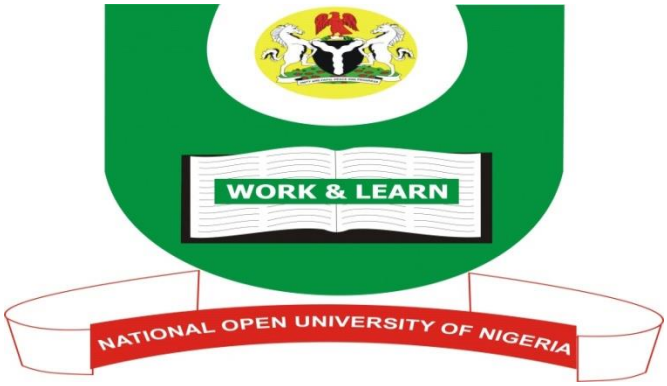

NATIONAL OPEN UNIVERSITY OF NIGERIA

FACULTY OF HEALTH SCIENCES

DEPARTMENT OF PUBLIC HEALTH SCIENCE

COURSE CODE: PHS811

COURSE TITLE: PRINCIPLES OF HEALTH PLANNING AND MANAGEMENT

COURSE GUIDE

PHS811: PRINCIPLES OF HEALTH PLANNING AND MANAGEMENT

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INTRODUCTION

PHS811: Health Planning and Management is a two-credit units compulsory course for students offering Postgraduate studies in Public Health, National Open University of Nigeria.

This course 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.

Health management is considered an important skill area for Public Health professionals. This Health Management course thus forms one of the core modules of the Postgraduate Certificate in Public Health. The course 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 modules.

This course 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.

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 organization 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.

WHAT YOU WILL LEARN IN THIS COURSE

In this course, you have the course units and a course guide. The course guide will tell you what the course is all about. It is a general overview of the course materials you will be using and how to use those materials. It also helps you to allocate the appropriate time to each unit so that you can successfully complete the course within the stipulated time limit. The course guide also helps you to know how to go about your Tutor-Marked Assignment which will form part of your overall assessment at the end of the course. Also, there will be regular tutorial classes that are related to this course, where you can interact with your facilitator and other students. This course exposes you to communication in health care setting.

COURSE AIMS

The course aims to give you an understanding of health planning and management.

COURSE OBJECTIVES

To achieve the aim set above, there are objectives. Each unit has a set of objectives presented at the beginning of the unit. These objectives will give you what to

concentrate/focus on while studying the unit. Please read the objectives before studying the unit and during your study to check your progress. The comprehensive objectives of the course are given below. By the end of the course, you should be able to:

i. Understand what Health planning and management is, and examination of various management theories and principles.
ii. Introduction to planning and some analytic and non-analytic health planning techniques
iii. The concept of management decision techniques, the change nature of administration and management and the place of modern techniques in management.
iv. Types of organizational functions, settings of organizational objectives and goals, effective organization-authority, power and delegation, formal and informal organizational structures and design management techniques, line and staff function and authority.
v. Describe organizational development and change.
vi. Know management techniques in practice, quantitative techniques, organization and method (Q&M), management by objective (MBO), project management (PM), project evaluation and review techniques (PERT), decision making techniques, management services and queuing theory, inventory management problem, dynamic programming etc.
vii. Quality assurance principles, overview of monitoring and evaluation, evaluation methods, PHC implementation and evaluation, community diagnosis.

WORKING THROUGH THIS COURSE

To successfully complete this course, you are required to read each study unit, textbooks and other materials provided by the National Open University of Nigeria. Reading the referenced materials can also be of great assistance. Each unit has self- assessment.

Exercises which you are advised to do. At certain periods during the course, you will be required to submit your assignment for the purpose of assessment. There will be a final examination at the end of the course. The course should take you about 17 weeks to complete. This course guide will provide you with all the components of the course how to go about studying and how you should allocate your time to each unit so as to finish on time and successfully.

THE COURSE MATERIALS

The main components of the course are:

1. The Study Guide

2. Study Units

3. Reference/Further Reading

4. Assignments

5. Presentation Schedule

STUDY UNIT

The study units for this course are made up of three (3) modules and nine (9) units as given below:

MODULE 1: Introduction to Health Planning and Management

Unit 1: Definition and concept of management theories and principles

Unit 2: Introduction of some analytic and non-analytic health planning techniques

Unit 3: Planning and implementation of health programs and power delegation

MODULE 2: The Concept of Management

Unit 1: Decision techniques in management and management techniques in practice

Unit 2: Changing nature of administration

Unit 3: Quality assurance and monitoring and evaluation in modern management techniques

MODULE 3: Organizational Structures

Unit 1: Types of Organizational function and changes in organizational development

Unit2: Settings of organizational objective and goals with effective organizational authorities

Unit 3: PHC implementation, Evaluation and Community Diagnosis

There are activities related to the lecture in each unit which will help your progress and comprehension of the unit. You are required to work on these exercises which together with the TMAs will enable you to achieve the objectives of each unit.

Each unit will take a week or two. Lectures will include an introduction, objectives, reading materials, self -assessment exercises, conclusion, summary, tutor-marked assignments (TMAs), references and other reading resources. There are activities related to the lecture in each unit which will help your progress and comprehension of the unit. You are required to work on these exercises which together with the TMAs will enable you to achieve the objectives of each unit.

PRESENTATION SCHEDULE

There is a timetable prepared for the early and timely completion and submissions of your TMAs as well as attending the tutorial classes. You are required to submit all your assignments by the stipulated date and time. Avoid falling behind the schedule time.

ASSESSMENT

There are three aspects to the assessment of this course. The first one is the self-assessment exercises. The second is the tutor-marked assignments and the third is the written examination or the examination to be taken at the end of the course. Do the exercises or activities in the unit by applying the information and knowledge you acquired during the course. The tutor-marked assignments must be submitted to your facilitator for formal assessment in accordance with the deadlines stated in the presentation schedule and the assignment file. The work submitted
to your tutor for assessment will account for 30% of your total coursework. At the end of this course, you have to sit for a final or end of course examination of about a three-hour duration which will account for 70%of your total course mark.

TUTOR-MARKED ASSIGNMENT (TMAs)

This is the continuous assessment component of this course and it accounts for 30% of the total score. You will be given 3 TMAs by your facilitator to answer. Three of them must be answered before you are allowed to sit for the end of course examination. These answered assignments must be returned to your facilitator. You are expected to complete

the assignments by using the information and material in your reading references and study units. Reading and researching into the references will give you a deeper understanding of the subject.

1. Make sure that each assignment reaches your facilitator on or before the deadline given in the presentation schedule and assignment file. If for any reason you are not able to complete your assignment, make sure you contact your facilitator before the assignment is due to discuss the possibility of an extension. Request for extension will not be granted after the due date unless there in exceptional circumstances.

2. Make sure you revise the whole course content before sitting for the examination. The self-assessment exercises and TMAs will be useful for this purposes and if you have any comments pleased o before the examination. The end of course examination covers information from all parts of the course.

FINAL EXAMINATION AND GRADING

The end of Course of Examination for Principles of Health Planning & Management will be for about 1½ hours and it has a value of 70 percent of the total course work. The examination will consist of questions, which will reflect the type of self-testing, practice exercise and tutor marked assignment problem you have previously encountered. All areas of the course will be assessed.

You are advised to use the time between finishing the last unit and sitting for the examination to revise the whole course. You might find it useful to review your self-tests, TMAs and comments on them before the examination. The end of Course examination covers information from all parts of the course.

COURSE MARKING SCHEME

Assignment Marks

Assignments 1 – 3 Three assignments, three marks at 10% each = 30% of course marks.

End of course examination 70% of overall course marks.

Total 100% of course materials.

FACILITATORS/TUTORS AND TUTORIALS

Sixteen hours are provided for tutorials for this course. You will be notified of the dates, times and location for these tutorial classes. As soon as you are allocated a tutorial group, the name and phone number of your facilitator will be given to you. These are the duties of your facilitator:

He or she will mark and comment on your assignment. He will monitor your progress and provide any necessary assistance you need. He or she will mark your TMAs and return to you as soon as possible.

Do not delay to contact your facilitator by telephone or e-mail for necessary assistance if:

You do not understand any part of the study in the course material.

You have difficulty with the self -assessment activities.

You have a problem or question with an assignment or with the grading of the assignment. It is important and necessary you attend the tutorial classes because this is the only chance to have face to face contact with your facilitator and to ask questions which will be answer instantly. It is also a period where you can point out any problem encountered in the course of your study.

SUMMARY

Health planning and management is a course that introduces you to day-to-day and tomorrow activities in health system. The increasing demand for medical and health care

services, in the face of limited resources has brought out the need for careful planning and management of health services. Planning and management are considered essential if higher standards of health and health care are to be achieved.

Health Planning has been defined as "the orderly process of defining community health problems, identifying unmet needs and surveying the resources to meet them, establishing priority goals that are realistic and feasible and projecting administrative action to accomplish the purpose of the proposed programmed" while Management is the act of engaging with an organization’s human talent and using the physical resources at a manager’s disposal to accomplish desired goals and objectives efficiently and effectively.

In completion of the course, you will have an understanding of basic knowledge of concept of planning and managing the health system. In addition, the course will be able to introduce you to analytical and non-analytical planning techniques, theories and principles of management, quality assurance, organizational structure, evaluation, community diagnosis and many more.

Best wishes

PHS811 HEALTH PLANNING MANAGEMENT

MODULE 1: INTRODUCTION TO HEALTH PLANNING AND MANAGEMENT

Unit 1: Definition and Concept of Management Theories and principle

Unit 2: Introduction of some Analytic and Non-Analytic Health Planning Techniques

Unit 3: Planning and Implementation of Health Programs and Power Delegation

UNIT: 1 DEFINITION AND CONCEPT OF MANAGEMENT THEORIES AND PRINCIPLES

CONTENT

1.0 INTRODUCTION

A problem being experienced in probably the majority of countries across the world is that the public health function is still not receiving firm enough support at political level.

Even where that commitment appears to exist, and there are signs of a new-found commitment to public health, under-resourcing of the public health infrastructure and capacity prevents public health from playing the strong role advocated for it. As a consequence, the levels of health achieved by populations are seriously below what could be obtained if application of current knowledge in public health was pursued more vigorously through a stronger public health approach and infrastructure (WHO).

Modern public health practice is considerably more complex in the 21st century than it was 100 years or so ago when some of the great advances in public health were achieved. It includes not merely scientific and technical practice but also the knowledge and skills to build effective coalitions and partnerships for health and collectively to manage actions for health improvement. This applies to both national and international health efforts. This focus on managing for health has been described as public health management (PHM).

It is clear that public health practice in both developed and a developing country needs sustained political support and substantial development. In particular, there is a dearth of appropriate public health training and dissemination of public health experience and practice. This material will try to address some of the concept of health management and how it might serve as a unifying concept, linking policy-makers' newfound interest in public health with the ability of public health practitioners, wherever they may be located, to secure the desired policy goals.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

1. Understand the Concept of Public Health Management
2. Learn the Importance of Public Health Management in Both National and Local Level

3. Describe the Skills and Competencies Required of Managers and Practitioners Working in Public Health System

3.0 MAIN CONTENT

3.1 OVERVIEW OF MANAGEMENT AND BASIC ACTIVITIES OF MANAGEMENT

The term "management" is used in many senses. It is sometimes confused with administration: sometimes with organization. Some equate the terms, management and administration. Others view it as a technique of leadership. The widely prevalent view is that administration broadly means "getting things done" and management as "the purposeful and effective use of resources - manpower materials and finances - for fulfilling a pre-determined objective".

Management is the act of engaging with an organization's human talent and using the physical resources at a manager's disposal to accomplish desired goals and objectives efficiently and effectively. Management comprises planning, organizing, staffing, leading, directing, and controlling an organization (a group of one or more people or entities) or effort for the purpose of accomplishing a goal.

One of the most important duties for a manager is effectively using an organization's resources. This duty involves deploying and manipulating human resources (or human capital), as well as efficiently allocating the organization's financial, technological, and natural resources.

Since organizations can be viewed as systems, management can also be defined as human action, such as product design, that enables the system to produce useful outcomes. This view suggests that we must manage ourselves as a prerequisite to attempting to manage others.

In theory, management consists of four basic activities:

i. planning: determining what is to be done
ii. Organizing: setting up the framework or apparatus and making it possible for groups to do the work.
iii. Communicating: motivating people to do the work.
iv. Monitoring (controlling): checking to make sure the work is progressing satisfactorily.

Management techniques are familiar in business, industry, defense and other fields. The current emphasis by WHO and many governments is on improving the efficiency of the health care delivery systems through the application of modern management methods and techniques.

3.1.1 Planning

Planning is the process of thinking about and organizing the activities required to achieve strategic objectives, planning is the process of thinking about and organizing the activities required to achieve a desired goal. Planning involves the creation and maintenance of a given organizational operation. This thought process is essential to the refinement of objectives and their integration with other plans. Planning combines forecasting of developments with preparing scenarios for how to react to the developments. Planning is also a management process, concerned with defining goals for a company's future direction and determining the missions and resources to achieve those targets. To meet objectives, managers may develop plans, such as a business plan or a marketing plan. The purpose may be achievement of certain goals or targets. Planning revolves largely around identifying the resources available for a given project and utilizing optimally to achieve best scenario outcomes.

Strategic Planning

Strategic planning is an organization's process of defining its strategy or direction and making decisions about allocating its resources to pursue this strategy. To determine the direction of the organization, it is necessary to understand its current position and the

possible avenues through which it can pursue a particular course of action. Generally, strategic planning deals with at least one of three key questions:

What do we do?

For whom do we do it?

How do we excel?

The key components of strategic planning include an understanding of the firm's vision, mission, values, and strategies. (Often a "vision statement" and a " mission statement " may encapsulate the vision and mission).

Tools and Approaches

There are many approaches to strategic planning, but typically one of the following is used:

Situation-Target-Proposal: Situation – Evaluate the current situation and how it came about. Target – Define goals and/or objectives (sometimes called ideal state). Path/Proposal – Map a possible route to the goals/objectives.

Draw-See-Think-Plan: Draw – What is the ideal image or the desired end state? See – What is today's situation? What is the gap from ideal and why? Think – What specific actions must be taken to close the gap between today's situation and the ideal state? Plan – What resources are required to execute the activities?

Among the most useful tools for strategic planning is a SWOT analysis (Strengths, Weaknesses, Opportunities, and Threats). The main objective of this tool is to analyze internal strategic factors (strengths and weaknesses attributed to the organization) and external factors beyond control of the organization (such as opportunities and threats). You can give specific examples of what are expected when using SWOT as necessary tools for planning. Scenarios are usually useful to guide the students on the approaches.

3.1.2 Organizing

Management organizes by creating patterns of relationships among workers, optimizing use of resources to accomplish business objectives.

Management operates through various functions, often classified as planning, organizing, staffing, leading/directing, controlling/monitoring, and motivating. The organizing function creates the pattern of relationships among workers and makes optimal use of resources to enable the accomplishment of business plans and objectives.

Structure

Structure is the framework in which the organization defines how tasks are divided, resources are deployed, and departments are coordinated. It is a set of formal tasks assigned to individuals and departments. Public health is not a single product or service provided by one type of professional, it is a web of relationships between many people and organizations about a wide variety of topics. This web of relationships serves to assure conditions that result in a healthy public. The responsibility for assuring the health of the public rests in specific agencies at different levels of government that is local, state, federal and international. The structure at the local level are PHC at the LGA. At the state there many structures like, State Primary Health Care Board, Department of Public Health and other agencies in the ministry of health. At the Federal level, there are many agency and parastatals like NPHDA, NCDC, NMEP, NTBCP and many more. At the international level are WHO, UNICEF etc.

Authority/Chain of Command

Authority is a manager's formal and legitimate right to make decisions, issue orders, and allocate resources to achieve desired outcomes for an organization. Responsibility is an employee's duty to perform assigned tasks or activities. Accountability means that those with authority and responsibility must report and justify task outcomes to those above them in the chain of command.

The chain of command in public health is divers and depend from organization to organizations. For example, at the state Ministry of Health, you look at the organogram, there are department, directorate, Agency, Board etc. From the Commissioner of Health down to Permanent Secretary, Director Public Health, Director Nursing, Director Pharmacy. Under public health, State epidemiologist, Program Manager Malaria, Program Manager TB control etc.

Types of Authority (and Responsibility)

I. Line authority: Managers have the formal power to direct and control immediate subordinates executing specific tasks within a chain of command, usually within a specific department.
II. Functional authority: Managers have formal power over a specific subset of activities that include outside departments. For instance, a production manager may have the line authority to decide whether and when a new machine is needed, but a controller with functional authority requires that a capital expenditure proposal be submitted first, showing that the investment in a new machine will yield a minimum return.
III. Staff authority: Staff specialists manage operations in their areas of expertise. Staff authority is not real authority because a staff manager does not order or instruct but simply advises, recommends, and counsels in the staff specialists' area of expertise; the manager is responsible only for the quality of the advice (in line with the respective professional standards, etc.).

3. 3 PUBLIC HEALTH MANAGEMENT AT A NATIONAL AND LOCAL LEVEL

Better shared understanding between public health practitioners and managers of health care systems, who occupy two rather distinct camps, might trigger a new way of thinking and hasten appropriate action. But for this to happen on a significant scale, public health has to be seen to be everyone's responsibility. Public Health cannot remain the preserve

of a few practitioners trained in the specialty of public health medicine who are either ignored or who become co-opted into the running of health care services thereby losing sight of their core function. This is to improve the health of the populations for whom they are responsible. As the British secretary of state for health puts it in a lecture 'the time has come to take public health out of the ghetto. The notion, public health management (PHM), is aimed at doing precisely this.

Public health has been defined as 'the science and art of preventing disease, prolonging life and promoting health through the organized efforts of society (Acheson, 1988; WHO). Furthermore, the synthesis of many definitions of public health has brought the evolution of six basic principles of contemporary public health theory and practice. Public health management has been defined as 'the optimal use of the resources of society and its health services towards the improvement of the health experience of the population (WHO, 2002).

Health Management embraces a number of elements as displayed below.

Distinguishing features of public health management include:

i. is multi-sectoral and professional
ii. combines knowledge and action
iii. has epidemiology at its core
iv. is influential across all health determinants
v. involves public health reporting, leading to health strategy development
vi. communicates with politicians, professionals and the public
vii. is influential organizationally and financially
viii. lies at the heart of the civic society

Public Health Management (PHM) is directed towards managing systems based on health outcomes both at the level of population-based health programmes and at the level of patient care. Above all, PHM is about leadership and managing change. This is often weak and poorly organized and provided in respect of training and development.

Roles of public health Managers. The main role of a public health manager is to manage different public health threats, and these types of public health professionals can work in a vast array of different fields. A public health manager will also typically be in charge of administrative duties for a public health team, and it is the public health manager who will be in charge of promoting the overall good health of a population as a whole.

Some of the daily jobs of a public health manager may be:

i. Overseeing the tasks of other public health professionals
ii. Developing various new public health testing and data collection methods
iii. Implementing any new methods or procedures that are developed
iv. Evaluating new public health initiatives
v. Analyzing and developing public health programs to be implemented within a population or community
vi. Working with other public health officials to resolve problems or hazards that may arise in public health
vii. Review reports submitted by other public health professionals, and approve or deny any changes that may be requested
viii. Prepare budgets revolving around procedures, departments, or programs related to public health.
ix. Delegating responsibilities to other appropriate managers within a public health team

An issue is whether public health management is able to serve as the instrument required to bring about change and contribute to a realization of policy. It is the weakness of the infrastructure through which policies become translated into action that has contributed to the failure of repeated attempts to shift the policy debate beyond a continuing bias towards a downstream agenda focused on treatment services. Several countries have sought to shift policy debate towards an integrated 'whole systems' perspective, notably Canada, New Zealand and the UK. Their experiences share a similar outcome, namely,

the disconnection between the thrust of policy and the means to achieve it. The result in each country has been frustration for lack of progress in shifting resources, or even the attention of managers and practitioners, away from health care to health. Over the past decade or so in many developed countries, tackling the broader health agenda has been a priority to a greater or lesser degree. But the abiding tension in health policy, namely, that between developing a long-term public health agenda on the one hand and improving rapid access to acute services on the other hand, persists and has usually been in favor of the immediate, short-term agenda. Of course, improved access to health care services can contribute significantly to health and to an improved quality of life but it is still often a case of treating symptoms rather than root causes.

What is absent from policy-making is any attempt to ensure that a balance is maintained in the public health management. Both upstream and downstream determinants of health need to be tackled. Economic and social policy needs to be mutually reinforcing.

A related problem in public health is an inability to crystallize good practice; however, it is defined, and rolls it out across populations and geographical areas. PHM demands particular skills, especially in respect of change management and leadership. Traditional public health models and training programmes have not seen these as either relevant or important to the specialty of public health. But to be effective, public health managers must possess both public health and management skills. Presently there are deficits in skills in public health management. As was noted earlier, achieving health goals cannot be done through the health system acting in isolation. Partnership working is essential to build capacity.

Key issues for PHM at a strategic policy level are:

i. vision
ii. political leadership for health
iii. central government policy-making approaches that support the vision and provide leadership
iv. delivery mechanisms through regions, localities and communities that serve as instruments for implementation.

Vision: There is some debate over whether those governments that have sought to shape a vision for public health have retreated from their initial commitment to it. Ensuring effective linkages lies at the heart of the commitment by many governments to 'joined up' policy but it is proving difficult to secure in practice as many governments themselves acknowledge. In all countries more might be done to ensure that complementary policies are genuinely coordinated and effectively communicated.

Political leadership: In considering political leadership of the public health function, there are issues surrounding the role of ministers with a particular responsibility for public health. In particular, has the model been perceived as successful? Might it be recommended to other health care systems? There are important questions about the conditions required to make a success of a cross departmental 'champion' of public health and also where that post should be located. Certain reviews concluded that probably the location of the post was less important than a recognition that wherever it was based there would remain a need to ensure effective coordination with other government ministries and departments. As explained earlier is, to answer these question there is need for multi-sectoral approach and partnership with all key stakeholders in health management ranging from government at all level, community leaders, religious leaders, CSO and many other that in one or another contribute to health and wellbeing of the society.

Central government policy-making approaches: 'Joined up' thinking and action – integrated policy-making and delivery – are key 'process' objectives of government policy in many countries. There are various mechanisms for achieving them, including the following:

i. Cross-departmental co-ordination units;

ii. Ministers with responsibility for issues such as public health, women, the family which cut across traditional departmental boundaries;

iii. Initiatives that require cross-governmental commitment – Violence and injuries prevention programmes; teenage pregnancies programmes; tobacco and health regulation and programmes.

iv. Common approaches to problems – e.g., targeting resources on area based initiatives or 'zones';

v. Impact assessment of policy proposals;

vi. Efforts to achieve common approaches to improve performance.

Many Governments acknowledge that a truly joined up approach is some way off but they resolve to achieve this objective. That is involving each and every key stakeholder. The dilemma of central government initiatives that affect the same people in local areas but which are run separately and not linked together is generalized in most countries. Joined up government has to be supported not by rhetoric or good intentions but by strong incentives and sustained political commitment.

Delivery mechanisms: Effective delivery requires cross-service and cross-agency approaches with horizontal integration at the local, regional, national and international levels and vertical integration of these levels.

Improving the quality of practice requires:

i. Information – evidence of what works and good practice that is tailored to local needs
ii. Communication – helping local agencies to see the links between their activity and the national public health framework
iii. Training and capacity development – taking account of the diversity of organizations, disciplines and professional cultures involved in the new public health · The development of evidence-based standards
iv. Not necessarily a case of new resources but a better use of what already exists – it is crucial to bring initiatives into the mainstream, including their funding;

all too often a rash of well-intentioned schemes are subject to short-term funding – 'projectitis' is rife

v. Community/customer engagement – people for whom life is tough are not motivated to engage in healthy lifestyles or community schemes for reasons of civic concern or self-articulation. The community do have a set of basic material wants, which will interest them. These concern good housing, a clean environment, and freedom from crime/drugs.

Managing public health in an integrated health system embraces a number of issues, including:

i. National policy framework
ii. Integration or de-integration
iii. Organizational options
iv. Management and funding.

Political commitment from the top is essential if a public health agenda is to be advanced beyond fine words. There need to be national goals and targets as well as clear and explicit policies, strategies and priorities. Funding must be population needs based.

To achieve integration, a number of conditions need to be met, including:

i. Adoption of a health outcomes focus
ii. Security of public health resources
iii. Competent purchasing
iv. Provider organization and network
v. Political commitment

Regardless of the country and precise configuration of health policy and services, numerous barriers exist to the effective application of a public health management approach although they are not insuperable. Health care systems tend to suffer from a dysfunctional intermingling of politics and management so that structures and systems

emerge which are less than optimal. As noted earlier, short-term time horizons for delivering improved health outcomes run counter to changes in the public's health which often take many years to achieve. Within this overall policy and governmental context, the implications of public health management for education and training are considered next.

4.0 CONCLUSION

The public health challenges in today's complex societies cannot be met without an effective public health infrastructure but few countries either have in place the necessary policies and resources to ensure effective operation of the public health functions at national and sub national levels or are prepared to equip public health practitioners with the requisite skills to exploit fully their potential to improve the public's health. The notion of PHM has been advocated as one means for addressing health, as distinct from health care, is not yet taken seriously enough in health planning and budgeting. There is a need for incentives to encourage thinking in population terms. The link between local and national frameworks is problematic. Ministries of Health are often weak institutions. This may be the result of decentralization, the absence of proper policy frameworks, or undue donor (often conflicting) influence over policy frameworks.

Developing policy networks is important at national and local levels. The health sector ought to be included in the general policy agenda. There is a need to have models of integrated care. Above all, management strengthening is necessary through a variety of means including short courses, and other types of training. Such training should include people from sectors other than health so as to demonstrate the breadth of public health.

The adoption of an international perspective entails the following: Learning processes (including from South to North in areas like working with communities, primary care frontline workers); Contextualization in preference to the importation of standard reform packages; Health services research to improve the knowledge base; Clarifying and

agreeing WHO/World Bank roles: policy advocacy to Ministries of Health in developing countries; Capacity: the preference being for building it in country rather than imposing solutions on countries.

5.0 SUMMARY

In summary, the focus should be on developing principles rather than devising a blueprint. Some key principles can be drawn from the experiences of a number of countries and organizations that may be fundamental in the successful application of a PHM approach. Principles of a PHM Approach. Public health can find a legitimate place within an integrated set of provider services and hence be strongly supported within a provider framework. Critical to the success of this integration is strong central government commitment to public health outcomes for all provider services thus reinforcing the contribution public health can make to an integrated provider system. Contracting for outputs/outcomes, with ring fencing of public health funding, can ensure an appropriate place for public health within an integrated provider system. Organized primary care is a key service division of an integrated district health system, with symbiotic relationships with public health. District health systems need a strong central government policy framework, an important component of which is national health goals to be delivered through an integrated provider system and affecting all services, including clinical. A service, rather than an institutional framework centered on hospitals, may serve to reduce the power of the hospital as the centerpiece of a health care system and may be a critical factor in providing a more supportive environment for the development of public health services and management directed towards improving the health of local populations.

6.0 TUTOR-MARKED ASSIGNMENTS

1. How do you differentiate management from leadership?
2. What do you think could be the main obstacles in managing health care centers?
3. Who is a manager and what are the major qualities of a good leader?

7.0 REFERENCES/FURTHER READING

WHO, & U.D. (2001). *Public Health Management,* World Health Organization - University of Durham meeting report.

Sharon B.B., & Nancy H.S. (2017). *Introduction to health care management.* Burlington: Jones & Barrlett Learning

Green, A. (1992). *An Introduction to health planning in developing countries*. Leeds: University of Leeds

The National strategic health development plan 2010- 2015.November 2010. Retrieved September 4, 2020, from https://www.mindbank.info/item/2140

Olumide A. (1997). *Fundamentals of health service management for doctors and senior health workers in Africa*. Ibadan: Keita Publishers

Challi J., Amsalu F. & Getnet M. (2004). *Health Planning and Management.* Lecture note. In collaboration with the Ethiopia Public Health Training Initiative, The Carter Center, the Ethiopia Ministry of Health, and the Ethiopia Ministry of Education. Retrieved September, 4, 2020, from https://www.cartercenter.org/resources/pdfs/health/ephti/library/lecture_notes/health_extension_trainees/healthplanningmanangement.pdf

MODULE 1: INTRODUCTION TO HEALTH PLANNING AND MANAGEMENT

UNIT: 2 INTRODUCTION OF SOME ANALYTIC AND NON-ANALYTIC HEALTH PLANNING TECHNIQUES

CONTENT

1.0 INTRODUCTION

Planning is essential for the efficient achievement of all human endeavors. Individuals as well as organizations used to plan because of the uncertainties in a constantly changing environment. Whether we plan for a party, a workshop, a health facility or a health service, planning is that process which we use to select our goals and objectives and to determine how best to achieve them. Put very simply, the process involves taking

decisions on what needs to be done in future to attain objectives in view of past and prevailing circumstances.

Planning is the most basic of all management functions and precedes all the others. Indeed, it is considered to be the most strategic of all management functions as it established institutional objectives and determines how the other major functions of the manager will be executed towards the attainment of the objectives.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

i. Match the limited resources with many problems;
ii. Understand how to eliminate wasteful expenditure or duplication of expenditure;
iii. Develop the best course of action to accomplish a defined objective.
iv. Understand planning process and cycle

3.0 MAIN CONTENT

3.1 CLASSIFICATION OF HEALTH PLANS

Several criteria have been used for the classification of formal health plans. The major criteria of practical significance include: (1) the flexibility of the plan, (2) the duration of the period covered by the plan and (3) The nature and scope of the plan.

3.1.1 The Flexibility of the plan

Plans may be classified as) fixed plans b) rolling plans.

a) FIXED PLANS cover a rigid period of time, and have fixed aims and objectives. The resource inputs for the implementation of the plan are also fixed and rigid.

b) ROLLING PLANS are flexible and are continuously revised and updated so as to remain current with the prevailing conditions. They cover a fixed period, which is subdivided into units, which dove tail one into the other. For instance, a three-year rolling

plan may be revised yearly, modified as necessary and extended into the following year. This is repeated for the duration of the plan. The targets and resource inputs are flexible and are dictated by prevailing circumstances. Rolling plans enhance continuity and relevance.

3.1.2 Duration of the plan

a) Long-term plans also known as perspective plans which cover a fixed period of ten or more years.
b) Medium term plans cover a period of between three and ten years, usually 5 years.
c) Short-term plans are operational plans covering a period of one or two years. They may be fixed or rolling plans.

3.1.3 Nature and scope of the plan

Planning is a function of all health managers. However, the nature and scope of planning vary according to the level of management at which the plan is being formulated i.e. whether at top (strategic) management level, middle (tactical, executive or administrative) management level or at junior (operational or supervisory) management level.

Accordingly, two broad categories of health plans have been distinguished:

a) Strategic, Corporate or Comprehensive health plans, and
b) Operational, Tactical or Functional health plans

Like management itself, each type of health planning takes place at all levels of management, but at varying degrees, while top and middle level management is primarily concerned with strategic planning, the supervisory management level is more pre-occupied with the formulation of operational health plans prepared at the departmental or unit level.

3.2 STRATEGIC, CORPORATE OR COMPREHENSIVE HEALTH PLANNING

Strategic, corporate or comprehensive health planning involves the preparation of broad goals, policies and strategies. Strategic planning takes a broad overview over an extended period of time usually ten years and more. Also, strategic plans usually cover a large service area such as a country. In other words, they are long-range plans, which plan for comprehensive health development covering a broad scope and extending over a long period of time. Strategic health plans set priorities for general health development, and plot the general course of action (strategies) to be taken towards the attainment of health goals. The National Health Policy and strategy to achieve health for all Nigerians (FMOH, 1988) is a strategic health plan.

The goals, policies and strategies contained in a strategic health plan could not have been formulated without the process of "promising or fore-casting". This involves a consideration of both the prevailing and anticipated future environment in which the plan will operate. Thus both strategic and operational health planning involve scanning of factors in the environment which might affect the operation of the plan i.e. economic, political, social, ethical, technological, legal, etc. Effective plans anticipate these factors and make adequate provision for them i.e. the good planner is one who can forecast obstacles or constraints imposed by changes in the planning environment and takes appropriate action by formulating strategies which are likely to be effective.

Usually the strategic planning start at the health facility to LGA department of health to state Ministry of health then to Federal Ministry of Health. As is demonstrated in the Nigerian National Health Policy document, strategic health planning uses information which emanated from the lowest level of the health system, the local government areas in the Nigerian context, and filtered upwards through the Ministries of Health in the various states to the health planners at the Federal level. The desirability of this "bottom-up" type of planning must be emphasized. "Bottom-up" planning as opposed to "top-down" planning guarantees that local realities are fully taken into account by top managers in formulating strategic plans. By providing an opportunity for peripheral units to provide

not only information, but also ideas and suggestions, “bottom-up” planning enhances the relevance of strategic plans for solving health problems at the local level.

In order to ensure that strategic health plans formulate strategies, which will indeed be effective, the following key requirements should be fulfilled:

(a) Corporate self-appraisal on a regular basis to assess the impact of current and past health policies and strategies on health development and on the health status of the nation. This enables strategic health planners to learn from experience and ensures that costly mistakes made in the past are not repeated.

(b) (b) Forecasting should be carefully done in order to determine, major changes in the future environment which are likely to have an impact on health and health development. For example, the current depression in the economy, the AIDS pandemic, etc. The more accurately the organization can foresee the future. Environment the better she is able to establish policies and strategies which are likely to be able to operate effectively within the future environment. For example, is a system of voluntary village health workers likely to succeed in a situation of rapidly escalating food prices and galloping inflation?

(c) An organizational structure that allows for participation by lower levels. In scanning the environment and assessing national health needs and priorities, it is emphasized once again that information should be obtained from the lowest possible level within the grass roots so as to ensure that policies and strategies are relevant to local health needs.

(d) Alternative contingency strategies should be formulated since planned strategies are expected to operate in a future that is always subject to uncertainty. Such alternative strategies must be supported by contingency operational plans that can be put into effect quickly if the need arises so as to avoid crisis management.

3.3 OPERATIONAL, TACTICAL, FUNCTIONAL HEALTH PLANNING

As described in the foregoing, the main function of strategic planning is to give a united direction to national health development. Strategies and policies furnish the framework for further planning. To be effective, they must be followed by operational planning which considers the detailed activities, the very "nuts and bolts" as it were, required for the execution of the health programmes at the local level. A strategy may be good but could fail woefully because of poor "tactics", a military term which is defined as "the action plans by which strategies are executed". There are many examples of excellent strategic plans such as which have failed because of poor planning of the tactics or actions required for their execution. Operational planning is thus also known as "tactical", "functional", planning.

Operational planning has been described as a "process by which decisions are reached on the actual changes in the pattern of service" (DHSS, 1976). They contain very detailed proposals for the provision of specific health programmes and services. Such plans formulate detailed objectives and timed targets as opposed to general goals proposed by strategic plans. Operational planning requires the use of a "functional analysis" technique.

3.3.1 Functional analysis technique

This is a very detailed and systematic analysis, which examines.

a) What type of services would be required to fulfill the targets set?
b) What health activities and specific tasks are involved in providing the identified services (i.e. the activities are carefully dissected out into the component tasks)?
c) Who should be assigned to carry out the tasks and when should the tasks be executed?

Functional analysis breaks down the health service activities systematically into their component procedures and tasks. Functional analysis continues with a quantification of all the material and financial resources needed per service and supportive activity,

including the time requirements of each activity. Thus, another useful bye-product is a detailed schedule of activities i.e. time-table. It should be obvious from this description that such a detailed functional analysis provides the health planner with an opportunity to confront situational realities by responding appropriately to local circumstances.

3.3.2 Operational planning at the regional level

Under the guidance of strategic national plans, health planners in the middle or intermediate level such as regional ministries of health face the challenge of formulating tactical operational plans which attempt to reconcile the political and financial responsibilities of the central government with the needs of the local health services. In other words, national strategies are translated into action plans to solve regional problems. At this level, operational plans also seek to establish mechanisms for forging intersectoral coordination between the various governmental agencies working in the same geographical region.

3.3.3 Operational planning at the local level

It is at the local level (be it within the health facility or in the community) where policies and practical realities meet that the need for detailed operational planning becomes most pressing and crucial. Operational planning for primary health care, for example, should ideally be formulated at the local government level. The district level which is most sensitive to local health needs, can respond more readily to changes in local circumstances and can most effectively ensure the participation of the community in the planning process and to ensure “bottom-up” planning. This is equally true for operational planning within health facilities. For instance, in planning for a new diabetic clinic in a hospital, it is the planners within the hospital itself who will be most familiar with local hospital needs, hospital policy, local hospital culture and practices and the demands of the local internal environmental milieu within which the clinic will operate.

3.4 PLANNING PROCESS/PLANNING CYCLE

The planning process is essentially the same for both strategic and operational health plans. Planning requires a systematic approach i.e. the process involves a series of systematic stages. However, we must caution that planning does not consist of moving rigidly up a static stairway of steps. In practice, the continuity of the process may be constrained at any points by environmental factors, and may not therefore proceed in the cyclical form. In other words, planning is a dynamic movement back and forth between various stages of the process, culminating in a purposeful projection of actions to achieve pre-determined goals. It is however necessary to describe it in stages, in order to provide a general framework or outline of what needs to be done to ensure a systematic approach.

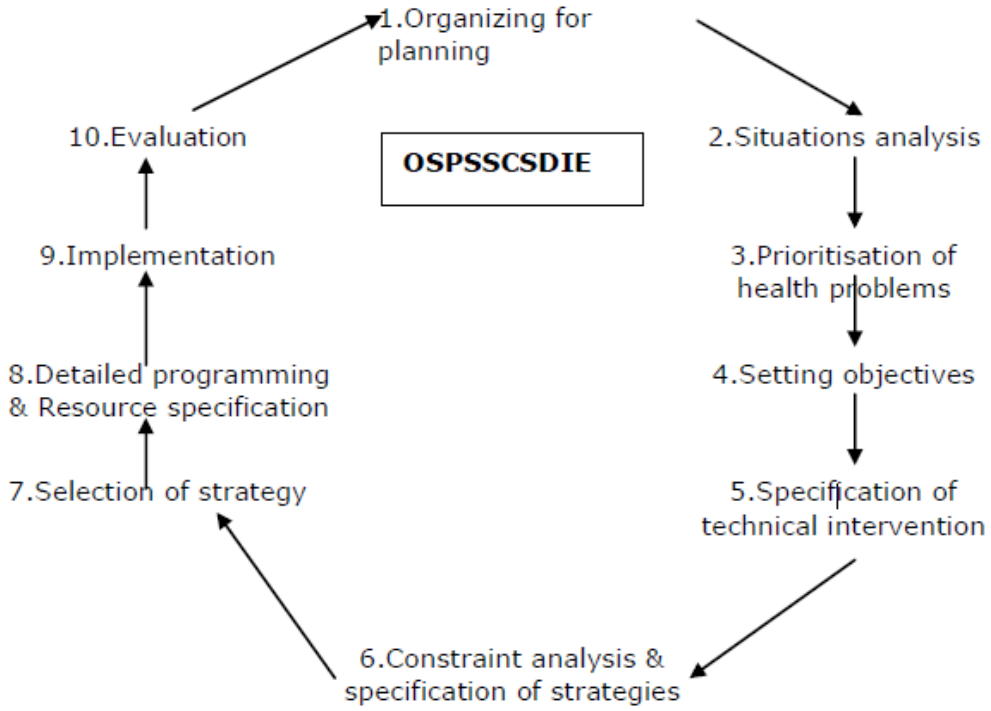


Fig. 1: Planning Cycle

Source: (Olumide, 1997)

The first stage in the process consists of organizing for planning, also known as "planning the planning" during this stage, the planning team is assembled and prepared

for the task ahead. The detailed composition of the planning team will vary with the level at which the plan is being formulated.

The second stage is situation analysis, the main purpose of this stage of the process is to determine the most common health and health related problems and the population groups which they affect, the factors which contribute to the development of the problems and so to identify obstacles and constraints to the improvement of health care. The situation analysis requires a definition of the common health problems in quantified terms, for example, incidence and prevalence rates. It also requires fore-casting of situations which are likely to have direct or indirect implications on health and health care in future.

The third stage is prioritization of health problems; this step is informed by the fact that the resources for the implementation of our plans are presumed to be insufficient to address all the health problems which are discovered.

Fourth is setting objectives-specification, for each priority problem, set objectives in terms of the specific results to be achieved e.g. proportional reduction in incidence of the disease. These will be guided by personal experience of disease control in the field, given the prevailing conditions. It will also be guided by reported experiences of other workers in similar situations. The objectives should be SMART- Specific, Measureable, Achievable, Realistic and Time-bound.

Fifth, specification of technical interventions, for each desired objective, alternative technical interventions which will be required to make the prescribed impact on the health status of the community should be specified in terms of desired proportional increase in coverage e.g. “to increase coverage with potable water from 22% to 50%”. These technical interventions consisted of appropriate promotive, preventive, curative and rehabilitative services, which would result in the desired changes.

Six stage, Constraints analysis and specification of strategies (identification of constraints to implementation and alternative strategies for circumventing the constraints), For each technical intervention specified, the major obstacles, problems, bottlenecks and constraining factors, which were likely to impede implementation, were identified. These generally are resource and operational deficiencies, which had been identified in the health system during the situation analysis.

Seven stage, selection of strategies -selection of priority strategies, The strategies should be evaluated and selected on the basis of perceived cost effectiveness, feasibility, cost-efficiency logistical requirements, etc. Economic evaluation techniques are invaluable tools for the effective selection and priority strategies.

Eight stage, detailed programming and resource specification, this stage involved the translation of the interventions and strategies through the techniques of activity analysis and task analysis into specific activities and tasks to be carried out by the health system, and other sectors and the community i.e. identify the activities required for the execution of each strategy and clearly specify what exactly was to be done, by whom, where it should be done, when and with what resources.

Nine stage, output of the planning process, the exercise produced a detailed plan of work which clearly specified the objectives to be attained, activities to be executed, standards and procedures, who was responsible for each task, the time of execution and completion and the resource and budgetary requirements for each direct task and support activity." Planning does not really end at this stage. It is important, particularly at the local level that the planners should also participate in the implementation and evaluation of the programmes. The planning cycle thus continues through implementation and evaluation, during which valuable information is collected. These are fed-back for the improvement of the next planning cycle.

3.5 MAKING PLANNING EFFECTIVE

Ineffective planning has been ascribed to various factors including the following:

I. Lack of real commitment to planning by managers at all levels; it is so much easier and probably more interesting to manage crises than to think rationally by planning. Lack of meaningful, feasible and verifiable goals and objectives.

II. Lack of a hierarchical approach to the development of plans such that plans at different levels do not "fit" each other i.e. are not formulated under a unified direction such that there is a hierarchy of plans and objectives. Non-participation in the planning process. Consultations should be made with appropriate officers when plans are formulated for programmes, which come under their jurisdiction.

III. Failure to develop sound strategies based on an accurate scanning of the environment.

IV. Excessive reliance on past experience and failure to take account of current and future changes in the environment i.e. failure of accurate premising. There is indeed a limit to which change can be predicted since the future cannot be known with total certainty. Resistance to change – It has been said that to plan is to change. Indeed, it is well known that people resist change.

4.0 CONCLUSION

The health planning process involves an assessment of health needs and of tasks, which must be accomplished in order to satisfy the identified health needs. In other words, health planning is deciding in advance, what to do, who is to do it, how to do it and when. Planning bridges the gap between the present health situation i.e. where we are and the desired health situation ie. where we want to be with regard to health. Planning makes the desired health situation more certain by not leaving it entirely to chance. Furthermore, planning ensures that the most cost-effective and cost-efficient health care activities are pre-selected and thus rationalizes the use of scarce resources.

5.0 SUMMARY

The manager in order to ensure the attainment of objectives which have been expressed in health plans, organizes resources appropriately, decides what types of staff are required to fulfill the objectives of the organization, chooses the most appropriate leadership and supervisory activities, control and evaluates all activities according to well-planned standards. There are two types of planning commonly used in the health sector: strategic planning and operational planning. Strategic planning is the process of determining what the health sector should be achieving in the future and how it will carry out the actions necessary to bring about those achievements while Operational planning refers to the action plans that guide your day-to-day work. This unit also demonstrated the importance of planning cycle and process.

7.0 TUTOR-MARKED ASSIGNMENT

1. Explain two types of health planning commonly use
2. How do you succeed as a good planner in an organization?
3. Describe planning cycle

7.0 REFERENCES/FURTHER READING

Olumide A. (1997). *Fundamentals of health service management for doctors and senior health workers in Africa*. Ibadan: Keita Publishers

West African Postgraduate Medical College. Fundamentals of health service management. Odusote K, editor.

Koontz H, Heinz W. Essentials of management.An international perspective. New Delhi: Tata McGraw-Hill Publishing Company Limited.

Alakija W. (2006). *Selected topics on essential elements of primary health care and family medicine*. Benin: Medisuccess Publications.

MODULE 1: INTRODUCTION TO HEALTH PLANNING AND MANAGEMENT

UNIT 3: PLANNING AND IMPLEMENTATION OF HEALTH PROGRAMS AND POWER DELEGATION

CONTENT

1.0 INTRODUCTION

The development of infrastructures to facilitate the sharing of data for healthcare delivery and research purposes is becoming increasingly widespread. In addition to the technical requirements pertaining to efficient and transparent sharing of data across organizational boundaries, there are requirements pertaining to ethical and legal issues. Functional and non-functional concerns need to be balanced, for resource sharing to be as transparent as possible, an entity should be allowed to delegate a subset of its rights to another so that the latter can perform actions on the former's behalf, yet such delegation needs to be performed in a fashion that complies with relevant legal and ethical restrictions.

The process of planning helps the health manager to decide on the best course of action to take and the various tasks to be undertaken towards the attainment of the goals and

objectives of the organization. Several health plans have been formulated in the countries of the West African sub-region dating from the colonial era. However, experience in many countries in the sub-region has shown repeatedly that many well planned health programmes fail to meet expectations because of failures in implementation. Putting a plan into action through implementation is a delicate process, requiring careful attention to the implementation functions - organizing, staffing, leading and controlling the activities of the health team. Successful implementation also depends on adequate budgeting and funding of the programme.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

i. Understand the concept of delegation and power
ii. Know the advantages of delegation and power
iii. Describe the delegation of power relevance to health care system
iv. Understand team building

3.0 MAIN CONTENT

3.1 THE CONCEPT OF DELEGATION AND POWER

Delegation of powers is the act whereby a political authority invested with certain powers turns over the exercise of those powers, in full or in part, to another authority. Furthermore, those actions for which the right of delegation is granted must be clearly indicated. Delegation of Authority means division of authority and powers downwards to the subordinate. Delegation is about entrusting someone else to do parts of your job. Delegation of authority can be defined as subdivision and sub-allocation of powers to the subordinates in order to achieve effective results.

Delegation of power may be defined as the spread of power from higher to lower levels in a hierarchy (Encyclopedia.com). For hospitals, decentralization in an organizational change of especial importance, in hospitals may be accomplished through

decentralization to departments; more general changes in organizational structure (reduction in the number of hierarchical levels and division); and, delegation of tasks.

3.1.1 Benefits for Delegators

Effective delegation gives delegators more time for their other managerial activities, which enables them to focus on doing few tasks well rather than many tasks poorly. Even if managers believe they can perform tasks better than delegatees, it is a more efficient use of managers' time to concentrate on these other managerial activities.

Effective delegation can also result in increased productivity because several team members are involved in particular tasks or projects at any given time so that more can be achieved than would be possible by one individual.

Marquis and Huston (2000) suggest that for many managers the volume of work becomes too much for one person and that delegation is a necessity not an option. They further suggest that in such situations delegation is often regarded as synonymous with productivity.

The development of effective delegation skills can enhance the personal and professional advancement of delegators. For example, delegating allows managers to concentrate on improving their specific skills, including policy making, managing people, conflict resolution and evaluation.

3.1.2 Benefits for Delegatees

Failure to delegate or ineffective delegation can result in fewer opportunities for team members to improve or expand their skills and knowledge.

Team members can leave organizations if their skills are not developed or enhanced and can become disillusioned if such situations are allowed to continue.

Effective delegation offers team members the opportunity to become competent and this can improve confidence. Participation in decision making by all team members results in greater employee motivation, morale and job performance.

Effective delegation can also result in a greater understanding and appreciation of the work of wards and organizations. In undertaking delegated tasks, delegatees often have to work with other members of staff and may need to develop further their negotiation and interpersonal skills. It also enables delegatees to manage tasks that are of particular interest to them, thereby increasing initiative and enthusiasm. The development of these skills can improve chances of promotion and future career opportunities.

3.1.3 Stages in Effective Delegation

Deciding to delegate is only the beginning of the delegation process. Effective delegation requires significant investment in terms of thought, planning and commitment. The process can appear complex initially but a consistent approach to delegation should succeed.

Six stages of delegation, based on the key steps described by Culp and Smith (1997), are described in this article. This step-by-step guide should assist both novice and experienced delegators to become more effective.

Stage 1: Deciding what to delegate

Delegators must decide what tasks should be delegated. To accomplish this, they must examine the current situation within a particular work environment. For example, they must determine who does what, and when and how tasks are to be completed. This stage enables managers who are overloaded with other responsibilities to manage time better.

Stage 2: Selecting delegatees

Delegators must identify what skills are needed for particular tasks and then decide whether delegatees are the best people to carry them out. It is necessary to match the skills required for the tasks with delegatees' skills.

It is also important that delegators take into account the experience and competence of the delegatees and decide whether they need extra training before undertaking the task. Selecting the right people can enhance the professional development of delegatees.

Stage 3: Assigning tasks

Delegators should describe the particular task in detail and offer an explanation as to why delegatees were selected. They must also discuss the responsibilities associated with the task and outline clearly the level of authority associated with it.

It is important at this stage to check that carrying out the delegated tasks and the responsibilities are within the skill and experience of the delegatees. The activities involved in this stage are important because they can promote trust between delegators and delegatees.

Stage 4: Assessing and discussing

Delegators need to include delegatees actively in the delegation process so that delegatees are given an opportunity to assess the tasks and determine whether they are happy to undertake them.

This may include further discussion of the skills required and the delegatees may like some time to consider whether the tasks have well defined goals, whether they are competent to undertake them and whether further training and education are required.

Delegatees may also want to establish how the tasks or projects affect overall workload and what new responsibilities and levels of authority are associated with them. If the

activities at this stage are followed through, duplication of effort and the possibility of team members working at cross purposes can be reduced.

Stage 5: Executing the task

Delegatees should keep delegators informed of how the tasks progress, and it is important that delegators inform other team members of the level of authority that has been assigned to delegatees while they undertake the tasks.

Delegators must also decide on the supervision and feedback that is necessary during the process. According to Tappen (1995), supervision and feedback can improve self-confidence of the delegatees.

Stage 6: Completion of the task

It is essential that delegators share with the rest of the team the success or shortcomings of the completed tasks or projects. Celebrating success can increase the delegatees' commitment and self-esteem.

3.1.4 Factors that can Hinder Effective Delegation

When staff levels are sufficient and pleasant work has to be allocated, delegation is usually easy. Delegation can become more difficult however when staff levels are too low, unpleasant work has to be delegated or when delegatees are inexperienced.

In addition to delegating effectively, it is important that both delegators and delegatees know some of the factors that can hinder effective delegation. Some of these factors are outlined below.

3.1.4.1 Working in a hierarchy

Regardless of how well delegation is executed, the process presumes a superior-subordinate relationship between delegators and delegatees. This difference in status can conflict with the ideals of democratic states, in which citizens expect to be treated equally.

Traditional nursing hierarchies can conflict with this notion that everybody should be treated equally. This can cause delegators to feel guilty so that, in order to reduce this guilt, they try to take on a greater share of the work. It is important therefore that team members appreciate the difference between equality as human beings and unequal status in organizational hierarchies.

3.1.4.2 Doubting delegatees' abilities

Some managers do not trust team members to undertake tasks, and may hold the view that 'if you want a job done well, you have to do it yourself' suggests that, if managers doubt delegatees' abilities, they are unlikely to delegate.

Fear of having to deal with the consequences of mistakes made by delegatees is another reason for inadequate delegation, and managers who are insecure or who are regarded as perfectionists are least likely to delegate. This can be avoided however by delegating difficult or large tasks to more experienced team members.

3.1.4.3 Difficulties in delegating

Some delegators may not realize that they have difficulty delegating; they may consider themselves hardworking and be unaware that they are restricting the effective functioning of the team. Some refuse to let delegatees share the leadership role or let them become proficient in too many tasks because of their strong need to maintain control or dominate others. This sometimes leads to important information being withheld from team members.

One way of overcoming this problem is to focus on it. Delegators should begin by sharing small amounts of responsibility and power with team members. Team members, meanwhile, can help by taking on more responsibilities, thereby reducing their dependency on the delegators.

3.1.4.4 Inadequate staffing

Inadequate staffing can he a common problem in health care, where 'inadequate' means there are too few members of staff in a team, or too many who are insufficiently educated or experienced. The problems associated with inadequate staffing vary at different times but it is important to stress that where they exist, unless staffing improves, team members cannot fulfill their responsibilities effectively.

3.1.4.5 Dustbin delegation

Delegating pleasant tasks or projects is easier than delegating unpleasant ones. Some delegators deal with this problem by delegating undesirable tasks to team members who seldom refuse. This violates the principle of fairness and team members lose respect for delegators if this continues.

3.1.4.6 Under-delegating

Under-delegating can occur if delegators believe that delegation can be interpreted as a lack of ability on their part to accomplish the jobs at hand.

Delegation does not necessarily reduce delegator control, prestige or power. It can in fact extend delegator influence and capabilities by increasing the amount of work that can be accomplished.

3.1.4.7 Over-delegating: dumping

While under-delegating places excessive burden on delegators, over-delegating places excessive burden on delegatees. Delegators may over-delegate if they are poor at time management and waste time trying to organize themselves. Others do so because they are unsure of their ability to perform given tasks.

3.1.4.8 Resistance to delegation

When delegatees resist delegation, delegators can choose to do the tasks themselves to avoid confrontation. This should be discouraged. Delegators should instead determine why delegated tasks are not being accomplished and act

3.1.4.9 Evaluating delegation

Many delegators never take time to evaluate delegated tasks or projects. Evaluation can help to prevent mistakes and help to improve communication between delegators and delegatees.

3.2 BENEFITS TO WARDS AND ORGANIZATIONS

A major consideration of any organization is efficiency. Through effective delegation, tasks and projects are matched against the skills and knowledge of delegatees thereby producing higher levels of work. In such scenarios, delegators make the best use of available human resources.

Effective delegation can result in faster and more effective decision making, and team members tend to respond better to change when they are involved in decision making processes. This is because team members can undertake tasks that interest them and use the knowledge and skills required to complete the tasks successfully.

Effective delegation also enables many team members to perform the same tasks so that, for example, if one becomes ill or an emergency requires them to perform tasks that are not usually part of their remit, they are familiar with the task elements.

3.3 EFFICIENCY, EFFECTIVENESS OF TEAM BUILDING

An effective team is a small number of people with complementary skills who are committed to a common purpose, performance goals and approach for which they hold themselves mutually accountable (Katzenbach and Smith 2005). Well-functioning health care teams are based upon the assumption that no single provider is able to meet all of the health care needs of any single individual over time that different disciplines bring different skills and experiences that can enrich the care an individual receives. Health care, by definition, is a multidisciplinary profession in which doctors, nurses, health professionals from different specialties must work together, communicate often, and share resources.

3.3.1 Characteristics of and effective team

i. Clear goals and a shared sense of purpose and commitment to achieving them;
ii. Members provide care to a common group of patients;
iii. Focus of members is on needs of the patient rather than on individual contributions of members;
iv. Members develop common goals for patient outcomes and work toward those goals;
v. Effective communication with patients is a value shared by all team members;
vi. Members work together in delivering patient care;
vii. Each individual is able to contribute their own ideas toward solving a common problem;
viii. Mutual trust, respect and support among members;
ix. Appropriate roles and functions are assigned to each member, and each member understands the roles of the other members;
x. Team possesses a mechanism for sharing information;
xi. Team has organizational structures, including regular meetings;
xii. Team possesses a mechanism to oversee the carrying out of plans, to assess outcomes, and to make adjustments based on the results of those outcomes;

xiii. Team recognizes it must work both within and between organizations; and

xiv. Leadership is shared according to the needs of a task.

3.3.2 stages in team development

Teams develop through a series of stages. One well-known model of team development was presented by Tuckman (Tuckman, 1965). This model outlines four stages of team development, with different challenges and tasks in each phase.

1. Forming, this is the very first stage of team development. Here team members meet for the first time, they determine their purpose, and they orient themselves to each other and the task as well as begin to establish trust between team members.
2. Storming, a key issue for teams is to effectively manage conflict while avoiding group think (i.e., where everyone blindly follows along and no one asks any questions). It is critical that teams balance both of these elements. Too much conflict can delay performance but too little conflict (i.e. group think) can stunt creativity. Consequently, in this stage teams must determine how they will manage conflict and encourage differing views and challenges to the status quo.
3. Norming, Here, the team starts to determine roles and responsibilities, sets and agrees on goals, develops operating guidelines for team functioning in their meetings and daily tasks, and determines the level of individual commitment needed to achieve the goals of the team.
4. Performing, once teams have reached this level, they are well-functioning machines. The team is cohesive, more strategically aware and knows clearly why it is doing what it is doing. It shares a vision and has a high degree of autonomy.

3.3.3 Evaluating Team Performance

Teams need to be able to look at their own performance to assess how they are functioning, at different stages of their development. This is part of healthy team development/functioning. A team also has to be able to recognize when it is not

functioning well, or having difficulty with specific tasks or area. In this instance it will need to be able to diagnose what is not working and come up with a plan to address that. This involves defining which outcomes to measure, how to measure them, and from these measurements distinguishing which elements of the team to improve upon. Evaluation measures for a team can focus on either clinical outcome look at or team process outcomes or both. Team effectiveness or success can be assessed both by measuring the team's performance at its specific tasks, such as patient health and functional status, satisfaction of team members/administrators/patients, office efficiencies, and also by evaluating team process. A team effectiveness survey can assist with that. It addresses different aspects of team functioning and helps a team and its leaders to assess how well the team is performing, the team's strengths and areas where improvement maybe required. They can also give an idea of the degree of cohesiveness within a team, the extent to which team members see specific issues or overall team performance in a similar way and where differences may lie. They are not an instant recipe for successful team functioning but they can help to identify where there maybe problems and allow a team to work out strategies to address these.

3.3.4 Improving Communication

Effective communication contributes in several ways to interdisciplinary teamwork. It helps with many of the other tasks in building a team and is the underpinning of effective collaboration. It also facilitates team members being able to let each other know about their skills and expertise or where care could be shared. Poor communication is a barrier to decision making, conflict resolution and problem solving. Looking at communication in a team is helpful at any stage of development. Being able to discuss concerns, both formally and informally, can provide support and reduce the stress of the work.

4.0 CONCLUSION

Delegation can appear simple: a decision is made that a task or project needs delegating, someone is told about it and the task gets done.

However, effective delegation requires skills such as sensitivity to the capabilities of team members. It also requires: the ability to communicate clearly and directly; knowledge of the stages involved in effective delegation; and a vision of how delegation can benefit delegators, delegatees, and wards or organizations. This may require learning new skills but delegation becomes easier when practiced regularly.

The process of planning helps the health manager to decide on the best course of action to take and the various tasks to be undertaken towards the attainment of the goals and objectives of the organization. Individual wellbeing is often linked to the wellbeing of the team; and teams are most productive where there is openness and trust and member are able to work to their strength.

5.0 SUMMARY

Power and delegation is complex in public health, particularly as public health professionals mostly lead without authority, working across health and social care organizations in the public and voluntary sectors. Professionals have to change to fit new circumstances, alter and modify behavior, and take into account different cultures that effect the situation and the organizations that they are leading. They also need to balance and ensure that there is a common agenda that all organizations are working towards. This unit discussed the concept of power and delegation, benefit of delegator, delegate and organization and also the stages involve in effective delegation.

Planned health programmes fail to meet expectations because of failures in implementation. Putting a plan into action through implementation is a delicate process, requiring careful attention to the implementation functions - organizing, staffing, leading and controlling the activities of the health team. Teamwork improves morale and organizational productivity. Therefore, healthcare leaders guide employees through steps promoting solidarity. Particularly during new team formation, individuals have yet to develop trust and camaraderie.

6.0 TUTOR-MARKED ASSIGNMENT

1. Differentiate power from delegation
2. List two benefits of power and of delegation to an organization
3. Mention advantages of delegation to both the delegator and delegate
4. Describe stages involved in effective delegation
5. What do you understand by team work?

7.0 REFERENCES/FURTHER READING

Curtis E., & Honor N. (2004). "Delegation: a key function of nursing: delegation is not a mysterious art but a management function that can be learned and improved with practice. Retrieved September, 4, 2020, from https://journals.rcni.com/nursing-management/delegation-a-key-function-of-nursing-nm2004.07.11.4.26.c1985

Curtis E. & Honor N.(n.d.). Outline six stages of effective delegation in the form of a step-by-step guide for novices and more experienced delegators, and describe some of the impediments to effective delegation." *Nursing Management* [Harrow], vol. 11, no. 4, p. 26+.*Gale General OneFile*, Retrieved September, 4, 2020, from https://go.gale.com/ps/anonymous?id=GALE%7CA119183469&sid=googleScholar&v=2.1&it=r&linkaccess=abs&issn=13545760&p=AONE&sw=w

SOPH, UWC - Postgraduate Certificate in Public Health – Health Management I. Retrieved September, 4, 2020 from https://www.uwc.ac.za/Faculties/CHS/soph/Pages/OER-Health-Management-I.aspx

Olumide A. (1997). *Fundamentals of health service management for doctors and senior health workers in Africa*. Ibadan: Keita Publishers

Nick K. (2009). The Team Building Resource Guide for Family Health. Ontario. Retrieved September, 4, 2020 from http://www.hqontario.ca/portals/0/Documents/qi/qi-rg-team-building-part-a-0901-en.pdf

Health Management, Ethics and Research Module: Planning Health Programs. Retrieved September, 4, 2020 from https://www.open.edu/openlearncreate/mod/oucontent/view.php?id=221&printable=1

MODULE 2: THE CONCEPT OF MANAGEMENT

Unit: 1 Decision Techniques in Management and Management Techniques in Practice

Unit: 2 Changing Nature of Administration

Unit: 3 Quality Assurance, Monitoring and Evaluation

UNIT: 1 DECISION TECHNIQUES IN MANAGEMENT AND MANAGEMENT TECHNIQUES IN PRACTICE

CONTENT

1.0 INTRODUCTION

Decision making is just like the basic discipline of differential diagnosis in medical practice. It is an adage that decisions should be made at the level where the best decisions can be made; it does not follow that the best decision is always made at the top of an organization. Decisions should not be made with incomplete data. In the health sector,

decisions have to be made about development of resources, optimum work load for medical and paramedical workers, strategies for providing health care, etc. The management process is essentially a decision making process. It is also a problem solving process. The health manager takes decisions as to the best solution to problems identified in the course of health care delivery.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

1. Know the meaning of decision making
2. Understand the techniques of decision making
3. Describe project management
4. Levels of Management
5. Understand what PERT is

3.0 MAIN CONTENTS

3.1 DICISSION MAKING PROCESS AND METHODS

The major priority in making a decision is to establish who are the decision-maker(s) and stakeholders in the decision - the audience for the decision. Identifying the decision-maker(s) early in the process cuts down on disagreement about problem definition, requirements, goals, and criteria.

Although the decision-maker(s) seldom will be involved in the day-to-day work of making evaluations, feedback from the decision-maker(s) is vital at four steps in the process:

i. Problem definition [step 1]
ii. Requirements identification [step 2]
iii. Goal establishment [step 3]

iv. Evaluation criteria development [step 4]

When appropriate, stakeholders should also be consulted. By acquiring their input during the early steps of the decision process, stakeholders can provide useful feedback before a decision is made.

3.1.1 Steps in decision making process

The process flows from top to bottom, but may return to a previous step from any point in the process when new information is discovered. It is the decision team's job to make sure that all steps of the process are adequately performed.

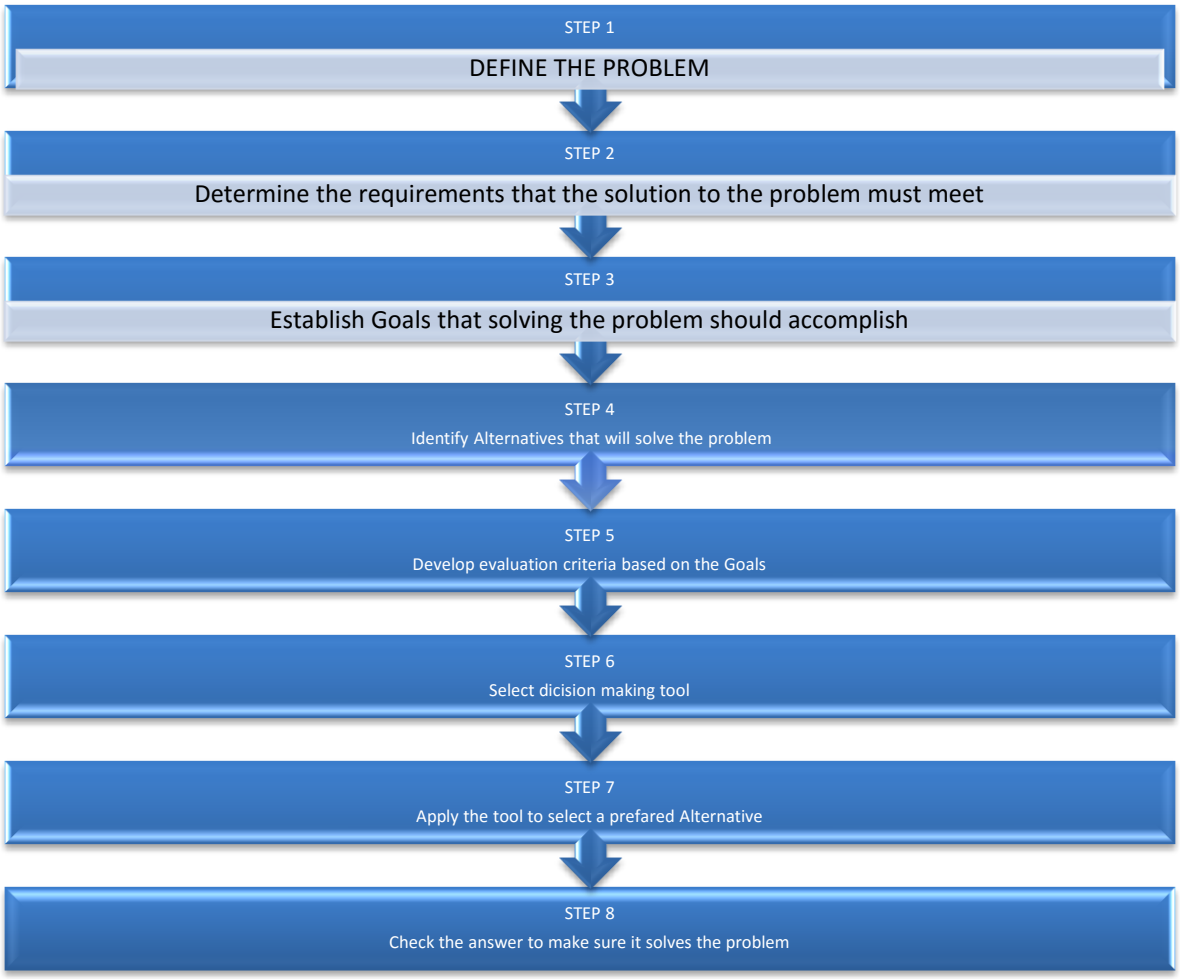


Fig. 1: Decision making process (Dennis et al, 2001)

Step 1, Define the Problem

Problem definition is the crucial first step in making a good decision. This process must, as a minimum, identify root causes, limiting assumptions, system and organizational boundaries and inter-faces, and any stakeholder issues. The goal is to express the issue in a clear, one-sentence problem statement that describes both the initial conditions and the desired conditions.

STEP 2, Determine Requirements

Requirements are conditions that any acceptable solution to the problem must meet. Requirements spell out what the solution to the problem must do. For example, a requirement might be that a process must ("shall" in the vernacular of writing requirements) produce at least ten units per day. Any alternatives that produced only nine units per day would be discarded. Requirements that don't discriminate between alternatives need not be used at this time. With the decision-maker's concurrence, experts in operations, maintenance, environment, safety, health and other technical disciplines typically provide the requirements that a viable alternative must meet.

Step 3, Establish Goals

Goals are broad statements of intent and desirable programmatic values. Examples might be: reduce worker radiological exposure, lower costs, lower public risk, etc. Goals go beyond the minimum essential must have's (i.e. requirements) to wants and desires. Goals should be stated positively (i.e. what something should do, not what it shouldn't do).

Step 4, Identify Alternatives

Alternatives offer different approaches for changing the initial condition into the desired condition. The decision team evaluates the requirements and goals and suggests

alternatives that will meet their requirements and satisfy as many goals as possible. Generally, the alternatives vary in their ability to meet the requirements and goals

Step 5 Define Criteria

Usually no one alternative will be the best for all goals, requiring alternatives to be compared with each other. The best alternative will be the one that most nearly achieves the goals. Decision criteria which will discriminate among alternatives must be based on the goals. It is necessary to define discriminating criteria as objective measures of the goals to measure how well each alternative achieves the project goals.

Criteria should be:

i. Able to discriminate among the alternatives
ii. Complete – include all goals
iii. Operational – meaningful to the decision maker's understanding of the implications of the alternatives
iv. Non-redundant – avoid double counting
v. Few in number – to keep the problem dimensions manageable

Step 6, Select a Decision-Making Tool

Decision making tools:

i. Pros and Cons Analysis
ii. Kepner-Tregoe Decision Analysis (K-T)
iii. Analytic Hierarchy Process (AHP)
iv. Multi-Attribute Utility Theory Analysis (MAUT)
v. Cost Benefit Analysis (CBA)
vi. Custom Tailored Tools

The method of selection needs to be based on the complexity of the problem and the experience of the team.

Step 7, Evaluate Alternatives against Criteria

Alternatives can be evaluated with quantitative methods, qualitative methods, or any combination. Criteria can be weighted and used to rank the alternatives. Both sensitivity and uncertainty analyses can be used to improve the quality of these processes. Experienced analysts can provide the necessary understanding of the mechanics of the chosen decision-making methodology.

Step 8, Validate Solution(s) Against Problem Statement

After the evaluation process has selected a preferred alternative, the solution should be checked to ensure that it truly solves the problem identified. Compare the original problem statement to the goals and requirements. A final solution should fulfill the desired state, meet requirements, and best achieve the goals within the values of the decision makers. Once the preferred alternative has been validated, the decision-making support staff can present it as a recommendation to the decision-maker(s).

3.1.2 Decision Making Methods

Decision Analysis techniques are rational processes/systematic procedures for applying critical thinking to information, data, and experience in order to make a balanced decision when the choice between alternatives is unclear. They methods provide organized ways of applying critical thinking skills developed around accumulating answers to questions about the problem. Steps include clarifying purpose, evaluating alternatives, assessing risks and benefits, and making a decision. These steps usually involve scoring criteria and alternatives. This scoring (a systematic method for handling and communicating information) provides a common language and approach that removes decision making from the realm of personal preference or idiosyncratic behavior.

3.1.2.1 Pros and Cons Analysis

Pros and Cons Analysis is a qualitative comparison method in which good things (pros) and bad things(cons) are identified about each alternative. Lists of the pros and cons, based on the inputs of subject matter experts, are compared one to another for each alternative. The alternative with the strongest pros and weakest consist preferred. The decision documentation should include an exposition, which justifies why the preferred alternative's pros are more important and its cons are less consequential than those of the other alternatives. Pros and Cons Analysis is suitable for simple decisions with few alternatives (2 to 4) and few discriminating criteria (1 to 5) of approximately equal value. It requires no mathematical skill and can be implemented rapidly

3.1.2.2 Kepner-Tregoe (K-T) Decision

Analysis K-T is a quantitative comparison method in which a team of experts numerically score criteria and alternatives based on individual judgments/assessments. The size of the team needed tends to be inversely proportional to the quality of the data available – the more intangible and qualitative the data, the greater the number of people that should be involved. In K-T parlance each evaluation criterion is first scored based on its relative importance to the other criteria (1 = least; 10 = most). These scores become the criteria weights. Once the wanted objectives (goals)have been identified, each one is weighted according to its relative importance. The most important objective is identified and given a weight of 10. All other objectives [are] then weighted in comparison with the first, from 10 (equally important) down to a possible 1 (not very important). When the time comes to evaluate the alternatives, we do so by assessing them relative to each other against all want objectives – one at a time.

3.1.2.3 Analytic Hierarchy Process (AHP)

AHP is a quantitative comparison method used to select a preferred alternative by using pair-wise comparisons of the alternatives based on their relative performance against the

criteria. The basis of this technique is that humans are more capable of making relative judgments than absolute judgments. “The Analytic Hierarchy Process is a systematic procedure for representing the elements of any problem, hierarchically. It organizes the basic rationality by breaking down a problem into its smaller and smaller constituent parts and then guides decision makers through a series of pair wise comparison judgments (which are documented and can be reexamined) to express the relative strength or intensity of impact of the elements in the hierarchy.

3.1.2.4 Multi-Attribute Utility Theory (MAUT)

MAUT is a quantitative comparison method used to combine dissimilar measures of costs, risks, and benefits, along with individual and stake holder preferences, into high-level, aggregated preferences. The foundation of MAUT is the use of utility functions. Utility functions transform diverse criteria to one common, dimensionless scale (0 to1) known as the multi-attribute “utility”. Once utility functions are created an alternative’s raw data (objective) or the analyst’s beliefs (subjective) can be converted to utility scores. As with the other methods, the criteria are weighted according to importance. To identify the preferred alternative, multiply each normalized alternative’s utility score results for all of an alternative’s criteria. The preferred alternative will have the highest total score. Utility functions (and MAUT) are typically used, when quantitative information is known about each alternative, which can result in firmer estimates of the alternative performance. Utility graphs are created based on the data for each criterion. Every decision criterion has a utility function created for it.

The MAUT evaluation method is suitable for complex decisions with multiple criteria and many alternatives. Additional alternatives can be readily added to a MAUT analysis, provided they have data available to determine the utility from the utility graphs. Once the utility functions have been developed, any number of alternatives can be cored against them.

3.1.2.5 The simple multi attribute rating technique

(SMART) can be a useful variant of the MAUT method. This method utilizes simple utility relationships. Data normalization to define the MAUT/SMART utility functions can be performed using any convenient scale. Five, seven, and ten point scales are the most commonly used. In a classical MAUT the full range of the scoring scale would be used even when there may be no real difference between alternatives scores. The SMART methodology allows for use of less of the scale range if the data does not discriminate adequately so that, for example, alternatives which are not significantly different for a particular criterion can be scored equally. This is particularly important when confidence in the differences in data is low. Research has demonstrated that simplified MAUT decision analysis methods are robust and replicate decisions made from more complex MAUT analysis with a high degree of confidence.

3.1.2.6 Cost-benefit analysis

Cost-Benefit Analysis (CBA) is "a systematic quantitative method of assessing the desirability of government projects or policies when it is important to take a long view of future effects and a broad view of possible side effects". CBA is a good approach when the primary basis for making decisions is the monetary cost vs. monetary benefit of the alternatives.

3.1.2.7 Custom tailored tools

Customized tools may be needed to help understand complex behavior within a system. Very complex methods can be used to give straightforward results. Because custom-tailored tools are not off-the-shelf, they can require significant time and resources for development. If a decision cannot be made using the tools described previously, or the decision must be made many times employing the same kinds of considerations, the decision-making support staff should consider employing specialists with experience in computer modeling and decision analysis to develop a custom-tailored.

3.2 MANAGEMENT TECHNIQUES IN PRACTICE

Management techniques are many. They are based on principles of behavioral sciences as well as quantitative methods.

3.2.1 Methods Based on Behavioral Sciences

i. Organizational design: Poor organization results in waste of resources. It is a theory of Management that organization must be suited to its current situation and the needs to be serviced. The organization of health services should therefore be so designed as to meet the health needs and demands of the people.

ii. Personnel Management: This is skillful use of human resources. Proper methods of selection, training and motivation; division of responsibility, distribution of roles; elimination of square pegs in round holes‟ (i.e. professional staff not suited to administration, either through training, selection or natural inclination, should not be entrusted with administrative and management burdens); incentive for better work; opportunities for promotion and professional advancement, effective design of “health teams” are all fundamental techniques of personnel management which could contribute to the efficacy of health service delivery.

iii. Communication: Better communication contributes to effective frequency of an organization. Communication road blocks such as exist at various levels: between the doctor and the patient; doctor and nurse; between the senior officials and junior; between the directorate and the health ministry; between the health ministry and other ministries and rest of the government.

iv. Information Systems: Information is needed for day-to-day management of the health system. Information comes from many sources – both formal and informal. The information system should be tailored according to the management needs of the individual health services.

v. Management by Objectives (MBO): Objectives are set forth for different units and subunits, each of which prepares its own plan of action – usually on a short-term basis. This helps in achieving the results more effectively and smoothly.

3.2.2 Quantitative Methods

Quantitative methods are derived from the field of economics, operation research and budgeting. Some of these techniques have a great role in the management of health services such as:

i. Cost-Accounting: It provides basic data on cost structure of any programme. Financial records are kept in a manner permitting costs to be associated with the purpose for which they are incurred. Cost-accounting has three important purposes in health services, (a) cost control, (b) planning, location of people and financial resources; (c) pricing of cost reimbursement.

ii. Cost-Benefit Analysis: This is a management technique, which has attracted the widest attention for application in health field. The economic benefits of any programme are compared with the cost of that programme. The benefits are expressed in monetary terms to determine whether a given programme is economically sound and to select the best out of several alternative programmes.

iii. Cost–Effective Analysis: This is a more promising tool for application in the health field than cost-benefit analysis. It is similar to cost-benefit analysis except that benefit, instead of being expressed in monetary terms, is expressed in terms of results achieved, e.g. number of lives saved or the number of days free from disease. However, even cost-effective analysis is not possible in many cases.

iv. Systems Analysis: The purpose of systems analysis is to help the decision maker to choose an appropriate course of action by investigating his problems, searching out objectives, finding out alternative solutions, evaluation of the alternatives in terms of cost-effectiveness, re-examination of the objectives if necessary and finding the most cost effective alternative.

v. Input-Output Analysis: Input- Output Analysis is an economic technique. In the health field, “input” refers to all health service activities, which consume resources (manpower, materials, money and time); and output refers to such useful outcomes as cases treated, lives saved or inoculations performed.

vi. Network Analysis: A network is a graphic plan of all events and activities to be completed in order to reach an objective. There are two categories of network analysis:

a. PERT

b. CMT

PERT (Programme Evaluation Review Technique): is a management technique, which makes possible more detailed planning and more comprehensive supervision. The essence of PERT is to construct an arrow diagram. The diagram represents the logical sequence in which events must take place. It is possible with such a diagram to calculate the time by which each activity must be completed and to identify those activities that must be completed and to identify those activities that are critical.

PERT is a useful management technique which can be applied to a great variety of projects. It aids in planning, scheduling and monitoring the project; it allows better communication between the various levels of management; it identifies potential problems; it furnishes continuous, timely progress reports; it forms solid foundation upon which to build an evaluation and checking system.

CPM (Critical Path Method): The longest path of the network is called “critical path”. If any activity along the critical path is delayed, the entire project will be delayed.

3.2.3 Project management

Project management in health system is complex process to manage the system effectively. One has to understand the functions of clinician, pharmacist, nurse, medical assistant and many others. There are no golden rules in project management, as to which one to follow to be a good manager. There are so many definitions of project

management and not one is universally accepted due its application in different field. However, there are certain principles of management and guidelines that one can follow to be a good manager.

Project management in a simpler term means the managing of a project from its start to a successful outcome, obviously there will be a whole range of considerations to make, and processes, tools and techniques to apply to achieve this. Other definitions are:

The planning, monitoring and control of all aspects of a project and the motivation of all those involved is to achieve the project objectives on time and to specify cost, quality and performance." British Standard BS6079 (1996).

The application of knowledge, skills, tools, and techniques to project activities is to meet the project requirements."PMBoK, 4th Ed. (2008).

"The art and science of managing a project from inception to closure is evidenced by successful product delivery and transfer." PMIS, (1997)

The project management considerations are:

i. Once an initial concept has been approved as being worth pursuing a clear description must be formed of what the project outcome will be, that is agreed to by the key stakeholders.
ii. There is need for a clear allocation of resources, time and budget to enable the project to be planned and executed.
iii. A Project Management Plan must be written in such a way that it outlines what will be built (scope) in which sequence and time durations (time) using what resources (cost and procurement) and by whom (human resources), to defined standards (quality).
iv. Good communication must be maintained throughout the project to enable stakeholders to have their requirements, concerns and expectations listened to and addressed in ways that allow the project to
v. Monitoring and controlling are important throughout execution to check the execution of the project against the plans earlier agreed to.

vi. At the end of what? There is need to ensure that the project has been completed, the deliverables formally verified and handed over.

vii. Lessons learned are documented and all the documentations are archived for use and referenced by future projects.

PMBoK advocates that for a Project to be properly managed the Project Manager must understand nine key knowledge management areas which are: Integration, Scope, Time, Cost, Quality, Human Resources, Communications, Risk and Procurement

Research has found key success factors for projects management as:

i. Processes (having a clear project scope and objectives, using good project management processes, planning well and then tracking and reporting progress well),

ii. People (Having well trained, experienced Project Managers, Having Stakeholder & management support, involving end users at the concept and planning stages) and

iii. Attitude (Realistic expectations, Communicating well and Emotional Maturity).

3.2.3.1 Project management method

There are a range of standards, guides and methodologies for helping you to successfully manage projects. There are also a number of methodologies that apply to only some aspects of managing a project. In this material we are going to mention few but students can for their benefits, explore more examples using references given for further reading.

i. PMBoK by PMI (Project Management Body of Knowledge)
ii. Prince2
iii. Critical Chain Project Management
iv. ISO 21500

The Project management cycle

This term is used to refer to the progression of a project through a number of phases from its inception to its close. Dividing a project into phases simplifies the process and enables leadership in the best possible direction. The five project process groups are defined as:

i. Initiating, before you can execute or even plan a project you have to show that there is need for it, and it's going to contribute to your organizational objective which will allow you to create feasibility study.

ii. Planning, once the project has been approved, it's time to create the schedule and task. Then secure the necessary resources for the project. You will also develop a mechanism communication and reports.

iii. Execution, once the roadmap has been created, it is time to start and begin to assign task to team members.

iv. Monitoring and Controlling, there will be issues that arise over the course of the project, so it's crucial that you are monitoring the project progress and controlling those changes.

v. Closing, the project it is not over once the deliverables have been delivered. There is still outstanding contracts and other paperwork that need signing, distributing and achieving for use when planning future work. Then you close the project.

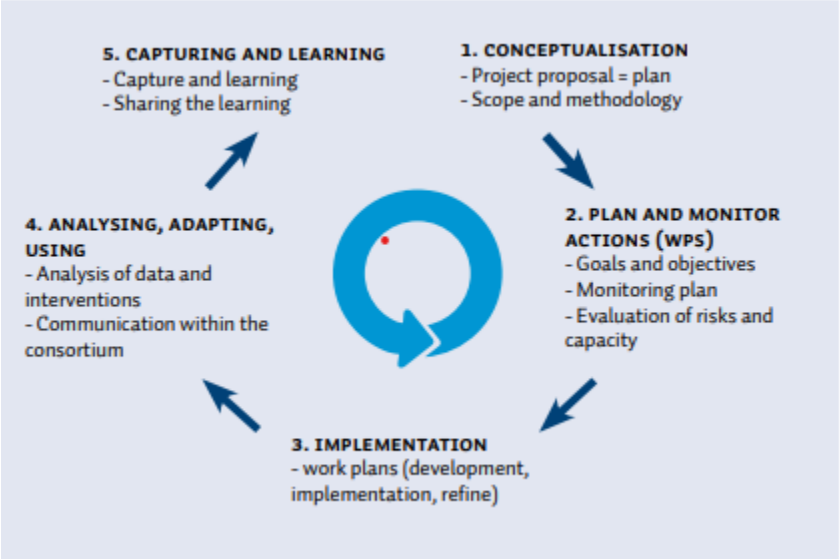


Fig. 2 project management cycle

Source: (Hyttinen, 2017)

3.3 LEVELS OF MANAGEMENT

Health care managers occupy several positions at various levels in health care organizations. There are three main levels

i. Strategic or top management level: Managers at the strategic or top level include Ministers and Commissioners of Health, Directors of various departments in Health Ministries, members of the Board of Management of Teaching Hospitals, Chief Medical Directors, Directors of Clinical Services and Training, Directors of Administration, Chief Matrons, chief Pharmacists etc. Top level managers take decisions concerning policy formulation, setting of organizational goals, strategic planning, general strategies to be used, allocation of resources, corporate evaluation, etc.
ii. Tactical, administrative or middle management level: at the tactical, administrative or middle management level, the decisions taken are concerned with translating policies formulated at the top and interpreting them according to local needs, defining the tactics of implementation, structuring authority and responsibilities, coordination of activities, etc. Health managers who occupy this position in a tertiary hospital setting would include Heads of departments, Consultants, Matrons etc.
iii. Operational or supervisory management level: at the operational or supervisory level, decisions are concerned with the day to day activities (processes) and services outputs, activity scheduling, monitoring of performance, utilization of resources, inventory control etc.

It must be emphasized that at each of these levels, health managers are concerned with the fundamental functions of managers at all levels: Setting objectives and choosing alternative courses of action towards their attainment (planning), ensuring that there is order in the deployment of resources (organizing), ensuring that the staff have the skills

required to get the work done (staffing), motivating staff to work with sustained zeal (leading), ensuring that work gets done (supervision) and assessing progress made towards predetermined objectives (evaluation).

Meaning of Some Terms Used in Management and Administration

The following are some basic terms used in management:

i. Planning is that process we use to select our goals and objectives and to determine how best to achieve them.
ii. Organizing means to mobilize and deploy all resources necessary for effective implementation of health plan.
iii. Staffing is the process of assuring that competent employees are selected.
iv. Leadership is the ability to influence people to work with a sustained zeal towards the achievement of group goals.
v. Directing is concerned with leadership, communication, motivation, and supervision.
vi. Motivation is the inner impulse which drives a person to act in a particular way.
vii. Supervision is the process of keeping surveillance over the performance of assigned tasks.
viii. Controlling is the process of assuring the efficient accomplishment of organization objectives. It takes place through supervision.
ix. Evaluation is the process of collecting information through various methods so as to determine the [RAPEEI] relevance, adequacy, progress, efficiency, effectiveness and impact of planned activities.
x. Monitoring is ongoing / progress / process / output / efficiency evaluation.
xi. Productivity is the output-input ratio within a time period with due consideration for quality. It can be expressed as follows: Productivity =

outputs/ inputs (within a time period, quality considered) Productivity implies effectiveness and efficiency in individual and organizational performance.

xii. Effectiveness is the achievement of objectives.

xiii. Efficiency is the achievement of the ends with the least amount of resources.

3.4 EVOLUTION OF MODERN MANAGEMENT CONCEPTS

The various dimensions of the management process will be better understood when viewed against the background of the evolution of modern management concepts.

The following phases have been identified in the historical development of modern management concepts: The Early influences, The Scientific Management Movement, The Classical School, The Social System Approach, The Systems Approach.

3.4.1 The scientific management movement

The mechanical engineer, Frederick Taylor, otherwise known as the Father of Scientific Management was the chief proponent of this concept. Taylor was concerned with the application of scientific methods and techniques in order to increase productivity. In his "Principles of Scientific Management" (1911), Taylor advocated the need to replace "rule of thumb" methods with more scientific methods based on organized thought.

3.4.2 The early influences

There is ample evidence to show that knowledge and application of management concepts date way back from time immemorial through the ages from the days of the ancient Egyptians even before the advent of Christianity and Islam.

3.4.3 The classical school

The chief proponent of this school of thought was the French industrialist, Henri Fayol, known as the "Father of Modern Operations Management Theory". He was a strong advocate of the belief that the principles of management are of universal application and

that management functions are performed by all managers regardless of where they are based.

3.4.4 The social systems approach, the behavioral science approach, the human relations school

This school of thought emphasizes the concept of the "social man" and considered the individual worker to be a product of group behavior. This emanated from the work of the industrial psychologist, Elton Mayo and his famous experiments, the Hawthorne studies which were conducted in the Hawthorne plant of the Western Electric Company in Chicago during the early part of the 1930s. Mayo and others viewed the organization as a social system and were able to demonstrate the effect of good interpersonal relationships on morale and productivity. This school emphasizes the need for managers to have good grasp of group behavior and group process.

3.4.5 The systems approach

This modern concept views management as a system of activities which are interrelated. It advocates a holistic approach which takes into account the entire enterprise or organization, its organizational objectives and the activation of interrelated management processes based on the formulation of a hierarchy of objectives and directed at the realization of the objectives of the institution.

3.4.6 Fayol, the Father of Operational Management Theory

At the age of 19 years, Fayol had joined Commentary-Fourchambault- a large French mining conglomerate. By 1888, he had become its managing director. At this time the company was on the brink of bankruptcy. Within a few years, Fayol made a successful company again by the application of good management or doctrine administrative, as he called it. At the time when the champions of scientific management were emphasizing the production problems of industry, Fayol was pointing to the importance of the executive's managerial roles. He said that management plays an important part in the administration

of things. Among other things, it coordinates things whether large or small, industrial, commercial, political, religious, etc

Fayol believed that better management depends on better training of managers. He also said that the functions of managers include planning, organizing, coordinating, commanding and controlling. In his monograph on the principles of management (1916), Fayol listed fourteen principles of management. The principles are:

i. DIVISION OF WORK- The major purpose of division of work in an organization is efficiency and proficiency.
ii. AUTHORITY AND RESPONSIBILITY- Authority is the right to give orders and the power to exact obedience while responsibility arises when authority is used.
iii. DISCIPLINE-Discipline basically refers to obedience to written and even unwritten agreements or policies governing the activities of an enterprise by its members.
iv. UNITY OF COMMAND-Everyone should have one and only one boss. According to Fayol, the principle of unity of command should not be undermined for any reason.
v. UNITY OF DIRECTION-This principle calls for one manager and one plan for all operations having the same objective.
vi. SUBORDINATION OF INDIVIDUAL INTEREST TO THE GENERAL INTEREST. The principle implies that the interest of one employee or a group of employees in a business organization should not prevail over the interest of that organization.
vii. REMUNERATION OF STAFF-Remuneration of personnel is the rate that is paid for services rendered by employees. According to Fayol, the compensation policies and practices should be fair and as far as possible, afford maximum satisfaction both to the employees and the employer.

viii. CENTRALIZATION- A centralized organization is one in which decision making authority is vested in the top level of the organization to which all matters pertaining to a particular matter has to be referred.

ix. SCALAR CHAIN OR THE HIERARCHY- This refers to the line of authority from the highest superior to the lowest subordinate in an organization.

x. EQUITY-For the personnel to be encouraged to carry out duties with all devotion and loyalty, equity must permeate all levels in the organization.

xi. STABILITY OF STAFF- For a business organization to be effective, it requires a relatively stable staff especially at the managerial cadre.

xii. ORDER- Order has both material and human connotations. From the perspective of material things, order implies a place for everything and everything in its place.

xiii. INITIATIVE-Initiative is the power to conceive and execute a plan of action. Fayol observed that initiative is one of the most powerful stimulants of human endeavor.

ESPIRIT DE CORPS- This principle emphasizes the dictum that in union there is strength. It stresses the need for teamwork and the important place of good communication system in achieving it.

4.0 CONCLUSION

The main objective of this unit is to raise students' understanding on project management so as to provide an adaptable guidance for project implementation from the management perspective. It also, describes the meaning of project management, project management methods and project management cycle.

In this unit also, we explored the meaning of decision making in health system, decision making techniques and various management practices in which quantitative techniques, organizational methods, Management by objective (MBO), project evaluation review techniques were discussed.

5.0 SUMMARY

Decision making is just like the basic discipline of differential diagnosis in medical practice. It is an adage that decisions should be made at the level where the best decision can be made; it does not follow that the best decision is always made at the top of an organization. Decisions should not be made with incomplete data. In the health sector, decision have to be made about development of resources, optimum work load for medical and paramedical workers, strategies for providing health care etc.

Realization of these objectives requires systematic planning and careful implementation. To this effect, application of knowledge, skill, tools and techniques in the project environment, refers to project management.

The concept of management was highlighted. Major theories and principle concerning management were also discussed. The applications of good managerial activities in achieving success with respect to policies and programs in health were also highlighted. Managing resources and human development in relation to the management process were discussed.

6.0 TUTOR-MARKED ASSIGNMENT

1. What do you understand by management techniques?
2. Describes two types of management techniques
3. Why is project management important?
4. Explain what you understand by Decision making in health care system
5. List the various theories that explain the concept of management see comments above.

7.0 REFERENCES/FURTHER READINGS

Hematram Y. (2007). *Hospital Management*. Kuala Lumpur: University Malaya Press

Olumide A. (2000). *Health management and planning*. Ibadan: Keita Publishers

Hyttinen K, (2017). *Project Management Handbook*.Laurea: Laurea University of Applied Sciences Publication

Free Online Course Open Study Guide. Principles of Project Management – Module 1.https://www.classcentral.com/course/open2study-principles-of-project-management-900 (Access 2020)

MODULE 2: THE CONCEPT OF MANAGEMENT

UNIT 2: CHANGING NATURE OF ADMINISTRATION

CONTENT

1.0 INTRODUCTION

Management sometimes confused with administration: sometimes with organization. Some equate the terms, management and administration. Others view it as a technique of leadership. The widely prevalent view is that administration broadly means "getting things done" and management as "the purposeful and effective use of resources - manpower materials and finances - for fulfilling a pre-determined objective".

Public health professionals focus on the health of individuals, families and communities. They do this by analyzing and developing healthcare programs with the goal of reaching as many people as possible. Health administration professionals work to administer, lead and manage healthcare systems, such as hospitals, hospital networks or large healthcare systems. These dedicated individuals work closely with other healthcare professionals to ensure that patients receive the best possible care. They also administer programs that teach healthy lifestyle habits and prevention of disease and illness, in the hopes of promoting a healthier overall community.

2.0OBJECTIVES

At the end of this unit, you should be able to:

I. Explore the Concept of Administration
II. The importance of public health administration in health care system
III. Describe the skills and competencies required of administrators and practitioners working in public health Administration.

3.0 MAIN CONTENT

3.1 OVERVIEW OF ADMINISTRATION IN HEALTHCARE SYTEM

The day-to-day work of a health administrator varies by the organization for which they work, but the essential core of the job remains the same: Health administrators are responsible for ensuring the smooth operation of a hospital, hospital system or healthcare organization. Job duties may include the following:

i. Wide-range planning and coordination and implementation of medical and health services
ii. Deep understanding of healthcare policy and laws, as well as current and upcoming issues that require administrators to stay ahead of the curve
iii. Attending and contributing to high-level meetings with investors or governing boards
iv. Supervising assistant administrators
v. Keeping open communication with medical staff and heads of departments
vi. Working to improve overall efficiency and financial effectiveness
vii. Paying attention to smaller details such as staff scheduling, hiring and salary issues, patient fees and billing, and even keeping records of supplies.

A health administrator might work for an enormous health company or hospital system, overseeing several facilities at once. Or they might work on a smaller scale, such as managing a group of medical practices, a particular department in a hospital system, or a single medical practice.

The bachelor's degree in health administration or a closely related field is typically minimum requirement for entry level positions. However, it is important to note that

those who hold a bachelor's degree might not be qualified for higher positions, and thus their chances for advancement could be limited.

A master's degree in health administration is a more common educational path for those who wish to reach upper management, and can open doors to positions with much more responsibility. Some choose to earn their doctorate in a management-related field in order to reach for even higher levels of employment in the healthcare system. Regardless of the degree level, most employers prefer to hire someone who has a strong background of experience in administration in a healthcare setting, or those with specialized experience in one particular area of healthcare.

3.1.2 Health Administration: Beyond the Hospital

The phrase "health administration" often brings to mind a busy executive sitting behind a desk, fielding calls and going over paperwork before the board meeting behind closed doors. But in reality, that vision of what a health administrator does is definitely not the whole story. Though working in a hospital setting is quite common, there are numerous other paths a healthcare administration professional can take, and the responsibilities of each vary widely.

The education and experience required for a health administration position also lends itself well to other areas of the healthcare field. Administrators could choose to move into private practice, managing large groups of physicians. They could do the same with ambulatory services, including groups of clinics. Some find work in laboratories, where the put their skills to work behind the scenes, making sure the laboratories and diagnostic areas are safe, secure and well-stocked. The same can be said for those who find their way into pharmaceutical services.

Another important area for health administration is nursing homes. Though this usually takes a more specific education or experience, nursing home administration is growing rapidly, and is expected to grow even more in the coming years. Home health care is another area that needs strong candidates to oversee both the long-term and day-to-day activities of these organizations.

3.2 UNDERSTAND THE ROLES AND RESPONSIBILITIES OF HEALTH ADMINISTRATOR

The work of public health could not be done nor its goals accomplished without managers and administrators. These individuals often obtain a graduate degree, either master public health (MPH) or master public administration(MPA) during which time they study management, administration, and policy. Other learn administration skills on the job or take coursework in other related field of management.

There are seven interconnected process and responsibilities commonly associated with administrative roles:

1. Planning, is the process of specifying goals, establishing priorities and otherwise identifying and sequencing action steps to accomplish goals.
2. Organizing, involves establishing a structure or set of relationship so plan can be implemented and goals accomplished.
3. Staffing, is the assignment of personnel to specific roles or function so the implementation works as design.
4. Directing, involves making decision and communicating them so they can be implemented.
5. Coordinating, is the task of assuring effective interrelationship.
6. Reporting, is the transfer of information and assurance of accountability.
7. Budgeting, is fiscal planning, accounting, and control.

3.3 UNDERSTAND THE CORE COMPETENCIES OF PUBLIC HEALTH ADMINISTRATOR

The council on education for public health is places considerable importance on administration by identifying management competencies for public health education and practice. The table below provides a list of core competencies in the leadership domain.

Table 1: Management Competencies, Health Policy and Management

Table 1.2 Management Competencies, Health Policy and Management

D. Health Policy and Management*

Health policy and management is a multidisciplinary field of inquiry and practice concerned with the delivery, quality, and costs of health care for individuals and populations. This definition assumes both a managerial and a policy concern with the structure, process, and outcomes of health services including the costs, financing, organization, outcomes, and accessibility of care.

Competencies: Upon graduation, a student with an MPH should be able to...

- D.1 Identify the main components and issues of the organization, financing, and delivery of health services and public health systems in the United States.
- D.2 Describe the legal and ethical bases for public health and health services.
- D.3 Explain methods of ensuring community health safety and preparedness.
- D.4 Discuss the policy process for improving the health status of populations.
- D.5 Apply the principles of program planning, development, budgeting, management, and evaluation in organizational and community initiatives.
- D.6 Apply principles of strategic planning and marketing to public health.
- D.7 Apply quality and performance improvement concepts to address organizational performance issues.
- D.8 Apply "systems thinking" for resolving organizational problems.
- D.9 Communicate health policy and management issues using appropriate channels and technologies.
- D.10 Demonstrate leadership skills for building partnerships.

*In this series, *health policy* is treated as a separate text and area of inquiry. As such, this text addresses only the health management competencies.

Source: ASPH.

Source (James & Shi, 2013)

Table 2: Management Competencies, Leadership

Table 1.3 Management Competencies, Leadership

H. Leadership

The ability to create and communicate a shared vision for a changing future, champion solutions to organizational and community challenges, and energize commitment to goals.

Competencies: Upon graduation, it is increasingly important that a student with an MPH be able to...

- H.1 Describe the attributes of leadership in public health.
- H.2 Describe alternative strategies for collaboration and partnership among organizations, focused on public health goals.
- H.3 Articulate an achievable mission, set of core values, and vision.
- H.4 Engage in dialogue and learning from others to advance public health goals.
- H.5 Demonstrate team building, negotiation, and conflict management skills.
- H.6 Demonstrate transparency, integrity, and honesty in all actions.
- H.7 Use collaborative methods for achieving organizational and community health goals.
- H.8 Apply social justice and human rights principles when addressing community needs.
- H.9 Develop strategies to motivate others for collaborative problem solving, decision making, and evaluation.

Source: ASPH.

Source (James & Shi, 2013)

3.5 DIFFERENCES BETWEEN HEALTHCARE ADMINISTRATION AND PUBLIC HEALTH

Many people confuse the roles of healthcare administrators and public health professionals. While both fields are focused on improving the quality of care, public health is geared towards improving community health at many different stages.

For example, a public health professional may work on statistics regarding the occurrence of a specific disease, initiate healthcare programs to champion for community health, and work on policies at the local, state, or national level.

The scope of responsibilities that public health workers cover is at a broader level than healthcare administrators. Healthcare admins focus on improving the performance of a specific location (such as a hospital) by digging deep into the daily operations of where they work.

On the other hand, public health personnel may cover all the hospitals in a specific location to find out the challenges that patients in the community are facing, so as to develop initiatives that can help address these challenges.

4.0 CONCLUSION

Management and administration are sometimes confused and some equate the terms, management and administration as the same. The widely prevalent view is that administration broadly means "getting things done" and management as "the purposeful and effective use of resources - manpower materials and finances - for fulfilling a pre-determined objective". Administration comprises planning, organizing, staffing, leading, directing, and controlling an organization (a group of one or more people or entities) as the roles and responsibilities of health care administrators. Healthcare administrators are one of the most important professionals in the healthcare industry. Not only do they work

directly with primary care providers to support patients, but they also run the administrative functions of many different locations. Competency of healthcare administrators were categorized as policy and management and leadership.

5.0 SUMMARY

The concept of management and administration were highlighted. Healthcare administrators are one of the most important professionals in the healthcare industry. Not only do they work directly with primary care providers to support patients, but they also run the administrative functions of many different locations.

As a healthcare administrator, you may be involved in managing patient records, allocating resources, and outlining workplace procedures. Healthcare admins also hire personnel and may be involved in evaluating performance.

6.0 TUTOR-MARKED ASSIGNMENT (TMAs)

1. What do you understand by Healthcare Administration?
2. What differentiates management from administration?
3. List the various roles and responsibility of Healthcare Administrators.
4. Described competency of public health administrator.

7.0 REFERENCES/FURTHER READING

Schram, R. (1971) Development of Nigerian Health Services, 1460.1960.MD thesis accepted by the Cambridge University, UK under the title. A brief history of public health in Nigeria., 1966. (Published by the University of Ibadan Press in 1971 under the title A History of the Nigerian Health Services)

Ogunlesi, T.O. (2003) Medicine my Passport. Ibadan: Spectrum Books Limited

Federal Ministry of Health. Health Sector Reform Programme: Strategic Thrust with a Logical Framework and Plans of Action 2004.2007. 2004.

Schram R. (1971). *A History of Nigeria Health Service*. Ibadan: Ibadan University Press.

James A. J. & Leiyu S. (2013) Overview of Public Health Administration. Retrieved September, 4, 2020, from http://samples.jbpub.com/9781449688332/Chapter1.pdf

A Guide to Careers in Health Administration Retrieved September, 4, 2020 from https://www.publichealthonline.org/healthcare-administration/#Being-a-Health-Administrator

MODULE 2: THE CONCEPT OF MANAGEMENT

UNIT: 3 QUALITY ASSURANCE MONITORING AND EVALUATION

CONTENTS

7.0 References/Further Reading.

1.0 INTRODUCTION

Dramatic increases in outreach and health coverage have been reported by most countries, many of which have posted modest declines in infant and child mortality and some reductions in selected morbidity. However, the reported improvements have not always been commensurate with the resources expended. Furthermore, not enough has been done to assess service quality or to ensure that resources are having an optimal impact. Quality assurance (QA) methods can help health program managers to define clinical guidelines and standard operating procedures, to assess performance compared with selected performance standards, and to take tangible steps toward improving program performance and effectiveness. This section will provide you with detailed information on quality assurance, monitoring and evaluation.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

1. Understand Quality
2. Define Quality Assurance
3 Understand Dimensions of quality Assurance
4 Describe the processes of quality assurance
5 Develop quality assurance programs
6 Understand Monitoring and Evaluation

3.0 MAIN CONTENT

3.1 QUALITY ASSURANCE PROJECT AND BUILDING A QUALITY ASSURANCE PROGRAM

First let’s define quality, according to Avedis 1980; the quality of technical care consists in the application of medical science and technology in a way that maximizes its benefits to health without correspondingly increasing its risks. Another definition of quality by

WHO 1988, is a proper performance (according to standards) of interventions that are known to be safe, that are affordable to the society in question, and that have the ability to produce an impact on mortality, morbidity, disability, and malnutrition.

The most comprehensive and perhaps the simplest definition of quality is that used by advocates of total quality management: Doing the right thing right, right away.

What is Quality Assurance?

Various definitions of quality assurance have emerged. Dr. Donabedian broadly defines it as all the arrangements and activities that are meant to safeguard, maintain, and promote the quality of care. Drs. Ruelas and Frenk, who have conducted extensive QA work in Mexico, define it as a systematic process for closing the gap between actual performance and the desirable outcomes. According to Dr. Heather Palmer, a QA expert in U.S. ambulatory care, it is a process of measuring quality, analyzing the deficiencies discovered, and taking action to improve performance followed by measuring quality again to determine whether improvement has been achieved.

All these definitions of QA share several characteristics. Each, for example, refers to a systematic, ongoing process that is oriented toward improving performance and using data in the process, either implicitly or explicitly. In essence, quality assurance is that set of activities that are carried out to set standards and to monitor and improve performance so that the care provided is as effective and as safe as possible.

Recent experience in applying quality management to health care systems suggests that four tenets should be adhered to in an ideal quality assurance program:

3.1.1Tenets of an Ideal Quality Assurance

Quality Assurance is Oriented Toward Meeting the needs and Expectations of the Patient and the Community.

Quality assurance requires a commitment to finding out what patients and the community need, want, and expect from the health services. The health team must work with communities to meet service demand and to promote acceptance of needed preventive services.

Quality Assurance Focuses on Systems and Processes.

By focusing on the analysis of service delivery processes, activities, and tasks as well as outcomes, quality assurance approaches allow health care providers and managers to develop an in-depth understanding of a problem and to address its root causes.

Quality Assurance uses Data to Analyze Service Delivery Processes.

Simple quantitative approaches to problem analysis and monitoring are another important aspect of quality improvement. Data-oriented methods allow the QA team to test its theories about root causes; effective problem solving should be based on facts, not assumptions.

Quality Assurance Encourages a Team Approach to Problem Solving and Quality Improvement.

Participatory approaches offer two advantages. First, the technical product is likely to be of higher quality because each team member brings unique perspective and insight to the quality improvement effort. Collaboration facilitates a thorough problem analysis and makes development of a feasible solution more likely. Second, staff members are more likely to accept and support changes that they helped to develop.

3.1.2 Quality Assurance Process

The Quality Assurance Process QAPs is based on experience working with health services in developing countries. However, it also integrates lessons learned from earlier quality assurance methodologies.

The QAP quality improvement model attempts to integrate the strengths of the various models into a simple, logical process for planning and implementing of QA activities. Consistent with earlier models, QAP's quality improvement model defines norms, conducts an assessment, works with health care providers in a participatory fashion, takes action based on the assessment, and monitors results.

Quality Assurance Process

I. Planning for quality assurance
II. Developing guidelines and setting standards
III. Communicating standards and specifications
IV. Monitoring quality
V. Identifying problems and selecting opportunities for improvement
VI. Defining the problem operationally
VII. Choosing a team
VIII. Analyzing and studying the problem to identify its root causes
IX. Developing solutions and actions for improvement
X. Implementing and evaluating quality improvement efforts

Many health center teams will find that they are already taking steps toward improving quality, although they might not use the term quality assurance to describe their activities. The time and effort required for each step will depend on which QA activities are already in place.

In practice, QA is a cyclical, iterative process that must be applied flexibly to meet the needs of a specific program. (See figure below). The process may begin with a comprehensive effort to define standards and norms as described in Steps 1-3, or it may start with small-scale quality improvement activities (Steps 5-10). Alternatively, the process may begin with monitoring (Step 4). Some teams may even choose to simultaneously begin in two places. For instance, comprehensive monitoring and focused

problem solving may start as a coordinated, parallel effort. The ten steps in the QA process are discussed in the following section.

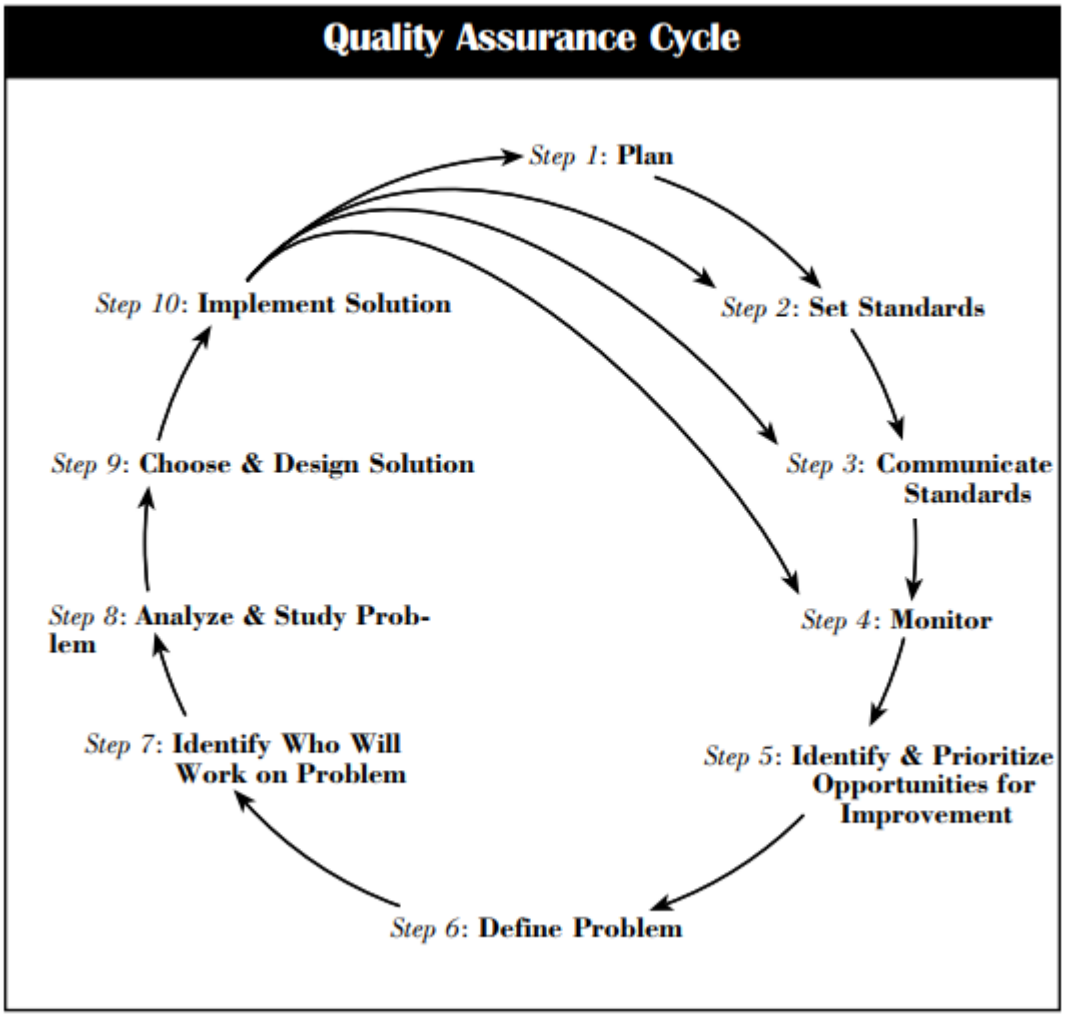


Fig. 1 Quality Assurance Cycle

Source: (Brown et al. 1993).

Planning for Quality Assurance

This first step prepares an organization to carry out QA activities. Planning begins with a review of the organization's scope of care to determine which services should be addressed.

Setting Standards and Specifications

To provide consistently high-quality services, an organization must translate its programmatic goals and objectives into operational procedures. In its widest sense, a standard is a statement of the quality that is expected. Under the broad rubric of standards there are practice guidelines or clinical protocols, administrative procedures or standard operating procedures, product specifications, and performance standards.

Communicating Guidelines and Standards

Once practice guidelines, standard operating procedures, and performance standards have been defined, it is essential that staff members communicate and promote their use. This will ensure that each health worker, supervisor, manager, and support person understands what is expected of him or her.

Monitoring Quality

Monitoring is the routine collection and review of data that helps to assess whether program norms are being followed or whether outcomes are improved.

Generally, all levels of staff should be involved in designing a monitoring system so that everyone receives all necessary information.

Identifying Problems and Selecting Opportunities for Improvement

Program managers can identify quality improvement opportunities by monitoring and evaluating activities. With effective monitoring systems, health programs can conduct special community or patient surveys or comprehensive assessments.

Defining the Problem

Having selected a problem, the team must define it operationally--as a gap between actual performance and performance as prescribed by guidelines and standards.

Choosing a Team

Once a health facility staff has employed a participatory approach to selecting and defining a problem, it should assign a small team to address the specific problem. The team will analyze the problem, develop a quality improvement plan, and implement and evaluate the quality improvement effort.

Analyzing and Studying the Problem to Identify the Root Cause

Achieving a meaningful and sustainable quality improvement effort depends on understanding the problem and its root causes. Given the complexity of health service delivery, clearly identifying root causes requires systematic, in-depth analysis.

Developing Solutions and Actions for Quality Improvement

The problem-solving team should now be ready to develop and evaluate potential solutions. Unless the procedure in question is the sole responsibility of an individual, developing solutions should be a team effort. It may be necessary to involve the personnel responsible for the processes to the root cause.

Implementing and Evaluating Quality Improvement Efforts

Implementing quality improvement requires careful planning. The team must determine the necessary resources and time frame and decide who will be responsible for implementation.

3.1.3 Building a Quality Assurance Program

A Quality Assurance QA program is a comprehensive set of quality assessment and improvement activities that is incorporated into an organizations routine management functions. As health care organizations learn more about the QA processes, they are likely to discover that some of their current activities are related to quality improvement.

In fact, most organizations already do some type of QA. These existing activities provide a foundation upon which to build a comprehensive QA program.

There are two distinct approaches to building a QA program:

I. The comprehensive QA strategy
II. Problem-oriented strategy

These two approaches will be briefly discussed below.

3.1.3.1 The Comprehensive QA Strategy

In the comprehensive approach, QA policies, procedures, and processes are implemented simultaneously, starting at the top and moving down the organizational structure. A comprehensive approach typically begins with a thorough review of standards and specifications. This may be followed by an assessment of health care and support services. This assessment may be conducted through an existing management information system or through a monitoring system specifically developed to measure service quality.

3.1.3.2 The Problem-Oriented Approach

The problem-oriented approach to QA emphasizes practical, small-scale, quality-related activities that will produce incremental quality improvements. Rather than carrying out a comprehensive assessment, individuals or teams focus on a single problem that is important to them. In this model, comprehensive assessment and monitoring are de-emphasized in favor of immediate action. With careful planning, problem-orientation can evolve into a more comprehensive approach.

Key Activities in the Development of a Quality Assurance Program

I. Foster commitment to quality
II. Conduct a preliminary review of QA-related activities

III. Develop the purpose and vision for the QA effort
IV. Determine level and scope of initial QA activities
V. Assign responsibility for QA
VI. Allocate resources for QA
VII. Develop a written QA plan
VIII. Strengthen QA skills and critical management systems
IX. Disseminate QA activities
X. Manage change

These activities will be explained below.

Foster Commitment to Quality

Building a permanent QA program requires the early support of top- and mid-level managers. Over time, this commitment to QA should be shared by all staff and reflected in the organization's mission, purpose, and procedures. The process of fostering and developing commitment is not an isolated activity; it must continue throughout the life of a project and at all levels of the organization.

Conduct a Preliminary Review of Quality-Related Activities

Before introducing new QA activities, it is important to conduct an initial review of the organization and to develop a general description of the existing system. This review will allow the new QA effort to build on existing strengths.

Develop the Purpose and Vision for the Quality Assurance Effort

Building commitment to QA within an organization requires that top managers and their staff share an overall vision of quality improvement. The purpose of a vision statement is to build consensus between managers and to set boundaries for the QA effort.

Determine Level and Scope of Initial Quality Assurance Activities

The level and scope of initial QA activities depend on the resources available, the implementation time frame, and the receptivity of management and program staff to the idea of QA. An organization must also consider external political factors.

Assign Responsibility for Quality Assurance

To ensure continuity, accountability for QA activities must be clear, and QA must be a prominent organizational emphasis. In some organizations a single person may be responsible for QA, while in others it may be the domain of quality committees.

Allocate Resources for Quality Assurance

Local resources must be allocated to quality assurance in order for a QA program to become a permanent part of a health care organization. Often, the initial QA effort may depend on outside technical and financial assistance. Over time, the organization should support its own QA program with minimal dependency on external resources.

Develop a Written Quality Assurance Plan

A QA plan is a written document that describes the program objectives and scope, defines lines of responsibility and authority, and puts forth implementation strategies. The plan should help staff members to relate quality goals and objectives to their routine activities.

Strengthen Quality Assurance Skills and Critical Management Systems

QA activities are an important part of management and may occasionally be reformulated into a total quality management system. In general, however, QA efforts will focus more narrowly on three critical management systems: supervision, training, and management information systems. Special effort should be made to strengthen these systems as a QA program develops.

Disseminate QA Experiences

Early in the life of a QA program, a dissemination strategy should be devised to share experiences inside and outside the organization. Some dissemination programs use newsletters that contain educational articles and project progress reports.

Manage Change

Resistance is almost inevitable when trying to implement a QA program. Initially, some managers and staff fear criticism, loss of power, and change. Staff members who are new to leadership and decision-making roles may be fearful or nervous about their new responsibilities. Even healthy changes involve discomfort, uncertainty, and conflict.

3.2 MONITORING AND EVALUATION

Monitoring and evaluation (M&E) is about collecting, storing, analyzing and finally transforming data into strategic information so it can be used to make informed decisions for program management and improvement, policy formulation, and advocacy

3.2.1 Monitoring

Monitoring is a continuing function that uses systematic collection of data on specific indicators to provide the management and the main stakeholders of an ongoing intervention with indications of the extent of achievement of objectives and progress in the use of allocated funds.

Indicators

An indicator is a quantitative or qualitative variable that allows changes produced by an intervention relative to what was planned to be measured. It provides a reasonably simple and reliable basis for assessing achievement, change or performance.

3.2.2 Evaluation

Evaluation is the systematic and objective assessment of ongoing and/or completed projects, programs or policies, in respect of their:

I. Design
II. Implementation
III. Results

The criteria applied in the evaluation are:

I. Objectives
II. Efficiency
III. Effectiveness
IV. Impact
V. Sustainability

Evaluation emphasizes the assessment of outcomes and impact rather than the delivery of outputs.

3.2.3 A framework for M&E of health systems strengthening

The results framework for Health System strengthening monitoring and evaluation is shown below (Figure). It comprises four major indicator domains: 1) system inputs and processes, 2) outputs, 3) outcomes, and 4) impact. System inputs, processes and outputs reflect health systems capacity. Outputs, outcomes and impact are the results of investments and reflect health systems performance. For each block of indicators, preferred and alternative data sources are recommended, spanning a time horizon from the immediate to the longer term.

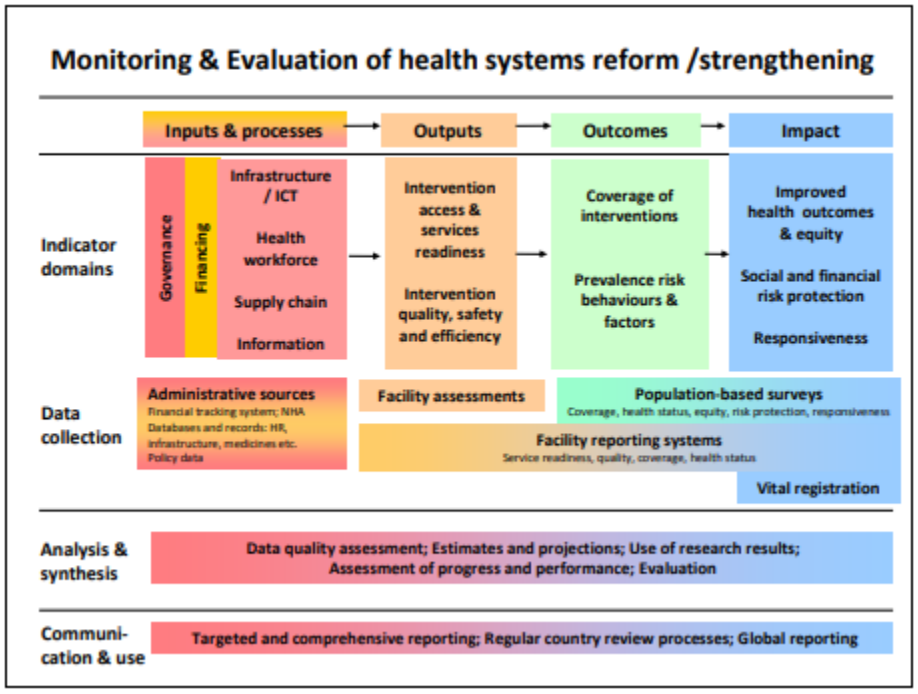


Fig. 2: Health System strengthening monitoring and evaluation

Source: (WHO, 2009)

The added value of this framework is that it brings together indicators and data sources across the results chain in entirety. Monitoring of health system performance needs to show how inputs to the system (resources, infrastructure etc.) are reflected in outputs (such as availability of services and interventions) and eventual outcomes and impact including use of services and better health status.

Uses of core indicators

The main issues are balanced selection of indicators covering all areas of the framework, identification of indicators that can be measured and are amenable to setting of targets, and appropriate metadata for the indicators, preferably in line with international standards. indicators are standardized measures that allow for comparisons over time, over different geographic areas and/or across programs. The ability to compare

temporally and spatially differentiates indicators from raw data, as does the ability to aggregate data for higher-level interpretation and application.

The first goal is that countries identify a comprehensive list of core indicators that capture all areas of the M&E framework. Such indicators should be drawn upon existing indicator lists and should focus on key priorities so as to cover the full range of health issues. definitions for indicator should be aligned with global standards and should also include all necessary metadata descriptors. The choice of the indicator and its attributes, such as frequency of measurement and level of disaggregation, should also take into account national and sub-national measurement capacities.

Data sources

The next stage is to review data sources used to generate the data. For each indicator, the preferred data source should be identified along with best alternatives. Sources of health data can be divided into two broad groups: those that generate data relative to populations as a whole, and those that generate data as an outcome of health- related administrative and operational activities. Other sources of information such as health research, clinical trials and longitudinal community studies may also feed into the health information system.

Data analysis and synthesis

A first step involves systematic data quality assessment and if necessary adjustment. Such analyses need to be transparent and in line with international standards. Identifying and accounting for biases because of incomplete reporting, inaccuracies, non-representatives etc. are essential, and will greatly enhance the credibility of the results for users.

Data dissemination, communication and use

The final step M&E is the translation of the data into information relevant for decision-making. This requires packaging, communication and dissemination of statistics in a format and language accessible to the higher- level policy- and decision- makers. Information is used at various levels of the health system for health service management, health system management, planning, advocacy and policy development.

3.2.4 Types of evaluation

Some authors use the terms **Process, Impacts**, and **Outcome** to determine the value of a program. Others use the term **Formative/ Diagnostic** or **Progressive Evaluation** to evaluate inputs and it is performed during implementation. **Summative** or **Terminal Evaluation** to evaluate outputs and it is done at the conclusion of the program

The type of evaluation reflects:

i. Whether the results are needed to improve a program before or during implementation.
ii. To assess the effectiveness of a program, or
iii. To determine whether the program met the goals and objectives.

1. Process Evaluation/Program Monitoring,

   Document the implementation of a project and explain cause and effect
2. Impact evaluation
   i. Document and explain cause and effect
   ii. Focus on the immediate observable effects of a program leading to the intended outcomes of a program, immediate outcomes. Requires at least 5 years from the inception of a program
3. Formative/ Diagnostic Evaluation
   i. Any combination of measurements obtained and judgment made before or during the implementation of materials, methods activities or programs to control or assure or improve the quality of performance or delivery.

ii. Is providing information on progress. It must therefore be continuously possible.
iii. Is designed to inform about the amount still has to go before achieving objectives.
iv. Measures the progress or gains made from the beginning until completed.
v. Enables activities to be adjusted in accordance with progress made or lack of it. Therefore, it is a teaching method.
vi. Is very useful in guidance and prompt to ask for help.
vii. Is carried out frequently.

4. Summative/ Certifying Evaluation

Any combination of measurements and judgments that permit conclusions to be drowned about impact outcome or benefits of the program or method.

3.2.5 A Framework for Program Evaluation

Effective program evaluation is a systematic way to improve and account for public health actions by involving procedures that are useful, feasible, ethical, and accurate. The Framework for Evaluation in Public Health guides public health professionals in their use of program evaluation. It is a practical, nonprescriptive tool, designed to summarize and organize essential elements of program evaluation.

Adhering to the steps and standards of this framework will allow an understanding of each program's context and will improve how program evaluations are conceived and conducted. Furthermore, the framework encourages an approach to evaluation that is integrated with routine program operations.

The emphasis is on practical, ongoing evaluation strategies that involve all program stakeholders, not just evaluation experts.

Understanding and applying the elements of this framework can be a driving force for planning effective public health strategies, improving existing programs, and demonstrating the results of resource investments.

The purposes of the framework are to

i. summarize the essential elements of program evaluation,
ii. provide a framework for conducting effective program evaluations,
iii. clarify steps in program evaluation,
iv. review standards for effective program evaluation, and
v. address misconceptions regarding the purposes and methods of program evaluation.

Effective program evaluation is a systematic way to improve and account for public health actions by involving procedures that are useful, feasible, ethical, and accurate. The recommended framework was developed to guide public health professionals in using program evaluation. It is a practical, nonprescriptive tool, designed to summarize and organize the essential elements of program evaluation. The framework comprises steps in evaluation practice and standards for effective evaluation.

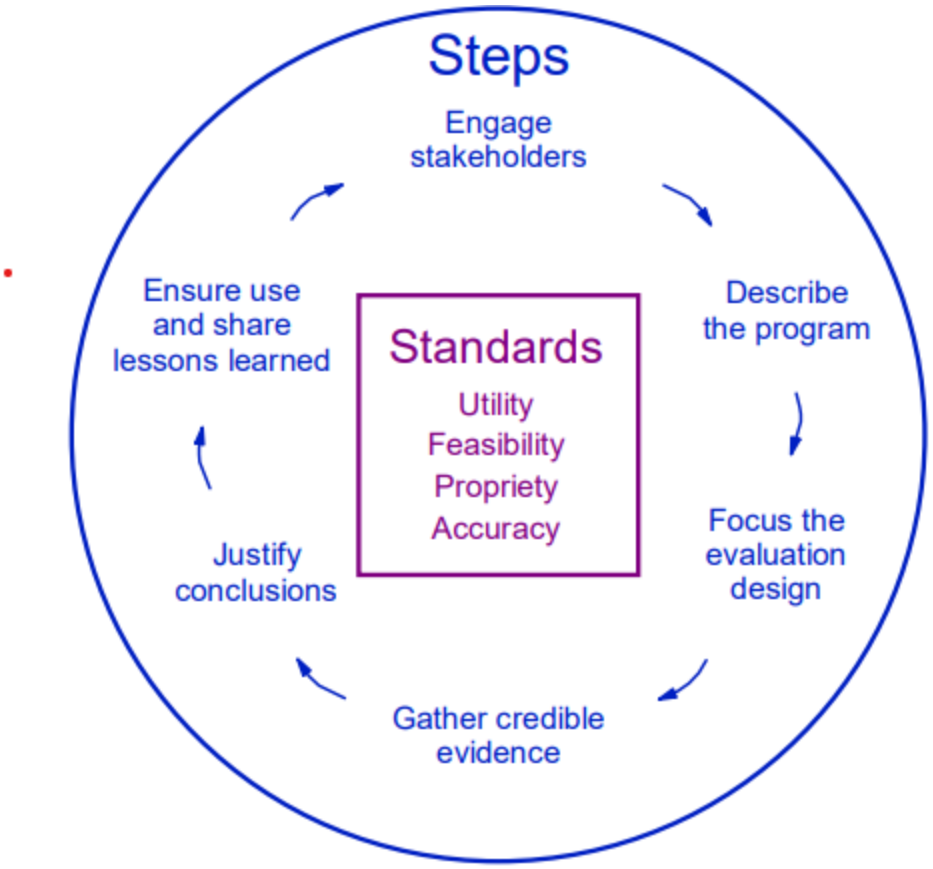


Fig. 3 Framework for program evaluation

Source **(**CDC 1999)

The framework is composed of six steps that must be taken in any evaluation. The steps are as follows:

Step 1: Engage stakeholders.

Step 2: Describe the program.

Step 3: Focus the evaluation design.

Step 4: Gather credible evidence.

Step 5: Justify conclusions.

Step 6: Ensure use and share lessons learned.

Adhering to these six steps will facilitate an understanding of a program's context (e.g., the program's history, setting, and organization) and will improve how most evaluations are conceived and conducted.

The second element of the framework is a set of 30 standards for assessing the quality of evaluation activities, organized into the following four groups:

Standard 1: utility,

Standard 2: feasibility,

Standard 3: propriety, and

Standard 4: accuracy.

Step 1: Engaging Stakeholders The evaluation cycle begins by engaging stakeholders (i.e., the persons or organizations having an investment in what will be learned from an evaluation and what will be done with the knowledge). Public health work involves partnerships; therefore, any assessment of a public health program requires considering the value systems of the partners. Stakeholders must be engaged in the inquiry to ensure that their perspectives are understood. When stakeholders are not engaged, an evaluation might not address important elements of a program's objectives, operations, and outcomes. Therefore, evaluation findings might be ignored, criticized, or resisted because the evaluation did not address the stakeholders' concerns or values. After becoming involved, stakeholders help to execute the other steps. Identifying and engaging the following three principal groups of stakeholders are critical:

i. those involved in program operations (e.g., sponsors, collaborators, coalition partners, funding officials, administrators, managers, and staff);

ii. those served or affected by the program (e.g., clients, family members, neighborhood organizations, academic institutions, elected officials, advocacy groups, professional associations, skeptics, opponents, and staff of related or competing organizations); and
iii. primary users of the evaluation.

Step 2: Describing the Program Program descriptions convey the mission and objectives of the program being evaluated. Descriptions should be sufficiently detailed to ensure understanding of program goals and strategies. The description should discuss the program's capacity to effect change, its stage of development, and how it fits into the larger organization and community. Program descriptions set the frame of reference for all subsequent decisions in an evaluation. The description enables comparisons with similar programs and facilitates attempts to connect program components to their effects. Sometimes, negotiating with stakeholders to formulate a clear and logical description will bring benefits before data are available to evaluate program effectiveness. Aspects to include in a program description are need, expected effects, activities, resources, stage of development, context, and logic model.

Need. A statement of need describes the problem or opportunity that the program addresses and implies how the program will respond. Important features for describing a program's need include a) the nature and magnitude of the problem or opportunity, b) which populations are affected, c) whether the need is changing, and d) in what manner the need is changing.

Expected Effects. Descriptions of expectations convey what the program must accomplish to be considered successful (i.e., program effects). For most programs, the effects unfold over time; therefore, the descriptions of expectations should be organized by time, ranging from specific (i.e., immediate) to broad (i.e., long-term) consequences. A program's mission, goals, and objectives all represent varying levels of specificity

regarding a program's expectations. Also, forethought should be given to anticipate potential unintended consequences of the program.

Activities. Describing program activities (i.e., what the program does to effect change) permits specific steps, strategies, or actions to be arrayed in logical sequence. This demonstrates how each program activity relates to another and clarifies the program's hypothesized mechanism or theory of change. Also, program activity descriptions should distinguish the activities that are the direct responsibility of the program from those that are conducted by related programs or partners. External factors that might affect the program's success (e.g., secular trends in the community) should also be noted.

Resources. Resources include the time, talent, technology, equipment, information, money, and other assets available to conduct program activities. Program resource descriptions should convey the amount and intensity of program services and highlight situations where a mismatch exists between desired activities and resources available to execute those activities. In addition, economic evaluations require an understanding of all direct and indirect program inputs and costs.

Stage of Development. Public health programs mature and change over time; therefore, a program's stage of development reflects its maturity. Programs that have recently received initial authorization and funding will differ from those that have been operating continuously for a decade. The changing maturity of program practice should be considered during the evaluation process. A minimum of three stages of development must be recognized: planning, implementation, and effects. During planning, program activities are untested, and the goal of evaluation is to refine plans. During implementation, program activities are being field-tested and modified; the goal of evaluation is to characterize real, as opposed to ideal, program activities and to improve operations, perhaps by revising plans. During the last stage, enough time has passed for the program's effects to emerge; the goal of evaluation is to identify and account for both intended and unintended effects.

Context. Descriptions of the program's context should include the setting and environmental influences (e.g., history, geography, politics, social and economic conditions, and efforts of related or competing organizations) within which the program operates. Understanding these environmental influences is required to design a context-sensitive evaluation and aid users in interpreting findings accurately and assessing the generalizability of the findings.

Logic Model. A logic model describes the sequence of events for bringing about change by synthesizing the main program elements into a picture of how the program is supposed to work. Often, this model is displayed in a flow chart, map, or table to portray the sequence of steps leading to program results (Figure below). One of the virtues of a logic model is its ability to summarize the program's overall mechanism of change by linking processes (e.g., laboratory diagnosis of disease) to eventual effects (e.g., reduced tuberculosis incidence). The logic model can also display the infrastructure needed to support program operations. Elements that are connected within a logic model might vary but generally include inputs (e.g., trained staff), activities (e.g., identification of cases), outputs (e.g., persons completing treatment), and results ranging from immediate (e.g., curing affected persons) to intermediate (e.g., reduction in tuberculosis rate) to long-term effects (e.g., improvement of population health status). Creating a logic model allows stakeholders to clarify the program's strategies; therefore, the logic model improves and focuses program direction. It also reveals assumptions concerning conditions for program effectiveness and provides a frame of reference for one or more evaluations of the program. A detailed logic model can also strengthen claims of causality and be a basis for estimating the program's effect on endpoints that are not directly measured but are linked in a causal chain supported by prior research.

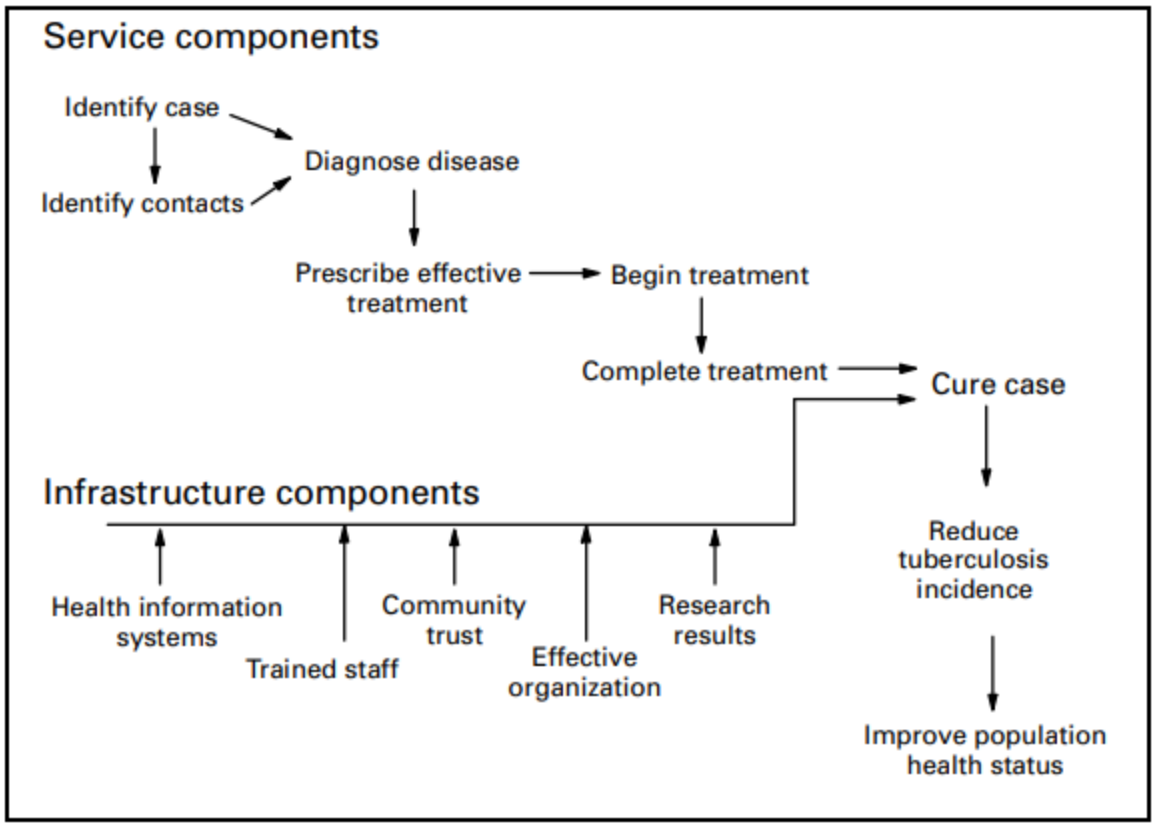


Fig. 4: Logic model for a tuberculosis control program

Source (CDC 1999)

Step 3: Focusing the Evaluation Design The evaluation must be focused to assess the issues of greatest concern to stakeholders while using time and resources as efficiently as possible. Not all design options are equally well-suited to meeting the information needs of stakeholders. After data collection begins, changing procedures might be difficult or impossible, even if better methods become obvious. A thorough plan anticipates intended uses and creates an evaluation strategy with the greatest chance of being useful, feasible, ethical, and accurate. Among the items to consider when focusing an evaluation are purpose, users, uses, questions, methods, and agreements.

Purpose. Articulating an evaluation's purpose (i.e., intent) will prevent premature decision-making regarding how the evaluation should be conducted. Characteristics of

the program, particularly its stage of development and context, will influence the evaluation's purpose. Public health evaluations have four general purposes.

The first is to gain insight, which happens, for example, when assessing the feasibility of an innovative approach to practice. Knowledge from such an evaluation provides information concerning the practicality of a new approach, which can be used to design a program that will be tested for its effectiveness. For a developing program, information from prior evaluations can provide the necessary insight to clarify how its activities should be designed to bring about expected changes.

A second purpose for program evaluation is to change practice, which is appropriate in the implementation stage when an established program seeks to describe what it has done and to what extent. Such information can be used to better describe program processes, to improve how the program operates, and to fine-tune the overall program strategy. Evaluations done for this purpose include efforts to improve the quality, effectiveness, or efficiency of program activities.

A third purpose for evaluation is to assess effects. Evaluations done for this purpose examine the relationship between program activities and observed consequences. This type of evaluation is appropriate for mature programs that can define what interventions were delivered to what proportion of the target population. Knowing where to find potential effects can ensure that significant consequences are not overlooked. One set of effects might arise from a direct cause-and-effect relationship to the program. Where these exist, evidence can be found to attribute the effects exclusively to the program.

A fourth purpose, which applies at any stage of program development, involves using the process of evaluation inquiry to affect those who participate in the inquiry. The logic and systematic reflection required of stakeholders who participate in an evaluation can be a catalyst for self-directed change. An evaluation can be initiated with the intent of generating a positive influence on stakeholders. Such influences might be to supplement the program intervention (e.g., using a follow-up questionnaire to reinforce program

messages); empower program participants (e.g., increasing a client's sense of control over program direction); promote staff development (e.g., teaching staff how to collect, analyze, and interpret evidence); contribute to organizational growth (e.g., clarifying how the program relates to the organization's mission); or facilitate social transformation (e.g., advancing a community's struggle for self-determination).

Step 4: Gathering Credible Evidence. An evaluation should strive to collect information that will convey a well-rounded picture of the program so that the information is seen as credible by the evaluation's primary users. Information (i.e., evidence) should be perceived by stakeholders as believable and relevant for answering their questions. Such decisions depend on the evaluation questions being posed and the motives for asking them. For certain questions, a stakeholder's standard for credibility might require having the results of a controlled experiment; whereas for another question, a set of systematic observations (e.g., interactions between an outreach worker and community residents) would be the most credible.

Step 5: Justifying Conclusions The evaluation conclusions are justified when they are linked to the evidence gathered and judged against agreed-upon values or standards set by the stakeholders. Stakeholders must agree that conclusions are justified before they will use the evaluation results with confidence. Justifying conclusions on the basis of evidence includes standards, analysis and synthesis, interpretation, judgment, and recommendations.

Standards. Standards reflect the values held by stakeholders, and those values provide the basis for forming judgments concerning program performance. Using explicit standards distinguishes evaluation from other approaches to strategic management in which priorities are set without reference to explicit values. In practice, when stakeholders articulate and negotiate their values, these become the standards for judging whether a given program's performance will, for example, be considered successful,

adequate, or unsuccessful. An array of value systems might serve as sources of norm referenced or criterion-referenced standards.

Analysis and Synthesis. Analysis and synthesis of an evaluation's findings might detect patterns in evidence, either by isolating important findings (analysis) or by combining sources of information to reach a larger understanding (synthesis). Mixed method evaluations require the separate analysis of each evidence element and a synthesis of all sources for examining patterns of agreement, convergence, or complexity. Deciphering facts from a body of evidence involves deciding how to organize, classify, interrelate, compare, and display information. These decisions are guided by the questions being asked, the types of data available, and by input from stakeholders and primary users.

Interpretation. Interpretation is the effort of figuring out what the findings mean and is part of the overall effort to understand the evidence gathered in an evaluation. Uncovering facts regarding a program's performance is not sufficient to draw evaluative conclusions. Evaluation evidence must be interpreted to determine the practical significance of what has been learned. Interpretations draw on information and perspectives that stakeholders bring to the evaluation inquiry and can be strengthened through active participation or interaction.

Judgments. Judgments are statements concerning the merit, worth, or significance of the program. They are formed by comparing the findings and interpretations regarding the program against one or more selected standards. Because multiple standards can be applied to a given program, stakeholders might reach different or even conflicting judgments. For example, a program that increases its outreach by 10% from the previous year might be judged positively by program managers who are using the standard of improved performance over time. However, community members might feel that despite improvements, a minimum threshold of access to services has not been reached. Therefore, by using the standard of social equity, their judgment concerning program performance would be negative. Conflicting claims regarding a program's quality, value,

or importance often indicate that stakeholders are using different standards for judgment. In the context of an evaluation, such disagreement can be a catalyst for clarifying relevant values and for negotiating the appropriate bases on which the program should be judged.

Recommendations. Recommendations are actions for consideration resulting from the evaluation. Forming recommendations is a distinct element of program evaluation that requires information beyond what is necessary to form judgments regarding program performance. Knowing that a program is able to reduce the risk of disease does not translate necessarily into a recommendation to continue the effort, particularly when competing priorities or other effective alternatives exist. Thus, recommendations for continuing, expanding, redesigning, or terminating a program are separate from judgments regarding a program's effectiveness. Making recommendations requires information concerning the context, particularly the organizational context, in which programmatic decisions will be made. Recommendations that lack sufficient evidence or those that are not aligned with stakeholders' values can undermine an evaluation's credibility. By contrast, an evaluation can be strengthened by recommendations that anticipate the political sensitivities of intended users and highlight areas that users can control or influence.

Step 6: Ensuring Use and Sharing Lessons Learned Lessons learned in the course of an evaluation do not automatically translate into informed decision-making and appropriate action. Deliberate effort is needed to ensure that the evaluation processes and findings are used and disseminated appropriately. Preparing for use involves strategic thinking and continued vigilance, both of which begin in the earliest stages of stakeholder engagement and continue throughout the evaluation process. Five elements are critical for ensuring use of an evaluation, including design, preparation, feedback, follow-up, and dissemination.

Design. Design refers to how the evaluation's questions, methods, and overall processes are constructed. As discussed in the third step of this framework, the design should be

organized from the start to achieve intended uses by primary users. Having a clear design that is focused on use helps persons who will conduct the evaluation to know precisely who will do what with the findings and who will benefit from being a part of the evaluation. Furthermore, the process of creating a clear design will highlight ways that stakeholders, through their contributions, can enhance the relevance, credibility, and overall utility of the evaluation.

Preparation. Preparation refers to the steps taken to rehearse eventual use of the evaluation findings. The ability to translate new knowledge into appropriate action is a skill that can be strengthened through practice. Building this skill can itself be a useful benefit of the evaluation. Rehearsing how potential findings (particularly negative findings) might affect decision-making will prepare stakeholders for eventually using the evidence. Primary users and other stakeholders could be given a set of hypothetical results and asked to explain what decisions or actions they would make on the basis of this new knowledge. If they indicate that the evidence presented is incomplete and that no action would be taken, this is a sign that the planned evaluation should be modified. Preparing for use also gives stakeholders time to explore positive and negative implications of potential results and time to identify options for program improvement.

Feedback. Feedback is the communication that occurs among all parties to the evaluation. Giving and receiving feedback creates an atmosphere of trust among stakeholders; it keeps an evaluation on track by letting those involved stay informed regarding how the evaluation is proceeding. Primary users and other stakeholders have a right to comment on decisions that might affect the likelihood of obtaining useful information. Stakeholder feedback is an integral part of evaluation, particularly for ensuring use. Obtaining feedback can be encouraged by holding periodic discussions during each step of the evaluation process and routinely sharing interim findings, provisional interpretations, and draft reports.

Follow-Up. Follow-up refers to the technical and emotional support that users need during the evaluation and after they receive evaluation findings. Because of the effort required, reaching justified conclusions in an evaluation can seem like an end in itself; however, active follow-up might be necessary to remind intended users of their planned use. Follow-up might also be required to prevent lessons learned from becoming lost or ignored in the process of making complex or politically sensitive decisions. To guard against such oversight, someone involved in the evaluation should serve as an advocate for the evaluation's findings during the decision-making phase. This type of advocacy increases appreciation of what was discovered and what actions are consistent with the findings.

Dissemination. Dissemination is the process of communicating either the procedures or the lessons learned from an evaluation to relevant audiences in a timely, unbiased, and consistent fashion. Although documentation of the evaluation is needed, a formal evaluation report is not always the best or even a necessary product. Like other elements of the evaluation, the reporting strategy should be discussed in advance with intended users and other stakeholders. Such consultation ensures that the information needs of relevant audiences will be met. Planning effective communication also requires considering the timing, style, tone, message source, vehicle, and format of information products. Regardless of how communications are constructed, the goal for dissemination is to achieve full disclosure and impartial reporting. A checklist of items to consider when developing evaluation reports includes tailoring the report content for the audience, explaining the focus of the evaluation and its limitations, and listing both the strengths and weaknesses of the evaluation.

3.2.6 Standards for Effective Evaluation

Public health professionals will recognize that the basic steps of the framework for program evaluation are part of their routine work. In day-to-day public health practice, stakeholders are consulted; program goals are defined; guiding questions are stated; data

are collected, analyzed, and interpreted; judgments are formed; and lessons are shared. Although informal evaluation occurs through routine practice, standards exist to assess whether a set of evaluative activities are well-designed and working to their potential. The Joint Committee on Standards for Educational Evaluation has developed program evaluation standards for this purpose. These standards, designed to assess evaluations of educational programs, are also relevant for public health programs. In the Joint Committee's report, standards are grouped into the following four categories and include a total of 30 specific standards (Boxes 13–16). As described in the report, each category has an associated list of guidelines and common errors, illustrated with applied case examples:

i. Utility,
ii. Feasibility,
iii. Propriety, and
iv. Accuracy

Standard 1: Utility

Utility standards ensure that information needs of evaluation users are satisfied. Seven utility standards (Box 1) address such items as identifying those who will be impacted by the evaluation, the amount and type of information collected, the values used in interpreting evaluation findings, and the clarity and timeliness of evaluation reports.

Standard 2: Feasibility

Feasibility standards ensure that the evaluation is viable and pragmatic. The three feasibility standards (Box 2) emphasize that the evaluation should employ practical, non-disruptive procedures; that the differing political interests of those involved should be anticipated and acknowledged; and that the use of resources in conducting the evaluation should be prudent and produce valuable findings.

Standard 3: Propriety

Propriety standards ensure that the evaluation is ethical (i.e., conducted with regard for the rights and interests of those involved and effected). Eight propriety standards (Box 3) address such items as developing protocols and other agreements for guiding the evaluation; protecting the welfare of human subjects; weighing and disclosing findings in a complete and balanced fashion; and addressing any conflicts of interest in an open and fair manner.

Standard 4: Accuracy

Accuracy standards ensure that the evaluation produces findings that are considered correct. Twelve accuracy standards (Box 4) include such items as describing the program and its context; articulating in detail the purpose and methods of the evaluation; employing systematic procedures to gather valid and reliable information; applying appropriate qualitative or quantitative methods during analysis and synthesis; and producing impartial reports containing conclusions that are justified. The steps and standards are used together throughout the evaluation process. For each step, a subset of relevant standards should be considered.

Box 1: Utility standards

The following utility standards ensure that an evaluation will serve the information needs of intended users:

A. **Stakeholder identification.** Persons involved in or affected by the evaluation should be identified so that their needs can be addressed.
B. **Evaluator credibility.** The persons conducting the evaluation should be trustworthy and competent in performing the evaluation for findings to achieve maximum credibility and acceptance.
C. **Information scope and selection.** Information collected should address pertinent questions regarding the program and be responsive to the needs and interests of clients and other specified stakeholders.
D. **Values identification.** The perspectives, procedures, and rationale used to interpret the findings should be carefully described so that the bases for value judgments are clear.
E. **Report clarity.** Evaluation reports should clearly describe the program being evaluated, including its context and the purposes, procedures, and findings of the evaluation so that essential information is provided and easily understood.
F. **Report timeliness and dissemination.** Substantial interim findings and evaluation reports should be disseminated to intended users so that they can be used in a timely fashion.
G. **Evaluation impact.** Evaluations should be planned, conducted, and reported in ways that encourage follow-through by stakeholders to increase the likelihood of the evaluation being used.

Source: Joint Committee on Standards for Educational Evaluation. Program evaluation standards: how to assess evaluations of educational programs. 2nd ed. Thousand Oaks, CA: Sage Publications, 1994.

Box 2: Feasibility standards

The following feasibility standards ensure that an evaluation will be realistic, prudent, diplomatic, and frugal:

A. **Practical procedures.** Evaluation procedures should be practical while needed information is being obtained to keep disruption to a minimum.
B. **Political viability.** During planning and conduct of the evaluation, consideration should be given to the varied positions of interest groups so that their cooperation can be obtained and possible attempts by any group to curtail evaluation operations or to bias or misapply the results can be averted or counteracted.
C. **Cost-effectiveness.** The evaluation should be efficient and produce valuable information to justify expended resources.

Source: Joint Committee on Standards for Educational Evaluation. Program evaluation standards: how to assess evaluations of educational programs. 2nd ed. Thousand Oaks, CA: Sage Publications, 1994.

Box 3: Propriety Standards

The following propriety standards ensure that an evaluation will be conducted legally, ethically, and with regard for the welfare of those involved in the evaluation as well as those affected by its results:

A. **Service orientation.** The evaluation should be designed to assist organizations in addressing and serving effectively the needs of the targeted participants.
B. **Formal agreements.** All principal parties involved in an evaluation should agree in writing to their obligations (i.e., what is to be done, how, by whom, and when) so that each must adhere to the conditions of the agreement or renegotiate it.
C. **Rights of human subjects.** The evaluation should be designed and conducted in a manner that respects and protects the rights and welfare of human subjects.
D. **Human interactions.** Evaluators should interact respectfully with other persons associated with an evaluation, so that participants are not threatened or harmed.
E. **Complete and fair assessment.** The evaluation should be complete and fair in its examination and recording of strengths and weaknesses of the program so that strengths can be enhanced and problem areas addressed.
F. **Disclosure of findings.** The principal parties to an evaluation should ensure that the full evaluation findings with pertinent limitations are made accessible to the persons affected by the evaluation and any others with expressed legal rights to receive the results.
G. **Conflict of interest.** Conflict of interest should be handled openly and honestly so that the evaluation processes and results are not compromised.
H. **Fiscal responsibility.** The evaluator's allocation and expenditure of resources should reflect sound accountability procedures by being prudent and ethically responsible, so that expenditures are accountable and appropriate.

Source: Joint Committee on Standards for Educational Evaluation. Program evaluation standards: how to assess evaluations of educational programs. 2nd ed. Thousand Oaks, CA: Sage Publications, 1994.

Box 4: Accuracy standard

The following accuracy standards ensure that an evaluation will convey technically adequate information regarding the determining features of merit of the program:

A. **Program documentation.** The program being evaluated should be documented clearly and accurately.
B. **Context analysis.** The context in which the program exists should be examined in enough detail to identify probable influences on the program.
C. **Described purposes and procedures.** The purposes and procedures of the evaluation should be monitored and described in enough detail to identify and assess them.
D. **Defensible information sources.** Sources of information used in a program evaluation should be described in enough detail to assess the adequacy of the information.
E. **Valid information.** Information-gathering procedures should be developed and implemented to ensure a valid interpretation for the intended use.
F. **Reliable information.** Information-gathering procedures should be developed and implemented to ensure sufficiently reliable information for the intended use.
G. **Systematic information.** Information collected, processed, and reported in an evaluation should be systematically reviewed and any errors corrected.
H. **Analysis of quantitative information.** Quantitative information should be analyzed appropriately and systematically so that evaluation questions are answered effectively.
I. **Analysis of qualitative information.** Qualitative information should be analyzed appropriately and systematically to answer evaluation questions effectively.
J. **Justified conclusions.** Conclusions reached should be explicitly justified for stakeholders' assessment.
K. **Impartial reporting.** Reporting procedures should guard against the distortion caused by personal feelings and biases of any party involved in the evaluation to reflect the findings fairly.
L. **Metaevaluation.** The evaluation should be formatively and summatively evaluated against these and other pertinent standards to guide its conduct appropriately and, on completion, to enable close examination of its strengths and weaknesses by stakeholders.

Source: Joint Committee on Standards for Educational Evaluation. Program evaluation standards: how to assess evaluations of educational programs. 2nd ed. Thousand Oaks, CA: Sage Publications, 1994.

3.3.7 Applying The Framework

Conducting Optimal Evaluations

Public health professionals can no longer question whether to evaluate their programs; instead, the appropriate questions are

i. What is the best way to evaluate?
ii. What is being learned from the evaluation? And,
iii. How will lessons learned from evaluations be used to make public health efforts more effective and accountable?

The framework for program evaluation helps answer these questions by guiding its users in selecting evaluation strategies that are useful, feasible, ethical, and accurate. To use the recommended framework in a specific program context requires practice, which builds skill in both the science and art of program evaluation. When applying the framework, the challenge is to devise an optimal — as opposed to an ideal — strategy. An optimal strategy is one that accomplishes each step in the framework in a way that accommodates the program context and meets or exceeds all relevant standards. CDC's evaluations of human immunodeficiency virus prevention efforts, including school-based programs, provide examples of optimal strategies for national-, state-, and local-level evaluation.

Assembling an Evaluation Team

Harnessing and focusing the efforts of a collaborative group is one approach to conducting an optimal evaluation. A team approach can succeed when a small group of carefully selected persons decides what the evaluation must accomplish and pools resources to implement the plan. Stakeholders might have varying levels of involvement on the team that correspond to their own perspectives, skills, and concerns. A leader must be designated to coordinate the team and maintain continuity throughout the process; thereafter, the steps in evaluation practice guide the selection of team members. For example:

i. Those who are diplomatic and have diverse networks can engage other stakeholders and maintain involvement.
ii. When describing the program, persons are needed who understand the program's history, purpose, and practical operation in the field. In addition, those with group facilitation skills might be asked to help elicit unspoken expectations regarding the

program and to expose hidden values that partners bring to the effort. Such facilitators can also help the stakeholders create logic models that describe the program and clarify its pattern of relationships between means and ends.

iii. Decision makers and others who guide program direction can help focus the evaluation design on questions that address specific users and uses. They can also set logistic parameters for the evaluation's scope, time line, and deliverables.

iv. Scientists, particularly social and behavioral scientists, can bring expertise to the development of evaluation questions, methods, and evidence gathering strategies. They can also help analyze how a program operates in its organizational or community context.

v. Trusted persons who have no particular stake in the evaluation can ensure that participants' values are treated fairly when applying standards, interpreting facts, and reaching justified conclusions.

vi. Advocates, clear communicators, creative thinkers, and members of the power structure can help ensure that lessons learned from the evaluation influence future decision-making regarding program strategy.

Addressing Common Concerns

Common concerns regarding program evaluation are clarified by using this framework. Evaluations might not be undertaken because they are misperceived as having to be costly. However, the expense of an evaluation is relative; the cost depends on the questions being asked and the level of precision desired for the answers. A simple, low-cost evaluation can deliver valuable results. Rather than discounting evaluations as time-consuming and tangential to program operations (e.g., left to the end of a program's project period), the framework encourages conducting evaluations from the beginning that are timed strategically to provide necessary feedback to guide action. This makes integrating evaluation with program practice possible. Another concern centers on the perceived technical demands of designing and conducting an evaluation. Although circumstances exist where controlled environments and elaborate analytic techniques are

needed, most public health program evaluations do not require such methods. Instead, the practical approach endorsed by this framework focuses on questions that will improve the program by using context sensitive methods and analytic techniques that summarize accurately the meaning of qualitative and quantitative information.

Finally, the prospect of evaluation troubles some program staff because they perceive evaluation methods as punitive, exclusionary, or adversarial. The framework encourages an evaluation approach that is designed to be helpful and engages all interested stakeholders in a process that welcomes their participation. Sanctions to be applied, if any, should not result from discovering negative findings, but from failing to use the learning to change for greater effectiveness.

4.0 CONCLUSION

In conclusion, Quality Assurance has demonstrated the impact it plays in health care system by closing the gap between actual performance and the desirable outcomes in health care delivery. Health care managers must consider the needs of multiple clients in addressing questions about resource allocation, fee schedules, staffing patterns, and management practices. The multidimensional concept of quality presented here is particularly helpful to managers who tend to feel that access, effectiveness, technical competence, and efficiency are the most important dimensions of quality. Every country needs to have a strong monitoring and evaluation system in place as the foundation for national health sector strategic planning, covering all major disease programmes and health systems activities.

5.0 SUMMARY

Quality assurance is that set of activities that are carried out to set standards and to monitor and improve performance so that the care provided is as effective and as safe as possible. M&E is an integrated organizational approach for meeting client needs and expectations involving both management and staff while improving processes and services using quantitative techniques and analytical tools. It also, provides a

comprehensive general framework for M&E of health system strengthening and reform. Evaluation is the only way to separate programs that promote health and prevent injury, disease, or disability from those that do not; it is a driving force for planning effective public health strategies, improving existing programs, and demonstrating the results of resource investments. Evaluation also focuses attention on the common purpose of public health programs and asks whether the magnitude of investment matches the tasks to be accomplished.

6.0 TUTOR-MARKED ASSIGNMENT

i. Define the concept of quality
ii. What is quality assurance
iii. Explain any three (3) tenets of an ideal quality assurance
iv. Describe the stages of quality assurance process
v. What do you understand by monitoring and evaluation?

7.0 REFERENCES/FURTHER READING

Brown L.D., Franco L.M., Rafeh N. & Hatzel T. (1998). Quality Assurance of Health Care in developing countries. *Quality Assurance Methodology Refinement Series*, (33)

WHO (2009). Monitoring and evaluation of health systems strengthening: An operational framework. Retrieved September 4, 2020, from https://www.who.int/healthinfo/HSS_MandE_framework_Nov_2009.pdf

CDC (1999). Framework for Program Evaluation in Public Health. *Morbidity and Mortality Weekly Report*, 48(11)

Toolkit to Combat Trafficking in Persons, (n.d).Overview of monitoring and evaluation. Retrieved September 4, 2020, from https://www.unodc.org/documents/human-trafficking/Toolkit-files/08-58296_tool_10-1.pdf

MODULE 3: ORGANIZATIONAL STRUCTURES

Unit: 1 Organizational Function and Organizational Development

Unit: 2 Settings of Organizational Goals and Objectives

Unit: 3 Primary Health Care (PHC) Implementation, and Community Diagnosis

UNIT 1: ORGANIZATIONAL FUNCTION AND ORGANIZATIONAL DEVELPPMENT

CONTENTS

1.0 INTRODUCTION

An organizational development is a core process or set of activities carried out within a department or areas of a company. Common areas of concern in organizational development include operations, human resources, information technology, customer service, Finance and many more as relate to health system. Organizational structure for

healthcare organization is a functional organizational whose key is a pyramid-shape hierarchy, which defines the functions carried out and the key management positions assigned to those functions. Healthcare team is in a transition that requires more focus on improving patient experience and reducing errors and the cost of services provided. This unit tend to focus on the role of the senior manager or lead administrator of an organization, it should be realized that management occurs through many others who may not have "manager" in their position title.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

1. Understand Organizational Development
2. Understand the changes in organizational development
3. Understand the process of organization development
4. Describe organization development in healthcare
5. Understand Organizational Function
6. Areas of Organizational Function

3.0 MAIN CONTENT

3.1 ORGANIZATIONAL DEVELOPMENT

Organizational development is a relatively new area of interest for business and the professions. While the professional development of individuals has been accepted and fostered by a number of organizations for some time, there is still ambiguity surrounding the term organizational development. The basic concept of both professional development and organizational development is the same, however, with an essential difference in focus. Professional development attempts to improve an individual's effectiveness in practice, while organizational development focuses on ways to improve an organization's overall productivity, human fulfillment, and responsiveness to the environment. These goals are accomplished through a variety of interventions aimed at dealing with specific issues, as well as through ongoing processes

Change is a constant, a thread woven into the fabric of our personal and professional lives. Change occurs within our world and beyond in national and international events, in the physical environment, in the way organizations are structured and conduct their businesses, in political and socioeconomic problems and solutions, and in societal norms and values. As the world becomes more complex and increasingly interrelated, changes seemingly far away affect us. Thus, change may sometimes appear to occur frequently and randomly. We are slowly becoming aware of how connected we are to one another and to our world.

3.1.1 Changes in Organizational Development

Organizational development (OD) is a field of study that addresses change and how it affects organizations and the individuals in the organizations. Effective organizational development can assist organizations and individuals to cope with change. Strategies can be developed to introduce planned change, such as team-building efforts, to improve organizational functioning. While change is a "given," there are a number of ways to deal with change -- some useful, some not.

Organization development is a planned process of change in an organization's culture through the utilization of behavioral science technology, research, and theory. (Warner Burke)

3.1.2 Benefit of Organization Development

Continuous improvement: institution that engage in organizational development commit to continually improving their business and offerings. The organization development process creates a continuous cycle of improvement whereby strategies are planned, implemented, evaluated, improved and monitored.

Increased communication: One of the key advantages to organization development is increased communication, feedback and interaction within the organization.

Employee development: Organizational development focuses on increased communication to influence employees to bring about desired changes. The need for employee development stems from constant industry and market changes

Product & service enhancement: A major benefit of organization development is innovation, which leads to product and service enhancement.

Increased profit: Organizational development affects the bottom line in a variety of ways. Through raised innovation and productivity, efficiency and profits are increased. Costs are also reduced by minimizing employee turnover and absenteeism.

3.2 ORGANIZATIONAL FUNCTIONS

Organizational function is a critical and science-based process that helps organizations build their capacity to change and achieve greater effectiveness by developing, improving, and reinforcing strategies, structures, and processes.

In order to achieve good health care delivery or service most organisations will need to undertake 6 key functions.

I. Design and Production. Product design describes the process of imagining, creating, and iterating products that solve users' problems or address specific needs in a given organization. The key to successful product design is an understanding of the organizational objective.
II. Finance. Financial structure refers to the mix of debt and equity that an organization uses to finance its operations.
III. Human Resources. Human resources is used to describe both the people who work for a company or organization and the department responsible for managing resources related to employees.
IV. Sales and Marketing. Sales include "operations and activities involved in promoting and selling goods or services. Marketing includes "the

process or technique of promoting, selling, and distributing a product or service."

V. Administration. Administration is the management of an office, business, or organization. It involves the efficient organization of people, information, and other resources to achieve organizational objectives.

VI. Research and Development. Research and development (R&D) includes activities that organizations undertake to innovate and introduce new products and services. It is often the first stage in the development process.

Each of the functions will need to work together so that the whole of the organisation has the same aims and objectives. To achieve this objectives, communication across the various functions is the key activity. A starting point for this type of communication is the creation of a clear set of objectives which each function is aware of. These objectives then need to be further broken down into specific objectives for each function. Regular reviews of firstly how each function is performing against its objectives and secondly how the system is performing against its overall objective should ensure that the whole company is pulling in the same direction.

Healthcare organizations are complex and dynamic. The nature of organizations requires that managers provide leadership, as well as the supervision and coordination of employees. Organizations were created to achieve goals that were beyond the capacity of any single individual. In healthcare organizations, the scope and complexity of tasks carried out in provision of services are so great that individual staff operating on their own couldnt get the job done.

3.3 TYPES OF ORGANIZATIONAL FUNCTION

3.3.1 Factors of Production in an Organization

To generate a product or service an organisation will need to combine labour, capital, energy, materials and information.

Labour is the mental and or physical effort of employees and can take a variety of forms including filing, lifting, data processing, decision making, and line management.

Capital is the machines and tools needed to produce the product or service.

Energy is provided through the use of gas, electricity, solar power and steam.

Materials in their raw form are needed to produce the product or service. For example, a hospital will need drugs to treat patient that come for treatment.

Information is the knowledge and expertise needed to produce the end product. For example, a consultant in various field of medicine will need to know what services are necessary for each problem.

3.3.2 Finance Function

The financial section of the organisation will keep manual/electronic records of money received and paid out by the organisation. This information will then be used to produce various financial statements and to comply with legal requirements. The information will also be used to produce management accounts to enable senior managers to plan and review services provision strategy.

3.3.3 Human Resources Function

Human resources or Personnel's main responsibility is the recruitment, selection, training and development of staff. This will involve developing staff to maximise their potential in a manner that furthers the organisation's objectives.

3.3.4 Sales and Marketing Function

This function is usually not related to health care system to some extend because health services provision is not a profit or loss organization, however, there are some exceptions. The marketing department will research on customer needs to develop strategy and products to satisfy customer needs.

3.3.5 Administrative (or Facilities Management) Function see comments above

This involves dealing with all administrative tasks including mail handling, dealing with enquiries/complaints, catering, and computer services. They will also produce documents (e.g. forms, stationary, and newsletters) for the organisation and maintain the organisation's premises and equipment.

3.3.6 Research and Development Function

The aim of research and development is to improve existing services in the health system, create new and better services, improve delivery methods, and create effective processes. This will enable the organisation to reduce costs, increase satisfaction and remain ahead of the competition. As not all research will lead to new/improved services/processes hospitals will need to allocate a specific portion of their budget to research and development activities.

4.0 CONCLUSION

In conclusion, organizational function as the name suggests is about controlling the team and resources so that the plan is implemented as planned and in accordance with the organization's rules and procedures. Managers have to ensure that the organization is on course to achieve targets. Controlling involves checking progress against management plans and taking remedial action to deal with under performance. However as circumstances can change controlling also involves amending plans when necessary and implementing Contingency Plans should a crisis occur.

5.0 SUMMARY

Organizational structure and development is the foundation on which other aspect of organization and management are build. Elements of the structures include those functions and department which constitute the various areas of specialization within the healthcare system. Structure provide the framework within which a whole range of other organizational components exist.

6.0 TUTOR-MARKED ASSIGNMENT

1. What do you understand by organizational function in health systems?
2. list and explain 6 organizational functions

7.0 REFERENCES/FURTHER READING

Gapenski L.C. (n.d.). Understanding Health Care Financial Management: AUPHA Press/Health Administration Press 1993). Retrieved September 4, 2020, from https://www.learnmanagement2.com/ORGANISATIONAL%20FUNCTIONS.htm

WHO, (n.d.). Management for health services delivery. Retrieved September 4, 2020, from https://www.who.int/management/functions/en/

Neil K. (2017). What Are the Duties of a Marketing Department? Retrieved September 4, 2020, from https://bizfluent.com/list-6803280-duties-marketing-department-.html

Understanding Healthcare Management. Retrieved September 4, 2002, from http://samples.jbpub.com/9780763759643/59643_CH02_5289.pdf

MODULE 3: ORGANIZATIONAL STRUCTURES

UNIT: 2 SETTINGS OF ORGANIZATIONAL GOALS AND OBJECTIVE

CONTENTS

1.0 INTRODUCTION

Effective organizational development can assist organizations and individuals to cope with change. Strategies can be developed to introduce planned change, such as team-building efforts, to improve organizational functioning. While change is a "given," there are a number of ways to deal with change some useful, some not. Organizational development assists organizations in coping with the turbulent environment, both internally and externally, frequently doing so by introducing planned change efforts. Changes in healthcare practice are welcome if they improve quality and safety, or save money. However, it is important to tailor health care delivery to the needs of the local population and create awareness programmes and clear communication between the public and organization is essential and highly required.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

i. Understand the changes in Organizational Development
ii. Understand the Process of Organization Development
iii. Describe Organization Development in Healthcare

3.0 MAIN CONTENT

3.1 ORGANIZATIONAL OBJECTIVE AND GOALS

Organizations cannot survive and flourish for a very long time without some basic goals. Goals give an organization a purpose and direction to move towards the entire period of its operations.

Goals—statements describing what your organization wishes to accomplish, stemming from your purpose. Goals are the ends toward which your efforts will be directed and often change from term to term or year to year, depending on the nature of the group.

Objectives—descriptions of exactly what is to be done, derived from the goals. They are clear, specific statements of measurable tasks that will be accomplished as steps toward reaching your goals. They are short term and have deadlines.

Steps for Setting Goals

1. Brainstorm goals as a group. (People support what they create, and will accept responsibility more easily.)
2. Choose from the brainstormed list those you want to attend to.
3. Prioritize as a group.
4. Determine objectives and plans of action for each goal. Be specific and include deadlines.
5. Move into action. Follow through.

6. Continually evaluate your progress.

7. Be flexible; allow your objectives to change to meet your new circumstances.

Here's a tip that might help: Make your goals VISIBLE

i. Post them.
ii. Give a copy to every member.
iii. Discuss them at meetings—put them on the agenda.
iv. Put them in newsletters and materials you send out

There is an increasing number of organizations implementing a lot strategies and methodology for objective setting. By making each objective in the organization visible and transparent, employees have a better line of sight of how they can contribute to the success of the organization. Better understanding of the objectives leads to higher engagement in the workplace.

Employees are encouraged to set their individual objectives by aligning their contributions to the departmental and organizational objectives. Setting organizational objectives are not easy. You have to take into consideration internal factors such as financial resources and human capital as well as external factors such as competitors, demand for the products, and the economy.

Many Managers struggle to set their organizational objectives because there are too many variables that can affect the end results. Here are some of the best practices recommend to my clients when consulting on how to set their objectives.

Know your strengths and weaknesses

Many businesses conduct a SWOT analysis where they identify their internal **S**trengths and **W**eaknesses as well as external **O**pportunities and **T**hreats. This information allows you to develop strategies that are relevant and realistic to your organization. Investigate

what the future trends may be in your industry. You want to develop objectives that will give you a competitive advantage.

Ask yourself where do you want to be in 3 months, 1 year, and 5 years

The vision that you have for your organization should be reflected in your company's objectives. Organizational objectives can be a mixture of both short term and long term goals. A great tip is to start with your 5 year goals. Where do you see your company in 5 years? What do you want to have achieved by then? Then think about the strategies you want to pursue in order to achieve those goals. These strategies are your 1 year objectives. What you have to do right now to support your business strategies are your quarterly or monthly goals.

Use the SMART model to set your organizational objectives

Try your best to make your objectives and key results **S**pecific, **M**easurable, **A**ttainable, **R**elevant and **T**ime bound.

Specific – What type of company do you want to be the best at? On what scale do you want to compete? Do you want to be the best company in your area or in the world?

Measurable – How will you know when you have achieved your objective? What benchmarks are you going to use to measure your success?

Attainable – Is this objective achievable given your resources? What are the obstacles that you are going to encounter and can you get past the hurdles?

Relevant – How relevant is this objective to the company and its employees? Will it benefit your organization?

Time bound – When do you want to achieve this objective by?

Think about who is contributing to the objectives

Sometimes CEOs may get confused about the difference between an organizational and a departmental goal. This situation arises within companies that are adopting a flatter organizational structure where they do not have a management level anymore. Ask yourself “who will contribute to the success of that objective?” and “who will have the greatest impact on the objective and its key results?” If anyone in the organization, given the nature of their position, can contribute to the objective, then it is on the organization level.

Brainstorm with your employees

Many companies leave the organizational objectives to their executive team since these objectives are more on the higher level. However, always encourage clients to ask for their employees’ feedback as they add more insights to your strategies. Working directly with your own customers, your employees receive information that your executive team may not get. You want to gather as much information possible about your internal processes and clients’ needs before setting your organizational objectives. Think about adding a 360 degrees’ feedback component to your objectives setting. More information is better than too little.

Setting organizational objectives is a daunting task, this is a general overview, therefore student should learn to apply in the health care system. Using these 5 tips will help you create a framework around what your company’s goals should be. The most important thing for you to do after setting your company’s objectives is to **COMMUNICATE** them to your employees. Engage your employees by clearly showing them where your company is heading and how you want to achieve your objectives. Understanding your company’s vision will get your employees to start thinking about ways they can contribute to the success of your organization.

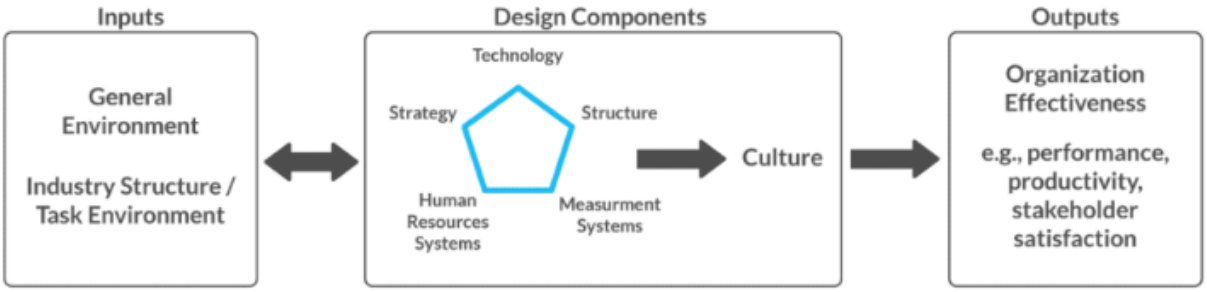
3.2 PROCESSES OF ORGANIZATIONAL DEVELOPMENT

The organizational development processes can be divided into seven steps. In this section, we will briefly discuss these steps.

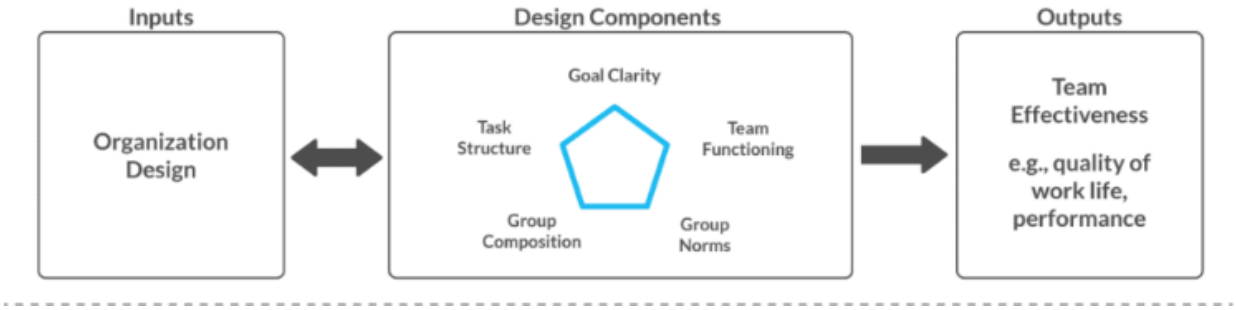
Entering and contracting: The first step starts when a manager or administrator spots an opportunity for improvement. There are different events that can trigger this, including external changes, internal conflicts, complaining customers, loss of profit, a lack of innovation, or high absence or employee turnover.

Diagnostics: In the second phase, diagnostics, the organization development practitioner tries to understand a system's current functioning. They collect information needed to accurately interpret the problem, through surveys, interviews, or by looking at currently available data to find the root cause. There are different models used in running the diagnoses. Below are three input process output (IPO) models, with a clear input, a (change) process, and an output. They who? help to structure different design components of the organizations. This model clearly shows different design components that play a role at different organizational levels (i.e. organizational, group, and individual).

A. Organizational Level



B. Group Level



C. Individual level

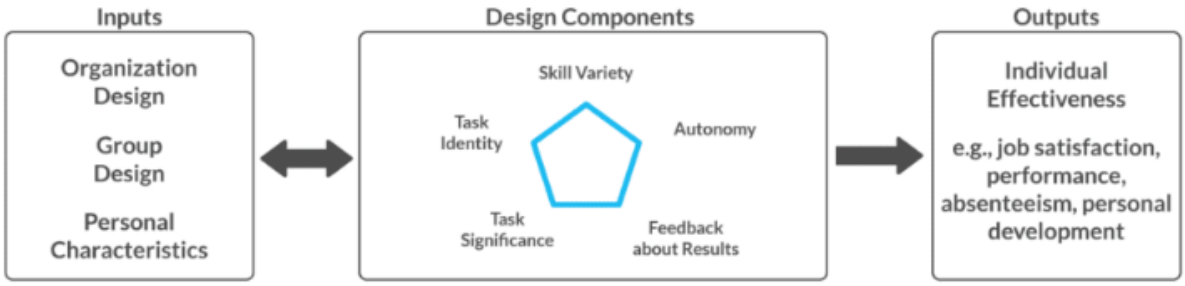


Fig 1: IPO Model

Source: (Cummings, 2008)

Data collection and analyzing: In the third phase, data are collected and analyzed. Data collection instruments include existing data from work systems, questionnaires, interviews, observations, and 'fly on the wall' methods.

Feedback: In this phase, it is the key to the organizational development consultant to give information back to the client in a way that is understandable and action-driven. Information given needs to be relevant, understandable, descriptive, verifiable, timely, limited, significant, comparative, and spur action.

Designing interventions: After providing the client with feedback, an intervention needs to be created. This intervention should fit the needs of the organization and should be based on causal knowledge of outcomes.

Leading and managing change: The next phase is about executing the change complete this sentence intervention. Leading and managing change are not easy. Estimates show that the failure rate of change is between 50-70%.

Evaluation and institutionalization of change: Once a system has been implemented, opportunities for improvement start to show. Implementing these will lead to a better user and employee experience.

3.3 ORGANIZATIONAL DEVELOPMENT IN HEALTH CARE SETTINGS

Health care is a dynamic and complex industry that experiences significant growth and change. In 2006, health care expenditures accounted for 16% of GDP in the United States as compared to about 9% of GDP in other Organization for Economic Development countries, in Nigeria healthcare expenditures accounted for about 3.9% in 2006. These expenditures are also highly concentrated. For example, in the United States, a small population bears a disproportionately high share of health care expenses; about 5% of health care spenders account for almost half the health care spending. In Nigeria evidence from a Public Expenditure Review of the health sector and National Health Accounts (NHA) suggests that on average, most states spend less than 5% of their total expenditure on health care. Expenditure from all tiers of government amounts to less than 6% of total government expenditure and less than 25% of total health spending in the country. The private sector accounts for the remaining 75% of health spending, with 90% of this coming from household out-of-pocket expenditures. Coupled with the lack of effective risk protection mechanisms such as fee exemptions and health insurance, the cost of seeking care is prohibitive for many people in Nigeria. Increased development aid grants and debt relief have been used to launch the National Health Insurance Scheme (NHIS).

The 2014 National Health Act in Nigeria (NHAct) aims to substantially increase revenue and improve primary health care services through the Basic Health Care Provision Fund (BHCPF). However, it is essential to ensure accountability between stakeholders at different levels of government for the flow of revenue to reach primary health care services.

The debates affecting the eventual definition of care, care delivery, financing, and access to care are being held in the halls of Congress and in the boardrooms of large and small employers, and found in the countless daily interactions between care providers and those they serve. In August of 2007, the Kaiser Family Foundation's Health Tracking Poll asked respondents to select two most important issues for the government to address. Health care was the second most cited issue at 27% just after the Iraq war. The health care industry represents a challenging context within which to practice organizational development.

3.3.1 Trends in health expenditure

Health care practitioners and leaders acknowledge several important trends. Many of these trends affect not only the health care industry but also society as a whole. The trends include:

i. Erosion of Comprehensive Health Insurance and Access to Care
ii. Moving Toward the Electronic Medical Record
iii. The Stabilization of Physician–Hospital Relationships
iv. A Growing Reliance on Philanthropy
v. Employer Support of Consumer-Directed Health care
vi. Increased Need to Manage New Clinical Technology
vii. Quality as a Strategic and Regulatory Imperative briefly discuss these trends as listed

3.3.2 Opportunities for Organizational Development Practices

Despite significant negative and difficult trends facing the healthcare industry, organization development practitioners can positively influence the process and outcomes of change in the health care environment. The opportunities include creating effective cultures; supporting and developing present and future leaders; creating systems and services that cost-effectively differentiate and meet needs; redesigning jobs and processes to maximize effective use of expertise; and restoring trust in and among stakeholders.

Creating Effective Cultures. The past decade's focus on mergers and alliances still requires some cultural integration in human systems development, and work process improvement. However, the focus now needs to shift to creating effective cultures that attract and retain key stakeholders, engage employees, and promote patient safety. The workforce shortages and the need to restore trust will prompt attention to cultures that welcome, support, and engage commitment from all stakeholders.

Health systems that enable consumers, physicians, and employees to feel a sense of belonging and trust will achieve a sustainable competitive advantage. Alignment of recruitment, orientation, performance management, and other systems with the culture will be critical to success. Recent articles about the workforce challenges cite the importance of attention to culture. An American Hospital Association (AHA) commission studying the workforce issue suggested that culture changes and fostering meaningful work are as important as compensation for the long term. Ideas for making the best of scarce resources include creation of mid-level professionals and increasing teamwork designs.

High-quality, cost-effective human resource systems and organization development practitioners can contribute to the creation of systems and services that strengthen health care employers' ability to attract and retain qualified workers. Please edit this section.

Effective job and work designs. According to a national survey, the number-one concern of nurses is their increased daily workload. Another survey on worker retention showed that the primary reason why people leave is the inability to use their skills and abilities.

Restoring trust in and among Stakeholders has a significant impact on workplace relationships and performance. Healthy relationships need trust, and the stronger the level of trust, the stronger the relationship.

3.3.3 Success Principles for Organizational Development in Health Care

A set of principles and beliefs that describe effective organizational development interventions which posed future challenges to the practice and practitioners of organization development in health care.

i. **Demonstrate the Relevance of the Subject to Strategic Performance** A central debate in organization development is whether it should be focused only on quality-of-work-life issues or if performance and systems improvement issues should be of equal importance. The challenge of keeping up with demand, while addressing workforce shortages and tenuous financial conditions, strongly suggests that health care leaders and clinicians would label any organizational intervention that is not linked to strategy performance as "irrelevant." Thus, in the health care industry, organization development interventions must be linked clearly to issues of the organization's strategic performance—those things that help the organization achieve and sustain competitive advantage, such as cost position, clinical excellence, and market share. Organization development interventions must be seen as relevant and necessary to the life-and-death matters in operating a health care organization. Otherwise, organization development practitioners will not be credible and will not be invited to be part of the executive team where they can have a positive influence on the health of the organization. In some situations, where organization development practitioners had not convinced executives of their ability to add value to the organization, the practice of organization development became viewed as a frivolous luxury and did not survive the first round of budget cuts.

ii. **Demonstrate the Importance of Depth for Sustainability** Health care's life-and death focus, coupled with the crisis of insufficient capacity (i.e., human, facility, and financial) to care for the increased patient demand could prompt interest in quick fixes or reactions rather than more-lasting systemic and holistic solutions. organization development practitioners must be able to make a compelling case for attention to deeper systemic issues for sustainable change such as cultures built on trust and learning, rather than shorter term "feel good" training and development. Often times, longer-term initiatives occur in parallel to the shorter-term activities that may seem more important to non-organizational development professionals.

iii. **Demonstrate Competence** The changes taking place within health care will require constant reevaluation and redefinition of competencies in a particular field or discipline. This will be as true for medical professionals and health care managers as for organization development practitioners. That may include enhanced knowledge and skill for leaders in intervention technologies, exposure to important business trends and regulatory issues, and practice in the principles of large-scale change. Leading health systems and hospitals are already providing skills and awareness training to managers in areas of leadership, strategy, restructuring clinical care, human resources issues, and change management.

iv. **Facilitate Integration Among and between the Diverse Parts of the System** A universal theme of the practice of organization development in health care today is integration among traditional and nontraditional stakeholder groups. For example, medical staffs, physician offices, community agencies, and insurance companies are typically untouched by organization development processes. Now, in addition to new opportunities for improving the health and performance within each of those groups, significant efforts are necessary to facilitate their integration to improve health care delivery and effectively deploy limited resources. A good example is in the practice of community building, which is currently under way among stakeholder groups such as medical practices, citizens, employers, and

hospitals. The purpose of this intervention is to construct a common vision for what constitutes health for the entire community, across all health care providers. organization development practitioners are uniquely qualified to assist in developing such a vision. Many have the skills and knowledge to work in complex settings with diverse stakeholders and they possess the technologies of large-group intervention to create such a process. Under what are these?

4.0 CONCLUSION

The health care industry offers unprecedented challenges and opportunities. Organization development practitioners can influence positive growth and development by linking their efforts to the strategies of the organization, demonstrating competence and integrity, and being able to facilitate integration of people and processes across traditional departmental and organizational boundaries. This opportunity comes with a challenge. At a time when each dollar and every resource in health care is being closely scrutinized, the inherent value of the organization development approach is being tested for validity. Clients, under increasing pressure to demonstrate the benefit of key activities, will, in turn, subject organization development practitioners and their change interventions to the same testing. The practitioner must seek a balance between responsiveness and relevance while maintaining a commitment to the core values that have defined organizational development namely the equal importance of human needs and the creation of a work environment that allows growth, fulfillment, and performance. Ultimately, the ability of the organizational development practitioners to influence health care leaders and stakeholders has the potential to help health care to survive and thrive and this will positively affect individuals, communities, and societies.

5.0 SUMMARY

Dramatic changes in the health care industry are affecting the practice of organizational development. It shows how changes in the nature of the health care products and the way they are delivered, how technology is being adapted, and how health care is paid for are

altering fundamentally the industry's structure and making it more difficult to identify the target of change. To be effective under these new conditions, organization development practitioners will be under considerable pressure to demonstrate their competence in areas such as culture, alliances and networks, and organization design. Change projects will likely be focused on integrating a diverse set of previously uncoordinated stakeholders. They will be more reactive than proactive; more solution oriented than people oriented.

6.0 TUTOR-MARKED ASSIGNMENTS (TMAs)

1. What is organizational development
2. Describe the process of organization development
3. List trends of organization development in healthcare settings
4. What are the benefits of organizational development in hospital administration?
5. Describe ways to develop organizational objective and goals

7.0 REFERENCES/FURTHER READING

Cummings, T. G., & Worley, C. G. (2008). *Organization Development & Change.* Natorp Boulevard: South-Western Cengage Learning.

https://explorance.com/blog/5-key-benefits-organizational-development/

https://www.digitalhrtech.com/organizational-development/

USAID (n.d.). African Strategies for Health. Retrieved September 4, 2020, from https://www.msh.org/sites/msh.org/files/country_profile_-_nigeria_-_us_letter_final.pdf

The World Bank, (2007). Current Health Expenditure (% of GDP) Nigeria. Retrieved September 4, 2020, from https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=NG

Goal Setting: How to Define Your Organizational Objectives. Retrieved September 4, 2020, from https://7geese.com/goal-setting-how-to-define-your-organizational-objectives/

Student leader (1992). Organizational Goal Settings. Retrieved September 4, 2020, from https://www.nspe.org/resources/students/student-chapters/organizational-goal-setting

MODULE 3: ORGANIZATIONAL STRUCTURES

UNIT 3: PRIMARY HEALTH CARE IMPLEMENTATION AND COMMUNITY DIAGNOSIS

CONTENTS

1.0 INTRODUCTION

The World Health organization (WHO), which was established in 1948, has always had as a major objective the attainment by all people of the highest possible level of health. Health according to the WHO definition is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". However due to political and socio-economic factors the various health care approaches implemented in different countries between 1948 and 1978 did not enable WHO to meet the stated objective. Therefore, the international conference on PHC held at ALMA-ATA in 1978.

This unit highlights key aspects of comprehensive PHC implementation and discusses factors that have contributed to its successful implementation or that continue to hinder its progress in various countries. The important of community diagnosis also going to be discuss.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

i. Define Implementation,
ii. Understand the Factors that Affect Implementation
iii. Identify what Community Diagnosis is,

3.0 MAIN CONTENT

3.1 PRINCIPLES OF PHC IMPLEMENTATION

It is putting a program into action or doing the work. What is to be implemented depends on the plan. Once a program has been planned and marketed, it must be implemented. Implementation "consists of initiating the activity, providing assistance to it and to its participant, problem-solving issues that may arise, and reporting on progress." To accomplish all of this, one has to select the most appropriate implementation strategy and see that any special concerns associated with implementation are handled properly.

Factors that facilitate Implementation of PHC

1. The implementer needs to
    i. Know and review the plans drafted,
    ii. Understand the goals/objectives,
    iii. Write detailed activities based on the goals/objectives,
    iv. Arrange time-table,
    v. Assign responsible bodies, and

vi. Discuss with the stakeholders.

2. Allocating the necessary Resources/Inputs
    i. Manpower Secure and deploy on time the necessary manpower in kind and number.
    ii. Money - Clear budget for capital and recurrent uses have to be available and utilized effectively and efficiently. Know the amount of budget allocated for implementing the project/program/activity. Close control of the utilization is very essential.
    iii. Materials - Obtain the necessary equipment and supplies on time. Need strict controlling on the utilization to prevent corruption.
    iv. Information - Document all the necessary information about the progress of the implementation. Inform the stakeholders about the development and if there is any constraint, etc.
    v. Time - Use time effectively. Develop time-table to follow the implementation.

Table 1: Gantt chart

Task and Activities	Time /Month											
	J	F	M	A	M	J	J	A	S	O	N	D
Phase intervention	x											
Total implementation	x	x	x	x	x	x	x	x	x	x	x	x
Collect and analyzed data for evaluation			x									
Prepare evaluation report				x								
Distribute report					x							
Continue with follow-up for a long-term evaluation						x	x	x	x	x	x	x

3. Create good relation with the stakeholders at all levels. More emphasis has to be given to the immediate manager.
4. Coordination of the work will facilitate implementation and will help to complete the program on time. Some of the areas to be considered in coordination are:
    i. Give defined responsibilities to the staff.
    ii. Give authority that can balance the authority offered.
    iii. Person in charge has to be assigned and be known by all.
    iv. Develop check lists that will guide coordination such as:
        a) What is to be done?
        b) Where does the action take place?
        c) When will be the action take place?
        d) Which materials and equipment are needed?
        e) Who will be responsible at each level? General and specific responsibilities have to be clearly stated and known by all concerned. etc.
5. Communication, directives and coordination will go smoothly if there is proper communication on the ground:
    i. Create link with the necessary stakeholders including the community.
    ii. Develop organizational structure, which will help you to know the authority, responsibility and who makes decision, etc.
    iii. Communicating with staff, government agencies, community, and other relevant stakeholders will enhance and facilitate the implementation process.
    iv. Create networking with all stakeholders.
    v. Inter-sectoral communication and collaboration will enhance the implementation process.
6. Monitoring and Supervision, monitoring is a continuous, systematic and critical review of a project/program/activity with the aim of checking progress. Corrective

action has to be taken if any gap is detected during monitoring. During monitoring check:

i. If activities are implemented as planned or not,
ii. If the time is properly utilized,
iii. If the necessary manpower is deployed,
iv. If the necessary resources are utilized properly,
v. If there is a need for modifying/changing, etc.

Use of Log Frames, Activity Plans, and Schedules will help to monitor progress. Periodic supervision has to be made to know the progress of the implementation. It needs to be planned. It will maintain and improve the quality of implementation of program/activity. Supervision can be conducted either directly by observing the implementation at the site or indirectly by checking reports.

3.1.1 Factors Affecting Implementation/ Causes of Poor Implementation

Poor implementation means delayed or non-implemented or different from that planned. The factors for such causes could be unavoidable or failure at earlier parts of the planning cycle or failure at the programming and implementation stages. The factors could be internal, such as turnover of trained staff or external such as natural calamities, shortage of fund, etc.

The solutions for the above factors depend on the individual cause. The implementer has to find the main causes and act accordingly.

3.1.2 Effective Performance Measurement Processes

These measurement process needs due attention by any implementer:

i. Incorporate stakeholders input;
ii. Promotes top leadership support;
iii. Creates a clear mission statement;

iv. Formulate short-term goals
v. Devises simple, manageable approaches; and
vi. Provides support and technical assistances to those involved in the process.

3.2 PRIMARY HEALTH CARE IMPLEMENTATION

The goal of any health care system is to provide universal access to appropriate, efficient, effective and quality health services, in order to improve and promote people's health. In most developing countries, the 1970s saw grave inequalities in the provision of health services and a worsening burden of disease with rising costs. As a result, in the mid-70s, international health organizations began exploring different approaches to improve health. During this period, China had made significant achievements in its health programmes which, compared to developing country disease-focused programmes, were community based. This bottom-up approach, which focused on prevention and management of health problems in their social setting, turned out to be a better option to the typical top-down, technological approach and rekindled hope about the possibility of addressing inequality to improve universal health. Thus, in 1978, 'health for all' was introduced and endorsed at an international conference on Primary Health Care (PHC) in Alma Ata, Kazakhstan. To achieve the goal of health for all, global health organizations and national Governments promised to work together toward providing people with basic health needs through a comprehensive approach called PHC.

Primary Health Care is essential care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation, and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community.

3.2.1 Key aspects of comprehensive PHC implementation

The Declaration of Alma Ata highlighted eight elements that form the basis of comprehensive PHC programme interventions in order to achieve the goal of health improvement. These elements include:

i. Education on prevailing health problems and methods of preventing and controlling them
ii. Promotion of food supply and proper nutrition
iii. An adequate supply of safe water and basic sanitation
iv. maternal and child health care including family planning, immunization against major infectious diseases
v. Appropriate treatment of common diseases and injuries and
vi. The provision of essential drugs.

According to Denhill, King and Swanepoel 2012, overall, in any health care programme or strategy, the successful implementation of PHC must be guided by the following principles:

i. **Political commitment**: The presence of progressive political will is central to the success of a health system.
ii. Integration of promotive, curative, preventive and rehabilitative health care services.
iii. **Equity**: Everyone must have equal access to basic health care and social services without segregation of sub groups and provision of care.
iv. **Accessibility**: Services must reach all people in the country in terms of geographical, financial and functional accessibility.
v. **Affordability**: Level of health care must be in line with what the community and country can manage to pay for. The inability to pay should not be a limiting factor to receiving health care.
vi. **Availability**: There should be adequate and appropriate services to meet particular health needs of each community.

vii. **Effectiveness**: Services provided must meet the objectives for which they were intended and should be justifiable in terms of cost.

viii. **Efficiency**: Results accomplished should be proportionate to resources used.

These guiding principles determine the success or failure of any PHC programme worldwide.

3.2.2 Factors that have contributed to the successful implementation of comprehensive PHC

Most successful comprehensive PHC programmes are as a result of good government policies and legislature for equitable implementation of efficient and cost-effective health care interventions, and have emphasized the need for community and individual participation. Before the implementation of any PHC programme or strategy, there must be political commitment by the ruling Government.

Active community participation is also a critical support activity for the PHC system to achieve the goal of health for all. There are three basic characteristics to the concept of community participation: "Participation must be active, people have the right and responsibility to exercise power over decisions that affect their lives, and there must be mechanisms to allow for the implementation of the decisions by the community." For example, in 2006 Jigawa State expanded their PHC by incorporating health facility committee to oversee the activities of PHC in the state and that has significantly improved their health indicators. These accomplishments were largely driven by active community involvement, political will to meet basic health needs of citizens, and increased economic and social equity.

Therefore, it is clear that political commitment, community participation as well as cost effectiveness and equity in the delivery of health services are key factors crucial to the success of PHC, without which, the goal of health for all remains unattainable.

3.2.3 Factors that Continue to Impede Progress in Achieving Comprehensive PHC

Despite the evidence of the benefits of PHC, most developing countries have not been able to commit to fully incorporating all the essential elements and principles of PHC in their implementation thereof. In many developing countries, health care systems are seriously under-funded and overwhelmed by multiple, disease-orientated programmes.

In an effort to improve health outcomes following the Alma Ata Declaration, most developing countries developed PHC implementation strategies. However, the implementation of these strategies has been met with serious challenges which include falling gross domestic product (GDP) and shrinking health budgets, inadequate political will, and increased burden on health care services as a result of infectious diseases. Comprehensive PHC is expensive to implement as it requires a multi-sectoral approach.

Despite these challenges, most developing countries continue to strive to abide by the guiding principles of the Alma Ata declaration in their aim to provide comprehensive health care as close to all individuals as possible.

3.3 COMMUNITY DIAGNOSIS

According to WHO 2009 definition, it is "a quantitative and qualitative description of the health of citizens and the factors which influence their health. It identifies problems, proposes areas for improvement and stimulates action". Also, the identification and quantification of health problems in a community as a whole in terms of mortality and morbidity rates and ratios, and identification of their correlates for the purpose of defining those at risk or those in need of health care.

3.3.1 Purposes of Community Diagnosis

i. Identification and quantification of health problem
ii. Identification of those who are at risk
iii. Identification of community needs and problems

iv. Determination of available resources

v. Setting priorities for planning.

3.3.2 The practical Relevance of Community Diagnosis in Health Project includes:

i. To act as a data reference for the district, it means community diagnosis will serve firsthand information that can be used for future reference.

ii. to provide an overall picture of the local community and the residents' concerns, this will help to give a clear background about the whole regarding their health.

iii. to suggest priority areas for intervention and the feasible solutions, since it like a baseline information for future reference, it also create areas for corrective action and support.

iv. to indicate the resource allocation and the direction of work plans, this study tried to evaluate the whole community and bring about areas that need to be prioritize for given intervention.

v. to create opportunities for inter-sectoral collaboration and media involvement, the create areas for stakeholder's collaboration and engagement.

vi. to form basis of setting indicators for project evaluation

Community Diagnosis is done using a tool called "Health Indicators" which are the variables used for the assessment of community health. Indicators must be: valid, reliable, sensitive, specific, feasible and relevant.

3.3.3 Health Indicators can be Classified as:

i. Mortality indicators

ii. Morbidity indicators

iii. Disability rates

iv. Nutritional status indicators

v. Health care delivery indicators

vi. Utilization rates

vii. Indicators of social and mental health

viii. Environmental indicators

ix. Socio-economic indicators

x. Health policy indicators

xi. Indicators of quality of life

xii. Other indicators please explain all these indicators

3.3.4 Types of Community Diagnosis

i. Comprehensive community diagnosis
    - Aims to obtain general information about the community

ii. Problem oriented community diagnosis
    - Respond to particular needs

3.3.5 Characteristics of community diagnosis

i. Ability to address important community problems. Because the study tries to evaluate the whole community and bring areas for intervention, so community diagnosis serve as probe solving.

ii. Ability to identify most of the targeted health events. It has the capacity to recognize areas that need most intervention.

iii. Adequacy in reflecting changes in distribution of events over time, place and person, it is specific in people time and place and it goes with change in the community.

iv. Participatory, the process involves the community at all level.

v. Uncomplicated, that means it straight forward and not complex.

vi. Sensitive, timely,

vii. and inexpensive

3.3.6 How to conduct community diagnosis?

The process of community diagnosis involves four stages:

i. Initiation
ii. Data collection and analysis
iii. Diagnosis
iv. Dissemination

Initiation

In order to initiate a community diagnosis project, a dedicated committee or working group should be set up to manage and coordinate the project. The committee should involve relevant parties such as government departments, health professionals and non-governmental organizations.

Data collection and analysis

The project should collect both quantitative and qualitative data. Moreover, Population Census and statistical data e.g. population size, sex and age structure, medical services, public health, social services, education, housing, public security and transportation, etc.

Diagnosis

Diagnosis of the community is reached from conclusions drawn from the data analysis. It should preferably comprise three areas:

i. health statuses of the community
ii. determinants of health in the community
iii. potentials for healthy city development

Dissemination of information and result

The production of the community diagnosis report is not an end in itself, efforts should be put into communication to ensure that targeted actions are taken. The target audience for

the community diagnosis includes policy-makers, health professionals and the general public in the community.

It is important to realize that Community Diagnosis is not an one-off project, but is part of a dynamic process leading to health promotion in the community. Therefore, community diagnosis should be conducted at regular intervals to allow the project to be continuously improved.

Table 2: Comparing individual diagnosis with community diagnosis

Clinical diagnosis	Community diagnosis
Similarities	
1. Obtain history of the patient symptoms. 2. Examine the patient and observe sign 3. Perform laboratory test, x-rays and others 4. To infer causation from the history and test result 5. Provide treatment 6. Follow up and assess effectiveness of the treatment	1. Obtain health awareness of the community by informal meeting and discussion 2. Obtain measurable fact of causes through basic demographic survey (indicator) 3. Conduct specific survey based on the finding of basic demographic surveys 4. Make inference from the data (indicator) to make the community diagnosis. 5. Prescribe community treatment or community health action 6. Evaluate (follow up) the effect of community health action
Differences	
1. Patient aware of the problem 2. Patient take initiative for problem solving 3. Pathological condition affect patient alone 4. It may or may not be related to environment	1. Community may not be aware of the problem 2. Community rarely takes initiative 3. Cannot be treated as isolated occurrences 4. Each condition is linked to the inter-related factors in the

environment

4.0 CONCLUSION

Comprehensive PHC is costly to implement because its participatory and it involve inter-sectoral collaboration, however, it provides a more holistic approach to addressing the health needs of individuals, promotes the development of health infrastructure and is critical for sustained improvements in the health of communities. Since the Declaration of Alma Ata, lessons learned from developing countries, that are also applicable to developed countries regarding PHC implementation, include the recognition that better cost-effectiveness measures are necessary; equity is an integral part of a health strategy; and that disease prevention involves community participation and consequently, this needs to be encouraged. Community diagnosis assessment is the foundation for improving and promoting the health of community members. The role of community assessment is to identify factors that affect the health of a population and determine the availability of resources within the community to adequately address these factors.

5.0 SUMMARY

Primary health care was put forward thirty years ago as a set of values, principles and approaches aimed at raising the level of health in deprived populations. In all countries, it offered a way to improve fairness in access to health care and efficiency in the way resources were used. Community diagnosis provides baseline information about the health status of the community and helps to set priorities that will provide a lasting solution to the community problems.

6.0TUTOR-MARKED ASSIGNMENT

1. What is implementation?
2. Differentiate between implementation and planning?
3. List the necessary factors that are relevant to implement any health activity/program.
4. What are some of the causes for poor implementation and what measures do you take to alleviate them?
5. Write short note on PHC implementation
6. What is community diagnosis?
7. List the processes of community diagnosis and explain two of the process.

7.0 REFERENCES/FURTHER READINGS

Shannon D.R. (2012). Primary health care implementation: A brief review. Polity and Multimedia publication. Retrieved September 4, 2020 from https://www.polity.org.za/article/primary-health-care-implementation-a-brief-review-2012-08-21

Challi J., Amsalu F., Getnet M., (2004). Health Planning and Management for Health Extension Workers. Ethiopia Public Health Training Initiative, The Carter Center, the Ethiopia Ministry of Health, and the Ethiopia Ministry of Education. Retrieved September 4, 2020 from https://www.cartercenter.org/resources/pdfs/health/ephti/library/lecture_notes/health_extension_trainees/healthplanningmanangement.pdf

Hong Kong Department of Health, (2009). Basic principle of healthy Cities: Community Diagnosis. Retrieved September 4, 2020 from https://www.chp.gov.hk/files/pdf/hcp_community_diagnosis_en.pdf you can add more recent references