Leadership and Governance in Primary Healthcare

An Exemplar for Practice in Resource Limited Settings

EDITED BY
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Good leadership and governance at all levels of the healthcare system are necessary for better performance of the system and health outcomes. A lack of good leadership and governance practices can lead to the misuse of health system inputs such as human resources, health commodities and financial resources, hence lowering the quality of services delivered. Thus, this practical handbook was developed through collaborative efforts to respond to the need to improve good governance practices at the primary healthcare level in resource-limited healthcare systems.

Key Features:

- Improves the management of primary health facilities.
- Helps the health facility managers and teams at the primary healthcare level to effectively and efficiently lead and manage facilities.
- Enumerates practical scenarios on health issues that commonly occur in health facilities and provides alternative ways of addressing the issues raised in these scenarios.


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Foreword

Tanzania is a pioneer in primary healthcare. Since 1961, Tanzania has been implementing health policies to achieve primary healthcare for all. These policies were decades in advance of the 1978 World Health Organization's landmark Alma Ata *Declaration of Health for All,* based on primary healthcare. By 1978, Tanzania had already built and staffed a health services infrastructure placing a staffed primary care health facility within 5 km of 90% of its largely rural population—a remarkable achievement unmatched anywhere else in Africa at the time. The basic, well-tested architecture of the Tanzanian health system remains fundamentally the same today, with its hierarchy of at least one regional hospital at the regional level, at least one district hospital at the district level, one health center at the division level and one dispensary at the ward level, matching the administrative governance structures of the county.

In the mid-1980s, I had the privilege of working with the Tanzania Ministry of Health and witnessing the early years of this endeavor. At that time, the Primary Health Care Unit in the Ministry of Health was led by Dr Faustin Magari, working out of a closet-sized office in the Ministry's headquarters along Samora Avenue Street in Dar es Salaam. In those days, Tanzanian primary healthcare efforts were focused on exploring the use of community health workers supporting the communities in the catchment areas of their nearest dispensary. These lightly trained community health workers were intended to bring the most commonly needed primary healthcare curative services beyond the district level to the village or community level, providing accessible care while taking some of the load off of dispensaries for the most common, easily treated conditions.

In the meantime, a global debate developed among international health development partners fearing that the original ideals of Alma Ata for "comprehensive primary healthcare", with its strong emphasis on community participation and intersectoral collaboration and characterized by a continuum of promotive, preventive, rehabilitative and curative services to sustainably address underlying causes of ill health, would be too slow, costly and impractical. Donor attention was diverted away from comprehensive primary healthcare and instead, development partners invested heavily in primary healthcare focused on "selective primary healthcare" with the intention of more rapid

interim gains based on professional technical inputs for selected curative and preventive health services such as immunization, growth monitoring and oral rehydration. As a result, efforts directed at less qualified community health worker services came to an end in Tanzania and a disease-driven, rather than health-driven, prioritization in the health sector emerged and prevailed for many years.

Fast forward 35 years to today, and a wealth of experience in managing the complex and evolving primary healthcare scene in Tanzania has accrued. In this interval, the whole context of the health sector has evolved. Decentralization has been more carefully executed. Health system definitions and frameworks, such as the six building blocks, have been widely adopted. New metrics for the burden of disease have been developed and applied. A new appreciation of the relative cost-effectiveness of interventions and strategies has improved resource allocation and the efficiency of health services. Major global investments have been addressing selected high-burden diseases such as HIV/AIDS, tuberculosis and malaria for highly cost-effective immunization. Most importantly, child mortality has been reduced by over 70%, and overall life expectancy in Tanzania has improved dramatically. Today, there is a movement back toward more comprehensive primary healthcare approaches under the umbrella of health systems for universal health coverage.

Nevertheless, problems and questions remain. How best can primary healthcare be integrated into the health system still dominated by the disease approach, especially given the rising ratio of chronic, non-communicable disease to declining communicable disease rates? How best can primary healthcare be managed within rapidly changing complex adaptive systems such as the health system which, in turn, is embedded in the wider, ever-changing socio-political-economic systems of which it is a part? How best can system-wide thinking be applied to the prevailing framework of the health system? There has been well-documented attention, investments and progress across most of the health system framework's building blocks, especially health services, health financing, health informatics, medicines and technologies and, to some extent, in health human resources, but virtually no progress in the governance of health systems.

This handbook, edited by Anasel, Kapologwe and Kalolo, puts a much-needed focus on practical leadership and governance issues for primary healthcare in Tanzania. It is based on contemporary, real-world scenarios and lessons from the front lines. The scenarios chosen as worked examples are fascinating and vexing governance problems faced by communities, health workers, managers and other stakeholders. Important in the authors' approach is that they have gone far beyond the Governance building block of health systems to unpack governance issues as they play out in each of the other five health building block sub-systems of health service delivery, workforce, information

systems, commodities and technologies and financing and financial management. In addition to the rich description and systems analysis of the scenarios, the authors complete the story for each scenario with guidance on how to shape an action plan to resolve the issues.

This handbook is a welcome approach given that so much of the literature on governance in health systems has been abstract, academic and theoretical. Reflecting on the primary healthcare efforts of the '80s in Tanzania, I recall that in every dispensary there were well-worn, practical handbooks on the shelf such as *Mahali Pasipo na Daktari* (Where there is no Doctor) and other practical guides and handbooks for community health and community health workers at the primary care level. It is high time that such a handbook for the governance of primary healthcare is now available as an essential resource to front-line managers and management teams.

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Preface

Leadership and governance at all levels of the healthcare system are cornerstones for improved system performance and health outcomes. When leadership and governance structures operate optimally, often there are gains such as effective, accountable, responsive, high-quality and inclusive health service delivery to the population. Lack of good leadership and governance practices instead can lead to misuse of health system inputs such as human resources, infrastructures, health commodities and financial resources, hence lowering the quality of services delivered. Thus, this handbook was developed through collaborative efforts envisioned to respond to the needs of improving leadership and governance practices at the primary healthcare level in the Tanzanian healthcare system.

This handbook is a first edition geared to improve the management of primary health facilities in Tanzania. This handbook's objective is to improve the ability of primary healthcare facility managers and management teams, as well as to assist them in leading and managing the facilities in an effective and efficient manner. The handbook provides a practical guide and scenarios regarding health issues that commonly occur in health facilities, along with alternative ways of addressing them.

This practical handbook provides various methods that can be used to improve the performance of health facilities. Therefore, it has been developed to reflect the six World Health Organization (WHO) health system building blocks, namely, management of health facilities, service delivery, health workforce, health information systems, health commodities and technologies, and health financing and financial management.

This handbook highlights the ongoing government initiatives to enhance Tanzanians' health status and develop the country's health systems by fostering good governance and leadership in primary healthcare and beyond. Therefore, the Ministry of Health (MoH) and the President's Office—Regional Administration and Local Government (PO-RALG) urge all health facility in-charges and management teams to use this practical guide consistently. The handbook is envisaged to serve as a quick, day-to-day reference for leading and managing all facility operations such as planning, budgeting, implementation, monitoring and evaluation processes.

The readers will find this handbook useful in leadership and governance that respond to the needs of improving good governance practices at the primary healthcare level, especially in resource-limited countries. We hope this handbook will stimulate practitioners, students and researchers to study these examples and come up with new ones for others to learn.

We would like to express our gratitude to all of the authors who contributed chapters to this handbook, as well as to the publishers for all of their support throughout the entire publishing process. We want to express our sincere gratitude to Himani Dwivedi and Shivangi Pramanik in particular for their tireless efforts, persistent reminders and patience with us during the editing process.

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The successful development of this handbook is a tribute of individuals and institutions who committed their valuable time and resources. MoH and PO-RALG appreciate the technical and financial support that facilitated the development of this book.

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Appreciation is also extended to Dr. Ntuli A. Kapologwe—Director of Health, Social Welfare and Nutrition Services (PO-RALG), for initiating the development of the handbook and facilitating its completion and Mr. Edward Mmbaga—Director of Policy and Planning, Mr. Lusajo Ndagile—Assistant Director of Policy and Planning (MoH). In the same way, appreciation is extended to Dr. Paul Chaote—Assistant Director of Health, Social Welfare and Nutrition Services (PO-RALG), Dr. Yahaya Hussein, Dr. Boniface Richard, Mr. Raymond Kiwesa, Ms. Juliana Mawalla, Ms. Sarah Hussein, Dr. Jumanne Mwasamila and Dr. Bakari Salum for coordination and provision of technical inputs during the whole process of developing this handbook.

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Leadership and Governance

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Ntuli A. Kapologwe, Idda Lyatonga Swai, Anosisye Mwandulusya Kesale and James Kengia

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1.1 BACKGROUND INFORMATION

The concepts of leadership and governance are relatively new to health systems (Smith et al., 2012). The definition of leadership focuses on leaders' traits and attributes, exercising of power and influence, roles and relationships between leaders and subordinates. The definition of governance, on the other hand, focuses on a set of values, policies and institutions through which social, economic and political processes are managed on the basis of interaction among the government, civil society and private sectors. Leadership is the ability of a person to influence the behavior of others to willingly take responsibility to accomplish or achieve a common goal. It is about the ability to convince or seek compliance from followers and, by doing so, to comply with the directives

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or wishes of the leader to achieve a common purpose. Leadership is defined as a social influence process in which the leader seeks the voluntary participation of subordinates in an effort to reach organizational goals (Afegbua & Adejuwon, 2012). Followers are an important part of the leadership process, and all leaders are sometimes followers as well (Daft, 2014). Leadership is the most influential factor in shaping organizational culture and ensuring direction, alignment and commitment within teams and organizations. In the health system, leadership is the ability of health managers to influence their subordinates to willingly accept their responsibilities and perform them to achieve health system outcomes (Daft, 2014). Therefore, it is expected that health managers will not only use managerial powers and authorities to run health institutions but will also apply leadership skills and techniques to complement managerial power in the course of managing their health institutions.

Governance is about how society, organizations and individual groups make and implement collective choices. It comprises shifting decision-making responsibilities from individuals to a governing authority, with implementation by one or more institutions and with accountability systems to monitor and assure the progress of the decisions taken. Governance in the health system is the way in which powers and control are exercised and shared among health stakeholders over health facilities for the best interest of the whole community. For instance, governance in the health sector involves a variety of stakeholders who share a common set of interests, privileges and means of community control. In order to operate a health system or a health facility, professionals in leadership and managerial positions must coordinate and support the efforts of all stakeholders to provide input for improving the health system.

Strong leadership contributes to good governance by facilitating interagency collaboration, common understanding and defined roles and duties. Approaches to leadership and governance, particularly in healthcare systems, vary substantially (Smith et al., 2012). Leadership contributes to good governance by ensuring that the requirements of clients, patients and healthcare providers remain at the forefront of the agenda. Indeed, leaders at all levels give health stakeholders opportunities to offer support in enhancing the effectiveness of the healthcare system. In turn, governance structure provides strategic direction for leaders, helps to build commitment and shared goals and holds individuals accountable.

Governance frameworks play an important role in providing strategic direction for leadership and establishing accountability arrangements, which is partly leadership and partly governance. When things are taken under scrutiny, the process is governance and the way it is pitched is leadership. While leadership sets a direction and makes sure that it happens, governance maintains accountability. Accountability is central to ensuring that decision

making is transparent and consequently allows leadership to flourish. Governance, as a structural and important element of monitoring and evaluation, is put in place to underpin the leadership focus on improving health outcomes. Governance directs leadership and provides boundaries for leadership.

The leadership and governance block of the health system is central to improving the performance of the healthcare system and achieving Universal Health Coverage. The World Health Organization (WHO) category of leadership and governance is among the health system building blocks, along with service delivery, health workforce, health information systems, health commodities and technologies and health financing. The leadership and governance building block is viewed as the cornerstone for proper operation of other WHO building blocks. This is due to the fact that the leadership and governance block is a cross-cutting component that provides the basis for the overall policy and regulation of all other health system blocks (Manyazewal, 2017; World Health Organization, 2010). Leadership and governance play a coordinating role at any level of the health system to make sure all other health systems run efficiently and effectively and improve the performance of the health system. Therefore, leadership and governance in the health sector can also be operationalized as new organizational practices and policies, best use of all types of resources, appropriate use of staff working hours, satisfaction of clients and providers and capacity of health facilities to collect, utilize and manage resources (Manyazewal, 2017; Savedoff & Smith, 2011). Through leadership and governance, both health managers and health stakeholders such as communities, civil societies and the private sector define their boundaries, roles and influence in health service provisions.

Different aspects of the health system building blocks require unique leadership and governance mechanisms to be effective (Fryatt et al., 2017). For instance, procurement of health commodities and medical supplies requires governing entities to make decisions on the services to be provided, the roles of the purchaser(s) and providers and the level of resources required to meet service entitlements and improve access (Pezzola & Sweet, 2016). To ensure that health workers perform to the desired standard, leadership and governance are essential. This can be accomplished by health managers when they make critical leadership decisions to enhance the performance of health workers, such as through hiring, training and development, performance management, motivation and disciplinary action. These differences have an influence on the measurement of governance. Governance in the health sector is measured based on its determinants and outcomes (Savedoff, 2011), whether a governing entity is in place and functioning (structure), whether the decisions made are being implemented (process) and whether

there is desired improvement in the performance of health outcomes (Greer et al., 2016; Savedoff & Smith, 2011). Governance and leadership are thus critical due to the fact that most conceptualizations and descriptions of health systems developed over the past decade refer to aspects of governance in terms of stewardship, regulation, oversight or governance itself and its effectiveness in the health sector (Fryatt et al., 2017).

In Tanzania, reports from various supportive supervisions and assessments conducted by the MoH and PO-RALG in primary healthcare facilities found that weak leadership and governance practices are among the major hindrances to the delivery of quality health services in Tanzania. For instance, the assessment conducted by PO-RALG in 2020 to evaluate the performance of constructed and renovated health centers that provide comprehensive emergency obstetric and newborn care (CEmONC) services indicated that over 95% of health centers were manned by medical doctors, according to central government directives. However, most of these medical doctors were newly recruited to public services and had never been oriented on leadership and managerial roles or responsibilities. It was also found that there was no guideline that provided practical guidance to these doctors in managing health facilities and related health services. The development of a practical handbook guide for quick reference was deemed important to provide practical guidance to the health facilities in-charge and management teams. This guide aims to promote the practice of good leadership and governance at the primary healthcare level.

This handbook covers and provides practical guidance on the following dimensions of good governance:

(i) **Participation:** All key actors should have a voice in decision making (assessment, planning, management, evaluation) for health, either directly or indirectly. The government in many countries today pledges their citizens to come forward and participate in decision making to debate on complex and difficult issues (Davies et al., 2006; Dent, 2007). Participation is seen as empowerment by handing over a degree of control to improve responsiveness. Participation in healthcare decision making is categorized into three dimensions: (1) information exchange, (2) deliberation and (3) control over the final decision. Patients are the key stakeholders in healthcare whose preferences for each of the dimensions vary and thus reflect the complex nature of their engagement when it comes to participation in healthcare visits (Davies et al., 2006)

(ii) **Transparency:** Transparency is one of the crucial elements of good governance in facilitating decision making and better health

outcomes. Existence, sharing and use of result-oriented information and audit-reporting mechanisms are key factors to understand and monitor health matters and resources. Transparency allows both leaders and subordinates to monitor the implementation of activities and evaluation of their performance. Increased transparency in healthcare management, policy and practice can facilitate the important prioritizations that are likely needed over the next decade (Afegbua & Adejuwon, 2012; Jaffe et al., 2006).

(iii) **Accountability**: Leadership and governance approaches highlight issues of state responsiveness and accountability, as well as the impact of these factors on the development of health systems (Afegbua & Adejuwon, 2012). Health managers and staff in health facilities are accountable to the public and to institutional stakeholders. There are theoretical relations between transparency and accountability, such that when transparency exists, accountability is likely to be in place. Transparency facilitates horizontal accountability, strengthens vertical accountability and reduces the need for accountability. Under certain conditions and situations, transparency contributes and facilitates accountability when there is a significant increase in the available information and utilization of the same information, especially when there is a direct or indirect impact on the government or public agency (Meijer, 2014). Strong community health system accountability in primary healthcare is vital to creating accountable community health systems (Kesale et al., 2022; Kessy, 2014).

(iv) **Responsiveness**: Responsiveness in health services refers to meeting the expectations of clients and caregivers. Health managers and health facilities are expected to serve all stakeholders to ensure that the policies, programs and services are responsive to the health and non-health needs of its users. Clients' views and opinions are being recognized as an appropriate measurement of health system responsiveness (Robone et al., 2011). The concept of responsiveness is multi-dimensional and is measured across various domains, including prompt attention, dignity, communication, autonomy, choice of provider, quality of facilities, confidentiality and access to family support (Kapologwe et al., 2020; Mohammed et al., 2013)

(v) **Health equity**: All men and women should have opportunities to improve or maintain their health and well-being, or "the absence of systematic disparities in health (or in the major social determinants of health) between groups with different levels of underlying

social advantage/disadvantage—such as wealth, power, or prestige" (Braveman & Gruskin, 2003). Pursuing health equity means striving for the highest possible standard of health for all people and giving special attention to the needs of those at the greatest risk of poor health based on social conditions (Braveman, 2014). Health equity must take into account how resources are allocated and social arrangement is linked with other features of the state of affairs (Sen et al., 2004).

(vi) **Effectiveness and efficiency**: Processes and organizations should produce results that meet population needs, influence health outcomes and make the best use of resources. Common measures of organizational performance are effectiveness and efficiency (Bartuševičienė & Šakalytė, 2013). Health organizations assess their performance in terms of effectiveness, focusing on the extent to which they have achieved their mission, goals, vision and efficiency in terms of the resources used to achieve the goals.

(vii) **Rule of law**: Refers to the presence and impartial enforcement of policies, laws, regulations and guidelines pertaining to health. The Rule of Law, accountability and transparency are technical and legal issues that interact to produce institutions that are legitimate and effective by ensuring the enforcement of policies, laws and regulations (Johnston, 2006). Legitimate institutions are entrusted by the people and provide law and order, protect fundamental human rights and ensure rule of law and due process of law (Afegbua & Adejuwon, 2012).

(viii) **Ethics:** Ethics is concerned with the rules and standards for determining what is "correct" conduct and behavior. The idea that ethics is important in any organization is central to healthcare systems (Kolthoff, 2007). Ethics is about following or adhering to accepted principles of healthcare ethics in health service provision and research, or promoting ethical management and standards among health professionals. Ethics determine how the organizational objective/goals are established and implemented, as well as the ethical reasoning that involves explaining how the decisions were reached. Healthcare organizations are likely to face new, business-oriented ethical issues due to changes in the delivery and financing of healthcare. Addressing these issues, among others, requires clear guidance of healthcare professionals to ensure that healthcare ethical standards are ensured in the whole process of delivery of primary healthcare.

1.2 ORGANIZATION OF THE HEALTHCARE SYSTEMS IN TANZANIA

The national healthcare system operates under a decentralized system of governance. It is organized in a referral pyramid, made up of three main levels: (1) primary level, (2) secondary level and (3) tertiary level. This guide is intended for the primary level.

At the primary level, council and all other hospitals are referral centers for all primary health facilities, including both public and private dispensaries and health centers. The facilities at this level are fully fledged to provide services to both inpatient and outpatient clients. In the current arrangement, the local government authorities through their technical team—for example, a council health management team (CHMT) headed by a district medical officer (DMO)—have a full mandate for planning, implementation, monitoring and evaluation of health services within the council.

1.3 WHAT IS THE PURPOSE OF THIS PRACTICAL HANDBOOK?

The purpose of this practical handbook is to provide guidance on leadership and governance issues in primary healthcare facilities and to improve the quality of health service provisions. Furthermore, the guide is envisaged to serve as a quick, day-to-day reference for leading and managing all facility operations. The facility operations in this guide revolve around six WHO health system building blocks, where leadership and governance are unpacked as they play out in each of the other building blocks.

1.4 FOR WHOM WAS THIS PRACTICAL HANDBOOK DESIGNED?

The handbook is for everyone involved in the management of health facilities at the primary health facility level. More specifically, the guide is designed

for health facility in-charges, health facility management teams (HFMTs), facility quality improvement teams (FQITs), heads of sections/units, facility medicine and therapeutic committees (FMTCs) and working improvement teams (WITs).

1.5 HOW WAS THIS PRACTICAL HANDBOOK DEVELOPED?

In October 2020, the MoH and PO-RALG convened in a panel of individuals from different institutions with expertise in healthcare service delivery, health systems, local government, leadership and governance and shared reports highlighting weak leadership and governance that affected the delivery of quality services in primary healthcare in Tanzania. The reports further indicated that most of the health centers were manned by medical doctors who were newly recruited and had never been oriented to leadership and managerial roles. The panel came to a consensus to develop a practical handbook and implementation plans informed by the best available evidence to serve as a guide. The process of developing this handbook involved the following steps:

(i) **Inception meeting:** An inception meeting between experts and management of the PO-RALG and MoH was held to share and digest various assessments and supportive supervision reports conducted in the primary healthcare facilities. Weak leadership and governance in the primary healthcare facilities was among the major concerns that needed immediate attention. This called for the development of a practical guide handbook to serve as a quick reference for managers of health facilities. Experts were given terms of reference to guide the development of the practical handbook.

(ii) **Desk review:** Experts in collaboration with the technical team from the PO-RALG conducted a desk review. The review was aimed at identifying leadership and governance elements that were not featured in the assessments, along with supportive supervision reports. Through desk review, the components of governance that were either left out or omitted in the assessments and supportive supervision reports were captured and embedded in WHO's six health building blocks to inform the development of the practical handbook to suit the Tanzanian context.

(iii) **Development of a draft practical handbook:** The development of the draft practical handbook was guided by the information gathered from the inception meeting and the desk review.

(iv) **Stakeholder's forum:** The draft of a practical handbook that was developed based on the assessment and desk review was presented to stakeholders. The stakeholders included representatives from dispensaries and health centers, medical officers in charge (MOIs), district medical officers (DMOs), regional medical officers (RMOs), district health secretaries (DHSs), regional health secretaries (RHSs) and officials from both the MoH and the PO-RALG. The stakeholders provided technical and practical experiences in managing health facilities. Their inputs contributed significantly to improving the contents and the structure of the draft. Specifically, the stakeholders developed two scenarios that have been included in this practical guide.

(v) **Ministerial review workshop:** The draft practical guide was presented to the management and staff of the PO-RALG and MoH, as well as co-opted members from the regional health management team (RHMT), council health management team (CHMT) and facility health management team (FHMT), and their input facilitated improvement and finalization of the guide. The ministry officials provided policy implementation practices and experiences regarding the management of health facilities that were very pertinent in shaping the finalization of the practical guide.

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