and decide whether you will complete everything or whether you need to reschedule some of the work for another day.

Most managers also find it useful to spend a few minutes at the start of each day trying to visualise how the day will flow and thinking about how they will handle the events that are expected to happen.

It is important not to think that answering the phone and giving attention to people is poor use of time. It all depends on your job and role/s. If one of your main functions is to make sure that day-to-day services are delivered smoothly, you will have to devote time to the people running or using the services. However, as a manager, you also need to be able to stand back from the front line and take an overview of the work …"
(Adapted from MESOL, 2000: 55-56)

(Adapted from MESOL, 2000: 55-56)

### 4.2.2 Where do I want to be? (Planning)

Time management often requires changes in work habits which may have become second nature to you. After reviewing your time management habits, think about whether you need to make any changes. Draw a framework of the way you want to use your time: allocate appropriate time to each category of activity per day and/or week.

### 4.2.3 How will I get there? (Implementing)

This is the *taking action* phase of the planning cycle.

**TASK 10 – Changing your time management style**

Consider the strategies listed below and tick the ones which could improve your management of time.

- Delegate work that others can do.
- Adjust the balance of your working day between immediate and long-term tasks.
- Develop your skills in some aspect of the job to make yourself more efficient.
- Plan and schedule your use of time more carefully.
- Use your diary as a planning tool to help you fit everything in.
- Plan your work in terms of tasks for the week and tasks for the day.
- Make a daily list and review it at the end of each day to check your progress.
- Start the day by visualising and mentally preparing for the main events.

(Adapted from MESOL, 2000: 57)

Select three things from the list and/or use your own time management strategies and carry them out during the next two weeks.

### 4.2.4 How will I know when I get there? (Monitoring/Evaluating)

There are two aspects to this question: making sure you are still moving in the right direction (monitoring) and checking that the place where you end up is where you intended to go (evaluating)!

**Task 11 – Reviewing your plan**

After two weeks of taking action to improve your use of time, ask yourself:

What went well according to my plan?
What could have gone better?
What went badly wrong and why?

**FEEDBACK**

By comparing what actually happened with what you planned to do, you can learn more about your ways of managing time. If one approach did not work well, try something else. It is important to find an approach that works in your setting.

The process of reviewing your progress at intervals is called *monitoring*. After six months or a year, you may want to evaluate to what extent your time management has improved since you first implemented your plan. We will return to these concepts in later units.

Learning to make the best use of your time at work will help you to carry out your responsibilities more effectively and will reduce your stress levels. In Task 10 we noted that one way of improving your time management is through appropriate delegation of tasks to other staff members. This is the third survival strategy for managers.

## 5 DELEGATING EFFECTIVELY

Delegation is a key skill for managers. In reflecting on your use of time, you may have realised that you could delegate more. Delegation is the art of giving work to your staff in such a way that they are accountable to you for it. Although you have overall responsibility for the work, effective delegation makes it possible to reach objectives as a team in less time and with less stress.

Perhaps you may think that delegation is not appropriate in your situation or that it causes so much trouble that it is not worth trying. There <u>are</u> challenges associated with delegation, but there are also distinct advantages.

<u>Advantages of delegation:</u>

- Delegating some decision-making saves time for other duties.
- When work is spread over a large area, as in rural health work, the health workers on the spot must be able to make decisions according to circumstances.
- Delegation of responsibility saves long delays that occur when awaiting decisions from a central office or other distant authorities.
- Health workers who are allowed to make decisions enjoy their work more and become more knowledgeable and skilful i.e. It facilitates staff development.

<u>Disadvantages:</u>

- A leader who does not delegate properly may pass all the work on to the team members, leaving very little for her or himself to do.
- A leader may delegate decisions to people with insufficient experience or without sufficient explanation.
- Some staff may make it difficult to delegate by resisting delegation and this can cause interpersonal stresses.

(Adapted from McMahon et al, 1992: 63)

**TASK 12 – Reflecting critically on your own delegation experience**

a) Think of a situation where you successfully delegated a task to a staff member.
b) Think of a situation where delegation led to problems.
c) Write down possible reasons for the success and difficulty in each case.

**FEEDBACK**

Some managers feel they must do everything themselves because the ultimate responsibility for the results rests with them. This is a misunderstanding of the nature of a manager's job. Effective management must involve delegation of certain work and decisions. This means giving someone the authority (and the necessary resources, including time) to do something on your behalf. You retain the overall responsibility for it, but develop methods for monitoring and getting feedback to satisfy yourself that the results are being achieved. It is the way in which delegation is done which determines its success.

*'Well then, Johnson, if we agree that I pay you to do all the worrying for me, would you mind explaining how it is I get all the ulcers?'*

There are a number of factors which make delegation successful:

- Deciding which tasks can be delegated.
- Deciding to whom a task can be delegated.
- Appropriate support.
- Appropriate monitoring.
- Delegating tasks at the right time.

We will now explore these key factors in delegation in more detail.

## 5.1 Deciding which tasks can be delegated

Robert Maddux (1990) has suggested that there are certain types of work that can often be delegated. His suggestions are summarised below.

## Tasks which could be delegated

a) Decisions you make most frequently.
Minor decisions and repetitive routines often consume a major part of a manager's day. Many of these can be delegated by teaching your staff the policies and procedures that apply. They may already know the details better than you do!

b) Functions that you are expert in.
These are usually operational tasks rather than managerial functions. Your challenge as a manager is to guide and motivate others to produce better results than you ever did as an individual performer.

c) Tasks and projects for which you are least qualified.
It is almost certain that some of your staff are better qualified and can do parts of the job better than you can. Let them!

d) Functions you dislike.
Performing tasks we dislike means we often put them off or do them poorly. Examine the likes and dislike and the talents of your staff. Often you will find someone who likes the job and can do it well. If they need training, provide it.

e) Work that will provide experience for staff.
A manager should be committed to building the capacity of others to perform new tasks and to take more responsibility. This makes growth in the job a reality and keeps staff challenged and motivated.

f) Assignments that will add variety to routine work.
A change of pace is usually welcomed by staff and is often a good way to motivate those whose job is growing boring to them.

g) Tasks that will increase the number of people who can perform critical assignments. Maximise the strength of your team by giving people the necessary experience to back one another up during emergencies or periods of unusually heavy work.

h) Tasks that provide opportunities to use and reinforce creative talents. Give staff some freedom and the opportunity to show initiative. Stimulate them with difficult problems and projects, and reward creative solutions.

(Adapted from MESOL, 2000: 59-60)

**TASK 13 - Reviewing opportunities for delegation in your own context**

Study Maddux's list and think about whether there are delegation opportunities in your situation.

**FEEDBACK**

Here is an example to which you may relate. A manager in a health education NGO experienced much stress because she felt that did not have time to delegate, and also because she did not feel confident of the capacity of her team members. Partly as a result of her stress level, she became ill for a period of three weeks. During that time members of the team were forced to take on the day-to-day management of the project, to run scheduled workshops and weekly planning meetings, and to answer most queries that came to the office. This helped her to recognise the potential for delegation and she was able to discuss the issue with her staff. Together they worked out a delegation plan.

Often the process of delegation may seem too time-consuming to take on. However, if done appropriately, it can make you a much more effective manager of a more contented team.

## 5.2 Deciding to whom a task should be delegated

"… It is important to identify the most appropriate person for each delegated task, although sometimes it could be appropriate simply to identify someone who has the time and interest to take on something new. You might consider how the task links with a staff member's other areas of work. There might be someone with the necessary skills who is interested in the area of work and who would welcome a chance to demonstrate his or her ability. Or there might be an opportunity to offer a challenge to someone who has become bored with routine work …" (Adapted from MESOL, 2000: 61)

Delegation implies a level of trust in the person to whom you are delegating. Some people respond positively to the increased responsibility and the fact that you trust them to do it. It can be very motivating for them. However, others may feel that you are over-burdening them or may simply lack the confidence to accept additional responsibility. There is also the risk of delegating to the person who least resists it, and this can also become a problem for that person. Here it is important for the manager to understand the person and their needs. We will explore these issues further in later sessions.

## 5.3 The process of delegation

Once you have identified the person to whom you will delegate the task, you need to do the following:

- Agree with the staff member on exactly what you expect and how you will measure or evaluate how well the job is being done.
- Explain to other staff members that you have delegated certain tasks and to whom.

- Provide the staff member with the necessary resources for the job, including the relevant authority, training and time.
- Have regular follow-up sessions and provide support where necessary.
- Do not interfere unless asked to and be prepared to support the staff member if she or he makes some mistakes.

**TASK 14 – Planning the delegation process**

a) Think about a task you would like to delegate in the future.
b) Identify the person to whom you will delegate.
c) Identify who else needs to be informed.
d) Write down exactly what you expect from them.
e) Write down how you will monitor the job.
f) List the resources they will need to perform the task.

**FEEDBACK**

Effective delegation is an essential part of effective management. Thinking through the process of delegation in a systematic way will help you to delegate the right tasks to the right people and to provide the right kind of support.

The fact that you, the manager who is doing the delegating, remain responsible for what happens is central to delegation. However, your role becomes one of support and systematic monitoring, rather than that of a policeman or a strict school teacher! Remember that one of your responsibilities as a manager is to develop your staff so that they are able to perform delegated tasks effectively and without constant supervision.

## 6 SESSION SUMMARY

This session has highlighted a few issues you will face as a manager. You will inevitably encounter pressure and stress in your job, but it is possible to find ways of reducing stress, both for yourself and for others.

Managing time effectively is one of the most important skills a manager should develop. Poor time management all too commonly leads to stress. Analysing the way you are using your time now and planning how you will use your time in the future are both important aspects of developing time management skills.

Delegation is an essential element of management. It is a strategy for managing your time: it gives you more time for other activities. It is also an important means through which you can develop the capacity of your staff. However, when you delegate, you need to select the right person for the job, be absolutely clear about what you expect and how you will support and follow up. Remember that the final responsibility still remains with you. Having explored some aspects of managing yourself, we will move on in Unit 2 to look at further skills and issues relevant to managing people.

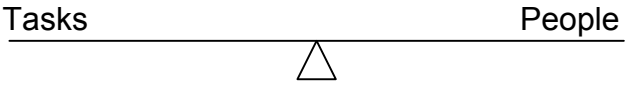
# Unit 2 - Introduction Managing People

In Unit 1, we focused on the issue of managing yourself as the first step towards being an effective manager. In this unit, the focus is outwards towards your staff and co-workers. As health managers our primary responsibility is to provide the best possible services to the people who depend on us for health care. Those services are provided to people *through* people. You will recall the definition from Unit 1:

Management is … getting things done *through people.*

As managers we have to make sure that services are provided by getting the best out of our staff, but at the same time we need to consider the needs of the people who are our staff and colleagues. We need to get the best out of our staff, to their advantage, to our clients' advantage and to our organisation's advantage.

There is thus a balance to be reached between focusing on tasks and focusing on people. The important thing to recognise is that both the job and the people who do the job are important.




In Unit 2, we focus on understanding people as the basis for managing people. We will also look at conflict as a normal part of life and work and we will study some of the skills that can help a manager in the challenge of managing people. You will be asked to think about situations of misunderstanding or conflict in your workplace and apply new understandings and strategies to these situations.

There are two Study Sessions.

Study Session 1: Understanding People
Study Session 2: Managing Conflict

In Session 1 we will examine the ways in which we perceive other people and then look at some of the factors which influence people's behaviour. We also look at learning to communicate effectively through empathic listening.

In Session 2 we will examine symptoms, causes and management of conflict.

## Intended learning outcomes of Unit 2

| **By the end of Unit 2, you should be able to:** |
| --- |
| ▪ Demonstrate recognition that people's differences will affect the way they behave at work.<br>▪ Practise empathic listening.<br>▪ Apply conflict management concepts and models to your work situation. |

There are also a number of academic skills which have been integrated into the unit including the application of concepts and models for conflict management, and the process of reading strategically for specific information. Try this strategy as it can save a lot of time in the long run. This unit provides the basis for part of your assignment, so re-read the assignment requirements and try to identify relevant theories and issues that may be applicable. Enjoy the unit!

# Unit 2 - Study Session 1 Understanding People

## Introduction

The people you manage are a source of many different talents, perspectives and styles. This diversity can improve the quality of services and add to the richness of working life. The fact that people are so different should be seen as a reality to be welcomed, not as a difficulty to be overcome.

In order to get the best out of our staff and to have productive relationships with our colleagues and seniors, we need to accept their diversity and try to understand why people behave the way they do.

Before you start the session, read over the requirements of Assignment 1, and as you study, mark the sections of this session which seem relevant to your analysis.

## Session contents

## Timing of this session

There are five activities and one reading in this session. It will take at least two hours to complete and a logical point to take a break is at the end of section 4.

| **Intended learning outcomes**<br>By the end of this session, you should be able to: | |
|---|---|
| **Management outcomes:**<br><br>▪ Reflect on how the perceptions of others may differ from yours.<br>▪ Practise empathic listening.<br>▪ Explain some of the reasons why people have different perceptions.<br>▪ Demonstrate recognition that people's different perceptions, values and goals will affect the way they behave at work. | **Academic outcomes:**<br><br>▪ Apply some new concepts and theories to your work context.<br>▪ Critically reflect on your own values and goals.<br>▪ Differentiate points of view and explore the notion that *realities* are relative to individuals and contexts.<br>▪ Categorise information. |

## 2 READINGS AND REFERENCES

| **Reading** | **Publication details** | **Page numbers** |
|---|---|---|
| 3 | Covey, S. (1999). "Principles of Empathic Communication." *The Seven Habits of Highly Effective People.* UK*:* Simon and Schuster. | pp 236-259 |
| **References** | | **Page numbers are in the text.** |
| | Covey, S. (1999). "Principles of Empathic Communication." *The Seven Habits of Highly Effective People*. UK*:* Simon and Schuster. | |
| | Kakabadse, A., Ludlow, R. & Vinnicombe, S. (1987). *Working in Organizations*. In MESOL, The Open University. (2000). *Managing in Health and Social Care, Module 2, Book 1.* Milton Keynes: Walton Hall. | |
| | Leavitt, H.J. (1978). *Managerial Psychology*, University of Chicago Press. In MESOL, The Open University. (2000). *Managing in Health and Social Care, Module 2, Book 1.* Milton Keynes: Walton Hall. | |

# 3 DIFFERING REALITIES

You have probably had many experiences of working with people where you could not understand why they said something, or why they behaved in a particular way. This task aims to sensitise you to the fact that there are always reasons underneath the things that people say and do.

**TASK 1 – Reflecting on behaviour**

Think of a few situations where you had difficulty in understanding the behaviour of staff members. Try to think of all the possible reasons which may have contributed to their behaviour. Think about the *whole person* not just the *worker*.

**FEEDBACK**

Most of the things that people do and say (however strange or unacceptable they may seem), can be explained if you are prepared to try and understand what lies behind them. Explaining unusual behaviour is sometimes mistakenly seen as a way of defending the behaviour. However, explaining something is not the same as agreeing with it. The value of trying to find possible explanations for behaviour is that it can help you to cope with different forms of behaviour among the people with whom you must work.

Perhaps one of the worst things a manager can do is to regard people as being stupid or difficult, simply because they do not see things in the same way as you do. You may also mistakenly assume that disagreeable behaviour is a personal attack on you, while in fact there are other reasons behind the behaviour.

**TASK 2 – Trying to see another point of view**

Think of a recent situation where you disagreed with a colleague. What was your point of view? What was their point of view? Now try to put yourself in their position and argue their side of the case against yours.

**FEEDBACK**

Leavitt (1978) observed that managers commonly make "… the mistake of assuming that the 'real' world is all that counts, that everyone works for the same goals, and that the facts speak for themselves ..." (MESOL, 2000: 9)

The *real* world here is the way the manager sees the world.

"… Most psychologists accept that human beings tend to act on the basis of what they perceive to be reality. Problems arise because we do not all see the same reality. Even when we are looking at exactly the same thing, we often see it differently …" (MESOL, 2000: 9)
So what is *reality*? The answer is that for each of us, *reality* is what we believe it to be.

An important step towards understanding people is to recognise that we each have our own view of reality and that other realities do exist. Exploring other people's views enriches our view of a situation. But first we need to understand why people have different views of reality.

## 3.1 Questioning the way you see *reality*

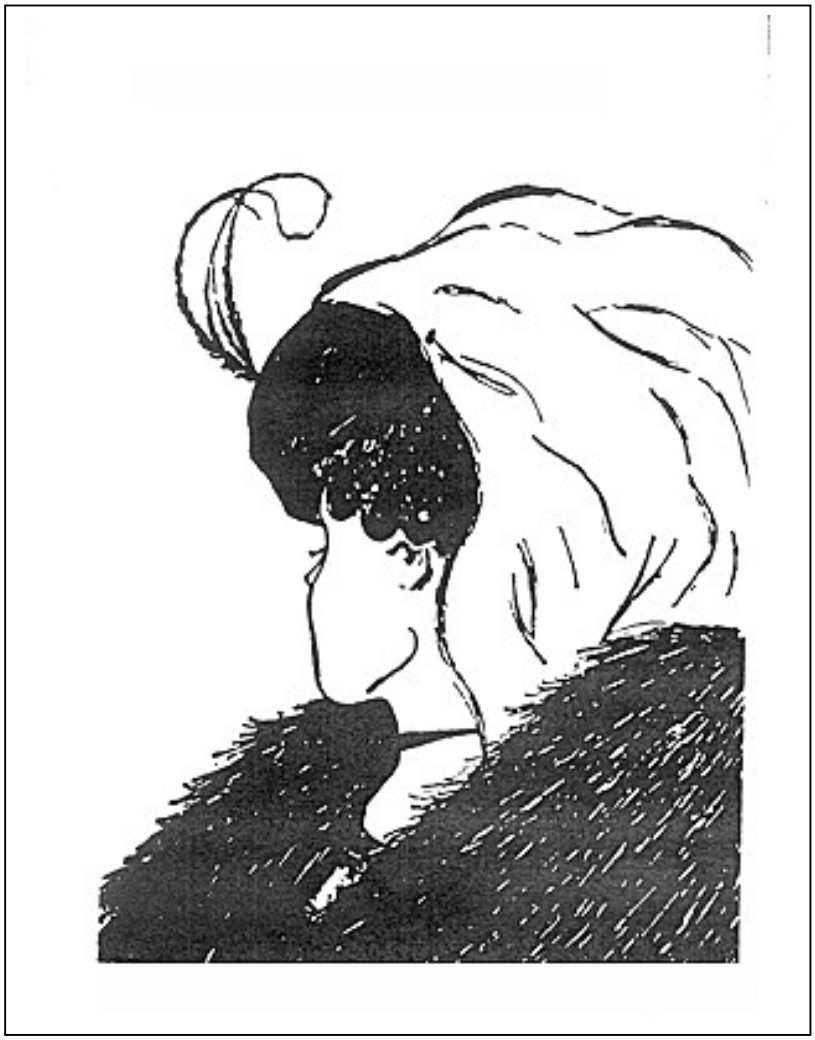
The way in which you perceive *reality* is called your point of view or your perspective. The way you see things is the source of the way you think and the way you behave. If you are not conscious of how you see things, you are unlikely to recognise that others see things differently.

"…Take a few seconds to look at picture A. Write down what you see.

**Picture A**

Now look at picture B and write down what you see.

**Picture B**



“Do you see a woman? How old would you say she is? Is she wearing any jewellery?

You would probably describe the woman in picture B as being about 25 years old and rather attractive. She is wearing a necklace.

But what if we were to tell you that you’re wrong? What if we said this is a picture of an old woman with a huge nose who looks rather sad. There is no necklace in this picture.

Who is right? Keep looking at the picture. Try to see the old woman. Try to see the shawl over her head, her large nose, her sad eyes. Now look at picture C.

**Picture C**

“Can you see the old woman now? It’s important that you see her before proceeding.

This exercise was used by an instructor to demonstrate to a group of students that two people can see the same thing, disagree and still both be right.

He brought along a stack of papers, half of which had the image of the young woman in picture A and the other half of which had the image of the old woman in picture C. He passed the papers out to the students, the picture of the young woman to one side of the room and the picture of the old woman to the other side. He asked the students to study the papers for about 10 seconds and then to pass them back in.

“He then projected on a screen the image you saw in picture B, which combines the images in A and C, and asked the class what they saw.

Almost everyone who had first seen picture A saw a young woman again and almost everyone who had first seen picture C, saw an old woman again.

The instructor then asked one student to explain what she saw to a student on the opposite side of the room. As they talked back and forth, communication problems flared up.

> ‘What do you mean, *old lady*? She couldn’t be more than 25 years old!’
> ‘Oh come on. You must be joking. She’s at least 70!’
> ‘What’s the matter with you? Are you blind? This lady is young and good-looking!’
> ‘Good-looking? She’s old and ugly!’

The arguments went back and forth, each person sure of, and insisting on, his or her position. All this occurred in spite of one very important advantage that the students had – most of them knew early in the demonstration that another point of view did, in fact, exist – something many of us would never admit.

After a period of futile communication, one student went up to the screen and pointed to a line on the drawing. ‘There is the young woman’s necklace.’ Another student said, ‘No, that’s the old woman’s mouth.’ Gradually, they began to discuss specific points of difference, and finally one student and then another was suddenly able to see both images. Through calm, sustained, respectful and specific communication, each person was finally able to see the other point of view.

This exercise shows how powerfully our perspectives are influenced by our conditioning. If ten seconds of conditioning can have that kind of impact on the way we see things, what about the conditioning of a lifetime? The influences in our lives – family, school, religion, work environment, friends, associates, fashions in society – all have made their silent unconscious impact on us and helped to shape the way we see reality.

The exercise also suggests how powerfully our perspectives affect the ways in which we interact with other people. As clearly and objectively as we think we see things, we begin to realise that others see them differently, from their own apparently equally clear and objective point of view.

Each of us tends to think that we see things as they are, that we are objective. But this is not the case. We see the world, not as *it is,* but from our own viewpoint*,* or *as we are conditioned to see it.*

"This does not mean that there are no facts. In the demonstration, two individuals who were initially conditioned (or influenced) by different pictures, look at the third picture together. They are now looking at identical pictures (or facts) - black lines and white space, and they would both acknowledge these as facts. But each person's interpretation of these facts represents their previous experience of the picture, and the facts (picture B) have no meaning without the interpretation.

We need to be aware of our perspectives and the extent to which we have been influenced or conditioned by our experience. In the same way, we need to be aware of the perspectives of other people. This will help to expand our view of reality and our understanding of people …" (Adapted from Covey, 1999: 23-29)

In this section, we saw that the way people think and act is influenced by their idea of reality: their idea of the way things *are* may also be influenced by experiences or cultural, religious, political and other norms. In the next section, we will explore another strong influence on the behaviour of people: their idea of the way things *should be.*

## 4 DIFFERING VALUES

Our values are our sense of the way things should be. Values are "… the underlying drives which influence the attitudes and behavioral patterns of individuals, groups and even organizations." (Kakabadse et al,1987) Values give people their sense of right and wrong.

It is helpful to categorise values into three sets: individual, professional and group values.

Individual values

Each of us has ideas about what is right or wrong, what is good or bad. These ideas develop over time and form our personal value base. Although many of our values can be traced back to childhood, they do not necessarily stay constant; circumstances and personal choices can change them. Also, different people attach different relative importance to particular values, for example, equality and honesty.

Professional or occupational values

There are many professional and occupational groups within health and social care, each with recognisable sets of values. Some of these are expressed through codes of ethics, for example, the Hippocratic Oath.

Group/team values

Most of us have to work within at least one group or team to do our job. A group will usually have some shared ideas on what is right for the group. Organisational values are an example of group values.

Understanding people's values is particularly important for managers, because they often have the difficult task of working with different sets of values at the same time. They have to accommodate the values of those working above, below, alongside and within their team, as well as their own values. Conflicting sets of values can lead to difficulties. (Adapted from MESOL, 2000: 10)

**TASK 3 – Analysing how values operate in the workplace**

Think of recent conflict situations in your workplace. Could differences in the participants' values have played a role in the disagreements? If so, were individual, professional or group values at play?

**FEEDBACK**

An example of conflicting sets of professional values is the different ways in which some health care providers and public health professionals view the use of resources. The values of the public health group focus on the health of the community as a whole, while the health care providers are concerned with the well-being of individual patients. Neither group is wrong. They merely have different ideas of the way things should be done.

Conflict of values is probably one of the most difficult issues a manager may have to face. Often there are no easy solutions but the first step remains to try and understand the reasons underlying the behaviour of the parties involved.

As a manager, you will have to gain the co-operation of people with different perspectives and different sets of values in order to achieve the objectives of your job. Getting people to work towards common objectives is at the heart of the manager's role. This leads us to the next issue: that people have personal goals which may differ from organisational or project objectives and goals.

## 5 DIFFERING GOALS

"… Managers often fall into the trap of assuming that everyone is working (or should be working) towards the same goals - the goals of the organisation. A lot of managerial decisions take it for granted that the people who will implement them will co-operate willingly to achieve the organisation's collective goals. But often the real reasons why people co-operate have nothing to do with achieving the organisation's goals and everything to do with achieving their own goals. Fortunately, in many cases the two are not incompatible. Indeed, it has been suggested that effective management of people is about ensuring that personal, team and organisational goals match, so that all can be achieved simultaneously …" (Adapted from MESOL, 2000:13)

**TASK 4 – Analysing how goals operate in the workplace**

Identify two key goals of your organisation to which your job contributes. Now analyse whether your personal goals fit in with the goals of the organisation.

**FEEDBACK**

Hajira, a nurse, had a special interest in malnutrition in children and wanted to learn more about it. She applied to work in the nutrition unit of a hospital. The unit manager wanted to improve the care of acutely malnourished children and was looking for a nurse who would be particularly dedicated to the job. Hajira worked very hard because she loved the children and wanted to learn as much as possible about malnutrition. In time, she became an expert and the quality of nursing care in the unit became exceptionally high.

In this example, Hajira has achieved her personal goal of learning more about malnutrition in children. The goal of the unit manager to improve patient care has also been achieved. Personal and organisational goals have worked together.

If you manage people, you need to know something about the goals that people want to achieve: this is part of what motivates them to work. We will address the issue of motivation in detail in a later session. It is also very important that all staff who work with you have a very clear understanding of the goals and objectives of the project or section in which they work: sometimes they seem so obvious that you may forget to reinforce them amongst the staff. In the previous sections we saw that the behaviour of people is influenced by their perspectives, values and goals. In order to understand people, we need to be aware of this. But this is not enough: we also have to listen to people.

## 6 SEEKING TO UNDERSTAND

Dealing with other people's different views of reality is an important part of a manager's function. It often requires careful listening, as well as a particular attitude to the other person's reality while you listen. It requires you to hold your judgement and your opinion and that you seek first to understand, then to be understood. This is called empathic communication and will be explored in Reading 3.

Reading 3: Covey, S. (1999). "Principles of Empathic Communication." *The Seven Habits of Highly Effective People.* UK: Simon and Schuster, pp 236-259.

While reading, note that on page 238, there is a reference to "the personality ethic". The writer is referring to the idea that successful communication can be achieved by applying techniques such as friendly behaviour or a positive attitude. He calls this "the personality ethic" and disagrees with the idea, saying that meaningful communication requires something much deeper than superficial techniques. Rather, it requires empathic listening.

**TASK 5 – Practising empathic communication**

Using the strategy provided by Reading 3, try to respond empathically to these staff members. Write down your responses:

a) Ward supervisor: "I'm sorry, I am not able to take on any more responsibilities! There is only one of me and only eight hours in a shift and I can't take on any more!"

b) Administrator: "I can't get the others to help. They say they are too busy. I think it is because I am younger than them that they think they can push me around."

c) Newly qualified nurse: "You do it much better than I can. Why should I have to do it when I will take twice as long as you?"

Finally, try out empathic listening at work and consciously monitor whether you are:
- Trying to understand.
- Rushing in with your own experience or opinion before you have listened to the full story. You should not do this.
- Identifying the possible reasons for the other person's point of view

**FEEDBACK**

Here is a suggestion of how you could have responded to the newly qualified nurse: Firstly, try to understand his/her viewpoint: "Let me see if I understand what you are saying. You feel that this task will take you twice as long as it takes me? And that you will not do it as well as I do?" Then let her/him respond. Then check again:
"You seem to be getting frustrated by comparing yourself with others who have had years of practice. Do you find any aspects of the task difficult, or do you feel frustrated that it takes time to do?"

Here is my response where I try to identify reasons for the nurse's feelings: "You might be feeling frustrated about the time it takes, but speed is not really the measure of quality. Have you found that it's getting easier with practice?" Hopefully s/he will see the value in getting practice in the task by this stage. Do you think this is successful empathic communication?

# 7 SESSION SUMMARY

In this session, we explored some issues around understanding people. We looked at the factors which influence the way people think and behave: their perspectives, values and goals. We also looked at the art of empathic listening.

Being aware of the ways in which people differ and trying to understand staff members and colleagues through listening to them carefully, are two very important aspects of management. They can contribute significantly towards getting work done and maintaining harmony in the workplace. But, given the different realities, values and goals to be found in any group of people, it is inevitable that there will be some conflict. In the next session, we explore conflict in the workplace.

# Unit 2 - Study Session 2
# Managing Conflict

## Introduction

In Session 1, we explored the importance of understanding differences of perspective amongst colleagues in order to maintain harmony in the workplace. Conflict is however neither bad nor unusual in organisations. On the contrary:

- One should not assume that co-operation is always normal, healthy and proper and that conflict and opposition are pathological, deviant or aberrant.
- It is a mistake to assume that conflict arises because those in opposition are wrong, misled, confused or psychologically disturbed. Those who disagree can have views which are as reasonable and rational as ours.
- Conflict and co-operation are both present in teams and organisations, like other social institutions such as families and leisure groups, often at the same time.

Conflict is normal and can be healthy; it can be useful for improving understanding and generating new ideas. However, conflict can also be painful and destructive and result in waste of time and resources. The challenge for a manager is to be able to recognise the symptoms of conflict and respond to them appropriately. A manager needs to acknowledge the differences between people and channel them in ways that result in positive outcomes for the parties involved as well as for the organisation.

In this session we look at symptoms and sources of conflict in the work situation and at some strategies for managing conflict. We have included several academic activities to help you improve your strategic readings skills. You may wish to start by studying Reading 5, which introduces you to an advanced kind of mind-mapping: it is helpful both in reading actively and in recalling important information later for an assignment or exam. Once again, this session is relevant to your first assignment, so make a note of relevant parts of it while you study.

## Session contents



## Timing of this session

This session contains one main reading (Reading 4) which is divided into four parts and an academic skills text (Reading 5) which can be read at any stage of the session. There are seven activities in this session. It is likely to take you at least three hours: a logical point to take a break would be at the end of section 4.

# 1 LEARNING OUTCOMES OF THIS SESSION

| **Intended learning outcomes**<br>By the end of this session, you should be able to: | |
|---|---|
| **Management outcomes:**<br><br>▪ Define conflict.<br>▪ Recognise a range of symptoms of conflict.<br>▪ Explain a range of sources of conflict.<br>▪ Apply different responses to conflict.<br>▪ Discuss the collaborative approach to handling conflict.<br>▪ Propose solutions to interpersonal problems. | **Academic outcomes:**<br><br>▪ Develop a range of concepts and categories and apply them.<br>▪ Use previewing strategies to read more strategically.<br>▪ Select information from a text.<br>▪ Develop the skill of making graphic representations of the contents of a text. |

# 2 READINGS AND REFERENCES

There is one main text for this session. You are invited to preview it in Task 3 and then to read it section by section. You will be directed to reading the relevant sections during the session.

| **Reading** | **Publication details** | **Page numbers** |
|---|---|---|
| 4a-4d | Whetten, B. A.. & Cameron, K.S. (1991). *Developing Management Skills.* Ch 7, "Interpersonal Conflict Management." New York: Harper Collins. | 4a: pp395-400<br>4b: pp400-403<br>4c: pp407-410<br>4d: pp410-428 |
| 5 | Jones, B., Pierce, J. & Hunter, B. (1989). "Teaching students to construct graphic representations". *Educational Leadership.* Dec 1988/Jan 1989. | pp 20-25 |
| **References** | | **The page numbers are in the text** |
| | George, J. (1990). "Why stress is a management issue" *Health manpower management*, Vol. 16, No.3, pp17-19. In Management Education Scheme for Open Learning (MESOL), The Open University. (2000). *Managing in Health and Social Care, Module 2 Book 3*. Milton Keynes: Walton Hall. | |
| | Handy, C. (1993). *Understanding Organisations.* London: Penguin Books. | |
| | Management Education Scheme for Open Learning (MESOL), The Open University. (2000). *Managing in Health and Social Care, Module 2 Book 3*. Milton Keynes: Walton Hall. | |

# 3 WHAT IS CONFLICT?

## 3.1 Defining conflict

What do you understand by the word *conflict* and how do you feel about it as a manager?

Conflict can be defined as:
"… a struggle between opposing interests, principles, values, or feelings …" (MESOL, 2000: 48)

This definition is very generalised. To clarify your understanding, apply the definition to your workplace by identifying some opposing interests that could lead to conflict: think of a principle over which people might disagree e.g. whether staff should get time off for their studies. Identify some diverse values which could cause conflict e.g. women's right to choice in relation to abortion, or some feelings which could cause conflict e.g. support for a new manager who is a woman. These situations could result in very different kinds of conflict.

> "… People's feelings and values may coincide over a wide range of issues, and yet they may find themselves in conflict over whether one department or another should have access to certain resources. This would be a conflict of interest. Alternately, two people may have no actual conflict of interest, but they may nevertheless clash because one happens to say something, knowingly or not, which offends the other's feelings.
>
> There is also the possibility that a conflict may arise 'by mistake', through misunderstanding of each other. One person may think that a colleague has certain values or feelings e.g. that they are racist, or that they are being obstructive. However, they could be mistaken in their assessment. They could be making assumptions on the basis of a stereotype, for example, 'The finance people can never understand the nursing staff's difficulties' or 'All white people think they are superior'. Alternately, an incorrect assessment of a normally very polite person could be made if they behave in an uncharacteristically rude way during a time of severe stress …" (Adapted from MESOL, 2000: 48)

The possibility of a true misunderstanding is always worth bearing in mind in situations of conflict.

## 3.2 Symptoms of conflict

> "… Conflict does not always manifest itself in overt strife, battles round the meeting table or 'blood on the carpet'. The bitterest conflicts are sometimes conducted with perfect manners, perhaps without the underlying cause ever being mentioned …" (Adapted from MESOL, 2000: 49) This can be quite confusing for the people involved and those around them.

How can you as a manager tell when conflict has arisen or whether it is likely to surface in the future?

**TASK 1 – Identifying the symptoms of conflict**

From your own experience, what kinds of behaviour among your staff would alert you to the possibility of conflict among them?

**FEEDBACK**

> "… A useful way of thinking about the symptoms of conflict is to categorise them as either 'hot' or 'cold'. 'Cold' conflict often creates an atmosphere of false cheerfulness … In other words, the person who is angry or upset tries to hide their tension by behaving in socially acceptable ways which are not really appropriate to the situation. [For example, even if someone is very upset with you, on the surface they may behave as though nothing is wrong. You need to be aware of this sort of behaviour in order to pick it up.] The person who is upset is often too unsure or too angry to risk expressing their feelings for fear of the consequences. 'Hot' conflict, on the other hand, may be [much more] apparent. It reveals itself in outbursts of feeling and actions which leave little … doubt that … there is a problem. 'Hot' conflict is often easier to handle than 'cold' …" (Adapted from MESOL, 2000: 51)

In addition to symptoms of interpersonal conflict, symptoms of organisational conflict may be manifested in a more generalised way. Handy categorises the symptoms of organisational conflict as follows:

> "… Poor communications laterally and vertically:
> Decisions are taken on the wrong information. Group A is unaware that Group B is working on another part of the same problem. Two levels in the same division are moving in different directions on the same problem.
>
> Inter-group hostility and jealousy:
> This usually comes out in statements beginning:
> *'Department A is only concerned with keeping their lines straight …'*
> *'Division B is totally unaware that …'*
> *'If it wasn't for those people in X department …'*
> *'They never tell us anything …'*
> *'They expect us to know by intuition …'*
> *'They seem to have the MD's ear …'*
>
> Inter-personal friction:
> Relations between individuals, usually in different groups, deteriorate to icy formality or argument. Problems seem to get polarized around people and personalities.
>
> Increase in need for arbitration:
> More and more inter-group conflicts are passed [upwards] for arbitration. The cross-over point [for arbitration] becomes ever higher in the hierarchy as successive levels of superiors take up the defence of their interested parties. For example, what started as a disagreement between a driver and a clinic midwife becomes a problem between the MCH co-ordinator and the logistics co-ordinator, which ends up having to be resolved by the district manager.

Proliferation of rules and regulations, norms and myths:
It becomes more and more difficult to do anything without over-stepping somebody's regulations, somebody's established way of doing things, somebody's essential permission.

Low morale of the type expressed in frustration at inefficiency:
*'We don't seem to be able to get anything moving …'*
*'It's no use trying to be imaginative around here …'*
*'You would think they didn't want anything to happen …'*

Most of this frustration under conditions of conflict is directed at the higher levels in the organisation. These symptoms will be found at some time in almost every organisation …To treat the symptoms will be ineffective if the underlying disease is left untouched. A plaster on a boil will cover it up but if the boil is the result of a deeper ailment, another boil will pop up somewhere else …The strategy for resolving conflict must be related to the disease, not the symptom. Diagnosis, therefore, differentiating between symptoms and cause, is the key to the proper management of conflict …" (Adapted from Handy, 1993: 299)

In addition to the symptoms described here, a further clue to conflict may be identified in the fact that staff members are displaying signs of stress as was described in Session 1 of this Unit.

## 4 SOURCES OF CONFLICT

Handy refers to two important causes of conflict in the extract above: inter-group jealousy and poor communication. There are many other possible causes. In the next task, you are asked to identify some of them.

**TASK 2 – Identifying some of the causes of conflict**

a) Think of two episodes of work-related conflict in which you have been involved. Analyse what you think were the causes.
b) Think of two episodes of conflict among your staff which you had to help resolve. What do you think were the reasons for the conflict?

Besides the obvious issues, try to use the concepts discussed so far (e.g. differences in values, realities or goals) as part of your analysis; try to think of some underlying factors which may not necessarily have been mentioned, but which could have contributed to the problems.

**FEEDBACK**

You will have come up with examples from your own context, but here is an example which illustrates some of the issues discussed:

A group of non-governmental health fieldworkers are surprised to find a new staff member working in the office as assistant to the co-ordinator. They have heard nothing about this appointment and feel that the resources would be better spent employing an extra fieldworker. They are asked to "make him feel welcome", and then to help to induct him into his new role. They resist helping and make him feel very unwelcome. What are the causes of the conflict?

Probably, the causes included a combination of poor information-sharing on the part of the co-ordinator, and a sort of inter-group jealousy on the part of the fieldwork team. The co-ordinator has not taken the present stresses and expectations of the health worker team into account and has taken decisions without any discussion. She has overlooked the team's expectations of due process in what they thought was a democratic organisation. The team members feel resentful that she does not regard their views as important.

One could also say that the co-ordinator and the team have different perspectives on how the pressures in the organisation would best be alleviated. The team feels that a staff increase is needed for the field; the co-ordinator may feel that if the central office was more effective, she could support the team better. One way or another, the team does not see the co-ordinator's viewpoint, and nor does she see theirs, because of poor communication. She did not discuss the issue with them.

The above example illustrates an important source of conflict: differences in expectations. The co-ordinator expected the team to accept the new staff member without question. The team expected to be involved in the decision.

> "… Conflict often has its origins in a breakdown of the psychological contract – the set of unwritten, often unspoken, but nevertheless implicit, expectations which exist in the minds of parties to [or participants in] enduring relationships." (George, 1990: 47)

> "Conflict may occur if the expectations that one person brings to a situation are not matched by those of the other involved …" (MESOL, 2000: 47)

We will examine the causes of conflict in further detail in the next section.

## 5 MANAGING CONFLICT

So far in this session, we have identified symptoms of conflict and have started to think about the causes of conflict. In this section, we will categorise the causes of interpersonal conflict and examine some strategies for managing such conflicts. At the same time, we will revise the strategy of reading effectively by previewing. The reading for this session is situated in the business context rather than the health sector, but the issues are relevant to both. While you read it, try to identify the parallels in your own work context.

Reading 4: Whetten, B. A. & Cameron, K.S. (1991). *Developing Management Skills.* Ch 7, "Interpersonal Conflict Management." New York: Harper Collins, pp 395-428.

## 5.1 Strengthen your strategic reading skills

Before you start reading, revise the strategy of previewing. It can save you a lot of time when reading to understand.

**TASK 3 – Reading about conflict management**

Previewing is a process that leads to what could be called *intelligent* or *strategic reading*. Prepare to read the chapter by Whetten et al by following these steps taking not more than 5 minutes:

- Explore the text for any clues which the publication features provide – look for the author, clues to the purpose of the chapter, the date of publication, the place where it was published. What do these features suggest to you? Remember that you should be critically aware that not everything you read is going to be helpful: it may be biased or confined to a specific perspective, or out of date.
- Scan through the text looking closely at the *advance organisers.* These are the text features which structure the text. These include headings, diagrams, sub-headings, summaries, photos, captions. Even skim-read the first and last paragraphs of the whole text, or of the different sections. By doing this, try to get an overview of the contents of the text. This means that there are no surprises ahead. Although this may seem like a loss of time to you, it creates a mental picture of what lies ahead. Experts on reading tell us that this gives you confidence as a reader, enables you to speed up, and allows you to skip over difficult phrases or parts that seem less important for your purpose. Now think of a few things that you already know about this topic. (This is important – it creates *hooks* for you to hang new information on, and it prepares your mind to be receptive to this topic.)
- Finally jot down two questions that you are going to bear in mind while you read the text e.g. *What does this writer say are the causes of interpersonal conflict?* and *What strategies does the author suggest for managing conflict?* The questions are suggested by the text, but should serve the reader's needs too. This means that you are likely to read actively, searching for specific information, and maybe jotting down notes on these two topics too. You could also bear questions in mind which relate to your assignment.

Try out this strategy for reading now, and time yourself on the previewing process (not more than 5 minutes). Then note how much time it takes you to read the text.

**FEEDBACK**

Did you take the time to try this process or have you already developed your own reading strategies? It is worth working on your strategy as it speeds up reading and enables you to concentrate and read actively. Try to monitor your own reading processes while you read – how long does it take, does your mind drift while you read? If it does, try to be more active while you read by answering a question or taking notes on a mind-map. If you have not skim-read Reading 5 yet, this would be a good time to do so.

## 5.2 Categorising the causes of interpersonal conflict

Teasing out categories of information is useful because it helps one to organise the information in one's mind and to understand concepts on a deeper level. For example, in Session 1 of this Unit, we categorised values into three groups – individual, professional and group values.

As you already know, Reading 4a explores the causes of interpersonal conflict. The writers argue that managers often wrongly attribute conflict to a worker's *personality defect*. As an alternative, they propose four categories of causes of interpersonal conflict. Read Task 4 before reading 4a in detail.

Reading 4a: Whetten, B. A. & Cameron, K.S. (1991). *Developing Management Skills.* Ch 7, "Interpersonal Conflict Management." New York: Harper Collins, pp 395-400.

**Task 4 – Reading for specific information from the text**

a) List the four broad categories of causes of interpersonal conflict described in the reading.
b) Try to identify an example of each category of conflict in your own experience.
c) Go back to the causes of conflict you identified in the Task 2. Group them according to the four categories.

**FEEDBACK**

a) The four categories of conflict which Whetten et al identify are:
- Personal differences.
- Information deficiency.
- Role incompatibility.
- Environmental stress.

The feedback for questions (b) and (c) is combined:
The conflict between the co-ordinator and the fieldworkers of the NGO in Task 2 was probably a combination of three causes. Firstly, it is an example of *information deficiency*: the co-ordinator did not tell the team that she was going to employ someone to assist her, did not consult them and also did not disclose why she thought she should employ an assistant. If they had understood her rationale, they may have been less resentful. Secondly, the pressures on the fieldwork team added to their anger which is an example of *environmental stress*. But at another level, the *roles* of the manager and the fieldwork team are to some extent *incompatible*: management and fieldworkers are in competition to obtain more capacity and inevitably resources are limited. It seems that a number of these categories could overlap, but this in itself is helpful in understanding the cause of conflict more fully.

## 5.3 Different ways of responding to conflict

Now that you have developed a framework for understanding the causes of interpersonal conflict, how do you as a manager respond to conflict? Reading 4b on "Conflict response alternatives" explores several kinds of responses according to their impact. (The section on negotiation is interesting but more relevant to the business sector so we will not study it further here.) Preview reading 4b and read the instructions for the task below as part of your previewing strategy.

> Reading 4b: Whetten, B. A. & Cameron, K.S. (1991). *Developing Management Skills.* Ch 7, "Interpersonal Conflict Management." New York: Harper Collins, pp400-403.

**TASK 5 – Responding to conflict**

a) While reading the section on "Conflict response alternatives" (pp400-403), list the five categories of response to conflict which are discussed. Take brief notes on each while you read and then write a definition of each type of response. Compare your definitions with those in the feedback before doing question (b).

b) In each of the examples of conflict you listed in Task 2, decide which kind of response was used to resolve it. Do you feel that this was the most appropriate response in each case?

**FEEDBACK**

a) Here are the five responses to interpersonal conflict mentioned in the reading:
- Forcing: This is an attempt to satisfy one's own needs at the expense of the other individual's i.e. *"Do it my way."*
- Accommodating: This response satisfies the other party's concern while neglecting one's own i.e. *"Ok, we can do it your way."*
- Avoiding: This is a response which neglects the interests of both parties by side-stepping the conflict or postponing a solution i.e. *"I'd rather not deal with this right now."*
- Compromising: This is an attempt to obtain partial satisfaction for both parties. Both parties are asked to make sacrifices to obtain a common gain i.e. *"I'll meet you half way".*
- Collaborating: This response is an attempt to fully address the concerns of both parties. It is also sometimes called the Win/Win method i.e. *"Let's find the solution together."*

b) In our NGO example in Task 2, the conflict situation was resolved as follows. The co-ordinator was fairly quick to pick up the tension, both through her assistant's reports and through her own observations. She called a meeting with the fieldworker to whom she felt closest and asked what the problem was. The fieldworker was direct in explaining what had offended the staff. The co-ordinator then called a meeting with the fieldwork team, but without the new assistant. She listened to their grievances and explained her perspective. She then agreed to meet with them for a planning session about their own sense of pressure in the field. She apologised for not sharing her plans with them, and together they discussed a future procedure for new appointments. They agreed to discuss it as part of organisational policy at the next General Staff Meeting. Her response was collaborative so far but would only continue to be so if she followed through on the team's needs and found a way to resolve their problems. The consequences of not following through would be that she would lose credibility and would be seen as simply talking her way out of the problem in the short-term without any follow up.

## 5.4 Choosing your conflict management approach

One of the points made in the reading (Whetten et al, 1991: 410) is that ineffective conflict managers fall into one of two traps: they either rely on the same strategies whatever the conflict situation, or they struggle to implement the collaborative approach. They argue that effective managers tailor their response to conflict according to the situation. We'll deal with the issue of matching the conflict management approach with the situation first, using Reading 4c. Preview the text and then refer to Table 7.4 reproduced here from page 409.

> Reading 4c: Whetten, B. A.. & Cameron, K.S. (1991). Developing Management Skills. Ch 7, "Interpersonal Conflict Management." New York: Harper Collins, pp 407-410.

| **SITUATIONAL CONSIDERATIONS** | **CONFLICT MANAGEMENT APPROACH** | | | | |
|---|---|---|---|---|---|
| | Forcing | Accommodating | Compromising | Collaborating | Avoiding |
| Issue importance | High | Low | Med | High | Low |
| Relationship importance | Low | High | Med | High | Low |
| Relative power | High | Low | Equal-High | Low-High | Equal-High |
| Time constraints | Med-High | Med-High | Low | Low | Med-high |

(Adaptation of Table 7.4 Whetten et al, 1991: 409)

What the table sets out to do is to show which of the five conflict management approaches are suitable in certain situations. On the left are the situational considerations which include assessing whether the issue is of high or low importance; whether the relationships between the different parties in the conflict are of high or low importance; whether the relative power of the different parties is very different (high), equal or low (not much difference) and whether there are significant time constraints or not. Having identified the situational characteristics of a conflict situation, one can see which approach is most appropriate.

For example, if there is an issue at stake which is of high importance e.g. an important visitor refuses to comply with safety procedures, *forcing* or *collaborating* would be the appropriate approaches. However, if it is important to maintain a good relationship with the person concerned, it may be better to use *collaborating* instead of *forcing*. However, if the visitor has more power than the manager, s/he may be led to think that *accommodating* might be the best approach: but if the issue is really important, and time is a constraint, then the manager should probably choose the *forcing* approach for time and safety reasons. The table offers guidance, but choices still have to be made.

**TASK 6 – Evaluating your own examples of conflict**

a) Analyse one of the conflict situations you identified in relation to the model presented in Table 7.4.

**FEEDBACK**

If we analyse the NGO example from Task 2, the situational considerations were, in my view, as follows:

| **Analysis of situational considerations** | **Suitable conflict management approaches** |
|---|---|
| The conflict was over the use of resources (staff allocations) and communication; both were important issues. | Forcing, collaborating. |
| Maintaining good relationships was of high importance. | Accommodating, collaborating. |
| The manager seemed to have relatively equal power with the fieldwork team, although she exercised much more power in this instance. | Accommodating, compromising, collaborating. |
| Time was not a major issue. | Compromising or collaborating. |

If one considers the consequences of *forcing, compromising or avoiding*, all would be negative in this instance. *Collaborating* therefore seemed to be the most appropriate. In the next section, we will look at the collaborative approach in more detail.

## 5.5 Resolving interpersonal conflict using the collaborative approach

The collaborative approach is not an easy approach. It works best when time is not an issue, when the focus of the conflict is important and when the need for maintaining or rebuilding a relationship is significant. The manager involved has to be willing to give away some power in the process.

The collaborative approach is described in Reading 4d. It is structured as a problem solving cycle, according to the perspectives of those involved in the conflict. A confrontation between two individuals involves an *initiator* and a *responder*. In the NGO example, the co-ordinator is the initiator; the fieldwork team are the responders. If the two parties are unable to resolve their differences by themselves, a mediator may be called upon to assist them in reaching a constructive solution. The reading suggests guidelines for each of the three roles, to assist with the problem-solving process.

Reading 4d: Whetten, B. A. & Cameron, K.S. (1991). *Developing Management Skills*. Ch 7, "Interpersonal Conflict Management." New York: Harper Collins, pp 410-428.

This is a long reading and contains some useful information in it. Try to develop a diagram which summarises the collaborative approach, and bear it in mind next time you encounter conflict. To help you to get to grips with the reading and to make more sense of it afterwards, read it with a sheet of paper at hand.

Try to make a mind-map or graphic representation of it as you read, writing down only the main points. Divide the page horizontally into three columns: one for the initiator, one for the responder and one for the mediator. In each column, note down the stages of the process in sequence. If there is particular advice about what to do and what not to do, highlight these points as DO's and DON'Ts. While you read, try to apply the process to a real situation that is familiar to you. A graphic like this does not have to look perfect at the end of the process, but it can be a useful way of reminding yourself of the contents of a reading. Compare your notes with the list of "Behavioral guidelines" on pages 425-428.

**TASK 7 – Evaluating your conflict management skills**

a) Think about conflicts in which you have played a role. Were you the initiator, the responder or the mediator?
b) To what extent did you behave according to the suggestions in the guidelines? What could you have done differently?

**FEEDBACK**

In this instance, your responses will be individual. Try to reflect critically on your conflict management skills, as this is a good way to strengthen your own skills. Remember also that the collaborative approach is best used when the issue is critical and when maintaining staff relations is important.

Take a look at Reading 5 after you have completed this session: it provides further detail on the study skill of making graphic representations while you read. This is a very helpful academic skill to develop: it can make you more alert while reading and saves you time when doing an assignment or revising before an exam.

Reading 5: Jones, B., Pierce, J. & Hunter, B. (1989). "Teaching students to construct graphic representations". *Educational Leadership.* Dec 1988/Jan 1989, pp20-25.

## 6 SESSION SUMMARY

In this session we looked at symptoms and causes of conflict. We examined different ways in which people respond to conflict and then looked in detail at the collaborative approach to managing conflict.

Conflict management is an unavoidable part of a manager's job. It requires perceptiveness, sensitivity and skill. As a manager you need to be able to stand back so that you do not become drawn into the conflict yourself, while at the same time having a clear understanding of the issues involved. Having some knowledge of different approaches to handling conflict can help you, whether you are in the role of initiator, responder or mediator.

You have reached the end of Unit 2. In this Unit we looked at some of the skills which are important in managing people: how to understand people better and how to manage conflict. In Unit 3, we look at the leadership roles of the manager - motivating people, leading people and building teams.

# Unit 3 - Introduction
# Leading People

> "… Leadership is many things. It is patient, usually boring, coalition building. It is meticulously shifting the attention of the institution through the mundane language of management systems. It is altering agendas so that new priorities get enough attention. It is being visible when things go awry, and invisible when they are working well. It's building a loyal team … that speaks more or less with one voice. It's listening carefully much of the time, frequently speaking with encouragement, and reinforcing words with believable action …" (Peters,T.J. & Waterman, R.H., 1988: 41)

In Unit 2, we focused on understanding people as the basis for managing people. In this unit, we build on the concept of understanding people as a means of helping a manager to motivate, lead and guide individual staff members as well as teams. Over the course of the unit, we will ask you to develop your own interpretation of the meaning of leadership and to reflect on the ways in which you lead your team.

There are three Study Sessions in this Unit:

Study Session 1: Motivation
Study Session 2: Leadership
Study Session 3: Building Teams

In the first session, we will examine the factors which influence motivation and explore the manager's role in developing staff to meet both the goals of the individual and the goals of the organisation.

In Session 2, we will study leadership theories, exploring the question, "What makes an effective leader?"

In Session 3, we will look at the way teams develop and at the manager's role in guiding the process of team building.

## Intended learning outcomes of Unit 3

| **By the end of Unit 3, you should be able to:** |
| --- |
| ▪ Describe factors which influence people's motivation to work.<br>▪ Describe several theories of leadership and the concept of fitting the leadership approach to the situation.<br>▪ Describe the manager's role in leading a team through its stages of development. |

The unit also offers opportunities to further develop your academic skills including the application of models and theories to your own experiences, and problem-solving in the context of managing people. At the end of this unit, you are expected to submit your first section of your assignment: look back at its requirements so that you are alert to the models, theories and concepts in Unit 3 which you could use in your assignment. While working on this unit, you should be preparing the first draft of your assignment.

## Reference

Peters,T.J. & Waterman, R.H. (1988) *In Search of Excellence.* Harper and Row. In MESOL. *Managing Health and Social Care*. Book 2, Unit 3.

# Unit 3 - Study Session 1 Motivation

## Introduction

It has been said that motivation is the key to management. This session looks at why people are willing to work harder in some circumstances than in others. We examine what we know about the factors that motivate people and the factors that demotivate them, and how these factors may differ from person to person. As a manager, you have considerable influence over some of the circumstances that can affect people's motivation, such as developing their jobs so that they are more satisfying. During this session, we will explore how you, as a manager, can help people both to satisfy their own needs and to meet the needs of the organisation.

## Contents



## Timing of this session

There are three tasks and two readings in this session. It should take you about an hour and a half. A logical point for a break would be at the end of section 4.

# 1 LEARNING OUTCOMES OF THIS SESSION

| **Intended learning outcomes**<br>By the end of this session, you should be able to: | |
|---|---|
| **Management outcomes:**<br><br>▪ Define motivation.<br>▪ Analyse the needs of an individual using Maslow's model.<br>▪ Describe six main motivating factors in work.<br>▪ Describe six common causes of dissatisfaction in work. | **Academic outcomes:**<br><br>▪ Apply concepts.<br>▪ Reflect on your own experiences and analyse them.<br>▪ Propose solutions to problems using a set of guidelines. |

# 2 READINGS AND REFERENCES

There are two readings for this session. You will be directed to reading them while you study. They are listed here.

| **Reading** | **Publication details** | **Page numbers** |
|---|---|---|
| 6 | World Health Organisation. (1993). *Training Manual on Management of Human Resources for Health,* Part A, Annex 3 - "Motivation". Geneva: WHO. | pp1-8 |
| 7 | McMahon, R., Barton, E., Piot, M. (1992). *On Being in Charge.* Chapter 2 - "Leading a health team." Geneva: WHO. | pp58-63 |
| **References** | **Publication details** | **The page numbers are in the text.** |
| | Management Education Scheme by Open Learning (MESOL), The Open University. (2000). *Managing in Health and Social Care. Module 2 Book 1.* Milton Keynes: Walton Hall. | |
| | McMahon, R., Barton, E., Piot, M. (1992). Chapter 2 - "Leading a health team." *On Being in Charge.* Geneva: WHO. | |
| | Ridge, G. (2001). In Cook, C, & Hunsaker, P. *Management and Organizational Behavior*. Boston: McGraw-Hill/Irwin. | |
| | World Health Organisation. (1993). *Training Manual on Management of Human Resources for Health*, *Part A,* Annex 3 - "Motivation". Geneva: WHO. | |

## 3 WHAT IS MOTIVATION?

Motivation is a commonly used word in everyday speech, but what does it mean in the workplace?

Motivation is:

- "An inner impulse that induces a person to act in a certain way; a series of internal drives within a person at different levels." (McMahon et al, 1992: 58)
- "The psychological drives or forces that cause people to behave in a particular way: to work well and hard, to persist and overcome obstacles, to be enthusiastic about their work." (MESOL, 2000: 21)

Part of your job as manager is to get others to work well and to be a model for them by working well yourself. To be able to do this, you need to understand the factors that can motivate and demotivate people in the workplace.

## 4 THE NEEDS OF AN INDIVIDUAL

The first reading in this session explores the *forces that motivate individuals* and it relates Maslow's hierarchy of needs to working life. The reading also explores how needs and motivation change across the lifespan and in relation to gender and life circumstances.

Reading 6: World Health Organisation. (1993). *Training Manual on Management of Human Resources for Health,* Part A, Annex 3 - "Motivation". Geneva: WHO, pp1-8.

Explore Reading 6 with the following questions in mind and then do Task 1.

- According to the authors, what individual needs affect our motivation in the workplace?
- Do the authors see the differences in women's and men's needs as mainly physiological or social? What do you think and why?
- Which of our individual needs are best met in the workplace?
- In what ways can employers give recognition to employees?
- Why do the authors believe that motivation in a job is important?

**TASK 1 – Analysing whether your job meets your individual needs**

a) Study Figure 1, *Individual Needs* on page 2 of Reading 6. Which of the needs listed here do you feel are met by your job? Write brief notes describing how each need has been met.

b) Now list your unmet needs. What do you think your employer or supervisor could do to help with some of your unmet needs at work?

c) Are there any needs which your job cannot realistically fulfil? Why not?

**FEEDBACK**

Here is an answer from Daniel, a recently-graduated junior pharmacy technician, employed as a storekeeper in a district level warehouse for drugs.

a) Physiological needs:
"My salary is low, but it allows me to rent a place to stay, to buy enough food and clothing for myself and also to send some money back home to help my parents and younger siblings."

Safety needs:
"I think it is usually very difficult to fire a government employee, so at least I feel my job is quite secure!"

Social needs:
" My co-worker Karriem, who is in charge of the warehouse for medical supplies and equipment, is a good friend to me. We help each other and laugh together."

b) Self-esteem needs:
"In the workplace my status is low. I don't feel that junior staff like Karriem and me are respected. Sometimes field staff from the clinics and hospitals will come at any time and demand that we supply them immediately, even if we had planned other work. This disrupts our job: if we don't get time to keep the store well organised and maintain our stock cards, we will lose track of what we have and the drug management system will become chaotic. Our supervisor is harsh. He doesn't understand the pressures we must face with all the different people making demands. He doesn't stand up for us. Even if we are trying our best, we receive no praise, only criticism."

Self realisation:
"I don't think there is much opportunity for self-realisation in this job. Because I don't have a degree qualification, there is not much hope of advancement and storekeepers never seem to get sent on any training courses. It seems that only the senior people get such opportunities. I want to learn computer skills but I have no access to a computer at work, so now I am studying in the evenings. As soon as I have completed the course, I am going to look for a different job."

c) In terms of the needs which the job cannot fulfil, Daniel said: "I wish my supervisor would make a proper schedule for field staff to come and collect drugs and then insist that they follow it. Then we could organise our work and keep the store in good order. If someone would only occasionally recognise some of the things we do well, it would make us want to work even harder.

My salary is very low, but I know that this is a government job and I can't expect to earn as much as someone working in the private sector."

# 5 CAUSES OF JOB DISSATISFACTION AND SOURCES OF MOTIVATION

In Reading 6, the implications for an organisation to meet an individual's needs were listed on page 7. Some ways of countering job-dissatisfaction, such as "… providing the best financial rewards …"(WHO, 1993: 7) are sometimes beyond your immediate control as a manager. McMahon et al in Reading 7 highlights a number of sources of dissatisfaction which are more within a manager's control. Read pages 61-63 and note the six causes of job dissatisfaction which the writers identify. Then do Task 2.

**Reading 7:** McMahon, R., Barton, E., Piot, M. (1992). On Being in Charge. Chapter 2 - "Leading a health team." Geneva: WHO, pp58-63.

**TASK 2 – Identifying causes of job dissatisfaction**

a) Study the six common causes of dissatisfaction described in McMahon. Are you experiencing any of these frustrations in your job at present?
b) Are you aware of any of your staff being dissatisfied?

**FEEDBACK**

Although you may have identified other causes of dissatisfaction in your workplace, Daniel's frustrations are examples of the following causes of dissatisfaction discussed in Reading 7:

- Inefficient administration: There is a lack of schedule for collecting drugs and medical supplies.
- Poor personal relations: There is tension with field staff and harsh criticism from the supervisor.
- Poor leadership qualities: There is unfair treatment by the supervisor and no support in dealing with unreasonable demands from field staff.
- Bad working conditions: The lack of a proper schedule means that it is very difficult to work in an organised and satisfying way.

In situations of dissatisfaction, there is a high likelihood of staff looking for another job, becoming less effective or conflict developing in the workplace. Conversely, there are also substantial gains to be made, not just by removing the causes of dissatisfaction, but by developing a motivated team.

The CEO of a successful Australian company, Garry Ridge says this:

> "…Too many people go into management without seeing the difference a motivated team or individual can make in closing the gap between where they are and where they could be. People need … a progressive opportunity to make a difference. When they become passionate about making a difference, they get caught up in creating a desired future …" (Ridge, 2001:222).

It is therefore extremely important for the manager to do what she can to address those sources of dissatisfaction which are within her capabilities. However, even when staff appear satisfied, managers waste opportunities if they do not seek ways to motivate staff to become passionate about their work. This is your challenge in the next task.

**TASK 3 – Finding ways of motivating your staff**

Using McMahon et al's suggestions in Reading 7 for "Motivating team members" (pp58-61) and your own ideas, what could you do to improve the situation for them?

**FEEDBACK**

Daniel's supervisor could do the following:

- Help him to achieve his objectives by setting up a time-table for collecting drugs.
- Praise him for good work and also let field staff know that he is a competent and valued employee whose work schedule should be respected.
- Emphasise to him that although the work is sometimes difficult and people are trying to push him around, his job is very important. Through managing the drug warehouse well, he is making an important contribution to health service provision in the district.
- Lobby for training opportunities for junior staff.
- Encourage Daniel's interest in computers by arranging for him to sometimes practise on one of the office computers.

## 6 WHAT EMPLOYEES REALLY NEED

In the previous three tasks you were asked to give your view of your staff's needs and consider possible unmet needs and sources of dissatisfaction. You had to develop some strategies for motivating them. Probably you had their best interests at heart. However, you may be guilty of *thinking for your staff* rather than consulting them.

Surveys of staff attitudes often show that their views of what would bring job satisfaction often differ widely from those that their seniors presume they hold. The results of one such survey are shown in the table below. In the first row of the table, the supervisor expected that employees would find it very satisfying to be *in on* things or involved in what is going on in the organisation – they ranked it at 10. It was however the opposite – the employees did not derive much satisfaction from this at all – they ranked it at 2.

**What do employees really need?**

| Job factors | Employees' ranking | Supervisors' expectation of ranking |
|---|---|---|
| Feelings of being *in on* things | 2 | 10 |
| Job security | 4 | 2 |
| Interesting work | 6 | 5 |
| Personal loyalty to employees | 8 | 6 |
| Tactful disciplining | 10 | 7 |
| Good working conditions | 9 | 4 |
| Promotions and growth in the company | 7 | 3 |
| Good wages | 5 | 1 |
| Sympathetic help on personal problems | 3 | 9 |
| Full appreciation of work done | 1 | 8 |

(WHO, 1993: 12)

# 7 SESSION SUMMARY

The factors influencing motivation are complex. People have different needs, because they have different perceptions of reality, different values and different goals. There is no single formula that can be used to stimulate motivation. However, all staff have important needs in common which employers or managers can help to satisfy. As a manager, you may not be in a position to address all the needs of your staff. However, it is important that you make the effort to understand the needs of your staff and to address those issues over which you do have influence.

During this session we looked at factors influencing motivation in the workplace. We noted that poor leadership contributed to job dissatisfaction. In the next session, we will explore the concept of effective leadership.

# Unit 3 - Study Session 2 Leadership

## Introduction

"… Leadership in management is the task of setting goals and objectives, and obtaining the commitment of others to reach them. This is not easy, but successful managers gain such commitment through the constructive involvement of people in the work of the organization. It requires not only the manager's basic ability to achieve objectives and standards through setting and checking the work tasks of other people, but in addition the capacity to motivate, enthuse and energize them to work well and willingly towards goals in which they also believe …" (WHO, 1993: 3)

We can all usually recognise an effective leader. But what exactly does that person have that makes them a leader? Are leaders born or are they made? Can anyone be an effective leader?

In this session we will explore the meaning of leadership by looking at various theories about what makes an effective leader. Is it personality or style, or the situation, or a combination of these factors which makes a leader effective? You are invited to analyse your own leadership style: by becoming conscious of your style, you are able to modify it where necessary and so to become more responsive to the needs of your staff and the roles you fulfil.

## Session contents

## Timing of this session

There are no readings for this session but the three tasks require reflection and discussion with colleagues. Set aside about an hour and a half for the session. A logical break would be at the end of section 6.

## 1 LEARNING OUTCOMES OF THIS SESSION

| **Intended learning outcomes**<br>By the end of this session, you should be able to: | |
|---|---|
| **Management outcomes:**<br><br>▪ Briefly describe the theories of leadership under the headings: Trait, Style and Contingency theories.<br>▪ List common tendencies among effective leaders.<br>▪ Describe two ways of looking at leadership style.<br>▪ Describe the four variables in Contingency theories.<br>▪ Understand the *best fit* approach.<br>▪ Analyse leadership in your own context. | **Academic outcomes:**<br><br>▪ Define new concepts.<br>▪ Apply concepts, models and theories to your own experience.<br>▪ Reflect on your own experiences. |

## 2 READINGS AND REFERENCES

There are no readings for this session.

| References | Publication details | The page numbers are in the text. |
|---|---|---|
| | Blake, R. & Mouton, J. (1985). *The New Managerial Grid III: The Key to Leadership Excellence.* Gulf. In Management Education Scheme for Open Learning (MESOL), The Open University. (2000). *Managing in Health and Social Care. Module 2 Book 1*. | |
| | Handy, C. (1993). *Understanding Organizations.* London: Penguin Books. | |
| | Hersey, P. & Blanchard, H. (1993). *Management of Organizational Behavior: Utilizing Human Resources*. Prentice-Hall. In Management Education Scheme for Open Learning (MESOL), The Open University. (2000). *Managing in Health and Social Care. Module 2 Book 1*. | |

| | | |
|---|---|---|
| | Hunt, J.W. (1992). *Managing People at Work.* Mcgraw-Hill. In Management Education Scheme for Open Learning (MESOL), The Open University. (2000). *Managing in Health and Social Care. Module 2 Book 1*. | |
| | Kouzes, J. M. & Pozner, B.Z. (1997*). The Leadership Challenge: How to Keep Getting Extraordinary Things Done in Organizations.* Jossey-Bass. In Management Education Scheme for Open Learning (MESOL), The Open University. (2000). *Managing in Health and Social Care. Module 2 Book 1*. | |
| | Lewin, K. & Lippit, R. (1938). "An experimental approach to the study of autocracy and democracy: a preliminary note." *Sociometry*, Vol 1, pp292-300. In Management Education Scheme for Open Learning (MESOL), The Open University. (2000). *Managing in Health and Social Care. Module 2 Book 1*. | |
| | Madi, P.M. (2000). "Leadership lessons from emperor Shaka Zulu the great". Randburg: Knowledge Resources. | |
| | Management Education Scheme for Open Learning (MESOL), The Open University. (2000). *Managing in Health and Social Care. Module 2 Book 1*. | |
| | Management Education Scheme for Open Learning (MESOL), The Open University. (2000). *Managing in Health and Social Care. Module 3 Book 2.* | |
| | World Health Organization. (1993). *Training Manual on Management of Human Resources for Health, Section 1, Part A.* "Leadership." Geneva: WHO. | |

# 3 LEADERSHIP AND MANAGEMENT

We have already explored the meaning of *management* and defined it as "getting things done through people.'' Before reading on, try to define for yourself how management differs from leadership.

- Some people say that management and leadership are the same thing.
- Some say management is part of leadership.
- Some say leadership is part of management.
- Some say leadership and management are two completely separate things.

Handy offers an interesting alternative view by saying:
"A manager is someone who does things right; a leader is someone who does the right thing." (Handy, 1993:115 )

The World Health Organisation gives the following definition of leadership in the managerial context:
"Leadership is the capacity to secure the willing support of people in the achievement of the organisation's worthwhile goals." (WHO,1993: 3)

But what exactly is this *capacity*?

Although there is no clear answer to this question, we will explore some different ways of looking at leadership. You can then draw your own conclusions about what you understand by leadership. We will also help you to reflect on your own style of leadership.

Academics have speculated about whether the secret of an effective leader lies in the characteristics of his/her personality, or in the style he/she uses, or in the nature of the task or situation. Approaches to or theories of leadership usually fall under three general headings:

- Trait (personality) theories.
- Style theories.
- Contingency (situation) theories.

We will explore each of these theories in more detail.

# 4 TRAIT THEORIES

These theories suggest that there are certain personality characteristics (or personality traits) that make a person into a good leader.

Think of some of the great leaders the world has seen: Alexander the Great, Mother Theresa, Mahatma Gandhi, Winston Churchill, Nelson Mandela. These people were able to inspire others to do remarkable things and even to see the world in a different way. What special qualities did they have that enabled them to do this?

There has been plenty of debate about the qualities that a leader should have, but there has been little agreement on the precise set of characteristics that make a good leader. Even good leaders display too many different characteristics to be able to identify a clear pattern. However, many studies identify four qualities which leaders have in common:

- Intelligence: Above average intelligence but not genius level.
- Initiative: The capacity to perceive the need for action and then do something about it.
- Self-assurance: The self-confidence to believe in what you are doing. (This does not have to be aggressive: it can be expressed in a very low-key way).
- The *helicopter* factor: The ability to rise above a situation to see it in its broader context and then to descend to attend to the detail.
  (Handy, 1993: 98)

Hunt (1992) studied senior managers in the public and private sectors and concluded that those who were effective as leaders had a number of common tendencies which are listed below.

**Effective leaders tend to:**

- Be high achievers: They are highly motivated to succeed, competitive and take their careers seriously.
- Have high energy levels: They are able to persist and fight back if disappointed.
- Think about the longer term (3 to 5 years).
- Be goal-directed: they get involved in an endless pursuit of goals, even to the point of creating goals when none were necessary.
- Be politically active.
- Be loners who are content with and confident in their own company.
- Be psychologically capable of differentiating the important from the unimportant. (Hunt in MESOL, 2000: 61)

**TASK 1 – Examining the profile of an effective leader**

Using the above lists of qualities, think of a senior manager you know reasonably well. Tick any of the characteristics he or she might possess. Then underline any of the characteristics you feel you possess, and make a star next to those you think you could work on developing.

**FEEDBACK**

Did the profile of an effective leader apply in your work context? Were there any characteristics which you feel are not important and are there any which you have noted in a number of effective leaders which are not mentioned here?

Some of the characteristics such as "Thinking about the longer term, being goal-directed and taking initiative" could be consciously developed. The other traits such as "being a high achiever" seem to have been developed through experiences or inborn qualities and are difficult to develop in the short-term. What do you think?

We can conclude that many good leaders seem to have certain qualities in common. However, having these qualities will not guarantee that someone will be a good leader. This is the trait theory of leadership i.e. that people with certain traits make good leaders, and that some of these traits can be developed. While personality factors or *traits* should be considered, there are further ways of looking at leadership.

## 5 STYLE THEORIES

The assumption behind *Style theories* is that employees will work harder for managers who use certain styles of leadership. This can be linked to the issue of staff motivation in Session 1.

You, the manager - your style, ability and personal preferences - are an important variable. You probably have a preferred style of management – a preferred way of exercising your power and authority. Your preferred style probably reflects your values and your sense of what is important. You will tend to fall naturally into your preferred style unless you have carefully considered the situation and consciously or intuitively decided that some other style would be more appropriate.

Researchers have developed different ways of looking at leadership styles: Blake and Mouton (1985) describe leadership style through distinguishing between being task-focused or people-focused. (Blake and Mouton in MESOL, 2000: 68) Some managers feel that the most important thing is to get the job done; others are more concerned with keeping people around them happy.

Lewin and Lippitt (1938) chose to define style in terms of distribution of power and identified three different leadership styles:

- Autocratic: The leader decides what will be done and how.
- Democratic: Staff participate in decision-making.
- Laissez-faire: Group members work on their own and the leader is much the same as the other group members.
  (Lewin and Lippit in MESOL, 2000: 67)

There is some evidence that the democratic style leads to more contentment and group involvement amongst staff. Within the democratic style, however, the leader can utilise different types of participation which include:

> "…
> a) Consultation
> The leader listens to the ideas, preferences and suggestions of the group, but it is the leader - not the group - who makes the decision. If there is strong agreement in the group, the leader would be foolish to ignore it, although this is theoretically possible. This form of participation is often used when plans and proposals are issued to a wide variety of staff (and in some cases the public), inviting their comments. The decision on what to do still rests with the responsible authority.
>
> b) Consent
> The group has the power of veto (or refusal) over any decision. It is not the job of the group to make the decision, but since it has to carry out the decision, it has the right to say that it will not work. If this happens, the leader must go away and come back with a new decision. This is a sensible recognition that managers need the consent of their staff to get work done.
>
> c) Consensus
> Agreement on the decision has to be reached within the group. This is the most difficult and slowest form of participation to implement.
>
> However, in practical terms, it is not possible or even desirable for every decision to be taken participatively. Often there is no time. Also, groups usually don't want to be consulted about everything, sometimes preferring the manager (who is paid to take responsibility for them) to take the difficult decisions …" (Adapted from MESOL, 2000: 70-71)

Kouzes and Posner (1997) did research on leadership and as a result chose to define style in terms of characteristics which created credibility amongst the followers. They

> "… asked the led [the followers] what they expected from their leaders. They found consistent patterns that hinge largely on credibility in the leaders.

"The key expectations of followers were, in order of importance:

i) Honesty
Followers wanted someone they could believe and trust, and whose words were supported by consistent action.

ii) Competence
Leaders were expected to have a comprehensive grasp of how the organization worked, and a thorough understanding of how to make things happen.

iii) Inspiration
Followers wanted leaders who didn't just dream, but could communicate their dreams with clarity and enthusiasm.

iv) Vision
Followers wanted their leaders to be 'forward looking', to be able to see ahead and to give a sense of direction. It was also important that the led understood their place and importance in the future …"
(Kouzes and Pozner in MESOL, 2000: 66)

To summarise, Style theories suggest that leadership can be defined in terms of three different models: the first is defined in terms of distribution of power (e.g. autocratic, democratic etc), the second in terms of their focus (e.g. focused on people or on the task) and the third in terms of indicators of credibility (e.g. honesty) as a leader. Think about where you would place yourself in terms of style.

**TASK 2 – Identifying your management style**

What do you believe is your own preferred leadership style? Review the different approaches to style that we have cited and describe your style. Then clarify which model of leadership style you have used. Have you defined your leadership style in terms of power, focus or indicators of credibility? Then try to explain the different models of leadership style to a colleague and ask where he or she feels you fit in best.

**FEEDBACK**

Explaining information to another person is one of the best ways of really understanding and internalising it. But this exercise could also be helpful in understanding how your staff see your leadership style. Remember that there is a likelihood that your style can be defined in terms of all three models.

Here is a statement by a senior manager from MESOL, involved in developing a management course for health workers in South Africa:

> "I know my preferred style. I am a benevolent autocrat at heart. I tend to reach conclusions much more quickly than most people, and I get impatient with their endless discussions in search of the answer. Experience also tells me that my solutions are usually right – so my natural tendency is to impose them if I possibly can. Fortunately, perhaps, I recognise that I must be a pain to work for: so generally I try to curb my natural preferences, and manage in a way that is better suited to the very experienced and qualified people who report to me." (MESOL, Module 3, Book 2, 2000: 60)

Think about whether you believe at this point that leadership is an inborn trait or an adopted style; or is it, as this assertion by Madi suggests, dependent on how the leader responds to the situation, and the underlying values that drive his actions?

> "… What distinguishes great leaders from ordinary leaders is that the former see themselves as instruments of a greater mission, whilst the latter see the greater mission as the instrument of their own personal glory …" (Madi, 2000: 111) This has relevance for last set of theories about leadership which we will introduce.

# 6 CONTINGENCY THEORIES

The word *contingency* means an event or plan which is dependent on another situation or context. Contingency theories of leadership suggest that in addition to personality and style, a range factors are involved in any leadership situation and that the leader adjusts his/her style to the particular situation. If you think of yourself as a leader, can you think of instances when you have had to adapt your way of leading to the situation?

In any situation, there are said to be four variables that need to be taken into account. They are:

> The manager/leader – their personality and preferred style.
> The led – the needs, attitudes and skills of staff.
> The task – the requirements and goals of the job to be done.
> The context – the organisation with its values and culture, as well as external factors. (Adapted from MESOL, 2000: 66)

We will look at these contingency variables in more detail.

## 6.1 The manager/leader

You have already thought about your personality and style as a leader.

## 6.2 The led

Hersey and Blanchard (1993: 69) saw the "readiness" of people to be led as crucial in determining leadership style. They identified two important variables that determine readiness: ability and willingness. What they are saying is that leaders respond to the led, and adapt leadership-style according to the combination of ability and willingness among the led.

| **Level of readiness i.e. ability and willingness of staff** | **Leader's response** | **Leadership role** |
|---|---|---|
| People are unwilling and unable. | TELLING | The leader must provide specific instructions and monitor performance closely. |
| People are willing but unable. | SELLING | The leader must explain the task very carefully and give a lot of support. |
| People are unwilling but able. | ENCOURAGING PARTICIPATION | The leader encourages debate and sharing of ideas on how the task should be done, but lets the led decide how it should be done. |
| People are willing and able. | DELEGATING | The leader passes on authority for making decisions and doing the task. |

(MESOL, 2000: 70)

In other words, leadership is contingent on the readiness of the led.

Participation is an important factor in leadership, and it is interesting to note that you could unwillingly become an autocratic leader because of contingent factors.

## 6.3 The task

Three task factors influence the choice of management style:

- The nature of the task, for example: *Is it straight forward or complex? How many people will be involved?*
- The time scale: In emergencies managers are often forced to make decisions independently.
- The consequences of being unsuccessful: Some situations may allow the leader to be flexible and try new approaches. However, if the consequences of things going wrong can be potentially catastrophic, especially where patients are concerned, a manager may have to insist on certain ways of doing things. (Adapted from Handy, 1993:110)

### 6.4 The context

This refers to the environment in which the work is being done and includes the power position of the leader in the organisation, the position of the leader with regard to the staff or group, the way things are done (the norms) in the organisation and also factors outside the organisation (e.g. a cut in government spending). For example, a leader may want to try a new approach, but this may not fit in with the accepted way of doing things in the organisation.

In the next section, we will explore the idea of choosing a leadership style appropriate to a situation.

## 7 THE *BEST FIT* MODEL

We have seen that there are several tricky variables for a leader to consider in getting a job done. The challenge is to find the *best fit* among the four variables:

| | |
|---|---|
| **The leader:**<br>their personality and preferred style. | **The led:**<br>the needs, attitudes and skills of the staff. |
| **The task:**<br>the requirements and goals of the job to be done. | **The context:**<br>the organisation with its values and culture. |

You, the leader, need to work out how your needs, the needs of your staff, the needs of the job and the requirements of the context will best fit together to get the job done. If they don't fit, the leader must decide which factors can be altered.

**TASK 3 - Analysing the contingencies that affected your leadership approach**

Think of a situation in your job where you had to lead your team to accomplish a specific task.

a) What style of leadership did you use?
b) Were you selling, telling, delegating or inviting participation?
c) Rate all the team members in terms of willingness and ability.
d) Analyse the task in terms of its nature, time scale and consequences.
e) What contextual factors influenced the style you used?
f) Did any of the four *Contingency Approach* factors have to be adjusted?
g) Looking back, what would you have done differently?

**FEEDBACK**
Here is an example of a leadership situation which comes to mind:

A team within an organisation were faced with a crisis because of the resignation of a staff member who had become dissatisfied with the workload and authoritarian atmosphere at work. The leader, who was now under stress because of an increased workload, chose to *tell* the remaining staff what additional roles they would now have to play in terms of this situation. As a person, the leader was very goal-directed, a high achiever, able to take initiative and well able to distinguish between issues of high priority and lesser priority. (Trait theory identifies these as leadership traits.)

Two of the staff were able to manage the new tasks they had to take on, but one was now required to write reports to donors, to collate statistics and to supervise her colleagues. Although she could have done this with support, she already had a full workload and was not able to keep up with the new demands. (Contingency theory – the manager addressed the task to the exclusion of the led or the context.)

Having delegated, the manager assumed a *laissez faire* style, and expected staff to *get on with* the job. Occasionally she checked on progress, but when questioned, staff had become dissatisfied, feeling that the capacity shortage was not recognised by the leader. She had failed to review the context, and to fit her leadership style to the situation. (With the words *laissez faire*, I am using the *distribution of power* model of Style theory.)

When they discussed her leadership style, the team concluded that she was only task-focused (Style theory/Contingency theory), she did not care about them, and in fact they felt that she had not been leading at all. This was surprising as she had been authoritarian at first, but then withdrawn to a *laissez faire* style. They felt that they would have preferred her to be more directing and would have seen this as more supportive. The group were in other words ready to be led, and felt that the leader should have taken the context into account instead of focusing only on the task.

To improve the situation, the leader should have ascertained the level of willingness and skill for each job in the group, and adjusted her style to the situation of stress and lack of capacity. Her choice of a *laissez faire* style was a poor choice in a stressful context. She needed to look for a *better fit* based on the contingencies of the situation.

Your examples will be different, but this gives you an example of discussing leadership in terms of the different approaches we have studied.

# 8 SESSION SUMMARY

> "… Beyond all else, leadership is to be people-centered … People leading people in order to benefit people …" (WHO, 1993: 9)

Leadership is not easy to define or to put into practice. We have looked at the characteristics of leaders and at different leadership styles. It is important to realise that different leadership styles suit different situations. To be aware of this can help you. Each task situation will contain the four contingency factors and they need to fit together to get the job done. You may need to adapt your behaviour or you may need to adjust the other three factors. Skilful managers do not rely on the leadership styles they happen to prefer. They know how to adjust their styles to suit the situation. In the final session of this unit, we will explore the leader's role in working with teams.

# Unit 3 - Study Session 3
# Building Teams

## Introduction

In many work situations, people work individualistically, often in competition with one another. Essentially people are motivated by achieving benefits for themselves and hopefully also those they serve. Work teams are one of the main ways in which organisational tasks are accomplished.

> "… So much of human activity is co-operative. Co-operation is at the heart of all economic systems: members of the same company [or organization] have to work together to achieve their mutual goals." (Brombacher & Gibbon, c1997: 1)

The management of teams is thus a key aspect of a manager's job. In this session we will look at the way in which teams develop and at the manager's role in guiding this process.

## Session contents



## Timing of this session

This study session is fairly short but involves reading a book and three tasks. The book is written in dialogue, so it is light to read, but very informative on issues of effective management. Allow about an hour and a half for the session.

# 1 LEARNING OUTCOMES OF THIS SESSION

| **Intended learning outcomes**<br>By the end of this session, you should be able to: | |
|---|---|
| **Management outcomes:**<br><br>▪ Define the terms *group* and *team*.<br>▪ Identify advantages of working in teams.<br>▪ Describe the stages of group/team development.<br>▪ Describe the management styles used in the different stages of team development.<br>▪ Summarise the manager's role in team-building. | **Academic outcomes:**<br><br>▪ Compare models.<br>▪ Identify and select information.<br>▪ Summarise information. |

# 2 READINGS AND REFERENCES

There is only one reading for this session. You are asked to read the whole book and to review specific parts of it section by section.

| **Reading** | **Publication details** | **Page numbers** |
|---|---|---|
| 8 | Blanchard, K. (1994). *The One Minute Manager Builds High Performing Teams.* London: Harper Collins. | pp10-109 |
| **References** | **Publication details** | **The page numbers are in the text.** |
| | Brombacher, A. & Gibbon, J. (c1997). *Co-operative Learning: Potential and Implications.* Undated paper distributed at a trainers workshop in Cape Town. | |
| | Cook, C. & Hunsaker, P. (2001). *Management and Organizational Behavior.* Boston: Mcgraw-Hill/Irwin. | |
| | Hope, A. & Trimmel, S. (2001). *Training for Transformation,* Book 2. London: ITDG Publishing. | |
| | Management Education Scheme for Open Learning (MESOL), The Open University. (2000). *Managing in Health and Social Care. Module 2 Book 2.* | |

# 3 THE VALUE OF TEAM WORK

Before proceeding to study teams, we will first examine the difference between a group and a team. Think of an example of a group and an example of a team. What do you see as the difference?

Here is an explanation:

> "A *group* is any collection of people who interact with one another because they perceive themselves to have a similar purpose or similar interests.
>
> A team is something more. It is a group with a sense of a common goal or task, the pursuit of which requires collaboration and the co-ordination of the activities of its members, who have regular and frequent interactions with one another.
>
> However, the distinction is not a clear-cut one. It is a matter of degree - a group becomes a team when a similar purpose becomes a common goal and when interaction becomes collaboration and co-ordination …" (MESOL, 2000: 6)

When working with teams, the job of the manager or team leader is to guide a group through the process of developing into a productive team. This is the subject of Reading 8, which you are asked to preview and then read as directed in the tasks.

Reading 8: Blanchard, K. (1994). *The One Minute Manager Builds High Performing Teams.* London: Harper Collins, pp19-24.

**TASK 1 – What makes teams work?**

a) Think of an experience of working in a team where you felt comfortable and satisfied. List the reasons why it felt good to be part of this team.
b) Think of a team situation where you felt frustrated and unhappy. List the reasons for your feelings.
c) Now read pages 19-24 of *The One Minute Manager Builds High Performing Teams*. Study the characteristics of effective groups listed by Dan on page 20. How do these points compare with your list of what makes a team work? Try rating the team you considered in (a) and (b) according to the rating form in the reading.
d) List some advantages of working in a team.

**FEEDBACK**
Here is an answer from a manager in the field of health education:

(a) & (c) In my experience, the things that make teams work are similar to Dan's but I would add trust as an important factor, as well as shared commitment to the project goals and ownership of the task. One of the other things I noted when comparing my experience to Dan's is that he assumes that all team members play similar roles. In my experience, it is important in teams with mixed roles to have absolute clarity about each one's responsibilities.

(b) The things that I have found hamper teams are: insufficient emphasis on process and too much pressure on the outcome, dominance by one member or passivity by others, and loss of interest and commitment to the goals if a project is implemented over a long period.

(d) There are many advantages to working in teams: the combination of ideas is often very creative and challenging. Teams are often said to be "more than the sum of their parts". Working in teams also seems to challenge members and the group produces a dynamic, a life of its own, which encourages flexibility and patterns of change. There are also opportunities for staff members to play different roles, to offer their strengths, and have others do the things that they are less effective in doing. Teams obviously also allow substantial jobs to be done quickly when time is limited.

On page 17 of the *One Minute Manager*, these advantages are noted:
"… [W]hen groups are operating effectively they can solve more complex problems, make better decisions, release more creativity and do more to build individual skills and commitment than individuals working alone ..." Dan sums up the value of teams by saying: "None of us is as smart as all of us." Probably you have identified other advantages too.

An effective team is an asset in any work situation, but building teams which are effective is one of the manager's big challenges.

Now spend some time reading quickly through the whole of Reading 8. It is important that you do this at this stage because you need to get an idea of the team building process as a whole. Then, as you work through the session, you will be asked to examine specific sections in more detail. As you read, note down the four stages of team development.

Reading 8: Blanchard, K. (1994). *The One Minute Manager Builds High Performing Teams.* London*:* Harper Collins, pp10-109.

# 4 HOW TEAMS DEVELOP

Have you ever been part of a team and noticed it changing over time? This is the process of *development* which is common to any team. In this section, we look at two models of this development process. Once again, you are referred to Reading 8.

**TASK 2 – Stages in the development of teams**

a) List the four stages of team development.
b) Review pages 41 - 45. Are elements of this situation of tension in the team and Dan's feelings familiar to you?

**FEEDBACK**

a) *The One Minute Manager* describes the stages of group development as follows:
Orientation (stage 1)
Dissatisfaction (stage 2)
Resolution (stage 3)
Production (stage 4)

b) The team that Dan observes has reached what is called Stage 2 in their development. *The One Minute Manager* describes the characteristics of this stage on page 46 and regards it as a productive stage although the team members may seem frustrated.

Cook and Hunsaker (2001: 344) give different names to these four stages: *forming* (orientation), *storming* (dissatisfaction), *norming* (resolution) and *performing* (production). They also add a fifth stage: *adjourning*.

> "…Forming
> In a newly formed team a lot of uncertainties exist about the team's purpose, structure and leadership. Teams are concerned about exploring friendship and task potentials. They don't have a strategy for addressing the team's task. They don't know yet what behaviors are acceptable as they try to determine how to satisfy needs for acceptance and personal goal satisfaction. As awareness increases, this stage of team development is completed when members accept themselves as a team and commit to team goals.
>
> Storming
> The next stage involves intragroup conflict about the clarification of roles and behavioral expectations. Disagreement is inevitable as members attempt to decide on task procedures, role assignments, ways of relating, and power allocations. One objective at this stage is to resolve the conflicts about power and task structure. Another is to work through the accompanying hostility and replace it with a sense of acceptance and belonging that is necessary to progress to the next stage.

Norming

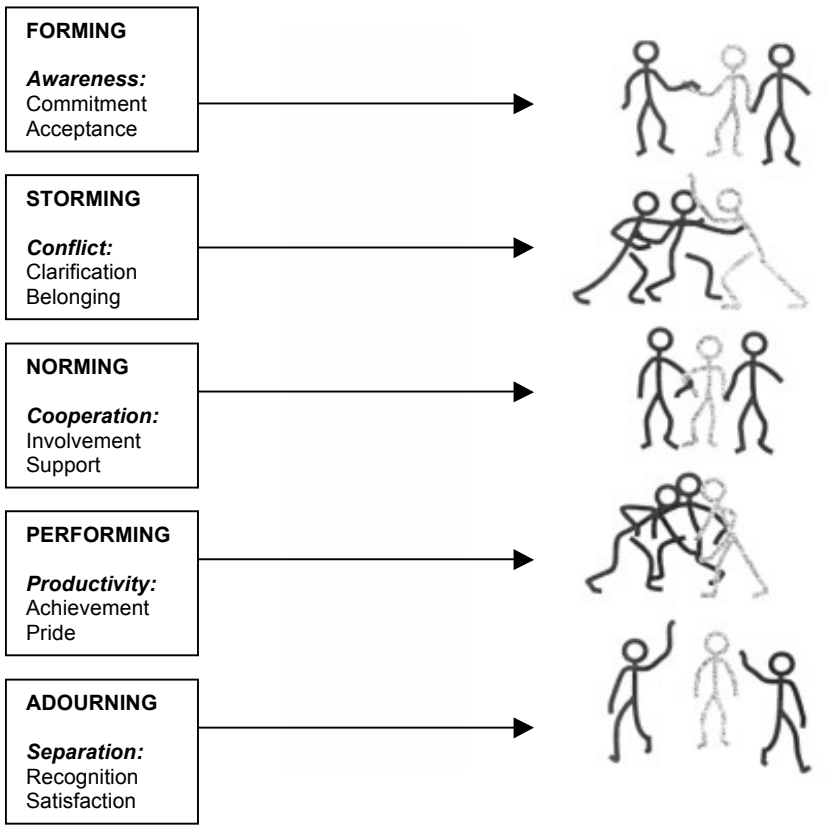
Co-operation is the theme of the norming stage, which involves the objectives of promoting open communication and increasing cohesion as members establish a common set of behavioral expectations. Members agree on a structure that divides work tasks, provides leadership, and allocates other roles. Desired outcomes for this stage of team development are increased member involvement and mutual support as team harmony emerges. If teams become too contented however, they can get stalled at this stage because they do not want to create conflict or challenge established ways of doing things.

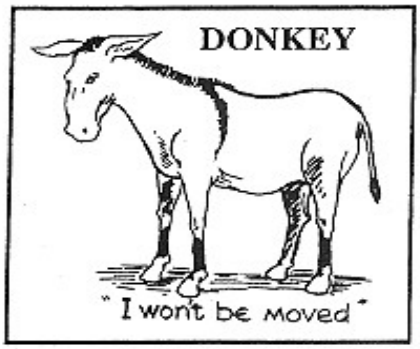
Performing

In this stage of development, team members are no longer conflicted about acceptance and how to relate to each other. Now members work interdependently to solve problems and are committed to the team's mission. Productivity is at its peak. Desired outcomes are achievement and pride, and major concerns include preventing loss of enthusiasm and sustaining momentum. For permanent work teams, this is hopefully the final and ongoing stage of development.

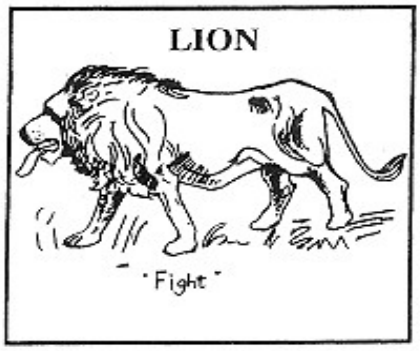
Adjourning

The adjournment or separation phase occurs when temporary teams like task forces and committees disband after they have accomplished their goals. Feelings about disbanding range from sadness and depression at the loss of friendship to happiness and fulfillment due to what has been achieved. The leader can facilitate positive closure at this stage by recognizing and rewarding team performance …"

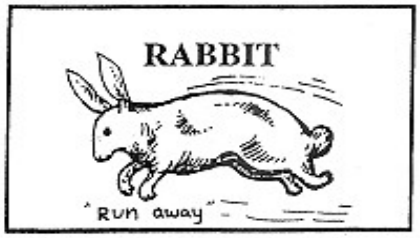





**The Donkey**
who is very stubborn, will not change his/her point of view.

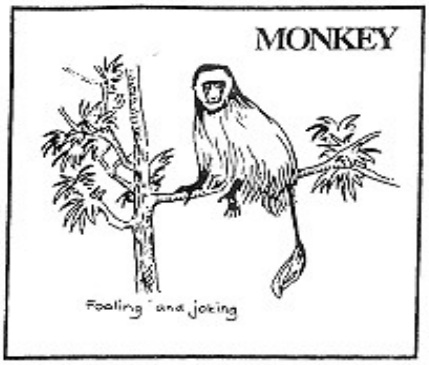



**The Lion**
who gets in and fights whenever others disagree with his/her plans or interfere with her/his desires.

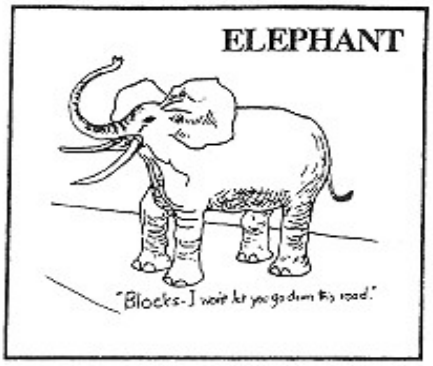



**The Rabbit**
who runs away as soon as (s)he senses tension, conflict, or an unpleasant job. This may mean quickly switching to another topic (flight behaviour).

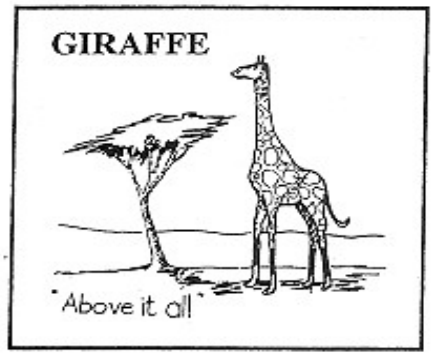

**The Ostrich**
who buries his or her head in the sand and refuses to face reality or admit there is any problem at all.



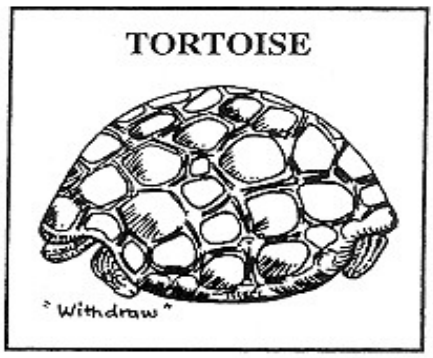

**The Monkey**
who fools around, chatters a lot and prevents the group from concentrating on any serious business.




**The Elephant**
who simply blocks the way, and stubbornly prevents the group from continuing along the road to their desired goal.




**The Giraffe**
who looks down on the others, and the program in general, feeling, "I am above all this childish nonsense."




**The Tortoise**
who withdraws from the group, refusing to give his or her ideas or opinions.

**Some common behaviours of members of groups** (Hope & Timmel, 2001: 73-74)

## 5 MATCHING YOUR LEADERSHIP STYLE TO THE TEAM'S STAGE OF DEVELOPMENT

We have seen that all teams go through a series of stages during their time together. Whichever model you choose to use, there are similarities in the stages of team development. How should a team leader respond to these stages?

Study the leadership styles described on page 86 of *The One Minute Manager*. Then go back to the leadership session (Session 2) and revise the descriptions of leadership approaches under C*ontingency Theory*. Can you see the links? You will remember that we talked about leadership style being contingent on the situation. The stage of development of the team is just such a situation (at a micro-level). There is therefore the potential for team leaders to match the leadership style appropriately with the situation of the team.

The four leadership styles used in the four different stages of team development:

| **Team development stage** | | **Leadership style** | |
|---|---|---|---|
| Orientation | Forming | Directing | Telling |
| Dissatisfaction | Storming | Coaching | Selling |
| Resolution | Norming | Supporting | Encouraging Participation |
| Production | Performing | Delegating | Delegating |
| | Adjourning | | |

We have seen how leadership style is contingent on the stage of development of the team. We will now explore the team leader's role in relation to the team.

## 6 EMPOWERING TEAMS

In this section we will focus on the manager's role in building an effective team. As you read this section, think back to Unit 1 Study Session 2 on *Managing Yourself* where *delegating* was also presented as a critical aspect of effective management.

**TASK 3 - The manager's role in building empowered teams**

Review the section on delegation from *The One Minute Manager* pp102-105.

a) What is the key lesson for team managers?
b) What is meant by *empowering* team members?

**FEEDBACK**

a) The manager needs to educate and develop the team to the point where team members are able to take responsibility and perform tasks without constant supervision by the manager.

b) Empowering team members means having "the skills, knowledge and freedom to act" (Blanchard, 1994: 104) and the desire to take responsibility and risks.

The manager's role in team development is summarised in the diagram on page 107. The key roles of the manager in relation to team-building are:

- Diagnosing the stage of team development.
- Adapting his/her leadership style to the stage.
- Empowering the team to function at its best.

# 7 SESSION SUMMARY

"… Maria found that becoming an effective team leader was exciting, challenging, but not simple. It took time, persistence and commitment on her part. Being a good team leader was much harder than being an autocratic leader. She learned that when you want to empower people, it is exhausting to get them ready to share responsibility … It's not for the faint-hearted, but the results are worth it …" (Blanchard, 1994: 108)

In this session we looked at the benefits and challenges of working in teams and at the development stages that all teams must go through on the road to effective performance. We also examined the ways in which a leader can help the team to progress by using different leadership styles according to the development stage of the team.

Although working with a team may sometimes be difficult and tiring, it is worth remembering that "… none of us is as smart as all of us …" (Blanchard, 1994: 25)

At this stage, you should be ready to complete a draft of your assignment. We hope that Units 1-3 have been interesting and encouraged you to reflect on your own practices as a manager. Please complete the Evaluation Form which follows and send it to the Student Administrator of the School of Public Health with your Assignment.

# Unit 4 - Introduction Planning

In Units 1, 2 and 3, we focused on the role of the manager in understanding people and leading them towards achieving individual and organisational goals. In this unit we look at planning as an integral part of management.

> "… Underlying all health planning is a belief that the low and unacceptable health status faced by many communities and individuals … can be improved, and that the process of planning is a means to that end. Planning is concerned with creating the future from the constraints of the present. It is, however, not an easy process - and indeed it can be a very lonely one for planners. The type of radical changes needed to improve health status are not popular with many groups within the health sector, and such changes will continue to meet resistance. The development of a planning culture and planning system is a slow, a continuous, and indeed a never-ending process …" (Green, 1994: xi)

Throughout Unit 4, we will follow the theme:

*Planning is … using information from the past and the present to prepare for the future.*

We begin this unit by examining the District Health System as the context in which much health planning takes place. We will explore the rationale for planning, challenges in planning and methods and tools for planning. You will be asked to consider and apply these concepts through the development of a small-scale project plan.

There are five Study Sessions.

Study Session 1: The District Health System
Study Session 2: Planning: What and Why?
Study Session 3: The Planning Cycle
Study Session 4: Project Planning
Study Session 5: Information for Planning and Management

In Session 1 we will briefly examine the origins and structure of the District Health System as the context for much health planning.

In Session 2 we will examine the rationale for planning, looking at scarcity of resources and external factors as important influences within the planning process.

In Session 3, we will introduce the planning cycle and study the first two stages of it. We will focus on analysing the situation and determining the priorities.

In Session 4, we will explore the implementation stage of the planning cycle and introduce a planning tool called the Causal Pathway.

In Session 5 we will look at health information systems in relation to the final stage of the planning cycle: monitoring and evaluation.

## Learning outcomes of Unit 4

| **By the end of Unit 4, you should be able to:** |
| --- |
| ▪ Describe the District Health System and the rationale underpinning it.<br>▪ Define planning and discuss reasons for planning, including scarcity of resources and the influence of external factors.<br>▪ Describe the stages of the planning cycle and define key planning terms.<br>▪ Draw up a plan for a small scale project using a planning tool.<br>▪ Describe the role of health information systems in planning and management. |

As in other units, there are a number of academic skills which have been integrated into the sessions including using new concepts, selecting and summarising information from texts and applying models to one's own practice. The core skill of this unit, planning, as well as monitoring your own progress is also one which could be applied to your own studies.

By now you should have started your assignment. The next section of the assignment requires you to have completed Units 4 and 5. Check your work plan to make sure that you cover both units in good time allowing sufficient time to complete your assignment. As a manager or future manager, it would be good to practise your planning skills in the context of your own studies, and to succeed in reaching your target within the time planned. Try it out!

### Reference

Green, A. (1994). *An Introduction to Health Planning in Developing Countries*. Oxford University Press.

# Unit 4 - Session 1
# The District Health System

## Introduction

Over the past three units, we have explored the skills needed by health managers in managing themselves and the staff who provide health services. These health services are, however, delivered within a context. In many countries the District Health System (DHS) provides the context within which much of the planning and management of health and welfare services takes place.

The District Health System is viewed as a central concept in implementing Primary Health Care. It has been described as:

- The backbone of PHC.
- The vehicle for delivering PHC.
- The operational unit for PHC.

In this session we look at what a District Health System is, what it does, and how it fits into the health system and the community. We also assess some of the challenges associated with District Health Systems in different countries and how these could be addressed.

## Session contents



## Timing of this session

There are four readings and eight tasks in this session. It is likely to take you up to three hours, so aim to take a break after section 5.

# 1 LEARNING OUTCOMES OF THIS SESSION

| **Intended learning outcomes**<br><br>By the end of this session, you should be able to: | |
|---|---|
| **Management outcomes:**<br><br>▪ Define the term *district.*<br>▪ Describe the *District Health System* concept.<br>▪ Explain the functions of the DHS.<br>▪ Describe the rationale behind the DHS.<br>▪ Describe some of the challenges experienced in implementing the DHS. | **Academic outcomes:**<br><br>▪ Define concepts and explain a model.<br>▪ Select and summarise relevant information.<br>▪ Develop a mindmap. |

# 2 READINGS AND REFERENCES

The readings for this session are listed below. You will be directed to them in the course of the session.

| Reading | Publication details | Page numbers |
|---|---|---|
| 9 | Janovsky, K. (1988). *The Challenge of Implementation - District Health Systems for Primary Health Care.* Geneva: WHO. | pp9-16 |
| 10 | Monekosso, G.L. (1994). *District Health Management: From mediocrity to excellence in health care.* Geneva: WHO. | pp20-27 |
| 11 | World Health Organization (undated draft), *Decentralization and Health Systems Change in Africa: Case study Summaries*. Prepared for the Regional Meeting on Decentralization in the Context of Health Sector Reform in Africa. (No details of publisher available). | pp1-5 & 57-61 |
| 12 | Janovsky, K. (1988). *The Challenge of Implementation - District Health Systems for Primary Health Care.* Geneva: WHO. | pp65-67 |

| References | Publication details | The page numbers are in the text. |
|---|---|---|
| | Gilson, L., Morar, R., Pillay, Y., Rispel, L., Shaw, V., Tollman, S. & Woodward, C. (1996). *Decentralization and health systems change in South Africa*. Johannesburg: WHO/Health Policy Co-ordinating Unit. (Preface). | |
| | Nicholson, J. (2001). *Bringing Health Closer to People. Local Government and District Health System.* Durban: The Health Systems Trust. | |
| | Owen, C.P. (Ed). (1995). *A policy for the development of a district health system for South Africa.* Durban: Health Systems Trust. | |
| | Tarimo, E. & Fowkes, F. (1989). "Strengthening the backbone of PHC." *World Health Forum,* Volume 10. | |
| | Vaughan, J. P. & Morrow, R.H. (1989). *Manual of Epidemiology for District Management.* Geneva: WHO. | |

# 3 DEFINING A *DISTRICT*

Before examining the District Health System, you need to be clear about what a *district* is:

> "… It is the most peripheral fully organized unit of government, varying greatly from country to country in size and degree of autonomy and being designated by many different names …" (Tarimo & Fowkes, 1989: 75)

> "…The district is the most peripheral unit of local government and administration that has comprehensive powers and responsibilities. It may be called by various names: the *awraja* in Ethiopia, the *block* in India, the county in China, the *district* in Kenya and Malaysia, the *gun* in the Republic of Korea, the *kabupatan* in Indonesia, the *municipality* in Brazil, the *sharestan* in the Islamic Republic of Iran and the *upazilla* in Bangladesh.
>
> A typical district has a population of between 100,000 and 300,000 people and covers an area of from 5,000 to 50,000 square kilometers. The district headquarters is usually in the main town where there are the offices of all the principal ministries that are concerned with the district and local affairs, such as health, agriculture, education, social welfare, and community development. The district is the natural meeting point for 'bottom-up' community planning and organization, and for 'top-down' central government planning and development. It is therefore, a natural place for the local community needs to be reconciled with national priorities …" (Vaughan & Morrow, 1989: 1)

> "… A district must be large enough to be economically efficient but small enough to ensure effective management which is accountable to local communities and is responsive to local needs through the participation of communities and of staff in the planning and management of services …" (Owen, 1995: 2-3)

"…This is a clearly defined administrative area covering a defined population (whose size varies from country to country) at which some form of local government or administration takes over many responsibilities from central government departments. Districts are geographically compact and replicated throughout the country. They may be made up of urban or rural community groups, villages, communes which are managed by a few 'closely knit' officials based in one major town, the focus of communications and trade. A district is small enough for its major problems and constraints to be readily understood, but large enough to have professionally qualified staff … A district provides a real opportunity to forge a partnership between the people and their government …" (Monekosso, 1994: 20)

Ideally all government departments or sectors should use the same administrative boundaries for a district, so that health, education, housing, water and other services can work together on the same target population. When the district system was first introduced in South Africa, there was a lot of confusion because the administrative boundaries for different government sectors did not correspond. Measures have since been taken to ensure congruence of administrative boundaries.

**TASK 1 – Understanding the concept of a *district***

From the excerpts above, summarise the key points that define a district.
Find a map of the district in which you work and refer to it as you go through this session.

**FEEDBACK**

Here are some of the features which can be drawn out of the definitions.

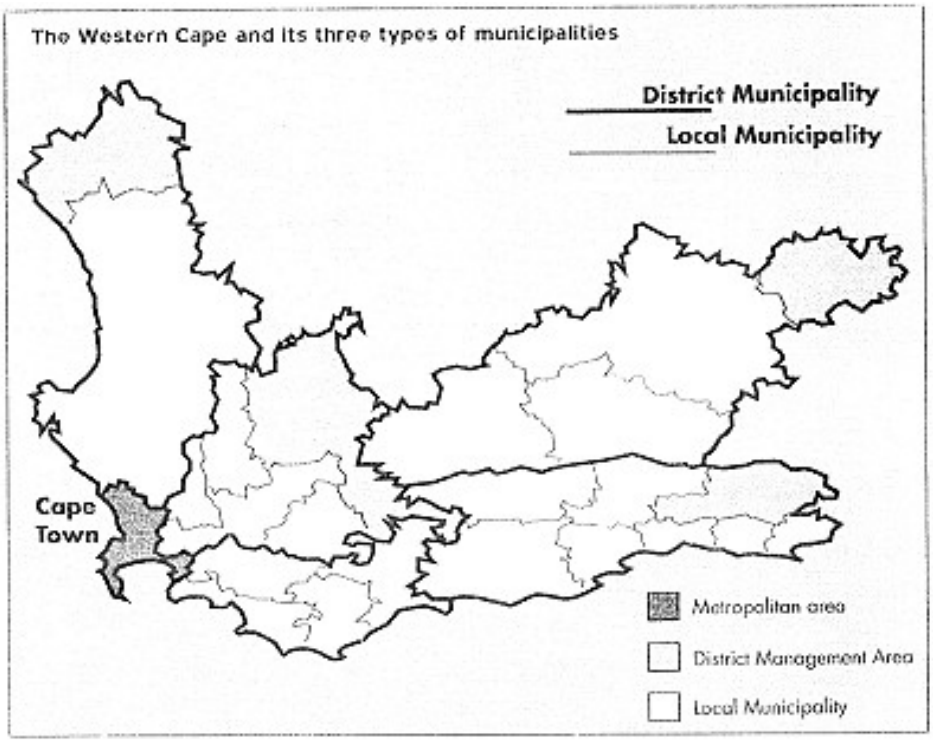
A district has:

- A defined geographic area.
- A defined population.
- A manageable size (geographic and population).

It is:

- The most peripheral organised unit of government.
- The interface of government with the community.
- It incorporates all sectors working together.

On the next page is a map of the districts of the Western Cape, South Africa.




We will build on this understanding of a district in the next section.

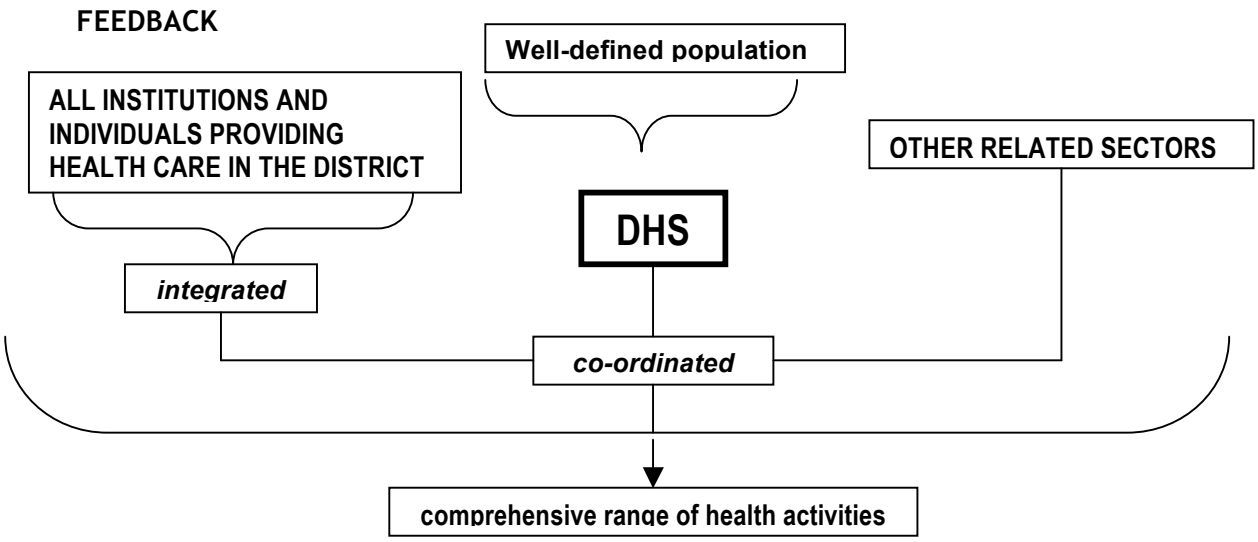
## 4 DESCRIBING THE DISTRICT HEALTH SYSTEM MODEL

Before examining the District Health System (DHS) in detail, it is important to understand that we are viewing the DHS as a *model*. In other words, it is a particular arrangement within a health system based on a framework of ideas which can be built upon and adapted. The details of structure and function will vary in different countries, according to local circumstances. Even within the same country, the DHS may change over time, as lessons are learned and better ways are sought and found to deliver services to communities.

Reading 9: Janovsky, K. (1988). *The Challenge of Implementation - District Health Systems for Primary Health Care.* Geneva: WHO, pp9-16.

**TASK 2 – Describe the District Health System**

a) In the WHO definition on page 9 of Reading 9, highlight the words and phrases that you think would best describe the DHS model of health care provision and make a mind map to show these key ideas.




All the different health-related activities which take place in the district need to fit together (*integrate*) and then pull together (*co-ordinate*) to best serve the health needs of the community.

The way in which a DHS functions is affected by the system of governance in the country. In the next task, we explore some concepts involving governance which will add to your understanding of the District Health System.

**Task 3 – Understand key terms relevant to the District Health System**

a) In Reading 9, underline the phrases *local government*, *central government* and *decentralization*.
b) What do you understand by the terms *govern*, *government* and *decentralization* in the context of the DHS?
c) What is the context in which the term *decentralisation* is presented here?
d) Why do you think it is important to understand the terms *government* and *decentralisation* when thinking about the DHS?

**FEEDBACK**

Here are some definitions and explanations to compare with your answers:

b) These definitions come from the Collins English Dictionary:

- *Govern*: "To direct and control the policy and affairs of. "
- *Government*: verb. "The exercise of political authority over a country or state."
- *Government*: noun: " The system by which a country or state is ruled."

In the DHS context, these terms refer to the process of ensuring political accountability and the way in which control is exercised over the activities of the health district.

- *Decentralise*: "To re-organise into smaller more autonomous units; transfer from central to local authority." (Oxford Pocket Dictionary)

c) *Decentralisation* is presented as one of the principles underlying the DHS. It usually refers to the transfer of power and/or the transfer of resources (human, financial, material). There are different types of decentralisation, two of which are particularly important in understanding the DHS:

- *Deconcentration:* The shifting of power and/or resources from central offices to peripheral offices of the same administrative structure.
- *Devolution:* The shifting of power and/or resources from the centre to separate administrative structures.

d) The process of decentralisation provides the starting point from which the District Health System is developed. It implies that resources and responsibilities are shifted from the national and provincial levels to the district level of the Department of Health. In South Africa, decentralisation is part of the process of redressing the inequities of the past, using the Primary Health Care approach to bring health care closer to the population.

# 5 STRUCTURES IN THE DISTRICT HEALTH SYSTEM

The DHS and its structures fit within the overall district administrative system and the national health system. The next reading describes some of these relationships. If you are a manager in the public health system, you should be able to recognise where your job fits within these structures. Even if you are not working within the government system, you will probably have encountered aspects of the system through interactions within your job or your community.

Study Reading 10 and answer the questions in Task 4 to check your own understanding.

Reading 10: Monekosso, G.L. (1994). *District Health Management: From mediocrity to excellence in health care.* Geneva: WHO, pp20–27.

**TASK 4 - Identify the structures in and around the DHS**

a) How do the terms *district system* and *district level* differ from each other?
b) What is the role of the district level within the national health system?
c) What are some of the pre-conditions necessary for a DHS to work?
d) Describe the position of the District Health Office in the DHS in terms of roles and relationships.
e) Draw a diagram to illustrate the position of the District Health Office within the overall district system
f) Study Figure 3 on page 21 of Reading 10. Draw a similar diagram showing by name all the different health facilities that make up the DHS in your district.

**FEEDBACK**

a) The District Health System is one of the systems that make up the overall district system. The *district system* may be seen as the framework of organisation for all the affairs of the district in all sectors e.g. health, housing etc including all levels of organisation within the district. The *district level* refers specifically to the management level that is located between the national and regional or provincial levels and the communities.

b) The *district level* is the key management level for delivering Primary Health Care. It is the level where national policies are turned into practical action plans and implemented.

c) In order for the district to function effectively in turning policies into action, a number of pre-conditions need to be in place. Underlying these conditions is the concept of *decentralisation.*

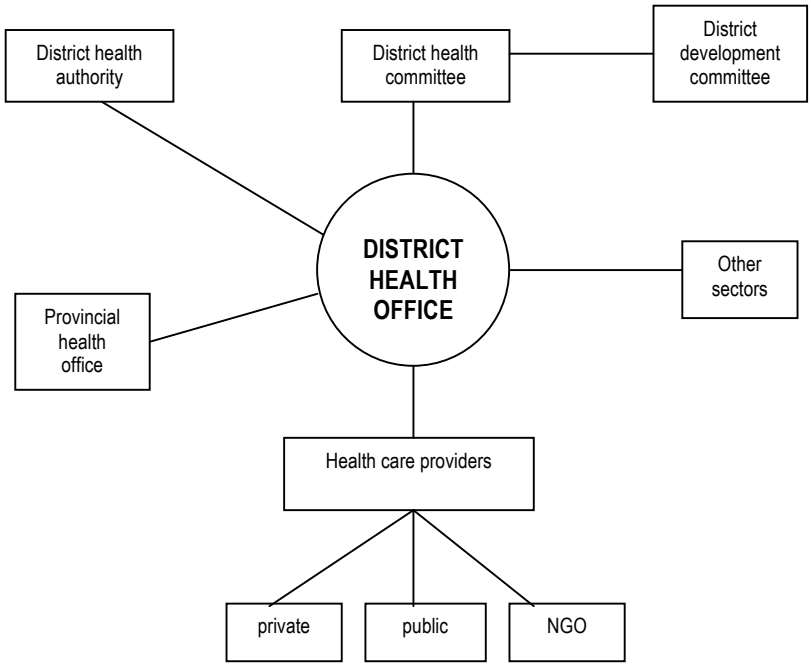
Decentralisation is essential for the development of a fully functional District Health System. Adequate financial and human resources have to be transferred to the district from other levels. The district must have some degree of autonomy and authority for planning services, for allocating financial resources and for managing human resources.

However, the DHS cannot function in isolation. National and provincial levels must provide clear policies, strategies, support and monitoring. Refer to the example of Zambia on page 14 of Reading 10.

d) The District Health Office is run by a multi-disciplinary District Health Management Team and led by the District Manager. It is the apex of government health services in the district. It is also the focal point for the co-ordination of all health-related activities within the district. Usually, the District Health Office is accountable to the local government authority for carrying out its functions, but receives technical support and supervision from the provincial/regional health office. The District Management Team may also be advised by a District Health Committee, which may be part of the District Development Committee.

The details of the way in which a District Health System is organised will depend on the specific situation in different countries and even in different districts. Remember that here we are looking at the DHS as a *model*.

e) Compare your diagram of the position of the District Health Office within the district system to this one.




Thus far we have looked at the definition of the District Health System and have identified structures within the DHS and external to the DHS. We now go on to examine why the District Health System is considered advantageous.

## 6 THE RATIONALE BEHIND THE DHS CONCEPT

The District Health System is not a new idea. It has been used in many countries for many years. Why has the DHS been so widely adopted?

**TASK 5 – Find the reasons behind developing the DHS**

a) Describe some of the advantages of using a DHS, drawing on the readings for this session.
b) In your own work setting, what do you think are the advantages that decentralisation and a DHS have brought or will bring?
c) Do you see any potential problems associated with the DHS in your setting?

**FEEDBACK**

a) "…The district is the most appropriate level for coordinating top-down and bottom-up planning; for organizing community involvement in planning and implementation; and for improving the coordination of government and private health care. It is close enough to communities for problems and constraints at community level to be understood. Many key development sectors are represented at this level, thus facilitating intersectoral cooperation and the management of services across a broad front.

Country experiences show that health workers operating within and from their health posts and health centers cannot function in a sustained and purposeful manner without support. The most appropriate level from which to organize and provide that support, is the district …" (Janovsky, 1988: 10)

"…Focusing action on the district has the following advantages:

- The district is geographically compact and all parts of it are usually accessible, often within one day.
- It is an administratively defined unit, replicated in all parts of the country.
- It is managed by a few key officers, thus facilitating liaison and coordination between the local representatives of different government departments and associated nongovernmental organizations.
- It often has one main town that is a focus of communications and trade, with associated roads and transport and other important services.
- It has a small enough population to facilitate the coordination and management of available health services.
- It is usually large enough to have specialized supporting technical and managerial staff, sufficiently skilled to allow substantial delegation of decision-making from national or regional management.

These factors make the district the best unit at which to introduce changes in the health system …" (Tarimo & Fowkes, 1989: 76)
"… A National Health system based on this approach is as concerned with keeping people healthy as it is with caring for them when they become unwell. These concepts of 'caring' and 'wellness' are promoted most effectively and efficiently by creating small management units of the health care system, adapted to cater for local needs" (Owen, 1995: 1)

b) The experience of a Primary Health Care Supervisor in the Eastern Cape, Mrs Lwandlekazi September, is that management problems are addressed more promptly. Peripheral staff take on more ownership of managerial issues and learn to solve their own problems. For example, in taking on responsibility for a budget, staff become more aware of costs and the implications of overspending.

c) Mrs September has found that the workload for managers in the still relatively new DHS in South Africa is very high. It is difficult to implement all the new policies required by the various directorates, especially within the time frames expected. This is made even more difficult by the fact that managers are frequently called away to meetings and workshops organised by the directorates; she notes that sometimes it seems as though more time is spent on meetings than on the work itself.

# 7 THE FUNCTIONS OF THE DISTRICT HEALTH SYSTEM

We have looked at what the District Health System is and at why it is used; now we look at what it should do, its functions. Again remember that we are looking at model or framework using particular terms and diagrams to describe concepts.

Within the DHS, we talk of the *pillars of the DHS.* This term attempts to convey the idea that the five components, or pillars are important to support or *hold up* the system, as a pillar in a building holds up the roof or floor above it.

Task 6 will help you to understand the functions of the DHS and how these relate to the principles underlying the DHS.

**Task 6 – Summarise the functions of the DHS as described by the WHO**

a) What do you understand by the phrase *to implement,* in relation to Primary Health Care?
b) What is the main purpose of the DHS?
c) List the components of PHC as described at Alma Ata. (Refer back to the module *Health, Development and Primary Health Care I*).
d) List the pillars of the DHS described on page 10 of Reading 9 by Janovsky.
e) On page 9 of Reading 9, revise the principles underlying the DHS. Draw a diagram to show how the components of PHC, the principles underlying the DHS and the pillars of the DHS all fit together.
f) Read the list of functions of the DHS as described by Janovsky in Reading 9 on page 14. How do these relate or fit into your diagram?

**FEEDBACK**

Make sure that you understand how the principles, structures and functions of the DHS fit together and how they relate to the delivery of Primary Health Care.

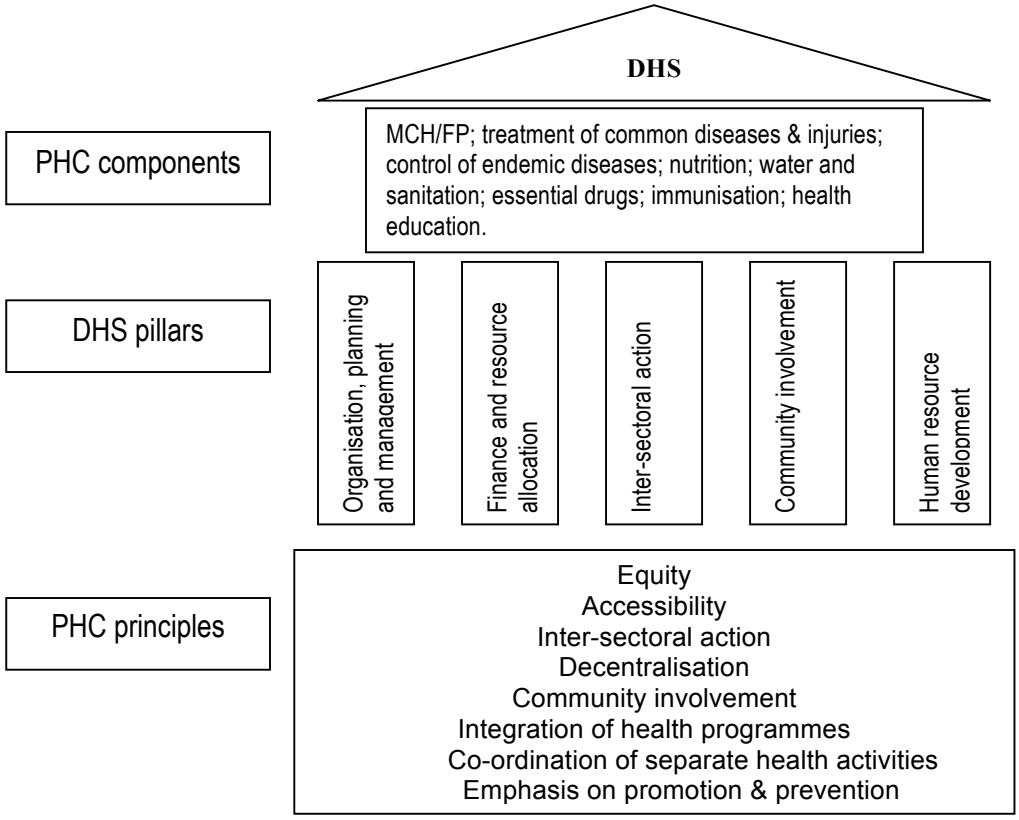
a) The phrase *to implement* means *to carry out, to put into action.* Implementation of PHC is the practical process of delivering health care to the community.

b) The central purpose of the District Health System is to implement the key primary health care strategies, in keeping with the Alma Ata philosophy, as an integral part of the district development process.

c) The main components of Primary Health Care are:

- Mother and child health care, including family planning.
- Treatment of common diseases and injuries.
- Prevention and control of endemic diseases.
- Health education.
- Adequate nutrition.
- Adequate water and sanitation.
- Immunisation.
- Provision of essential drugs.

e) Here is our diagram showing how the components of PHC, the principles underlying the DHS and the pillars of the DHS all fit together.




The PHC principles form the foundation of the DHS and support the pillars. The pillars support the implementation of the different components of PHC. They are a crucial part of the DHS. Without the pillars, PHC services would collapse.

f) The diagram illustrates some important concepts surrounding the DHS in broad terms. Janovsky lists some of the practical details that form part of the different pillars: the functions of a District Health System. For example, recruitment is one small element of the first pillar – Organisation, planning and management.

# 8 CHALLENGES TO IMPLEMENTING THE DISTRICT HEALTH SYSTEM

In the feedback to Task 5 of section 6, a health manager shared some of her experiences of the DHS, both positive and negative. While the DHS concept has many advantages, its implementation is not without challenges.

Many of the challenges associated with implementing a DHS relate to the way in which decentralisation is carried out. This section examines the process of decentralisation of health services in different countries and identifies some of the problems which may affect the implementation of an effective DHS. It concludes with a framework for action to address the challenges.

"… Many countries are in the process of undertaking ambitious reforms in the health sector. One of the major issues of current concern is decentralization. Apart from its intrinsic value in empowering people, it is widely assumed that decentralization leads to improvement in health systems performance, resulting in greater efficiency, equity, quality and responsiveness to users. Yet, many countries that have adopted decentralization policies have been unable to make significant progress in implementation and it is not evident whether the desired effects are being achieved. Also, the policies pursued in the name of decentralization vary widely as regards the role and importance of local government, the creation of executive agencies within the sector and the establishment of autonomous district health boards and provider institutions. Different forms of decentralization exist side by side, not necessarily linked or functioning in mutually supportive fashion ..." (Gilson et al, 1996: *Preface*)

The country case studies in the next reading summarise some of the main problems associated with decentralisation.

Reading 11: World Health Organization (undated draft), *Decentralization and Health Systems Change in Africa: Case Study Summaries.* (No details of publisher available), pp1-5 & 57-61.

**TASK 7 - Identify the problems associated with the implementation of the DHS**

Revise pages 9, 14 and 15 of Reading 9 by Janovsky and also read the country studies on Botswana and Zambia in Reading 11. Drawing on these readings and your own experience, summarise the main problems associated with decentralisation and the creation of the DHS.

**FEEDBACK**

Here are some of the main problems associated with decentralisation and the creation of the DHS:

- Broad policy statements are made at national level but insufficient guidance is given for the practical implementation of these policies. There may be a lack of clarity among district level staff as to their exact roles and responsibilities.
- Decentralization takes place rapidly and district staff members are unprepared for their new roles. Training and ongoing support are inadequate.
- Decentralisation may occur in name but district level staff are not given sufficient authority or resources to effectively manage according to the district model.
- Staff at all levels of the national health system may resist the changes, thus slowing the process.
- Health information systems at district level are often poor. A solid basis for planning and rational decision-making is thus lacking.
- Community participation and inter-sectoral collaboration remain weak.

We have seen that while there are clear advantages associated with the idea of District Health System, there are often practical problems related to its implementation. The next reading proposes ways in which to address some of these challenges. Read the instructions in Task 8 before going through it.

Reading 12: Janovsky, K. (1988). *The Challenge of Implementation- District Health Systems for Primary Health Care.* WHO, pp65-67.

**TASK 8 – Addressing the challenges of implementing a DHS.**

a) List the "Directions for Strengthening District Health Systems" as described in Reading 12.
b) To what extent are these directions being followed in your setting?

**FEEDBACK**

a) The guidelines or directions given for strengthening District Health Systems are:
   - Decentralisation and national support.
   - Organisation, planning and management.
   - Resource allocation and finance.
   - Inter-sectoral action.
   - Community involvement.
   - Development of human resources.

b) Probably you will have noted that the directions described in the reading are being implemented to varying degrees in your setting. In South Africa much effort has gone into the establishment of the District Health System and much progress has been made. Many areas are, however, still in a state of transition. It is important to remember that the DHS is a fluid concept, and managers should always be ready to adapt it in order to improve the delivery of services.

Two of the directions suggested in the reading are "organisation, planning and management" and "resource allocation and finance". In the remainder of this Unit and in Unit 5, we will be studying these issues in detail.

# 9 SESSION SUMMARY

In this session you gained an understanding of what the DHS is and how it works. You will have recognised that the DHS is an internationally used model which is considered to be an effective vehicle for the delivery of Primary Health Care. The concept of decentralisation is key to the creation of a District Health System, but the details of structure and function will vary from country to country. The DHS and the decentralisation process are not without challenges. The implementation of a DHS should be viewed as a fluid process, constantly adapting to new ways of improving PHC. In the following four sessions of this unit, we will look at one of the important directions for strengthening the District Health System: *planning*.

# Unit 4 - Session 2
# Planning: What and Why?

## Introduction

"… For many health-care professionals, the term 'planning' may be confusing as it is used by different people in very different ways. The activity itself may be seen as mysterious, complex, and possibly irrelevant to their daily lives either at work or at
home …" (Green, 1994: 1)

However, planning is one of the key aspects of a manager's job.

During this session, we examine the meaning of planning, the reasons for planning and the issue of reluctance to plan. We look at the need for planning in the context of three broad issues: organising activities, scarcity of resources and the presence of external factors.

Throughout this session and in Sessions 3 and 4 of this Unit, we will explore the planning process from different angles, gradually increasing the detail and level of complexity. We will use a simple case study to introduce the concepts of planning through asking particular questions and anticipating potential problems.

## Session contents



## Timing of this session

This session has three short readings and seven tasks. It will probably take you about two hours. A logical point to take a break is after section 4.

# 1 LEARNING OUTCOMES OF THIS SESSION

| **Intended learning outcomes**<br>By the end of this session, you should be able to: | |
|---|---|
| **Management outcomes:**<br><br>▪ Explain the meaning of planning.<br>▪ Understand the need for planning.<br>▪ Understand the planning implications of resource scarcity.<br>▪ Analyse reluctance associated with planning.<br>▪ Begin the planning process for a small-scale project.<br>▪ Analyse the influence of external factors. | **Academic outcomes:**<br><br>▪ Use concepts relevant to planning.<br>▪ Develop mind maps and graphic representations.<br>▪ Analyse and select information in terms of a set of questions. |

# 2 READINGS AND REFERENCES

The readings for this session are listed below. You will be directed to them in the course of the session.

| **Reading** | **Publication details** | **Page numbers** |
|---|---|---|
| 13 | McMahon R., Barton E.& Piot, M. (1992). *On Being in Charge. Geneva:* WHO. | pp267-270 |
| 14 | World Health Organisation. (1993). *Training Manual on Management of Human Resources for Health.* Section 1 Part B. Geneva: WHO. | pp3-6 |
| 15 | "Case studies on sanitation and hygiene in Cameroon and Tanzania." *MSc Course Notes.* (1998). London School of Hygiene and Tropical Medicine. | p1 |
| **References** | **Publication details** | **The page numbers are in the text.** |
| | Covey, S. (1999). *The 7 Habits of Highly Effective People*. UK: Simon & Schuster Ltd. | |
| | Green, A. (1994). *An Introduction to Health Planning in Developing Countries.* Oxford University Press. | |
| | Green, A. (1994). "Why Plan? An Introduction to Health Planning." *Lecture notes, Post Graduate Diploma in Health Management.* Nuffield Institute for Health. | |
| | International Rescue Committee (IRC). (2000). *IRC's Proposal Guidelines based on the Causal Pathway,* Draft 10 December 2000. | |

| | | |
|---|---|---|
| | McMahon R., Barton E.& Piot, M. (1992). *On Being in Charge. Geneva:* WHO. | |
| | National Department of Health, South Africa. (1999). *Health Planning for District Management Teams.* National Department of Health. South Africa. | |
| | National Health Planning Unit, Ministry of Health, Ghana. (1991). *Guidelines for Health Planning at District Level*. Ghana: Ministry of Health. | |
| | Norwegian Agency for Development Co-operation (NORAD). (1992). *The Logical Framework Approach*, NORAD. | |

# 3 WHAT IS PLANNING AND WHY PLAN?

In order to get started, imagine this scenario: you and your health team have decided that in the village of Venka, the following should be achieved during the coming year:

"- 60% of the pregnant women will attend antenatal clinics at least once during their pregnancy;
- daily clinics will be held from 9.00am to 3.00 pm;
- the drugs inventory will be completed and a new supply ordered from the district health officer;
- a staff discussion on child malnutrition in Venka will be held;
- the staff jeep will be serviced at 45 000 km."

In deciding what should be done, you have set *objectives*. Some of these objectives refer to aspects of the population's health-related behaviour, some refer to services that will be made available to the population … still others refer to tasks that will be performed during a particular period." (Adapted from McMahon,1994: 14) Without a process of planning, it would not be possible to achieve this variety of different objectives.

**TASK 1 – What do you understand by *planning*?**

a) Write down your own definition of *planning*.
b) Why would it be impossible to achieve the above objectives without planning?

**FEEDBACK**

a) Here are some explanations of what planning entails:
"… Planning is the art of working out what we want to do and how to do it …" (National Health Planning Unit, Ministry of Health, Ghana, 1991: 9)

"… Planning is a method of trying to ensure that the resources available now and in the future are used in the most efficient way to obtain explicit objectives …" (Green, 1994: 3)

"… Planning is an attempt to answer questions *before* they actually arise, anticipating as many implementation decisions as possible by foreseeing possible problems, and deriving principles and setting rules for solving them …" (McMahon, 1992: 268)

"… Planning is concerned with change and has a variety of means of achieving such change …" (Green, 1994: 4)

"… all planning approaches share one common element – a concern about making decisions relating to the future …" (Green, 1994: 1)

So, in summary, we could say that:

*Planning is: using information*
*from the past and the present*
*to prepare for the future.*

b) The intended objectives for next year in Venka would be very difficult to reach unless they were carefully planned. Some can only be achieved over time e.g. 60% of mothers will attend antenatal care at least once during their pregnancy. This requires a sequence of smaller objectives and activities, such as preparing to make the antenatal care service available and all the related organisational tasks; in addition, awareness of the benefits of antenatal care must also be developed among the village women. On the other hand, servicing the jeep is a simple task but it must be done at a particular time i.e. 45 000km.

No manager can hope to achieve all these levels of objectives and activities, nor to sequence and time them effectively, unless she or he plans well in advance, identifies all the steps and delegates the tasks appropriately. In the above example you can see that in order to prepare for the future and get things done, it is necessary to plan.

## 3.1 Scarce resources – a reason for planning

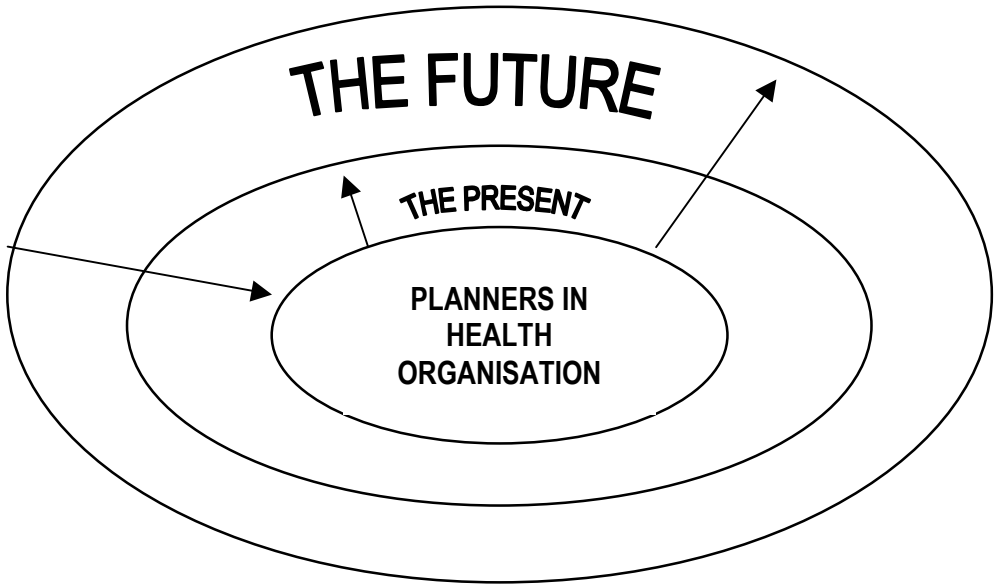
There is however another very important reason underlying the need for careful planning in health care - scarcity of resources.

In the text which follows, Green, a health planner who has worked in a number of countries, discusses this issue and coins the term "allocative planning" to describe the sort of planning which is driven by the allocation of resources. Green points out that this is a difficult and often political process, because in health care, there will never be sufficient resources to meet every level of need.

**TASK 2 – Making a graphic representation of a complex text**

Green presents a complex argument, so use this opportunity to make a graphic of it while you read. Here is a suggestion for the form of your graphic representation:

- Make a circle to represent the planners within the health organisation.
- Surround it with two concentric circles, and label the first circle "the present" and the outer one "the future."
- Make arrows and write down all the constraints which impact on decision-making e.g. resources, legislation. Those from inside the organisation should point outwards, and those from outside should point inwards.




a) What kinds of decisions are required when planning in the context of scarce resources?
b) What does Green say about unmet needs through the comparison of the UK with Bangladesh?
c) What does he say about constraints in relation to planning?
d) What does he say about planning and the future?
e) How would you describe Green's view of planning?

"… **Scarcity and choice – the basis for planning**

"At the individual level it is not difficult to recognize that most of us have wants that outstrip our available income, and that we have to make choices between them which are often difficult. Choices are also needed in organizations …Organizations providing services – such as the health sector – need to consider whether the current mix of services provided should change to meet future requirements, and whether the location and means of provision of services are appropriate. Not all requirements will be able to be met, and decisions as to which are the most important are also needed. Such prioritizing decisions again stem from the scarcity of resources referred to above.

As economists would say, resources are scarce in comparison to the uses to which a society or an organization wishes to put them. This scarcity is not confined to developing countries, but *as a concept* is applicable equally to the more wealthy countries of the world. In the UK, for example, over 550 dollars is currently spent on health care for each citizen each year; yet significant health needs remain unmet, and health professionals argue strongly for more funds. Despite the much higher levels of resources available to the health service in such countries, compared with a country such as Bangladesh, decisions are still necessary as to which needs will be met and which will be left unmet. This is not of course to imply that the decisions are not more acute in such a resource-starved country; but to say that even when resources are more plentiful, prioritizing decisions are still necessary …

Planning involves the making of choices - and so requires the possibility of real alternatives …The range of alternatives available, and hence the degrees of freedom with which an individual or an organization can operate, is therefore crucial to the real importance of planning for that body. This range may be curtailed internally within an organization (by, for example, its constitutional structure, or by professional attitudes) or externally (by, for example, legislative controls). One aspect of planning revolves around the amount by which such constraints can be removed or minimized…

Decisions, then, are needed in the present about actions which will affect the future. For an individual such decisions may be made to some degree subconsciously, and as such may involve less explicit considerations of alternatives. However, for organizations which involve groups of people, each with their own sets of values and interests, a greater degree of transparency is required about such decisions. In this sense planning is inescapable. Real alternative courses of action do exist for organizations and these will affect their futures. As long as choices are there to be made (or created), explicit decision-making would seem inevitable …" (Green, 1994: 4-6)

**FEEDBACK**

a) Green talks of prioritisation being the main focus of decisions when planning in a context of scarcity. In health care, there will always be tough choices to be made.

b) Green asserts that although the levels of need are very different between these two countries, there will still be unmet needs in both countries.

c) He notes that effective planning is the product of how much freedom the planners have to make certain decisions. He cites a range of constraints both inside and outside the health organisation, and suggests that part of the planning process is working out which of these can be minimised.
d) He notes that planning must be undertaken with the recognition that present actions will affect the future.
e) Green speaks fairly convincingly about the need for planning, noting that the making of choices within the context of scarcity of resources, is integral to the planning process. Planners have a complex task to carry out as they prioritise needs, identify alternatives, decide which constraints can be minimised and identify needs which cannot be met in terms of scarce resources. The value of planning for Green is that it is a process of addressing a complex set of decisions, which he argues are inescapable.

The process of allocating resources can be seen at different levels: for example, at national level when decisions are made about how much of the national budget goes to health or education and how much to defence etc; or at project level when deciding how much to spend on certain aspects of the programme e.g. staff salaries or drugs or training. At this level, we usually think of allocative planning as budgeting. We will look at budgeting in Unit 5 Session 1.

Allocative planning does not, however, only concern financial resources: other resources are also allocated according to priority needs, for example, skilled manpower or, as we have seen previously, a manager's time!

Here is a summary of why planning is important in the district context. It brings together issues relating to getting things done in time and allocative planning. Planning is necessary so that:

- "… all stakeholders know what they can expect – it provides some certainty.
- It provides a road map so that everyone knows the direction in which the district is moving.
- It is a process through which difficult decisions about linking resources to needs can be made.
- Planning helps to co-ordinate service rendered both within the district (between different service providers) and between districts (if resources are being shared).
- It helps to determine if the right services are being directed at the right users at the right time at acceptable quality levels and
- It helps the organisation to determine if it fulfilled its objectives and to account for the money that was given to the community or elected councillors. i.e. to improve accountability …" (National Department of Health, South Africa, 1999:7-8)

In this section we have looked at what planning is and why it is important to plan. You will possibly agree that in general, not enough effective planning takes place in health organisations. In the next section we ask why this happens, so that you can anticipate possible reluctance towards planning, both in yourself and in your staff.

# 4 RELUCTANCE TO PLAN

"…Most health managers, when asked why they do not plan, usually put forward the following arguments:

a) they already have a lot of work to do
b) they are always busy and
c) there is no guarantee that districts will get all the resources they need to do what they have laboriously planned for.
d) planning does not really directly result in getting anything done. It takes time and energy; time and energy which could have been spent in carrying out programmes and serving people …" (National Health Planning Unit, Ministry of Health, Ghana. 1991: 7)

**TASK 3 – Finding out why people are reluctant to plan**

Do you agree with any of the above statements about reluctance to plan? Can you give any additional reasons for this kind of reluctance?

**FEEDBACK**

Maybe you feel that planning is a waste of time because it takes a lot of time and often plans just don't work. Such a feeling is to some extent understandable, but one needs to look closely at *why* some plans don't work. There may be problems associated with planning, which cannot be blamed on the actual *process* of planning, but rather on the quality of the plans or the way in which the health system as a whole is conceptualised. These problems are illustrated in the following two extracts:

"…Inadequate planning is a persistent fundamental problem in international development aid. Planning documents are often specific and clear as to the physical and financial inputs, personnel, activities and expected physical results. But thorough assessment of the overall objectives, the target groups and the external factors which determine success or failure is often lacking …[An example might be, the objectives are clear but they do not fit the needs of the community.]

As a result, projects often develop in unintended directions, and fail to respond to the needs of the intended beneficiaries. Projects may have unforeseen negative results which could have been avoided with more systematic planning …" (NORAD, 1992: 5)

Another extract, this one by Green, points to a range of important factors which may lead to the failure of plans, but which do not necessarily mean that the concept of planning is the problem:

"… The record of planning is not very good, with plans often failing to be implemented. The reasons for this are varied but common problems include:

*Fit* of the health system to the needs of the coutnry

- emphasis on health care rather than health
- emphasis by governments on internal services
- planning confined to a small group [with] failure to involve health service managers, professional groups and users
- failure to recognize the political nature of planning [e.g. a new clinic is built in an area mainly housing a particular ethnic group. Other ethnic groups then also demand new clinics.]

problems in the planning

- overly rigid systems of planning (e.g. all plans have to fit into a five year planning period)
- role of center versus local levels is unclear, and frequent overcentralization of planning

problems in implementation and Resources

- inadequate skills [e.g. insufficient skilled manpower to implement the plans]
- concentration on donor projects to the detriment of ongoing services [e.g. A donor wants to focus on malaria only and institutes new activities which absorb a lot of the staff's time so that they have to cut short routine clinic activities.]

problems in the quality of planning

- over-ambitious or non-prioritized plans
- failure to relate planning process to other decision-making processes such as budgeting and human resources [i.e. You can't plan to do things if you don't have the money or the staff needed to get them done.]
- inappropriate information [Planning decisions must be based on accurate information.]
- inadequate attention to and resources for planning.

This should not however be interpreted as a failure of [the] planning [concept], but rather a recognition of the need to develop systems appropriate to the particular health needs and resources of a country …" (Adapted from Green, 1994: 3)

Green's points touch on many different kinds of problems including the *fit* of the health system to the needs of the country, problems in the planning process, problems in implementation and resources, and problems in the quality of planning.

# 5 INTRODUCING THE PLANNING PROCESS

"Sometimes when I see what tremendous consequences come from little things … I am tempted to think … there are no little things" (Bruce Barton in Covey, 1999: 287)

This statement captures an important point about planning – it is a detailed process where you are forced to think of all the *little things,* but one should not underestimate the value of the process.

In this section, we begin to examine the process of planning using a fairly simple case study. This will enable us to clarify the value of planning, and to recognise that even a simple project offers challenges to a thorough planner.

Study the first part of the McMahon et al chapter on planning (Reading 13) in the context of their view of the planning function of management "… to answer questions *before* they actually arise …".

> Reading 13: McMahon, R., Barton, E. & Piot, M. (1992). *On Being in Charge*. Geneva: WHO, pp267-270.

**TASK 4 – Identifying key points in the reading about planning**

a) Why does McMahon place such emphasis on anticipating decisions and problems?
b) Make a diagram which captures the planning questions that must be asked in terms of what McMahon calls the three primary areas of planning: *objectives, activities and resources*.
c) McMahon says that planning requires "analysis, design and quantification". Should the manager perform this function alone? Why or why not?

**FEEDBACK**

a) McMahon et al are concerned that work should be according to a plan because this, in their view, is the only way to reach one's destination effectively and without unnecessary delays.

b) A diagram can be a helpful way of remembering something at a glance or seeing what to consider in taking a decision. There is no wrong or right way to do it – just try to make the way different things relate to each other as clearly as possible. Go back to the article on developing graphic representations in Unit 2 Session 2 for guidance on graphic representations.

c) The process of planning requires sustained decision-making at a detailed level, which can be very tiring for one person alone. Often different members of the team have different parts of the information which is required for the planning process. Involving a number of people will add different ideas. As we noted in the session on teamwork, “none of us is as smart as all of us”. In addition, projects are seldom successful if you do not develop ownership by the team who implement the job as well as the community. Planning is therefore best done as a joint process.

While doing the planning task below, bear in mind that you are making planning decisions around *objectives, activities and resources*. Do the task thoroughly and keep your work for future reference, as we will use it as the context for part of Unit 5.

**TASK 5 - A planning exercise**

You are the chairperson of a community action group in the community of Motown. Over the past several years, probably as a result of the HIV/AIDS epidemic, there has been a significant increase in the number of street children in Motown. Following a recent anthropometric survey, health workers have expressed concern about the nutritional status of these street children. Your group has decided to assist by organising a meal project. A donor has been found who will provide funding for initial capital outlay and running costs for the first year. After the first year, the meal project, if successful, must be sustained through fund raising efforts of the Motown Community Action Group.

Brainstorm everything that the Action Group would need to decide on or plan to get the meal project started. Do this by writing down questions starting with: *what, where, when, who, how, how many, how often and any others you can think of*.

Note: Working with street children is a very complicated issue. They can be a difficult population to reach for many reasons and nutrition is only one element of their needs. We are using this meal project as a relatively simple illustration of a *planning process*

**FEEDBACK**

Your questions may include some of the following:

- Where will the meals be prepared and served? *(This is an activity question).*
- How many children need to be fed? *(This is an objective and resource question).*
- What equipment is needed? *(This is a resource question).*
- How many staff are needed to buy food, cook, serve and clean?
- How many will need to be hired and how many will be volunteers?
- How will transport be provided to go and buy food?
- What kind of food is needed?
- How often will meals be provided?
- How often will food shopping have to be done?
- What kind of administrative aspects and costs will be involved?
- How much will it all cost?
- How will we know whether everything is going according to plan?
- How will we know whether the money is being used in the right ways?
- How will we decide if it is worth carrying on after one year?

Everyone who does this exercise will have a slightly different list of questions. Your questions may even be more detailed. That's good. The important thing is to go through the process of thoroughly thinking through everything that needs to be done and as McMahon says: "… answer … these questions *before* they actually arise … " (McMahon, 1992: 267-268) Detailed thinking at the beginning often makes the difference between success and failure. Keep your list of planning questions for later use.

McMahon also stresses that part of planning is foreseeing possible problems before they arise. This is very important as some problems will require specific action to prevent the plan from failing. The problems may also be of such a nature that the plan itself has to be changed. Either way, a lot of time, work and money can be saved if enough effort goes into thinking carefully and anticipating possible problems.

It would now be useful to decide how serious each problem may be, its likelihood of occurring and what preventive actions can be taken. This is another phase of planning called the *Problem Analysis*. Take a look at Reading 14, in which the author does a problem analysis and presents a framework which can be used to evaluate your plans.

> Reading 14: World Health Organisation. (1993). *Training Manual on Management of Human Resources for Health.* Section 1 Part B. Geneva: WHO, pp3-6.

Based on the reading, the essential problem-analysis questions to be asked are:

a) What problems may occur?
b) How serious would it be if they occurred?
c) What could cause these problems?
d) What is the probability of each one occurring?
e) Which possible problems should be your first priority?
f) What preventive action can be taken?

The problem analysis opens another important angle of the planning process. Looking at the list of possible problems, we can say that the extent to which a project is going to succeed or fail depends upon both *internal* factors, which can be controlled by the project management, and *external* factors, which are beyond the control of the management team. Look back at the diagram you made in Task 2 where you mapped internal and external factors which could impact on planning.

Since external factors may be critical to the success of a plan, it is *extremely* important that these factors are identified, monitored and analysed. The manager needs to decide how best to address needs and achieve objectives in the presence of external factors. This may require some manoeuvring or working out. We will examine external factors in more detail in the next section.

# 6 EXTERNAL FACTORS

External factors include unforeseen events such as heavy rains which disrupt activities, a drug supplier who fails to deliver a promised shipment on time, an accident involving a project vehicle or an unexpected decrease in funding. However, probably the most significant external factors are those which involve *human factors* of power and interest i.e. politics. To address external factors, we will discuss undertaking a political and a stakeholder analysis. When seeking to identify external factors, it is useful to look at planning as a political process.

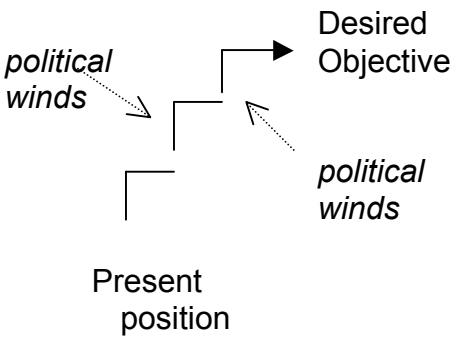
Political analysis

Green makes this point in the extracts following. As you read this text, make a mind-map capturing political factors which influence planning e.g. the structure of the organisation, the aims of the organisation etc. Also, as you read, think back to what you learned about differing goals and values in Unit 2 Session 1.

> "… how planning is carried out within any organization will reflect a variety of factors. These include organizational structure, the stated or constituted aims of the organization, the relative power of different groups within the organization and their own aims, the political or ideological climate of the country, and the relationship between the organization and its users or consumers. Many examples of planning failure can be traced to a very narrow notion of planning as the application, by a small group of technocrats [people who solve problems using technology], seemingly oblivious to these broader factors, of apparently rational planning procedures. Planning involves change; and each change has its opponents as well as it proponents [or those who speak for it]. Which changes (if any) occur will depend to a large extent on the relative power of those with different values and attitudes to those endorsing the proposed change. The art of successful planning must therefore involve analysis of power structures, alongside its more apparently objective technical aspects.
>
> An example may clarify this. A health service may have as its stated aim the improvement of the health status of the country. A technocratic planner may look at this aim, look at the limited resources available, recognize that the greatest improvements to health status would be made by preventive services, and suggest a plan to close a number of hospital beds, diverting the resources thereby released to health centers, dispensaries and preventive services. Such an approach may be apparently rational to the planner, but is unlikely to be achievable. Resistance to such closures is bound to be met from hospital workers, from doctors to auxiliaries. In such a situation, the objectives of such groups clash with that of the overall organization either in terms of their interpretation of health status or their own objectives of career advancement and professional protection and employment. Resistance may also be met from community members who perceive the hospital as

the main form of health care. Whether the apparently 'rational' plan is actually so rational, and indeed whether it is implementable, hinges on whose values or objectives one is concerned with, and where the power lies, both within and outside an organization. The last point then to be made … is that planning is very much concerned with the analysis of power structures and values alongside its use of certain more apparently objective techniques …" (Green, 1994: 19-20)

"… [A] planner should take account of such political forces and adapt their plans accordingly. This can perhaps be compared to wind-powered sailing. The sailor who takes no account of prevailing winds and attempts to steer a straight-line course will soon capsize. The successful sailor is rarely sailing *directly* towards the desired destination, but rather recognizes the direction of the wind and tacks in a series of steps towards the desired destination …" (Green, 1994: 27)




Stakeholder analysis

Green talks about the importance of "political forces". Understanding and working with the influences of the different people and groups who could have an interest in and influence on the project, is a crucial part of planning. These interested parties are the "stakeholders" and getting to know them is called a "stakeholder analysis".

The International Rescue Committee (IRC), an American non-governmental organisation, outlines the process of stakeholder analysis as follows:

"… Describe the key stakeholders and your basic analysis of whether or not they will want to project to succeed … Then where appropriate, describe the activities you have designed in your project that work to improve their level of support. Stakeholders may include local suppliers, ethnic groups, gender groups, local staff, host communities, local and regional politicians, etc. Completing this exercise will help you to answer important project evaluation questions, e.g. who is being unintentionally affected both in the negative and in the positive by the project? … To accurately identify the negative and the positive unintended consequences of the project, it is a useful exercise to try and predict who they might be at each step of the pathway ..." (IRC, 2000: 7)

Reading 15: "Case studies on sanitation and hygiene in Cameroon and Tanzania", *MSc Course Notes* (1998). London School of Hygiene and Tropical Medicine, p1.

**TASK 7 – The importance of stakeholder analysis**

a) Read the Cameroon/Tanzania case studies and answer the questions: Why did the programme succeed in Ukerewe and why did it fail in Kumba? Can you identify an error in the planning procedure?

b) Think of an aspect of your work where there are several parties involved. Write down what their interests could be and how it could impact on the work.

**FEEDBACK**

a) In Ukerewe, the problem was presented to the community in such a way that community members were able to relate to it and see it as impacting on them as individuals. They took the initiative for improving their own lives.

In Kumba, the information was presented in more general terms, so perhaps it would be easier for people to think that the problem was not actually affecting them and that they did not need to take responsibility for it. Also, the village health committees appear to have made the decision to construct latrines and imposed the idea on the community without first consulting with them.

It is probably becoming clear to you that planning is a very detailed and labour-intensive process. Some people tend to avoid it, but in doing so, they risk the success of the project.

"Failing to plan means you are planning to fail" – Shaun Turner

# 7 SESSION SUMMARY

In this session, we looked at the meaning of planning, the reasons behind planning and at why people are sometimes reluctant to plan. We examined important issues underlying the planning process, namely scarcity of resources and external factors, particularly political influences. We also started the process of planning a project and conducted a problem analysis in order to get into more detail within the plans. In the next session, we will study some terms and concepts commonly used in planning and also look at a model for planning called the planning cycle.

# Unit 4 – Session 3
# The Planning Cycle

## Introduction

There are many different methods of planning. In addition, many definitions and different shades of meaning are given to planning concepts by donors, government departments and in the literature. None of these is *right* or *wrong*, but the variety does get confusing at times.

During this session we will look at some different terminology used in planning, and then explore the planning process in relation to project planning, using a model called the *planning cycle*. We will explore the first two stages of the planning cycle in detail in this session, and the next two in the sessions which follow.

## Session contents



## Timing of this session

There are four readings and one task in this session. Two of the readings will provide revision of some of the processes in earlier sessions. It should take you about two hours. A logical point for a break would be after section 4.2.

# 1 LEARNING OUTCOMES OF THIS SESSION

| **Intended learning outcomes**<br>By the end of this session, you should be able to: | |
|---|---|
| **Management outcomes:**<br><br>▪ Understand key terms related to project planning.<br>▪ Describe the planning cycle, and apply it to familiar contexts.<br>▪ Discuss the process of doing a situational analysis and a district profile.<br>▪ Develop SMART objectives. | **Academic outcomes:**<br><br>▪ Apply concepts to familiar contexts.<br>▪ Analyse a reading.<br>▪ Make a mind-map of key information in a text.<br>▪ Critically assess objectives statements using a set of criteria. |

# 2 READINGS AND REFERENCES

The readings for this session are listed below. You will be directed to reading them in the course of the session.

| **Reading** | **Publication details** | **Page numbers** |
|---|---|---|
| 16 | Adonisi, M. & Kahn, S. (1998). Ch 6 -"Project Management for Health District Managers". *Handbook for District Managers.* South Africa: Department of Health. | pp50-53 |
| 17 | Heywood, A., Campbell, B. & Awunyo-Akaba. (1994). *Using Information for Action: A Training Manual for District Health Workers.* The Netherlands: Royal Tropical Institute. | pp12-15 |
| 18 | McMahon, R., Barton, E. & Piot, M. (1992). *On Being in Charge.* Geneva: WHO. | pp272-288 |
| 19 | McMahon, R., Barton, E. & Piot, M. (1992). *On Being in Charge.* Geneva: WHO. | pp289-298 |
| **References** | **Publication details** | **Page numbers are in the text** |
| | Monekosso, G.L. (1994). *District Health Management: Planning, implementation and monitoring a minimum health for all. From mediocrity to excellence in health care.* WHO Regional Office for Africa. | |

## 3 PROJECT PLANNING

The concept, *project* refers to "… a short term, temporary set of activities undertaken to achieve a particular purpose …" ( Adonisi & Kahn, 1998: 50).

You may not think of your job in terms of a *project*. However, Adonisi & Kahn, suggest that a job can be seen as a project or a *collection of projects.* Read their explanation and consider whether it might be useful to see your job in this way.

> Reading 16: Adonisi, M. & Kahn, S. (1998). Ch 6 - "Project Management for Health District Managers", *Handbook for District Managers.* South Africa: Department of Health, pp 50-53.

One of the useful things about looking at work as a collection of projects is that it helps to break the work down into smaller *chunks* which can make both planning and management easier. For the remainder of this unit, we are going to describe planning in relation to projects rather than, for example, comprehensive district management. We do this because using the project model helps to simplify the concepts of the planning process. However, the same principles (i.e. a logical, step-by-step approach) would apply to any planning process, on a larger or smaller scale.

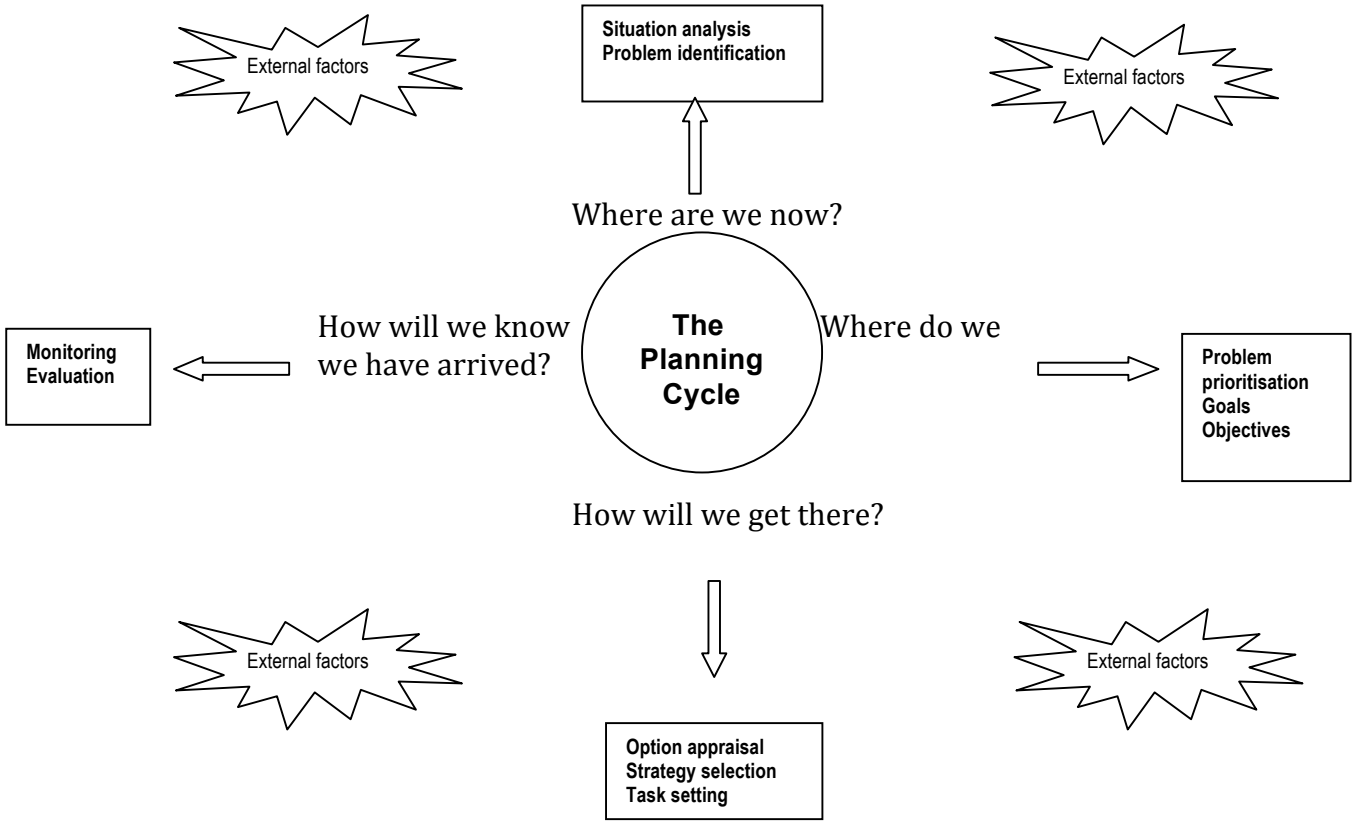
If you are a district manager, your job may consist of seeing that a number of different *projects* are implemented *under one umbrella*. Thus, a very important role for you would be that of co-ordinator: ensuring that all the different projects fit together in such a way that resources are used with maximum efficiency and to maximum benefit of the people in the district.

## 4 THE PLANNING CYCLE

A useful strategy for planning is to ask four basic questions:

a. Where are we now?
b. Where do we want to go?
c. How will we get there?
d. How will we know we have arrived there?

Most discussions of the planning process address these four questions, which are often represented as a circle or spiral called the *planning cycle*. The diagram on the next page shows the planning cycle. We are going to work our way through the four stages in turn, starting with the question *Where are we now?* Some planning cycles add more detail in between the main questions, but the basic idea remains the same. Note the presence of external factors at all stages of the cycle.




Each of the questions in the planning cycle implies a process and some decision-making. Here is a table which shows some of the common processes we go through to answer these key planning questions.

| Planning question | Planning process |
|---|---|
| a. Where are we now? | Analysing the situation; identifying the problems or needs. |
| b. Where do we want to go? | Prioritising problems; setting goals, objectives and targets; deciding on the indicators of success. |
| c. How will we get there? | Assessing strategy options; selecting strategies; setting activities or tasks and identifying their outputs (the things that will have been achieved); identifying the inputs necessary to achieve the outputs. |
| d. How will we know we have arrived? | Monitoring and evaluating outputs and effects, using the indicators selected during the 2nd stage. |

Don't worry if you don't fully understand all the elements of this table at this stage. All the terms will be explained as we go along. As you work through the unit, try referring back to the table at intervals. You may also find it useful to refer to the glossary of terms at the end of this session.

## 4.1 How do projects come about?

A project is usually based on a particular problem or need that is to be dealt with. The planners formulate goals which aim to address needs.

In the national health system, policies and goals for the health system are usually established at national level. They are transmitted to other levels of the health system (region and district) as objectives to be worked towards. The job of the district team would then be to plan how to achieve the objectives through the implementation of activities, using the resources at their disposal. Depending on the size and diversity of the goals, one might see them as the focus of one or more projects. In non-governmental projects or even in district health departments, time-based, donor-funded project goals and objectives might be identified.

We are going to explain the terms *goal, objective, activity* and *resource* as we proceed through the unit, but you may find it useful at this point to get an idea by referring to the glossary.

Before goals can be formulated, we first need to know what the problems or needs are and then decide which ones are going to be addressed. We therefore start with the first question of the planning cycle.

## 4.2 Where are we now?

To make decisions about which health needs to address, we have to start from where we are now. The first step is to have enough information to help us understand the situation as fully as possible and to identify the most important problems. We therefore conduct a *situational analysis*. This is also called a *needs assessment* or *gathering baseline information*. One type of situational analysis is the development of a *district profile*. You have already developed the skills of conducting a situational analysis in the *Measuring Health and Disease I* module.

To refresh your memory, go through the short article in Reading 17, which provides some guidance for developing a district profile.

> Reading 17: Heywood, A., Campbell, B. & Awunyo-Akaba. (1994). U*sing Information for Action: A Training Manual for District Health Workers.* The Netherlands: Royal Tropical Institute, pp12-15.

Think through some of the information that you would need to gather for a situational analysis relevant to the meal project in Motown: it might include information such as estimates of the number of street children in the community, places where they are known to gather and other organisations who are working with street children in the area.

In health care, there are many needs and there will always be more needs than resources. So how do you decide which needs to address? In other words, which problem do you prioritise?

McMahon et al discuss “Looking at the situation” and “Recognizing problems” in Reading 18: this reading provides guidance and tools for conducting a situational analysis. Work through it to refresh your memory on some of the sources of information, processes for collecting information and issues that would help you to prioritise needs.

> Reading 18: McMahon, R., Barton, E. & Piot, M. (1992). *On Being in Charge.* Geneva: WHO, pp272-288.

After conducting the situational analysis, identifying the needs and deciding on the priority needs, we should have a good idea of where we are now. So, we are ready to move on to the next question in the planning cycle.

### 4.3 Where do we want to go?

This stage involves setting goals, objectives and targets, and deciding on indicators which will tell us to what extent we are making progress.

The goal is a broad statement which provides the overall direction in which the project should be moving. It is the endpoint at which the project is aimed - that ultimate *happening* to which the project will contribute if the project objectives are achieved. In the health sector, the goal is often expressed as an improvement in some aspect of the health status of a population, for example, the goal of a particular MCH project is a decrease in the maternal mortality rate in a particular population.

Objectives tell us exactly what the project aims to achieve. They are the *mini-goals* or the steps towards the goal of a project. As Monekosso suggests, these objectives give “specific direction” (1994: 40) to a project, whereas the goal gives *general* direction. The achievement of the objectives contributes to the realisation of the goal.

It is very important that objectives are carefully decided. However, before we move on to evaluating objectives, a third concept must be defined: *targets*. Targets are “short-term objectives [which] may be achieved by a specific date as a step towards a long-term objective and are called ‘operational targets’.” (Monekosso, 1994: 40)

To summarise so far, reaching a target is a step towards reaching an objective: reaching an objective is a step towards reaching the overall goal.

Writing clear, precise objectives is an important part of planning. The more detailed processes of planning your strategies, activities, resources and budgets flow from this step.

According to McMahon, any planning objective should specify five things:

"- what is to be done
- how much is to be done
- where it is to be done
- when it is to be completed
- the standard by which it will be possible to tell whether, or the extent to which it has been achieved." (McMahon, 1992: 14)

A helpful way to check the clarity of your objectives is to assess whether they are "SMART" i.e.

**S**pecific: Must describe exactly what you want to achieve, with which target group, in which place.
**M**easurable: Must have a component that can be accurately measured, preferably without costing too much in time, money and effort.
**A**ttainable: Must be realistically achievable within the circumstances, budget and time frame. It is better at first to be cautious rather than too ambitious. A process which is essential to planning is setting objectives in relation to the overall goal which is to be accomplished.
**R**elevant: Must clearly contribute to achieving the goal.
**T**ime-bound: Must be achieved within a certain time-period.

**TASK 1 – Practise setting effective planning objectives**

a) Here is one of the planning objectives for a village-based project for which the overall goal is: "To improve the health of woman of reproductive age in Venka".
Assess the following objective in terms of McMahon's criteria:
"Next year in the village of Venka:
- 60% of the pregnant women will attend antenatal clinic at least once during their pregnancy.
Now assess whether it is SMART.

b) Write five management objectives for your health unit for the next six months. Evaluate them in terms of McMahon's guidelines and the SMART specifications.

c) Develop a goal and objectives for the Motown Meal Project. Evaluate whether the objectives are SMART.

**FEEDBACK**

a & b) The objective seems to specify *what*, *how much*, *where* and *when*. It does not mention *to what standard the objective will be met*. What you may not be conscious of is that each of these questions requires some planning decisions to be made. In addition, how the objectives will be reached also requires decision-making. Making all these decisions is the planning function of management.

In terms of whether the objective for the Venka project is SMART, my view is that it is *Specific*: it targets pregnant women and says exactly what it expects to happen; it is *Measurable*, although depending on the size of the village, it could be fairly labour intensive and costly to conduct a follow-up survey. Whether it is *Attainable* is difficult for us to assess. We do not know the size of the population, or their willingness to attend antenatal clinics. Perhaps 60% is ambitious. The planner will however need to ascertain this. The objective is definitely *Relevant* to the overall goal; the objective is *Time-bound* as it is expected to be reached over one year. This hopefully gives you a basis for evaluating your objectives for your project and for the meal project.

c) Here is the goal and objectives for the meal project, but yours obviously need not be exactly the same.

Goal:
- To improve the nutritional status of street children in Motown.

Objectives:
- To achieve attendance of 50 street children at the Motown feeding centre three days per week for one year.
- To have food ready for 50 street children three times a week for one year.
- To repair the cupboards and repaint the community centre kitchen by the end of the first project month.
- To purchase and install kitchen equipment by the end of the first project month.

(Note: In practice, we couldn't serve meals before the end of the first project month, as we would need to allow time to prepare the kitchen and purchase and install the equipment. However, for the sake of simplicity in this exercise, we are using a period of 12 months for all the objectives.)

Developing planning objectives is part of a particular approach to management called *Management by objectives*. Setting objectives sets in motion the processes of making other decisions including the methods you will use, who will do what and by when they will do it, what resources will be needed and when one can say that the objectives have been achieved. In other words "… a clear statement of objectives is essential for effectiveness." (McMahon, 1992: 115)

McMahon's text in Reading 19 on "Setting objectives" adds further detail to the process of setting measurable targets and recognising that objectives can be set at different levels of the health system. It provides a broader view of analysing obstacles, which is part of reviewing external factors. Read this text to contextualise your view of the process of setting objectives in the health system.

Reading 19: McMahon R., Barton E. & Piot M. (1992). *On Being in Charge.* Geneva: WHO, pp289-298.

Once the objectives of a project have been determined, it is possible to develop the indicators, or identify what visible evidence will show that the target has been reached. The value of indicators is however usually associated with the process of monitoring and evaluating a project: we will therefore deal with it at a later stage of the project planning process.

## 5 SESSION SUMMARY

Thus far we have introduced the project cycle and dealt with the first two questions – *Where are we now?* and W*here are we going?* We revised the concepts of situational analysis and prioritisation of needs. We have also defined the terms *goal*, *objective* and *target* and identified two sets of criteria for evaluating objectives.

In the next session, we will explore the third question *How will we get there?* We will also study a project planning tool called the Causal Pathway, developed by the International Rescue Committee.

## 6 GLOSSARY

**Activities:**

Activities are the technical and support tasks required to produce the outputs (which are needed to meet the objectives.) They constitute the practical implementation of the project. "Actions undertaken or work performed within a project in order to transform inputs … into outputs …" (NORAD, 1992: 107) e.g. the process of constructing a clinic; the process of ordering and delivering drugs

**Causal Pathway:**

A causal pathway is short "flow chart" of the entire project. It consists of five components:
Inputs → Activities → Outputs → Effects → Impact

**Effects:**

Effects are changes in a population's knowledge, attitudes, skills and/or behaviour that will contribute to the desired impact. (IRC, 2000:12)

**Goals:**

The goal is a broad statement which provides the overall direction in which the project should be moving. It the endpoint at which the project is aimed: that ultimate "happening" to which the project will contribute if the project objectives are achieved. In the health sector, the goal is often expressed as an improvement in some aspect of the health status of a population. e.g. particular population

**Impact:**

The impact describes to what extent the goal has been achieved. e.g. The impact of the nutrition project was that the prevalence of malnutrition fell from 20% to 10% in the under five population.

**Indicators:**

"An indicator measures changes caused by the project … Good indicators are measures that are consistent from one time to the next, (from one data collector to the next) and from one place to the next … Indicators are used to measure project outputs, effects and impact …" (IRC, 2000: 13)

**Output indicators:**

Output indicators "measure changes in products/services/systems provided" e.g. number of clinics constructed

**Effect indicators:**

Effect indicators "measure changes in knowledge, attitudes, skills, intentions and behaviors of the population of interest" (IRC, 2000:13) e.g. antenatal clinic attendance figures (routine data); % of women attending antenatal clinic (survey).

**Impact indicators:**

Impact indicators "measure changes in the health, social or economic status of the population of interest" (IRC, 2000:13) e.g. mortality rates; prevalence of malnutrition.

**Inputs:**

Inputs are the resources needed for the activities to be carried out e.g. funds, staff, materials.

**Monitoring:**

"Monitoring is the regular collection and use of information (usually from project records)" or routine data. (IRC, 2000:12)

**Objectives:**

Objectives tell us exactly what the project aims to achieve. The achievement of the objectives contributes to the realization of the goal.

**Outputs:**

Outputs are the things that the project itself puts into place and are not dependent on changes in the knowledge, attitudes or behaviour of the target population. e.g. a clinic has been built; drugs have been provided.

"…All products/services/systems that must be in place for the effects and impact changes to occur…" (IRC, 2000:12)

**Targets:**

Targets may also be called "operational targets" or "performance targets". They are steps along the way to achieving objectives. They represent amounts of output and/or effect to be achieved within a specific time period e.g. If one of the outputs to be achieved by the end of a one year project is to build 10 clinics, we could say that the 6 month target is to have completed 5 clinics and the one year target is to have completed 10 clinics.

# Unit 4 – Session 4
# Planning a Project

## Introduction

Thus far, we have explored two questions or stages in the planning cycle, *Where are we now?* and *Where do we want to go?* In this session, we will be answering the third question of the planning cycle *How will we get there?* We will do so through learning to use a project planning approach and tool or template developed by an international health organisation.

## Session Contents



## Timing of this session

This is a very practical session and you will need to engage with the tasks in order to gain the skill of project planning using this approach. There are two short tasks and one long one. It could take you up to two hours: take a break just before you start Task 3, but try to do the whole session on one day, so that you can apply the new concepts immediately.

## 1 LEARNING OUTCOMES OF THIS SESSION

| **Intended learning outcomes**<br>By the end of this session, you should be able to: | |
|---|---|
| **Management outcomes:**<br><br>▪ Use a set of planning concepts.<br>▪ Plan a project using the Causal Pathway approach. | **Academic outcomes:**<br><br>▪ Analyse a text using a graphic representation.<br>▪ Use a planning tool.<br>▪ Develop a flow chart.<br>▪ Write *causal statements*. |

# 2 READINGS AND REFERENCES

The readings for this session are listed below. You will be directed to reading them in the course of the session.

| **Reading** | **Publication details** | **Page numbers** |
|---|---|---|
| 20 | McMahon, R., Barton, E. & Piot, M. (1992). *On Being in Charge.* Geneva: WHO. | pp299-315 |
| **References** | **Publication details** | **The page numbers are in the text.** |
| | Green, A. (1994) *An Introduction to Health Planning in Developing Countries.* Oxford University Press. | |
| | International Rescue Committee (IRC). (2000). *IRC's Proposal Guidelines based on the Causal Pathway*. Draft 10/12/00. New York: IRC. | |
| | Norwegian Agency for Development Cooperation (NORAD). (1992). *The Logical Framework Approach.* NORAD. | |

# 3 ANSWERING THE QUESTION - *HOW WILL WE GET THERE?*

The third stage of the project cycle is the strategy and action or *implementation stage.* By this point, the team would have decided which of the problems identified in the situational analysis can and should be addressed within the organisation. This is the process of prioritising. The team would already have set the goal and developed the objectives.

The next step is to decide on the particular course of action (the strategy) to be used to achieve the objectives. We will look at different strategy options. This is called an *option appraisal*. We then select the one we think is best (*strategy selection*), and work out the practical details of implementing the strategy. This step is called *task setting*.

## 3.1 Exploring implementation options

Implementation is the *doing* part of the planning cycle. It involves the carrying out the plan through completing the set tasks. Sometimes however, things do not all go as planned. Green describes some causes of poor implementation in the health sector:

- "… changes in priorities or policies from those originally agreed;
- a resistance to the changes inherent in the plan, either from within the health service or from outside;

- a lack of the necessary resources which are required to implement the plan, whether these missing resources are financial or real (such as trained staff);
- imprecisely specified details of the project or programme to be executed; and
- a lack of the appropriate organizational structure or the appropriate managerial skills necessary …" (Green, 1994: 271)

One of the ways for reducing the possibility of poor implementation is careful strategy selection. To decide on a strategy for implementation, McMahon suggests that the planning team should *test out* the different implementation options or courses of action, and the resources they would require.

> Reading 20: McMahon, R., Barton, E. & Piot, M. (1992). *On Being in Charge.* Geneva: WHO, pp299-315.

A strategy is a particular course of action. For example, if your objective is to increase HIV awareness amongst teenagers, you could consider one or more of the following strategies for awareness raising:

- Radio and television programmes
- Posters
- Booklets available in schools
- Discussion sessions in schools
- Youth clubs
- Drama presentations

Each of these strategies would have its own particular group of tasks, some of which will be more feasible in terms of resources and practicalities than others, so you would have to decide which strategy or strategies are going to be the most realistic.

## 3.2 Making detailed planning decisions

Once the planning and implementation team is clear on the best strategy, they need to specify details of the project precisely, in terms of tasks and resources. For many planning teams, implementation planning is often a relatively intuitive process, based on experience, because they already have a track record within the field. They are not necessarily inventing strategies, but rather making conscious decisions about the detailed way in which the project will be implemented.

Writing a project description at this point (which could also serve as part of a project proposal) is a useful way to concretise the many decisions that must be made. In many organisations, this is the point when the planning team would need to get together and go through all the details of implementation, human and physical resource allocation, task planning and budgeting. To assist in this process, they would use a planning tool like the project planning and monitoring template that we shall introduce to you.

This project planning process and template, which is called the Causal Pathway, follows the planning cycle, but specifies particular information which must be identified during the planning process. It was developed by the International Rescue Committee (IRC), a USA-based non-governmental organisation assisting refugee and war-affected populations world wide.

Different donor agencies, organisations, government departments and management trainers have developed a variety of approaches and templates for this strategic planning process. They include log-frame methods, ZOPP and many others. The donors or departments also often specify which tools must be used, and expect service providers to use their particular choice of terminology to describe the same key elements. For example, the European Union calls the objective the “project purpose” while USAID calls it a “strategic goal’’.

The key to project planning is clarity, detail and rigour (or follow-through). The templates that we use have been developed in order to help us to be clear, detailed and rigorous: this is why it is important to have a good understanding of the categories of information that we are required to put down e.g. outputs.

These planning tools have been developed to strengthen the rigour of planning, making sure that the multiple factors which affect projects are addressed, but also providing a basis for monitoring and evaluation. We have selected the Causal Pathway approach because, although it demands a lot in terms of planning, it seems to be an effective tool in the field.

# 4 THE CAUSAL PATHWAY APPROACH TO PLANNING

You may find the Causal Pathway approach a little confusing at first and you may have to learn some new terms and concepts. However, once you are familiar with it, you will see that it is really not difficult and can be a very useful tool to help you in the planning and management process. This method of planning is useful in that it starts with the end-point, the goal (or stated slightly differently*, the impact*) and works backwards, identifying key information for implementation and ending with a budget. It clarifies all the steps of action and the resources needed and helps the manager and the implementation team to have both an overall view of the project as well as a close–up view of the details. It is particularly useful for monitoring progress, as there are clear indicators for the steps along the way.

## 4.1 What is a Causal Pathway?

A Causal Pathway is short flow chart of the entire project. The Causal Pathway planning approach follows on the first and second stages of the planning cycle. In other words, a situational analysis has been completed, a priority problem has been identified, and a goal and a set of objectives have been specified.

Based on an intended goal, the Causal Pathway describes a

"… set of inputs and activities
which will result in … products and services [outputs],
which will facilitate changes in knowledge, attitude or practice by the population [effects],
which will contribute to the desired impact …" (Adapted from IRC, 2000: 10)

The definition above includes five important concepts which are used in a specific way: they are *inputs*, *activities*, *outputs*, *effects* and *impact*. The concepts are used very specifically, and the value of this is to assist the planner (and the donor) in planning thoroughly and monitoring effectively. This is what the flow chart looks like:

**Inputs → Activities → Outputs → Effects → Impact**

This is simply a slightly different way of looking at the following:

**Resources → Activities → Objectives → Goal**

At this point it is important to clarify the meaning of these terms and to understand the relationship between "Goal" and "Impact" and between "Objective", "Effect" and "Output". Here are explanations of how the terms will be used.

| | |
|---|---|
| Goal | The goal is a broad statement which provides the overall direction in which the project should be moving. It the endpoint at which the project is aimed e.g. The goal of a nutrition project is to decrease the prevalence of malnutrition in the under-five population. |
| Objective | Objectives tell us exactly what the project aims to achieve. The achievement of the objectives contributes to the realisation of the goal. |
| Output | Outputs are "… all products, services, systems that must be in place for the effects and impact changes to occur …" (IRC, 2000: 12) Outputs are the things that the project itself puts into place and are not dependent on changes in the knowledge, attitudes or behaviour of the target population. |
| Effect | Effects are "… changes in a population's knowledge, attitudes, skills and/or behaviour that will contribute to the desired impact …" (IRC, 2000: 12) |
| Impact | The impact describes to what extent the goal has been achieved e.g. The impact of a nutrition project was that the prevalence of malnutrition fell from 20% to 10% in the under five population. |

Clarifying the differences between goals and objectives, and impact, effect and output is important. The goal and objectives describe what is intended to happen, although, as we have said, the goal is broad while the objectives are more specific.

The impacts and effects describe what actually happened or changed i.e. the achievement of the objectives leads to the outputs and effects. Effects are however the changes in the target population e.g. new skills or behaviours, while the impact is a change in the phenomenon or situation e.g. malnutrition levels in a population.

In this planning model, objectives are used to express intentions at three different levels - *effect* level objectives, *output* level objectives and *impact* level objectives. We will focus on the first two levels. The difference is that effects are changes in the target population's attitudes or knowledge, while outputs are the products which the organisation produces to achieve these effects or changes in people. So we can develop objectives for both the outputs and the desired effects.

**Objectives → Objectives → Goal**
(output level) (effect level)

**Inputs → Activities → Outputs → Effects → Impact**

Here are two examples to illustrate the use of effect level and output level objectives:

| | |
|---|---|
| Effect level objective: | To increase Antenatal Care clinic attendance by women in district X by 50% after one year. |
| Effect: | Antenatal Care clinic attendance in district X has increased by Y% after one year. |
| Output level objective: | To complete the construction of 2 new clinics after one year. |
| Output: | The construction of two new clinics is completed after one year. |

Here are two more terms which are important to this model:

| | |
|---|---|
| Activity | Activities are the technical and support tasks required to produce the outputs. They constitute the practical implementation of the project. "Actions undertaken or work performed within a project in order to transform inputs … into outputs …" (NORAD, 1992: 107) e.g. all the tasks involved in constructing a clinic. |
| Inputs | Inputs are the resources needed for the activities to be carried out. e.g. funding, staff, materials. |

**Task 1 – Understanding the Causal Pathway terminology**

In a survey conducted by the IRC, they identified that the community of a refugee village was suffering from illness and deaths from water-borne diseases. They came up with this goal statement:

> ''The staff, funds and community support will be used to build water sources and latrines and to provide public health education. As a result, the population will maintain and utilize latrines and clean water sources, which will contribute to … lower mortality and morbidity from water-borne diseases '' (Adapted from IRC, 2000: 10)

From this statement develop a brief outline of the inputs, activities, outputs, effects and impact.

**FEEDBACK**

| | |
|---|---|
| Inputs: | Staff, funds, community support. |
| Activities: | Construction process for water sources and latrines.<br>Public health education activities e.g. making posters, talking to community groups. |
| Outputs: | Latrines and water sources constructed. Posters up in village; various community groups reached. |
| Effects: | Population maintain and utilise latrines and clean water sources. |
| Impact: | Lower mortality and morbidity from water-borne diseases. |

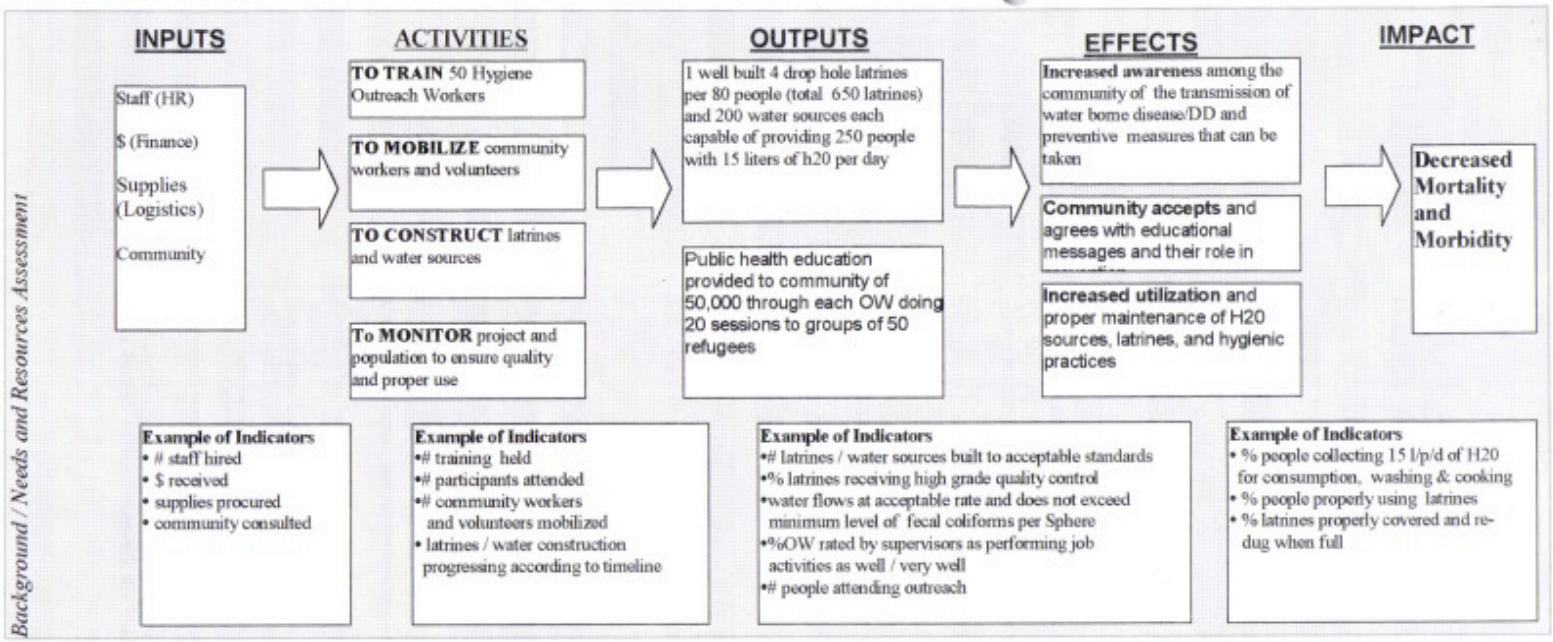
## 5.2 The process of planning using the Causal Pathway

On the next page is an example of the Causal Pathway diagram which was developed for the above project. Spend a little time locating each of the planning concepts above on the diagram.

### 5.2.1 The Causal Hypothesis

There is a concept on the diagram which may not be clear to you: you will find it in the box below the main diagram. We called it the goal statement, but in this approach it is called a "Causal Hypothesis". It states: "The IRC staff, funds and community support (input) will be used to build water sources and latrines and to provide public health education (activities and outputs). As a result, the population will maintain and utlilize latrines and clean water sources (effect), which will contribute to their lower mortality and morbidity from water-borne diseases (impact)." (IRC, 2000: 10) This statement is the generator of the whole plan, and the starting point for the planning team. Concentrate on this box for a moment.

## CAUSAL PATHWAY




**Causal Hypothesis** – IRC staff, funds and community support **(input)** will be used to build water sources and latrines and to provide public health education.**(activities and outputs)** As a result, the population will maintain and utilize latrines and clean water sources **(effect)**, which combined will contribute to their lower mortality and morbidity from water borne diseases **(impact).**

**S.M.A.R.T Objectives:** *Output* To provide 650 latrines (1 well built 4 drophole latrine per 80 people) and 200 water sources capable of providing 250 people with 15 liters of h20 per day by X date
*Output* To train 56 Hygiene outreach workers (14 per camp) to provide 50,000 people (12,500 per camp) 20 sessions (groups of 50) in latrine maintenance instruction and health education by X date
*Effect* To ensure that 95% of this population show proper use and maintenance of the latrines and water sources by X date
*Impact* % decrease in mortality and morbidity rates from water borne diseases by X date.

*Assumptions: a) Other organizations are addressing health issues through health clinics / medical campaigns – IRC responsible for Wat/San b)Project works in 4 camps each of 12,500 people c) No water sources and latrines currently exist in the camps d) Previous research, as well as a needs and resource assessment identified that lack of latrines and adequate water sources are a main contributor to disease e) All values follow sphere minimum standards

## PROPOSAL DESIGN

Budget | Project Management & Organization | Document and Disseminate Plan | M&E Plan | Activities and Outputs | Objectives | Beneficiaries | Program Strategy | Causal Hypothesis | Assessment of Unmet Needs and Resources | Problem Assessment | Background

### 5.2.2 Developing Objectives

Once the goal has been turned into a Causal Hypothesis statement, the planners must identify the S.M.A.R.T. objectives which flow from it. Remember that objectives are the steps towards the goal. They tell us exactly what the project aims to achieve. The achievement of the objectives contributes to the realisation of the goal. You will notice that there are three sets of objectives described in the same box: output objectives, effect objectives and impact objectives.

This is because the process of analysing what kind of outputs must we produce, what kind of effects we plan to achieve and what sort of impact should be evident, helps us to think through the plan in great detail and with more focus, and to identify the hard evidence which will prove that we have succeeded.

The reason for this level of detail is that donors and governments want a system which demonstrates accountability and effectiveness in order to ensure that resources are well used. Communities probably want this too. So a planning model has been developed to measure the outputs, effects and impact.

To develop your objectives, ask yourself: "To fulfil the Causal Hypothesis, what effects must we aim to achieve?" This results in the effect level objectives which are: "To ensure that 95% of the population show proper use and maintenance of the latrines and water sources by a particular date."

The next step is to ask yourself, "In order to achieve the effect level objectives, what outputs must we aim to achieve?" The answer provides the output level objectives which are: "To provide 650 latrines and 200 water sources capable of providing 250 people with 15 litres of h20 per day by a specific date."

### 5.2.3 Developing indicators

In order to measure whether objectives are being achieved, a set of indicators is developed at each stage.

An indicator "… measures changes caused by the project … Good indicators are measures that are consistent from one time to the next, (from one data collector to the next) and from one place to the next … Indicators are used to measure project outputs, effects and impact …" (IRC, 2000: 13) Indicators are usually expressed as numbers or percentages. They should be very specific:

"... Indicators should specify:
- the target group (for whom)
- the quantity (how much)
- the quality (how well)
- time (by when)
- location (where) …" (NORAD, 1992: 55)

This requires the planning team to sit and think: "What measurable evidence do we require to prove that this objective has been achieved?"

The *impact* of a project may be difficult to measure. It may not be feasible to measure indicators at all levels. In the health sector, impact indicators may be particularly difficult to measure e.g. Measurements of changes in maternal mortality require huge sample sizes and are difficult and costly to gather. In addition, when behavioural change is involved, it may take many years before a significant impact is seen. It is important therefore to select indicators on the basis of what can be realistically measured. Measurable indicators are sometimes developed to stand in for the evidence which would be time-consuming and costly to collect.

You will notice that there are three kinds of indicators, one for each stage of the process:

- output indicators which measure "… changes in products, services and systems provided e.g. number of clinics constructed." (IRC, 2000: 13)

- effect indicators which measure "… changes in knowledge, attitudes, skills, intentions and behaviours of the population of interest e.g. antenatal clinic attendance figures (routine data), % of women attending antenatal clinic (survey)." (IRC, 2000: 13)

- impact indicators which "measure changes in the health, social or economic status of the population of interest e.g. mortality rates; prevalence of malnutrition." (IRC, 2000: 13)

(Note: Sometimes *output indicators* are also called *process indicators* and *effect and impact* indicators are called *outcome indicators*.)

### 5.2.4 Developing targets

Finally, what is not visible on this diagram is the detailed process of developing targets or "operational or performance targets". Targets are steps along the way to achieving objectives. They represent amounts of output and/or effect to be achieved within a specific time period e.g. If one of the outputs to be achieved by the end of a one year project is to build 650 latrines, we could say that the 6 month target is to have completed 325 latrines and the one year target is to have completed 650 latrines.

**TASK 2 – Developing indicators**

Without looking at the indicators on the diagram, take the following output objectives and develop indicators for them:

- To provide 650 latrines and 200 water sources capable of providing 250 people with 15 litres of water per day by X date.
- To train 56 hygiene outreach workers (14 per camp) to provide 50 000 people with 20 sessions (groups of 50) in latrine maintenance instruction and health education by X date.

**FEEDBACK**

The indicators are in the flow chart box below *Outputs*. They are statements of what has been done and what evidence is visible e.g."650 latrines and 200 water sources have been built to acceptable standards". Note that standards are also mentioned.

As you can see, the Causal Pathway process of planning is detailed and demanding: it requires concentration and follow-through. But in the end, the implementation team, the manager who monitors the project and the donors can use the diagram as their guiding document. All the information is contained on one page; it is detailed, specific and measurable.

This may all look a bit daunting, but the only way to get to grips with a new approach, and its terminology is to try it out. So in the final task of this session, develop a Causal Pathway plan for the Motown meal project or, if it has more value to you, for your own project.

**TASK 3 - Develop a Causal Pathway plan**

Develop a Causal Pathway plan for the Motown meal project. If possible, work with another student or as a team. Follow these steps in terms of process.

a) Write down the goal, and then turn it into the language of a Causal Hypothesis i.e. To use … (*write down the inputs*) to …(*include the activities and outputs*). As a result, the street children will … (*write the effect*) which will contribute to … (*write the impact*).

b) Develop a brainstorm of the objectives of the project. Make sure that there are output, effect and impact objectives. Check that they are SMART using the evaluation criteria in Unit 4 Session 3.

c) Now detail the inputs, the activities, the outputs, effects and impact on a diagram like the IRC one. Develop your plan with sheets of paper or cards which you stick on a board or wall. This creates flexibility to move cards around and to add or remove them. It also gives you a chance to contemplate your plan as you develop it over time.

d) Go back to your objectives and develop indicators for each stage. Check them in terms of the criteria for indicators in section 5.2.3.

**FEEDBACK**

a) Causal Hypothesis: To use funds, staff and other resources to make meals available. As a result, street children will be encouraged to access healthy food, which will contribute to improving the nutritional status of street children in the Motown community.

b) Objectives:

| **Objectives (Output level)** | **Objective (Effect level)** | **Objective (Goal level)** |
|---|---|---|
| To repair the cupboards and repaint the community centre kitchen by the end of the first project month.<br><br>To purchase and install kitchen equipment by the end of the first project month.<br><br>To have food ready for 50 street children 3 times a week for 11 months. | To achieve attendance of 50 street children at the Motown feeding centre 3 days per week for 11 months. | To contribute to improving the nutritional status of street children in Motown community. |

c) & (d) The diagram on the next page details the whole Causal Pathway plan including the three levels of indicators.

Note that it would be difficult to accurately determine the impact in this case. Although a follow up anthropometric survey could be done, the total population of street children may be difficult to determine and unstable, and the children may not wish to be assessed. In addition, it would be difficult to link any change in the prevalence of malnutrition among street children specifically to the feeding scheme: there could be other factors influencing their nutritional status, for example, illness or food from other sources. However, in documenting that significant numbers of street children are getting nutritious meals, we can make the reasonable assumption that the feeding project is contributing to improvement in the nutritional status of the street children population.

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# Unit 4 – Session 5

# Information for Planning and Management

## Introduction

"... The purpose of collecting statistics is to provide information to help you plan and improve the services you provide. If you don't use the statistics, and just send them on to your district or regional office, you are wasting your time. (Health Systems Trust, 1997: 15)

"… The main purpose of a health care information system should be to foster the well-being of the population it serves, not to maintain bureaucratic or organizational power …" (Health Systems Trust, 1997: 409)

Although statistics can be intimidating, they are simply information which is collected regularly and in a consistent way. Studying information that tells you about the patterns of disease and service provision among the population you serve, is a very important part of a health manager's job. Sometimes the interpretation of health information can be quite complex. However, you are not expected to be an expert. There are many experts in this field who can assist you. You just need to be aware of the kind of questions you should be asking and the information you will need to allow you to make good decisions.

During this session we will introduce you to health information systems as tools for planning and management. Much of this will link back to the first planning cycle question "Where are we now?" and you will see how health information systems help with initial situational analysis and with ongoing monitoring of progress along the way of carrying out a plan. We also look at ways to answer the last planning cycle question "*How will we know when we have arrived?*" This is the evaluation question. The use of health information illustrates clearly how the planning and implementation of activities constitute a continuous cycle or spiral, using information at every stage and using this information to adapt plans where necessary.

## Session Contents

## Timing of this session

This session contains four readings and three tasks. For Task 2, you need to prepare yourself by studying Reading 22 and then do the task at work; this task may take you about 45 minutes. In all, the session should take you about two and a half hours. A good place to take a break would be after section 4.1.

# 1 LEARNING OUTCOMES OF THIS SESSION

| **Intended learning outcomes**<br>By the end of this session, you should be able to: | |
|---|---|
| **Management outcomes:**<br><br>▪ Describe the functions of a health information system.<br>▪ Identify common weaknesses of health information systems.<br>▪ Conduct an information audit.<br>▪ Use the concepts *monitoring* and *evaluation* in the planning context.<br>▪ Identify information for monitoring. | **Academic outcomes:**<br><br>▪ Apply new concepts in a familiar context.<br>▪ Evaluate a system in your workplace. |

# 2 READINGS AND REFERENCES

The readings for this session are listed below. You will be directed to them the course of the session.

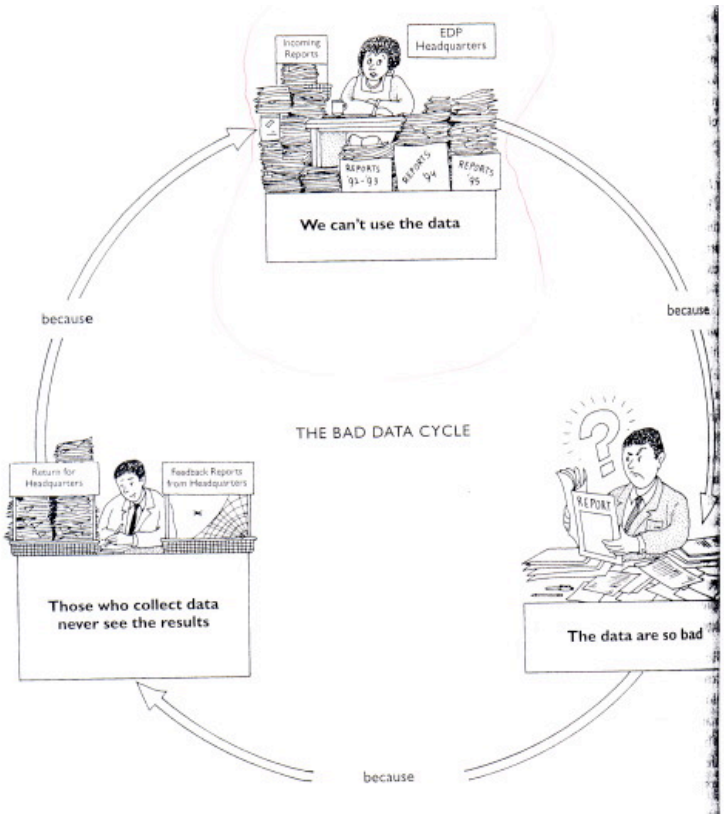
| Reading | Publication details | Page numbers |
|---|---|---|
| 21 | Heywood, A., Campbell, B. & Awunyo-Akaba. (1994). *UsingInformation for Action: A Training Manual for District Health Workers*, The Netherlands: Royal Tropical Institute. | pp2-6 & pp9-11 |
| 22 | McCoy, D. & Bamford, L. (1998).*How to Conduct a Rapid Situation Analysis*. Durban: Health Systems Trust. | pp30-32 |
| 23 | McMahon, R., Barton, E. & Piot, M. (1992). *On Being in Charge.* Geneva: WHO. | pp327-334 |
| 24 | McMahon, R., Barton, E. & Piot, M. (1992). *On Being in Charge.* Geneva: WHO. | pp341-355 |

| References | Publication details | The page numbers are in the text. |
|---|---|---|
| | Editorial. AHRTAG. (Dec 1992). "Dialogue on Diarrhoea". AHRTAG Issue 51. | |
| | Health Systems Trust. (1997). *A Pocket Guide to District Health Care in South Africa.* Durban: Health Systems Trust. | |
| | Heywood, A., Campbell, B. & Awunyo-Akaba. (1994). *Using Information for Action: A Training Manual for District HealthWorkers.* The Netherlands: Royal Tropical Institute. | |
| | International Rescue Committee. (2000). *IRC's Proposal Guidelines based on the Causal Pathway.* Draft 10/12/00., New York: IRC. | |

# 3 HEALTH INFORMATION SYSTEMS

"…The problem of getting accurate, up-to-date health information is almost everywhere a nightmare. It is not so much that it does not exist, but that there is too much of it, mostly unused. Health workers fill in forms and take them to their supervisors who pass them in turn to someone else. The end result of the hard labour of health workers is a half-sorted pile of dusty forms stacked to the ceiling in some bureaucrat's office …" (Heywood et al., 1994: 1)

Is this your experience of health information systems?



In Reading 21, some of the common weaknesses of information systems are identified as well as their purposes and objectives and the principles which guide them. Some of you may have encountered many of these issues in your module *Health Systems Research I.* Use the reading to think about the health information system in your own context.

Reading 21: Heywood, A., Campbell, B. & Awunyo-Akaba. (1994). *UsingInformation for Action: A Training Manual for District Health Workers*, The Netherlands: Royal Tropical Institute, pp2-6; 9-11.

**TASK 1 – Evaluate the problems with health information systems in your work context**

Relate the problems in information systems listed on page 2 of the reading to the way information is used in your job or in your workplace. In comparison, what is working well and what could be improved?

**FEEDBACK**

Your answers will be specific to your context, but these are some of the problems that a health manager in Tanzania noted; they show consistency with those problems described in the reading:

> "Each clinic and hospital seems to have their own system. Sometimes the same data is collected twice by different people. This leads to confusion. For example, sometimes deaths are registered in two different places and end up being counted twice. This is serious, because it gives an incorrect picture of very important information. Sometimes the data is incomplete, so you can't draw any proper conclusions. Then you have to send it back to be done properly; this wastes a lot of time and could mean that there is a delay in recognising the start of a serious problem like a disease outbreak ..."

On page 11 of Reading 21, the importance of health information in decision making or planning is advocated. The authors note that it provides information to make "… rational and informed decisions … "(Heywood et al, 1994: 10), and therefore leads to the improvement of service delivery. The authors suggest that managers and planners should gradually increase the number of decisions which are based on collected information. In summary, Health Management Information Systems (HMIS) are a tool for both planning and policy making and are a way of introducing the actual health needs of the population into planning, rather than "… the bureaucratic and institutional needs … " (Heywood et al, 1994: 10) of large organisations.

The next reading (Reading 22) provides a useful kind of situational analysis which aims to audit what kinds of information is available to planners. Study page 31, where the information flow in Mitchells Plain, Western Cape, South Africa is audited in both written and graphic form.

Reading 22: McCoy, D. & Bamford, L. (1998). *How to Conduct a Rapid Situation Analysis*. Durban: Health Systems Trust, pp30-32.

**TASK 2 - Conduct an information audit**

Using the example in Reading 22, explore the flow of information, if possible with colleagues. Use the questions on page 31 to prompt your audit. Map the information flow as a diagram. In addition, find out roughly how much time each person spends on information-collecting tasks. Then write a summary like the ones in the reading.

**FEEDBACK**

Compare your information audit to the ones in the Reading. Make sure that your audit is specific, detailed and that it contains your views and those of your staff on the value of the information. This audit will have value for your organisation generally. It also has specific value in the context of monitoring progress and evaluating projects.

# 4 MONITORING AND EVALUATION

Health Information Systems provide one of the key tools to carry out the important tasks of monitoring and evaluation. We have already spent time developing indicators for the outputs, effects and impact of a project. These indicators define the information which we will need to monitor and evaluate a project. Here are three views on the processes of monitoring and evaluation:

Monitoring and evaluation should be:

"… A friend, not a foe
An education not an enemy,
The opportunity to do better …"
(Editorial, *AHRTAG*, 1992)

"Monitoring and evaluation is the process through which we gain information about the activities and achievements of the project, in order to make decisions ... [about it] … Monitoring is the regular collection and use of information [usually from project records]" or routine data. (Adapted from IRC, 2000: 12 )

The following definition emphasises that the process is systematic but distinguishes the two processes from one another.

"… Monitoring and evaluation are similar processes – systematic models of measuring progress and measuring whether a programme is achieving its objectives. They help workers look at the achievements and failings of what is being done and where and how things need to be changed to do it better … The words *monitoring* and *evaluation* are often used interchangeably, but in fact answer different questions …" (Heywood et al, 1994: 21)

We will explore these questions and processes in more detail.

## 4.1 Monitoring

"… Monitoring follows the progress of activities and answers the question "Have the planned activities been carried out?" or "What is actually happening?"

McMahon et al describe the processes of monitoring in general terms and provide examples of the process. They make the point that monitoring is not an end in itself but rather a management tool whereby implementation can be redirected if and when problems are identified. Reading 23 explores the purpose of monitoring. Read it with the following questions in mind:

*What purposes does monitoring fulfil? What methods would suit your workplace and the Motown Meal Project? What does a manager do when targets are not being met?*

Reading 23: McMahon, R., Barton, E., Piot, M. (1992). *On Being in Charge*, Geneva: WHO, pp327-334.

**TASK 3 – Identify information for monitoring**

What information would you use to monitor whether or not the Meal Project is achieving its objectives? Think in terms of the information which the Causal Pathway approach provides.

**FEEDBACK**

Here are some examples of the information you might use to monitor whether you are reaching your targets:

Output indicators e.g. Number of days over the project period having sufficient and appropriate food ready for 50 children.

This tells us whether the planned tasks are being carried out e.g. If it frequently happens that transport is not available for shopping, or if insufficient food is being prepared, the output level objective has not been achieved and the way in which the activities are being carried out will have to be reviewed.

Effect indicators e.g. Number of children attending each day. This information tells us whether the meal project is being used by the street children. If attendance figures suddenly decrease, we would have to go and find the reason. If attendance figures increase steadily to over 50 children per day, we may need to apply for additional funding to provide for more children.

## 4.2 Evaluation

If monitoring assesses progress and whether outputs and effects are being achieved according to the plan, what purpose does evaluation fulfil?

"… Evaluation is a formal periodic review [of the project. It often takes place] … at baseline, midterm and project end …" (IRC, 2000: 12) Evaluation often involves special activities which go beyond routine data collection, such as surveys, focus groups and interviews.

In Reading 24, McMahon et al explore the purposes and processes of evaluation. Read it with the following questions in mind.

*Why is it necessary to conduct a project evaluation? How often should it be done? Who should do it? What kind of information is needed?*

> Reading 24: McMahon, R., Barton, E. & Piot, M. (1992). *On Being in Charge.* Geneva: WHO, pp 341-355.

Evaluations ask questions such as "Is this project really helping people to a significant degree?" and "Could we use a better method of achieving the goals and objectives?"

The Motown Meal Project organisers want to reach as many street children as possible. So in addition to recording numbers of children who attend, we also need to find out what percentage of the street children population is benefiting from the meal project. This information could be obtained by means of a special survey, although it will probably not be easy and may require some estimates. If we find that only 10% of the street children in Motown are coming to the meal centre, we need to find out why. It may mean that something about the project should be changed in order to reach more children.

Another way of evaluating the project would be to assess its impact on the nutritional status of the street child population of Motown. However, as we noted in the previous sessions, it would be difficult to accurately determine impact. Once again, it would be difficult to identify all the street children in the community and they may not want to be weighed and measured! Also, other factors such as illness could affect the nutritional status independent of what we are trying to do. However, we can make a reasonable assumption that if we are offering nutritious meals and the project is well attended, we are contributing to the nutritional health of street children in the Motown community.

In this session we have introduced the concepts of monitoring and evaluation. Much has been written about these concepts and many tools have been developed. You will return to these important processes in the course of your studies.

# 5 SESSION SUMMARY

In this session we examined the role of health information in the management and planning of health services. Both routinely collected data and information obtained periodically through, for example, surveys, are important tools to assist the manager in making decisions.

"… A Health Management Information System is not a means in itself, but a tool to help improve health management and to achieve better health by using health information …" (Heywood et al, 1994: 4) Such information also assists managers and their teams in monitoring and evaluating progress towards the achievement of the project objectives and goal. We have by now worked our way around the project cycle but, being a cycle, the results of evaluation can now be fed back into a further situational analysis of where we are now e.g. one year later.

This Unit has focused on a number of important aspects of planning, although not all of them. It seems appropriate at this point to remind you of the explanation of planning given at the start of this Unit, that: *Planning is about using information from the past and the present to prepare for the future.* At this point, do you think this is true?

This is the end of Unit 4 – well done, you deserve a short break! But since you have now spent several weeks working on planning strategies, this is a good time to review your work plan and map out how you will fit the next five study sessions and the related Assignment into the remaining weeks of the semester. Your final *Health Management I* unit focuses on managing a wide range of resources - financial, human, transport, medical equipment and drugs. It combines information about these areas of health management as well as guidance on the managing process in these contexts.

# Unit 5 – Introduction Managing Resources

This is the fifth and final unit of the *Health Management I* module. In the preceding units of this module, we looked at managing people and plans. In this Unit, we bring together people, plans and resources. The focus is on well-managed systems as essential tools for managers in using resources effectively and efficiently to achieve objectives and goals.

It is the manager's responsibility to ensure that the resources at your disposal are used in ways that ensure maximum benefit to the people you are serving. Yet this aspect of management is frequently neglected in public services and resources may be used inappropriately. Careless management of scarce health resources means that some people will lose out – often those most in need of assistance. Perhaps here it is useful to bring to mind the catch phrase of the 1997 *White Paper on Transforming Public Service Delivery* in South Africa: *Batho Pele - People First*.

Each health manager must take responsibility for the fact that the way in which they manage resources has direct bearing on the health of the population they are committed to serve.

There are five Study Sessions in Unit 5.

Study Session 1: Developing and Interpreting Budgets
Study Session 2: Managing Drugs
Study Session 3: Managing Medical Supplies and Equipment
Study Session 4: Managing Transport
Study Session 5: Managing Personnel

In Session 1, we will examine the process of developing a budget, define some basic financial planning terms and look at methods of costing.

In Session 2, we will explore some issues underlying effective drug management, including the concepts of *Essential Drugs*, *Standard Treatment Guidelines* and basic inventory management.

In Session 3, we will look at some of the challenges surrounding the management of medical supplies and equipment, focusing in particular on the concept of appropriate technology and the importance of maintenance.

In Session 4, we will examine the components of transport in a management system, looking at needs analysis, maintenance and accountability.

Finally in Session 5, we will explore personnel management, concentrating on the importance of clear procedures in issues such as hiring, supporting and monitoring staff.

## Learning outcomes of Unit 5

| **By the end of Unit 5, you should be able to:** |
| --- |
| ▪ Demonstrate a basic understanding of how to develop and interpret budgets.<br>▪ Summarise the concepts of *Essential Drugs* and *Standard Treatment Guidelines*, and inventory control.<br>▪ Discuss the concept of *appropriate technology* and the value of standardisation and maintenance in relation to medical equipment.<br>▪ Describe the components of a transport management system.<br>▪ Describe selected components of a personnel management system.<br>▪ Evaluate components of a variety of systems. |

This Unit also contains a range of academic skills and introduces new terminology and models. You are encouraged to take a critical look at resource management systems in your own environment and to propose improvements. By the end of the unit, you should be well on your way to developing your assignment, so plan your time carefully. Review the requirements of the assignment before you start studying and work through the sessions with these questions in mind.

Although you may not manage this range of resources in your present work situation, it is important in an integrated system such as health to be aware of the issues relevant to the full range of resources. We hope the sessions will be relevant to your situation.

# Unit 5 – Session 1

# Developing and Interpreting Budgets

## Introduction

> "… budgeting is an integral part of effective planning, being the means to achieve resources and hence action. Planners who fail to get involved in the budgeting process are handicapped from the beginning …" (Green, 1994: 264)

> "… Resource-allocation implies the distribution of resources, and in particular finance, from the center to the peripheral levels. It is generally used to refer to broad levels of aggregated financial resources. Budgeting implies the more detailed determination of precisely how these funds are to be used …" (Green, 1994: 243)

Public sector health services are usually "… non-profit and define their goals and objectives in terms of services they provide to the community … Once the goal and objectives have been set, the tools and techniques of financial management are used to ensure that adequate funds are available to achieve these planned objectives in the most cost-effective way …" (Management Sciences for Health, 2001: 2)

Financial management is the bedrock of resource management in a project or programme. A good financial system is central to good management. The manager ultimately carries the responsibility for how money is spent. It is therefore essential that the manager has a sound understanding of how a financial system works. There can be many varieties and levels of complexity in financial systems, but they will all be based on the same underlying principles. As Green notes above, developing and interpreting budgets is central to effective planning and management.

In this session, we will concentrate on this aspect of financial management. You will cost a project and prepare a small-scale budget. We will also look briefly at financial control systems.

# Contents



# Timing of this session

This session includes five tasks and four readings, two of which are for reference purposes while you develop your budget. The process of developing a budget (Task 2) and writing a budget narrative (Task 3) could take at least 45 minutes each. Allow three and a half hours for this session and take a break after section 3.

## 1 LEARNING OUTCOMES OF THIS SESSION

| **Intended learning outcomes**<br>By the end of this session, you should be able to: | |
|---|---|
| **Management outcomes:**<br><br>▪ Grasp the importance of understanding financial systems.<br>▪ Define some financial management terms.<br>▪ Carry out costing for project planning.<br>▪ Prepare a budget.<br>▪ Evaluate a financial control system. | **Academic outcomes:**<br><br>▪ Reflect on your own financial management experience.<br>▪ Estimate resources required.<br>▪ Categorise information<br>▪ Explain financial terminology.<br>▪ Research and calculate costs.<br>▪ Apply a set of guidelines to a workplace situation. |

## 2 READINGS AND REFERENCES

The readings for this session are listed below. You will be directed to them in the course of the session.

| Reading | Publication details | Page numbers |
|---|---|---|
| 25 | Management Sciences for Health. (2001). "Managing Your Finances" in *The Family Planning Manager's Handbook.* Website erc.msh.org | |
| 26 | Pillay, Y., Mzimba, M. & Barron, P. [Eds]. (1998). Makan, B., Collins, D. & Zuma, N. Ch 7- "Financial management for District Managers" in *Handbook for District Managers.* Pretoria: Dept of Health. | pp63-81 |
| 27 | Creese, A.& Parker, D. (undated). "Calculating Costs" in *Cost Analysis in Primary Health Care*. Geneva: WHO, UNICEF & Aga Khan Foundation. | pp29-40 |
| 28 | International Rescue Committee. (2000). *Budget and Budget Narrative for UNHCR Project: Assistance to Burundi Refugees in Kigoma.* Project Document. (Adapted) | |
| **References** | **Publication details** | **The page numbers are in the text** |
| | Green, A. (1994) *An Introduction to Health Planning in Developing Countries.* Oxford University Press. | |

## 3 BUDGETS AND COSTING

This session could be studied in one of two ways: if you have drawn up budgets before, you could study Reading 1 which explores financial planning more broadly, and then check your understanding of budgeting by trying it out in practice in Task 3. If you are not familiar with budgeting, follow the step-by-step process below and refer to the reading as a source of information.

Read pages 1-2 of Reading 25 as an introduction with the questions in Task 1 in mind.

> Reading 25: Management Sciences for Health. (2001). "Managing Your Finances" in *The Family Planning Manager's Handbook.* Website erc.msh.org

**Task 1 – Clarifying your own role in financial management**

a) What aspects of financial management are you responsible for? Tick them off on the list titled "Basic financial management skills" on page 3.
b) If you do not manage these processes, in which of them are you involved?
c) Which of these skills could you strengthen?

**FEEDBACK**

Although we are not going to tackle all these financial skills in this session, you now have Reading 25 at your disposal, and you can refer to it to strengthen the skills you need. We are going to concentrate on budgeting, so read pages 5-7. As you read, note down three ways in which a good understanding of budgeting would be of value to you and other managers in your workplace.

Developing a budget is a planning process, but budgets play several important roles within a project. Try to describe for yourself the roles budgets play in your work and then take a look at the reasons for preparing budgets on page 67 of Reading 26.

Reading 26: Pillay, Y., Mzimba, M. & Barron, P. [Eds]. (1998). Makan, B., Collins, D. & Zuma, N. Ch 7- "Financial management for District Managers" in *Handbook for District Managers.* Pretoria: Dept of Health, pp63-81.

Although budgets may be seen primarily as a tool for *financial* planning and monitoring, in projects and organisations they have also become a key tool for planning the overall implementation process. Budgets provide a means of clarifying priorities in community needs, and therefore resources and services. They are also used as a tool for review and evaluation. When preparing a budget, there are two main steps: identifying the resources you need and then costing them. Thereafter you will have to identify the sources of funding for them.

Read pages 68-69 of Reading 26: the authors provide an overview of the factors to take into account when budgeting. Think about how the budgeting process takes place at your workplace: is it a top-down or bottom-up process? Is the advice given on the process on page 69 realistic? What reservations do you have? Although the combination of top-down and bottom-up is no doubt the best process, the manager will have to prepare well for the planning session, identifying key areas for bottom-up input. This is because the detail and volume of decisions to be taken is often very exhausting, and staff will tend to avoid participating in planning if they have previous experience of tedious, slow sessions.

You started on this planning process in Unit 5 Session 2 Task 5, where, by asking a range of questions such as *what, where, when …?,* you identified some of the physical and human resources needed in planning the Motown Meal Project. Re-read your questions and answers, and then do Task 2.

**TASK 2 – Identifying the resources you need**

Take the list of resources you made for the meal project and cluster them according to categories. Each category can be called a budget line e.g. all the administrative items belong together. Now use the template below and cost each resource you identified for your budget. We have included some information which is necessary to this exercise at the end of the table.

Here are some guidelines for using this budget template:

- The budget line is the broad category of resources e.g. rental.
- Each item in the budget line is called a line item and appears in the next column.
- The unit cost refers to the cost per unit e.g. a full-time driver is one unit and costs R2000 per month, so from this you can work out how much 25% of a full-time driver's time will cost.
- The number refers to how many of these items are needed.
- The cost per month is only relevant to ongoing expenses e.g. rent, salaries, food.
- The cost per line item is a total arrived at by multiplying the relevant costs together i.e. Rent: R200 x 12 months = R2 400; or Kitchen assistants: 2 staff x cost per month (R600) x number of months (12) = R14 400. Sub- totals of the categories or budget lines are then added up to simplify and clarify the costs.
- The term contingency refers to a *reserve* amount budgeted for in case something unexpected happens.

## Budget Template

| Budget line | | Line item | Number of units | % of unit used | Cost per unit | Cost per unit per month | Number of months | Cost per line item | Cost per budget line |
|---|---|---|---|---|---|---|---|---|---|
| 1. Rent & utilities | 1a | Rent | | | | | | | |
| | 1b | Water & electricity | | | | | | | |
| | 1c | Minor maintenance | | | | | | | |
| | | | | | | | | | |
| 2. Administration | 2a | Stationery | | | | | | | |
| | 2b | Telephone | | | | | | | |
| 3. Transport | 3a | Vehicle maintenance | | | | | | | |
| | 3b | Vehicle insurance | | | | | | | |
| | | | | | | | | | |
| | 3c | Petrol | | | | | | | |
| 4.Staff | 4a | Cook | | | | | | | |
| | 4b | Kitchen assistant | | | | | | | |
| | 4c | Driver | | | | | | | |
| | 4d | Administrator | | | | | | | |
| | | | | | | | | | |
| 5. Equipment | 5a | Stove | | | | | | | |
| | 5b | Refrigerator | | | | | | | |
| | 5c | Cooking utensils | | | | | | | |
| | 5d | Eating utensils | | | | | | | |
| | 5e | Cleaning equipment | | | | | | | |
| | | | | | | | | | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 6. Supplies | 6a | Food | | | | | | | |
| | 6b | Cleaning materials | | | | | | | |
| | | | | | | | | | |
| 7. Project evaluation | 7a | Survey costs | | | | | | | |
| | | | | | | | | | |
| 8. Miscellaneous costs | 8a | Contingency | | | | | | | |
| | | | | | | | | | |

You will need the following information (which would have been determined during your planning process) in order to develop this budget.

> The community centre has agreed to allow their hall to be used as a venue for preparing and serving the meals. They request that you pay R200 per month in rent and also contribute to water and electricity charges. You will also contribute to minor renovations of the building. Kitchen equipment will also have to be purchased. You will be able to use the community centre vehicle but will have to contribute to maintenance, petrol and the salary of the driver. The community centre administrator will assist in the day-to-day administration of the project but you will have to contribute 20% of the salary. After one year, you should conduct a survey among street children in the community to measure the effect and impact of the project. The costs of the survey should be included in the budget. You should decide on the salary costs yourself. In order to get costs for equipment, you would have to phone around for quotes or consult catalogues or past budgets. You may wish to group the costs for smaller items as lump sums.

Now try to cost the budget using the "Tips for Budget Preparation" which is on pages 11-14 of Reading 25. Note that it is not always relevant to fill in all the columns. Think about exactly what you are trying to show in the calculations.

At this point, preview Reading 27, so that you know that you have it for this and future budgeting purposes. It provides guidance for costing some of the items e.g. Did you know, for example, that when costing a vehicle, you should cost it at the "… current cost for a similar vehicle, not the original purchase price." (Creese & Parker, undated: 30).

Reading 27: Creese, A. & Parker, D. "Calculating Costs" in Cost Analysis in Primary Health Care. Geneva: WHO, UNICEF & Aga Khan Foundation, pp29-40.

**FEEDBACK**

How does this style compare to the budgets you have worked with? Your final figures will be different depending on what salaries and unit costs you decided on, but compare your budget to this one to be sure that you have got the principles correct. Check to make sure you understand how to calculate the costs for the different line items.

## Budget for meal project - Funding period: 12 months

| Budget line | | Line item | Number of units | % of unit used | Cost per unit | Cost per unit per month | Number of months | Cost per line item | Cost per budget line |
|---|---|---|---|---|---|---|---|---|---|
| 1.Rent & utilities | 1a | Rent | 1 | 100% | | 200 | 12 | 2400 | |
| | 1b | Water & electricity | 1 | 100% | | 200 | 12 | 2400 | |
| | 1c | Minor maintenance | | | | | | 1000 | |
| | | | | | | | | | **5800** |
| 2.Administration | 2a | Stationery | 1 | 100% | | 50 | 12 | 600 | |
| | 2b | Telephone | 1 | 100% | | 50 | 12 | 600 | |
| | | | | | | | | | **1200** |
| 3.Transport | 3a | Vehicle maintenance | 1 | 25% | | 200 | 12 | 600 | |
| | 3b | Vehicle insurance | 1 | 25% | | 100 | 12 | 300 | |
| | 3c | Petrol | 1 | 25% | | 800 | 12 | 2400 | |
| | | | | | | | | | **3300** |
| 4.Staff (part-time) | 4a | Cook | 1 | 100% | | 1000 | 12 | 12000 | |
| | 4b | Kitchen assistant | 2 | 100% | | 600 | 12 | 14400 | |
| | 4c | Driver | 1 | 25% | | 2000 | 12 | 6000 | |
| | 4d | Administrator | 1 | 20% | | 4000 | 12 | 9600 | |
| | | | | | | | | | **42000** |
| 5.Equipment | | 5a.Stove | 1 | 100% | 2000 | | | 2000 | |
| | | 5b.Refrigerator | 1 | 100% | 3000 | | | 3000 | |
| | | 5c.Cooking utensils | | | | | | 1000 | |
| | | 5d. Eating utensils | | | | | | 720 | |
| | | 5e.Cleaning equipment | | | | | | 500 | |
| | | | | | | | | | **7220** |
| 6.Supplies | | 6a.Food | | | | 3000 | 12 | 36000 | |
| | | 6b.Cleaning materials | | | | 50 | 12 | 600 | |
| | | | | | | | | | **36600** |
| 7.Project evaluation | | 7.Survey costs | | | | | | 1000 | |
| | | | | | | | | | **1000** |
| 8.Miscellaneous costs | | 8.Contingency | | | | | | 2000 | |
| | | | | | | | | | **2000** |
| **Total Project Costs** | | | | | | | | | **R99120** |

You could also select one or two items and evaluate your calculation strategy in relation to Creese and Parker's guidance in Reading 27 e.g. Have you thought of the issues mentioned under "Buildings" (see page 31) and "Allocating Shared Inputs" (page 38)?

Now take a look at Reading 28 which presents a budget for health services in a camp for Burundian refugees in Kigoma, Tanzania, and compare its contents with the budget example above.

> Reading 28: International Rescue Committee. (2000). *Budget and Budget Narrative for UNHCR Project: Assistance to Burundi Refugees in Kigoma*. Project Document. (Adapted)

## 3.2 Preparing a budget narrative

The budget narrative part is often neglected but is a very important part of budget preparation. If you want to convince a donor to fund your project, it is important to show that you have carefully thought through how the money is to be used. Doing careful calculations also helps to prevent shortfalls in the course of the funding period, as well as excesses. An excess is an unspent portion of funding at the end of the project: you would have to explain why it was not used, and for the funder this may suggest poor planning or ineffective implementation.

Look at the example of a budget and narrative provided as Reading 28. By comparing the budget and the narrative section, try to explain the purpose of the narrative for the manager, the implementation team and the donors.

**Task 3 – The purpose and format of a budget narrative**

a) Look at the IRC Budget and narrative. What is the purpose of the narrative for the manager, the implementation team and the donor?
b) Is there an explanation for every line item? Why? Why not?
c) Is the presentation format easy to follow? What makes it easier?
d) By following this example, write a budget narrative for the Motown Meal Project budget which you developed.

**FEEDBACK**

a) The purpose of the narrative is to explain the assumptions and thinking behind the costing, and to make it clear how you arrived at these costs. It is also likely to be helpful for you and your team while implementing the budget, and acts as a kind of justification for the donors. For the manager, there is always a time-lapse between budgeting and implementation and the budget narrative can help you to refresh your memory on what the precise details of the plan were.

b) In this budget, there are certain items like salaries which are self-explanatory. There is no need to write a narrative section on them. However you may need to justify the number of staff or why you are paying them particularly high salaries. You need to guess which information will raise concerns for the donor and explain it.

c) The presentation is made clearer by the use of line codes e.g. F03 or F21h. They are coded according to where the item falls in the sequence of line items. Having numbers or codes for line items makes the narrative and your reports clearer. Using the line item names consistently from budget to narrative is also important for clarity. Notice however that some codes in the sequence have not been used. This is because the organisation has allocated a permanent code system to all likely resources for accounting purposes: so when the bookkeeper sees F24, she or he will know that this expense pertains to Inpatient Services and all the costs related to that category of activity.

d) Compare your budget narrative with the one below, and check that yours has all relevant details, that the line codes are accurate and that there is sufficient detail about proposed expenses to justify the costs.

**Budget for Motown Meal Project - Funding period: 12 months**

**1.Rent and utilities**

1a. Rent: A rental agreement was signed between the Motown Community Centre and the project staff. Rent will remain fixed over twelve months.
1b. Water and electricity: A similar project in a neighbouring township estimated their electricity costs at R200/month.
1c. Minor renovations: A lump sum of R1000 is estimated to be adequate for repair of cupboards and painting the kitchen.

**2. Administration**

2a. Stationery: Costs will cover items such as record books, ledgers, paper and minor supplies used in project support.
2b. Telephone: The amount budgeted for telephone bills is estimated at 20% of the current telephone expenses of the community group.

**3. Transport**

3a. Vehicle maintenance: The project will use 25% of the community centre vehicle's time and distances travelled. Thus the project will contribute to 25% of costs for maintenance.
3b. Vehicle insurance: The project will contribute to 25% of costs for maintenance and insurance.
3c. Petrol: The current fuel bill is R600 per month. Thus an additional R200 per month is needed.

**4. Staff**

4a & b. Kitchen staff will be employed for 3 days per week. Two assistants are needed to help with shopping and cleaning. Salaries are based upon those offered by community organisations with similar projects.
4c. Driver: The project will cover 25% of the driver's salary, as agreed with the Community Centre.
4d. Administrator: The project will cover 20% of the administrator's salary, as agreed.

**5. Equipment**

5a & b. The costs of the stove and refrigerator are based upon averages obtained by comparing prices of similar items at three retail outlets. (Quotations are attached as Appendix II)
5c & d. Costs for utensils are calculated as follows, using prices from local wholesale dealers:

| **Item** | **Number** | **Cost per item** | **Total cost** |
|---|---|---|---|
| Enamel bowl | 60 | R10 | R600 |
| Spoon | 60 | R2 | R120 |
| Cooking pot | 5 | R100 | R500 |
| Ladle | 5 | R10 | R50 |
| Knife | 5 | R30 | R150 |
| Storage containers | | lump sum | R200 |
| Miscellaneous items | | lump sum | R100 |

5e. Cleaning equipment includes items such as brooms, mops and buckets.

**6. Supplies**

6a. Food
Food items include: beans, meat, mealie meal, samp, vegetables, cooking oil, salt and spices and milk. It is estimated that food will cost R5 per day, 3 times a week for up to 50 children.

6b. Cleaning supplies include items such as soaps and disinfectants. Estimates of quantities needed and costs involved were provided by an organisation managing a similar project in a neighbouring township.

**7. Project evaluation**

7a. Survey costs:
Staff incentives to attend: 5 staff for two days at R50 per day: R500
Vehicle fuel: R250
Stationery: R250

**8. Miscellaneous:**

Provision is made for unexpected expenses under this item.

# 4 CATEGORIES OF EXPENSES IN BUDGETS

When preparing a budget, there is another level which you should think about while calculating costs: are these costs likely to be incurred once off, or will they be recurring (ongoing) costs? The value of this is to assess the sustainability of the project.

**TASK 4 – Clarifying financial terminology**

Take a look at the Glossary of Reading 26 and make sure you understand the meanings of the following kinds of costs: *capital costs, recurrent costs, fixed costs, variable costs*. Try to identify examples in your Meal Project budget. In addition, we have provided a table classifying the different kinds of costs that a project may incur as part of Reading 26.

Reading 26: Pillay, Y., Mzimba, M. & Barron, P. [Eds]. (1998). Appendix 2 – "Classifications of costs" *Handbook for District Managers.* Pretoria: Dept of Health, p79.

**FEEDBACK**

Examples of the three kinds of costs which are discussed are as follows in the context of the meal project example we used:

- *Capital costs* are the costs of buying a refrigerator and stove. The term is relevant to large equipment or building renovation. In the short to medium term, these may be viewed as *once-off* costs.
- An example of *recurrent costs* are rent, water, electricity and supplies: they will be incurred monthly, year after year.
- *Variable costs* are expenses that may vary over the duration of the funding period, for example, vehicle maintenance or catering for more people at certain times. They are usually described as a varying according to the amount of services provided. Even though such costs will vary, we have to estimate an average for budgeting purposes.
- *Fixed costs* are those costs that are expected to remain constant for the duration of the funding period and do not vary according to the amount of services provided. These could include staff salaries, rent and bank charges. Many fixed costs are also recurrent costs.

Although the costs for the meal project have been documented and calculated per budget line, you could also cluster all the capital costs under one heading. The donor then knows that these will be incurred only once. The fixed costs could come next, and the variables last. This gives you and the funder an idea of the long-term cost and sustainability of the project.

# 5 CONTROLLING AND MANAGING FUNDS

Once your budget has been approved, it then becomes a tool for implementing the project and for monitoring expenditure. Throughout the funding period, it is absolutely essential for the manager to remain aware of how much has been spent and how much of the funds remain for each line item. Your finance department should be able to provide you with such an update every month in the form of an expenditure report. Sometimes these reports can seem rather daunting, but are usually quite simple once you understand how to read them. It is a good idea to ask someone from the finance department to explain exactly what the different columns show and how the calculations are done. Remember that for you as the manager, the important parts are: what has been spent and what remains in each budget line.

Something to bear in mind is that sometimes finance departments experience delays in receiving and entering all the relevant documentation of expenses and monthly reports may not be completely up to date, so you should also keep your own records. A very simple way to do this is to make a note of the date, the amount and the line item involved each time you approve an expenditure, and then at the end of the month to check these against the remaining budget.

Reading 25: Management Sciences for Health. (2001). "Managing Your Finances" in *The Family Planning Manager's Handbook.* Website erc.msh.org

In Reading 25, read the section on "Controlling and Managing Funds" on pages 20-26 and then do Task 5. It is an evaluation process of the financial controls system in your workplace.

**TASK 5 – Developing tools for controlling funds**

Study the "Manager's Checklist to Ensure Good Financial Control" on pages 25-26 of Reading 25. In your unit, project or department, how many of these procedures do you have in place? In each case, discuss with the person concerned whether such a procedure is necessary in your context. Finally, rewrite the checklist for your own context.

**FEEDBACK**

Your evaluation will be context-specific, but you have probably found some gaps in your system. However, be careful to ensure that the financial procedures you put in place are realistic and manageable: if they are not, staff will start to ignore them and this can affect the more important controls.

There are alternative checklists and some additional input on financial controls in Reading 26 on pages 70-73. Select those guidelines which seem relevant and compile a financial control checklist for your own workplace.

Reading 26: Pillay, Y., Mzimba, M. & Barron, P. [Eds]. (1998). Appendix 2 – "Classifications of costs" *Handbook for District Managers.* Pretoria: Dept of Health, pp 70-73.

# 6 SESSION SUMMARY

During this session we looked at how to develop and interpret a budget. A manager in charge of a health or welfare programme is not expected to be a financial expert. However, as you will finally be accountable for how money is used in your programme or project, it is essential that you have a good understanding of basic budgeting principles. This will assist you in making sound decisions and in controlling your area of responsibility. In the next session, we will look at another set of resource management responsibilities, drug management.

# Unit 5 – Session 2
# Drug Management

## Introduction

> "… Drug management …directly affects the quality of health care. If drugs are consistently unavailable, patients suffer and staff loses motivation. Everyone loses confidence in the health system, and patient attendance decreases. A constant drug supply promotes effective care, inspires confidence in the health facilities, and contributes to job satisfaction among staff. Drug management is also a matter of saving money. Efficient inventory control leads to minimum wastage and minimum cost for holding stock …" (Sjolander, 2002: 1)

The availability of appropriate pharmaceutical drugs is a central component of a health care system and ensuring the availability of such drugs is an important part of a health manager's job. Careful planning, monitoring and evaluation are essential. The four basic questions of the planning cycle (*Where are we going?* etc) are easily applied to drug management. Drug management also illustrates the concept of allocative planning which was discussed in Unit 4 Session 2. In other words, it raises the issue of how much should be allocated to (spent on) one kind of drug as opposed to others.

Drug management is a vast and specialised field which cannot be covered in depth in this session. We have therefore chosen to focus on three important aspects: the concept of *Essential Drugs*, *Standard Treatment Guidelines* and *the basics of inventory control*. These are all sub-systems of what we could call a drug management system developed to facilitate effective functioning of this area of service provision.

## Session contents

## Timing of this session

This session contains seven tasks and five readings. It is likely to take you at least three hours. A logical place for a break would be after section 3. Tasks 5 – 7 in section 4 require you to do some research in your workplace, so allow an hour for on-the-job study after completing the readings.

# 1 LEARNING OUTCOMES OF THIS SESSION

| **Intended learning outcomes**<br><br>By the end of this session, you should be able to: | |
|---|---|
| **Management outcomes:**<br><br>▪ Explain the *Essential Drugs* and *rational drug use* concepts.<br>▪ Explain the *Standard Treatment Guidelines*" concept.<br>▪ Describe the components of the drug management cycle.<br>▪ Be familiar with the main aspects of inventory control. | **Academic outcomes:**<br><br>▪ Explain and apply new concepts related to drug management.<br>▪ Summarise information.<br>▪ Apply criteria to evaluating existing situations. |

# 2 READINGS AND REFERENCES

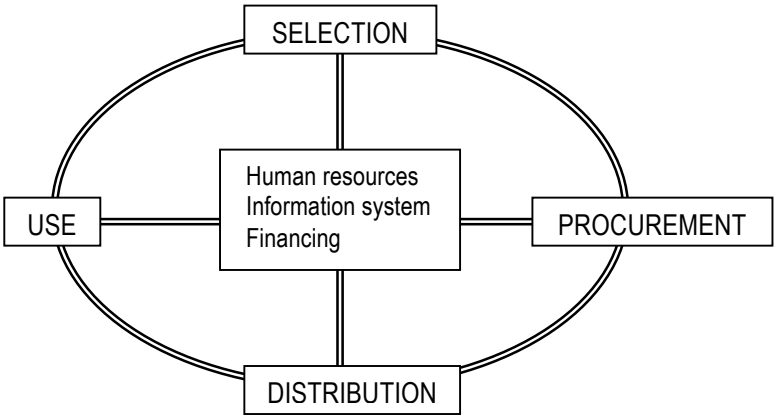
The readings for this session are listed below. You will be directed to them in the course of the session.

| Reading | Publication details | Page numbers |
|---|---|---|
| 29 | Management Sciences for Health. (1997). *Managing Drug Supply.* West Hartford, Connecticut: Kumarian Press. | 29a: pp122-126<br>29b: pp126-128 |
| 30 | Management Sciences for Health. (1997). *Managing Drug Supply.* West Hartford, Connecticut: Kumarian Press, | pp138-139,143 |
| 31 | Management Sciences for Health. (1997). *Managing Drug Supply.* West Hartford, Connecticut: Kumarian Press. | p143 |
| 32 | Province of the Eastern Cape, Department of Health. (2000). *Managing Drug Supply for Health Institutions.* Eastern Cape Province: Department of Health. | pp1-94 |

| References | Publication details | The page numbers are in the text |
|---|---|---|
| | Eastern Cape Province, Department of Health. (2000). Managing Drug Supply for Health Institutions. Eastern Cape Province: Department of Health. | |
| | Health Action International. (1998). *Developing Essential Drugs Policies: a Guide for NGOs".* Amsterdam: HAI. | |
| | Mamdani, M. (1992). "Early Initiatives in Essential Drugs Policy." In Kanji, Hardon, Harnmeijer, Mamdani, M. & Walt, *Drugs Policy in Developing Countries*. London: Zed Books. | |
| | Management Sciences for Health. (1997). *Managing Drug Supply.* West Hartford, Connecticut: Kumarian Press. | |
| | National Essential Drugs List Committee. (1998). *Standard Treatment Guidelines and Essential Drugs List for South Africa.* South Africa: The National Department of Health. | |
| | Sjolander, M., (2002). *Master's thesis*, Umea University, Sweden. | |
| | WHO. (1985). *Conference of Experts on the Rational use of Drugs.* Nairobi. | |

# 3 THE DRUG SUPPLY MANAGEMENT CYCLE

Drug management is often described in terms of the drug supply management cycle or logistics cycle:




**The drug supply management cycle**

Read this explanation of the cycle and return to it as you work through this session.

"…The Drug Supply Management Cycle includes:

**Selection:** Once prioritised health problems are identified, essential drugs that should be used to treat them are selected and Standard Treatment Guidelines (STG) are defined.

**Procurement:** This is the process of ordering good quality and cost-effective essential products from reliable suppliers.

**Distribution:** Once received, essential drugs and other essential medical supplies are stored and made available to the users through a reliable delivery network on a regular basis.

**Use:** At the facility level, drugs are prescribed to the patient according to predefined standard treatment guidelines and then dispensed.

**Human Resources, Information System and Financing:** These three components are described as support systems. They are key systems in supporting the management of personnel, the transformation of data into information and the allocation and monitoring of funds.

Directly or indirectly everyone involved in any health system has something to contribute towards the improvement of the management of drugs and medical supplies. This can be achieved, however, only if all the parties involved play their part and work together towards the improvement of the supply system …" (Eastern Cape Department of Health, 2000: 10)

The three aspects of drug management which form the focus of this session relate as follows to the drug supply management cycle: the *Essential Drugs* concept and *Standard Treatment Guidelines* apply mainly to the selection and use stages in the cycle, while *inventory management* is relevant to the procurement and distribution stages.

## 3.1 Drug selection

Drug selection involves deciding which drugs will be available and which drugs will be used to treat particular illnesses. To assist with drug selection in the public health context, lists of essential drugs and standardised guidelines for treatment have been developed. An overview of the background to these developments is helpful in understanding their value.

During the 1970's, the drugs situation in the developing world was one "… of an excessive waste of resources … The private sector market was flooded with thousands of inappropriate preparations under a bewildering choice of brand names, all at a prohibitive cost for a major fraction of the population …The absence of the necessary infrastructure and trained personnel for the efficient and safe distribution of medicines has led to the evolution of a chaotic and indiscriminate system of drugs distribution and use … aggravated by the lack of accurate and objective drugs information and inadequate or non-existent regulatory controls ..." (Mamdani, 1992)

At this time, the need for standards and regulations concerning pharmaceuticals came onto the international agenda and out of this came the Essential Drugs concept.

## 3.2 The Essential Drugs concept

The concept of Essential Drugs is important in deciding which drugs should be available within the public health system.

> "… Essential drugs are those that satisfy the health care needs of the majority of the population; they should therefore be available at all times, in adequate amounts and in the appropriate dosage forms …" (WHO, 1990 in HAI, 1998: 6)

The aims of the Essential Drugs concept are to ensure equitable access to necessary, safe and effective drugs at an affordable price.

The WHO has played a leading role in the establishment of the Essential Drugs concept, beginning with its first *Model List of Essential Drugs* in 1977. This included about 220 generic drugs needed for the most prevalent illnesses affecting the largest segments of the population. Most of these drugs were no longer protected by patent rights and were known to be effective and safe. Since then, the list has been updated on a regular basis. It serves as a model for countries to develop their own national lists and is intended as a practical tool for use by governments seeking to rationalise expenditure on drugs. At Alma Ata (1978), the Essential Drugs concept was validated when it became one of the eight basic components of Primary Health Care. In 1981, WHO established the Action Program on Essential Drugs (DAP) to assist governments in establishing national drugs policies.

By the mid 1980's, various international agencies, governments, professional bodies and NGOs had accepted and were advocating the Essential Drugs concept. By 1998, 51 national governments had drawn up drug policies based upon the Essential Drugs concept, and 140 countries were using an Essential Drugs list.

The use of Essential Drugs lists has proved advantageous to a number of developing countries.

> In the 1980's "... Mozambique reduced therapeutic items ... from 13 000 to 343 and ... managed to quadruple the quantity of pharmaceuticals imported without a significant increase in foreign exchange … [In Sri Lanka] … an essential drugs list facilitated the provision of more accurate information on the use of drugs than was normally provided by market mechanisms ..." (Mamdani, 1992)

> "... Working with a limited list of essential drugs makes it easier both to quantify needs and to procure and manage drugs efficiently. Staff members are better able to understand the drugs they are prescribing because there are fewer of them ... [This] provides a firm foundation on which to introduce treatment guidelines and for training and evaluation of performance ..." (Health Action International, 1998:10)

Using a limited list may be particularly beneficial in developing countries where access to independent information on drugs may be minimal and staff with limited training may lack the skills to make rational decisions as to the suitability of a new drug.

Before you do Task 1, preview Reading 29a, so that you can use its contents while doing the task. While going through this reading, focus on sections 10.1 – 10.4 Think about the following questions while you read: *What are the advantages of using the generic names for drugs? What is a generic drug? What are the arguments for using generic products over brand-name products?*

Reading 29a: Management Sciences for Health. (1997). *Managing Drug Supply.* Sections 10.1 – 10.4. West Hartford, Connecticut: Kumarian Press, pp122-126.

**TASK 1 – The value of the Essential Drugs concept**

a) Scan the input above and identify four reasons for the development of the Essential Drugs concept. Add to your list of reasons from pp123-124 of Reading 29a.

b) Explain the Essential Drugs concept in your own words.

c) In Reading 29a, study the WHO selection criteria for National Essential Drugs. Are there any criteria which are likely to be controversial? Why?

**FEEDBACK**

a) Some of the key reasons behind the Essential Drugs concept are:
- To provide guidelines for selection in order to buy affordable drugs for the majority of the population.
- To make sure that drugs are available on an equitable basis.
- To select safe drugs.
- To make sure that prescribers understand and can use the drugs effectively.
- To promote consistency in treatment methods among different providers.
- To try to ensure a regular supply of drugs is available all the time.
- To improve health care generally through availability, and therefore to reduce the cost of health care.
- To simplify logistics by ordering fewer items from fewer suppliers and to be able to monitor quality.

b) The Essential Drugs concept describes a list of drugs which are affordable and available to the majority at all times, which are safe and well-known to public health providers and therefore promote rational prescribing.

In any context, the Essential Drugs concept is based on the real needs of the population. A list of Essential Drugs will however be of little value unless coupled with the concept of rational prescribing.

c) Issues of costs and ethics may come up. For example, if an expensive drug is not needed by the majority of the population, but may save or prolong the life of a small proportion of the population, should it be on the Essential Drugs list? If it is, what portion of the drug budget should then go to this drug? Good examples of this are anti-retrovirals used in the management of HIV/AIDS.

A further issue is that clinicians may feel that their clinical freedom is curtailed by a restricted drug list and their ability to offer their patients the best possible care is hampered by unavailability of certain drugs.

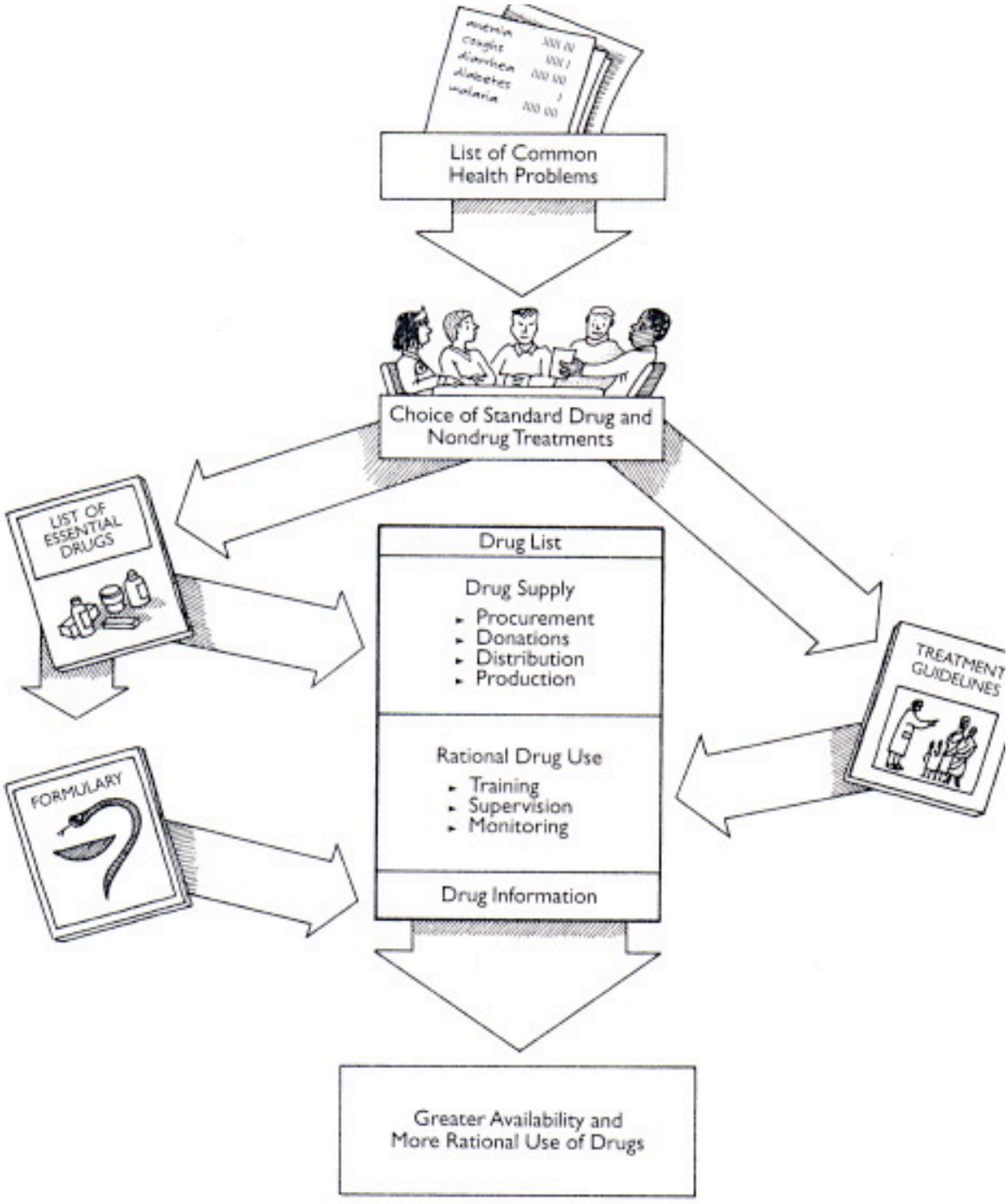
## 3.3 Rational Drug Use

WHO's Revised Drug Strategy (1988) expanded the Essential Drugs concept to include the rational prescribing and use of drugs.

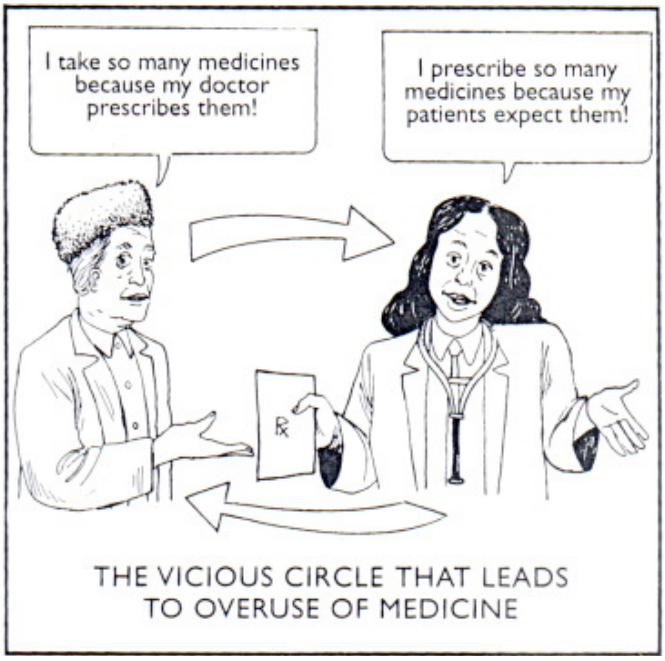
Resources in health care are scarce. Drugs and medical supplies make up the second largest health care expense after staff salaries. Therefore, it is essential that money used for drugs be spent in the best way possible. In other words, drugs should be used *rationally.*

> "Rational use of drugs requires that patients receive medications appropriate to their clinical needs, in doses that meet their own individual requirements for an adequate period of time, and at the lowest cost to them and their community." (WHO, 1985: 7)

Rational drug use is not only concerned with costs. It is also, very importantly, concerned with quality of care. Irrational prescribing practices may result in incorrect or inadequate treatment of a patient or subject them to unnecessary side effects. This may be a significant problem in both the public and private sector in many countries. Reasons for inappropriate prescribing may include lack of knowledge on the part of the prescriber or pressure from the patient. Think about whether you have ever put pressure on a health care provider to give you a certain drug, for example an antibiotic when you have a common cold, (which is a viral infection). This kind of pressure can sometimes make it very difficult for clinicians to prescribe in a rational way.




(Adapted from Management Sciences for Health. (1997). *Managing Drug Supply.* West Hartford, Connecticut: Kumarian Press, p129)




(Adapted from Management Sciences for Health. (1997). *Managing Drug Supply.* West Hartford, Connecticut: Kumarian Press, p424)

One of the ways in which to minimise irrational prescribing in public facilities is by having a "levelled essential drugs list." This means that, within the national essential drugs list, separate lists are compiled for different levels of health facilities and include only those drugs which are appropriate to the level of care and levels of expertise of the staff at each facility level. Reading 29b is a discussion of levelled Essential Drug lists. Section 10.5 of this reading also introduces the concept of Standard Treatment Guidelines which provide an additional way to promote rational prescribing.

> Reading 29b: Management Sciences for Health. (1997). *Managing Drug Supply.* Section 10.5. West Hartford, Connecticut: Kumarian Press, pp126-128.

## 3.4 Standard Treatment Guidelines

Based on public health needs in a community, standardised guidelines for treatment can be developed and compiled in such a way that they can be used as the basis for drug selection, for training and to ensure effective treatment.

Standard Treatment Guidelines are a useful tool in guiding the prescriber in making rational treatment decisions. They also guide the process of deciding which drugs should be on the Essential Drugs list.

Reading 30 defines treatment guidelines in more detail and presents the benefits of such guidelines for a range of stakeholders. Read it with these questions in mind: *What are Standard Treatment Guidelines? How often are they revised? Who are they aimed at? What is their value to you in your present role as part of a provider organisation? What is their benefit to the state?*

Reading 30: Management Sciences for Health. (1997). *Managing Drug Supply*. Section 11.1. West Hartford, Connecticut: Kumarian Press, pp138-139 and 143.

The next reading is a case study of the use of Standard Treatment guidelines in Papua New Guinea. Read the description of the development of their Standard Treatment Manuals and take note of: *the process of compiling the guidelines, the frequency of revision and the features of the manuals* before doing Task 2.

Reading 31: Management Sciences for Health. (1997). *Managing Drug Supply*. "Country Study Box". West Hartford, Connecticut: Kumarian Press, p143.

**TASK 2 – Critical analysis of a Standard Treatment Manual case study**

a) Why do you think the Standard Treatment Manuals have been widely used, and adhered to in Papua New Guinea?

**FEEDBACK**

The effectiveness of these guidelines could be attributed to the wide participation in their development in 1973, their regular revision (presumably to respond to additional issues which arose), the fact that the manuals are widely accessible, even to students and the fact that the drug supplies match the treatment guidelines. The guidelines are also introduced in pre-service training, making them widely known, they have been made simple to understand and the same treatments are used by practitioners at different levels. This would strengthen their credibility.

Now take a look at the extract below from the South African context.

## Essential Drugs and Standard Treatment Guidelines in South Africa

"…The government of South Africa clearly outlines its commitment to ensuring availability and accessibility of medicines for all people in the health objectives of the National Drugs Policy. They are as follows:

- To ensure the availability and accessibility of essential medicines to all citizens.
- To ensure the safety, efficacy and quality of drugs.
- To ensure good prescribing and dispensing practice.
- To promote the rational use of drugs by prescribers, dispensers and patients through the provision of the necessary training, education and information.
- To promote the concept of individual responsibility for health, preventive care and informed decision-making.

Achieving these objectives requires a comprehensive strategy that not only includes improved supply and distribution, but also appropriate and extensive human resource development. The implementation of an Essential Drugs Programme (EDP) forms an integral part of this strategy with rationalisation of the wide variety of medicines available in the public sector as a first priority. The private sector is encouraged to use these guidelines and the drug list wherever appropriate.

The working principles used by the National Essential Drugs List (EDL) Committee to draft the EDL/STGs (Standard Treatment Guidelines) for primary care were:

- Conditions to be included are those which comprise the majority of contacts at the primary level i.e. at the first point of contact with the health service. Prevalence and severity were factors also considered.
- Treatment for the conditions will be initiated at primary care level, will be competency based and not restricted to specific occupations.
- Treatment will follow standard recommended treatment guidelines, which will specify both treatment and referral details.
- Drug legislation will reflect and facilitate practice i.e. scheduling will enable health workers at primary level access to recommended drugs.

The criteria for the selection of Essential Drugs for Primary Health Care in South Africa were based on the WHO guidelines for drawing up a national EDL. They include the following points:

- Any drug included must meet the needs of the majority of the population.
- Sufficient proven scientific data regarding effectiveness must be available.
- Any drug scheduled in the EDL should have a substantial safety and risk/benefit ratio.
- All products must be of an acceptable quality, and must be tested on a continuous basis.
- The aim, as a rule, is to include only products containing single pharmacologically active ingredients.
- Combination products, as an exception, will be included where patient compliance becomes an important factor, or two pharmacologically active ingredients are synergistically active in a product.
- Products will be listed according to their generic names only.
- Where drugs are clinically equally effective, the drugs will be compared on the following factors:

- The best cost advantage.
- The best researched.
- The best pharmacokinetic properties.
- The best patient compliance.
- The most reliable local manufacturer.

A request for a new product to be included on the EDL must be supported by scientific data and appropriate references on its advantages and benefits over an existing product …"

(National Essential Drugs List Committee, 1998: iii - iv)

**TASK 3 – Reviewing your own national policy on public health drugs**

a) Does your country have a National Essential Drugs list and National Standard Treatment Guidelines?

b) Do staff members who are making decisions about selecting and prescribing have copies of the Essential Drugs list and the Standard Treatment Guidelines?

c) Ask clinical staff in your programme if they are aware of such documents and to what extent they use them. Ask clinicians how they feel about having a limited list of drugs available and about using Standard Treatment Guidelines.

d) If you wanted to distribute these guidelines, where would you get them?

**FEEDBACK**

Your answers will be specific to your situation, but here are some thoughts on questions (c) and (d).

c) Clinicians sometimes resist the use of Standard Treatment Guidelines as they feel it limits their clinical freedom to make the choice they feel is best for their patients. However, this is not the intention of such guidelines.

"… When treating patients, the final responsibility for the well-being of the individual patient remains with the health worker. It is therefore important to remember that the recommended treatment provided in this book are guidelines only and are based on the assumption that the prescriber is competent to handle patients' health conditions that present at their facility …" (National Essential Drugs List Committee, 1998: v) This means that it is acceptable for a clinician to deviate from the guidelines in particular cases. Such action should however be backed up by scientific reasoning.

d) Despite the importance of Essential Drugs lists and Standard Treatment Guidelines, health workers frequently do not have access to them, particularly in rural areas. As a manager, you should ensure that all staff who are involved in selecting and prescribing drugs have access to relevant documents.

In South Africa, copies of the Essential Drugs lists and Standard Treatment Guidelines may be obtained from: The Directorate: Pharmaceutical Programmes and Planning, Private Bag X828, Pretoria, 001

So far we have looked at important issues underlying the selection and use of drugs. In the next section, we will move on to a very important practical part of drug supply management: inventory control.

## 4 Inventory control

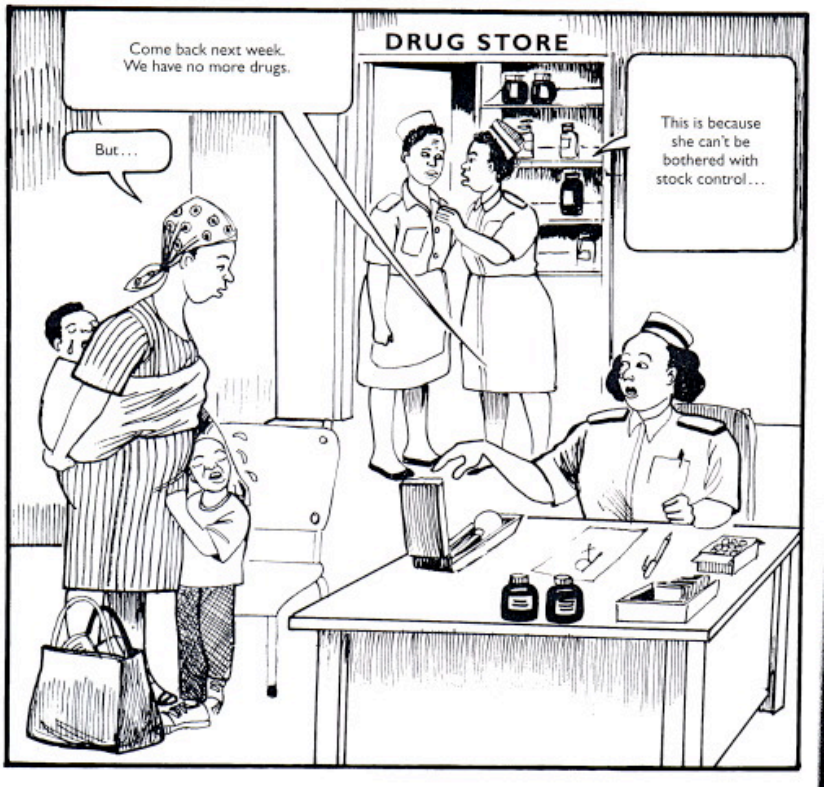
Inventory control or inventory management is one of the most important aspects of drug supply management and ultimately affects all parts of the drug management cycle. Unfortunately however, inventory control is often neglected, resulting in both wastage and shortage of drugs. A health manager should understand what inventory control means and why it is important:

> "…The goals of medical stores management are to protect stored items from damage, theft or wastage and to manage the reliable movement of supplies from source to user in the least expensive way. Effective use of information is the key to achieving these goals … [This] integrated process is known as inventory control." (Management Sciences for Health, 1997: 342)

> "… Inventory management is not something that can be done sometimes. It works only if records are maintained accurately and in a timely fashion. The long-term benefits of implementing such a system outweigh the efforts needed for its maintenance.

> The main objective of inventory control is to be able to supply the right quality product to the patient at the right time and in the right quantity. This is the only way to ensure people's confidence in the health system and to provide adequate quality of care …" (Province of the Eastern Cape, Department of Health, 2000: 4)

Proper drug inventory control is a crucial system of health services provision and is therefore a crucial responsibility of a health manager.




To emphasise this point, imagine this situation:

> You are living in a rural area. The only health facility nearby is a government clinic. Your child is seriously ill. She needs a particular drug urgently. The clinic in charge informs you that unfortunately the drug is out of stock and suggests that you go to the commercial pharmacy in the town. The town is 50km away. The main road is 20km away. There is no regular transport to the main road. You will have to walk. There are no regular buses on the main road. You will have to hitch a ride. People hitching rides are often attacked on this road. Women have been raped. Sometimes there are taxis but they are very expensive. If you pay for the taxi you may not have enough money for the drug. Even if you manage to buy the drug, you will not be able to buy food for your other children for a week, so you will have to ask your relatives for help. Your relatives have their own difficulties and you feel so bad to ask them.

**TASK 4 - Thinking about the results of poor inventory control**

How would you feel if you knew that the drug was out of stock because the clinic staff did not order it in time or because they did not keep proper records of how much they have in stock? What if the drug was not really out of stock but the store was so untidy that the staff could not find the drug even if they did have it?

**FEEDBACK**

You would probably feel very angry and you should be very angry. Maybe something like this has not happened to you, but it has happened to many people. Usually these people are poor and uneducated and there is nothing they can do about the situation. As health providers, we face many challenges and there are many things we cannot change, but it is unacceptable that a child should die or a family, already struggling to survive, should be further financially crippled because of a management issue that could very easily be improved.

We are now going to look at how to manage medical stock in order to minimise the chances of the above situation happening.

## 4.1 Management of medical stores and stock cards

As a manager, unless you are managing a drug programme specifically, you will probably not be directly involved in organising stores and keeping stock records. However, as we discussed in the financial management session, you are ultimately responsible for the way resources are used. Therefore, it is important for you to be familiar with what your staff members are doing if you are to supervise them adequately.

The readings for this section are taken from a manual which gives a detailed overview of two aspects of inventory control: *managing the storage and movement of drugs*, and *calculating future needs and ordering*. In this session we are only going to focus on the first aspect. The calculation of future needs and the ordering process are very important and as a manager, you will need to have some insights into these aspects of drug supply management. It is, however, beyond the scope of this session to present these issues adequately. However, we have included the entire manual so that you will be able to refer to it when necessary in your work.

We have provided a manual developed for the Eastern Cape Province of South Africa which will be referred to throughout this section. Read page 5 of it, Reading 32 - “The Manual Contents and how to use it” and then preview the manual for an overview of its contents.

Reading 32: Province of the Eastern Cape, Department of Health. (2000). *Managing Drug Supply for Health Institutions.* Eastern Cape Province: Department of Health, p5 & pp12-17.

Three key questions form the foundation of inventory control:

- What have we got in the store right now?
- What has gone out of the store, to where and when?
- What has come into the store, from where and when?

To help you answer the first question, you need to have a well-organised store. To answer the other two questions, you need to have an up-to-date stock card system.

Study pages 12 to 15 of Reading 32 and then do Task 5 to evaluate the storage conditions in the medical stores in your own work setting.

Reading 32: Province of the Eastern Cape Department of Health. (2000*). Managing Drug Supply for Health Institutions*, Eastern Cape Province: Department of Health, pp18-43.

**Task 6 – Checking incoming stock**

In your work situation, assess the system for checking incoming stock by completing the checklist on page 35 of Reading 32.

**FEEDBACK**

It is important to have a system for checking that what has arrived is what you ordered. Suppliers can make errors and can sometimes, even knowingly, supply expired or poor quality products. It is particularly important to check expiry dates. If you do not document such issues and take action in an appropriate and timely manner, it may be impossible to hold the supplier accountable and in the end your programme or project may have to bear the costs. Ultimately, the patients are the ones who lose out.

The issue of checking drug quality is difficult, as often the only way of completely assessing quality is by means of complex and expensive laboratory tests. However, there are some clues which can alert health workers to the possibility of inferior quality. These are listed on the checklist on page 17 e.g. item 12. Remember that poor quality packaging should be viewed with suspicion. No damaged containers should be accepted. If in doubt about any drug quality issues, contact the appropriate drug authority in your health system for advice.


Photograph of a drug storage system using BIN cards to record stock (W.Venter)

**Task 7- Assessing the stock card system**

Use the checklist on page 43 of Reading 32 to assess the stock card system in your work place.

**FEEDBACK**

The following points are worth noting when considering drug inventory control:

It is essential to update stock cards immediately items are added or removed, and to arrange newly received items in their proper places as soon as possible after arrival. If this is not done, the system will break down and it will require a great deal of work to get it functioning again. If you lose track of stock quantities even for a short while, you will probably have to do a complete stock-taking and start the system all over again. This can be very time-consuming. A little bit of effort in the short term will prevent a lot of headaches later!

Drugs differ from many other resources in that they have expiry dates. An inventory control system must include a method of tracking expiry dates. Some drug management systems use sophisticated computer programs to do this. However, a very simple method is to make sure that items expiring first are always stored in front on those expiring later, so that they are used first i.e. the FEFO method: First Expiring, First Out. In addition, the storekeeper should, at set intervals, identify stock which will expire soon and make a decision as to what should be done about it. For example, should it be distributed quickly, or destroyed, or if appropriate exchanged for something else? The definition of *expiring soon* may vary according to the drug and the circumstances, and different places may have different policies regarding approaching expiry. These are technical issues in which a manager may not be directly involved, but it is important to realise that loss of drugs through expiry is a common problem which can result in significant wastages.

It is very useful to have a specific area of space designated as a *receiving area* and a *dispatch area*. Newly arrived stock gets placed in the receiving area until it is checked. It is then moved to the storage area and entered onto the stock cards. Drugs that have been packed and are waiting to be distributed are placed in the dispatch area. This prevents them from getting mixed up with other stock.

The manual (Reading 32) from which you have been working describes an inventory control system used in the Eastern Cape Province of South Africa. In different contexts the system may be slightly different, but it will be based on the same principles: *knowing what you have in stock and recording all stock movements immediately*.

Some inventory control systems utilise a *double entry* method similar to the principles used in some financial control systems. Two kinds of stock cards are needed for the double entry method: the kind of card we have so far called a stock card, is called a *BIN card* in this context. It is used inside the store, placed next to the item and kept up to date by the storekeeper as s/he adds items or removes items from the shelves. The second kind of card is a called a *stock record card*. Stock record cards are kept in the office rather than the store and are filled in independently by a different person, using documents showing items received into or dispatched from the store. The BIN cards plus the stock record cards thus form a double entry system, facilitating control of the stock through a *check-back* mechanism. The amounts on the stock record cards should always match those on the BIN cards. If there are discrepancies, further investigation is necessary. This system thus safeguards against human error or potential dishonesty.

In this section we covered some of the very basic principles of inventory control: having a well-organised storage system and an up-to-date stock card system. These systems will provide the manager with accurate information not only about the present stock situation but also about past drug consumption, which is used to calculate future needs. This information should guide the manager in making important decisions about resource allocation. In the absence of a functioning inventory control system, it is almost impossible to ensure that patients will have access to the right drugs in the right quantities at the right time.

# 5 SESSION SUMMARY

During this session, we looked at the concepts of Essential Drugs, rational drug use and Standard Treatment Guidelines. We also examined important aspects of an inventory control system: organisation of medical stores and stock card systems. It is important to realise that Essential Drug lists, Standard Treatment Guidelines and effective inventory management all work together towards ensuring the rational use of drugs. Rational drug use is an essential component of making the best use of limited resources in the health sector in order to ensure maximum benefit to the population. In the next session, we will examine a related subject: the management of medical supplies and equipment.

# Unit 5 – Session 3

# Managing Medical Supplies and Equipment

## Introduction

Although medical supplies may use up to 40% of the drug budget, and large sums of money are spent on medical equipment, the management of supplies and equipment is often neglected. Wastage is common and unused or broken equipment are a frequent sight in many medical stores and health facilities. However, the availability of appropriate supplies and equipment is essential to the provision of health care. In this session we look at some of the challenges associated with the management of medical supplies and equipment and at options for improvement.

## Session contents



## Timing of this session

There are four tasks and seven readings in this session. It should take you about two hours to complete as many of the readings are short. Tasks 3 and 4 require a *research visit* to your workplace.

# 1 LEARNING OUTCOMES OF THIS SESSION

| **Intended learning outcomes**<br><br>By the end of this session, you should be able to: | |
|---|---|
| **Management outcomes:**<br><br>▪ Explain the difference between medical supplies and equipment.<br>▪ Grasp the value of standardisation.<br>▪ Understand the range of factors affecting the selection of equipment.<br>▪ Demonstrate awareness of resources available to you when making choices<br>▪ Describe the systems for strengthening quality assurance.<br>▪ Understand the importance of preventive maintenance. | **Academic outcomes:**<br><br>▪ Evaluate systems in your workplace terms of other models.<br>▪ Analyse the reasons for certain weaknesses in a system.<br>▪ Clarify terminology. |

# 2 READINGS AND REFERENCES

The readings for this session are listed below. You will be directed to them in the course of the session.

| Reading | Publication details | Page numbers |
|---|---|---|
| 33 | Management Sciences for Health. (1997) .*Managing Drug Supply*, Chapter 12- "Ëssential Medical Supplies and Equipment", West Hartford, Connecticut: Kumarian Press. | pp150-155 |
| 34 | Management Sciences for Health. (1997) .*Managing Drug Supply*, Chapter 12- "Ëssential Medical Supplies and Equipment", West Hartford, Connecticut: Kumarian Press. | pp160 |
| 35 | National Department of Health, South Africa. (2000). *Handbook for Clinic/CHC Managers*. | pp20-21 |
| 36 | Regional Health Bureau, Regional State of Tigray, Ethiopia. (2001). *Equipment List for Health Centers*. Unpublished document.. | pp1-9 |
| 37 | Health Manpower Development Staff. (1986). *Health Center Operations.* Honolulu: University of Hawaii. | pp46-47 |
| 38 | Health Manpower Development Staff. (1986). *Health Center Operations.* Honolulu: University of Hawaii. | pp42-43 & pp48-50 |
| 39 | Health Manpower Development Staff. (1986). *Health Center Operations.* Honolulu: University of Hawaii | pp51-53 |

| References | Publication details | The page numbers are in the text |
|---|---|---|
| | Health Manpower Development Staff. (1986). *Health Center Operations.* Honolulu: University of Hawaii. | |
| | World Council of Churches (WCC) & Community Initiatives Support Services (CISS). (1993). *Guidelines on Medical Equipment Donation.* Geneva/Nairobi: WCC & CISS. | |

# 3 PROBLEMS WITH MEDICAL SUPPLIES AND EQUIPMENT

You may not be directly involved in managing supplies and equipment. However, some insights into issues relevant to this important aspect of health service provision will assist you as a manager in supervising your staff and in making decisions about resource use.

Task 1 highlights some common problems and serves to draw your attention to the need for appropriate management systems concerning medical supplies and equipment.

**TASK 1 - Analysing some of the reasons for inadequate supplies and equipment**

Imagine that you are visiting a district hospital in a remote area. Before touring the facility you meet with the staff. They tell you that they are unable to provide adequate services because they lack the following equipment and supplies:

X-ray machine
Operating theatre lights
Refrigerators
Sterilisers
Anaesthetic machine
Opthalmoscopes
Glucometer
Microscope
Sterile gloves
Suture materials
HIV tests

While walking through the facility you notice an X-ray machine which appears to be brand new. There are lights in the operating theatre. In one of the stores, you count three refrigerators, four sterilizers, two anaesthetic machines, a box full of ophthalmoscopes and a glucometer. You also notice what appears to be a brand new EKG machine and as well as an older one. Then you remember that a new microscope was sent to this hospital two years ago. You also see many boxes of suture materials and HIV tests in the store and notice that the cleaner is wearing sterile gloves while washing the floor.

a) Write down some possible explanations for the situation described.

b) Identify the practices and underlying weaknesses within the health system that could contribute to these problems

**FEEDBACK**

a) Here is an explanation of the problems in the district hospital:

The new X-ray machine was installed two years ago. It has a sophisticated computerised operating terminal. Unfortunately no-one at the hospital knows how to operate it.

Two of the three refrigerators run on solar power. The solar battery system requires careful maintenance with distilled water. Unfortunately the person in charge of maintaining the battery system appears not to know about this. The other refrigerator runs on kerosene. It has been sent for repair twice. Each time it only worked for a few weeks before breaking down again. The hospital budget for maintenance for this year has already been spent. Two of the sterilisers were donated from the USA and require 110V input. Unfortunately the staff did not realise this and one sterilizer was burned out when it was plugged into the 220V power supply. The equipment budget did not allow for the purchase of transformers. The other two sterilisers only require new gaskets. No one appears to have ordered these.

A high quality operating theatre light was installed by a European donor several years ago. Unfortunately the bulbs have blown and new ones can only be purchased from Europe at considerable expense. Two mobile operating theatre lamps were also acquired. However, as a result of power surges from the town electricity supply, both have burnt out. The budget does not make provision for the purchase of stabilisers.

Two anaesthetic machines were purchased by a European donor. Unfortunately their fittings are for gases not routinely used in rural hospitals. The ophthalmoscopes were provided by a UN donor. The batteries they require are not available locally. The new EKG machine was provided by a Chinese donor. However all the instructions are in Chinese. The older EKG machine is also a donation. It is functional but the necessary connection cables were not included in the donation. As it is an old model, it is no longer possible to purchase the cables. The glucometer is functional but requires the use of test strips not available from the government supplier. To purchase them from commercial suppliers is very expensive.

There are conflicting reports about the presence of a microscope. The current laboratory technician says that there has been no microscope since her arrival one year ago. There appear to be no records concerning the microscope.

The suture materials consist of a very large number of very fine and very thick sutures, not appropriate for routine use in this hospital. They were part of an unsolicited donation. However, as a large amount of suture material was registered on the inventory, the financial controller questioned the purchase of additional sutures. An investigation is thus in progress and the matter will probably be resolved, but the appropriate sutures are needed now.

A few years ago, a supplier incorrectly sent a large number of size 6 sterile gloves, instead of the requested sizes 7, 7.5 and 8. Size 6 gloves are too small for most of the staff. As this was not appropriately documented at the time the gloves were received and when it was noted, the supplier refused to rectify the mistake.

The HIV tests were delivered after they had been on the back of a truck for 4 days in the middle of summer. This particular brand requires refrigeration. Although the items were packed in cold boxes, these were not appropriate for maintaining temperatures for a period as long as four days. The laboratory staff felt it unethical to use the tests under these circumstances as they could not guarantee their effectiveness. The truck was dispatched from the provincial office but it was not possible to ascertain who was responsible.

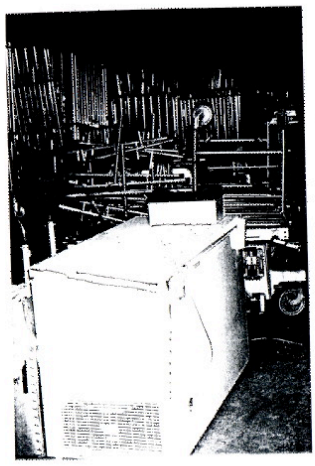
b) Weaknesses in the system which could contribute to these sorts of problems:

- The level of sophistication of the technology is inappropriate for the level of training of the staff.
- There is no system for training staff on how to use new and unfamiliar equipment.
- The system for reporting and follow-up on repair and maintenance is inadequate.
- The budget for repairs and maintenance is inadequate.
- The system for documenting received goods and following-up on problems is inadequate.
- There is excessive bureaucracy e.g. problem with finance department about sutures which results in unavailability of necessary items.
- The system for safeguarding equipment against theft is inadequate.
- Appropriate supervision and accountability appear to be lacking.
- There appears to be no policy regarding donated equipment to ensure that what is given is appropriate to the circumstances in terms of environment, staff capability, maintenance issues and ongoing costs.

This case study illustrates a number of common issues in the management of medical supplies and equipment. Such issues usually occur as a consequence of three main underlying problems: lack of policies, lack of standardisation, and lack of quality assurance. Can you relate the issues described in Task 1 to these three problems?

The three problems influence each other. The lack of policies may result in lack of standardisation or lack of quality assurance, or, even if policies do exist, the systems to implement them may be weak. A lack of standardisation may in turn contribute to difficulties with quality assurance.

In this session, we are going to examine the concepts of standardization and quality assurance. Although many of the issues discussed here are relevant to both supplies and equipment, the focus of much of the session will be on equipment.



Broken equipment crowding available space (W. Venter)

# 4 STANDARDISATION

As a health manager you will be required to approve budgets and purchases of supplies and equipment. Understanding the meaning and benefits of the concept of standardisation can assist you in making decisions and in guiding your team in effective resource management.

Study Reading 33 and then complete Task 2. Note the explanation of the difference between supplies and equipment on page 151 of Reading 33.

> Reading 33: Management Sciences for Health. (1997). *Managing Drug Supply.* Chapter 12 - "Ëssential Medical Supplies and Equipment." West Hartford, Connecticut: Kumarian Press, pp150-155.

**Task 2 - Understanding standardisation**

a) What is meant by standardisation of medical supplies and equipment?
b) What is meant by minimum specifications?
c) What are some advantages of standardisation?
d) What are some challenges associated with standardisation?

**FEEDBACK**

a) Standardisation in this context means that a country, a region, a district or even an individual health facility will decide upon a list of carefully selected items that will consistently be used as the standard when procuring supplies and equipment. Standardisation includes two components:
   - The variety of items needed at each level of facility e.g a list of the different pieces of equipment required for a district hospital or a health post. If the size of the facility or population is specified, the standard list may also include recommended amounts of each piece of equipment.
   - The details of what each item should be able to do as well as factors which affect its quality e.g. the type of metal from which a medical instrument should be made, its size, etc. These are called the product specifications.

     > "Like drugs, equipment and medical supplies should be selected on the basis of need … A national committee for supplies and equipment should then combine the lists for each level of care into one list of essential medical supplies and equipment. Like the list of essential drugs, this list should be the basis for standardized procurement and distribution of supplies and equipment, as well as for training …" (MSH, 1997: 152)

b) Minimum specifications are related to product specifications and describe the minimum functional and quality requirements of an item e.g. Figure 12.1 on page 153 of reading 33.
c) The variety of medical supplies and equipment potentially available is vast. A standard list helps to identify the most needed items, thus assisting in making important choices in the face of scarce resources. Having a limited variety of equipment types has the following advantages:

   - It simplifies inventory management.
   - It allows a province or a country to buy in bulk, which may reduce costs.
   - It makes maintenance and repair easier because technicians do not have to be familiar with a vast number of different items; spare parts can be bought in bulk, thus improving availability and keeping costs down.
   - It makes the training of staff in operation and maintenance easier, because again they do not have to be trained to manage a large number of different items.

d) While the advantages of standardisation are clear, in practice it may be difficult to achieve. Clinicians may try to insist on particular brands of equipment that they prefer. Regulations in the tender process may require that certain brands are purchased because of better prices, even though they are not on the standard list. As illustrated in the case study, donations present a particular problem. Here are a few possible reasons for problem donations:

- "… Donors of medical equipment may have no background in health issues, nor an understanding of the structure of health services of the recipient (usually based in a developing country), and do not recognise the need to seek expert advice.
- New but inappropriate equipment is donated as a means of promoting and marketing it.
- Companies, hospitals or private doctors donate outmoded, outdated equipment as it provides them with tax exemptions or as a means of getting rid of redundant equipment.
- Potential donors with patronizing attitudes towards recipients regard them as beggars desperate for any equipment and therefore don't consider it worthwhile to consult them. The recipient may compound this problem by feeling obliged to accept any donation, even though the equipment is unnecessary, or where charges such as import taxes and transport costs are prohibitive … " (WCC & CISS, 1993: 1)
- Rather than giving donations in kind, it is generally better when a donor provides the funding with which to purchase the equipment. The donor may not agree to this though. Even when such funding is provided, problems can arise as the donor may insist on specifying from where the items should be purchased.

These are challenging issues and often involve policy decisions at high levels. Frequently the manager has little control over such issues. However, if as a manager you do have some control over the type of equipment purchased and received, it is definitely worth trying to standardise as much as possible.

DONATIONS CAN THEMSELVES BE A DISASTER AREA

(From Management Sciences for Health. (1997). *Managing Drug Supply.* West Hartford, Connecticut: Kumarian Press, p307)

**Task 3 – Investigating standardisation in your setting**

a) Find out if there are standard supplies and equipment lists available in your workplace. These may originate from national or provincial level, or even have been established in your district or facility.

b) If standard lists do exist, obtain the most recent inventory list from each health facility and compare the inventory lists to the standard list to see to what extent the standards are being followed.

c) Are the standard lists used to guide procurement and donations?

d) Do the lists include minimum product specifications?

**FEEDBACK**

If no standard lists exist, the manager should consider initiating the process of establishing such lists. This process should be carried out by a team which includes managers, health workers from various levels and various disciplines, and very importantly, equipment technicians.

"… Important issues to consider with regard to standardisation include:

- Staff experience, and training required for installation, operation and maintenance. Consider both the clinical staff and the technical services staff required to operate the equipment.
- Location for the equipment, including site accessibility and the space available.
- Climatic and environmental conditions, such as … temperature, humidity, dust, ventilation, etc.
- Utilities: power supply (gas, generator, fossil fuel, wood fuel, solar, windmill, biogas, etc), reliability of supply (fluctuating power, interruptions, rationing, etc), type of power (voltage, frequency, phase, AC/DC), type of water (polluted, salty, hard, soft, etc) and the means of delivery (piped, stored, well, river, rain, etc).
- Support services required for operation, procedures and clinical use of equipment. Keep in mind that modern equipment may offer a wide variety of operational modes and may simplify the performance of certain procedures but it is often very expensive, and may need both health specialists and a manufacturer's service network for maintenance and repair. When these are available, spare parts and special maintenance tools that are costly may be required. Sophisticated equipment often has very sensitive parts. Also remember that sophisticated modes offered by the equipment are often not utilised.
- Maintenance costs: in terms of spare parts, downtime during normal servicing and level of expertise of technical staff required.
- Availability of consumables: some equipment may require consumables which are not available locally, for example, special papers, films, filters, etc. These are recurrent cost items and their availability must be assured.
- Other specific requirements related to the equipment. For example, whether a new edition will conform with existing equipment … or especially solid walls for x-ray machines … or power stabilisers for electronic equipment etc.
- Experience of others with similar equipment, brands or sources. Check whether equipment is manufactured locally or imported on a regular basis …" (WCC & CISS, 1993: 1)

The above points are useful not only for the establishment of standard lists, but can be used as a checklist when any new piece of equipment is to be purchased or received as a donation.

Here are some examples of standard lists:

Reading 34: Management Sciences for Health. (1997). *Managing Drug Supply.* Chapter 12 - "Ëssential Medical Supplies and Equipment." West Hartford, Connecticut: Kumarian Press, p160.

Reading 35: National Department of Health, South Africa. (2000). *Handbook for Clinic/CHC Managers,* pp20-21.

Reading 36: Regional Health Bureau, Regional State of Tigray, Ethiopia. (2001). *Equipment List for Health Centers*. Unpublished document, pp1-9.

Reading 34 provides a good example of a simplified but very adequate standard supplies list. Reading 35 shows a simple standard equipment list for a clinic or community health centre in South Africa, while Reading 36 provides a more detailed list from Ethiopia.

At the beginning of this section, we noted that there are three main problems in the management of medical supplies and equipment: lack of policy, lack of standardisation and lack of quality assurance.

We have so far examined the concept of standardisation. In the next section, we will look at the issue of quality assurance.

# 5 QUALITY ASSURANCE

This section focuses on medical equipment rather than on supplies. The availability of functional medical equipment is vital to the provision of adequate health services. Quality assurance means that appropriate and fully functional equipment is available in the right place at the right time.

Quality assurance can be strengthened through having systems in place for:

- selection of appropriate equipment.
- inventory control.
- training of health workers in operation and maintenance of equipment.
- preventive maintenance and repair.

## 5. 1 Selection of appropriate equipment

This has already been discussed in the previous section on standardisation.

## 5.2 Equipment inventory control

In session 2 of this Unit, we saw that the basic principles of drug inventory control are:

- Knowing what is in stock right now.
- Knowing what goes to where and when.
- Knowing what comes from where and when.

The same principles apply to equipment inventory control, whether you are dealing with items in a store or items in use in a health facility. The central issue is that all items must be accounted for.

The first step here is to ensure that an up-to-date inventory is available. Each facility should have a complete equipment inventory done at least once a year. For larger facilities, the equipment should be listed according to department or ward. All non-functional equipment should also be listed.

Such inventories help to identify needs as well as highlighting excess or unnecessary items which could perhaps be used elsewhere. Inventories also help to ensure accountability for items. If regular inventories are not done and appropriate records are not kept, it may be possible for equipment to "disappear" and it may then be very difficult to prove that it was there in the first place!

A common problem in assessing inventories is that different people describe the same piece of equipment in different ways or provide inadequate descriptions so that it can be difficult to interpret what has been written in the inventory. A way of improving this is to provide staff with standard lists which include item specifications to serve as a model to guide them when they describe equipment. It may also be helpful to hold a meeting to explain the value of inventories and the importance of clear and accurate documentation.

Study Reading 37 for an example of a simple inventory list. Note that this list is a good start, but can be improved upon by providing more detailed descriptions of some of the items. For example, instrument steriliser: Is it electrical or not? Is it steam or dry? What size? What brand?

Reading 37: Health Manpower Development Staff. (1986). *Health Center Operations.* Honolulu: University of Hawaii, pp46-47.

## 5.3 Training of staff

When new staff members are hired or a new piece of equipment arrives, it is essential that all concerned should understand how to operate and care for the equipment. If it is a complex piece of equipment, arrangements should be made with the supplier to install the item and train the staff. Sometimes this arrangement can be included in the purchasing contract. Make sure that the operating instructions are included with all new equipment. It is also good idea to keep a reference file of the operating instruction pamphlets for all equipment.

## 5.4 Preventive maintenance and repair

Preventive maintenance means taking good care of equipment to prevent breakdowns and to extend the useful life of the equipment. A lot of time, effort and money can be saved if a few simple procedures are followed in caring for the equipment. This can be achieved through having a regular preventive maintenance schedule, as described in the reading:

Reading 38: Health Manpower Development Staff. (1986). *Health Center Operations.* Honolulu: University of Hawaii, . pp42,43,48-50.

The reading describes a very simple but effective system. Depending on the size of the health facility, each department or ward should have its own schedule. A very important part of preventive maintenance is that specific staff members are assigned to such duties and that they are appropriately supervised.

It is essential to have a proper system for reporting non-functional equipment and for tracking the repair process. Items have been known to remain in warehouses for years and when questioned, the storekeeper will answer, "Well, I reported it two years ago!" One way of keeping track of repairs is to channel all repair requests through one person who is then in charge of following up on the process.

Provision for spare parts and maintenance is often forgotten when budgets are drawn up. Aside from ensuring that these are included, its also a good idea to order frequently-needed spare parts along with a piece of new equipment, so that they will be on hand when needed. It may also be easier to include them in the budget this way! It may also be possible to negotiate a maintenance contract with the supplier for a certain period in the purchase price.

Study Reading 39 for an example of a simple repair system.

Reading 39: Health Manpower Development Staff. (1986). *Health Center Operations.* Honolulu: University of Hawaii, pp51-53.

**TASK 4 – Evaluating your own equipment management system**

Even if this is not your direct responsibility, take the time to find out from the manager of equipment and medical supplies what the situation is in your workplace. Remember that as a manager, you are ultimately responsible for the way in which resources are used.

Find out if the following systems exist in your work place:

- Annual equipment inventory.
- Training of staff in operation and care of equipment.
- Preventive maintenance schedule.
- System for reporting and follow-up on repairs.
- An adequate budget line for maintenance and repair of medical equipment.

**FEEDBACK**

The availability of well-functioning equipment improves the quality of health service provision and contributes to job satisfaction among staff. Effective systems for quality assurance are needed to achieve this. Such systems are not difficult to implement, but the need to maintain them may have to be consistently reinforced. As a manager, you are in a position to motivate and support your staff on issues of quality assurance.

# 7 SESSION SUMMARY

In this session we looked at some of the challenges surrounding the management of medical supplies and equipment. The benefits of standardisation and the factors influencing selection were examined. We also noted the importance of training staff in operation and care of equipment and of having a proper maintenance and repair system in place. As a manager you will not be expected to be an expert on all the technical details concerning medical supplies and equipment. However, some insights into the issues associated with medical equipment and supplies will assist you in making important decisions to ensure the best use of resources. In the next session, we look at the management of transport resources.

In the next session, we will look at the management of another essential resource in the health care system – managing transport.

# Unit 5 – Study Session 4 Transport Management

## Introduction

A well-functioning transport system is an essential component of the provision of health care. The effective management of transport resources thus forms an important part of a health manager's job.

In this session, we will analyse transport needs and available transport resources and reflect on existing systems for doing this. We will also examine the components of a well-managed transport system.

## Session contents



## Timing of this session

There are three tasks and four short readings in this session. The tasks require research at your workplace, so you need to build this into your study schedule. It should take you approximately two hours.

# 1 LEARNING OUTCOMES OF THIS SESSION

| **Intended learning outcomes**<br><br>By the end of this session, you should be able to: | |
|---|---|
| **Management outcomes:**<br><br>▪ Conduct a situation analysis of transport needs and available resources<br>▪ Draw up a transport schedule<br>▪ Understand the importance of systems and procedures in a transport system. | **Academic outcomes:**<br><br>▪ Analyse systems.<br>▪ Gather and evaluate information about existing transport systems. |

# 2 READINGS AND REFERENCES

You will be referred to the readings below as you work through this Study Session. The references used in this session are also noted.

| **Reading** | **Publication details** | **Page numbers** |
|---|---|---|
| 40 | Nancollas, S. (1998). Chapter 9 - "Transport Management for District Managers" in *The District Manager's Handbook*, South Africa: Department of Health. | pp97-101 |
| 41 | Health Manpower Development Staff. (1982). *Health Center Operations*. The Medex Primary Health Care Series. Honolulu: John Burns School of Medicine, University of Hawaii. | pp57-61 |
| 42 | Nancollas, S.(1998). Chapter 9 - "Transport Management for District Managers" in *The District Manager's Handbook*, South Africa: Department of Health. | pp101-111 |
| 43 | Health Manpower Development Staff. (1982). *Health Center Operations*. The Medex Primary Health Care Series. Honolulu: John Burns School of Medicine, University of Hawaii. | pp62-74 |
| **References** | **Publication details** | **Page numbers are in the text** |
| | Nancollas, S. (1998). Chapter 9 - "Transport Management for District Managers" in *The District Manager's Handbook*, South Africa: Department of Health. | |
| | Hall, W. (2000).*No Transport, No Primary Health Care!* Health Systems Trust Website. | |
| | Adamafio, N.A. in Nancollas, S. (1998). Chapter 9 - "Transport Management for District Managers" in *The District Manager's Handbook*, South Africa: Department of Health. | |

# 3 PROBLEMS IN TRANSPORT MANAGEMENT

In many public sector workplaces, the issue of transport can be a source of frustration and conflict among workers.

"… Across the world, services delivery departments spend large amounts of capital and revenue providing transport services. In some countries this can represent 30-50% of the budget after salaries have been paid. In spite of this the most frequently given reason for the non-delivery of services is that there is no transport available. Even if funding for more vehicles is found, there is rarely the expected increase in service delivery. It has been shown that the effective management of transport has a much greater impact on service delivery than the provision of new vehicles …" (Nancollas,1998: 96)

**TASK 1 – Reflecting on transport problems in your workplace**

List a few problems you frequently experience with transport in your workplace. Write down some reasons that you think could be contributing to the problems.

**FEEDBACK**

Here are some examples of transport problems:

> "… In Mount Frere, management personnel were frequently expected to attend meetings and workshops, often at short notice, outside the district. Somehow, transport was always made available for these trips, even at the expense of other health-related trips, such as to the clinic or to the community. It was therefore questioned whether transport was more often used for administrative and bureaucratic purposes, rather than for supporting service delivery …" (Hall, 2000)

Often there is no clear system for determining transport needs and assigning vehicles ahead of time. This makes it very difficult for field staff to plan their activities as they are never sure whether or not a vehicle will be available. In many situations, rather than having official vehicles working out in the field, they frequently remain stationed at the district office or the hospital, for the convenience of senior staff, who may use vehicles for both official and personal reasons.

There may not be any system for monitoring where vehicles are or what exactly they are being used for. Staff in a rural district of Rwanda used to joke that the district ambulance transported a lot more bunches of bananas than patients!

Vehicles often break down and may be out of service for extended periods. Contributing factors include lack of systems for preventive maintenance and irresponsible driving practices which increase vehicle wear and tear. The repair process is often delayed because spare parts are not available or there is no budget to purchase them.

The above examples illustrate two very important underlying problems: lack of systems and a lack of accountability.

As a manager, you are responsible for ensuring the appropriate use of health resources.

"… In the context of health service delivery, vehicles must be treated as tools which are used to support service delivery. They must be managed by the managers responsible for managing health services. The district manager is a key individual in the process. It is important that everyone involved in service delivery is aware of the costs and benefits of using transport and takes responsibility for their use of the resource …

Transport management in health care is easy. It is simply resource management based on good quality data with a small prescribed technical element. It does not need technical experts to be employed at the district or regional level. It simply requires the allocation of transport duties to individuals who understand service delivery and can be trained in transport management …" (Nancollas, 1998: 96)

In the sections that follow, we will look at some of the ways in which a transport system can be strengthened.

## 4 ANALYSING THE NEEDS AND THE RESOURCES

In order to improve the transport system, first you need to carry out an assessment of the transport needs and the available transport resources i.e. conduct a transport situation analysis. Then you need to decide how to use the resources to best meet the needs. Through this process, you will be going through the stages of a planning cycle: *Where are we now? Where do we want to be? and How will we get there?* You will be using information from the past and the present to prepare for the future.

Study the reading, which focuses on a district level transport system, and then complete Task 2:

Reading 40: Nancollas, S. (1998). Chapter 9 - "Transport Management for District Managers" in *The District Manager's Handbook*, South Africa: Department of Health, pp97-101.

**TASK 2 – Conducting a situation analysis of transport in your workplace**

Conduct an analysis of the transport situation in your workplace, detailing all the currently available resources and the transport needs over a one-month period. It will be important to involve your team members in this process.

**FEEDBACK**

Your responses will be individual. The next reading presents an example of a very simple but comprehensive transport system at health centre level.

Reading 41: Health Manpower Development Staff. (1982). *Health Center Operations*. The Medex Primary Health Care Series. Honolulu: John Burns School of Medicine, University of Hawaii pp57-61.

# 5 EXAMINING THE SYSTEM

"… We have found that you cannot leave transport management to chance. You must plan it, control it, measure it and understand its role in service delivery …" (Adamafio in Nancollas, 1998: 96)

The next reading describes a transport management system implemented in several countries, including South Africa. The system consists of four main parts:

- Policy development.
- Management information.
- Operational management.
- Fleet management.

> Reading 42: Nancollas, S. (1998). Chapter 9 - "Transport Management for District Managers" in *The District Manager's Handbook*, South Africa: Department of Health, pp101-111.

The section on operational management illustrates some key features of a good system: clear procedures for what needs to be done, how it should be done, when it should be done and who will be responsible for it.

Having clear procedures in place simplifies the manager's job: it minimises the risks for conflict and abuse of the system as staff members have clear information on how things should be done and how they will be held accountable.

The next reading presents some examples of procedures within a health centre transport system.

> Reading 43: Health Manpower Development Staff. (1982). *Health Center Operations*. The Medex Primary Health Care Series. Honolulu: John Burns School of Medicine, University of Hawaii, pp62-74.

**TASK 3 – Analysing systems and procedures in your setting**

Document the systems and procedures pertaining to transport in your workplace. How do they compare with the procedure and systems described in the readings? Are you able to identify any adjustments that would improve transport management?

**FEEDBACK**

At a minimum your system should include monthly and weekly transport schedules, a regular vehicle maintenance schedule and a logbook system which documents who is using the vehicle for what purpose and the kilometres travelled. Ensuring accountability for vehicle use can be a challenging issue for the manager but clear procedures make the job a lot easier. Team members and drivers should be involved in drawing up the procedures. Simply having the procedures is not enough though: they need to be implemented. If procedures are not followed, there should be consequences. As part of the process of creating procedures, let the team decide on what the consequences should be.

# 6 SESSION SUMMARY

In this session we looked at some of the problems associated with transport management and at the importance of having clear and consistently maintained systems in place. A well functioning transport system is an essential component of a health care system. Poor transport management leads to poor health care delivery.

In the next session we will look at the last aspect of management to be discussed in this module: personnel management. Here too, clear systems and procedures are vital.

# Unit 5 - Study Session 5 Personnel Management

## Introduction

Welcome to the final session of this module. We will spend this session thinking about the last, but possibly most important resource you will ever manage – human resources. Think back to all that you have read and reflected on in relation to our definition of management:

> *Management is getting things done through people.*

Personnel management is concerned with the management of people. We have already looked at many of the issues surrounding the management of people in Units 2 and 3. *Personnel management*, however, usually refers to the organisational systems and procedures that should be in place in order to get things done through people.

In a health context, " …a personnel management system must ensure that:

- enough staff are available to provide health services in the district
- the right mix of different types of health workers is present in the district
- people fulfill the duties for which they are employed
- people can take leave without services shutting down
- training opportunities are available for people to develop further skills and improve qualifications
- people feel supported and happy in their work …" (HST:16)

The session looks at organising work through organising people, activities and time. We look briefly at the process of getting the right people for the work. Then we focus on the importance of clarity: clear job descriptions, clear rules, clear procedures and clear plans. Next we look at staff development and finally, revisit the important concept of time management.

Much of what we cover here links strongly to previous study units. Try to apply some of the concepts you learned in earlier sessions to the issues we examine here.

## Session contents

## Timing of this session

This session contains nine tasks and twenty short readings. It could take you up to three hours. The end of section 4.2 would be a good place to take a break.

# 1 LEARNING OUTCOMES OF THIS SESSION

By the end of this session, you should be able to:

| **Management outcomes:** | **Academic outcomes:** |
|---|---|
| ▪ Give an overview of staff establishment, recruitment and hiring procedures.<br>▪ Explain the concept of co-ordination.<br>▪ Draw up a job description.<br>▪ Develop an orientation checklist for a new employee.<br>▪ Discuss the importance of supervision.<br>▪ Draw up a supervision plan.<br>▪ Manage disciplinary and grievance procedures.<br>▪ Guide a team to make the best use of time. | ▪ Reflect on your own experiences of personnel management.<br>▪ Suggest improvements to existing practices.<br>▪ Select information from readings. |

# 2 READINGS AND REFERENCES

The readings for this session are listed below. You will be directed to them in the course of the session. Although there are many readings, many are provided as resources to return to when you need guidance, for example, to compile a job description. Familiarise yourself with what has been provided.

| Reading | Publication details | Page numbers |
|---|---|---|
| 44 | Pillay, Y., Mzimba, M. & Barron, P. (Eds). (1998). *Handbook for District Managers.* Pretoria: Dept of Health. | pp82-88 |
| 45 | WHO. (1993). Section 1 Part B - "Staff establishment and recruitment." *Training Manual on Management of Human Resources for Health*. Geneva: WHO. | pp1-10 & Annex 5 pp1-7 |
| 46 | McMahon R., Barton, E. & Piot, M. (1992). *On Being in Charge: A guide to management in primary health care.* Geneva: WHO. | pp74-78 |
| 47 | McMahon R., Barton, E. & Piot, M. (1992). *On Being in Charge: A guide to management in primary health care.* Geneva: WHO. | pp69-74 |

| | | |
|---|---|---|
| 48 | Management Sciences for Health. (1997). *Managing Drug Supply.* West Hartford, Connecticut: Kumarian Press. | pp752-755 |
| 49 | Flauhault, D. (1988). Ch 1- "Why supervision?" *The Supervision of Health Personnel at District Level*. Geneva: WHO. | pp2-18 |
| 50 | McMahon R., Barton, E. & Piot, M. (1992). *On Being in Charge: A guide to management in primary health care.* Geneva: WHO. | pp334-340 & pp355-361 |
| 51 | Health Manpower Development Staff. (1982). *Health Center Operations*.Section 6.6. The Medex Primary Health Care Series. Hawaii: John Burns School of Medicine, University of Hawaii. | pp102-105 |
| 52 | WHO. (1993). Section 1 Part B - "Staff relations." *Training Manual on Management of Human Resources for Health*. Geneva: WHO. | pp1-8 |
| 53 | WHO. (1993). Section 1 Part B - "Staff establishment & recruitment: Induction". *Training Manual on Management of Human Resources for Health*. Geneva: WHO. | p9 |
| 54 | Management Sciences for Health. (1997). *Managing Drug Supply.* West Hartford, Connecticut: Kumarian Press. | p753 & p755 |
| 55 | McMahon R., Barton, E. & Piot, M. (1992). "Coordinating the functions of the health team." In *On Being in Charge: A guide to management in primary health care.* Geneva: WHO. | pp322-333 |
| 56 | Health Manpower Development Staff. (1982). *Health Center Operations*. The Medex Primary Health Care Series. Hawaii: John Burns School of Medicine, University of Hawaii. | p160 |
| 57 | Pillay, Y., Mzimba, M. & Barron, P. (Eds). (1998). *Handbook for District Managers.* Pretoria: Dept of Health. | pp93-95 |
| 58 | Health Manpower Development Staff. (1982). *Health Center Operations*. The Medex Primary Health Care Series. Hawaii: John Burns School of Medicine, University of Hawaii. | pp106-110 |
| 59 | WHO. (1993). Section 1 Part B - "Staff relations." *Training Manual on Management of Human Resources for Health*. Geneva: WHO. | pp5-7 |
| 60 | McMahon R., Barton, E. & Piot, M. (1992). "Coordinating the functions of the health team." *On Being in Charge: A guide to management in primary health care.* Geneva: WHO. | pp89-101 |
| 61 | WHO. (1993). Section 1 Part B - "Staff development." *Training Manual on Management of Human Resources for Health*. Geneva: WHO. | pp1-13 |

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|---|---|---|
| 62 | McMahon R., Barton, E. & Piot, M. (1992). "Coordinating the functions of the health team." *On Being in Charge: A guide to management in primary health care.* Geneva: WHO. | pp195-208 & pp323-327 |
| 63 | Health Manpower Development Staff. (1982). *Health Center Operations*. The Medex Primary Health Care Series. Hawaii: John Burns School of Medicine, University of Hawaii. | pp171-176 |
| **REFERENCES** | | |
| **Reference** | **Publication details** | **Page numbers are in the text** |
| | Flauhault, D. (1988). Ch 1- "Why supervision?" The Supervision of Health *Personnel at District Level*. Geneva: WHO. | |
| | HST. Kwik-Skwiz #15.<br>HST. A Pocket Guide to District Health Care in South Africa. Durban: HST.<br>*2 different references or the same? Dates? | |
| | Management Sciences for Health. (1997).*Managing Drug Supply.* West Hartford, Connecticut: Kumarian Press. | |
| | McMahon R., Barton, E. & Piot, M. (1992). "Coordinating the functions of the health team." In *On Being in Charge: A guide to management in primary health care.* Geneva: WHO. | |

# 3 STAFF ESTABLISHMENT AND RECRUITMENT

Establishing and recruiting staff are wide subjects: we will cover them only briefly here to give you an overview of the issues involved. Read these two readings but consider the questions in Task 1 as you read.

Reading 44: Pillay, Y., Mzimba, M. & Barron, P. (Eds). (1998). *Handbook for District Managers.* Pretoria: Dept of Health, pp82-88.

Reading 45: WHO. (1993). Section 1 Part B - "Staff establishment and recruitment." In *Training Manual on Management of Human Resources for Health*. Geneva: WHO, p1-10 and Annex 5, p1-7.

**TASK 1 – Reflect on and draw guidelines from your experiences of recruitment**

- Think back to some of the selection interviews you have gone through when applying for a new job. Were you satisfied with the way in which the interviews were conducted?

- Now think about how you prepare for hiring staff and your own style when you conduct a selection interview. Did the readings give you any ideas for improving your interview technique?

**FEEDBACK**

In Reading 45, Annex 5, there are some useful guidelines on the structure of the interview. This reading makes it clear how important it is for all members of the interviewing panel to understand the future employee's job specifications nd the desired or required attributes of the person who will fill the role before the interview begins.

This is a very brief overview of the selection process. We now move on to the manager's co-ordinating role in relation to personnel.

# 4 CO-ORDINATION OF WORK, PEOPLE AND TIME

Another very important aspect of management is co-ordinating the work staff do in order to get things done effectively.

> "… Almost any work involves more than one person. As soon as two or more people are involved in work or activity, two complementary principles must be applied by management, namely *division of labour* and *convergence of work.*
>
> Division of labour
>
> When work is divided, or distributed, among members of a group, and the work is directed and co-ordinated, the group becomes a team. In teams where there is specialisation and division of labour, each category of staff exercises its own skills towards achieving the objectives. In this context, management consists in assigning a balanced proportion of each kind of staff to the work to be done. In other words, work must be shared by, or divided among, a number of different categories of skilled people.
>
> Convergence of work
>
> Convergence of work means that the activities of the various people who do the work come together in the achievement of objectives i.e. the activities should be designed, assigned and directed in such a way that they support each other in moving towards a common goal …" (McMahon et al, 1992: 17-18)

In order to achieve effective division of labour and convergence of work, a third principle comes into play: *co-ordination*. Reading 46 discusses the process of co-ordination using a very similar approach to the one we used in Unit 4 Session 2 when discussing planning: we asked the questions *who? what? when?* etc.

> Reading 46: McMahon R., Barton, E. & Piot, M. (1992). *On Being in Charge: A Guide to Management in Primary Health Care.* Geneva: WHO, pp74-78.

To co-ordinate effectively, it is important for the supervisor-manager and for the staff to have as much clarity as possible on who does what, where and when. This is very important for two reasons: it helps to get the work done smoothly and it minimises the potential for conflict. We also mentioned this need for clarity amongst staff about each others' roles when we discussed delegation in Unit 1 Session 2.

All staff members should have a clear understanding of the following questions:

- What exactly am I expected to do?
- Who supervises me and how is this done?
- What are the rules and the ways of getting things done in this workplace?
  - How is the office generally organised?
  - Where do I fit in relation to other staff?
  - What happens if my performance is below standard or if my conduct is considered unacceptable?
  - What can I do if I am unhappy with the way I am being treated?
- How do I get access to opportunities for training or promotion?
- How is the use of time organised?

**TASK 2 - Reflect on whether you and your colleagues are clear about roles**

Answer the questions listed above in relation to your own job. Then ask a colleague to do the same for their job.

**FEEDBACK**

You may have found a level of vagueness around who actually is responsible for what in the workplace. This sort of loose understanding can lead to conflict or in things not being done. It is the manager's responsibility to make sure that all staff are well-informed in relation to all these questions.

In the next section, we will address each of the questions individually.

## 4.1 What exactly am I expected to do?

Employees are told what they are expected to do through job descriptions. A clear job description helps employees to feel secure because they know what they are supposed to do. It also provides a framework for supervision. Each staff member should have a written job description and the job description should match the actual practical work! The next two readings give guidance on developing job descriptions. As you read through them, compare the guidelines they give to your own job description in preparation for Task 3.

Reading 47: McMahon R., Barton, E. & Piot, M. (1992). *On Being in Charge: A guide to management in primary health care.* Geneva: WHO, pp69-74.

Reading 48: Management Sciences for Health. (1997). *Managing Drug Supply.* West Hartford, Connecticut: Kumarian Press, pp752-755.

Sometimes job descriptions are very specific and detailed. Sometimes they only give broad areas of responsibility. In general, it is a good idea to be as specific as possible, particularly with staff who do the more basic tasks. Sometimes organisations provide *generic* job descriptions to fit the general duties of a particular category of staff. In this case, it is often helpful to attach a *task list* or *practical job description* which provides more detail for each member of staff in that category. Remember, the more clarity there is, the less chance there is for confusion and conflict.

It is important to remember, though, that sometimes staff members may have to do something that is not in their job description simply because it needs to be done or because a colleague needs some help. Team members should be willing to help each other. No one (including the manager!) should be too important help carry a box or sweep the floor if this is what is necessary! Being helpful does not diminish a manager's authority!

**TASK 3 – Evaluating your own job description**

- Do you have a job description?
- Does it reflect what you actually do?
- In comparison to the guidelines and template provided in readings 47 and 48, how could it be improved?

**FEEDBACK**

Developing job descriptions is a lengthy process, and is often left to human resources experts. However, as a manager, you should be able to critically appraise your staff's job descriptions and reflect on their relevance to the practicalities of their jobs. One of the greatest challenges is estimating the amount of time taken by staff members in meeting the requirements of their jobs. Managers should be able to balance workloads amongst staff members and ensure that no job description requires any staff member to be overloaded.

## 4.2 Who supervises me and how is this done?

"…The purpose of supervision is to promote continuing improvement in the performance of health workers ..." (Flauhault, 1988: 58)

"… Effective supervisors must be able to strike a balance between monitoring and evaluating services and providing support and encouragement to staff. Broadly defined, supervision includes setting realistic goals … and assisting … staff to meet such goals. (WHO, 1993)

"… supervision should no longer be seen as a policing and inspection function only, but one that involves consultation, participation, self criticism and working out solutions together … "


(Adapted from: Management Sciences for Health. (1997). *Managing Drug Supply.* West Hartford, Connecticut: Kumarian Press, p758)

Although supervision is an important part of programme activities, it is often the weakest part. Supervision has been defined as: "The support and guidance that a supervisor gives staff for whom he or she is responsible in order for them to perform their duties effectively, competently and receive job satisfaction." (WHO, 1993: 7) It has also been said that "poor quality supervision can lead staff to feeling isolated and unsupported, while too much supervision can lead to staff resentment … ." (Feuerstein, in Kwik-Skwiz #15)

Readings 49-52 are relevant to the issue of supervision. As you work through them, note how supervision links with issues of understanding people (their needs, values, motivation and leadership), as well as with issues of planning (objectives, targets, monitoring, evaluation, use of information) and other aspects of personnel management (job descriptions, time tables, training needs).

Think about supervision as a system within personnel management, and reflect on how it could be used "… to promote continuing improvement … " in the work of your staff.

Reading 49: Flauhault, D. (1988). Ch 1- "Why supervision?" *The Supervision of Health Personnel at District Level.* Geneva: WHO, pp2-18.

Reading 50: McMahon R., Barton, E. & Piot, M. (1992). *On Being in Charge: A Guide to Management in Primary Health Care.* Geneva: WHO, pp334-340 & pp355-361.

Reading 51: Health Manpower Development Staff. (1982). *Health Center Operations*.Section 6.6. The Medex Primary Health Care Series. Hawaii: John Burns School of Medicine, University of Hawaii, pp102-105.

Reading 52: WHO. (1993). Annex 7, Section 1 Part B. *Training Manual on Management of Human Resources for Health*. Geneva: WHO, p1-8.

**TASK 4 – Evaluate your own supervision approach**

Evaluate how you supervise your staff.

These questions could guide your evaluation:

- Do you use a checklist?
- Do you sit down and discuss your findings with individual staff members?
- Is there systematic follow up of issues identified during supervisory visits? (This is often neglected.)
- Based on the readings, are there ways in which you could improve your supervision methods?

**FEEDBACK**

Your evaluation of your supervision approach will be specific to your situation. Being systematic about supervision and following up is an important part of improving the way staff perform their jobs and co-ordinating their respective roles and work within the workplace.

The next question concerns the *rules* of the workplace, which can be spoken and unspoken rules.

## 4.3 What are the rules and the ways of getting things done in this workplace?

How is the office generally organised? In addition to understanding their own roles, staff members also need to know how things are organised in the office. Starting a new job can be very stressful, so it is really important to make a special effort to support new staff during their first week or two. A thorough orientation is essential. This helps to give them confidence to start carrying out their duties and makes them feel part of the team. Here is a thorough (although not exhaustive) orientation list from a clinic or CHC setting.

"… Orienting new personnel

New personnel should be oriented during their first day and informed about: the vision and mission of the clinic/CHC; the business plan of the facility; how the facility is managed; their roles and responsibilities (including supervisory issues); where supplies are kept and how to access and restock them; how the transport and communication system works; how to arrange for vacation and sick leave, etc. It would be useful to develop a *Standards of Operation Manual* for the facility which is a record of these issues, so that new staff can be given copies of the operating manual …" (Dept of Health, South Africa, 2000:10)

There is a reading on the induction process for you to explore. Study it in relation to an existing "procedures handbook" at your workplace. If no such manual exists, it would be worthwhile to compile one.

Reading 53: WHO. (1993). Section 1 Part B - "Staff establishment & recruitment: Induction". *Training Manual on Management of Human Resources for Health*. Geneva: WHO, p9.

Reading 54: Management Sciences for Health. (1997). *Managing Drug Supply.* West Hartford, Connecticut: Kumarian Press, p753 & p755.

**TASK 5 – Evaluating or developing a staff procedures handbook**

- Is there an up-to-date staff procedures handbook or operating manual in your workplace? How does it compare with the guidance in Readings 53 and 54?
- If not, perhaps you could start compiling an information sheet and build it into a handbook over the next few months.

## 4.4 Where do I fit in relation to other staff?

All staff members need to understand where they fit in relation to other staff. In addition to knowing who they will supervise and be supervised by, they also need to understand the organogram or organisational chart of their workplace.

Reading 55: McMahon McMahon R., Barton, E. & Piot, M. (1992). "Coordinating the functions of the health team." *On Being in Charge: A guide to management in primary health care.* Geneva: WHO, pp322- 323.

Reading 56: Health Manpower Development Staff. (1982). *Health Center Operations*. The Medex Primary Health Care Series. Hawaii: John Burns School of Medicine, University of Hawaii, p160.

**TASK 6 – Develop or evaluate your workplace organogram**

If there is an organogram in your workplace, you could make it your goal to check and update it. Make sure that it is on the wall somewhere in the office for everyone to see. If there is no organogram for your organisation, it would be a good idea to develop one and to display it in a prominent position, as well as using it for inducting new staff.

**FEEDBACK**

Make sure that the organogram is clear and that it is regularly updated if there are changes in the personnel structure.

## 4.5 What happens if my performance is below standard or if my conduct is considered unacceptable? What can I do if I am unhappy with the way I am being treated?

These are two very important issues of which all staff members and managers in particular should be aware. These issues are addressed by disciplinary procedures and grievance procedures. Again, it is important for everyone to have clarity about these procedures, for the protection of all parties concerned.

In this instance, the need for accurate documentation cannot be over-emphasised. Make sure that you, the manager, and the staff have a good understanding of the disciplinary procedure *before* any situation arises. Making mistakes here can lead to a lot of problems for a manager. These three readings provide information about these procedures.

Reading 57: Pillay, Y., Mzimba, M. & Barron, P. (Eds). (1998). *Handbook for District Managers.* Pretoria: Dept of Health, pp93-95.

Reading 58: Health Manpower Development Staff. (1982). *Health Center Operations*. The Medex Primary Health Care Series. Hawaii: John Burns School of Medicine, University of Hawaii, pp106-110.

Reading 59: WHO. (1993). Section 1 Part B - "Staff relations." *Training Manual on Management of Human Resources for Health*. Geneva: WHO, pp5-7.

**TASK 7 – Checking your own understanding of disciplinary procedures**

- Do you have a good understanding of the disciplinary procedure in your organisation?
- Do other members of staff have a good understanding of these procedures?

**FEEDBACK**

It will also be worth your while to ensure that disciplinary procedures are carefully checked, possibly by a labour lawyer, in relation to current legislation in your country. Procedures should be brought up to date if there are any changes in legislation.

## 4.6 How do I get access to opportunities for training or promotion?

Well-trained, competent staff members are a prerequisite for the provision of health services of appropriate quality. In addition, opportunities for further training are often strong motivating factors for personnel. Currently in South Africa, training is a key national development strategy, and many new opportunities exist which promote workplace training. We will not deal with this here, but health managers should make sure that they are aware of the opportunities which can be accessed through the Department of Labour's Skills Development Strategy. Staff development is thus an important component of a manager's job.

Reading 60: McMahon R., Barton, E. & Piot, M. (1992). "Coordinating the functions of the health team." *On Being in Charge: A guide to management in primary health care.* Geneva: WHO, pp89 -101.

Reading 61: WHO. (1993). Section 1 Part B - "Staff development." *Training Manual on Management of Human Resources for Health*. Geneva: WHO, pp1-13.

**TASK 8 – Assess staff development opportunities**

- Have you discussed opportunities for your own professional development with your supervisor?
- Make a list of areas where you feel you need further training.
- Have you identified training needs among your staff?

## 4.7 How is the use of time organised?

*"…Time is one resource which, when lost, is lost forever…" (MSH)*

Health managers responsible for personnel need to recognize the importance of time management, not just for themselves but for all staff. People and the work they do need to be organised in terms of time. Ways of organising the use of time include duty rosters, leave plans, timetables, meeting schedules, deadlines, etc. A number of readings touch on this issue: explore those listed below with the questions in Task 9 in mind.

Reading 62: McMahon R., Barton, E. & Piot, M. (1992). "Coordinating the functions of the health team." *On Being in Charge: A guide to management in primary health care.* Geneva: WHO, pp195-208 & pp323-327.

Reading 63: Health Manpower Development Staff. (1982). *Health Center Operations*. The Medex Primary Health Care Series. Hawaii: John Burns School of Medicine, University of Hawaii, pp171-176.

**TASK 9 – Improving the usage of time in the workplace**

- List all the methods used to organise time in your workplace.
- Are there ways that you have noted in the readings which could be used to improve the use of time?

**FEEDBACK**

This evaluation could best be undertaken with other staff, in order to develop a sense of ownership of such strategies. You could do this by getting the team together and asking everyone to analyse how they spend their time. See if the group can find a better fit for activities and timing that will be beneficial to everyone. Make diagrams of how different jobs fit together. Make timetables for weekly, monthly, quarterly, and yearly activities. You could stick them on the wall and get someone to be responsible for tracking progress and noting changes. Use these as tools to monitor progress and make adjustments to plans where necessary.

In the end, however, it is the manager's role to co-ordinate the most effective use of time in the process of *getting things done through people*.

# 5 SESSION SUMMARY

During this session we have looked at systems and procedures which assist in the management of human resources and their activities and time. The following quick personnel management checklist summarises the main points covered:

"…

- Are new clinic staff oriented upon appointment?
- Is staff establishment for all categories known; and vacancies discussed with supervisor?
- Are job descriptions for each staff category in the clinic file?
- Is an *on-call roster* or calendar displayed? Is it fair?
- Is an absenteeism and attendance register used and discussed?
- Is there a task list for the clinic with appropriate rotation of tasks?
- Are services and tasks not carried out due to lack of skills identified?
- For each staff member: are there records of meetings, workshops, training sessions attended? Is the balance of opportunity reviewed?
- Are staff meetings held regularly?
- Are in-service training activities taking place?
- Are files compiled for each staff member and regularly updated?
- Are discipline problems documented and copied to the supervisor? …" (Dept of Health, 2000)

Congratulations – you have completed the Unit.

Congratulations on completing the Health Management I module!

Please take a little time to complete the Evaluation Form which follows. SOPH is constantly striving to make the learning materials used with its courses as helpful as they can be to the students who use them. We would therefore like to hear about your experience of these materials so we can take it into account and adjust them to make them more helpful.

Over the course of the past few weeks, we have aimed to increase your competence in some of the basic areas of health and welfare management. Following the theme of *management is: getting things done through people*, we have attempted to strike a balance between a people-oriented approach and a task-oriented approach.

Time-management is a challenge for many managers. Through increasing your competence and managing yourself effectively, you will be able to work more efficiently and experience increased job satisfaction. In doing so you will hopefully feel less stressed and have more time and energy to devote to your most importance resource - people.

We emphasised the importance of adequate planning and of effective systems as management tools. Taking time to understand your environment and to carefully think through the details of your plans will increase the likelihood of success in implementation. Taking time to set up and maintain systems will help you in controlling your areas of responsibility. Taking time to understand people will help you to understand what motivates your staff and how best to lead your team to provide high quality services, thus meeting the needs of both the staff providing the services and the people you serve.

We hope that this module has provided a helpful foundation upon which you can build as you continue to develop your skills in the challenging job of being a manager.

Best wishes,

Wendy, Lucy and Kirstie

# CONTENTS

## HEALTH MANAGEMENT I - READER

There is one reader for this module. The readings have been put in order according to their numbers in the Units. Each one has a cover page to help you to find it.

All sources are gratefully acknowledged.

### UNIT 1 – THE MANAGER

### Unit 1 Session 1: What is Management

There are no readings in this unit.

### Unit 1 Session 2: Managing Yourself

**Reading 1a** Handy, C. (1993). *Understanding Organisations,* London: Penguin Books, pp 60-67.

**Reading 1b** Handy, C. (1993). *Understanding Organisations,* London: Penguin Books, pp72-74.

**Reading 1c** Handy, C. (1993). *Understanding Organisations,* London: Penguin Books, pp93-95.

**Reading 1d** Handy, C. (1993). *Understanding Organisations,* London: Penguin Books, pp334-339.

**Reading 2** Management Education Scheme for Open Learning (MESOL), The Open University. (2000). "Keeping a time-log". *Managing in Health and Social Care, Module 1 Resource File.* Milton Keynes: Walton Hall, pp25-27.

## UNIT 2 – MANAGING PEOPLE

### Unit 2 Session 1: Understanding People

**Reading 3** Covey, S. (1999). "Principles of Empathic Communication." *The Seven Habits of Highly Effective People. UK:* Simon and Schuster, pp 236-259.

### Unit 2 Session 2: Managing Conflict

**Reading 4** Whetten, B. A. & Cameron, K.S. (1991). *Developing Management Skills.* Ch 7, "Interpersonal Conflict Management." New York: Harper Collins, pp 395-428.

**Reading 4a** Whetten, B. A. & Cameron, K.S. (1991). *Developing Management Skills.* Ch 7, "Interpersonal Conflict Management." New York: Harper Collins, pp395-400.

**Reading 4b** Whetten, B. A. & Cameron, K.S. (1991). *Developing Management Skills.* Ch 7, "Interpersonal Conflict Management." New York: Harper Collins, pp400-403.

**Reading 4c** Whetten, B. A. & Cameron, K.S. (1991). *Developing Management Skills.* Ch 7, "Interpersonal Conflict Management." New York: Harper Collins, pp407-410.

**Reading 4d** Whetten, B. A. & Cameron, K.S. (1991). *Developing Management Skills.* Ch 7, "Interpersonal Conflict Management." New York: Harper Collins, pp410-428.

**Reading 5** Jones, B., Pierce, J. & Hunter, B. (1989). "Teaching students to construct graphic representations". *Educational Leadership.* Dec 1988/Jan 1989, pp 20-25.

## UNIT 3 – LEADING PEOPLE

### Unit 3 Session 1: Motivation

**Reading 6** World Health Organisation. (1993). *Training Manual on Management of Human Resources for Health,* Part A, Annex 3 - "Motivation". Geneva: WHO, pp1-8.

**Reading 7** McMahon, R., Barton, E., Piot, M. (1992). On Being in Charge. Chapter 2 - "Leading a health team." Geneva: WHO, pp58-63.

## Unit 3 Session 2: Leadership

There are no readings in this unit.

## Unit 3 Session 3: Building Teams

**Reading 8** Blanchard, K. (1994). *The One Minute Manager Builds High Performing Teams.* London: Harper Collins. pp10-109.

# UNIT 4 – PLANNING

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### Unit 4 Session 1: The District Health System

**Reading 9** Janovsky, K. (1988). *The Challenge of Implementation - District Health Systems for Primary Health Care.* Geneva: WHO, pp9-16.

**Reading 10** Monekosso, G.L. (1994). *District Health Management: From mediocrity to excellence in health care.* Geneva: WHO, pp20–27.

**Reading 11** World Health Organization (undated draft), *Decentralization and Health Systems Change in Africa: Case Study Summaries.* (No details of publisher available), pp1-5 & 57-61.

**Reading 12** Janovsky, K. (1988). *The Challenge of Implementation- District Health Systems for Primary Health Care.* WHO, pp65-67.

### Unit 4 Session 2: Planning: What and Why?

**Reading 13** McMahon, R., Barton, E. & Piot, M. (1992). *On Being in Charge*. Geneva: WHO, pp267-270.

**Reading 14** World Health Organisation. (1993). *Training Manual on Management of Human Resources for Health.* Section 1 Part B. Geneva: WHO, pp3-6.

**Reading 15** "Case studies on sanitation and hygiene in Cameroon and Tanzania", *MSc Course Notes* (1998). London School of Hygiene and Tropical Medicine, p1.

## Unit 4 Session 3: The Planning Cycle

**Reading 16** Adonisi, M. & Kahn, S. (1998). Ch 6 - "Project Management for Health District Managers", *Handbook for District Managers.* South Africa: Department of Health, pp 50-53.

**Reading 17** Heywood, A., Campbell, B. & Awunyo-Akaba. (1994). U*sing Information for Action: A Training Manual for District Health Workers.* The Netherlands: Royal Tropical Institute, pp12-15.

**Reading 18** McMahon, R., Barton, E. & Piot, M. (1992). *On Being in Charge.* Geneva: WHO, pp272-288.

**Reading 19** McMahon R., Barton E. & Piot M. (1992). *On Being in Charge.* Geneva: WHO, pp289-298.

## Unit 4 Session 4: Planning a Project

**Reading 20** McMahon, R., Barton, E. & Piot, M. (1992). *On Being in Charge.* Geneva: WHO, pp299-315.

## Unit 4 Session 5: Information for Planning and Management

**Reading 21** Heywood, A., Campbell, B. & Awunyo-Akaba. (1994). *UsingInformation for Action: A Training Manual for District Health Workers*, The Netherlands: Royal Tropical Institute, pp2-6; 9-11.

**Reading 22** McCoy, D. & Bamford, L. (1998). *How to Conduct a Rapid Situation Analysis*. Durban: Health Systems Trust, pp30-32.

**Reading 23** McMahon, R., Barton, E., Piot, M. (1992). *On Being in Charge*, Geneva: WHO, pp327-334.

**Reading 24** McMahon, R., Barton, E. & Piot, M. (1992). *On Being in Charge.* Geneva: WHO, pp 341-355.

## Unit 5 – MANAGING RESOURCES

### Unit 5 Session 1: Developing and Interpreting Budgets

**Reading 25** Management Sciences for Health. (2001). "Managing Your Finances" in *The Family Planning Manager's Handbook.* Website erc.msh.org

**Reading 26** Pillay, Y., Mzimba, M. & Barron, P. [Eds]. (1998). Makan, B., Collins, D. & Zuma, N. Ch 7- "Financial management for District Managers" in *Handbook for District Managers.* Pretoria: Dept of Health, pp63-81.

**Reading 27** Creese, A. & Parker, D. "Calculating Costs" in *Cost Analysis in Primary Health Care*. Geneva: WHO, UNICEF & Aga Khan Foundation, pp29-40.

**Reading 28** International Rescue Committee. (2000). *Budget and Budget Narrative for UNHCR Project: Assistance to Burundi Refugees in Kigoma*. Project Document. (Adapted). New York: IRC.

### Unit 5 Session 2: Drug Management

**Reading 29a** Management Sciences for Health. (1997). Managing Drug Supply. Sections 10.1 – 10.4. West Hartford, Connecticut: Kumarian Press, pp122-126.

**Reading 29b** Management Sciences for Health. (1997). *Managing Drug Supply*. Section 10.5. West Hartford, Connecticut: Kumarian Press, pp126-128.

**Reading 30** Management Sciences for Health. (1997). *Managing Drug Supply*. Section 11.1. West Hartford, Connecticut: Kumarian Press, pp138-139 and 143.

**Reading 31** Management Sciences for Health. (1997). *Managing Drug Supply*. "Country Study Box". West Hartford, Connecticut: Kumarian Press, p143.

**Reading 32** Province of the Eastern Cape, Department of Health. (2000). *Managing Drug Supply for Health Institutions.* Eastern Cape Province: Department of Health, pp1-94.

## Unit 5 Session 3: Managing Medical Supplies and Equipment

**Reading 33** Management Sciences for Health. (1997). *Managing Drug Supply.* Chapter 12 - "Ëssential Medical Supplies and Equipment." West Hartford, Connecticut: Kumarian Press, pp150-155.

**Reading 34** Management Sciences for Health. (1997). *Managing Drug Supply*. Chapter 12 - "Ëssential Medical Supplies and Equipment." West Hartford, Connecticut: Kumarian Press, p160.

**Reading 35** National Department of Health, South Africa. (2000). *Handbook for Clinic/CHC Managers*, pp20-21.

**Reading 36** Regional Health Bureau, Regional State of Tigray, Ethiopia. (2001). *Equipment List for Health Centers*. Unpublished document, pp1-9.

**Reading 37** Health Manpower Development Staff. (1986). *Health Center Operations*. Honolulu: University of Hawaii, pp46-47.

**Reading 38** Health Manpower Development Staff. (1986). *Health Center Operations*. Honolulu: University of Hawaii, . pp42,43,48-50.

**Reading 39** Health Manpower Development Staff. (1986). *Health Center Operations*. Honolulu: University of Hawaii, pp51-53.

## Unit 5 Session 4: Transport Management

**Reading 40** Nancollas, S. (1998). Chapter 9 - "Transport Management for District Managers" in *The District Manager's Handbook*, South Africa: Department of Health, pp97-101.

**Reading 41** Health Manpower Development Staff. (1982). *Health Center Operations*. The Medex Primary Health Care Series. Honolulu: John Burns School of Medicine, University of Hawaii pp57-61.

**Reading 42** Nancollas, S. (1998). Chapter 9 - "Transport Management for District Managers" in *The District Manager's Handbook*, South Africa: Department of Health, pp101-111.

**Reading 43** Health Manpower Development Staff. (1982). *Health Center Operations.* The Medex Primary Health Care

Series. Honolulu: John Burns School of Medicine, University of Hawaii, pp62-74.

**Unit 5 Session 5: Personnel Management**

**Reading 44** Pillay, Y., Mzimba, M. & Barron, P. (Eds). *Handbook for District Managers*. Pretoria: Dept of Health, pp82-88.

**Reading 45** WHO. (1993). *Training Manual on Management of Human Resources for Health*. "Staff establishment and recruitment." Section 1 Part B. Geneva: WHO, p1-10 and Annex 5, p1-7.

**Reading 46** McMahon R., Barton, E. & Piot, M. (1992). *On Being in Charge: A Guide to Management in Primary Health Care*. Geneva: WHO, pp74-78.

**Reading 47** McMahon R., Barton, E. & Piot, M. (1992). *On Being in Charge: A guide to management in primary health care*. Geneva: WHO, pp69-74.

**Reading 48** Management Sciences for Health. (1997). *Managing Drug Supply*. West Hartford, Connecticut: Kumarian Press, pp752-755.

**Reading 49** Flauhault, D. (1988). Ch 1- "Why supervision?" *The Supervision of Health Workers at District Level*, pp2-18.

**Reading 50** McMahon R., Barton, E. & Piot, M. (1992). *On Being in Charge: A Guide to Management in Primary Health Care*. Geneva: WHO, pp334-340 & pp355-361.

**Reading 51** Health Manpower Development Staff. (1982*). Health Center Operations.* Section 6.6. The Medex Primary Health Care Series. Honolulu: John Burns School of Medicine, University of Hawaii, pp102-105.

**Reading 52** WHO. (1993). *Training Manual on Management of Human Resources for Health.* Annex 7, Section 1 Part B. Geneva: WHO, p1-8.

**Reading 53** WHO. (1993). *Training Manual on Management of Human Resources for Health*. "Staff establishment & recruitment: Induction" Section 1 Part B. Geneva: WHO, p9.

**Reading 54** Management Sciences for Health. (1997). *Managing Drug Supply*. West Hartford, Connecticut: Kumarian Press, p753 & p755.

**Reading 55** McMahon McMahon R., Barton, E. & Piot, M. (1992). "Coordinating the functions of the health team." *In On Being in Charge: A guide to management in primary health care*. Geneva: WHO, pp322- 323.

**Reading 56** Health Manpower Development Staff. (1982). *Health Center Operations.* The Medex Primary Health Care Series. Honolulu: John Burns School of Medicine, University of Hawaii, p160.

**Reading 57** Pillay, Y., Mzimba, M. & Barron, P. (Eds). *Handbook for District Managers.* Pretoria: Dept of Health, pp93-95.

**Reading 58** Health Manpower Development Staff. (1982). *Health Center Operations.* The Medex Primary Health Care Series. Honolulu: John Burns School of Medicine, University of Hawaii, pp106-110.

**Reading 59** WHO. (1993). *Training Manual on Management of Human Resources for Health.* "Staff relations." Section 1 Part B. Geneva: WHO, pp5-7.

**Reading 60** McMahon R., Barton, E. & Piot, M. (1992). "Coordinating the functions of the health team." In *On Being in Charge: A guide to management in primary health care*. Geneva: WHO, pp89 -101.

**Reading 61** WHO. (1993). *Training Manual on Management of Human Resources for Health.* "Staff development." Section 1 Part B. Geneva: WHO, pp1-13.

**Reading 62** McMahon R., Barton, E. & Piot, M. (1992). "Coordinating the functions of the health team." In *On Being in Charge: A guide to management in primary health care*. Geneva: WHO, pp195-208 & pp323-327.

**Reading 63** Health Manpower Development Staff. (1982). *Health Center Operations*. The Medex Primary Health Care Series. Honolulu: John Burns School of Medicine, University of Hawaii, pp171-176.