

# HEALTH SYSTEMS IN ACTION

AN HANDBOOK FOR LEADERS AND MANAGERS

**SASCP ACTION PLAN**

ACTIVITIES	PERSON RESPONSIBLE	RESOURCES REQUIRED	TIMELINES				
			DEC 2010	JAN 2011	FEB 2011	MAR 2011	APR 2011
1) ADVOCACY	SAPC (Mr. Hassan)	• Advocacy Communication Materials • Advocacy Tools • Funding for Logistics	X	X	X	X	X
2) SUPPORTIVE SUPERVISION	Alhaji UWANI	HCT Personnel Approvals • Check List • Funding for Logistics	X	X	X		
3) AWARENESS CREATION	MRS ASABE	• Social Mobilization • Community Meetings • Flyers, Posters, etc. • Funding for Printing Materials & Logistics	X		X		
4) CAPACITY BUILDING (Training)	SAPC (MR. HASSAN)	• Training Materials • Training Venue • Logistics	X	X	X	X	X
5) SUPPLIES - HIV Test kits - Consumables - Registers & Forms - ETC	SAPC (Mr. Hassan)	• Logistics • Training grant or Logistics Personnel • Funding for Grants	X		X		



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Other Health Services  
*with the World Health Organization*

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Tel.: +1.617.250.9500

ISBN 978-0-9819616-2-0

Funding for this publication was provided by the US Agency for International Development (USAID) under the terms of the Leadership, Management & Sustainability Program, award number GPO-A-00-05-0024-00. The opinions expressed herein are those of the authors and do not necessarily reflect the views of USAID or the United States Government.

Book composition: Edna Jamandre  
Proofreader: Sue Blake  
Indexer: J&J Indexing

#### [Suggested citation](#)

*Health Systems in Action: An eHandbook for Leaders and Managers*. Cambridge, MA: Management Sciences for Health, 2010. Available online at  
<http://www.msh.org/resources/health-systems-in-action-an-ehandbook-for-leaders-and-managers>



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## Foreword

Over the past decade, the imperative of building strong national health systems has gained heightened global attention. The unprecedented resources made available for global health, and particularly for combating the major pandemics, have enabled countries to significantly expand the reach of life-saving health interventions. Yet, in many countries, efforts to scale up these programs have been impeded by weak health systems. If the six health system building blocks defined by the World Health Organization in *Everybody's Business* offer countries a broad perspective on health system components, this practical electronic handbook goes further by providing health program managers with some of the essential nuts and bolts for strengthening health systems.

Turning the pages, I was struck by just how much of the knowledge contained in this volume resonates with our experience in Ethiopia, particularly since we embarked on a radical system wide effort to reform our health sector. We recognized early on that an integrated health system approach to service delivery was the only feasible strategy for reaching the ambitious targets in our Health Sector Development Program (HSDP).

Created by the Federal Ministry of Health in 1997, the HSDP constitutes a core component of our Government's cross-sectoral Plan for Accelerated and Sustained Development to End Poverty. The HSDP focuses on addressing the country's most pressing health problems. Directly aligned with the health-related Millennium Development Goals, the current third phase of our HSDP prioritizes the high-impact health system-strengthening interventions needed to accelerate scale-up and coverage of key health services in child health, maternal health, HIV/TB, and malaria. Underpinning this approach is our Government's firm commitment to a community-centered effort to ensure universal access to primary health care.

This national objective is being driven by our Health Extension Program (HEP), which has rapidly trained and deployed 30,000 health extension workers (HEWs) throughout the country—two HEWs for every village—almost doubling Ethiopia's health workforce in only three years. The engagement of HEWs as full-time salaried civil servants marks an important shift away from the volunteerism model, a change that we believe has been crucial to HEP's rapid progress and will foster its long-term sustainability and success. Using social mobilization and an innovative “model family” approach, our HEWs are promoting healthy behaviors in their communities and improving access to and use of basic health services.

The Health Extension Program, which focuses on health promotion and disease prevention, is the bedrock of Ethiopia's decentralized health system. And the broad-based health information and referral system that HEWs are developing at the grassroots level is broadening access to a continuum of care at the secondary and tertiary levels. In parallel, our Government has also been investing heavily in the expansion of our health infrastructure, an effort through which we aim to put in place 15,000 health posts and 3,200 health centers around the country. The bulk of these facilities have already been completed.

These efforts are being bolstered by our ongoing health sector reform, which aims to bring about a radical change in the way we work. We recognize that the ambitious goal of achieving universal access to basic services requires a fundamental departure from “business as usual.” As part of this reform, now in its second year of implementation, we have redesigned and introduced new business processes and established institutional frameworks for essential functions. These functions include public health emergency and management planning; monitoring and evaluation; pharmaceutical supply and management; health services and products regulation; resource mobilization; and insurance. Staff throughout the sector have been trained on the policies and strategies underpinning these new, people-centered, and results-based processes, which emphasize efficiency and clear accountability structures. With the active engagement of our diverse and committed partners, we are also building inclusive and effective governance mechanisms in line with our International Health Partnership Compact, which emphasizes sustainability, harmonization of resource mobilization and allocation, and coordinated monitoring and evaluation.

This manual addresses, in remarkable detail, all the practical management aspects of these essential areas for health systems strengthening. Given that many developing countries, including Ethiopia, are currently grappling with the manifold challenges of this endeavor, the timeliness of this publication is in itself a tremendous contribution. But perhaps the most important contribution of this book is its emphasis on the central element for building an effective national health system: skilled and motivated people as the indispensable cement needed to construct a cohesive, well-functioning health system.

The centrality of people is well reflected in the first four chapters, which elucidate the inextricable linkages between systems and people, both as deliverers and beneficiaries of health services; identifying key leadership and management competencies for the health sector; and underscoring the importance of good governance and effective planning. It is precisely in these areas that I believe this handbook will serve us as an excellent resource in Ethiopia. Our efforts to strengthen the “people orientation” of our new business processes and our ongoing initiatives to build vital management and leadership skills—including notably, our pioneering graduate training program for hospital CEOs—stand to benefit from the practical insights contained in this manual.

Likewise, much can be gleaned from this manual to strengthen our efforts to institutionalize a culture of evidence-based planning throughout our health sector. This culture ranges from the persistent pursuit of our overarching objective of “one plan, one budget, one reporting system” at the national level, to the reinforcement of our planning processes at the district level, to the details of the weekly plans each manager draws up to direct their daily activities.

Going forward, we hope that our own practical experiences in these areas can contribute to future editions of this comprehensive manual. While health systems strengthening may not be an exact science and there is no one-size-fits-all approach, this publication makes clear that much empirical knowledge and good practice can be distilled to help countries accelerate and refine their efforts in the ways best suited to their needs, capacities, and circumstances.

Management Sciences for Health and USAID should be commended for collaborating to produce this very timely and valuable handbook. It is a vital contribution that underscores not only the indispensability of strong health systems for achieving the health Millennium Development Goals but also for dealing with new and emerging global health problems in the future. I look forward to seeing the wide dissemination and practical application of this manual in Ethiopia and throughout Africa and the rest of the developing world.

Dr. Tedros Adhanom Ghebreyesus  
*Minister of Health, Federal Democratic Republic of Ethiopia*

## WHAT PEOPLE ARE SAYING ABOUT HEALTH SYSTEMS IN ACTION

The substance is impressive. I doubt that there is anything else in this field that offers remotely as much between two covers.

Guy Pfeffermann  
*Founder and CEO, Global Business School Network*

This publication provides a wealth of information for managers ... who wish to improve their performance and that of their teams.... It addresses the key issues for aspiring leaders in health and provides a wide array of links to useful resources. It also encourages reflective practice and combines theoretical concepts with practical examples. This publication will be especially useful for managers in resource-constrained settings who have to make difficult decisions about how to direct limited resources to obtain the largest health gain, as well as how to motivate teams and nurture high-quality care in challenging circumstances.

Professor Andy Haines  
*Director, London School of Hygiene & Tropical Medicine*

Distilling decades of experience, MSH's handbook underscores the importance of health systems performance to achieve MDGs and more, and places people at the core of each of the building blocks of health systems, with an emphasis on the critical competencies of leadership and management for development organizations and governments. The handbook should become a helpful companion of health leaders and managers around the world.

Ariel Pablos-Mendez  
*Managing Director, The Rockefeller Foundation*

The eHandbook is the most important single reference for health care managers at all levels in the organization and the health care system. It is a learning system. The manager who goes through the entire eHandbook will grow in competence and confidence. The manager who consults it to solve problems will find the answers. The eHandbook is also a portal providing the essential websites through which the user is guided to dig deeper, making the Handbook a virtual consultant. With the eHandbook, the health manager is never alone.

Gary L. Filerman  
*Senior Vice President and Chairman, Health Management and Policy Group, Atlas Research*

The eHandbook clearly meets a gap in many of our health systems in Africa.

Alex Coutinho  
*Director, Infectious Disease Institute, Kampala, Uganda*

## Preface

**T**he creators of this handbook have been listening carefully to people like you for many years. You have told us that you wished you had been better prepared to manage, lead, and govern health facilities or programs and health care providers. You spoke to us about your commitment to health as a human right and your struggles to ensure that your health facilities and staff produce high-quality health services for people in need. We heard your descriptions of the challenges of working under less-than-ideal circumstances and always in the face of significant resource constraints.

*Health Systems in Action: An eHandbook for Leaders and Managers* (which includes those responsible for leading, managing, and governing) was written for you. We hope it will help you to work with your team or unit, program, or organization to realize the dream you set out to accomplish: universal access for individuals, families, and communities to the best possible health care. We first published the handbook in 2010, and in 2014 we revised it by adding a chapter on gender mainstreaming, rewriting much of the chapter on governance, substantially editing the first two chapters, and updating information such as URLs throughout the handbook.

We believe the following pages will provide insights and tools that will help you to enable others to face challenges and produce desired results. We want to help you reach your goals by improving the responsiveness of the health system or your specific organization to the needs of clients, staff, and others who have a stake in quality health care.

The topic of effective health systems is on everyone's mind these days. Much is known about the elements of a health system, and many frameworks exist. Yet there is still a major gap related to the "how" of making health systems work.

This handbook brings together effective practices in leadership, management, and governance from decades of our worldwide field experience in public health. It includes effective practices in key management systems that all work together to improve health. In addition, it draws on the practical approaches for leading and managing available to you in *Managers Who Lead: A Handbook for Improving Health Services*, which was published in 2005 and reprinted in 2009. The revised edition also builds on the experience gained under the Leadership, Management, and Governance (LMG) Project that was awarded to MSH in 2011.



Our aim is to give you a comprehensive, practical guide and a set of tools and resources that address common issues in leading, managing, and governing health services. We have designed this handbook as an electronic resource that you can access with ease on the Internet and read online, print, and download.

We wrote this book for health professionals working in the public sector and for those working in civil society organizations large and small, including those that are faith-based and community-based. Teachers, trainers, and facilitators can use the materials in this book to design trainings in leadership, management, governance, and organizational development, and to provide orientation materials for new managers.

Wherever you are in the organizational hierarchy, this book is meant for you. Use the handbook for your own reference and learning or for training. We encourage you to also use this book with your team. Consider the time spent reading it as an investment in your career as well as in the quality of your team's or organization's performance. The handbook is a resource to help you become more aware and more disciplined about five critical elements of organizational success: leadership, management systems, good governance, change management, and the establishment of a conducive work climate.

With this handbook, we hope to contribute to efforts to place the human element at the center of the health system. We contribute a language and a set of good leadership, management, and governance practices that anyone can master and that have been proven to strengthen organizational management systems. We also address your needs as someone with a stake in making all the parts of the health system work together for quality health services.

The material is organized around those core elements into ten chapters, as follows:

Chapter 1.	Achieving Results by Strengthening Health Systems
Chapter 2.	Leading and Managing: Critical Competencies for Health Systems Strengthening
Chapter 3.	Governance of Health Systems and Health Organizations
Chapter 4.	Mainstreaming Gender Equality into Health Systems
Chapter 5.	Planning the Work and Working with the Plan
Chapter 6.	Managing Human Resources
Chapter 7.	Managing Finances and Related Systems
Chapter 8.	Managing Medicines and Health Products
Chapter 9.	Managing Information: Monitoring and Evaluation
Chapter 10.	Managing Health Service Delivery

You can consult or read the chapters from start to finish, in part, or in any order.

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Every chapter includes links to online resources so that you can learn more about these topics. In many cases you will find detailed instructions for steps you can take in your organization. Each chapter ends with the same three sections: proven practices, a glossary of terms that might be unfamiliar to you and your team, and a list of references and resources.

Our hope is to put everything you need at your fingertips so you can easily and continuously refine your knowledge of management and leadership and strengthen your skills as a manager who leads.

Finally, we hope to hear from you. We are interested to know about your experiences as you use the eHandbook. What have you found most valuable? Is there information that we should update? Perhaps you have found a resource on the web that we should include. Are there any suggestions in the eHandbook that have not worked for you? There's a [feedback form](#) on the web that you can use. Or, you can simply drop an email to [HSinAction@msh.org](mailto:HSinAction@msh.org). We've spent decades listening to and learning from people working hard to improve health systems around the world. Please help us to make the eHandbook as useful for you as it can be.

Thank you, and best wishes as you face challenges, improve health systems, and help save lives in your communities.

## Where to Find *Health Systems in Action: An eHandbook for Leaders and Managers*

The handbook is available for download on the Internet at <http://www.msh.org/resources/health-systems-in-action-an-ebook-for-leaders-and-managers>.

## Acknowledgments

*Health Systems in Action* marks the culmination of the Leadership, Management and Sustainability Program funded by the US Agency for International Development (USAID). As the LMS Program ended, we welcomed the opportunity to reflect on and share the experiences and insights gained through USAID's generous support. This handbook is the vehicle for that reflection and sharing. The follow-on USAID-funded Leadership, Management, and Governance Project has been tasked with continuing the promotion and facilitation of good leadership and management in health, with the addition of a governance component and with a stronger gender focus. As a result, USAID has given us the support needed to update this handbook with a revised governance chapter and an additional chapter on gender.

The updated handbook was written by a team of authors from Management Sciences for Health (MSH): Sylvia Vriesendorp, Mahesh Shukla, Karen Johnson Lassner, Lourdes de la Peza, Belkis Giorgis, Judith B. Seltzer, Steve Reimann, Mary O'Neil, Natalie Merlini Gaul, Malcolm Clark, Andy Barraclough, Nancy LeMay, and Ann Buxbaum. They drew not only on their professional expertise but also on what they have learned from their colleagues in health organizations and institutions around the world.

Several MSH staff members reviewed selected chapters and provided valuable technical inputs to the authors. They included Joan Bragar Mansour, Karen Johnson Lassner, Timothy R. Allen, Susana Galdos, Pat Barros-Smith, Alison Ellis, Joseph Dwyer, Sarah Johnson, Kimberly Hirsh, Susan Brinkert, Nazzareno Todini, Steve Sapirie, Cary Peabody Perry, Steven Solter, Diana Silimperi, Ashley Stephens, and Jeffrey Aubuchon.

We would particularly like to thank the reviewers outside of MSH, colleagues whose willingness to share their knowledge and experience in leading and managing health programs added immensely to the authenticity of the handbook. Dr. Peter Mugenyi of the Joint Clinical Research Centre in Uganda, Lourdes Quintanilla of the Instituto Carso de Salud in Mexico, and Susan Wright of USAID in Ghana read and offered their perspectives on the entire manuscript. Individual chapters were reviewed by Marguerite Farrell, Estelle Quain, Nandita Thatte, and Nadira Kabir of USAID; Dr. Delanyo Dovlo of the World Health Organization; and Kathy Cahill, an independent consultant in the United States, formerly of the Bill & Melinda Gates Foundation. The revised governance chapter was reviewed by David Winters, an independent consultant in international health, development, and governance; and Tom Dolan, President Emeritus of American College of

Healthcare Executives. In addition, the new chapter on gender was reviewed by Constance Newman, Senior Team Leader, Gender Equality and Health, at IntraHealth International; Susana Galdos, former Executive Director of Movimiento Manuela Ramos and former MSH Latin America Director; and Azucena Ugarte, Director of Education and Training at Women Against Abuse.

Every publication needs good editors. We would like to thank Ann Buxbaum and Barbara Timmons for their technical review and edits of the chapters in the original version and Sylvia Vriesendorp for editing the new chapters. Tempe Goodhue copyedited the manuscript and managed the production process. The handbook would have been a very different product without her persistence and care, and we thank her. Nina Breygin provided essential assistance with the preparation of the CD-ROM of the original version. Stacey Irwin Downey was the last person to review the original version of the publication from start to finish, and we benefited greatly from her combination of broad technical grasp and attention to detail. Erin Dowling designed the revised version of the publication and we thank her for her ideas and for her eye for detail.

Alison Ellis, Karen Johnson Lassner, and Ashley Stephens managed the development of the handbook, and were joined in the later stages of production by Meghann Lindholm. Production of a publication is a major piece of work, and they each did an outstanding job.

Joseph Dwyer, Director of the LMS Program at MSH, provided inspired leadership, firm guidance, and steadfast support in the effort to distill the best of our experience for this handbook. Jim Rice, Director of the LMG Project, helped guide the revision and the development of the new and updated content.

Finally, we thank Marguerite Farrell, USAID Cognizant Technical Officer for the LMS Program, for her commitment to this handbook and her ongoing encouragement and support. We greatly appreciate the continued investment of USAID in improving the leadership and management capacity of health programs so that managers of public, private, and nonprofit organizations around the world can realize their vision of high-quality, accessible, and sustainable health services for all. We also thank Ann Hirschey, the LMG Project Agreement Officer's Representative, and Temi Ifafore, Giuliana Morales, Rebeen Pasha, and Matthew Schneider, who contributed to the review of the updated content.

Lastly, we thank the LMG team who helped usher through the updated content and keep everyone on track: Corinna Banda, Jessica Koval, Megan Kearns, and Katie Martin.

## Acronyms

ACF	allocable cost factor
ACT	artemisinin-based combination therapy
ADDO	Accredited Drug Dispensing Outlet
AIDS	acquired immune deficiency syndrome
AMC	average monthly consumption
ART	antiretroviral therapy
ARVs	antiretrovirals
CBD	community-based distribution
CHW	Community health worker
CBPHC	community-based primary health care
CCM	country coordinating mechanism
CCM	community case management
CEO	chief executive officer
CHBC	community home-based care
COPE	client-oriented, provider-efficient services
CPR	contraceptive prevalence rate
CSO	civil society organization
CYP	couple-years of protection
DHCC	District Health Coordination Committee
DHS	Demographic and Health Survey
DLDB	Duka la dawa baridi (private drug shops in Tanzania)
EDL	essential drugs list (now called “list of essential medicines”)
ELCO	ELigible COuples
FEFO	first expiry, first out
FIFO	first in, first out
FLEP	Family Life Education Programme
FP	family planning
G&A	general and administrative costs
GAAP	generally accepted accounting principles
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HCW	health care worker
HIS	health information system
HIV	human immunodeficiency virus
HMIS	health management information system(s)
HR	human resource(s)
HRH	human resources for health
HRM	human resource management
IMCI	integrated management of childhood illness
IMCNI	integrated management of childhood and neonatal illness
IPPF	International Planned Parenthood Federation
IYWG	Interagency Youth Working Group
KAP	knowledge, attitudes, practices
LDP	Leadership Development Program
LLINs	long-lasting insecticide-treated nets
LMS	Leadership, Sustainability and Management Program

LQAS	lot quality assurance sampling
MDG	Millennium Development Goal
MIS	management information system
MOH	Ministry of Health
MOPH	Ministry of Public Health
MOST	Management and Organizational Sustainability Tool
MSH	Management Sciences for Health
NAC	National AIDS Commission (or Council)
NGO	nongovernmental organization
OR	operations research
OT	opportunities and threats
PAC	postabortion care
PBF	performance-based financing
PDQ	Partnership Defined Quality
PEPFAR	President's Emergency Plan for AIDS Relief (US)
PHC	primary health care
PIP-PH	performance assessment & improvement process—public health
PMI	President's Malaria Initiative
PPHCC	Provincial Public Health Coordination Committee
PVC	polyvinyl chloride
QA	quality assurance
QAP	quality assurance project
QI	quality improvement
RFQ	request for quotation
RH	reproductive health
SBM-R	standards-based management and recognition
SMART ( <i>criteria</i> )	Specific, Measurable, Appropriate, Realistic, and Time bound
SMART ( <i>financial criteria</i> )	Simple, Meaningful, Accurate, Relevant, and Timely
SOPs	standard operating procedures
STI	sexually transmitted infection
SW	strengths and weaknesses
SWOT ( <i>analysis</i> )	Strengths, Weaknesses, Opportunities, Threats
USAID	US Agency for International Development
USG	United States Government
VCT	voluntary counseling and testing
VEN	vital, essential, nonessential
VPP	voluntary pooled procurement
VSC	voluntary surgical contraception
WHO	World Health Organization



# Achieving Results by Strengthening Health Systems

*Sylvia Vriesendorp*

1. Achieving Results by Strengthening Health Systems
2. Leading and Managing: Critical Competencies for Health Systems Strengthening
3. Governance of Health Systems and Health Organizations
4. Mainstreaming Gender Equality into Health Systems
5. Planning the Work and Working with the Plan
6. Managing Human Resources
7. Managing Finances and Related Systems
8. Managing Medicines and Health Products
9. Managing Information: Monitoring and Evaluation
10. Managing Health Service Delivery

**T**his chapter makes the case for putting people—health professionals who are responsible for getting quality health services to the people who need them—at the center of health systems strengthening. When you examine the health system building blocks that contribute to positive health outcomes—leadership and governance, human resources, financial management, health information, supply management, and health service delivery—you will see that none of them can operate without skilled, supported, and motivated people. These people may work in their neighborhoods, in health centers or hospitals, in private organizations, or in the government.

This chapter introduces the Framework for People-Centered Health Systems Strengthening, which takes into account the connections between systems and the people who provide and use them. At the center of the framework are the management, governance, and leadership skills of the people who design and operate the health management systems needed to deliver efficient, effective, high-quality health services to clients and their communities.

## Introduction

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One of the biggest challenges facing health managers and health service providers is how to turn a demoralized or overworked and stressed staff into a proactive, motivated team that delivers high-quality health services every day. Weak management systems are major contributors to the frustration and the sense of futility that countless professionals feel when they are not able to make sustainable contributions to improved health outcomes.

But any attempt to improve management systems without addressing the needs of the people who do the work is bound to end in disappointment, more stress, and even lower morale, reinforcing a vicious circle of ineffectiveness and inefficiency. Addressing this challenge requires attention at every level to both systems and people.

Medical knowledge exists to reduce illness and death caused by preventable diseases. Applying knowledge and scaling up evidence-based practices requires strong health systems with skilled and motivated leader-managers who can support and motivate the health workforce.

Over the years, the authors of this handbook have learned that improving the ability to lead, manage, and practice good governance of those who “make the health system happen” is one of the most important ways to achieve the ambitious [Millennium Development Goals](#). Even in the face of poverty, illiteracy, discrimination, and conflict, the existence of resilient management systems, the practices of good governance, and leadership that sets direction and inspires followers are vital to health services and health outcomes.

This handbook is dedicated to all staff, at any level, in any kind of organization—large or small, private or public—who are committed to bringing health services to all who need them, wherever they live. The ideas, models, and practices presented in the handbook have been used in Africa, Asia, Europe, and North and South America. They represent the best thinking of academics and the best doing of practitioners.

## Turning frustration into a force for change

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Health systems are complex, and trying to change them is a major challenge. Those who struggle with poorly functioning health systems can use their frustration as a force for either inaction or action.

Everywhere in the world there are health care managers and providers who have turned their frustration outward through complaints or aggression against the health system, which they view as the source of all problems. They say, “It’s not my fault!” or “It’s not my problem!” At the other end of the spectrum are people who have turned the frustration inward and become so discouraged and disengaged that they cannot be effective. You will hear them say, “I just can’t do anything about it.”

Both types of frustrated workers see themselves as victims, with no control over the dysfunctional systems within which they work. They exist at every level in organizations, including at the top.

A third response is at the root of all major transformations in society: a sense of purpose born of indignation about the status quo that makes one say, “I won’t settle for this any longer, and I’m going to do something about it.” This attitude produces a surge of energy that turns indignant managers and providers into change agents. It is based on the reality that systems are created by people and can, therefore, be transformed by people. When people invite others to join together and change what is unacceptable, that is true leadership. This handbook is designed to help you become effective change agents and enlist others for the good of the whole.

## Building functional health systems

The ultimate aim of a health system is to equitably maintain or restore the health of all the people it serves. An effective health system begins with parents who have learned the best ways to keep their children healthy. If a child does become sick, the mother can bring the child to a clinic, be seen without a long wait, and have the health problem correctly diagnosed and appropriately treated by well-trained and supervised health staff who have the right medicines available. If the mother is also informed about family planning and freely

### Strong Leadership and Management in Action to Improve Public Health— Country Examples from Afghanistan, Brazil, and Tanzania

In **Afghanistan** the Ministry of Public Health has reached out to more than 1,800 health managers in 13 provinces to make them more aware of their role as leaders and stewards of the health system. Under a program supported by USAID, these managers have increased vaccination coverage and access to family planning services, resulting in improved child and maternal health. The most significant improvements were an increase of almost 70 percent in health facility births and a 28 percent increase in family planning consultations.

In **Brazil**, the Secretariat of Health of Ceará mandated that public servants participate in leadership training before they could apply for management positions, breaking the mold of automatic promotion. The improvement in health results was significant; in one municipality, infant mortality dropped from 26 to 11 deaths per 1,000, while the percentage of women receiving prenatal care increased from just over 50 percent to 80 percent. Overall, 70 percent of the 25 municipalities that participated in the leadership development process reduced their infant mortality—some by as much as 50 percent.

In **Tanzania**, where many people in rural areas seek health care and medicines from retail drug shops, MSH collaborated with the Government of Tanzania to establish the Accredited Drug Dispensing Outlet (ADDO) program. An assessment before the project showed that many shops sold prescription drugs illegally and that most drug sellers were unqualified and untrained. To address this challenge, the government and MSH designed a program that combined training, accreditation, business incentives, and regulatory enforcement. A survey showed that only 14 percent of ADDO drug sellers provided the wrong treatment (antibiotics) for upper respiratory tract infections, as compared with a result of 39 percent in a nationwide survey.

chooses an appropriate family planning method so that she will not get pregnant again right away, the health system is fulfilling its role: attending to people's health and productivity so that they can contribute to the development and prosperity of all.

The World Health Organization (WHO) defines a health system as the sum of the organizations, institutions, and resources whose shared primary purpose is to improve health. The broad health system includes everyone responsible for good health, from the family in a rural village to the surgeon in a hospital in the capital city. It encompasses sanitation and nutrition, involves all branches of government, and operates within the public sector, civil society, and for-profit entities.

Six building blocks constitute the overarching [WHO health systems framework](#). They are:

1. service delivery
2. health workforce
3. information
4. medical products, vaccines, and technologies
5. financing
6. leadership and governance (stewardship)

If all six components function effectively and deliver their intended results, the assumption is that the entire health system—which includes the health care organization or program—is strong.

Together, these building blocks are the foundation for health systems that support access to high-quality health services, leading to positive health outcomes for clients and communities—especially those who are most vulnerable and underserved. In this handbook we have taken these six building blocks and show you how to strengthen them so they are aligned to achieve positive health outcomes. They are:

1. **leadership, governance, and gender mainstreaming** procedures and practices—including planning—that engender commitment and accountability (Chapters 2, 3, 4, and 5);
2. **human resource policies and procedures** that produce a supported and motivated workforce (Chapter 6);
3. **financial management**, which is concerned with accounting and budgeting, along with the related reporting and analysis that make it possible to ensure that the organization's resources are used in the service of its mission, for maximum impact, in compliance with laws and donor requirements, and in accordance with ethical standards and sound operational practices (Chapter 7);
4. **management of medicines and medical supplies** so that the right products are delivered in the right quantities, at the right time, and in the right place—and then used appropriately (Chapter 8);
5. **health information and associated monitoring and evaluation** practices that facilitate effective problem solving, informed decision-making, and the formulation of policy based on evidence (Chapter 9);
6. **health service delivery** that is supported by quality management processes and that addresses the basic health needs of the populations to be served (Chapter 10).

In these chapters, you will take a closer look at these building blocks and the management systems that put them into action. You will consider how well your organization is doing in creating functional systems that enable you, your colleagues, and your communities to provide high-quality health services to all the people you serve.

As you start to immerse yourself in these areas, you will discover the central element, people: those who lead, manage, and use the systems. On one side are the nurses, doctors, community health workers, laboratory technicians, pharmacists, midwives, and health facility administrators who lead and govern; manage human resources, financial resources, supplies, and information; and deliver health services. On the other side are the people in the cities, towns, and rural areas who need information and community support to engage in health-seeking behaviors.

The goal of providing quality health care cannot be achieved without the powerful interaction of these two groups of people. Health systems strengthening is an empty exercise if we forget the people at the center of it all.

Therefore, this handbook keeps a spotlight on the human element that defines “people-centered” health systems. It explores the competencies needed to lead and manage so that those who deliver health services to families and communities will feel motivated, confident, fully supported, and successful in their jobs.

You may think that strong health systems require a large staff and sophisticated equipment—especially computers. In small and fledgling civil society organizations with few, if any, paid staff and without computers, the notion of systems strengthening may at first seem irrelevant. But a system does not necessarily need to be computerized. Small organizations can often do their work manually until they become large enough to need more automated processes. Until such time, systems strengthening simply means that people become aware of the connections between the actions of the various workers. They realize that a set of activities poorly performed will affect other activities and, conversely, that the good performance of a set of activities raises the level of other activities as well. At the most basic level, then, the work of systems strengthening begins with people simply talking to one another and aligning themselves toward a common goal.

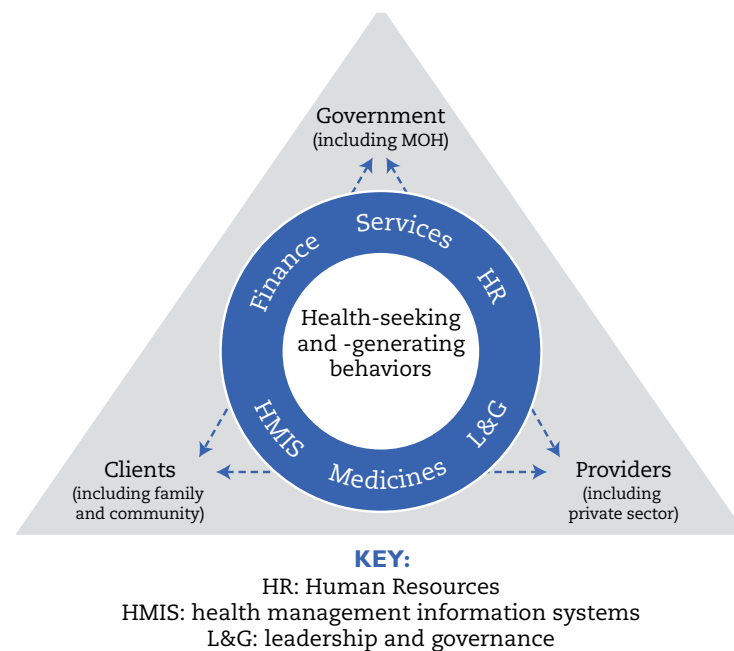
## A framework for people-centered health systems strengthening

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First, let us clarify our language. The word “system” can be defined as a set of interacting or interdependent entities that form an integrated whole. Within this broad definition, “system” can refer both to the entire national health system and to the various management systems that help organize and monitor the use of resources. This duality can create confusion when we talk about health systems strengthening.

In this handbook, we use the word “system” to refer to the entire health system. “Management systems” refers to the various components of the overall health system, such as the financial management system, the management information system, or the human

FIGURE 1. Framework for People-Centered Health Systems Strengthening



resources management system. And the word “subsystems” refers to the smaller systems that are nested within each management system and contribute to its effectiveness.

Using WHO’s building blocks as inspiration, Management Sciences for Health has adapted the WHO framework to create the Framework for People-Centered Health Systems Strengthening shown in Figure 1.

This figure illustrates how the various health systems work in concert to provide the critical link between health-seeking and health-generating behaviors on the one hand (demand) and the inputs provided by the various actors in the overall health system.

It is so obvious that people run a health system that we sometimes overlook this critical fact, whether in the public, nonprofit, or for-profit sectors. Much attention is devoted to the process aspect of systems. Often ignored are those who develop or improve processes and procedures to foster the smooth flow of information, money, medicines, and people within the overall health system. The Framework for People-Centered Health Systems Strengthening attempts to remedy this imbalance. It provides a way to think about this critical component of system performance and, ultimately, of improved health outcomes.

Who are the people in the “people-centered” framework? [Box 1](#) shows them as those who develop the systems, use the systems to do their work, and benefit from strong systems.

As the person responsible for a health program or health services facility, you can contribute to a healthier population by focusing on the people who need the skills and support to integrate and use the six building blocks and management systems to deliver high-quality health care.



### BOX 1. The People at the Center of Health Systems

**Health managers and administrators** who have the knowledge, skills, responsibility, and authority to build and maintain the management systems needed to deliver health services;

**Personnel at all levels**, including health care providers and administrators, who use the management systems to address challenges and achieve results;

**Communities and families** that are educated and empowered to promote their own health and demand quality services;

**Clients** who have adequate information to use health services appropriately and are not impeded by poor quality, high fees, gender disparities, or other forms of discrimination.

Your professional role might be specialized. You might focus on gathering information, combining it with information from others, and using it to make sure there is an uninterrupted supply of medicines, vaccines, and contraceptives. If you work at headquarters, your attention may be on filling staff positions with competent individuals. Maybe your role includes patient care as well as management.

Whatever role you play, you are both a contributor to and a beneficiary of your organization's and community's role in your country's health systems. Stronger systems will improve the quality of services, which will, in turn, encourage clients, families, and communities to use those services and to adopt sound preventive health practices and seek help in a timely manner when needed. The result will be prevention, treatment, and care that lead to a reduction of disease and malnutrition, and improved maternal and reproductive health.

## Designing management systems with people in mind

Interventions intended to strengthen management systems often do not work because of incomplete information: the people who manage the systems were not fully included in the design process.

Chapter 2 of this handbook discusses scanning as a leadership practice that involves gathering information about the current status of your environment, your organization, your work team, and yourself. You can design better systems by asking questions about the people who will use those systems.

- Who are the health managers (administrators, doctors, nurses) who need a better management system?
- Who will be affected by the proposed changes? Do they think the new or improved management system will make their work easier and more effective, and in what ways?
- What roles do these health managers and other stakeholders and their teams play in leading and managing the work related to the management system in question?

- Are they themselves aware of a gap in the performance of their facility or organization?
- What challenges are the people who use the management systems facing?
- What skills, mindset, and abilities do they need to succeed?
- How can their needs be met in ways they can maintain over time?
- What preparation (pre-service) or training (in-service) is available and how accessible is it?

Answers to these questions will be invaluable to you in designing and carrying out management systems–strengthening work. Your job is to make sure that the human element is not left to chance.

## Interventions to build stronger health systems

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Although everyone recognizes that improving health systems is an important aspect of making health services more responsive and more effective, people do not always agree about which interventions will produce these results. As you make changes, you may want to do so in ways that bring people together rather than pull them apart, but it may be unclear how to achieve this secondary goal.

You can begin by recognizing that, at any level, all management systems have a few characteristics in common, some of which can undermine health systems strengthening if you do not understand and counterbalance them. Management systems convert the materials and resources needed to carry out an implementation plan (“inputs,” such as money, equipment, staff time, and expertise) into activities (“outputs,” such as training programs, information, or behavior change communications). Systems often embody specialized knowledge and expertise that make it easy to (mistakenly) draw a boundary around each one.

Experts have a tendency to consider “their” management system not only as capable of standing alone but also as central to health systems–strengthening work, thereby fragmenting the larger health system. In addition, some people approach systems strengthening as a repair job. But the notion of “fixing” the health system suggests something mechanical, as if strengthening were a matter of replacing broken pieces or reconnecting pipes. The assumption is that if you can “fix” a particular management system, such as the health information or human resource management system, the overall health system will perform better.

In countries all over the world, this assumption has turned out to be incorrect. A “fix” may resolve a particular problem, but if the underlying issues remain, new problems are likely to arise. Strengthening health systems takes time and careful thought. It brings into play all the management and leadership practices you will learn about in Chapter 2 of this handbook.

## The role of management systems in health systems strengthening

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Robust management systems make routine transactions systematic, replicable, consistent, and complete. Critical information is well documented so that the system does not rely on the knowledge of individuals, who can come and go, and maintenance is continuous so that the system remains responsive and up to date.

### MANAGEMENT SYSTEMS ARE RUN BY PEOPLE— AND PEOPLE ACT IN A CONTEXT

Health care managers and providers in facilities, ministries, and nongovernmental and civil society organizations have to operate and sustain management systems and service delivery after the technical experts leave. As a health manager in Nicaragua said some years ago, “Now we have put in the systems, but we have no one to run them.” Kenya’s Ministry of Health, in its *National Health Sector Strategic Plan II 2005–10*, reached the same conclusion: “People make service delivery and support systems happen.” The report also noted that “effective leaders and managers in health are the foundation for the success of *Vision 2030*.”

Cultural or organizational factors, if not addressed, can undermine the ability of people to use a system successfully. For example, the design of a nationwide training curriculum for community health workers might require a literacy level above what exists in many rural areas. If the curriculum developers fail to scan the environment and gather information on the potential trainees, a much-needed human resource improvement could fail. With better information, the developers would know to create a parallel curriculum for workers with limited ability to read and write.

### MANAGEMENT SYSTEMS ARE CONNECTED

As these examples illustrate, the health system relies on overlapping and interconnected management systems and subsystems. Changes in one system can trigger changes in another system—changes that might go undetected until they cause trouble. For example, moving an organization’s financial management system onto computers might mean that financial reports take less time to prepare and, therefore, might lead to new responsibilities for staff or perhaps a reduction in accounting staff. In this instance, the human resource management system needs to be fully aligned to support the changes in the financial management system.

As described in Chapter 10 of this handbook, the service delivery point is where a country’s health system meets its beneficiaries—where clients and providers interact. Every service delivery point—whether a community-based health post or a tertiary hospital in the capital city—has its own systems, which can range from sophisticated databases to simple paper-and-pencil checklists. In a well-functioning health system, the various management systems and subsystems are connected and integrated so as to provide the best possible health services to all the intended beneficiaries of those services.

This interdependence of higher- and lower-level systems has real consequences for fulfilling the purpose of the overall health system. If a functional system is changed or divided, or parts of it are removed, it will not simply become smaller or less complex. It is more likely to become defective and fail to perform (Colindres 2007, p. 39). This is the risk of working on one component of the health system without awareness of or concern for the larger context in which services are provided.

For a while, this might seem sensible, because delivery of services can move faster. But in the long run, such uneven development will benefit some management systems to the detriment of others and foster imbalances and inequities that can disturb the functioning of the entire health system.

## Proven practices

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- Recognizing that no system can operate without skilled and motivated staff, you should always put people first when designing, modifying, or improving a health management system. Recognize, support, and reward the staff members who take on the management and leadership roles that make the health system work every day, at every level.
- Rather than depending on outside experts to “fix” things, arrange for managers and providers to work side-by-side as partners with technical experts. This will build the ability and confidence of the people who will operate and sustain management systems and deliver services when the experts are gone.
- Keep management systems as practical as possible: overly complicated management systems usually cannot be sustained when external support is withdrawn.
- Use the Framework for People-Centered Health Systems Strengthening to help your staff understand how each management system strengthens and supports others and how all the systems work together to allow your organization to fulfill its mission.

## Glossary of health systems terms

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**fully functional health system:** A point at which the various management systems and subsystems are connected and integrated so as to provide the best possible health services to all the intended beneficiaries of those services.

**health system:** The expertise, structure, and organization that make possible the delivery of health services nationwide, comprising leadership and governance; human resources for health; financial management; health information; management of medicines; and health service delivery.

**management systems:** The various components of the overall health system that managers use to plan, organize, and keep track of resources.

**service delivery point:** The physical location (for example, health center or hospital) or other place of interaction (for example, the Internet or printed materials) where health care providers and clients interact and the benefits of a service are made accessible and usable.

**subsystems:** The smaller systems that are nested within each management system and contribute to its effectiveness.

## References and resources

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Colindres, Hector. *Modernizing Health Institutions in Latin America*. Cambridge, MA: Management Sciences for Health, 2007.

Kenya, Republic of. "Reversing the Trends. The Second National Health Sector Strategic Plan of Kenya, 2005–2010." Nairobi: Ministry of Health, Health Sector Reform Secretariat, 2005, [http://www.healthpolicyinitiative.com/Publications/Documents/796\\_1\\_796\\_1\\_NHSSP\\_II.pdf](http://www.healthpolicyinitiative.com/Publications/Documents/796_1_796_1_NHSSP_II.pdf) (accessed Dec. 1, 2009).

———. *Kenya Vision 2030* (popular version). Nairobi, 2007, <http://www.scribd.com/doc/3480381/Vision-2030-Popular-Version> (accessed Jan. 12, 2010).

Quick, James C., et al. *The Financial Times Guide to Executive Health*. Harlow, Scotland: Pearson Education Ltd., 2002.

World Health Organization. "What Is a Health System?" Geneva: World Health Organization, 2005, <http://www.who.int/features/qa/28/en/index.html> (accessed July 1, 2009).

———. 2007. *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action*. Geneva: World Health Organization, [http://www.who.int/healthsystems/strategy/everybodys\\_business.pdf](http://www.who.int/healthsystems/strategy/everybodys_business.pdf) (accessed August 3, 2014).





# Leading and Managing: Critical Competencies for Health Systems Strengthening

*Sylvia Vriesendorp*

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9. Managing Information: Monitoring and Evaluation
10. Managing Health Service Delivery

People-centered health systems cannot be strengthened without good management and leadership. In this chapter we will show how you, as a manager of a health program or health services, can apply proven practices for managing and leading to address the challenges you face. We consider good governance to also be an aspect of good leadership and have devoted Chapter 3 to this important topic.

Leadership and management skills are needed at all levels of the health system. This chapter throws light on the topic by focusing on behaviors that managers and providers can use in any setting, whether in a community health post or the national Ministry of Health. We discuss the special case of the leadership of senior health managers because “derailment” or disruptions at this level can have enormous consequences. Finally, we present a simple action-learning approach to applying sound management and leadership practices and working through challenges.

## Introduction

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Millions of people still die every year from infectious diseases and other preventable causes, no matter how much money we put into improving health services, health systems, educational campaigns, health worker training, equipment, and facilities. From a clinical point of view, we know what to do to save these lives and significantly reduce illness. Scaling up these high-impact interventions and proven best practices is the key to preventing avoidable deaths and achieving major improvements in health on a national scale and to getting on track to meet the [Millennium Development Goals](#) for health. However, scale-up does not happen without inspired leadership and skilled management.

You do not have to be like Mother Teresa, Mohandas Gandhi, Nelson Mandela, or the Guatemalan Nobel Peace Prize winner Rigoberta Menchú to make a difference in the lives of others. Unlike each of these heroes, you do not have to make enormous personal sacrifices. You can be like the many health care managers and providers who have quietly—and without great personal sacrifice—made critical changes in their organizations that brought good services and good health to their clients. We believe that you can join these people by becoming a manager who leads.

Wherever you are in your organization's hierarchy, you will probably have a mixture of responsibilities that require management, leadership, and governance skills. Thus, this handbook is meant for you. Consider the time you take to read it as an investment in not only your own career, but also the performance of your immediate team and your entire organization. It is a resource to help you become more aware of and disciplined about applying five critical elements of organizational success:

1. the intentional practice of good leadership and management;
2. robust management systems;
3. good governance;
4. the thoughtful application of the principles of change management;
5. the establishment of a conducive work climate.

These five elements are relevant to each of the management systems described in this handbook. They standardize and organize processes for a variety of organizational tasks, such as working with a board of directors; making long- and short-term plans; hiring, firing and promoting staff; accounting for expenditures and results; ordering medicines; and measuring the results of your work.

### LEARNING TO MANAGE AND LEAD

You already know much of what you need to know about management and leadership. If you use what you know more consciously, systematically, and intentionally, you can become what we call “a manager who leads” (see [Box 1](#)). This handbook will complement what you already know with what you would like to learn.

The aim is for you to manage and lead better so that your team, unit, or organization can fully use and continuously develop its potential to transform human and financial resources and other inputs into improved services and, ultimately, improved health outcomes for your clients.

## IMPROVING THE WORK CLIMATE

“Work climate” is a term for the prevailing atmosphere as employees experience it: what it feels like to work in a group. Experience in varied settings has shown that many positive changes emerge when the climate improves. People become more caring and compassionate and less impatient with one another, and their commitment and energy increase. People pay more attention to the quality of their work, and they do what needs to be done, even if it is not in their job description or requires long hours.

## APPLYING THE PRINCIPLES OF CHANGE MANAGEMENT

If you keep your eyes and ears open, you can often detect when a change is needed before a crisis occurs. Changes in the external environment might signal a need to adjust the way something is done in your organization or your team. For example, systems might need to be updated or adapted, staff might need to modify their roles, or you might need to measure different aspects of your work. Certain skills might become outdated or no longer relevant, and staff might need to learn new ones.

Change can be difficult to manage. You will sometimes have to change not only systems but also your own behavior, and then model that change for those at lower levels. You can read more about a leader’s role in bringing about change in [\*Managers Who Lead\*](#).

## When managers lead: A path to results

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*The servant-leader is servant first. It begins with the natural feeling that one wants to serve. Then conscious choice brings one to aspire to lead. The best test is: do those served grow as persons; do they, while being served, become healthier, wiser, freer, more autonomous, more likely themselves to become servants?*

Robert K. Greenleaf  
*The Power of Servant Leadership*

If you have recently risen to a mid-level or senior management position, you probably have many questions about your new managerial and leadership responsibilities, but few people to ask for help. After all, you were promoted because you were good at your job. Admitting that you do not know exactly how to do something can be embarrassing or awkward at best, especially if you have to ask a member of your team who is younger or less experienced than you.

Some of the questions we hear from people who have been promoted into positions where their technical and clinical skills are less important than their management and leadership skills are:

- How can I support—rather than control—my staff to help them “own” and face challenges, and learn their way through them?
- How can I inspire passive or demotivated staff members and encourage them to take initiative and act responsibly, even though we lack resources and work under very difficult conditions?
- How can I reduce arbitrary decision-making, guesswork, and last-minute crises that use up enormous amounts of resources and create stress?
- How do I streamline and systematize the flow of information to reduce waste or improper use of resources?
- How do I get my people to use existing systems more fully?

Questions like these led us to write this handbook. We hope it will help you find answers and practical information you cannot find anywhere else. We also hope you will acquire strategies to develop your management and leadership skills so that you can be proud of the results you and your team produce. Most of all, we hope you will gain confidence that you are positively contributing to improving the commitment and motivation of the people you work with and that, ultimately, this will translate in better health for the people you serve.

## From better leadership and management to improved health outcomes

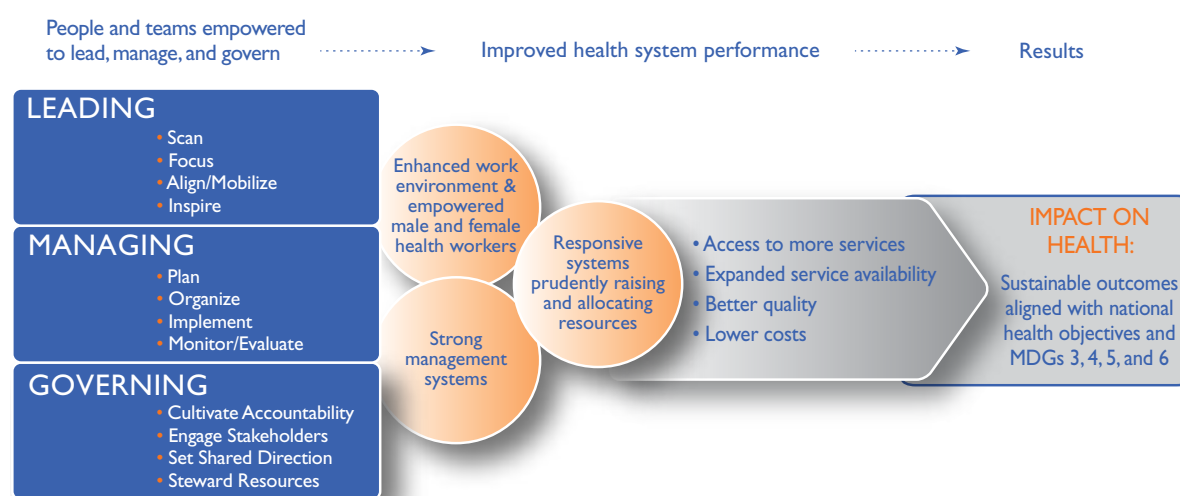
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Drawing on many years of close observation of effective public health leaders, Management Sciences for Health (MSH) and its partners in the field have distilled 12 critical practices that describe the behavior of managers who lead. These practices are divided among the three areas of leading, managing, and governing. [Figure 1](#) shows how these practices contribute to improved services and health outcomes.

Health professionals at different levels of the health system and with varied managerial backgrounds and responsibilities have found that an understanding of these practices helps them to lead and manage more effectively. Whether experienced or recently promoted into positions of authority, managers find that when they begin to use the language of these practices (“I think we need to do more scanning now.” or, “Let’s focus on the most important changes we can start on now!” or, “Who are our critical stakeholders and how can we align them?” or, “It is time to acknowledge the work of our front line providers!”) and implement the practices in their workplaces, they start to see changes.

These practices improve the work environment in such a way that both male and female health workers feel empowered and motivated to put in their best efforts. They make sure that management systems are responsive and robust, making management tasks easier to execute. They make sure that the health system is responsive to changed circumstances and needs, raising and allocating resources in prudent ways. Most important, they begin to take ownership of challenges rather than waiting for their others to solve problems for

FIGURE 1. Leading, Managing, and Governing for Results Model



them. We know that these changes result in increased service access, expanded service utilization, better quality, and lower cost, and that they contribute to the ultimate impact of sustainable health outcomes and impact aligned with national health goals and Millennium Development Goals 3, 4, 5, and 6.

The Leading, Managing, and Governing for Results Model serves as a road map to guide you, your team, and your organization to improved services and better health outcomes. By following it, you can transform discouraged, passive employees into active managers who lead. And once you start, one change will lead to another; you will see improvements in team spirit, customer service, quality, and even the physical environment in which people work.

Creating these transformations is an act of leadership that will transfer power to your team. Its members will learn by doing and become more systematic in the way they themselves manage and lead.

## THE CHALLENGE

Many of the performance problems in the health system—for example, a broken supply chain, rising infections in hospitals, poor patient care, leakage of supplies, or low staff morale—are related to weak or absent management, governance, and leadership skills. Doctors or nurses in charge of facilities or units might lack the confidence or skills to deal with particular challenges, for example addressing staff complaints, preparing a budget, or inspiring staff, to mention just a few. The absence of such skills may not be seen as a problem—until it leads to a crisis that requires immediate attention, extra resources, and setting aside other, less urgent (at the moment) activities that could prevent future crises. Every crisis sets in motion a chain reaction; the less skilled the response, the longer or bigger the crisis.

In a recent survey in Kenya, several health professionals commented on their lack of preparation to manage. We heard comments such as, “I am prepared to solve patients’ problems. Solving staff problems though, is a different thing,” or, “What we know now about management we have learned on the job. I am expected to do technical work, but now I have drifted off to public health work and I have to do management work.” A senior manager in Afghanistan confided that she was well prepared for her clinical duties but entirely unprepared for dealing with the politics and dynamics of change or with the reluctance of male staff to follow the direction of a woman.

The responsibilities of leading, governing, and managing require skills that can be learned and practiced. If you are not already familiar with these practices, you can learn how to cultivate accountability, set direction, steward resources, and engage stakeholders. If you do, you are practicing good governance—as we discuss at greater length in Chapter 3. You can learn how to scan your environment when critical information is missing, or to focus activities when there is too much to do. You can learn to align others and mobilize them to support your cause and inspire people when things get difficult. If you do these things, you are practicing good leadership. And finally, you can learn how to plan, organize, execute, monitor, and evaluate without having to obtain an academic degree in these subjects. If you do this, you are also practicing good management.

Unfortunately, management and leadership skills are rarely included in the education of health care professionals and barely developed as people focus on building technical skills. The intensity of many academic programs leaves little time for topics that are not considered to be of immediate relevance to aspiring doctors and nurses. Even hospital administrators have told us that their preparation for managerial and leadership roles was too theoretical to be of much use in real life. It seems that the majority of health care professionals enter the workplace unprepared for what awaits them.

## Developing managers who lead

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### MANAGING AND LEADING: WHAT’S THE DIFFERENCE?

Managing and leading go together, each working toward a common goal but contributing in ways that the other does not. Because the two functions are complementary, the concept of “managers who lead” has gained acceptance as a holistic approach to running a health care program, organization, or facility. Governance is also relevant as it is closely linked to managing and leading (see [Box 1](#)).

When either function is absent, the results will be mediocre or even entirely unsatisfactory. To look more closely at the challenge of better preparing health care professionals to manage and lead, we must distinguish the two functions.

We define “managing” as planning and using resources efficiently to produce intended results. Managing is focused on making sure present operations are going well. This includes making sure that our most precious resource—the energy of people to give their best to the job at hand—is not wasted on unnecessary or demotivating activities, lost

because of unfair practices, or squandered while attempting to solve problems that could have been prevented.

We define “leading” as mobilizing others to envision and realize a better future. Leading is about the future. It is involved in the creation of work that generates new energy or reactivates untapped skills that have lain dormant because there was nothing to which they could be applied.

As described in [Box 1](#), the notion of managers who lead also has a governance aspect: the ability to cultivate accountability, engage stakeholders, set shared direction, and steward resources—with each of these practices drawing on the practices of managing and leading. More about this in Chapter 3 of this handbook.

As a manager who leads, you enable yourself and others to set direction, face challenges, and achieve intended results. Producing results is what sets a manager who leads apart from people who are officially a manager or leader but are ineffective when it comes to improving the health of the people they are supposed to serve. And when we refer to results, we mean increased access to services, especially by those usually left out; expanded service utilization, especially by those who for a variety of reasons traditionally haven’t used available services; better quality, both in terms of clinically sound and evidence-based best practices and client response; and, finally, lower costs due to less wastage and more effective and efficient use of available resources.

**Leading without managing.** If you lead without managing, although you might be able to create a surge of energy about a future vision, you are unlikely to be able to organize and implement the activities that make things happen. This is similar to being in charge of a space program and looking wistfully at the moon without making coherent plans, organizing the needed training and equipment for the astronauts, and tracking progress toward the moon shot. Strong management skills will decrease the amount of energy you and your team waste when procedures and processes are overly complex, not clearly related to desired results, and unfair. Your ability to manage will enable you and your team to move efficiently toward a desired future.

#### BOX 1. Managers Who Lead and Governance

We use the term “manager who leads” because we have learned over the years that managing by itself, or leading by itself, are not enough. If you consider that managing is about making sure that things run smoothly in the present and leading is about the future, then one without the other is incomplete. And now, with renewed emphasis on good governance, we acknowledge that a “manager who leads” is also expected to practice good governance. Good governance is about making decisions that are based on information, evidence, and shared values and processes that are transparent, inclusive, and responsive to the needs of the people being served. Good governance means decision-makers are held accountable and strategic objectives are effectively, efficiently, ethically, and equitably met, all the while ensuring that the vitality of the ministry or the organization is maintained.

[Chapter 3](#) of the handbook is about governance. Another resource is the [Leadership, Management, and Governance Project website](#).



**Managing without leading.** This is like being a mouse on a treadmill—you may engage in a lot of activity and expend a great deal of energy, but it will get you nowhere. Concentrating only on managing, you lose track of the vision, the changing environment, and the need to prepare for the future. If you lead well, you will increase the energy and commitment of your team and gain the support of the stakeholders who are so critical to success.

**Managing or leading without good governance.** Good governance is also essential. With good governance, for example, the right people are held accountable for mistakes or poor performance, decision-making processes are transparent rather than opaque, and politics does not take over and jeopardize fairness and equity. In the absence of good governance, it doesn't matter how well leadership is able to inspire and attract followers or how sound management practices are. Unless managing, leading, and good governance are all operative, the greater good cannot be served, and people will suffer the consequences.

## PRINCIPLES OF DEVELOPING MANAGERS WHO LEAD

The more an organization recognizes the importance of the management and leadership skills of its staff, the better it will function. Worldwide observation of the practices of managers who enable themselves and others to face challenges and produce results have led to a few simple principles for developing managers who lead.

**Focus on health outcomes.** Good health management and leadership result in measurable improvements in health services and outcomes. Only if you focus on real organizational challenges and commit publicly to producing measurable results (thus making yourself accountable) will your improved skills make a difference.

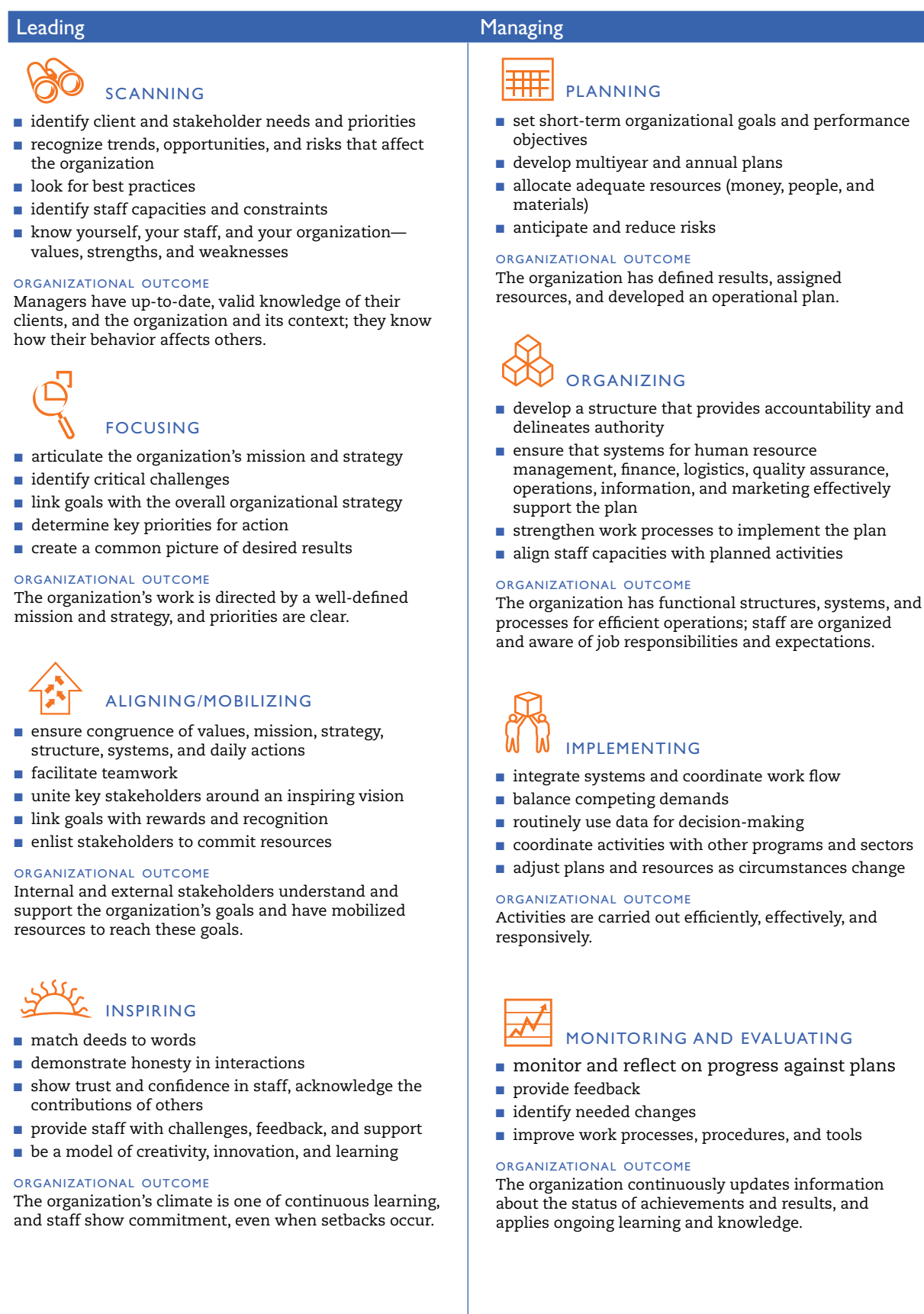
**Practice leadership and good management at all levels.** Your skills in these areas matter to your team and to those who benefit from your team's improved performance, no matter where or at what level you work. Your skills are relevant whether you are a community health worker or director general, a supervisor or the dean of a medical school.

**You can learn to lead and manage better.** Three processes can help you learn and improve your leadership and management practices: challenge, feedback, and support. If any one of these is left out, you are unlikely to learn and grow in your role as a manager who leads.

**Learning to lead and manage takes time and practice.** Leading and managing comprise skills, knowledge, and attitudes that you learn through much practice. The earlier you start to practice, the better.

**Sustain progress through management systems.** Health gains can be sustained only by making sure that leadership and management practices are used in all health services and supported by organizational systems and processes for managing governance, planning, human resources, financial resources, supplies and medicines, and information.

FIGURE 2. Leading and Managing Framework



## Putting management and leadership into action

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Leading and managing are behaviors—which can be changed—rather than personality characteristics—which generally cannot be changed. Practices that enable work groups and organizations to face challenges and achieve results are shown in [Figure 2](#).

A discussion of each of the leading and managing practices follows. Although you may study them separately, you need them all to manage and lead well.

### THE PRACTICES OF LEADING

We have defined leading as the set of practices you use to mobilize yourself and others to envision and realize a better future. The practices of leading are scanning, focusing, aligning/mobilizing, and inspiring

**Scanning.** Managers who lead encourage their teams to scan their environments, organizations, teams, and themselves. Scanning includes looking for feedback from clients, colleagues, supervisors, communities, and the system to stay informed about changes or developments that may require adjustments to strategies and plans.

A manager who asks for feedback from clients or community members is scanning. So is the health administrator who reads an evaluation report or a new government directive about national or provincial priorities. A community health worker who asks community leaders about the most common illnesses in the village is also scanning. A nurse who learns about new counseling techniques or inquires about the latest treatment protocols is scanning.

Scanning involves getting information so you can act on it no matter where you are in the large health care delivery system. A critical skill for scanning is listening to others, including those whose voices are usually not heard because they have little power.

Scanning becomes particularly important when there are many different views or opinions and when facts are hard to come by. Try to get into the habit of asking yourself “do we know enough about this to make a decision or is there something else we should look at first?” Of course, for some people this is a habit that leads to never making a decision because there always is more information. For them, focusing is what they need to work on.

One particular scanning activity is analyzing your stakeholders. See the exercise on analyzing stakeholder interests and concerns in the [Managers Who Lead Toolkit](#), on pages 195–198.

**Focusing.** Managers who lead focus their limited time, energy, and resources on the people and activities that are most important. How do you know what is most important and how to set priorities? You use what you have learned from scanning and then run it through a filter made up of criteria such as: profoundly important to the survival of the organization; can be done quickly and without many resources, providing quick wins and motivation; or affects the largest number of people with the least amount of money; no one else is doing it; and so on.

Managing your time is focusing, because time is a scarce resource. So also are your energy, your funds, and your workforce, which is nearly always insufficient for the tasks that need to be done.

As a manager who leads, if you are to achieve your objectives, you have to make sure that attention goes first to those people and those matters that require attention. This means understanding the root causes of frequent stock-outs of medicines and taking action so that stock-outs become a thing of the past. It means addressing staff morale issues when they interfere with productivity and quality, focusing on making the changes that turn things around.

Focus requires a clear understanding of what is important, and making sure it does not get crowded out by what is urgent, but not important. (See the Important and Urgent Matrix on page 215 in the [Managers Who Lead Toolkit](#).) You will probably always have more work than can be accomplished. Develop the crucial ability to decide what not to do.

**Aligning and mobilizing.** A manager who leads aligns and mobilizes others to achieve objectives. This means seeking out other groups or people whose objectives are in line with yours and getting them to work shoulder to shoulder with you. You may also have to reach out to people who do not completely share your objectives, but whose support is so critical that you cannot progress without them. You may also have to deal with individuals or groups that are sabotaging or undermining your work.

However, your leadership can make others want to move forward with you, which is what we mean by mobilizing—participating in a campaign, talking with people who are affected by your work, and convincing them that their support will produce good outcomes for them as well as for their stakeholders.

Advocating for a service or a behavior that you want from others is a way of aligning and mobilizing. The essential skill needed for this practice is being able to connect and work with others toward a common vision, crossing boundaries of gender, professional status, language, cultural background, or politics.

**Inspiring.** “Inspiring” literally means “breathing life into” something. We can be inspired by people who believe in what they do, care about a cause, and know that others care, too. They are people whose example moves us to follow in their footsteps. Those who inspire us may be heroes or family members, friends, colleagues, teachers, politicians, or religious figures.

You do not have to be famous or a great public speaker to inspire others. Supervisors, for example, can inspire staff when they:

- look out for the interests of their supervisees;
- encourage them to be the best they can be;
- create an environment where employees can use their ingenuity;
- acknowledge efforts and successes or small acts of commitment and caring;
- take the time to turn failure into success.

People who inspire can tap into the vast reservoir of energy that is unused when people are demoralized, discouraged, or feel unacknowledged. Sometimes the simple act of saying thank you for work well done brings goodwill and energy. In our leadership programs,

we ask participants to acknowledge someone's effort or work once a day, both at home and at work, for six weeks. For those who made an effort to complete the assignment, not only did they report how positive and helpful people who were on the receiving end of these "thank you's" became, it also became a habit for them.

Inspiring becomes particularly important when things are not going well, when there are breakdowns or crises. Remember that looking for scapegoats or blaming people will undo all the inspiring you have done. On the other hand, staying positive, looking for opportunities to learn from adversity and acknowledging and validating the feelings people have (e.g., "it is understandable that you feel that way given all the hard work and the long hours you put into this...[when a project is prematurely terminated]") will go a long way towards keeping spirits up.

**Using the leading practices.** When you become more conscious of these leading practices, you will begin to be more systematic in how you approach challenges. You might ask yourself and your team, "Have we scanned enough?" "Are we focused enough?" "Have we aligned and mobilized the right people?" and "Are we inspiring our teams?"

When you do this, you will find that your team members become more confident about leading their own supervisees and co-workers to take on challenges and produce results. It is a matter of practice and coaching, of learning and being coached: sometimes you follow and sometimes you lead.

These practices do not require learning a whole new set of behaviors. Most people already know how to scan, focus, align and mobilize, and inspire—although they tend not to do those things consciously, systematically, or intentionally. Using a common language allows you to build on what you and your team members already know and to remind one another to keep doing it.

## THE PRACTICES OF MANAGING

Our definition of "managing" means planning and using resources efficiently to produce intended results. Given that organizational needs always exceed the resources that exist to satisfy these needs, no organization can succeed in this world without good management. "Whether we realize this or not," writes Joan Magretta (2002, p. 3), "every one of us stakes our well-being on the performance of management."

Managing well requires the conscious and systematic use of four practices: planning, organizing, implementing, and monitoring and evaluating. Most of us are familiar with these practices, which have been recognized in the for-profit sector for decades. As with leadership practices, we are building on what many people already know.

**Planning.** Managers who lead plan. The practice of planning requires you to think through the logical sequencing of activities and resources needed to achieve stated objectives. Without plans, your work environment will be chaotic and performance will be haphazard. All organizations and institutions require some form of planning to guide their efforts for both the long and short terms. They also need to match their plans with budgets, to be sure that they have the financial resources to carry out their activities.

Planning is a way to counter insecurity and ambiguity. It also indicates how separate pieces of work by units or individuals eventually lead to desired results. For a more complete description of planning skills and practices, see Chapter 5 of this handbook.

**Organizing.** Managers who lead must also organize work. The practice of organizing ensures that resources are available at the right time, in the right place, of the right kind, and in the right quantities to get the work done.

Organizing means making sure that you have in place the systems, procedures, and processes that make it possible for staff to execute assigned tasks. When you see to it that each vaccinator has a functioning cold box, a full supply of vaccines, and vehicles ready on the first day of an immunization campaign, you are organizing. An organized workplace means that people can find what they are looking for, whether it is medical supplies, timesheets, pens and paper, or permission to fill their cars with gasoline.

If being organized is not your strength, you can get better at it by working with someone who is good at organizing and learn from them. Sometimes visualization can help: visualize yourself executing the planned task from beginning to end and make a note of all the supplies, resources, permissions, and systems that you would need. For example, for a workshop, visualize the participants arriving at a venue: Where is the registration form? Who is sitting at the registration table? Are there signs and welcome letters explaining where participants should go and when? Are the name badges prepared? Is everyone receiving a conference packet with required reading, an agenda, and participant lists? How are participants being reimbursed for travel expenses? What's the formula for calculating reimbursements, and who is handling the money? And so on and so on.

**Implementing.** In the end, if you do not implement the activities presented in plans, you have wasted the effort spent producing them. There are many reasons why things do not happen or plans are not implemented, but few of them are valid excuses. If staff have no time to do the work or other resources are not there, either the planning or the organizing has gone awry. If the activities are not implementable or not acceptable, the scanning and focusing have not been done well.

Implementing requires decision-making, problem solving, coordination, negotiation, and communication—all skills that can be taught or improved through practice. The toolkit in [\*Managers Who Lead\*](#) has a number of exercises designed to help build these skills; there's a list on page 175. Consider which ones might be particularly appropriate for you and your team.

**Monitoring and evaluating.** Managers who lead monitor and evaluate how well their programs are doing. They set up feedback loops between the work and the results of the work, and between the worker and his or her observed performance. Monitoring and evaluation are needed to make sure that activities are progressing as planned and that intended results are achieved. This practice enables you to alter plans if they are not working and to learn lessons for future improvements. For a full discussion of monitoring and evaluation in the context of information management, see Chapter 9 of this handbook.

## INTEGRATING THE PRACTICES OF LEADING AND MANAGING

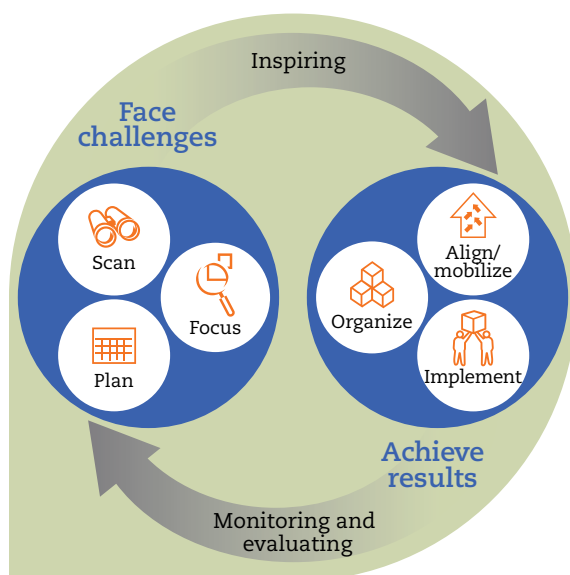
Although we have listed and discussed the practices of leading and managing sequentially, they actually repeat in a cycle, as shown in [Figure 3](#).

The practices also overlap, meaning that each practice has other practices implicit in it. For example, you cannot scan, align, and mobilize without focusing; and you cannot focus, align and mobilize, or inspire without scanning. This is equally true for the management practices; planning and organizing are empty shells if you do not implement the plans.

Inspiring is often implicit in successful aligning and mobilizing and requires some degree of focusing and scanning. The same is true for monitoring and evaluation, which depends on the other three practices of good management.

And finally, Figure 3 shows how the managing and leading practices are intertwined. You articulate a particular challenge, such as reaching more couples with family planning services, by engaging in scanning, focusing, and planning. You produce results by aligning, mobilizing, organizing, and implementing. The energy to do the work is partially fueled by inspiring people and appealing to their sense of purpose and values. Lessons learned about effectiveness and performance are cycled back into new plans through monitoring and evaluation.

FIGURE 3. Integrated Leading & Managing Process





## Leading and managing at the top

Leadership at the top levels of an organization is different from leading teams at lower levels, mostly because of the heightened visibility, the politics of power, and the fact that many crises are pushed upward to senior people for them to handle. In countries where many external agencies vie for the attention of top leadership, the pressure can become intense.

At the higher levels of leadership, management and governance practices start to blend: **Setting shared direction** is a combination of aligning, focusing, and inspiring; **cultivating accountability** requires a mixture of scanning, implementing, and monitoring; **stewarding resources** requiring a blend of planning, scanning, implementing, and monitoring; and **engaging stakeholders** requires a combination of inspiring, aligning, and mobilizing.

Anyone at a senior level in any organization has an impact that goes far beyond his or her unit or directorate:

- As **stewards** of the health of a large population, senior leaders like you are responsible for the whole system—which means that you have to be able to think systemically, clarify accountabilities, and optimize capacity at all levels—from your department or directorate all the way down;
- As **aligners and coordinators** of various constituencies, senior leaders like you have to promote and lead productive conversations and make sure that essential information reaches everyone;
- As the ones to whom others look for **guidance and inspiration**, senior leaders like you have to act from a shared vision and agreed-upon strategies, model the behavior that is desired throughout the system, and set the tone for a positive and empowering work climate.

### BALANCING ACTS

The reality of leading and managing at the top is that you must constantly choose between competing demands. You have to pay attention to one thing—while not neglecting or appearing to neglect other options—and to discern the best course of action at each moment. [Box 2](#) illustrates these balancing acts.

While you engage in these balancing acts, you are expected to provide leadership in at least five ways:

1. Set direction for the health system *as a whole*.
2. *Continuously* communicate the vision and direction.
3. Engage with *internal and external* stakeholders for alignment, but also for bringing in new ideas.
4. Coordinate and integrate planning and execution *across the entire system*.
5. *Continually* reflect, learn, and improve performance.

### BOX 2. Striking a Balance

If you lead and manage at the top, you will need to learn to balance:

- the needs of the present AND the needs of the future: the necessity of crisis management on the one hand and the slow and steady pursuit of long-term strategy on the other;
- the needs of diverse stakeholders: the need to respond to pressure from specific groups on the one hand AND, on the other, the need to pay attention to the organization's management systems as a whole;
- the use of authority AND the need for inclusion: the pressure to decide and act quickly on the one hand and, on the other, the need to take the time for reflection, collective learning, and empowerment;
- the need for “fit” of the organization, seeking coherence that comes from centralization and control in order to create synergies AND “split,” seeking the opposite by giving freedom to individual units and staff to create, differentiate, compete, and produce the variety that is essential to innovation and adaptation to an ever-changing environment. (Stacey, 1992).
- preventive and curative health services: heeding calls to seek the greatest good for the greatest number of people on the one hand AND to improve curative care for all and tertiary care for the few, on the other.

Each of these roles brings with it countless challenges. To face these challenges with confidence, you need specific skills, as follows.

**Seeing and operating from the big picture.** Seeing the big picture is necessary to create a shared vision, set strategies, and maintain the long view. This perspective will help you reorient people's attention and energy when they become immersed in struggles over short-term interests or are unsure how to prioritize their work.

[Chapter 5](#) of this handbook discusses in detail the nature of a shared vision, how to create one, and its importance to an organization and effective strategic planning.

**Communicating the vision.** Managers who lead know how to communicate, over and over and in many different ways, where their organization and staff are headed and why so that all are rallied around the organization's vision. By communicating the vision and getting others in key positions to reinforce it, you demonstrate that you are on the same team and that you are all progressing together, even when there is tension around competing ideas and rivalry for resources and recognition.

**Recognizing stakeholders' interests.** The ability to bring stakeholders together, negotiate, and manage the tension that comes from competing interests and agendas, and turning conflict into win-win situations for maximum effectiveness is essential to leadership and good governance. Recognizing others' interests will help you find allies, as well as anticipate and be prepared for any groups whose interests are in opposition to your organization's mission, values, and goals.

The [Managers Who Lead Toolkit](#) includes an exercise on pages 195–197 for analyzing stakeholders' interests.

**Making the best use of your time.** Delegation will save you time. If you are aware of and trust your colleagues' strengths and capabilities, you will be comfortable delegating tasks, freeing up time to pay attention to things that need leadership and good governance at the highest levels. In the process, you are developing your staff. Delegation should be coupled with setting priorities: determining the extent to which your many tasks contribute to or detract from achieving the vision. You must know how to lead meetings effectively, saving not only your time but also the time of everyone who attends. Careful listening and observation will enable you to respond thoughtfully to issues and avoid the crises that can consume everyone's time and energy.

**Soliciting feedback and advice.** Asking for feedback—positive and negative—from colleagues and subordinates will help you work with others to address issues effectively. Acknowledging that you can always improve will strengthen your personal support system, which you can go to for advice and sustenance during difficult times.

### PITFALLS AT THE TOP THAT CAN BRING YOU DOWN

A few attitudes and behaviors on your part can derail and disrupt the functioning of the entire organization. In your position of leadership, you will want to be especially alert to these pitfalls and to avoid or correct them wherever you find them, in others or in yourself.

**Hubris.** Hubris: excessive pride or arrogance. Hubris is easy to spot. You can see it in people who have become overconfident in their own abilities and do not believe they could ever fail or be wrong.

Although it is often difficult to bring someone who is suffering from hubris down to earth, you can make sure that you do not let yourself fall into this trap. When things have been going too well for too long, when no one dares to disagree with you, or when close friends or colleagues seem less comfortable around you, these may be signs that you need to take action. You can ask for corrective, as well as supportive, feedback. You can make a point of assisting others to reach their objectives and rejoice in their success without taking credit for their achievements. Finally, you can show some genuine humility by recognizing your limitations and not taking yourself too seriously.

**Fear.** Many organizational mishaps, derailments, misuse of resources, or even disasters result from fear of real or imagined consequences of speaking “truth to power.” Big firms and small organizations have collapsed or been reduced to insignificance because the rank and file did not dare to question the foolhardy or unethical practices and decisions of their top leaders.

Fear exists throughout the ranks of some organizations, from top to bottom, although the reasons for fear usually differ, depending on the level. At the top, the fear is about being humiliated, removed from power and, in some places, a fear for one's safety. Fear at the bottom of the organizational ladder is primarily about losing one's job and livelihood, being passed over for promotion, or being sidelined.

In your leadership role, you can do a great deal to set a tone that reduces fear at all levels. If you demonstrate the willingness to listen respectfully to dissenting opinions, your staff will feel free to express them. If you encourage and reward appropriate risk-taking, accepting that some ventures will fail, you will set an example for managers throughout your organization. If you refuse to tolerate humiliating behavior or abuse of power, others will follow in your footsteps.

**Lack or betrayal of trust.** Where fear is pervasive, trust tends to be low. Trust is a precious resource in organizations, but people often squander it by repeatedly betraying others. People's ability to trust depends on two things: trust in oneself and trust in others.

The exercise in [Box 3](#) will help you consider your own levels of trust. It is taken from the work of Dennis and Michelle Reina (2006).

Repeated betrayal of trust has important consequences for an organization's climate, because the result of untrustworthiness is low productivity. When this is the reality in your organization, you have some options.

As a manager or supervisor of someone who feels betrayed, you can make good use of the practices of leading. As indicated by Dennis and Michelle Reina (2006), you can scan to get the facts and acknowledge what happened that caused people to feel their trust was betrayed. You can then focus on the feelings that the betrayal has created and make space for people to express themselves so that those feelings will not come out in other ways that you cannot see or manage. This is the time for you to offer your support, realign people with the organizational vision and mission, and redirect everyone's energy toward the future.

### BOX 3. Reflective Exercise on Trust

On a piece of paper, write your answers to the following questions:

- In what types of situations do I trust myself?
- In what situations do I not trust myself?
- In what ways do I consider myself reliable?
- In what ways do I feel that I am unreliable?

Continue the exercise with the following questions:

- In what situations do I trust others?
- In what situations do I not trust others?
- What do I look for when considering whether another person is trustworthy?
  - Do I assume they are trustworthy unless proven otherwise?
  - Do I wait for people to prove that they can be trusted?
- How does this affect my relationships at work?

After writing the answers to these questions, decide whether there is there anything you would like to change about the way you trust (or do not trust) others and yourself.

Source: Reina 2006.

TABLE 1. The Betrayal Continuum

MAJOR		MINOR	
Unintentional	Intentional	Unintentional	Intentional
Restructuring resulting in layoffs	Disclosing organizational secrets	Repeatedly arriving late (at work, at meetings)	Gossiping, backbiting
Delegating without giving authority	Sabotaging organizational data	Not honoring agreements	Accepting credit for another's work

Source: Reina 2006.

If you are the person who feels betrayed, whether by superiors or subordinates, you can begin by drawing on the same leading practices: scan the situation as objectively as possible, acknowledge the facts, and then focus on your feelings of betrayal by naming them and expressing them. Now you will be ready to align with others and get their support in helping you reframe the experience. This will involve moving beyond a sense of victimization to look honestly at what you may have contributed to the experience. The final steps are to forgive yourself and the other(s), drop the heavy load of anger and resentment, and move forward.

Dennis and Michelle Reina propose that betrayal—whether intentional or unintentional—can have repercussions that fall along a continuum from major to minor. [Table 1](#) illustrates the continuum with a few examples.

## Leader shifts: A change in thinking and behavior

So far, we have stressed the importance of behaviors by introducing practices rather than personality traits or personal attributes. However, behaviors are not enough. Our behaviors are anchored in how we think. Therefore, attitudes are important, too.

We have observed that managers who lead think differently from those who do not lead; they are more conscious of and systematic and intentional in their actions. They reflect more about what they do as they interact with others at work. And when they get better at applying the practices of managing and leading and at reflecting on what happens as a result of their actions, they notice that something else begins to change. They see the world differently.

We call these changes in attitudes and beliefs “leader shifts.” [Table 2](#) describes some of the shifts in attitudes that most clearly define a manager who is learning to lead.

Awareness of these leader shifts is an important part of the transformation you can bring about in yourself and others. But be warned: the shifts may not represent permanent changes. They tend to occur when you are feeling competent and are doing good work that makes a difference in the lives of others. When things are not going so well, they may begin to slide away.

Your personal challenge is to monitor yourself and recognize when you are becoming more preoccupied with your own needs, reputation, or image and less focused on the common good.

TABLE 2. Leader Shift

FROM	TO
counting on individual heroism	collaborative action
despair and cynicism	hope and possibility
blaming others for problems	taking responsibility for challenges
scattered and disconnected activities	purposeful, interconnected actions
a preoccupation with oneself	a concern for the common good and generosity toward others

Let’s take a closer look at each shift and see what you can do to develop and maintain these changes in yourself.

**Leader Shift 1: From heroic leadership to collaborative action.** The challenges you face cannot be addressed by thinking that some heroic leader (for example, your supervisor, your executive director, the Minister of Health, or a donor) will come to the rescue. Nor does it help if you think that you must—and are the only one who can—solve all prob-

lems. This leader shift brings with it a recognition that it takes “all hands on deck” to do difficult work and that developing and acknowledging everyone on the team is critical, even when there are dissenting voices.

To move toward collaborative action, ensure that everyone is clear about and has agreed to their roles and responsibilities, and then hold them accountable for fulfilling them. Check that you are delegating tasks that you do not need to execute yourself and that others can do. If you are holding on to work you could delegate, ask yourself why. Are you comfortable letting people learn from their mistakes?

See Box 4 to learn more about how to make the shift from heroic leadership to collaborative action.

#### BOX 4. Moving in the Right Direction: Away from Heroic Leadership and toward Collaborative Action

Even if you could do it all—and you can’t—it’s a bad idea. Teams work best when their members play four critical roles:

1. **initiate** (an idea or action)
2. **follow** (accept the new idea)
3. **oppose** (question the idea to make sure decisions are not made impulsively and to sharpen the team’s thinking)
4. **observe** (watch and give feedback on how the team is doing)

Are all these roles represented on your team? If you are always the initiator, try playing a different role, perhaps following another team member’s lead or sitting back and observing. You will find suggestions in the exercise [“Understanding Roles in Teamwork,”](#) in *Managers Who Lead* (MSH 2005, Toolkit, p. 248).

In addition, practice speaking less, listening more, and leaving more room for others. Ask yourself:

- **If there is conflict:** How am I dealing with the conflict? Am I avoiding it and letting it simmer? Am I dealing with it too directly? Do I know where to seek help in dealing with conflict on my team?
- **If you call a meeting:** Do I have a clear outcome for our meeting in mind? Have I designed the agenda so that it will lead us to the desired outcomes?
- **Before you speak at a meeting:** Is everyone fully participating? Am I achieving a balance between inquiring about others’ viewpoints and advocating my own? Am I listening to others as if their viewpoints matter? Has someone already said this? Can someone else say this better than I can?
- **If points of view differ:** Am I willing and able to negotiate if we seem stuck? Do I try to understand the interests that underlie positions? Do I have an alternative if we cannot come to agreement?



**Leader Shift 2: From despair and pessimism to optimism and hope.** It is hard to attract followers if you preach a message of despair and powerlessness. Yet most planning methodologies start by listing all the problems, which can quickly overwhelm a group and feed a feeling of helplessness. Ask people about their dreams and see how their eyes light up. Conflicted parties can find common ground in a shared vision and change their positions about how to deal with obstacles.

See Box 5 for some ideas on how you can make the shift from despair and pessimism to optimism and hope.

**BOX 5. Moving in the Right Direction: Away from Despair and Pessimism and toward Optimism and Hope**

- Learn how to create a shared vision. You can do this by asking people about their hopes and dreams for the team, unit, department, organization, or community. Avoid abstractions, which usually have less power than concrete images. An image of “a clinic I would send my sister or mother to” is more powerful in propelling people into action than “a clinic with high quality of care.” The more detailed and concrete the image, the more power it has to attract people to work toward its realization.
- Shared visions can be idealistic and long range, but they can also be immediate. For example, a team could envision an outcome for a meeting. Get into the habit of always asking yourself and your team members what success would look like.
- Once you have agreed on your vision, you can work backwards by asking, “If that is what we want, what stands in the way of achieving it?” This way of thinking allows you to identify the obstacles that are obscuring the vision. Resist the temptation to start working on obstacles without knowing the vision that these obstacles obscure.
- When you give feedback to a staff member on a piece of work, start with the positive. Begin by stating what is good and should be continued. Then consider the opportunities for improvement, and, as a last step, what needs to be stopped or removed.
- This leader shift requires that you develop the leadership practice of inspiring your staff and breathing life into their work by appealing to their hopes and values. Remember, it is much more compelling to think of your goal as a dream to be realized than as a problem to be solved.

**Leader Shift 3: From blaming others to taking on challenges.** Reframing an issue from being a problem that is caused by—and must be solved by—others to being a challenge that you will take on is not just a matter of using different words. By looking at the issue in a new way, you can stop feeling like a helpless victim and become an agent of change.

See [Box 6](#) for ideas about how to shift from blaming others to taking responsibility for challenges.

### BOX 6. Moving in the Right Direction: Away from Blaming Others and toward Taking on Challenges

If you are alert to the following, you will probably become more positive and effective.

- **Learn to recognize feelings of powerlessness** that make you feel passive.
- **Look for examples of successful actions** that you and others have taken to accomplish things that did not seem possible, such as earning a degree, writing an article, or leading a team to improve the quality of care at a clinic.
- **Consider how you might be contributing to problems.** For example, a disorganized clinic may reflect your own disorganization or, conversely, your excessive control of details, which keeps employees from developing a sense of responsibility. A difficult relationship with a staff member may be at least in part due to your own attitudes and behaviors.
- **Practice reframing a problem into a challenge** by setting up a tension between a desired future situation and a current, undesired situation. For example, “How can we ensure a consistent supply of contraceptives to our clinic in spite of seasonal inaccessibility?”
- **Use proactive language,** rather than reactive language. Instead of saying, “There is nothing I can do!” say, “Let’s see what we can do about that.” Instead of saying, “That’s just how things are,” say, “How can I (or we) change this?” Instead of saying, “They will not allow that,” see if you can negotiate. Instead of saying, “I have to” or “No one will help me,” try saying, “I want to” or “Could you help me?”

**Leader Shift 4: From disconnected activities and busyness to concerted and purposeful action.** Overspecialization can lead to the creation of independent vertical programs and separate organizational units, and inhibit development of a comprehensive approach to improving health services. The activities and solution applied in one program might undermine progress in others. For example, increased funding for HIV and AIDS programs has, in some instances, led to underfunding of family planning programs, even though they should be an integral part of any effort to prevent HIV transmission.

In addition, people who are preoccupied with their specific area of responsibility often lack the time to share ideas with people working in other relevant areas and miss opportunities to work together and contribute to each other’s objectives. Services, projects, or programs often have performance objectives that do not take into account what other related services, projects, and programs are doing, even those in the same geographic area, organization, or facility. So there is much duplication and waste of resources.

**Box 7** shows what you can do to shift from being engaged in disconnected activities and busyness to concerted and purposeful action.

### BOX 7. Moving in the Right Direction: Away from Disconnected Activities and Busyness and toward Coordinated and Purposeful Action

Learn to set priorities among your many tasks by looking at how each contributes or detracts from your intended results. A handy way of classifying competing demands is to distinguish “urgent” from “important.” Urgent activities are those that demand your immediate attention (often crises or “problems”), while important ones are those that contribute to your organization’s mission, values, and most important goals (Covey 2004).

With your team members, use the [Important and Urgent Matrix and exercise](#) (MSH 2005, Toolkit, pp. 213–215) to classify the activities of your typical work week. Give highest priority to those that are most important but not urgent, such as securing approvals and budgets ahead of time. Think of tasks like these as preventive, proactive work that will prevent crises later.

Bring your team members together and use their diverse skills and perspectives to solve problems as they occur. Ask for advice and input rather than trying to solve everything on your own.

Celebrate successes and small victories as a team rather than just singling out individuals for special recognition. Remind people of the mission and vision that you created together. Help people see how their work enhances or complements the work of other members of the team.

**Leader Shift 5: From a preoccupation with oneself to generosity and a concern for the common good.** When you feel hurt or diminished by an unsuccessful effort or a sense of having been treated unfairly, your world shrinks and your focus is likely to shift inward. You may find yourself dwelling on your own needs, whether these are physical—a body that needs to heal—or psychological—recovery from a disappointment, insult, or trauma.

The feeling that you are entitled to special privileges might accompany this self-focus. Many lapses in ethical behavior by those in charge can be linked to excessive concern about comfort, status, or prestige at the expense of the common good.

As long as you remain focused on yourself, for whatever reasons, you can no longer be effective or partake of the world around you, especially when there is work to do that requires compassion and concern for others. Your self-absorption will interfere with your ability to provide the stewardship that the health system needs from you.

See [Box 8](#) to find out what you can do to shift from a preoccupation with yourself to a concern for the common good.

### BOX 8. Moving in the Right Direction: Away from Self-Preoccupation toward Generosity and Concern for the Greater Good

- Check your motives whenever you find yourself a little too invested in being right, acknowledged, recognized, or simply comfortable. Are you forgetting about the bigger picture and your role in it?
- Remind yourself of your role and responsibility to help realize the mission and vision of the organization, agency, team, or department that you are leading.
- Think about the people you are serving, both your staff and your organization's beneficiaries, and check whether your attitudes and actions are helping them or distracting you from helping them.
- You can use ethical decision-making models to guide you. One of the simplest and most powerful appears in the tenets of all the world's major religions: "Do unto others as you would have others do unto you."

## Learning to manage and lead: A proven methodology for learning in action

It is common to hear people complain about the performance of their team, organization, district, or hospital, but few know how to play an active role in turning things around. They are so overwhelmed by the many obstacles they face that they remain passive. No one sees a way out.

The Challenge Model ([Figure 4](#)) is a tool that you can use right away to improve the performance of any group. It consists of a series of questions that help you and your team to systematically translate dreams into action.

If you follow the steps, completing each one before moving onto the next, you will be able to bring about positive change. This may not happen as fast as you would like, but the careful, thoughtful process is more likely to lead to lasting results.

**Step 1:** Start with a fundamental question about purpose, "Why are we here?" For most organizations, this question is answered in their founding documents: the organizational **mission**, or, for government agencies, the legislative act that created them.

**Step 2:** Stephen Covey (2004) teaches us to "begin with the end in mind." Thus, the next question is, "What would we like to create that currently does not exist?" This is the **vision** of a better future.

Although dreaming about a better future can be a creative, inspiring act, stopping at that point can lead to discouragement and even despair, especially if your current situation is far removed from your dream. The vision becomes compelling when you take the next step—defining actions to bring it down to earth.

**Step 3:** Now it is time to ask, "Where are we now?" In this step, you and your team will look at your **current situation** in relation to your vision. This step calls on the leadership

FIGURE 4. The Challenge Model: From Vision to Action to Results

**Mission:**

**Vision:**

**Measurable result:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Obstacles and root causes**

**Priority actions**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Current situation:**

\_\_\_\_\_

**Challenge:**

\_\_\_\_\_

[ How will we achieve our desired result in light of the obstacles we need to overcome? ]

practice of scanning: talking and listening to people, checking records, visiting facilities and communities, reading reports. It will help you create a baseline.

This is a critical step that is often overlooked because people often think that they know the current situation when, in fact, they are only seeing what they expect to see or have made a series of assumptions that may or may not be correct. How often is fiction confused with facts? Only a closer look can determine the reality. This may be the first time you and your team gather data or interview people you have never talked with before. A benefit of this exercise is that you will begin to appreciate, if you did not already, the importance of having good information systems and accurate and timely sources of information.

By thoroughly exploring the current situation, you are likely to discover factors that you consider unacceptable. This may produce indignation and anger, which you can transform into a resolve to mobilize yourself and others into action. It is at this point that you are ready to formulate your **challenge**, “How can we get to our vision, given that our current situation is...?”

**Step 4:** Once you have created a shared vision and have a good sense of the current reality, you and your team can focus on one aspect of the vision, something to work on right now. You can ask yourselves, “What can we achieve that will bring us a little closer to our vision?” The answer will be a **result** that is SMART:

- S** = Specific
- M** = Measurable
- A** = Appropriate<sup>1</sup>
- R** = Realistic
- T** = Time bound

The desired result should not be grandiose, but it should be a stretch, something you might not have accomplished if you had not taken on the challenge.

**Step 5:** The next question is, “Why are things the way they are?” This question helps you identify the **obstacles** that stand in the way of achieving your SMART result. It leads to other, more specific questions: “Why are people not showing up for work?” “Why are clients not coming back for resupply of contraceptives?” “Why haven’t we fixed this?” and “Why did we not know about that?”

The temptation at this stage is to blame poor performance on a lack of resources or deficient systems. This does not help much in finding a remedy. You will need to explore the answer to another specific question: “If this matters to us and our clients, why are we not putting sufficient resources behind it?” After all, it is rarely the case that there is no money at all in the system; the question relates to allocation and decision-making. Digging beneath the surface to find the **root causes** of the obstacles is likely to provide ideas for possible solutions. [Appendix A](#) of this chapter shows you how to use a fishbone diagram to uncover root causes and the five whys technique to fully understand them.

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1. Sometimes, the A stands for Achievable (which is similar to Realistic) and the R stands for Relevant (which is similar to Appropriate).

**Step 6:** After you and your team have identified and deepened your understanding of the root causes of the symptoms that show up in the current situation, you can begin to select the **priority actions** that might address those root causes. As health professionals, we know that treating symptoms can be costly and ineffective if the underlying causes are not addressed.

You will now need to identify those priority actions that are most likely to lead to success, asking two questions: “What interventions have proven successful in similar situations elsewhere?” and “Given the resources we have available, what are the things we can do right now?”

Up to this point, you have drawn on the leadership practices in answering the Challenge Model questions. You have created an inspiring vision; you have scanned the current situation, the root causes of obstacles, and the available interventions; you have focused on a measurable result and priority actions to achieve it; and you have aligned and mobilized your team to go through the entire process.

**Step 7:** Once you have done all the groundwork in the previous steps, you have everything you need to develop a feasible action plan to meet your challenge. Now the management practices come into play as you and your team plan the activities your organization will undertake, organize your resources for implementation, monitor the plan’s execution, evaluate the outcomes, and learn from them.

As a manager who leads, you can use the Challenge Model to create a road map for your team and yourself, no matter what your clinical or management specialty might be.

[Chapter 2 of \*Managers Who Lead\* has extensive information about using the Challenge Model.](#)

## Proven practices

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- You can strengthen your management and leadership skills no matter what position you hold: good management and leadership are needed at every level of an organization. If you do what you already know more consciously, systematically, and intentionally, and if you encourage your staff to do the same, you can become a “manager who leads.”
- Understanding and applying the [12 management, leadership, and governance practices](#) can help you and your staff enhance your work environment, improve management systems, prudently raise and allocate resources, proactively respond to change, and take ownership of your challenges. These changes will result in better services for your clients and their communities.
- If you monitor [“leader shifts”](#) in your own attitudes and beliefs, you can maintain the positive changes and resist any tendency to slide back into a preoccupation with your own needs, reputation, or image, rather than a focus on the common good.

- **The Challenge Model** is a simple tool for systematically translating dreams into action. By tying your day-to-day work to a compelling vision and carefully following the steps of the model, you and your team can get through difficult times and produce significant public health results.

## Glossary of management and leadership terms

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**challenge model:** A graphic analytical tool that helps users, in a systematic fashion, to determine how to get from a present undesirable situation to a desired and measurable result that contributes to achieving the vision and realizing the mission.

**governance:** A collective process of making decisions in organizations, health systems, or the health sector. Governance is (1) setting strategic direction and objectives; (2) making policies, laws, rules, regulations, or decisions, and raising and deploying resources to accomplish the strategic goals and objectives; and (3) overseeing and making sure that the strategic goals and objectives are accomplished.

**leader shift:** A change in a leader's attitudes, beliefs, and behavior.

**leading:** Mobilizing others to envision and realize a better future.

**leading and managing:** Enabling oneself and others to set direction, face challenges, and achieve results.

**manager who leads:** Someone who enables him- or herself and others to face challenges and achieve results.

**managing:** Planning and using resources efficiently to produce intended results.

**mission:** A clear and concise statement of an organization, program, or team's reason for being, an affirmation that answers the question, "Why do we exist?" A mission provides orientation, uniformity, and meaning to the organization's decisions and activities at all levels. It is the core around which staff members focus their best efforts.

**SMART result:** A specific, measurable, appropriate, realistic, and time-bound outcome.

**vision:** A picture of a desired future state that a team, organization, project, or program can move toward by taking action.

**work climate:** The prevailing atmosphere at work, as employees experience it.



## References and resources

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- Abrams, I., ed. "Rigoberta Menchú Tum: The Nobel Peace Prize 1992," in *Nobel Lectures in Peace 1991–95*. Singapore: World Scientific Publishing Co., 1999, [http://nobelprize.org/nobel\\_prizes/peace/laureates/1992/tum-bio.html](http://nobelprize.org/nobel_prizes/peace/laureates/1992/tum-bio.html) (accessed July 4, 2009).
- Bragar, Joan L. *Effective Leadership Practices for Managers: Balancing Interdependence and Autonomy*. PhD diss., Cambridge, MA: Harvard University Graduate School of Education, p. 143.
- Brown, Jonathan C., Didem Ayvalikli, and Nadeem Mohammad. *Turning Bureaucrats into Warriors: Preparing and Implementing Multi-Sector HIV/AIDS Programs in Africa: A Generic Operations Manual*. Washington, DC: The World Bank, 2004, <http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/EXTAFRHEA-NUTPOP/EXTAFRREGTOPHIVAIDS/0,,contentMDK:20488911~pagePK:34004173~piPK:34003707~theSitePK:717148,00.html> (accessed December 4, 2009).
- Covey, Stephen R. *The Seven Habits of Highly Effective People: Powerful Lessons in Personal Change*. New York: Simon & Schuster, 2004.
- Covey, Stephen R., A. Roger Merrill, and Rebecca R. Merrill. *First Things First*. London: Simon & Schuster, 1994.
- Daloz Parks, Sharon. *Leadership Can Be Taught: A Bold Approach for a Complex World*. Boston, MA: Harvard Business Press, 2005.
- Fritz, Robert. *The Path of Least Resistance: Learning to Become the Creative Force in Your Own Life*. New York: Fawcett Columbine, 1989.
- Greenleaf, Robert. K. *The Power of Servant Leadership: Essays*. Edited by Larry C. Spears. San Francisco: Berrett-Koehler Publishers, 1998.
- Heifetz, Ronald A. *Leadership without Easy Answers*. Cambridge, MA: Belknap Press of Harvard University Press, 1994.
- Heifetz, Ronald A., and Donald. L. Laurie. "The Work of Leadership." *Harvard Business Review* vol. 75, no. 1, (1997): 124–34.
- Heifetz, Ronald A., John V. Kania, and Mark Kramer. "Leading Boldly: Foundations Can Move Past Traditional Approaches to Create Social Change through Imaginative—and Even Controversial—Leadership." *Stanford Social Innovation Review* (Winter 2004): 21–31, [http://www.ssireview.org/articles/entry/leading\\_boldly/](http://www.ssireview.org/articles/entry/leading_boldly/) (accessed Dec. 4, 2009).
- Kotter, John P. "What Leaders Really Do." *Harvard Business Review* vol. 68, no. 8 (1990): 103–11.
- . "Leading Change: Why Transformation Efforts Fail." *Harvard Business Review* vol. 73, no. 2 (1995): 59–67.
- . *Leading Change*. Cambridge, MA: Harvard Business Press, 1996.
- . "Why Change?" *Executive Excellence Publishing* vol. 15 (1998): 5.

- Kouzes, James M., and Barry Z. Posner. *The Leadership Challenge: How to Get Extraordinary Things Done in Organizations*. San Francisco, Jossey-Bass Publishers, 1987.
- Lewin, K. *Field Theory in Social Science: Selected Theoretical Papers*. Edited by Dorwin Cartwright. New York: Harper & Row, 1951.
- Magretta, Joan. *What Management Is: How It Works and Why It's Everyone's Business*. New York: Free Press, 2002.
- Management Sciences for Health. "Managers Who Lead Effectively: Internal Report on the Management & Leadership Project's Leadership Inquiry." Cambridge, MA: Management Sciences for Health, 2000.
- . *Managers Who Lead: A Handbook for Improving Health Services*. Cambridge, MA: Management Sciences for Health, 2005. [www.msh.org/resource-center/managers-who-lead.cfm](http://www.msh.org/resource-center/managers-who-lead.cfm) (accessed April 23, 2010).
- Mansour, Morsi, Joan Bragar Mansour, and Abdo Hasan El Swesy. "Scaling Up Proven Public Health Interventions through a Locally Owned and Sustained Leadership Development Programme in Rural Upper Egypt." *Human Resources for Health* vol. 8, no. 1, 2010, <http://www.human-resources-health.com/content/pdf/1478-4491-8-1.pdf> (accessed Feb. 17, 2010).
- Raelin, Joseph A., and David Coghlan. "Developing Managers as Learners and Researchers: Using Action Learning and Action Research." *Journal of Management Education* vol. 30 (2006): 670–89.
- Reina, Dennis, and Michelle L. Reina. *Trust and Betrayal in the Workplace—Building Effective Relationships in Your Organization*, 2nd ed. San Francisco: Berrett-Kohler, 2006.
- Schein, Edgar H. "Kurt Lewin's Change Theory in the Field and in the Classroom: Notes Toward a Model of Managed Learning." *Systems Practice*. <http://link.springer.com/article/10.1007%2F02173417> (accessed December 4, 2009).
- Senge, Peter M. *The Fifth Discipline: The Art and Practice of the Learning Organization*. New York: Doubleday Currency, 1990.
- Srivastva, Suresh, and David L. Cooperrider. *Positive Image, Positive Action: The Affirming Basis of Organizing: Appreciative Management and Leadership*. Euclid, OH: Williams Custom Publishing, 1999.
- Stringer, Robert. *Leadership and Organizational Climate*. Upper Saddle River, NJ: Pearson Education, Inc., 2002.

## APPENDIX A. Diagnosing Root Causes—The Fishbone Diagram and Five Whys Technique

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### THE FISHBONE DIAGRAM

After using the Challenge Model to uncover obstacles that keep you from achieving your intended result, you can use the fishbone diagram to identify the root causes of those obstacles.

Continue working with your team so you can draw on the knowledge and perspectives of many people, which will improve the quality of your analysis. If possible, draw the Fishbone Diagram shown in [Figure A-1](#) on a flip chart or chalkboard so everyone can look at it and discuss it together.

**Step 1:** Write one obstacle you have defined in your Challenge Model in the box on the far right of the Fishbone Diagram.

**Step 2:** Brainstorm possible reasons why this obstacle is creating a gap between the current situation and your intended result. Discuss each of the main factors—people, policies, processes and procedures, and environment—and how it might contribute to the obstacle.

- People: knowledge, skills, motivation, support
- Policies: rules and regulations that you have the ability to affect
- Processes and procedures: standards, equipment
- Environment: Ministry of Health, community, other stakeholders

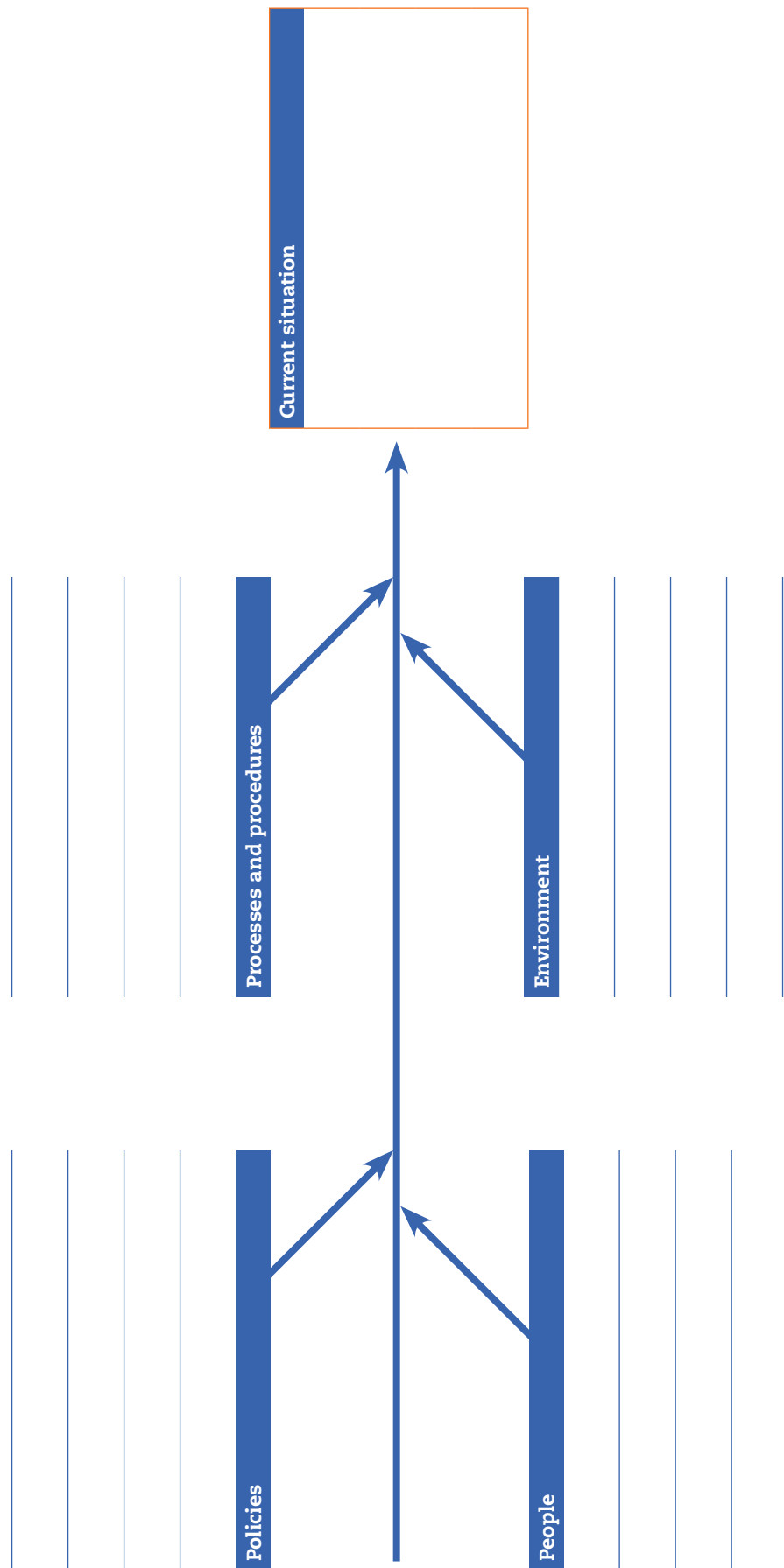
Using these four categories will help you organize your ideas. As a group, look for the possible causes of the performance gap and classify them by category. You can select other categories if these four don't apply to your situation.

**Step 3:** Write the possible reasons on the diagram, grouping them by category. The categories are connected to the central spine of the diagram.

**Step 4:** Identify the causes that are most responsible for the problem. Do this by probing deeper to understand the factors that sustain the current situation and keep you from moving to your desired result. Use the [Five Whys technique](#) (see next page) to help you probe.

Discuss and select those causes that, if successfully addressed, will allow you to make the most progress toward the desired result. Circle these causes.

FIGURE A-1. The Fishbone Diagram

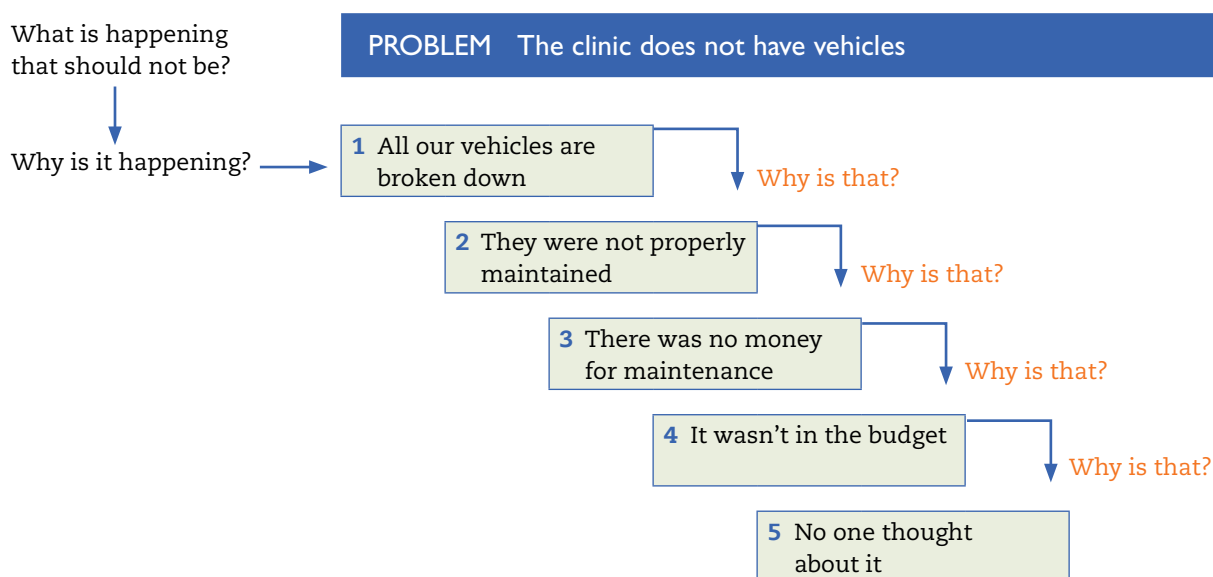


## THE FIVE WHYS TECHNIQUE

The Five Whys exercise is a questioning technique developed by Imai Masaaki and made popular as part of the Toyota Production System in the 1970s. It will help your team get beyond obvious symptoms and identify the primary or root causes of a problem. Asking “why” five times prevents mistaking symptoms for causes and gives a more complete picture of how the problem came into being.

When you are working with a cause-and-effect diagram and have identified a probable cause, ask, “Why is that true?” or “Why is that happening?” To each answer ask “why” again. Continue asking “why” at least five times, until the answer is “That is just the way it is, or that is just what happened.” Then you can work on addressing the underlying factors that are truly causing the problem.

FIGURE A-2. An Example of the Five Whys Technique



## CHAPTER 3

# Governance of Health Systems and Health Organizations

*Mahesh Shukla  
Lourdes de la Peza  
Karen Johnson Lassner*

1. Achieving Results by Strengthening Health Systems
2. Leading and Managing: Critical Competencies for Health Systems Strengthening
3. Governance of Health Systems and Health Organizations
4. Mainstreaming Gender Equality into Health Systems
5. Planning the Work and Working with the Plan
6. Managing Human Resources
7. Managing Finances and Related Systems
8. Managing Medicines and Health Products
9. Managing Information: Monitoring and Evaluation
10. Managing Health Service Delivery

This chapter is intended to support the important work of the leaders who govern health service delivery organizations. While the principles and practices described in this chapter apply to diverse organizations in a country's health sector, including health insurance organizations and pharmaceutical and biomedical supply organizations, the focus here is principally on organizations that deliver health services or advocate for better health care and health gain.

This chapter can help governing bodies improve their performance and their decision-making processes. It examines the essential roles and duties of governing bodies of health services delivery organizations—what they do—and explains that they can best fulfill their roles and accomplish their duties by mastering four key governing practices.

There are four main sections in this chapter. The first presents the four essential practices for good governance in health sectors and health institutions. The second, third, and fourth sections explain the application of the four practices within governmental organizations, multi-sectoral organizations, and nongovernmental organizations (NGOs) or civil society organizations (CSOs), respectively.

While governance for health also occurs at the trans-national level (for example at the World Health Organization, World Trade Organization, and World Bank), this chapter focuses on governing multi-sectoral, public, and not-for-profit organizations dedicated to planning, coordinating, and delivering health services to respond to communicable and non-communicable diseases. The chapter also covers governing within a ministry of health, provincial and district health governance, and community health governance.

## Introduction

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Governance for health is a process in which a group of international, national, subnational, or community leaders create (via policies, regulations, and oversight activities) the conditions in which scarce resources are mobilized and deployed to protect, promote, or restore the health of populations. The four key practices of good governance are to:

1. cultivate accountability
2. engage stakeholders
3. set strategic direction
4. steward resources

Those who manage health services organizations will increasingly need to interact with, work for, and partner with governing bodies. Their work and performance as health managers can be enhanced by productive partnership with the governing body or, in the absence of a productive relationship, can face significant frustrations and constraints affecting the success of both their organization and their career.

It is important to understand the basic role of a governing body. It is the party responsible for making policies and strategies and mobilizing resources for accomplishing the mission of the organization. The fundamental role the governing body plays in addition to management oversight is to be the champion for and conscience of the organization's mission (the reason the organization exists), and to ensure that this mission contributes optimally to meeting the needs of the population the organization exists to serve. The duties of care, loyalty, and obedience are the governing body's legal responsibilities; they describe the manner in which the governing body carries out the central role of oversight for the organization's mission.

**Duty of Care** is the responsibility of the governing body to gather and consider all reasonably available and pertinent information before taking action. The members of the governing body should act in good faith, with the care of an ordinarily prudent person in similar circumstances, and in a manner they reasonably believe to be in the best interests of the organization.

**Duty of Loyalty** expects the governing body and its members to candidly discharge their duties in a manner designed to benefit only the health services organization, not their own individual interests. It includes the duty to disclose situations that may present a conflict—or a potential for conflict—between themselves and the organization's mission, as well as the duty to avoid competition with the organization.

**Duty of Obedience** requires the governing body to ensure that the organization's decisions and activities adhere to its fundamental purpose and mission, usually stated in the organization's initial documents of registration or formation.

To effectively carry out the above three duties, the governing body works with its managers and staff to fulfill the organization's mission by developing specific policies in six key areas: (1) quality performance, (2) financial performance, (3) planning performance (4) management performance, (5) governance effectiveness, and (6) stakeholder relations and advocacy. The governing body implements these policies by working with health workers and management and adopts specific outcome targets that measure the organization's overall performance relative to each policy.

## Why good governance is important

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Good governance has become an essential factor in the pursuit of stronger health systems and greater health impact. Good governance enables effective use of medicines, information, human resources, and finances to deliver higher health service performance and better health outcomes. Poor governance, on the contrary, undermines the vitality of a health system, and makes it less effective, less efficient, less equitable, less trustworthy, and less responsive to people it is intended to serve.

There is an emerging body of evidence demonstrating that effective governance improves health outcomes. For example, a study conducted by Björkman and Svensson (2009) in 50 rural communities in Uganda showed that community monitoring of health care providers improved health outcomes; communities with such an oversight intervention saw a significant increase in the weight of infants, and as much as a 33 percent reduction in mortality rates of children under five years of age. Community members were engaged in overseeing public dispensaries and demanded accountability of health care providers in their provision of health services.

In their study of 46 African countries, Olafsdottir et al. (2011) found good governance was inversely associated with under-five mortality rate after controlling for health care, finance, education, and water and sanitation. On the other hand, multiple studies have found poor governance overall, and especially in the health sector, has contributed to poor health outcomes (Gupta et al. 2009; Azfar et al. 2001; Delavallade 2006; Lindelow, Serneele, and Lemma 2006; Rajkumar and Swaroop 2008). Poor governance allows corruption to flourish; Hanf et al. (2011) conclude that the deaths of more than 140,000 children annually could be indirectly attributed to corruption.

Furthermore, good governance helps bring about the kind of institutional change that contributes to country ownership of health programs implemented through international aid.

## What makes governance good?

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Good governance aligns multiple actors, resources, and interests to promote **collective and responsible actions toward agreed-upon goals**. Why “collective”? Because the challenges are too big and the relationship between inputs and outputs too complex for any one actor to be able to do it alone. Why “responsible”? Because we live in a world with limited resources—be they money, medicines, human energy, or attention—which, if not



used wisely and judiciously are squandered, or benefit only some while harming others, or do not address priority needs. Why “agreed-upon goals”? Because we have to recognize that perceptions, needs, and experiences differ widely, and we can only move forward together if the destination is a place we all want to go to. In the absence of shared goals, we can expect apathy at best and sabotage at worst.

To understand governance for health as it is practiced around the world and what makes it good, we surveyed more than 500 people holding leadership, governance, or senior management positions in health sectors and health institutions of 80 countries (access synthesis report [here](#)). It is from their responses that we learned what governance is and what makes it good in the context of health.

Governance is a collective process of making decisions in organizations, health systems, or the health sector. Governance is (1) setting strategic direction and objectives; (2) making policies, laws, rules, regulations, or decisions, and raising and deploying resources to accomplish strategic goals and objectives; and (3) overseeing and making sure that the strategic goals and objectives are accomplished. Governance enables an environment in which legitimate action can be taken to meet stakeholder needs.

Governance is effective when strategic objectives are successfully and efficiently met, but good governance goes even further. Governance is good when (1) decisions are based on information, evidence, and shared values; (2) the process is transparent, inclusive, and responsive to the needs of the people, the ministry, or the organization that it serves; (3) those who make and those who implement decisions are accountable; (4) strategic objectives are effectively, efficiently, ethically, and equitably met; and (5) the vitality of the ministry or the organization is sustained.

#### BOX 1. A Vision of Good Governance in the Context of Health

In a health sector, health system, or health organization that is governed well, we would expect to see the following:

- Openness and transparency
- Accountability
- Inclusion and participation
- Equity
- Gender-responsive policies and programs
- Inter-sectoral collaboration
- Effective leadership and management practices
- Ethical and moral integrity
- Pursuit of efficiency and sustainability
- Measurement and reporting of performance
- Use of information, evidence, and technology in decision-making

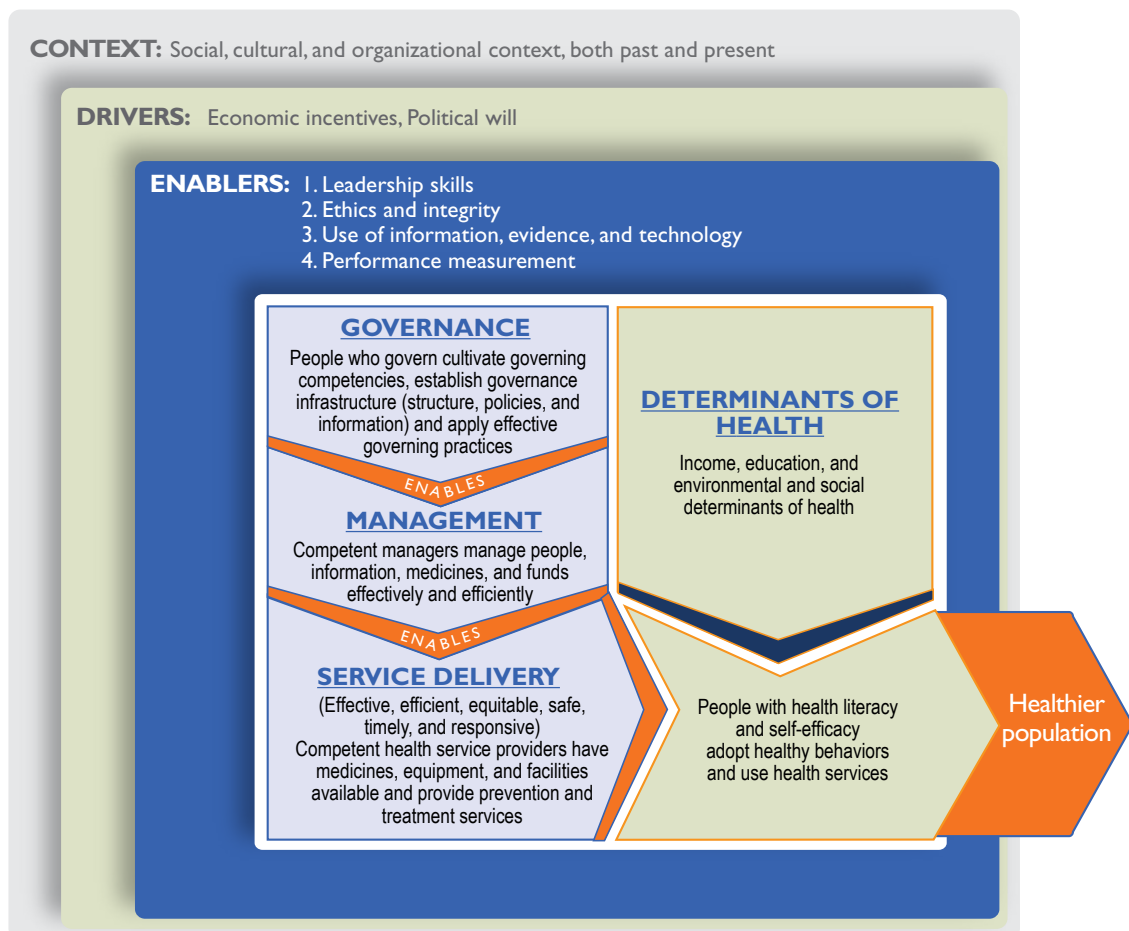
From the responses of these more than 500 health leaders, we also arrived at the four practices that make governance good: (1) cultivate accountability, (2) engage with stakeholders, (3) set shared direction, and (4) steward resources. When all these practices are put into operation in a health system they enable higher health system performance and better protection, promotion, and restoration of health. We will discuss how you can carry out these practices in your organization in the forthcoming sections.

**Linkage between leadership, management, and governance.** Leadership, management, and governance are interdependent, overlapping, and mutually reinforcing. All three work together to achieve a desired result, with effective leadership a prerequisite for good governance, and effective management a critical support for good governance. Good governance provides purpose, resources, and accountability to the management.

In a health system, there are leaders at all levels: leaders who govern or governance leaders, leaders who manage or senior managers, clinician leaders, leaders of health worker teams, and so on. Without good leadership, we cannot have good management or good governance. Let's take a closer look at the model and practices of good governance.

**Conceptual model of health systems governance.** As you can see in the model (Figure 1), we consider governance to be a collective responsibility shared by leaders who govern, senior managers, those who provide services and interface with the population, and those who are being served. Each group has a role in making governance good and helping it achieve its strategic objectives. At all levels of a health system—national, provincial, district, institution or facility and community—we can utilize the four practices to improve governance.

FIGURE 1. Conceptual Model of Health Systems Governance



People are at the heart of this model. People include leaders who govern and manage health systems, the health sector and various other sectors that impact health. People also include health care providers—physicians, nurses and other clinicians, and health workers who provide public health services in the community. Finally, people include communities and families who are clients of health systems and who promote their own health and demand quality services. Leaders who govern do so in close partnership with health managers, health providers, health workers, community leaders, and patients as well as governance leaders in other sectors. They facilitate the work of managers, who in turn facilitate the work of clinicians and health workers.

**A matter of governance shifts.** In Chapter 2, we mentioned leader shifts—the attitudinal and behavioral shifts that leaders can make to improve their effectiveness as leaders. Similarly, we see a series of governance shifts that leaders who govern need to make to govern well. Consider the ones in Table 1—to what degree are these shifts being made in your organization?

TABLE 1. Governance Shifts

FROM	TO
Labor-intensive 20 <sup>th</sup> -century governance processes	Technology-supported 21 <sup>st</sup> -century governance processes
Governance as usual	Pursuit of efficiency and sustainability in health systems
Input-oriented governance	Results-oriented governance, i.e., a culture of measuring and reporting results
Arbitrary decision-making processes	Transparent decision-making processes
Intuition- and opinion-based governance	Evidence-based governance
Authoritarian decision-making	Stakeholder engagement in governance decision-making
Management-driven strategic planning	Stakeholder needs-driven strategic planning
Appointments to governing positions based on personal relationships	Appointments to governing positions based on competence
Static governance process	Continuous governance enhancement
Male-dominated governance	Women holding governance positions
Silo-like health ministry	Whole-of-society and whole-of-government governance
Central health ministry control	Decentralized provincial and district health governing bodies

## Cultivate accountability

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*Accountability is the obligation of any public entity or nonprofit organization to answer to a higher authority—popular trust—which is the ultimate source of its mandate, of its authority.*

Kevin Kearns, cited in Kurtz 1995

There are many dimensions of accountability. We will take a closer look at some of them.

**Share information.** Sharing information is critical for establishing transparency and accountability. Here are some ways to do that. Use this list to assess how well you are sharing information.

- Create mechanisms for sharing information and make reports, plans and budgets, financial statements, and performance data available to those who need such information in order to participate meaningfully in governance decision-making.
- Share information about strategy, goals, standards, and performance with stakeholders.
- Access to information should be granted to those who are affected by the decisions, transactions, or work of your organization.
- Present information in an easy-to-understand format.
- Use appropriate information and communication technologies for dissemination of information to a variety of audiences.
- Establish formal consultation mechanisms through which constituencies may voice concerns or provide feedback.

**Enhance your personal accountability.** As governing body members or leaders who govern, you are entrusted with resources to serve the common good. The trust of your stakeholders is a precious commodity: hard to gain and easy to lose. Here are some ways to maintain their trust and build your personal accountability. Use this list to assess how well you are already doing this.

- Listen with an open mind, regardless of your own agenda, to the perspectives of stakeholders.
- Speak openly and candidly.
- Make only those promises you have the authority to make and can keep. Keep your promises and hold others to their promises independent of rank and status.
- Answer questions as truthfully as you can.
- Welcome constructive feedback on your actions and decisions.
- Refrain from making excuses and blaming others for mistakes.
- Own up to your mistakes and take quick action to make corrections.
- Explain your decision-making process and reasons for your decisions. Take ownership of your decisions. Accept responsibility for the future direction and current performance of your organization.
- Provide explanations for the underperformance of your organization and indicate what you will do about it.

**Enhance internal accountability, i.e., accountability within your organization.**

Internal transparency increases employee loyalty and collaboration. Here are some ways to establish internal transparency and accountability. Use this list to assess how well you are already doing on this dimension.

- Ensure a free flow of information internally within the organization so managers and staff have the information they need to make decisions. Ensure they are allocated enough resources to succeed.
- Create an environment in which acting with accountability is rewarded rather than feared.
- Encourage your managers not to be afraid of failure.
- Encourage calculated risk-taking by recognizing effort and courage, even when intended results are not achieved.
- Provide clear guidance to staff on goals and tasks for which they will be held accountable, without micromanaging the process to accomplish them.
- Provide timely, clear, and specific performance expectations and feedback.
- Make sure performance is measured in your organization, including your own governance performance.
- Improve performance by establishing consistent consequences for nonperformance or underperformance and rewards for excellence, independent of rank, gender, or status.
- Encourage staff to share both successes and challenges.

**Enhance external accountability of your organization.** It is hard to have external accountability without having internal transparency and accountability. For external accountability to be effectively established, leaders who govern need to:

- Make it clear to stakeholders the behavior they should expect of the governance leaders, management, and staff as well as the criteria by which their performance might validly be judged;
- Establish mechanisms to investigate whether the governance leaders, management, and staff have met the expected standards, goals and targets, e.g., an ombudsman office and an office of an inspector general;
- Establish a process in which governance leaders, management, and staff are required to defend their actions, face questions, and explain themselves to the public and stakeholders (the Global Fund Partnership Forum is an example);
- Establish a process in which those who hold a responsibility are in some way held to account for falling below the standards expected or, conversely, rewarded for achieving or exceeding standards.

**Social accountability.** Social accountability refers to a range of actions and mechanisms that citizens, communities, independent media, and civil society organizations can use to hold public officials to account. These mechanisms contribute to better health service

### Use of Technology for Enhancing Transparency and Accountability— An Example from Kenya, Tanzania, and Uganda

Mobile phones and modern information and communication technologies can help you cultivate accountability. Mobile phones can facilitate citizen-led public accountability, for example, through SMS-based applications that generate frequent overviews of health worker attendance, waiting time at clinics, availability of medicines and vaccines, medicine stock-outs, functionality of equipment, and so on.

Twaweza (“we can make it happen” in Swahili) is a 10-year citizen-centered initiative for public accountability in Kenya, Tanzania, and Uganda. It seeks to foster conditions and expand opportunities through which millions of people can get information and make change happen in their own communities directly and by holding government to account.

The Twaweza-supported pilot initiative CU@school in Uganda used basic mobile phones with a GPRS-based application openXdata to generate weekly overviews of teacher and pupil attendance at 100 primary schools. The idea was to use real-time data for better school administration by local governments, to enhance transparency and public accountability, and to reduce teacher and pupil absenteeism. Results were mixed. While the technology functioned well and turned out to be extremely economical, and while adherence to the reporting schedule by schools was somewhat satisfactory, the information was not used effectively by the local governments. Programs and discussions on local radio created some public awareness of the problem, but not enough to put pressure on the system.

Absenteeism is also a problem with respect to health workers, and mobile telephones can similarly be used to enhance transparency and accountability. A key lesson from the above and other pilot experiences in designing information and communication technology-driven solutions is to start with the users and their context, and not with the technology.

Read more about Twaweza [here](#) and click [here](#) to see an example of reporting stock-outs in South Africa using an iPhone or Android application, by sending an email, or by filling out a form on a website.

delivery and empowerment. Here are some ways to increase social accountability. Use this list to assess how well you are carrying out the following actions.

- Involve stakeholders in budgeting (click [here](#) and [here](#) for examples) and public expenditure tracking (click [here](#) for an example).
- Use citizen report cards and community score cards (click [here](#) for examples).
- Facilitate social audits (read about social audits [here](#) and [here](#)).
- Conduct public hearings (read how to conduct a public hearing [here](#)).
- Use community radio to discuss community initiatives, successes, and challenges, and also for establishing accountability and transparency (click [here](#) for examples).
- Use data generated using modern communication technology to enhance performance accountability. (See the country examples that follow and also click [here](#) for more examples)
- Use technology for knowledge exchange and capacity development (click [here](#) and [here](#) for examples).

## Engage with stakeholders

*The business case for leadership and engagement is compelling: organisations with engaged health providers deliver better patient experience, fewer errors, lower infection and mortality rates, stronger financial management, higher staff morale and motivation and less absenteeism and stress. Patient engagement can deliver more appropriate care and improved outcomes.*

The King's Fund,  
*Leadership and Engagement for Improvement in the NHS*, p. vi

Stakeholders of a health system are groups or individuals who have an interest in the performance of the health system and who can affect, or are affected by, its workings. The primary stakeholders in a typical health system are communities, health service users, health providers and other health workers, health managers, and leaders who govern the health system. Other stakeholders include government representatives (local, state, and national), elected public officials, and members of civil society organizations, professional associations, and the media, among others.

There are five ways to engage stakeholders in the health system, depending on the degree of shared decision-making authority you think would be optimal in a given situation.

1. **Inform** (keep stakeholders informed of current decisions, goals, and activities, and educate them on your organization's policies)
2. **Consult** (listen to stakeholder concerns and provide feedback)
3. **Involve** (coordinate with stakeholders to make sure that their concerns are directly reflected in your decisions)
4. **Collaborate** (work with stakeholders to formulate problem definitions and solutions)
5. **Empower** (put decision-making in the hands of the people)

A well-structured stakeholder engagement process requires time and money. Those who govern must consider these costs and plan accordingly, based on available resources.

### BUILD BROAD-BASED RELATIONSHIPS

To engage with stakeholders, it is important to build coalitions and networks across all levels of government and civil society and with different sectors. Actions in many sectors, in addition to the health sector, can impact the determinants of health and, ultimately, health outcomes.

- Build partnerships with ministries that play a role in improving the health of the people (e.g., social development, public works, environment, education, agriculture, trade, labor and employment).
- Establish alliances for joint action with other groups or networks that reach into constituencies with whom you currently have no relationship.
- Work with private for-profit and civil society organizations.
- Work with different levels—local, state, national, and international.



What does it take to bring together the key players, adopt a collaborative approach for addressing an issue, and then adopt a collaborative process that negotiates different interests?

- **Be visible.** Eighty percent of success in life is showing up and participating. Attend forums and events where key stakeholders who can influence health policies and practices come together. Give speeches, cite evidence, and point out the benefits of good health for all. Use language that the audience can relate to.
- **Make connections.** Seek out opportunities to create advocates for health in different spheres of government and public life.
- **Invest in relationships.** Time spent on creating and managing relationships with influencers is time well spent.
- **Identify your key stakeholders.** Who are the people who can make or break deals? Know where the power is and cultivate good relationships by showing up, sharing information, and looking for common interests.
- **See possibilities rather than problems and obstacles.** Point out what is possible rather than what is wrong; look for win-win scenarios.
- **Seek out new perspectives.** Find out the points of view of those usually not considered: the voiceless, the powerless, and opponents. The voiceless and powerless can give you perspectives you might not have considered.
- **Create and maintain a safe space for sharing ideas.** Genuine participation across diverse stakeholder groups is feasible when everyone feels it is safe to share their ideas.
- **Provide an independent conflict resolution mechanism.** Be prepared to address competing interests, and possible conflict, among diverse stakeholders with an unbiased approach that will be acceptable to all.
- **Do not avoid difficult issues.** Deal with difficult issues quickly and courageously, lest they turn into major problems.
- **Build the capacity of civil society.** Help civil society know how to engage effectively with your organization.
- **Solicit extensive input from stakeholders.** Conduct open meetings, surveys, forums for public comment, and public workshops. Establish citizen advisory committees.
- **Value feedback.** Elicit, and respond to, all forms of feedback in a timely and respectful manner.

### ENGAGE AND SUPPORT KEY GROUPS WITHIN HEALTH SERVICES

**Engage with staff and health workers.** Staff and health workers feel engaged when they have jobs with meaningful, clear tasks, some autonomy to manage their work, involvement in decision-making, and supportive line managers. Engaged staff feel valued, respected, and supported. They are engrossed in their work and take pride in what they do.

**Engage with doctors and clinicians.** You can improve engagement with doctors and clinicians in many ways: by mutually discovering a common purpose such as improving outcomes and efficiency, making them partners in improving quality, involving them from beginning, valuing their time, making it easy for them to do the right thing for patients,



identifying and encouraging champions among them, and by supporting their career development all the way into governing positions.

**Be gender-sensitive in consultation.** Women are disproportionately affected by negative health outcomes, so it is especially important for governance leaders to be proactive in incorporating women's voices in governance decision-making and allowing them to influence governance decisions. Consulting primarily with men provides only half of the picture. Seek out the views of women to get a more complete picture of potential risks, impacts, and opportunities. Get more women in the room. It is important to make meetings more accessible and convenient for women. Use active facilitation to solicit women's input. Hold separate meetings when necessary. Raise issues that are a priority for women. Disaggregate your data by gender. Seek advice from women's organizations, women leaders, and gender experts.

When thinking of health equity, think of women, youth, and poor populations as well as key vulnerable and marginalized groups, including lesbian, gay, bisexual, and transgender people.

## Set shared direction

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*The Governing Body determines the organization's strategic direction and policies. It sets out the organization's strategic direction to deliver its mission, goals and objectives. With the Chief Executive, it makes certain that the organization's programs, activities and services reflect its strategic priorities. It concentrates on strategic thinking and does not involve itself with day-to-day operational and management matters. It creates policies and monitors the organization's activities in all areas.*

International Planned Parenthood Federation  
Code of Good Governance

Shared direction comes from agreeing on which “ideal state” everyone is trying to get to. If there is no agreement on what or where you are moving to, agreeing on approaches for how to get there will be that much more difficult. If you know that you are all moving in the same direction, you will find it easier to gather support for the planning process, assess readiness, and define strategy to achieve this vision. You can then design a shared action plan with measurable goals for reaching it and set up accountabilities to accomplish the plan.

[Chapter 2](#) of this handbook has more information about setting a shared vision, and pages 182–188 of the [Managers Who Lead Toolkit](#) provide exercises for creating a common vision.

TABLE 2. Process of Setting a Strategic Direction

ASK	ANALYZE
Where are we now?	Internal and external assessment
Where do we want to be?	Vision Mission and principles Goals and Objectives
How will we get there?	Strategy Action Plan
How can we measure our progress?	Performance Measures Monitoring and Tracking Evaluation

As you set a direction and work on achieving it, check how well you are adhering to the following practices:

- Apply knowledge and evidence.
- Develop the strategic direction or vision for your organization by working with all your stakeholders.
- Communicate the vision.
- Embody the vision.
- Inspire everyone in the system to achieve it.
- Define a strategy to achieve this vision and design a shared action plan with measurable goals for reaching it.
- Set up accountabilities to accomplish the plan.
- Raise and allocate resources to implement the action plan and achieve the vision.
- Make decisions to accomplish the vision.
- Evaluate their impact.

The governing body will also need to ensure the availability of sound management systems to achieve the shared direction, i.e., systems to manage services, people, and other resources. You should also make sure that your health managers consistently follow effective management practices: planning; organizing to implement the plan; implementing activities efficiently, effectively, and responsively; and monitoring and evaluating the results.

The four key management principles of planning, organizing, implementing, and monitoring and evaluating are discussed in more detail in [Chapter 5](#).

## Steward resources

*[The boards that govern local health departments] assure the availability of adequate resources (legal, financial, human, technological, and material) to perform essential public health services.*

National Association of Local Boards of Health  
NALBH's Six Functions of Public Health Governance

A steward is someone who manages another's property or financial resources acting as their agent. Stewarding resources is raising, mobilizing, and allocating resources, and making sure that the resources are ethically and efficiently used for delivering services that are of high quality, affordable, cost-effective, and appropriate to the needs of the population, and that achieve better health for the people. Good stewards protect and wisely use the resources entrusted to them to serve people, as if these resources were their own. They use resources and advocate for using resources to maximize the health and well-being of the public. They collect, analyze, and use information and evidence for making decisions on the use of resources. They also use technology, especially modern information and communication technologies, for this purpose.

Health sector leaders who practice good governance must: (1) define the scope and nature of the resources required to implement their organizations' strategic plans; (2) raise these needed resources from diverse sources; and (3) cause to have these resources carefully used and expended by managers, clinicians, and health workers. Smart governance requires the careful stewardship of scarce resources—human, technological, physical, and financial.

What does it take to be a good steward? Check to what degree the following behaviors are being practiced in your organization.

**Ethical and moral integrity.** There is a two-fold meaning here: one relates to embracing moral and ethical principles, the other to living those principles through one's actions. Here are some ways to demonstrate ethical and moral integrity. Use this list to assess how well you are already carrying out the following actions.

- Establish, champion, practice, and enforce code of ethics and code of conduct.
- Establish and enforce a policy requiring declaration of conflicts of interest.
- Avoid activities or relationships that would create a perceived or actual conflict of interest.
- Often ask the question, "If these were my own resources, would I be using them for this purpose?" to make sure the public interest is served.
- Be truthful and true to your public statements. Be consistent.
- Take measures to prevent corruption. Tighten control systems such as financial management and procurement systems and take action when irregularities surface.
- Demonstrate high standards of personal integrity, truthfulness, honesty, loyalty, and responsibility in all your activities in order to inspire confidence and trust in others.
- Discharge your duties unselfishly, to benefit only the public.

- Keep your personal interests separate—work for the people’s health, not your own good.
- Avoid behaviors that will generate questions regarding your integrity.
- Do not solicit or accept a gift in return for an official act, or accept frequent or expensive gifts.
- Make sure that any outside employment does not interfere with your responsibilities to your organization or its mission.

**Provide oversight.** Stewards establish oversight and review processes to assess the impact of decisions made by managers and leaders. They are mission focused, always asking, “Are we achieving what we set out to achieve?” and “Is this the best way to get there?” Consider the following:

- Are policies and decisions followed and implemented? And if not, are you asking “why?” and “what can be changed?”?
- Is the performance of health managers reviewed on a regular basis?
- Are managers and staff acting with integrity and, if not or when confronted with warning signs, are you taking a look at internal controls and making changes as required?
- Is the organization on a stable and strong financial footing? If not, are you encouraging and supporting the organization’s leaders to correct the situation?
- Are you using actual financial data for planning, oversight, and evaluation, using key financial indicators?
- Is your organization audited in a professional way, and are findings being addressed?
- Will you be able to continue to mobilize and allocate sufficient and appropriate resources (manpower, technology, information, and finance) for activities that meet health needs of your communities in the future?

The governing body or the governance leaders hold ultimate responsibility for the quality of care provided by an organization. Smart oversight processes help them fulfill this responsibility.

**Make periodic field visits.** Not only would field visits allow you to see for yourself and hear directly from the people and service providers in the field, without filters created by the hierarchy, if carefully conducted, such visits can be motivating to frontline health workers. People on the periphery often feel forgotten and neglected. The fact that someone from the top level makes the effort to go see and listen to them carries much weight and creates much goodwill. Wise governing bodies do this in partnership with management to avoid situations in which health workers go around their managers to inappropriately lobby governing body members.

**Facilitate community monitoring.** Create opportunities for the public to be included in monitoring and evaluating how resources are raised, allocated, and used and how health services are provided. Click [here](#) and [here](#) and [here](#) for examples.

**Pursue efficiency and sustainability.** Pursue efficiency and sustainability by re-orienting processes toward concrete and measurable results. Pay close attention to the quality of service, focus on monitoring and continuous quality improvement, develop cost-effective procurement, storage, and distribution solutions, and strengthen oversight of service delivery and health management processes.

**Establish a culture of performance measurement.** Performance measurement should not be confined to measurement of performance of managers and staff. As governing body members or governance leaders, pause periodically for self-reflection, diagnose your own strengths and limitations, and consider:

- How well are you getting stakeholders to participate meaningfully in decision-making?
- How aware and responsive are you and your organization to gender differences?
- How accountable are you and your organization to its stakeholders?
- How transparent is your governance?
- What are your performance measures—how well is the health system performing? How much better off are the people in terms of health and financial protection?
- How well are resources used? What have they produced?

To access self-assessment instruments you can use to assess your governance, you may use our *Guide on Continuous Governance Enhancement*, which is under development in spring 2014 and will be made available [here](#).

Establishing a culture of performance measurement helps improve the efficiency of your organization. Use the list below to assess how well you are establishing such a culture:

- **Develop your governance competencies** (knowledge, skills, and capabilities), especially in cultivating accountability, leading change, health care delivery and performance, business and finance, human resources and talent development, collaboration, community orientation, achievement orientation, information seeking, innovative thinking, organizational awareness, professionalism, relationship building, strategic orientation, and team leadership).
- **Develop a measurement strategy** by identifying measures for all strategic and operational objectives.
- **Measure your own performance** with regard to governance, health system performance, health outcomes, and health impact.
- **Regularly seek feedback** on your health system performance and your governance performance.
- **Involve the stakeholders** in measurement of results and assessment of your own governance performance.
- **Use performance information** to improve the services, and to evaluate, to control, to budget, to motivate, to promote, to celebrate, to learn, and to improve.
- **Use data, information, evidence, and technology** for governance decision-making.

**BOX 2. How Can Technology Assist Good Governance?**

Mobile phones and modern information and communication technologies can be effectively used for promoting transparency, cultivating accountability, and engaging with stakeholders. Data generated or transmitted via these technologies is valuable for strategic decision-making. These technologies will help you rapidly collect evaluation data and evaluation evidence. They will also help you with governance knowledge exchange and capacity development.

mHealth and eHealth strategies can help you improve transparency and accountability in health care through health information management and its display on public website. Use of mobile phones facilitates citizen-led public accountability and monitoring of health services.

Check how well you are:

- using technology to manage information and gather evidence;
- using valid and reliable evidence to make decisions;
- using evidence to identify problems, frame solutions, and decide how solutions will be implemented;
- engaging stakeholders in using evidence as a basis for their decisions;
- building capacity among the staff to generate and use evidence.

In this section we have looked at generic good governance practices in the context of health. In the following sections we will take a closer look at what can be done to govern well within the public sector, multi-sectoral bodies, and civil society organizations.

## Public sector governance

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In this section, we describe the characteristics of the public or government sector (we use the two terms “public” and “government” synonymously for the sake of simplicity and at the expense of precision) and the challenges of governing it. We then explain how the four governing practices can be applied at the central, provincial, district, and community levels.

Historically, public sector governance has evolved from public management and public administration.

### PUBLIC ADMINISTRATION

(A focus on administering set rules and guidelines, and a central role for the bureaucracy in policymaking and implementation)

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### PUBLIC MANAGEMENT

(Borrowing lessons from private-sector management, the emphasis shifted to evaluation, performance management, and cost management in service delivery, and use of markets, competition, and contracts for service delivery.)

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### PUBLIC GOVERNANCE

(Multiple interdependent actors contribute to the policymaking and delivery of public services, and inter-organizational relationships matter.)

In most countries we can find elements of public administration, public management, and public governance coexisting with each other.

## CHALLENGES OF GOVERNANCE IN THE PUBLIC SECTOR

Governance in the public sector is different from governance in the private sector, which includes both for-profit firms and not-for-profit organizations. In the private sector, the board and senior management have authority over two critical resources: people and money, whereas in the public sector a civil service system and a system of checks and balances may enable protection of tenure. Removal of staff can often occur following a complicated due process. Governance in the public sector can also be more challenging due to the effects of making decisions in open and transparent meetings and the requirement to follow due process. This may put some restraint on the governing body’s ability to swiftly and efficiently address sensitive issues about strategic service investments, procurements, and executive performance reviews.

The public sector is primarily set up to ensure that the public interest is served. Such public interest may lie in equity, transparency, or whatever else the legislators and leaders who govern the society decide to define as the public interest. Public policies made to achieve

equity or broader public interest may not necessarily serve efficiency well. Public policies may also present a disincentive to innovation, or lead to an excessive emphasis on process versus results. For example, citizen participation in decision-making is a messy process and takes time—disorder and delays are two foes of efficiency. Profit-making entities are free to choose efficiency over equity.

Fixed compensations and career paths as well as the difficulty of removing unproductive and incompetent personnel due to stringent hiring and firing controls may fail to provide strong incentives for bureaucrats to improve performance on a continuous basis. This may explain the widespread impression that public servants do not care. Of course this perception is a gross overgeneralization, and we acknowledge the multitude of public servants who are deeply committed to public service.

Unfortunately, in many jurisdictions the agendas of politicians and public administrators do not necessarily serve the interests of the citizens, e.g., their behavior is predominantly directed toward seeking personal gain or rewards (e.g., status, promotions, visibility, etc.). We find politicians and public administrators of both types, some serving, and some dis-serving their constituents, depending on the political system in which they act. Division of power, term limits for elected officials, and competitive elections can help restrict the accumulation and abuse of power in the public sector.

In the health arena, public sector governance failures can manifest in many ways, such as corruption, inefficiency, inequity, and unresponsiveness in service provision, or even complete unavailability of services. Enacting and enforcing laws and regulations that protect health and ensure safety remain the responsibility of governments alone, and we want this essential public health function to be done well. For these reasons, the four governance practices are all the more relevant to governance in ministries of health and the decentralized structures working within them. If applied consistently, they will help you avoid governance failures.

1. **Cultivate accountability** to make sure that elected officials and public servants are held accountable for their promises, actions and tasks
2. **Engage with stakeholders** to build trust, to learn, to serve, to achieve the shared strategic goals and objectives
3. **Set shared direction** to align stakeholders, to promote cooperation, to reduce the probabilities of resistance and sabotage
4. **Steward resources** in order to use resources wisely, fairly and with integrity, as if they were one's own.

**Governance within the context of decentralization.** Many countries are pursuing decentralization of their political, administrative, fiscal, and service delivery authority with the aim of bringing services and decision-making power closer to the citizens. Although the degree and extent of decentralization varies across countries, good governance in the ministry of health and other ministries of the government, and good governance in the decentralized entities is critical to the success of decentralized entities in providing better health services to their citizens. In the following pages we look at good governance at different levels in the health ministry's hierarchy.



## GOVERNANCE STRUCTURES AT CENTRAL, PROVINCIAL, AND DISTRICT LEVELS

Ministries of health are at the top of the hierarchy of health governance structures, and are increasingly requiring governance structures in the provinces, districts and communities. Each level's organization, authority, accountabilities, responsibilities, and access to resources vary across countries. See [Box 3](#) to read how Afghanistan has organized its governance structures from the village all the way to the central ministry in Kabul.

## APPLICATION OF THE FOUR GOVERNANCE PRACTICES IN THE PUBLIC SECTOR

Let us see how the four governance practices, (1) cultivating accountability, (2) engaging with stakeholders, (3) setting a shared strategic direction, and (4) stewarding resources, can be applied in ministries of health and their offices in the provinces and districts to obtain measurable results.

**In ministries of health.** In the six examples from various countries around the world that follow, you can see the application of one or more of the four governance practices. Try to identify the operative governing practice(s) in each, and consider whether any of them could be applied in your situation, and how.

1. In Croatia, hospitals are required to make waiting lists public in order to reduce the practice of patients bribing doctors to jump ahead of the queue. The Ministry of Health and Social Care introduced a national-level waiting list early in 2008. In each hospital, there is a unit responsible for the registration of the patients on the waiting list; all details are listed on the Internet. This initiative has reduced the waiting time by from 30 to 50 percent.
2. In Ghana, transport officers in the Ministry of Health were told to calculate fuel use per kilometer and display the results on a public notice board. This transparency in publicly reporting fuel use led to a 70 percent improvement in fuel use per kilometer over a couple of years, dramatically reducing vehicle running costs.
3. Using information from a 2008 study in three districts in Lesotho about gender segregation of HIV and AIDS caregiving work, a USAID-funded project implemented a variety of interventions to arrive at a more equitable division of the HIV and AIDS caregiving burden, and made policy recommendations to the Government of Lesotho.
4. A Leadership Development Program that was implemented in several districts in Upper Egypt led to an increase in the number of new family planning visits of between 20 and 68 percent. The number of prenatal and postpartum visits also rose. One important element of the program was the creation of a long-term shared vision, made concrete in a series of measurable results for the near future. Without external funding, the inspired leaders cascaded the program downward, reaching more than 184 health care facilities and training more than 1,000 health workers how to create a shared vision and set measurable goals. The resulting reduction in maternal mortality was much greater than in similar governorates in Egypt.

### BOX 3. Health Governance Structures in Afghanistan's Provinces, Districts, and Communities

In Afghanistan, the Provincial Public Health Coordination Committee (PPHCC) is a formal multi-stakeholder committee at the provincial level with a set of distinct responsibilities established by the Ministry of Public Health (MOPH). The MOPH has also established consultative community health councils and health facility councils at the health post, health facility, and district hospital levels. Hospital community boards have been established at the provincial hospital level. The MOPH is now establishing District Health Coordination Committees (DHCCs) in the districts.

PPHCCs provide a forum for coordination and information sharing among various stakeholders in the provincial health system. They discuss community health concerns, and coordinate and participate in all stages of a public health emergency response. They also monitor and supervise health posts and health facilities. They are expected to meet on a monthly basis and coordinate delivery of the basic package of health services and the essential package of hospital services.

The PPHCC is chaired by the Provincial Public Health Director and has 21 members, including provincial public health officers, provincial hospital director, director of the Institute of Health Sciences, two representatives of NGOs that provide health services in the health posts and health facilities, two district health officers, and a representative from each of the following: the Ministry of Women's Affairs, the provincial reconstruction team, the private health sector, elected provincial council, UNICEF, and WHO. Thirteen members have voting powers. Decisions in the PPHCC are usually based on consensus. If there is no consensus, the decision is put to a vote. A decision requires a quorum, with a majority of voting members in favor of the decision.

Similarly, the DHCC is chaired by the District Public Health Officer and its members include district governor's representative, private health sector representative, religious leader from the district, director of the district hospital, an implementing NGO representative, head of the district education department, and head of the district council.

LEVEL	GOVERNING BODY	SERVICE AREA
Province	Provincial Public Health Coordination Committee (PPHCC)	Many districts
District	District Health Coordination Committees (DHCC)	District (Tens or hundreds of villages)
Health facility	Health facility shura or consultative assembly	Several communities served by a health facility
Communities	Health post shura or consultative assembly	A village community

The PPHCCs, DHCCs, and community and facility health councils are performing a governing role. Their governance decision-making can make a difference in the care delivered during patient visits at health facilities by improving the health system performance, especially the responsiveness of the health system. If these committees and councils work in coordination with each other, community health concerns can be effectively represented and addressed.

We have documented empirical evidence of the impact of their governance. In a pilot study, three PPHCCs and 11 DHCCs consistently applied the four effective governing practices over a period of six months, and as a result their governance improved by from 13 to 21 percent, and the antenatal care visit rate in the three provinces increased by 20 percent.

5. Nigeria's National Agency for Food and Drug Administration and Control was able to bring down unregistered and potentially counterfeit drugs in the market from 68 to 20 percent between 2001 and 2011, working closely with mobile phone networks and pharmaceutical companies. Nigerian consumers can report counterfeit drugs through mobile texting of a code revealed by a small scratch strip on the packaging. The text is instantly answered, either with the word "YES"—the drug is genuine—or "NO." The latter response includes a local number to alert the authorities about this potentially counterfeit medicine.
6. The Afghan Ministry of Public Health (MOPH) uses an annual Balanced Scorecard, an integrated management and measurement tool consisting of 29 performance indicators and performance benchmarks in six domains: patients and community, staff, capacity for service provision, actual service provision, financial systems, and overall vision. Every year the MOPH selects a random sample of health facilities, collects data including thousands of patient observations and interviews with patients or their caregivers and health providers. The scorecard findings track performance over time and identify priority areas for improvement, improving health system capacity and health service delivery through performance benchmarking. The Balanced Scorecard also helps the MOPH to demonstrate the results of its investments, make policy changes, and create an evidence-based decision-making culture.

*Answer key:* (1) and (2) are examples of cultivating accountability, (3) is an example of engaging with stakeholders, (4) is an example of setting a shared strategic direction, (5) exemplifies cultivating accountability, engaging with stakeholders, and stewarding resources, and (6) exemplifies all four practices.

**In provincial and district health systems.** Having read examples of how the central ministries of health apply the four governance practices with good results, you will now see how the governing bodies that govern health systems in the provinces and districts can apply these practices. Here are some examples of governance actions you can take, based on actions taken by the Provincial Public Health Coordination Committees and District Health Coordination Committees in select provinces and districts of Afghanistan.

1. **To engage stakeholders**, interview patients and health service users; invite religious, youth and women leaders to meetings; provide feedback to shuras or consultative assemblies at the health-facility level; and consult community leaders on a regular basis.
2. **To cultivate accountability**, your own and that of health workers, share information on resources and performance with communities and stakeholders; encourage health workers to share their challenges during joint monitoring visits to the health facilities; review health workers' job descriptions; and give them clear targets and monitor their progress toward achieving them.

3. **To set shared direction**, constitute a team of representatives from the community, health service users, other health system stakeholders, and district health officers from each district; identify the health needs and challenges faced by the communities; communicate these needs to the provincial health governing committee for consideration while deciding the strategic direction. Alternatively, invite health facility governing body members to provincial governing committee meetings to better understand community concerns.
4. **To steward resources** in an ethical and efficient way, train provincial public health office staff and health workers in ethics; recognize health workers with outstanding performance; involve the community in health facility monitoring; and use data, information, evidence, and technology for decision-making.

The four governing practices, when applied consistently, have the potential to significantly contribute to the success of decentralization in achieving its objectives.

**In communities.** Community health governance, in essence, is a broadly participatory and collaborative process where community is defined geographically; health is defined as a broad, positive concept consistent with the WHO definition; and governance is defined as a process by which communities make decisions. Participatory and collaborative processes are expected to lead to better community problem solving, which in turn is expected to improve community health.

Community health governance happens through participatory processes led by community stakeholders to improve the health of those residing in the community. Community health governance structures may exist in many forms: a citizen board of a health center, a village health council, a local health committee, or a community hospital board. Community groups governing village-level health services in Bangladesh, South African health facility boards, community health shuras (or consultative assemblies), and health facility shuras in Afghanistan are a few examples of the broad array of community health governance bodies.

The success of community health governance depends on who is involved, how they are involved, and having leaders who deeply believe in the capacity of diverse people to work together to identify, understand, and solve community health problems. Successful community leaders promote broad and active participation by community members.

Community health governance bodies are expected to provide leadership and support to health-related activities in their communities. For example, they may be involved in some of these activities:

- promoting healthy lifestyle among the community members,
- adopting and promoting healthy behaviors and social norms,
- encouraging families to make full use of preventive and curative health services,
- working closely with the community and the health providers, linking people to the health services they need,
- supporting the health of mothers and young children,
- selecting and supervising community health workers,
- mobilizing the community and health workers to identify and solve the community's health challenges, and
- advocating for sanitation, clean water, and clean air.

Community boards attached to a health facility are expected to serve as a link between the community and the health facility, and to ensure that the facility meets the needs of the community. They nurture relationship with the community, generate community support for the facility, provide oversight to the health facility, and involve people in community health planning and in monitoring of the health facility.

The governing practices described earlier have the potential to make the governance of community health governance bodies effective. We illustrate this with the example of Bolivian hospitals.

#### Citizen Health Boards Help Deter Corruption and Reduce Overpayment— An Example from Bolivia

A study of 30 hospitals in Bolivia published in 2001 found that citizen voice, as measured by active participation on citizen health boards, had a statistically significant effect on lowering informal payments for services that should have been free and reducing overpayment for supplies, as measured through procurement price data. The citizen boards exposed bribery and deterred informal payments and the overpricing of medical supplies. Citizen health board activism proved to be an important deterrent of hospital corruption, whereas institutional controls such as administrative regulations and procedures seemed to have had little impact. Rules and regulations are important foundations for holding public officials accountable: these are necessary, but not sufficient. In this case, it was board activism that made the difference.

Source: Gray-Molina G, Perez de Rada E, Yañez E. (2001). "Does voice matter? Participation and controlling corruption in Bolivian hospitals." In: Di Tella R, Savedoff WD, (eds). *Diagnosis corruption: fraud in Latin America's public hospitals*. Washington, DC: Inter-American Development Bank.

We have looked at governance in general and examined its four practices, as they apply to the public sector and to the various levels in the health system hierarchy. Let's now take a look at governance in other organizational settings: multi-sectoral bodies and civil society organizations.

## Governance of multi-sectoral bodies

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What is a multi-sectoral body? Multi-sectoral bodies differ from traditional governance models in which national health policy decisions are made by a single entity, such as a ministry of health; multi-sectoral bodies share decision-making responsibilities among multiple members representing different sectors and diverse constituency groups. In the last 25 years, the number of multi-sectoral partnerships dedicated to public health have increased because of the need to support decentralization of health services, respond to the rising prevalence of specific diseases, and better meet the broader needs of specific populations, such as women and children.

At the same time, there has been an explosive growth in new funding mechanisms focused on specific diseases and health systems strengthening. These include the President's Emergency Plan for AIDS Relief (PEPFAR), the President's Malaria Initiative (PMI), the World Bank Multi-Country HIV/AIDS Program (MAP), the Global Alliance for Vaccines and Immunization (GAVI), and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). These funding mechanisms have also fueled the need to advance local ownership and participatory decision-making through multi-sectoral initiatives.

Examples of multi-sectoral bodies include:

- health councils at national, state, municipal, and local levels
- AIDS Commissions (Councils, Committees) at national, provincial, district, and local levels
- Country Coordinating Mechanisms (CCMs)
- Children's Council or Women's Council

Each of these has governance functions. AIDS Commissions, for examples, govern the multi-sectoral response to HIV, health councils oversee the functioning of the health system, and CCMs oversee the performance of GFATM-funded grants for AIDS, TB and malaria. Councils for specific populations (e.g., women or children) ensure that all sectors are working together to meet the needs of that population.

### ORGANIZATION OF MULTI-SECTORAL BODIES

Multi-sectoral bodies comprise members from different sectors and vary in size. The complexity of managing governing bodies is proportionate to the number of members; the more members, the greater the need to manage governance tasks. For this reason, many CCMs that were originally founded as large bodies with many members are now restructuring to reduce the number of members so their governance tasks can be more easily managed.

Multi-sectoral bodies also vary in composition. Members can be individuals or organizations, depending on the body.

Members are nominated or elected from within each sector to represent their constituencies. In the case of CCMs, for example, civil society members are elected from within

their respective sectors, while members from government and international development partners are nominated by each sector.

Multi-sectoral bodies can be legally established organizations—or not. For example, some CCMs are legally established while others are not, depending on the country. Those CCMs that are not legally established use a budgetary recipient for financial management. An example of such an arrangement is the Zambia CCM, which uses the Zambia National HIV/AIDS/TB/STI Council as its budgetary recipient.

Earlier in this chapter the four governance practices were introduced: cultivate accountability, engage stakeholders, set shared direction, and steward resources. Similar to other governance bodies in the public and nonprofit sectors, multi-sectoral governing bodies also embrace these practices. How the governance practices can be carried out within multi-sectoral groups is discussed below.

### CULTIVATING ACCOUNTABILITY IN A MULTI-SECTORAL BODY

Like other governing bodies, multi-sectoral bodies are accountable to the public and to the constituency groups or sectors they represent. Being accountable goes hand in hand with conducting business in a transparent manner. An accountable multi-sectoral body readily makes its accounts and records available to donors, constituency groups, and other stakeholders for public scrutiny. Areas in which multi-sectoral bodies can demonstrate accountability and transparency include the following.

**Selection of members.** An accountable multi-sectoral body establishes transparent procedures for selection of members, whether by nomination and/or election. Indeed, one of the GFATM's six requirements for CCMs to be eligible to apply for grant funds is that the process for selecting members be documented and transparent. In general, each sector determines how it will select its representative. Government representatives are generally nominated, whereas nongovernmental representatives are elected from within the sector. Procedures for selection of members follow the multi-sectoral body's by-laws or statutes, and should be made publicly available.

[Click here](#) to find out more about GFATM's eligibility requirements, minimum standards, and guidelines for CCMs.

**Election of officers.** Just as the process for selection of members is transparent, the process for election of officers is also transparent. Election procedures are based on the multi-sectoral body's by-laws or statutes and made publicly available. Multi-sectoral bodies often create electoral commissions to oversee the election process, including preparation of the election schedule (time line) and review of all candidates for eligibility.

**Managing conflict of interest.** Multi-sectoral organizations provide the benefit of opportunities for working together with a common purpose, but they are also accompanied by competing interests. When those closest to the problem that the multi-sectoral body addresses become a part of the governance structure and participate in decision-making, conflict of interest is unavoidable. However, conflict of interest is also manageable. For this reason, multi-sectoral bodies manage the inherent tension in conflict of interest and do so transparently. CCMs, for example, are multi-stakeholder bodies that mobilize signifi-



cant resources and determine the organizations that receive and distribute the funds. The potential for conflict of interest is considerable, particularly since many CCM members are increasingly also recipients of GFATM grants and responsible for grant implementation. Indeed one of the six eligibility requirements of CCMs to be able to apply for GFATM funds is to have a process in place to manage conflict of interest.

For more information on managing conflict of interest within CCMs, go to the [Global Fund website](#) and search for Implementer Series for their sheet on conflict of interest.

#### BOX 4. Steps Multi-Sectoral Bodies Can Take to Manage Conflict of Interest with Transparency

Ensure that

- the organization has a conflict of interest policy,
- all members disclose conflicts of interest periodically in writing and orally at the opening of meetings,
- members' conflict of interest declarations are available publicly, preferably on a website,
- members with a conflict of interest recuse themselves from participating in discussions and decision-making involving their specific interests,
- sanctions are applied to members who fail to disclose conflict of interest,
- management of conflict of interest during meetings is documented in the minutes of the meeting.

**Meeting proceedings and decision-making.** Multi-sectoral bodies generally represent large constituency groups across sectors. They are responsible for documenting and communicating to those they represent the discussions carried out during meetings and the decisions resulting from those discussions. Communications should be timely, comprehensible, and accessible. Meeting discussions, decisions, and actions to manage conflict of interest should be documented in minutes, distributed to all members and made available publicly, preferably on a website.

GFATM recommends use of a standard template for CCM meeting minutes that can be found [here](#) on the GFATM website.

**Periodically assessing effectiveness of the multi-sectoral body.** Multi-sectoral bodies should assess their performance periodically and make the results available to the public, preferably on a website. For internal assessments to be effective, members need to have a strong sense of ownership of the body's mission and vision and a strong stake in its success. Otherwise, internal assessments will not be undertaken in good faith, and/or the results will not be acted upon. External assessments can be far more effective in changing practice or affecting behavior.

Starting in 2014, CCMs are required to participate in annual Eligibility and Performance Assessments in terms of adherence to GFATM eligibility requirements. The assessment tool is available in several languages on the GFATM [website](#).



**Clarifying expectations through terms of reference for members, officers, and committees and through training.** All members, officers, and committees of multi-sectoral bodies need clear terms of reference that clarify their responsibilities and accountabilities. All members require training in these responsibilities when they join and periodically throughout their terms. Training should focus on member duties, including how to inform, consult with, and represent constituencies. Training is particularly important for members who represent civil society organizations.

### ENGAGING STAKEHOLDERS IN A MULTI-SECTORAL BODY

**Broad representation of stakeholders.** Multi-sectoral bodies are only effective insofar as they represent their stakeholders and constituencies. They should have not only members who represent government sectors, but also civil society, the private sector, academia, and development partners. Each constituency brings a unique and important perspective, thus increasing the probability of achieving measurable impact. Multi-sectoral bodies should also strive for gender balance among their members. Users of the health system must be included, and in the case of disease-specific bodies, those who are infected or affected by the disease(s). As an example, one of six requirements for a CCM to be eligible to apply for GFATM grant funds (see [here](#)) is that it must have at least one person, representing an organization, who is infected or affected by HIV and/or affected by TB and/or malaria (depending on the country's grants).

Click [here](#) for more information on civil society participation in CCMs and relevant case studies in Kenya and India,

**Communication with stakeholders.** Multi-sectoral bodies engage with stakeholders through two-way communication: members both consult with and inform their constituencies. Members proactively seek information from their constituencies in order to optimize their input to the multi-sectoral body's deliberations and decision-making. They also inform their constituencies about decisions made and plans moving forward.

**Membership renewal.** To assure the continuous engagement of stakeholders, multi-sectoral bodies periodically renew their membership through election/nomination of new members. Members have specific term limits and elections are held within each sector when terms expire. Membership renewal is important to encourage sustained interest in and commitment to the multi-sectoral body and its mission.

**Participation of nonmembers.** To broaden the scope of stakeholder engagement, multi-sectoral bodies often encourage the participation of nonmembers in their activities. For example, CCMs are required to include nonmembers on CCM committees. Where the CCM has an oversight committee, often stakeholders from constituencies representing those infected or affected by the diseases or from development partners who have specific expertise needed are committee members.

## SETTING SHARED DIRECTION IN A MULTI-SECTORAL BODY

**Clear purpose and role.** A well-governed multi-sectoral body has a clear purpose and role, differentiating itself from other organizations. A typical multi-sectoral body found in many countries is the National AIDS Commission or Council (NAC), whose role is to govern the national multi-sectoral response to HIV and AIDS. The NAC's role differs from the role of the National AIDS Program, which is to implement the national response to HIV and AIDS in the health sector. Likewise, the role of CCMs is to mobilize additional resources from GFATM and other sources for AIDS, TB, and malaria in a country, and oversee the implementation of the grants. And this role differs from that of the Principal Recipients, who are responsible for implementation of the grants. In many countries, governing bodies' roles often overlap or have subtle differences. A common example is the NAC and the CCM. In these situations, it is particularly important to clarify the purpose and role of each.

**Vision and strategy.** In addition to a defined purpose and role, well-governed multi-sectoral bodies have a clear vision and strategy with regard to their intended impact. An NAC, for example, is generally responsible for preparation and implementation of the national multi-sectoral strategic plan to respond to the HIV epidemic. Similarly, national, state, and municipal health councils are multi-sectoral bodies that formulate health plans at their respective levels. Multi-sectoral bodies that are not intrinsically part of the health system or government structure (such as a national AIDS commission or a state health council) should ensure that their visions and strategies are harmonized with national or local initiatives or processes. Multi-sectoral bodies should map how their actions will relate to and interface with official (i.e., governmental and inter-governmental) agendas in order to assure proper coordination with other actors and institutions.

## STEWARDED RESOURCES IN A MULTI-SECTORAL BODY

**Raising and allocating resources.** Some multi-sectoral bodies have governance responsibilities with regard to raising their own financial resources; others receive financial resources from government or other budgets. Many are responsible for allocating resources. CCMs are exemplary in that they raise and allocate significant resources for AIDS, TB, and malaria by analyzing national plans for these diseases, identifying funding gaps, harmonizing resources, preparing concept notes for funding from GFATM, and allocating resources to a specific Principal Recipient. CCMs also mobilize resources from sources other than GFATM for prevention, care, and treatment of the diseases as well as for their own secretariat operations.

**Providing programmatic and financial oversight.** Provision of programmatic and financial oversight is a key governance function of a multi-sectoral body. Oversight ensures proper resource utilization—that activities are implemented as planned and results are achieved, and that funds are used efficiently and effectively. To do so, multi-sectoral bodies can create Oversight Committees. Indeed, one of the six eligibility requirements for CCMs concerns oversight; they must have an oversight plan and an oversight body, such as a committee. CCM Oversight Committees oversee both programmatic and financial performance of the grants. These committees review reports from Principal Recipients, make site visits, and help to resolve other grant performance bottlenecks that arise. They seek feedback from non-CCM members and persons from affected communities. Many Oversight Committees use dashboards as a governance tool to monitor grant performance and

to assist with reporting to the full CCM and general public. The dashboard tool, instructions, sample dashboard, and videos about the tool can be found on the GFATM website.

To see the six eligibility requirements, click [here](#), and for more information on CCM oversight, click [here](#) to see the Global Fund Implementer Series on oversight.

**Ensuring financial sustainability.** Multi-sectoral bodies also have the governance responsibility for assuring the long-term financial sustainability necessary to achieve their purpose and vision. A number of CCMs, for example, are beginning to plan for continued funding for AIDS, TB, and malaria beyond the time when their countries are no longer eligible for funding from GFATM.

## Good governance in civil society organizations

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We now turn from governance in the public sector and multi-sectoral bodies to civil society organizations focused on protecting, promoting, or restoring health.

Good governance in the health sector and other sectors that have an impact on health is a critical factor in achieving national and international development goals and alleviating sickness and poverty in low- and middle-income countries. There is a growing global awareness that the health problems faced in these countries are too serious and pervasive to be addressed by the public sector alone. In a coordinated public, nongovernmental, and private sector approach, civil society organizations (CSOs) need to be able to manage large-scale health projects and use donor funds in an effective and transparent way. Like public-sector institutions, CSOs require sound leadership, management, and governance as well as highly functioning organizational structures and systems so that they can provide high-quality services and use resources appropriately.

### WHAT IS A CIVIL SOCIETY ORGANIZATION?

The World Bank has adopted a [definition of civil society](#) developed by a number of leading research centers, and uses the term “civil society” to refer to:

*...non-governmental and not-for-profit organizations that have a presence in public life, expressing the interests and values of their members or others, based on ethical, cultural, political, scientific, religious or philanthropic considerations. Civil Society Organizations (CSOs) therefore refer to a wide array of organizations: community groups, non-governmental organizations (NGOs), labor unions, indigenous groups, charitable organizations, faith-based organizations, professional associations, and foundations.*

CSOs are mission-driven organizations, with a commitment to the communities and individuals they serve. They operate under many different types of legal structures, which vary by country: companies, membership associations, societies, foundations (in which property is dedicated for a specific purpose), charities, trusts, and cooperatives. The choice of the type of CSO to constitute is based on the laws of each country and is best made in consultation with an attorney. Regardless of their legal structure, all CSOs differ from for-profit entities because they cannot distribute profits or net earnings to individuals.

## WHAT IS GOOD GOVERNANCE IN CIVIL SOCIETY ORGANIZATIONS?

Good governance in CSOs has been defined in many ways. The following definition of good governance (also presented earlier in this chapter) is equally applicable to governance in CSOs: *Governance is good when* (1) decisions are based on information, evidence, and shared values; (2) the process is transparent, inclusive, and responsive to the needs of the people, the ministry, or the organization served; (3) those who make and those who implement decisions are accountable; (4) strategic objectives are effectively, efficiently, ethically, and equitably met; and (5) the vitality of the ministry or the organization is sustained.

A CSO requires a formal structure that is based on the established values of the organization and designed to achieve the CSO's mission and guarantee the proper use of resources. Good governance involves providing direction so that the organization knows where it is going; engaging the stakeholders; protecting the interests of its beneficiaries; and being accountable to society, the beneficiaries, and donors through a process that is transparent, equitable, and appropriate to the needs of the people the CSO serves.

Good governance in CSOs is not exercised only at the top of the organizational structure; this function is shared at all organizational levels. Nevertheless, the higher the level in the organization, the more responsibility people have for maintaining good governance throughout the organization.

This section of the handbook can guide a CSO of any size in becoming a more structured organization. For a new organization, it offers tools to pave the road to establish its governance structure. Once a CSO has grown beyond the one- or two-person phase, this structure almost always consists of a board of directors and a management team.

## WHY DO CIVIL SOCIETY ORGANIZATIONS NEED BOARDS OF DIRECTORS?

Unlike corporations or businesses whose main purpose is to make a profit for their shareholders or owners, CSOs are founded to work for the common good while governing wisely to enhance achievement of their organizational mission. They do not have direct owners to guide them toward their goals. Instead, a volunteer board of directors is responsible for seeing that the organization acts in the public interest. The board has the authority to lead the organization, make decisions, and set policies to guarantee the proper use of funds, effective management of human resources and provision of quality services (according to the organization's mission). The actual work of operationalizing the pursuit of their mission is usually entrusted to hired managers and executives.

**The composition of the board.** The board of directors of a CSO is made up of elected or designated volunteer leaders, often including the founders and other prominent citizens, who are committed to the organization's mission. Effective boards follow “competency-based governance” in which the organization's strategic challenges guide the knowledge and skills represented by the governing body's members. Board members may thus have skills that are useful for guiding the organization, such as communications, advocacy, fund-raising, management, and technical knowledge about the type of work the

organization carries out. Board members should also have prestige and a good reputation in the community.

A supplement to [The Manager](#) offers more information about selecting board members and a sample chart that can be used to analyze the characteristics, skills, and experience of current and prospective board members.

[BoardSource](#), a nonprofit organization, provides practical information, tools and best practices, training, and leadership development for board members of nonprofit organizations worldwide.

### WHAT ARE BOARDS' ROLES AND RESPONSIBILITIES?

The board has the ultimate authority and responsibility to guide the organization to achieve its mission and secure its viability over time. Because they are not part of management and receive no financial benefit, board members can exercise independent judgment when overseeing the functioning of the organization.

The board members hire and delegate authority to a chief executive officer (CEO)—sometimes also called an executive director—who is responsible for putting into action the board's decisions. The CEO heads the management team, which is responsible for planning, organizing, implementing, monitoring, and evaluating activities to achieve the organization's goals.

The most effective CSOs clearly separate governance and management: in general, the board of directors governs and the management team manages day-to-day operations, as detailed below. The roles and responsibilities of the board and management team should be very clear, with checks and balances that enable the board to provide an independent and disinterested counterweight to management control. Enlightened management, supported by sound policies and an informed board, forms the foundation of good governance.

You can read about [Policy Governance®](#), a board leadership model created by Dr. John Carver that enables boards to focus on the larger issues, to delegate with clarity, to control management's job without meddling, and to rigorously evaluate the accomplishments of the organization.

### HOW DO CSOS APPLY GOVERNANCE PRACTICES?

Similar to the public sector and multi-sectoral bodies, CSOs also embrace the four governance practices (cultivate accountability, engage stakeholders, set shared direction, and steward resources) to govern more effectively. [Table 3](#) details the roles and responsibilities of the board and the management team, and organizes them according to the four governance practices.

**TABLE 3. Roles and Responsibilities of the Board of Directors and Management Team**  
*(How the management team supports the board to carry out governance practices)*

CULTIVATE ACCOUNTABILITY	
Board Governance Responsibilities	Management Team Responsibilities
<ol style="list-style-type: none"> <li>1. Maintains board transparency and accountability</li> <li>2. Oversees organizational effectiveness and provides support</li> <li>3. Hires, supports, and evaluates the CEO</li> <li>4. Upholds a transparent decision-making process</li> <li>5. Promotes the quality of services and programs</li> <li>6. Maintains the effectiveness of the board</li> </ol>	<ul style="list-style-type: none"> <li>■ Provides administrative support for hiring the CEO</li> <li>■ Implements a transparent decision-making process</li> <li>■ Works on planning and implementing new projects</li> <li>■ Develops and implements quality assurance processes</li> <li>■ Provides information to the board about the quality and cost effectiveness of services</li> <li>■ Supports reporting and communicating performance to stakeholders</li> </ul>
ENGAGE STAKEHOLDERS	
Board Governance Responsibilities	Management Team Responsibilities
<ol style="list-style-type: none"> <li>1. Engages and responds to the interests of government, community, partners, and donors</li> <li>2. Maintains good community, government, and donor relations and represents the CSO publicly on occasion</li> <li>3. Promotes changes in public policy</li> </ol>	<ul style="list-style-type: none"> <li>■ Builds external relationships and represents the CSO publicly</li> <li>■ Provides administrative and logistics support for the public and stakeholder relations activities of the board and organization</li> <li>■ Develops policies for the board's consideration</li> </ul>
SET SHARED DIRECTION	
Board Governance Responsibilities	Management Team Responsibilities
<ol style="list-style-type: none"> <li>1. Defines the organization's mission in context of community needs</li> <li>2. Develops the organizational vision and strategy and approves the strategic plan</li> <li>3. Promotes the organization's values</li> </ol>	<ul style="list-style-type: none"> <li>■ Participates in defining and disseminating the mission and vision</li> <li>■ Organizes and participates in developing the strategic plan</li> <li>■ Develops the annual operational plan based on the strategic plan</li> <li>■ Applies organizational values in day-to-day activities</li> </ul>
STEWARD RESOURCES	
Board Governance Responsibilities	Management Team Responsibilities
<ol style="list-style-type: none"> <li>1. Ensures financial sustainability</li> <li>2. Promote rational use of resources to achieve mission, vision and achievement of strategic objectives</li> <li>3. Participates in fund-raising</li> <li>4. Provides financial oversight</li> </ol>	<ul style="list-style-type: none"> <li>■ Exercises responsible financial stewardship and provides up-to-date, reliable financial information to the board and donors</li> <li>■ Leads, organizes, and implements fund-raising</li> <li>■ Proposes budgets to the board</li> </ul>

## CULTIVATING ACCOUNTABILITY AT CIVIL SOCIETY ORGANIZATIONS

**Maintaining board transparency and accountability.** The lack of adequate funding has been the main concern of many CSOs for some time. The good news is that there is money available through mechanisms such as GFATM and PEPFAR. Although there are also more CSOs competing for those funds, some are unable to demonstrate the administrative capacity and transparency required to qualify for funding.

An important responsibility of the board of directors is helping the CSO meet donor requirements for funding eligibility by ensuring that the organization has processes in place to ensure accountability and that its management of funds is ethical and transparent. Board support for addressing accountability will strengthen the organization's eligibility to receive funding to address priority health problems.

Accountability involves being transparent, as seen in [Box 5](#). This means disclosing information to clients, donors, and the public about the organization's mission, the programs or activities being carried out to advance the mission, the results obtained, and the use of funds.

A [real-life example](#) follows that shows how one CSO's board and management dealt with serious governance issues.

### BOX 5. Ways in Which CSOs Can Achieve Transparency and Accountability

- Select board members who are recognized as honorable members of the community and have no conflicts of interest related to their political or business activities.
- Choose some board members with financial expertise.
- Adopt a statement of values and code of ethics.
- Develop and follow a policy on conflict of interest.
- Document the processes of recruiting and selecting new members.
- Implement an effective orientation for new board members.
- Use meeting minutes to document all decisions made by the board.
- Ensure that financial records are honest, complete, up-to-date, available, and reviewed by the board.
- Conduct an annual audit using outside auditors.
- Put policies and procedures in place to establish internal controls (see Chapter 7 of this handbook).
- Report to partners and donors annually on the organization's programmatic and financial results.
- Produce an annual report and periodic newsletters.
- Set up a website to make information publicly available.



### Transparency and Accountability in Action: A Story from the Field

An International Planned Parenthood Federation (IPPF) affiliate that provided family planning services faced several governance challenges because of the nature of its board and the assembly of members from which the board was selected. The assembly, which once represented different sectors and professions, had become a closed circle of physicians, and the turnover of board members was very low.

Some members of the board were using their positions for personal benefit. The chair of the board wanted to sell the organization a property on which it would build a clinic, but without considering the best price or the location of the property. One member of the board owned the repair workshop that maintained the organization's vehicles. Another board member provided training to the clinics based on his own assessment of deficiencies. The board approved a large acquisition of contraceptives that were close to their expiration date and would have to be discarded at a huge loss to the organization. All these actions involved conflicts of interest, and there were suspicions that corruption was involved in the procurements.

When a new CEO was hired, he was very concerned about these irregularities and determined to end illegal transactions. When the time came to change board members, the CEO found an ally in the new chair, a woman who was very committed to the organization and aware of the bad practices. With two more members of the board as allies, she started an investigation to clarify the procurement of contraceptives. The investigation produced a conflict that divided the board and the assembly into two camps. Each side tried to incriminate the other or return to the status quo, when conflicts of interest were not addressed.

At the same time, the new chair and the CEO developed a strategy to change the composition of the assembly so that in upcoming elections new people could join the board and the destructive practices could be eradicated. Following the IPPF's regulations, the chair and the CEO gained approval from the board to open the registration of new assembly members to include more women and young people. Using this strategy, they increased the number of assembly associates from 20 to 45 and verified that the new members were honest and committed.

In addition to investigating the cases of abuse, the IPPF affiliate selected a new board and removed some former members from the assembly. From this point forward, abuses were not tolerated.

**Good governance policies.** Establishing board policies and overseeing compliance with them is one way that boards regulate their own activities, bring about effectiveness and transparency, and cultivate accountability. These policies generally expand on the regulations contained in the by-laws of the CSO, provide further details and explanations, and address compliance issues.

Boards generally have policies pertaining to conflict of interest, confidentiality, use of information, meeting attendance, and compensation.

**Conflict of interest policy.** Board members are expected to make responsible, informed decisions that serve the interests of the organization. This decision-making process may be affected if the board member has personal interests that compete with the interests of the organization, as we saw in the real-life example above of an IPPF affiliate. Effective boards develop and rigorously adhere to policies to prevent conflicts of interest. [Box 6](#) is an example of a conflict of interest policy.



**BOX 6. Sample Conflict of interest Policy**

- When completing an application form, all prospective board members must state the organizations or businesses to which they are connected and the interests they have in them, particularly if there are any potential conflicts of interest.
- If there is a serious conflict of interest, the person cannot serve on the board. For example, a serious conflict of interest exists when the person owns or holds a management position in a competing organization or is a paid staff person in the organization for which he or she wishes to serve as a board member.
- When the board is going to make a decision about the purchase of goods or services during a board meeting, members are asked at the beginning of the meeting if such a decision could give rise to a conflict of interest.
- When the board is making a decision that could affect the private interests of a board member, he or she should abstain from participating in the discussion and voting.
- In general, board members and their close relatives should not sell to, buy from, or trade with the organization.
- Board members are expected to adhere to a transparent process in selecting and hiring employees. They may not participate in the selection process when relatives, friends, or acquaintances are applying.

**Confidentiality and use of information policy.** A use of information policy must be developed and implemented to protect the organization's strategic and sensitive information. This policy is closely linked to the conflict of interest policy as board members whose personal interests conflict with those of the organization should not have access to strategic information.

**Meeting attendance policy.** A common problem of boards is the absenteeism of members at both regular and special meetings. The voluntary nature of member participation and the fact that boards are generally composed of people with high social status and experience often stand in the way of full member participation. A quorum is usually defined as the majority of members. When a quorum is lacking, critical decisions might have to be postponed, to the detriment of the smooth functioning of the CSO. A clear meeting attendance policy can help avoid this problem.

**Compensation policy.** CSO board members serve voluntarily and should not be compensated for services or products provided to the organization. Conflicts of interest could arise if they are compensated financially for some service or product that the board has recommended. For example, board members might identify the need to train staff in customer service, and a board member then offers to provide paid training. This is clearly a conflict of interest, because the person who participates in the decision also stands to gain from it financially. On the other hand, CSOs can pay board members for expenses related to board work, such as those involved in participating in board meetings and retreats and conducting site visits. In those cases, the CSO can reimburse board members directly for expenses they incur so they can participate.

**Overseeing organizational effectiveness and providing support.** In protecting the interests of the CSO and being accountable to its clients, stakeholders, and the general public, the board oversees and supports the staff in meeting organizational objectives. The board also makes sure that the CSO complies with laws and regulations. The board is not intended to manage an organization but rather to strategically oversee its performance, provide advice, and help to obtain resources. The board plays these roles by hiring, supporting, and evaluating the CEO, promoting transparent decision-making, and promoting high-quality services and programs. Provision of oversight is a function of governance and thus a responsibility of the board of directors. It is different from evaluation, which is the responsibility of staff who implement programs.

Read more about the difference between oversight and evaluation in the GFATM Oversight Guidance Paper found [here](#).

**Hiring, supporting, and evaluating the CEO.** The CEO acts on behalf of the board to implement its decisions. She or he accepts the authority to hire, organize, and supervise the staff; develops appropriate policies and procedures; and allocates resources within budgetary guidelines. Because the CEO plays such a key role in the organization's performance and overall accountability, the most important responsibilities of the board are to select an appropriate person, offer guidance and advice, monitor his or her performance, and conduct periodic formal evaluations.

**Upholding a transparent decision-making process.** The decision-making process can vary significantly from one organization to another. Some organizations with very participatory cultures have a strong and committed management team that the board fully trusts. In these cases, the board delegates a great deal of responsibility to the management team and asks them simply to report on their decisions every month or quarter. In other cases, if the board does not feel the management team is mature enough, the directors may want to participate in all major decisions. Effective boards understand their management teams and are able to delegate authority appropriately. They pay close attention to their management teams' actions but avoid intruding unnecessarily. In short, they give their management teams room to learn and grow.

The CEO and management team will generally mirror the board's decision-making style. Authoritarian boards set a standard that the management team replicates and that is replicated in turn at lower levels of the organization. On the other hand, when boards encourage the management team to participate in decision-making, their style permeates all levels, fosters a broad commitment to implement decisions, generates a positive work climate, and promotes accountability.

In any case, good governance means that the decision-making process is transparent and the authority of each level of the structure is clear and respected. For example, since it is a board responsibility to approve a purchasing policy for the CSO, it must be very clear who has authority to sign. The financial director can approve small purchases, whereas the CEO must approve purchases that exceed a certain amount, and the board usually approves major investments. In this and other instances, clear policies, procedures, and levels of authority are important to control risk and fraud and, ultimately, to cultivate accountability.

**Promoting the quality of services and programs.** It is the board's responsibility to ensure that professional staff are accountable for the quality of services and programs, holding them to the highest standards for providing services and supporting them in making improvements when they are needed. In these circumstances, it is important to distinguish the role of the board from that of the management team. Some boards feel uncertain about how to carry out this responsibility and hesitate to become involved in any way at all, while others interfere with the management role by trying to supervise operations and micromanage service delivery.

Since the management team and staff are responsible and accountable for providing high-quality services, they should provide the board with information that will enable board members to assess the quality of services. Based on this information, the board can make suggestions on how to improve services. It is the management team's responsibility to put the board's recommendations into action.

To certify that high-quality services are being maintained, the board should: set quality goals; review the results; keep in close contact with the community to obtain feedback; and make sure that necessary actions to improve service quality are implemented quickly.

Chapter 9 of this handbook discusses the establishment and maintenance of high-quality services. For more information on this topic and on continuous quality improvement, please see MSH's online resource, [Managing Community Health Services](#). For more information on how to introduce or scale up effective health services, you can use the [MSH Guide to Fostering Change](#).

**Maintaining the effectiveness of the board.** The board has to carry out some activities to keep itself active and effective, and thus accountable. The most important actions to sustain the board are recruiting and selecting board members, educating the board, conducting board meetings, and evaluating and improving board performance.

**Recruiting and selecting board members.** It is important for the board to be made up of members with a common commitment and integrity, as well as diverse backgrounds, skills, and experience. This diversity will secure a broad base of community support and professional experience for the organization. Many boards have a small governance committee that searches for new candidates to serve on the board. All board members should have a job description that indicates their roles and responsibilities and the duration of their term of service.

**Educating the board.** Educating new and current board members is an ongoing process that is the responsibility of both the board and management. Initially, board members should receive orientation or training that helps them learn about the CSO and understand their roles and responsibilities. Periodic retreats, workshops, or site visits can provide time for concentrated learning about the organization, the issues it is dealing with, and the general area of expertise of the organization. Some CSOs produce guides for board members to use as self-training tools.

**Conducting board meetings.** Board business is usually conducted at monthly or quarterly meetings. Although board members are not paid for their work, bringing them together is still costly both to the individual members who give up their time to attend the meeting and to the CSO which is usually expected to reimburse their travel expenses. For this reason, it is very important for meetings to be well organized and well run. It is usually the responsibility of the chair or president of the board, with the help of the CEO, to plan board meetings so that they make the most effective use of people's time. The quality of board decisions will depend on planning, preparation, and efficient running of the meetings. At effective board meetings, the members will:

- receive information,
- be consulted about their opinions,
- discuss important policy and strategic issues,
- make decisions on these important issues,
- review or ratify previous decisions.

The Manager offers more information to consider before, during, and after board meetings.

**Evaluating and improving board performance.** Every year, depending on their term of office, the board should formally evaluate its performance. This can be done by holding a retreat or by using a self-assessment tool. The goal of the evaluation is to assess the board's fulfillment of its roles and responsibilities. It should provide the opportunity to assess the extent to which the board is effectively carrying out the four governance practices and define ways to improve board performance.

Handbook of NGO Governance by Marilyn Wyatt includes a useful checklist for self-assessment on pages 66–69.

## ENGAGING STAKEHOLDERS AT CIVIL SOCIETY ORGANIZATIONS

CSOs practice good governance by engaging effectively with a myriad of stakeholders, including the community, donors, and government.

**Engaging with the community.** Maintaining a mutually beneficial relationship with the community should be a goal of all CSO and reflected in their strategic plans. Community representation on the board will promote this relationship and will help ensure that community needs, concerns, and service opportunities are not overlooked. The management team should provide the board with up-to-date information about the community and the services that have been provided to them. Access to comprehensive information about the community helps boards make better decisions.

**Engaging with other partners, including donors.** CSOs are not alone in their environment. There are many actors interested in achieving similar goals in health. The board should investigate who is working on similar issues in the region, find those with a shared interest in establishing good relationships, and look for opportunities to work together.

Creating good relationships and partnerships with donors or other partners can increase the organization's capacity to achieve its goals and assure its sustainability in the long run.

**Engaging with government.** Responding to the government's requirements is essential to maintain the organization's legal status and enable it to provide services. But good relationships with the government go beyond legal compliance; they can facilitate or impede the CSO's ability to carry out its mission. In many countries, especially in Africa, CSOs have close relationship with their governments and provide a substantial portion of health services. In other places, such as Central Asia, the relationship between CSOs and the government is tense, at least in part because many CSOs tend to criticize government performance and advocate for better services.

Depending on the circumstances, boards should help CSOs look for the best way to maintain a good relationship with their government and seek opportunities to work together for the common good. A strong relationship with the government provides an opportunity for the board to lobby for positive legislation and regulations, and to prevent legislation that would be detrimental to the organization's mission and the community's needs and interests.

**Maintaining good external relationships.** Board members are the CSO's ambassadors and advocates. The board represents the organization in different forums, promoting and maintaining a good image and good relationships with the community, donors and other partners, and the government. How well the organization relates to all these groups affects its ability to influence the public health agenda by proposing needed changes in policy.

**Proposing changes in public policy.** The board can develop a public affairs strategy that includes contacts with high-level officials, directors of other organizations, and donors. Such a strategy will help further the CSO's mission, position the organization to receive funds, and influence public policy, all of which will help the CSO achieve its goals, as illustrated in [Box 7](#).

The management team can assist board members in this task by keeping them and the staff informed of public policy developments affecting the organization, by working with the media, and by coordinating volunteer activities that deal with public affairs.

[Click here](#) to find a tool you can use to analyze and manage the political dimensions of decision-making and public policy.

#### BOX 7. Board Activities to Position the CSO's Public Image and Its Potential to Influence Policy

- Advocate for the organization's mission and goals with influential colleagues
- Write letters to legislators, policymakers, and decision-makers
- Lobby legislators and policymakers on issues important to the organization
- Speak at conferences, public events, and community meetings
- Speak up about public affairs and make the CSO's opinions heard in the media

## SETTING SHARED DIRECTION AT CIVIL SOCIETY ORGANIZATIONS

As the governing body, the board sets the path the organization should follow to achieve its mission. It exercises this governance practice by carrying out three responsibilities: defining the organizational mission, helping develop the organizational vision and strategy, and adhering to organizational values.

**Defining the organization's mission.** The CSO's mission expresses its purpose—the reason it exists. Through the mission statement, the board, management, and staff can focus their efforts on meeting the needs of the organization's beneficiaries. The mission helps align the board, management, staff, and volunteers and provides meaning to all activities. It is the central point around which the organization develops its goals and strategies.

The mission is a broad statement that explains the type of organization, its main purpose, and its values. It should answer the questions: What do we do? Whom do we serve? How do we do it? Why do we do it?

**Developing the organizational vision and strategy, and approving the strategic plan.** The board of directors assumes a large share of the responsibility for the success of a CSO. It must make certain that the organization reaches the population it intends to serve and meets the needs of its clients. To fulfill this function, the board works with the management team to create a shared vision and strategic plan.

The vision provides a picture of where the organization wants to go and what it wants to become in the future. Experience has shown that a vision is more powerful when it is produced with the participation of many people in the organization, since people usually support what they help create. Good boards create a shared vision that is owned by those who will carry it out.

Pages 182–188 of the [Managers Who Lead Toolkit](#) provide exercises for creating a common vision.

The vision sets the stage for strategic planning. The strategic plan establishes the steps that the organization will take to achieve its goals and objectives and fulfill its mission during a three-to-five-year period. In developing a strategic plan, the board and staff ask themselves four questions: Where do we want to go? (our vision and mission); Where are we now? (external opportunities and threats, our internal strengths and weaknesses); How will we get from where we are to where we want to go? (our strategic objectives, strategies, and operational plans with actions to be taken to achieve the objectives); and How can we make sure we will get there? (mechanisms for monitoring progress and measuring results)

The board should provide guidance and input to the management team throughout the strategic planning process. Boards can be particularly effective in providing and analyzing information about the external environment, current trends in health and social policy, the needs of the population, and new funding opportunities. The board must formally approve the final strategic plan and commit to it. Once the strategic plan is in place, the board needs to see that the CSO's annual operational plans support the strategic objectives and strategies.

For details on the strategic planning process, tools, and country examples, see Chapter 5 of this handbook.

**Promoting the organization's values.** In setting direction, organizational values light the path to fulfillment of the mission. They are the ethical principles that underlie choices about how the CSO serves its beneficiaries, supports its staff, and works with its partners. Boards that are sustained by strong values gain the respect of management, staff, partners, and the community.

These values are a reflection of the organization's history. They usually express the beliefs and expectations of the founders and focus on serving the public and building a common good. Sometimes these values are declared; sometimes they are not clearly stated but are implied by the organization's culture and actions.

The organization's values should influence the way the board governs and leads, and the way management and staff work. It is the board's responsibility to make these values explicit, invite management and staff to reflect on them, and refer to the values whenever difficult decisions must be made. Good boards live the values they profess, supporting positive words with positive actions. They take responsibility for seeing that the organization's choices are based on its values.

Each organization has its own values, but there are some values that are common to many successful CSOs, as follows:

- commitment to the mission
- integrity and transparency
- accountability
- service orientation
- solidarity with the most vulnerable people
- respect for differences
- community participation

### STEWARDED RESOURCES AT CIVIL SOCIETY ORGANIZATIONS

As a governing body, boards of directors are responsible for raising and allocating resources, making sure that the resources are used in a responsible way and ensuring long-term financial sustainability.

**Ensuring financial sustainability.** When resources are scarce, it is critical for the board to set policies, make decisions, and promote projects that give the CSO access to the resources it needs to sustain and expand its projects. Financial sustainability is an often-repeated mantra. If it is true that there are more resources widely available in the development community, it is also true that each day there are more CSOs competing for these resources.

The board can ensure financial sustainability and organizational growth through three activities: (1) promoting the rational use of the organization's resources, (2) developing projects and programs to increase its income, and (3) raising additional funds.



**Promoting the rational use of the organization's resources.** When there is plenty of money, there is a tendency to relax and spend more without paying much attention to the bottom line. When board members recognize that resources are likely to shrink, they should look for ways to save money without affecting the quality of services. The costs of supplies and utilities—water, electricity, and telephone service—may be a rich source of savings. The board should also consider whether underused infrastructure or human resources might be moved or reorganized for greater efficiency and cost savings.

**Developing projects and programs to increase income.** The board is also responsible for developing strategies to increase revenue. Many CSOs have diversified their services and expanded their target groups to populations that can pay for some services. Offering obstetric care for deliveries, medical consultations by specialists, laboratory services, pharmacy services, dental services, and optometric services may be good sources of cost recovery. Board members who know the economic and business environment of their country can make good recommendations about new services that could be offered or new business that could offset the cost of sustaining the organization.

**Raising additional funds.** Caring for the most underserved populations will always require donated funds. To raise funds effectively, board members must persuade prospective donors of the importance of the CSO's work and continually cultivate their goodwill and interest. The board may help the organization consider responding to requests for proposals from donors or contracts with public institutions. In many CSOs, board members also make annual contributions to the organization.

Box 8 offers examples of other fund-raising activities.

#### BOX 8. Typical Fund-Raising Activities of Board Members

- Soliciting annual contributions to cover operating costs
- Organizing fund-raising campaigns to fund specific capital equipment or facility improvements
- Competing for funds by developing proposals for specific projects or special programs
- Establishing an endowment through income from interest, dividends, rental of real estate, and contributions to help provide for future institutional needs

**Providing financial oversight.** The board has the ultimate responsibility for the financial viability of the CSO. Board members and senior management should work together to determine financial targets and establish financial policies. The oversight function consists of six responsibilities, as shown in [Box 9](#).

To provide effective financial oversight, boards often establish a finance committee, consisting of members with experience in financial management, the CEO, and the chief financial officer of the CSO.



All financial information should be reviewed in the context of the programmatic results achieved during the period under review. At each board meeting, the board will need financial reports that detail the organization's income, expenses, and any surplus or deficit. The reports should highlight deviations from the budget, projected revenues, and whatever actions management is taking to correct those deviations.

The board must know how to review and interpret three key financial documents:

1. a cash flow projection worksheet
2. a balance sheet
3. an income statement

For details on financial management, tools, and examples, see Chapter 7 of this handbook. For information about financial oversight, go to the [MSH Electronic Resource Center](#).

#### BOX 9. Six Main Financial Oversight Responsibilities of the Board

1. Determine the financial targets of the CSO and monitor progress in reaching those targets.
2. Review financial policies, institute sound policies, and monitor adherence to those policies.
3. Review financial control systems to safeguard the resources of the organization.
4. Comply with donor or government requirements; arrange for a financial audit to be conducted by a licensed independent auditing firm annually or as otherwise required.
5. Approve the annual budget.
6. Approve the management's intentions and plans to seek additional revenue from different sources.

## Common board challenges and how to deal with them

As you can see from the examples in this chapter, boards can face a host of challenges that range from being weak, unproductive, and largely ceremonial to being too deeply involved and taking over the CEO's responsibilities and interfering with the administration of the organization. In [Table 4](#), we describe six of the most common challenges faced by boards and suggest strategies to deal with them.

With health challenges growing every day, donors are seeking governmental programs, multi-sectoral partnerships, and CSOs with which they can partner to address health needs. Strong governance is crucial to this effort, and potential donors require it. By advocating for and implementing the proven practices in this chapter, you, as a manager

TABLE 4. Common Board Challenges and How to Address Them

Challenge	Description of the Challenge	Solution
<b>Lack of experience</b>	Board members have a poor understanding of the organization, lack experience in reviewing financial and programmatic reports, and/or do not fully understand their roles. The board intervenes as little as possible in defining the direction of the organization or makes inappropriate decisions.	Conduct an orientation for every new member when he or she starts. On an ongoing basis, educate both new and old board members about their roles and responsibilities. Provide information about the organization's programs and guidelines for reviewing financial reports.
<b>Interference with management tasks</b>	Committed, well-meaning board members misinterpret their roles and try to interfere with the decisions made by the CEO and other senior managers. They question how business is conducted and constantly suggest changes.	During orientation, clearly define board members' roles and their relationship with professional staff, especially with the CEO and management team. Distribute written guidelines for this relationship. Careful oversight on the part of the board chair should help address this challenge.
<b>Lack of commitment</b>	Board members were selected without consideration of their availability and do not clearly understand the time commitment involved.	Carefully select board members, providing potential candidates with detailed information about their duties and required time commitment. Develop and implement a meeting attendance policy.
<b>Power struggles</b>	Board members have hidden agendas or previous relationships with other members that reduce their objectivity or promote unproductive conflict among members.	Establish a diversified board that makes decisions objectively, based on evidence, and is not unduly influenced by external pressures. The board chair should be alert to inappropriate alliances or conflicts and address them as soon as they appear.
<b>Conflicts of interest</b>	Members seek some type of financial gain from their service on the board by providing paid services, selling services through friends or acquaintances, or expecting and demanding other perquisites (e.g., use of the organization's vehicles, paid trips, lavish meals). Board members serve on the staff of a competing organization and thus have divided loyalties.	Develop, implement, and strictly enforce an explicit and comprehensive conflict of interest policy.
<b>Too long a term of office</b>	Boards may become lethargic, disconnected, and uninspired. Although they are ineffective, board members are reluctant to leave the board because they are founders, think they are indispensable, or want to retain the prestige of serving on the board.	Develop, implement, and enforce an office term limit and requirements for continuing service on the board. For continuity, however, do not replace the majority of the board members at one time.

of a health program or health service, can make a difference in bringing about good governance where you work.

To learn more and exchange ideas and resources about boards, please visit the [National Council of Nonprofits](#), [BoardSource](#), or The NGO World group on [LinkedIn](#).

## Proven practices

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For good governance in the public sector, leaders are encouraged to discuss how best to adapt and apply the following practices within their unique reality.

- Consistently apply the four effective governing practices (cultivate accountability, engage stakeholders, set shared direction, and steward resources) to improve the governance of your health system. This will enable you to achieve optimal utilization of medicines, information, human resources, and finances, and as a result, superior health system performance and better health outcomes.
- Use modern information and communication technologies and measurement of performance to facilitate the application of the four governance practices and enhance their effectiveness.
- Commit to regular assessment of governance performance. Good governance is not static, it is dynamic, and leaders who govern a health system or institution must make a commitment to regularly assess their governance performance. Continuous governance enhancement becomes possible when an objective and structured evaluation of how well you believe you are governing is done on a regular basis.
- Continuously improve your governance competencies. Wise, effective, and efficient governance does not just happen. Those who govern must invest individually and collectively to continuously improve their competencies (knowledge, skills, and capabilities). Governance leaders must explore and use opportunities to sharpen their governance competencies.
- Do an excellent job at setting your strategic direction. Governance should be driven by a clear strategic direction based on the health needs of the people the health institution exists to serve and supported by policies, plans and programs, and resources to meet those needs.

For good governance within multi-sectoral bodies:

- Assure good leadership. Multi-sectoral bodies need committed, motivated, democratic, and empowered leadership. Budgeted funds that support leadership development for multi-sectoral bodies are a worthwhile investment.
- Clear terms of reference delineating the responsibilities, of members, officers, and committees are crucial for the effectiveness of multi-sectoral bodies.

- Civil society organizations should have a formal role in the governance structure of multi-sectoral bodies. Their representatives should truly represent their constituencies.
- Clear policies and procedures to manage conflict of interest and training of members in conflict of interest help to assure that non-interested decisions are made and resources are deployed wisely.
- An adequately staffed and equipped administrative secretariat contributes significantly to the performance of a multi-sectoral body.

If you govern or manage a CSO:

- Select board members who are committed, motivated, honest, and who have key experience in an area of the work of the organization.
- Regularly induct board members with ongoing orientation and training in the CSO's mission, strategy, interventions, and results, as well in the by-laws and board roles and responsibilities.
- A clear division of responsibilities and functional decision-making processes between the board of directors and the management team is fundamental to both the successful governance and management of the organization.
- Clear rules and processes regarding the use of funds, including a conflict of interest policy and procedures, help to assure transparency and accountability.

## Glossary of governance terms

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**accountability:** Accountability means ensuring that officials in public, private, and civil society organizations are answerable for their actions, and that there is redress when duties and commitments are not met. Individuals, agencies, and organizations are held responsible for executing their powers properly through accountability mechanisms. Accountability is an institutionalized relationship between different actors. An accountability relationship has four stages: *standard setting*, *investigation*, *answerability*, and *sanction*.

**articles of incorporation:** Legal documents, filed with the appropriate agency, that establish a CSO, provide basic information about it, and specify its purpose.

**by-laws:** Documents that set out the rules under which a CSO's governing body—often a board of directors—operates.

**civil society organization (CSO):** A nongovernmental and nonprofit organization with a presence in public life that expresses the interests and values of its members or others, based on ethical, cultural, political, scientific, religious, or philanthropic considerations. CSOs advance the collective or public good and include community groups, labor unions, indigenous groups, charitable organizations, faith-based organizations, professional associations, and foundations.

**data, information, evidence, and evidence-based decision-making:** Data are facts and are one source of information. Information comprises data, ideas, and concepts that have been recorded, analyzed, and organized in a way that facilitates interpretation and subsequent action. Analysis is the examination and evaluation of relevant information in order to select the best course of action from among various alternatives.

**decentralization:** Within national health systems, the transfer of political, financial, and administrative power from central control to regional and local authorities.

**efficiency:** Efficiency describes the extent to which time or effort is well used for the intended task or purpose. It is the capability of a specific amount of effort to produce a specific outcome effectively with a minimum waste. Efficiency is quantitatively determined by the ratio of output to input. Efficiency in the governance context means that processes and institutions produce results that meet the needs of society by making the best use of resources at their disposal.

**eHealth:** The use of information and communication technologies for protecting, promoting, or restoring health, for example, for treating patients, conducting research, educating the health workforce, tracking diseases, or monitoring public health.

**ethical and moral integrity:** Ethics are standards of right and wrong. Morality, on the other hand, is what an individual actually does. If an individual does what she or he believes and says is right and avoids doing what she or he believes and says is wrong, that individual has integrity.

**equity:** Equity means fairness. Equity in health means that people's needs guide the distribution of health services and opportunities for health and well-being. Inclusion and participation are vital for achieving equity in health, for example, when all men and women have opportunities to improve or maintain their health and well-being.

**evidence:** Evidence is information or facts from a variety of both qualitative and quantitative sources that are systematically obtained, i.e., obtained in a way that is replicable, observable, credible, verifiable, or basically supportable. Evidence comprises information such as analyzed data, published research findings, results of evaluations, prior experience, and expert opinions, any or all of which may be used to reach conclusions on which decisions are based.

**evidence-informed public health:** This involves integrating the best available evidence into the decision-making process in public health practice and policy development. It means finding, using, and sharing what works in public health.

**gender responsiveness:** Gender responsiveness is being aware of and clearly responsive to different needs based on gender.

**governance:** A collective process of making decisions in organizations, health systems, or the health sector. Governance is (1) setting strategic direction and objectives; (2) making policies, laws, rules, regulations, or decisions, and raising and deploying resources to accomplish strategic goals and objectives; and (3) overseeing and making sure that the strategic goals and objectives are accomplished.

**governance for health:** Governance done with the objective of protecting and promoting the health of the people the ministry or the organization serves

**mHealth:** Use of mobile and wireless devices to improve health outcomes, health care services and health research

**multi-sectoral:** Including institutions from all segments—public, private, voluntary, and faith based—and, importantly, local communities.

**multi-sectoral agencies:** Organizations that draw from many sectors to address specific diseases and health systems. Examples are the Global Alliance for Vaccines and Immunization (GAVI), and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).

**participation:** Participation can be broadly defined as active involvement. Citizen participation is the processes by which public concerns, needs, and values are incorporated into decision-making. It refers to the whole set of activities processes, and public participation techniques and methods chosen to engage people. It may be indirect or direct.

**stewardship:** The ethical and efficient administration and management of another's property or financial affairs.

**sustainability:** Sustainability in the context of health systems refers to the capacity to continue activities in the future and to expand activities to keep up with population growth and with the additional demand created by epidemiological situations. A health service is sustainable when operated by an organizational system with the long-term ability to mobilize and allocate sufficient and appropriate resources (manpower, technology, information, and finances) for activities that meet individual or public health needs.

**transparency:** Transparency is the opposite of secrecy: it is about shedding light on rules, plans, processes, and actions. It is a characteristic of governments, companies, organizations, and individuals that clearly disclose information, rules, plans, processes, and actions. Public officials, civil servants, managers, directors, and trustees are in a fiduciary relationship or relationship of trust with the stakeholders, and they have a duty to act visibly, predictably, and understandably—i.e., transparently—vis-à-vis their stakeholders.

## References and resources

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- Azfar, Omar, Satu Kähkönen, and Patrick Meagher. *Conditions for effective decentralized governance: A synthesis of research findings*. IRIS Center, University of Maryland, 2001, 67–73.
- Battacharyya, Karabi, and John Murray. *Participatory Community Planning for Child Health: Implementation Guidelines*. Arlington, VA: Published for the U.S. Agency for International Development by BASICS Project, 1999, linked on <http://erc.msh.org/tool-kit/Tool.cfm?lang=1&CID=1&TID=173> (accessed Dec. 17, 2009).
- Björkman, Martina, and Jakob Svensson. “Power to the People: Evidence from a Randomized Field Experiment on Community-Based Monitoring in Uganda.” *The Quarterly Journal of Economics* 124(2) (2009): 735–769.
- BoardSource. *The Nonprofit Board Answer Book: A Practical Guide for Board Members and Chief Executives*. 2nd ed. Washington, DC: BoardSource, 2007.
- Delavallade, Clara. “Corruption and distribution of public spending in developing countries.” *Journal of Economics and Finance* 30 (2006): 222–239.
- Duvvury, Nata, Helen Cornman, and Carolyn Long. *Participation of Civil Society in Global Governance: Lessons Learned from the Global Fund to Fight HIV, AIDS and Tuberculosis*. Washington, DC: International Center for Research on Women, 2005, <http://www.icrw.org/files/publications/Participation-of-Civil-Society-in-Global-Governance-Lessons-Learned-from-the-Global-Fund-to-Fight-HIV-AIDS-Tuberculosis-and-Malaria.pdf> (accessed Feb. 10, 2014).
- Edward, Anbrasi, Binay Kumar, Faizullah Kakarm, et al. “Configuring Balanced Scorecards for Measuring Health System Performance: Evidence from 5 Years’ Evaluation in Afghanistan.” *PLoS Med* 8(7) (2011): e1001066.
- Global Fund to Fight AIDS, TB and Malaria. *Country Coordinating Mechanism Model – Conflict of Interest*. The Global Fund Implementer Series. Geneva: no date, [http://www.gfcu.org.ls/ccm/CCM\\_Conflict\\_Of\\_Interest.pdf](http://www.gfcu.org.ls/ccm/CCM_Conflict_Of_Interest.pdf) (accessed Dec. 9, 2013).
- . *Country Coordinating Mechanism Model – CCM Oversight Practices*. The Global Fund Implementer Series. Geneva: no date, [http://www.gfcu.org.ls/ccm/CCM\\_Oversight.pdf](http://www.gfcu.org.ls/ccm/CCM_Oversight.pdf) (accessed Dec. 9, 2013).
- . *Country Coordinating Mechanism Model – Lessons Learned in the Field: Health Financing and Governance*. The Global Fund Implementer Series. Geneva: no date, <http://www.icaso.org/media/files/4700-CCMreport.pdf> (accessed Dec. 9, 2013).
- . *Country Coordinating Mechanisms – Partnerships and Leadership*. The Global Fund Implementer Series. Geneva: November 2008, [http://www.gfcu.org.ls/ccm/CCM\\_Partnership\\_Leadership.pdf](http://www.gfcu.org.ls/ccm/CCM_Partnership_Leadership.pdf) (accessed Dec. 9, 2013).
- . “Guidelines and Requirements for Country Coordinating Mechanisms.” Updated November 6, 2013, <http://www.theglobalfund.org/en/ccm/guidelines/> (accessed December 10, 2013).



- Gray-Molina G, Perez de Rada E, Yañez E. (2001). "Does voice matter? Participation and controlling corruption in Bolivian hospitals." In: Di Tella R, Savedoff WD, (eds). *Diagnosis corruption: fraud in Latin America's public hospitals*. Washington, DC: Inter-American Development Bank.
- Gupta, Sanjeev, Hamid Davoodi, and Erwin Tiongson. "Corruption and the provision of healthcare and education services." In Jain, Arvind, ed., *The Political Economy of Corruption*. 1st ed., London and New York: Routledge, 2009, 111–141.
- Hanf, Mattheiu, Astrid Van-Melle, Florence Fraisse, et al. "Corruption kills: estimating the global impact of corruption on children deaths." *PLOS ONE*, 6(11) (2011), e26990.
- Health Evidence*. Based at McMaster University, this is a free, searchable online registry of systematic reviews on the effectiveness of public health and health promotion interventions, no date, <http://www.healthevidence.org> (accessed Feb. 6, 2014).
- Ingram, Richard T. *Ten Basic Responsibilities of Nonprofit Boards*. 2nd ed. Washington, DC: BoardSource, 2009.
- International Planned Parenthood Federation. *Welcome On Board: A handbook to help IPPF Membership Associations improve their Governance*. London: International Planned Parenthood Federation, 2010, <http://www.ippf.org/resource/Welcomes-Board-governance-handbook> (accessed Feb. 10, 2014)
- IPPF Governance Task Force. *IPPF Code of Good Governance*. International Planned Parenthood Federation. 2007, [http://www.ippf.org/sites/default/files/ippf\\_code\\_of\\_good\\_governance.pdf](http://www.ippf.org/sites/default/files/ippf_code_of_good_governance.pdf) (accessed Feb. 10, 2104).
- K4H (Knowledge for Health)'s mHealth resources can be accessed from <http://www.k4health.org/topics/mobile-technologies-health-mhealth>. K4Health is building a brand new website to provide easy access to all of their mHealth tools and resources.
- King's Fund, The. *Leadership and Engagement for Improvement in the NHS. Report from the King's Fund Leadership Review 2012*. London: The King's Fund, 2012, [http://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/leadership-for-engagement-improvement-nhs-final-review2012.pdf](http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/leadership-for-engagement-improvement-nhs-final-review2012.pdf) (accessed Feb. 11, 2014).
- Lassner, Karen Johnson, ed. *Guide to Effective CSO Governance*. Cambridge, MA: Management Sciences for Health, supported by US Agency for International Development, 2010, <http://erc.msh.org/toolkit/Tool.cfm?lang=1&TID=136&CID=9>.
- Lavis, John, Andrew Oxman, Simon Lewin, and Atle Fretheim. "SUPPORT Tools for Evidence-Informed Health Policymaking (STP)." *Health Research Policy and Systems* 7 (Suppl 1) (2009):11, <http://www.health-policy-systems.com/content/pdf/1478-4505-7-S1-I1.pdf> (accessed Feb. 6, 2014).
- Lindelow, Magnus, Pieter Serneels, and Teigist Lemma. "The Performance of Health Workers in Ethiopia: Results from Qualitative Research." *Social Science and Medicine* 62 (2006): 2225–2235.
- Malena, Carmen. "Strategic Partnership: Challenges and Best Practices in the Manage-



ment and Governance of Multi-Stakeholder Partnerships Involving UN and Civil Society Actors.” Background paper prepared for the Multi-Stakeholder Workshop on Partnerships and UN-Civil Society Relations, Pocantico, New York, February 2004. <http://www.un-ngls.org/orf/partnership-carmen-malena.doc> (accessed Dec. 9, 2013).

- Management Sciences for Health. “Learning to Think Strategically.” *The Manager* (Boston) vol. 3, no. 1, 1994, [http://www.msh.org/resources/learning-to-think-strategically?keywords=Learning%20to%20think%20strategically&field\\_resource\\_type\[0\]=Publication](http://www.msh.org/resources/learning-to-think-strategically?keywords=Learning%20to%20think%20strategically&field_resource_type[0]=Publication) (accessed Dec. 14, 2009).
- . “Working with Boards of Directors.” *The Family Planning Manager* (Boston) vol. 3, no. 5, 1994, [http://www.msh.org/sites/msh.org/files/v3\\_n5\\_en.pdf](http://www.msh.org/sites/msh.org/files/v3_n5_en.pdf) (accessed Feb. 6, 2014).
- . “Pocket Guide to Improving Board Performance.” Supplement to *The Family Planning Manager* (Boston) vol. 3, no. 5, 1994, <http://www.msh.org/resources/working-with-boards-of-directors> (accessed Dec. 17, 2009).
- . *Managers Who Lead: A Handbook for Improving Health Services*. Cambridge, MA: Management Sciences for Health, 2005. <http://www.msh.org/resource-center/managers-who-lead.cfm> (accessed April 23, 2010).
- . Guide for Training Community Leaders to Improve Leadership and Management Practices. Cambridge, MA: Management Sciences for Health, 2008, <http://www.msh.org/resources/guide-for-training-community-leaders-to-improve-leadership-and-management-practices> (accessed Feb. 25, 2014).
- . “Good Governance in Civil Society Organizations.” *The eManager* (Cambridge) 2009, no. 2, [http://www.msh.org/sites/msh.org/files/emanager\\_2009-no2\\_governance-english\\_0.pdf](http://www.msh.org/sites/msh.org/files/emanager_2009-no2_governance-english_0.pdf) (accessed Feb. 6, 2014).
- . “How to Govern the Health Sector and its Institutions Effectively.” *The eManager* (Cambridge) March 2013, <http://www.lmgforhealth.org/content/emanager-how-govern-health-sector-and-its-institutions-effectively> (accessed December 10, 2013).
- . *The Manager’s Electronic Resource Center*. <http://erc.msh.org/> (accessed July 6, 2009).
- Mikkelsen-Lopez, Inez, Kaspar Wyss, and Don de Savigny. “An Approach to Addressing Governance from a Health System Framework Perspective.” *BMC International Health and Human Rights* 11:13 (2011), <http://www.biomedcentral.com/1472-698X/11/13> (accessed Feb. 6, 2014).
- National Association of Local Boards of Health. *NALBH’s Six Functions of Public Health Governance*. 2012, [http://www.nalboh.org/documents/Governance\\_Functions.pdf](http://www.nalboh.org/documents/Governance_Functions.pdf) (accessed Feb. 11, 2014).
- National Collaborating Centre for Methods and Tools (NCCMT). The NCCMT website offers numerous governance resources and methods and tools for using evidence, not dated, <http://www.nccmt.ca/registry/browse/all/1/view-eng.html> (accessed Feb. 6, 2014).
- NHS Leadership Academy website. National Health Service (UK), no date, <http://www>.

- leadershipacademy.nhs.uk (accessed Feb. 6, 2014).
- NHS Leadership Academy. *The Healthy NHS Board 2013. Principles for Good Governance*. <http://www.leadershipacademy.nhs.uk/wp-content/uploads/2013/06/NHSLeadership-HealthyNHSBoard-2013.pdf> (accessed February 3, 2014).
- Olafsdottir, Anna, Daniel Reidpath, Subhash Pokhrel, et al. "Health systems performance in sub-Saharan Africa: governance, outcome and equity." *BMC Public Health* 11 (2011):237–244.
- Omaswa, Francis, and Jo Ivey Boufford. *Strong Ministries for Strong Health Systems: An overview of the study report Supporting Ministerial Health Leadership: A Strategy for Health Systems Strengthening*. New York City: The New York Academy of Medicine and ACHEST, 2010, p.32, <http://www.rockefellerfoundation.org/uploads/files/8819cca6-1738-4158-87fe-4d2c7b738932.pdf> (accessed Feb. 6, 2014).
- Rajkumar, Andrew, and Vinaya Swaroop. "Public spending and outcomes: Does governance matter?" *Journal of Development Economics* 86(1) (2008): 96–111.
- Reich, Michael R., and David Cooper. *PolicyMaker Software: Computer-Assisted Political Analysis*. Brookline, MA: PoliMap, 1996, <http://www.polimap.com/> (accessed August 4, 2014).
- Twaweza website. Twaweza, no date, <http://www.twaweza.org/> (accessed Feb. 6, 2014).
- Vian, Taryn. "Review of Corruption in the Health Sector: Theory, Methods and Interventions." *Health Policy and Planning* 23(2) (2008):83–94. <http://heapol.oxfordjournals.org/content/23/2/83.full.pdf> (accessed Feb. 6, 2014).
- Wilkinson, Richard, and Michael Marmot, eds. *Social Determinants of Health: The Solid Facts*. 2nd ed., World Health Organization, 2003, [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0005/98438/e81384.pdf](http://www.euro.who.int/__data/assets/pdf_file/0005/98438/e81384.pdf) (accessed Feb. 4, 2014).
- World Bank. "The World Bank and Civil Society." Washington, DC: 2009, <http://go.worldbank.org/PWRRFJ2QH0> (accessed Feb. 17, 2010).
- World Health Organization. *The Health Manager's Website*. <http://www.who.int/management/en/> (accessed July 6, 2009).
- . *A Handbook of NGO Governance*. Budapest: European Center for Not-for-Profit Law, 2004, [http://www.dochas.ie/pages/resources/documents/Governance\\_Handbook.pdf](http://www.dochas.ie/pages/resources/documents/Governance_Handbook.pdf) (accessed Feb. 11, 2014).



# Mainstreaming Gender Equality into Health Systems

Belkis Giorgis

1. Achieving Results by Strengthening Health Systems
2. Leading and Managing: Critical Competencies for Health Systems Strengthening
3. Governance of Health Systems and Health Organizations
4. Mainstreaming Gender Equality into Health Systems
5. Planning the Work and Working with the Plan
6. Managing Human Resources
7. Managing Finances and Related Systems
8. Managing Medicines and Health Products
9. Managing Information: Monitoring and Evaluation
10. Managing Health Service Delivery

The 2012 World Development Report *Gender Equality and Development* states that during the past three decades women's and girls' education and health levels have improved significantly. Two-thirds of all countries have reached gender parity in primary education. In addition, in over one-third of all countries, girls significantly outnumber boys in secondary education.

However, in many parts of the world, too many women suffer needlessly, both physically and economically, and they have limited opportunities to voice their needs to a responsive audience. Such inequality is not only an affront to human rights, it is also shortsighted: under-investing in women obstructs poverty alleviation strategies by denying them the opportunity to achieve important gains in health outcomes and, more broadly, by limiting their overall advancement in economic and social development. Gender equality is a longer-term driver of community and country competitiveness, and equity is even more important in an era of increasingly globalized economies.

For more information on the status of women and girls, please see the full [WDR 2012: Gender Equality and Development](#) and a [Harvard Business Review blog](#) with data on global gender equality, as well as an [OECD report](#) on tackling the root causes of gender inequalities in the post-2015 development agenda.

“Sex” refers to biological differences between men and women. “Gender” concerns the characteristics that are considered “masculine” and “feminine” in a society; it refers to an array of socially constructed qualities, behaviors, and opportunities associated with being male or female as well as with the relationships between men and women.

A wide range of attributes is associated with gender: dress, household roles, economic status, definitions of success, and so on.

The health conditions of men and women are a result of both biological and social factors. Biologically, although men and women share many health risks (e.g., TB, malaria, polio), there are sex-specific health concerns and threats unique to the biology of each sex (e.g., cervical and uterine cancer for women and testicular cancer for men). Socially proscribed gender roles can compound health risks, for example men work as drivers so are more likely to be in traffic accidents, and women are more likely to suffer lung damage as a result of exposure to smoke from traditional cooking practices.

#### BOX 1. Disease Burden Among Females and Males in Developing Countries

A World Bank study on health investment in developing countries found a clear differential in disease burden between genders. In adults aged 15 to 24 years, females experienced the greatest disease burden from maternal health issues, followed by sexually transmitted diseases (STDs), Tuberculosis, HIV infection, and depressive disorders, respectively.

Males, on the other hand, were most affected by HIV infection, followed by complications from Tuberculosis, motor vehicle injuries, homicide and violence, and war. This data provides a glimpse into the disparate biological and social factors that help define the health risks that men and women face.

Source: Fatalla, Mahmoud. "Issues in Reproductive Health: Health and being a woman." UN News Center. United Nations. Web. 26 Aug. 2014.

In the health sector, gender inequality contributes to health disparities in access to health care and health status. Conversely, well-designed health systems ensure men and women benefit equally from high-quality services, which ultimately contribute to family, community, and societal well-being. The range of factors that limit access for poor women includes time constraints, intra-household resource allocation and decision-making relating to health care, and legal and sociocultural constraints, [as reported by Bridge \(development-gender\)](#). This will require people to think differently, learn new ways of viewing gender, and adopt new behaviors that run contrary to what they have been socialized to believe and how they have been socialized to behave. As the manager of a health program or health services, you must challenge the often long-held, entrenched values of male-dominated power structures and patriarchal norms in order to achieve the goal of gender equality.

In this chapter we will review concepts, approaches, and tools that will help you bring about a change of perspective in designing and implementing policies and programs in health. Throughout the chapter we have included links to resources in case you want to explore a topic in greater detail. As any discussion about gender requires clarity about terms, in the [glossary](#) at the end of this chapter we have defined the relevant constructs.

For further exploration of gender-related terms and concepts, you can consult a [USAID policy document](#) on gender equality and female empowerment, some [FAQs concerning gender-related concepts](#), and an extensive [glossary prepared by the United Nations \(UN\)](#).

The Leadership, Management & Governance project of Management Sciences for Health has a web page titled [Gender](#), which includes links to many invaluable resources in support of work toward gender equality.

## Myths and realities related to gender

One of the many challenges faced by those working to achieve gender equality are the myths and misconceptions surrounding the topic. [Box 2](#) provides some common myths as well as language you can use to counter these misconceptions.

### BOX 2. Myths and Realities Regarding Gender

#### Myths

“All this talk of gender, but what they really mean is women.”

“We have a women’s project, and therefore we have mainstreamed gender.”

“Working with ‘gender’ rather than a ‘women’s’ focus means that there is no place for ‘specific actions’ focusing on women as a separate target group.”

“Gender equality means that women and men are the same.”

“We are here to save lives, not to ask whether someone is a woman or a man.”

“Only gender advisors are responsible for addressing gender issues.”

“Our problem is poverty. Once we reduce poverty, gender issues will not be relevant.”

#### Realities

It is true that a lot of gender-related work focuses on women. This is primarily because women’s development outcomes (e.g., health, education, employment) are more negatively affected than those of males. However, gender equality is not just about women and girls. It’s about addressing the different needs of women, girls, boys, and men equally so that all members of society benefit from development strategies.

A gender mainstreaming strategy involves bringing gender analysis into all initiatives, not developing just an isolated subcomponent or project.

There is a place for specific, women-focused interventions in a gender mainstreaming approach. However, such interventions are identified as a result of strategic choice rather than by default. A gender analysis may result in the formulation of interventions bringing women and men together, or concerning women as a separate group or men as a separate group.

Equality does not mean that women and men are the same, rather that their enjoyment of rights, opportunities, and life chances are not governed or limited by whether they were born female or male.

When we have limited resources, we must be even more vigilant to ensure that we use our resources to assist the most affected, which are often the most vulnerable, marginalized, and underprivileged. In this way, including findings from gender analysis as part of program design is simply about good programming and responsible stewardship of available resources that is accountable to improving overall health outcomes.

We are all accountable for improved health outcomes. When gender disparities exist, it is everyone’s responsibility to address them. Program staff have to ensure the assistance and protection they provide meets the needs of all members of the population equally.

Gender inequality causes and perpetuates poverty and vulnerability. But greater gender equality can help to reduce the root causes of poverty and vulnerability and contribute to sustainable pro-poor growth (Overseas Development Institute 2008).

Source: Adapted from Mercy Corps, BRIDGE & Gender Mainstreaming: A Guide for Program Staff. p. 6.

## The basics: gender mainstreaming

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Gender mainstreaming was established as a global strategy for promoting gender equality in the Platform for Action adopted at the United Nations Fourth World Conference on Women, held in Beijing in 1995. The strategy recognizes that gender equality is a primary goal in all areas of social and economic development (e.g., health, education, employment). Mainstreaming gender is not merely about adding a “women’s” or “gender” component to a program or increasing women’s participation in an intervention. Gender mainstreaming is about including all members of society and all the experience, knowledge, and interests that they bring into setting and implementing the development agenda.

Gender mainstreaming suggests a need for changes in goals, strategies, and actions to allow both women and men to influence, participate in, and benefit from development processes. At an organizational level, gender mainstreaming requires a review of and subsequent changes in the organization’s structures, procedures, and culture in order to create an environment in which all can contribute and flourish.

The Economic and Social Council of the United Nations defines gender mainstreaming as follows (UN 1997):

*Mainstreaming a gender perspective is the process of assessing the implications for women and men of any planned action, including legislation, policies or programs, in any area and at all levels. It is a strategy for making the concerns and experiences of women as well as of men an integral part of the design, implementation, monitoring and evaluation of policies and programs in all political, economic and societal spheres, so that women and men benefit equally, and inequality is not perpetuated. The ultimate goal of mainstreaming is to achieve gender equality.*

Thus mainstreaming gender equality into the health system is a process that requires a major transformation of how we view the world and our and others’ role in it and broadening the perspectives we bring to the table. Gender mainstreaming requires us to understand the socially constructed roles of men and women and how these roles impact their ability to access power and resources, including health care.

You can also view the complete [UN Council document](#) from which the preceding definition is taken, as well as a [fact sheet](#) describing the UN’s gender mainstreaming strategy.

[Box 3](#) presents several statements that reflect the key principles of gender mainstreaming; use them to help you consider their application in your organization.



**BOX 3. Gender Mainstreaming: Are You Advancing It?**

Review the key principles of gender mainstreaming below and check which ones are relevant to your work and/or position. Then reflect on how well your organization is living by these principles:

I **recognize** that gender equality is critical to achieve all of my organization's goals.

I work to **ensure** that gender considerations, concerns, and experiences of women and men, girls and boys, are integral to the design, implementation, monitoring, and evaluation of all legislation, policies, and programs.

I work to **promote** equality between women and men, girls and boys, in all of my organization's policies, programs, strategies, and interventions.

I work to **ensure** that women and men equally participate in setting priorities and goals and in planning so that programs meet the priorities and needs of both women and men, girls and boys.

I **analyze** the potential positive and negative impact of all of our interventions in all areas on men and women, girls and boys.

I **require** that gender analyses be conducted prior to making important decisions on goals, strategic plans, and resource allocations.

After reviewing this list with your team and colleagues, identify areas where you could do better.

**WHY AND HOW TO MAINSTREAM GENDER IN THE HEALTH SECTOR**

Much of gender mainstreaming in the health sector is guided by the recognition of the central roles women play as both providers and recipients of health care at different levels of the health system. These roles include the following:

**Women as health care providers in the household.** Women are often responsible for health-related matters within the family. They care for the young, the sick, the elderly, and the disabled. Often women have to care for family members when they themselves are sick; data show that women's burden of disease and disability between the ages 15 and 49 is high (Fatalla 1998). In places where health systems do not deliver high-quality care and/or have limited points of access to care, women become the primary—and sometimes the only—providers of health care in their families. In turn, this socially constructed role for women as the household caretaker can translate into challenges to gaining education and employment. Although gender norms may leave family health issues as a woman's responsibility, it's also important to note that these responsibilities reduce time available for other health activities (e.g., breastfeeding) and may inhibit men from supporting women's and children's use of formal health services. Women may also have limited control over family resources (i.e., for health care) relative to men.

**Women as health care providers in formal health systems.** Gender segregation in medical or allied health education programs in most low-income

countries results in an unbalanced representation of women in the health workforce. Women are generally underrepresented in higher health posts or parts of the profession where income is high. Conversely, women hold most of the lower positions in the health workforce, those with the lowest pay and benefits. This disproportionate representation of women across the health care workforce can pose challenges to improving the quality of health care services for women. (Standing 2000)

**Women as consumers of health care.** Because of their reproductive and caregiving roles, the major users of health systems are women and their children. One would thus expect a “women-centered approach” but, sadly, that is rarely the case as there are many cultural, social, and economic barriers that keep women from accessing the services they need. Maternal and child mortality is high in most low-income countries; access to good health care is critical for improving the health status of women and children.

Mainstreaming gender equality into the health sector is therefore of particular relevance because gender plays such a key role in determining the health status of men and women and their access to health information and services.

The primary aims of gender mainstreaming are to:

- Recognize the different health risks men and women are exposed to so health program practitioners can make sure both receive the services and information that is most critical for them.
- Recognize socioeconomic and cultural factors that inhibit access to services in order to make changes to how, when, and where women and men are served.
- For example, for women, these factors include their heavy workload, lack of autonomy and income, and the unwillingness of their families to invest in their health.
- For men, the considerations might be their unwillingness to visit a clinic that is frequently used by women or where clinic hours do not accommodate their work needs.
- Collaborate with all stakeholders to fully understand the issues and specific needs of all beneficiaries, including those whose voices are often not heard, and to use that understanding to design, implement, monitor, and evaluate health programs.
- Strengthen capacity in different sectors (e.g., nongovernmental and governmental organizations, including women’s organizations) and at different levels (local, regional, and national) to bring perspectives and contributions to policy development, program management and administration, human resource planning, service delivery, management information systems, and accountability.

## CHALLENGES YOU CAN EXPECT

Gender roles and norms are deeply entrenched and culturally embedded values of societies. Therefore, as a manager of a health program or health services, you can expect many challenges as you attempt to mainstream gender into your organization, your programs, your project, and your everyday life. You should plan how you will address some of the common challenges you will encounter. For example:

- Health is determined by many factors that lie outside the sphere of influence of health professions.  
*So how do you engage with actors from others sectors and ministries to reduce gender disparities in health outcomes?*
- It is easier to talk about gender mainstreaming than it is to implement it.  
*So how do you secure real political and resource commitments within your organization or in government, including at the highest levels?*
- Health policy professionals and practitioners, both male and female, are all products of their culture.  
*So how do you get them to examine their own attitudes toward their clients and patients, male and female, old and young?*
- Gender mainstreaming may take a falsely simplistic approach to addressing health inequities by excluding other social determinants of health inequities, including race, class, ethnicity, and educational level.  
*So how can you refrain from applying stereotypes and acknowledge the multiple identities that both men and women have?*
- There is sometimes a perception that interest in gender equality and equity in low-income countries is championed by Western donors' agendas but is not independently present in the country itself.  
*So how can you make the gender conversation relevant to all stakeholders and a local agenda rather than one that is perceived as being imposed from the outside?*

It is important to acknowledge the validity of these tough questions and to prepare thoughtful and comprehensive responses that demonstrate an understanding of the issues and offer ways to address them. You will invariably find that each of these challenges require using one or more of the practices discussed in other chapters (especially Chapters 2 and 5): aligning, mobilizing, scanning, focusing, setting shared direction, engaging stakeholders, cultivating accountability, and more. Our experiences have shown that the conscious, intentional, and systematic application of these practices will help you face these challenges with confidence.

## HOW TO CONDUCT A GENDER ANALYSIS

Gender analysis is a first step in gender mainstreaming because it provides the necessary information required for health policy, planning, and programming. Information not easily observed is often brought to the fore in the process of asking questions. A gender analysis reveals the consequences of gender inequality in relation to the vulnerability of men and women to different diseases and highlights the differences in access to health resources to prevent or treat disease and illness. The findings of a gender analysis will help you to improve the effectiveness and quality of health services by delivering appropriate services for men and women.

An example of a gender analysis matrix for health appears in a [WHO learning module](#) on sex and gender. In addition, Chapter 10 of the handbook, which has a section titled “Assuring Equitable Access for All People and Communities,” concludes with Appendix A, “Framework for Gender Analysis.”

### BOX 4. How to Conduct a Gender Analysis

In a gender analysis, in addition to considering the biological risks of men and women for disease and disability, examine factors that relate to gender.

- Examine the roles, relationships, and differences between women and men as established by cultural norms and practices and whether they make them more or less susceptible to health problems.
- Highlight how inequalities impose constraints on seeking and maintaining good health, and/or identify ways to address and overcome these constraints.
- Analyze influences in decision-making and who makes decisions in the household and the related consequences with regard to access to quality care, health outcomes, and overall livelihood.
- Reveal the health risks and problems that men and women face as a result of the social construction of their roles, e.g., contact with waste water, fumes from indoor cooking fires.
- Analyze men’s and women’s position within the community and how this influences their assumption of leadership positions and participation in community activities.

WHO’s *Gender Analysis in Health* is an invaluable resource for those working on gender and health; it includes a critical review of 17 widely used tools and their usefulness for gender analysis in health. In addition, USAID’s Automated Directive System (ADS), includes Chapter 205, “[Integrating Gender Equality and Female Empowerment in USAID’s Program Cycle](#).” Another USAID resource is its “[Guide to Gender Integration and Analysis: Additional Help for ADS Chapters 201 and 203](#).”

## GENDER INTEGRATION IN THE PROGRAM CYCLE

By integrating gender considerations into the program design phase and throughout the entire program cycle, you will avoid making gender an “afterthought” inserted at the very end for compliance reasons. This “afterthought” approach does not give consideration for how the entire program might affect gender disparities. Take a look at the process outlined in [Box 5](#) (next page) to see whether you are making gender considerations an integral part of the program cycle, and if not, what you can change to do so.

To read more information on gender integration throughout the program cycle, you can consult a [program guide](#) prepared by FHI 360 as well as a [manual](#) prepared by the Interagency Gender Working Group.

## BOX 5. Process for Integration of Gender in a Program Cycle

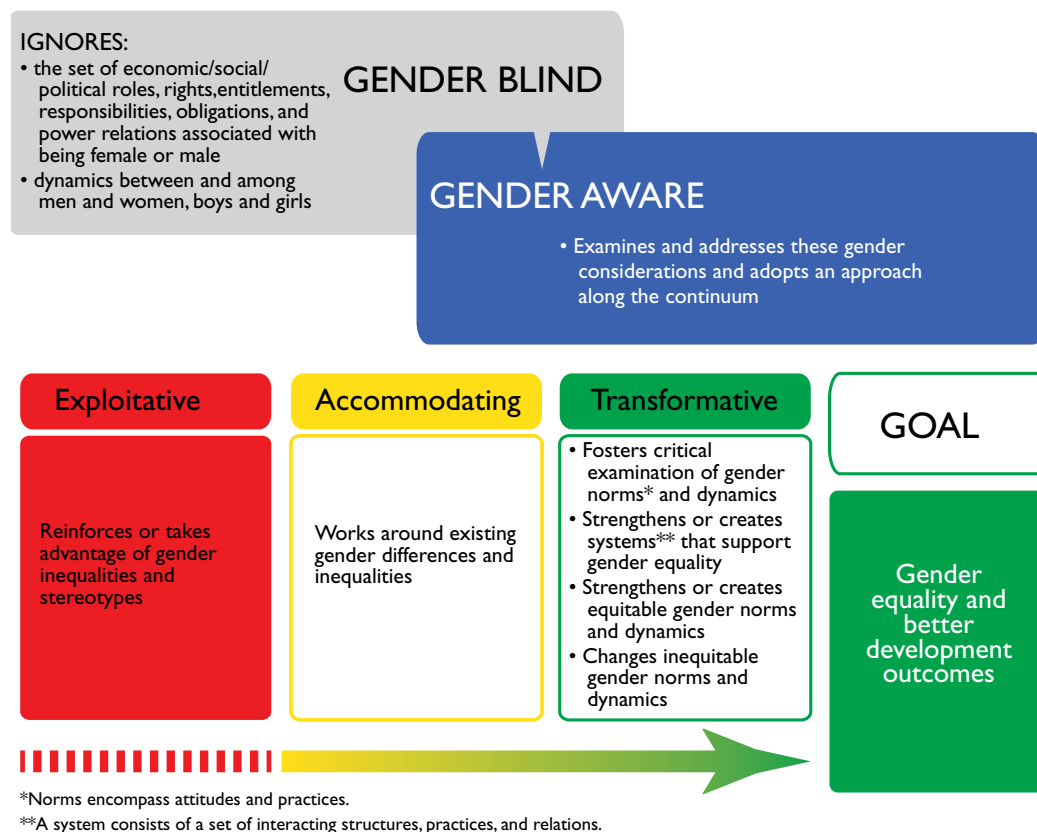
<b>Assessment</b>	<p>First, collect or access available data on existing gender relations, roles, and identities in relation to the health needs or problems to be addressed by the program.</p> <p>Second, analyze the data to assess any potential relationship between gender-based constraints and opportunities that may affect achievement of health objectives or the relative status of women and men.</p> <p>The assessment phase is important to gaining a better understanding of the problems your program intends to address and the context in which you will implement the program. You will need to assess both the role gender plays in the problems you want to address and how your program is likely to affect gender norms and relations. This process is called <i>gender analysis</i>.</p>
<b>Strategic Planning</b>	Examine program objectives for their attention to gender constraints and opportunities. This may require a restatement of objectives so that they strengthen the synergy between gender and health goals.
<b>Design</b>	Program approaches, interventions, and activities must support achievement of health and gender equity objectives. In the design phase, findings from the gender analysis must be used to consider the gender-related issues the program needs to address, and to design program objectives and activities for achieving those objectives. Often it is necessary to develop additional objectives that focus on gender issues; other times it may be more feasible to incorporate gender considerations as sub-objectives in activities that do not specifically target gender.
<b>Monitoring</b>	<p>Develop indicators to measure gender-specific outcomes, especially the alleviation of gender-based constraints and application of opportunities.</p> <p>Monitor process indicators regularly to ensure the program is functioning as planned, without any unplanned or unintended adverse effects to beneficiaries. In the implementation and monitoring phase, gender-related activities are implemented to ensure the full participation of and benefit to girls, women, boys, or men, as appropriate. It is necessary to continually collect and analyze data to track progress toward the gender-related objectives. Careful monitoring also helps identify situations in which midstream changes can be made to the program so that it has the intended effect on gender norms and relations.</p>
<b>Evaluation</b>	Collect and analyze baseline (perhaps including the assessment data from above) and end-line data to evaluate the effectiveness of program elements (i.e., to demonstrate that program objectives were met, or to document any changes in health outcomes that were a result of the program). It is also useful to consider a midterm gender analysis to identify any gender-related constraints not anticipated at the beginning that the program faces, and to adjust design and activities based on findings.

*Adapted from: A Manual for Integrating Gender Into Reproductive Health and HIV Programs: From Commitment to Action (2nd Edition), The Interagency Gender Working Group, 2009.*

## GENDER INTEGRATION CONTINUUM

The Interagency Gender Working Group (IGWG) developed a Gender Integration Continuum conceptual framework (Figure 1) to use as a diagnostic tool for integrating gender analyses and findings into programs by determining whether they are “gender blind” or “gender aware.” Among those that are gender aware (i.e., that explicitly recognize local gender norms, differences, and relations), a program can be exploitative, accommodating, or transformative.

FIGURE 1. The Gender Equality Continuum



Source: IGWG training module found at [http://www.igwg.org/igwg\\_media/Training/FG\\_GendrIntegrContinuum.pdf](http://www.igwg.org/igwg_media/Training/FG_GendrIntegrContinuum.pdf).

The [IGWG website](#) and an [IGWG handout](#) on the continuum of gender strategies further describing the four categories.

Let us take a closer look at the various positions on this continuum with examples that have been collected by the Interagency Gender Working Group.

**Gender-blind** projects or programs use generic terms such as children, adolescents, youth, families, etc. They do not identify differences between women and girls and between men and boys with regard to their activities, access to and control of resources, and participation in decision-making. Gender-blind projects thus do not consider or address gender. A gender-blind strategy ignores gender implications and assumes that gender norms, roles, or power differentials are either immutable or do not influence who participates in or benefits



from a project or program. For example, a poverty assessment that does not consider differences between male-headed and female-headed households, or any of the gender-based differential effects of poverty, is an example of an approach that is gender blind.

**Gender-aware** programs or projects make explicit mention of gender issues and propose specific solutions to address the needs and concerns of women, girls, men, and boys who use the program or whom the project intends to serve. Here we would see recognition that activities benefitting men and women may require different inputs and designs, such as separate latrines, or bursaries or workshop schedules that accommodate women's special needs. Gender considerations are apparent when sex-disaggregated data are used to make decisions on how the work environment is being structured.

**Gender-exploitative** strategies exploit gender inequalities and stereotypes in pursuit of a program's or project's ultimate goal. This type of gender strategy reinforces gender inequities and perpetuates stereotypical images of women's and men's roles. For example, in the area of human resources for health (HRH), an educational recruitment strategy might (unwittingly) play on the stereotype of women in nurturing roles (in contrast to that of men in diagnostic and curative roles). Or, employers may assume that men are family "breadwinners" and that male employees therefore require higher compensation than female employees in the same cadre. Exploitative strategies in the area of reproductive health (RH) programming include appealing to male opinion leaders as gatekeepers of women's reproductive health behavior or alluding to male sexual dominance in marketing slogans aimed at encouraging men to use condoms. Practices such as these inadvertently reinforce male decision-making power and dominance. In clinical settings, we may see the good trend of involving men in their female partner's health care undercut by providers who direct all their attention to the man rather than the couple.

**Gender-accommodating** strategies recognize and account for gender differences in pursuit of program or project goals. Such strategies do not attempt to challenge inequitable gender norms. Instead, they may make it easier for women to fulfill the duties ascribed to them by their gender roles. At times, accommodation (or working within existing gender inequality/inequity) may be a faster way to achieve intended objectives than trying to change gender relations. It's important to note, however, that gender-accommodating interventions may result in short-term outcomes and are an important first step in the gender equality continuum. However, longer-term goals are best achieved through gender-transformative interventions. Health care professionals shouldn't stop at gender-accommodating strategies.

An example of this type of strategy is the creation of a day-care program in a hospital so that nurses can more easily combine childcare with paid work. Such a program supports women's continued workforce participation but does not challenge the prevailing norm that women are the sole providers of childcare. An example from the field of RH is delivering contraceptive supplies to women's doorsteps in places where their mobility outside the home is limited. Doorstep distribution of contraceptives has helped raise contraceptive prevalence rates in many countries and given many women the power to control their fertility as they desire—but in most cases, doorstep distribution does little to challenge the belief that women who leave the home without a male relative's permission are not respectable.

**Gender-transformative** projects and programs seek to transform unequal power relations between men and women through changes in roles and status, and through the redistribution of resources. Gender considerations are incorporated into the design of the project, and the causes of inequality are addressed directly to promote equity as a means to reach project goals. Transformative strategies attempt to overcome gender-related barriers to workforce participation or health service use by shifting the balance of power, the distribution of resources, or the allocation of duties between women and men service providers or beneficiaries. They may also work to build critical awareness of gender norms, for example, when there is a targeted recruitment of men for jobs that are traditionally considered “women's work.” This can be gender transformative because it seeks to transform unequal power relations. In the area of RH programming, a transformative strategy might support community dialogue to rebalance gender relations so that women can get contraceptive services without needing the permission of their husbands.

### Case studies that highlight the different stages of the gender integration continuum—Examples from Zimbabwe, Zambia, and Kenya

#### Gender Exploitative: Campaign to Increase Male Involvement in Zimbabwe

To increase contraceptive use and male involvement in Zimbabwe, a family planning project initiated a communication campaign promoting the importance of men's participation in family planning decision-making. Messages relied on sports images and metaphors, such as "Play the game right, once you are in control, it's easy to be a winner," and "It is your choice." The campaign increased the use of contraceptive methods. When evaluating impact, the project asked male respondents whether ideally they, their partners, or both members of the couple should be responsible for making family planning decisions. The evaluation found that: "Whereas men were far more likely to believe that they should take an active role in family planning matters after the campaign, they did not necessarily accept the concepts of joint decision-making. Men apparently misinterpreted the campaign messages to mean that family planning decisions should be made by men alone."

#### Gender Accommodating: Youth Roles in Care and Support for People Living with HIV (PLHIV)

In Zambia, one project has sought to involve young people in the care and support of PLHIV. This project carried out formative research to assess young people's interest and to explore the gender dimensions of care. The assessment explored what care-giving tasks young women and young men feel more comfortable with and able to carry out, as well as what tasks PLHIV themselves would prefer to have young women or young men carry out. Based on this research, the project adopted an approach that incorporates preferred tasks for young women and young men in order to develop youth care and support activities for PLHIV.

#### Gender Transformative: Female Genital Cutting (FGC) Prevention Program in Kenya

A FGC intervention in Kenya sought to reduce the incidence of harmful cutting. Project staff realized that legislation to prohibit the practice would not address the cultural and social motivations of the community and would likely result in driving the practice "underground." Instead, the project hired a medical anthropologist to work with the community. Through qualitative interviews with groups of women, men, and religious leaders, the project sought to understand the meaning and functions that the ritual provides to the community. Together with community members, the project staff adapted the FGC ritual by eliminating the harmful cutting but keeping the "healthy" cultural elements, such as seclusion of girls, dance, story-telling, gift-giving, health and hygiene education, etc. As a result, a new right-of-passage ritual has been created for girls called "circumcision with words," which has become accepted by the entire community.

Source: Interagency Gender Working Group and USAID, "[Case Studies: Gender integration continuum](#)"

## A gender lens for viewing the health systems building blocks

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To illustrate gender mainstreaming in the context of the health sector: if health care systems are to respond adequately to problems caused by gender inequality, it is not enough simply to “add in” a gender component late in a given project’s development. Research, interventions, health system reforms, health education, health outreach, and health policies and programs must integrate gender equality from the planning phase. An approach such as this will also ensure that gender perspectives are reflected in health policies, services, financing, research, and health workforce training curricula (World Health Organization 2010a, 16).

In this handbook, other chapters take a closer look at each of the six building blocks that, together, make up the health system. Although there is now a greater effort to gather evidence on how gender considerations in programming influence each of the building blocks, the information gathered is neither complete nor comprehensive. For example, there is literature on how gender affects the ways and types of services that can be targeted to women and men, boys and girls, but there is less information available about how gender affects the other building blocks. Each of these building blocks is addressed in this section to demonstrate how gender considerations are important. Descriptions of the six health systems building blocks can be found on the [WHO website](#).

As indicated in Chapter I, the ultimate aim of a health system is to equitably maintain or restore the health of all. This chapter focuses on equity regarding gender because, as has been discussed earlier, women and men have different problems and needs. Additionally, it focuses on gender equity because women are the major providers and consumers of health care in low-income countries. Taking these factors into consideration, the following sections provide a general discussion on how gender issues are relevant within the framework of health systems strengthening.

A Gender and HSS eLearning course is available on the [USAID Global Health eLearning Center site](#). This course is housed under the Gender and Health certificate program.

### SERVICE DELIVERY

Good health services are those which deliver effective, safe, quality health interventions to those that need them, when and where they are needed, with a minimal waste of resources. Gender-sensitive service delivery is designed to address gender norms, roles, responsibilities, and needs that affect access and use of services. For example, a gender-sensitive PMTCT program explicitly acknowledges that women may not have the status, rights, and decision-making power to practice safer sex or adopt safer infant-feeding practices, but might not take action to overcome these barriers.

Data from demographic and health surveys show that in some countries of sub-Saharan Africa and South Asia women were not involved in decisions concerning their health in 50 percent or more of the households. In Burkina Faso, Mali, and Nigeria, almost 75 percent of women reported that their husbands alone took decisions concerning their health care (WHO 2010a, 18).

Services become gender sensitive when measures are taken to act on that awareness by reaching out to the male partners of the women (with the women's permission, of course) to promote joint decision-making regarding safer sex or infant feeding (WHO 2009a). The most gender-sensitive programs deliver integrated and comprehensive health services that offer a complete package of health interventions ranging from promotion, prevention, diagnosis, treatment, disease management, and rehabilitation all the way to palliative care services. These services are also delivered at various levels and sites of care within the health system, catering to the needs of young and old, and men and women at all stages of the life cycle.

Family Care International has prepared a [PowerPoint presentation on the life-cycle approach to addressing the sexual and reproductive health of women](#).

Integrated health services address the needs of women to access services for themselves and their children at the same time, thereby saving effort, time, and money. One-stop access to a comprehensive range of services would go a long way in increasing access to care, especially for women. For example, rather than making child health care, antenatal care, and family planning available on different days or times of day, providing all of these services at all times would enable a woman who comes to immunize her child to also have a pregnancy test or get her contraceptive supplies within a much shorter time frame. In addition to the time convenience, integration of some services could enhance privacy and/or reduce stigma as, for example, when STI or HIV and AIDS services, abortion, or infertility services are all made available in the sexual and reproductive health clinic (WHO 2010a).

Additionally it is important to consider the health needs of the lesbian, gay, bisexual, and transgender (LGBT) community. Ensuring access to this marginalized group is a gender issue and should constitute part of the gender equality agenda. Studies show that LGBT people experience health issues and barriers related to their sexual orientation and gender identity, and that they avoid or postpone care or receive inappropriate or inferior care because of homophobia and stigma and discrimination by health care providers and institutions. This has been particularly important in the prevention, treatment care, and support for those infected or affected by HIV/AIDs where these groups have been marginalized in getting care.

## HEALTH WORKFORCE

A well-performing health workforce is one that works in responsive, fair, and efficient ways to achieve the best health outcomes possible, given available resources and circumstances. This translates to services being provided by sufficient staff that is not only competent but also responsible to their clients. Women make up about 42 percent of the estimated global paid formal workforce, however in the health workforce they make up over 75 percent, making them indispensable as contributors to the health system (WHO, Dept. of Human Resources for Health, 2008). At the same time, unequal access to educa-

tion and training in low-income countries results in a disproportionate number of women in the health workforce at the lowest-paid levels. Gender stereotypes and practices keep women health care workers in certain occupations and bar them from others. Some of these occupations are poorly supported and are often unpaid, keeping women outside the formal employment sector. Last but not least, once in the workforce, women often run into a “glass ceiling,” where social roles and expectations hinder their ability to advance to leadership positions. On the other end of the spectrum, where posts demand higher salaries, benefits, and prospects of supporting families and comfortable lifestyles, we see mostly men (Standing 2000; WHO 2009).

Cultural expectations about women’s childbearing and child rearing responsibilities often result in women cycling in and out of employment. The assumption that a woman will become pregnant or that she is her children’s primary caregiver directly affects her career prospects, a stereotype few men in those same cultures experience. It is therefore not surprising that fewer women than men progress to upper-level and management positions, even if family duties are shared or household help is possible—circumstances that are not typical. The following measures can be taken to bring about equality in the health workforce (WHO 2010a, 39–40):

**Create a gender-bias-free working environment for health workers.** Health workers who are expected to have respectful, bias-free, and empowering interactions with patients require a working environment that nurtures these same values and is supportive of them.

**Train health workers in gender competencies.** A good deal of effort has focused on in-service training of health professionals on gender equity issues, often at a local level. However, there have been few assessments of the impact that these have had in changing attitudes and practices.

**Recognize the contribution and reduce the burden of unpaid and invisible health work.** Unpaid health work is the informal care provided by a member of the same household or community, or a friend, without financial compensation, to a person who is unwell or disabled. It also includes voluntary work carried out by members of a community for health promotion or prevention. Unpaid health work includes personal care such as bathing, feeding, or providing company; medical care such as bandaging, dispensing drugs, or monitoring temperature; and domestic services such as cooking, cleaning, or shopping. Most unpaid health work is carried out by women and is invisible because it is seen as an extension of women’s domestic responsibilities within the home, or as part of their role as mothers and caregivers.

## HEALTH INFORMATION SYSTEMS

A well-functioning health information system is one that ensures the production, analysis, dissemination, and use of reliable and timely information on health determinants, health system performance, and health status; gender considerations must be incorporated into these systems. In addition to being left out of the data, women are not well represented within the field of informatics.

*A gender perspective should be adopted in all processes of policy formulation and implementation and in the delivery of services, especially in sexual and reproductive health, including family planning. This includes the development and availability of sex-disaggregated data and appropriate indicators for monitoring progress at the national level.*

—Key Actions for the Further Implementation of the  
Program of Action of the ICPD, Paragraph 46

Health information systems do not always contain sex-disaggregated data—the most basic requirement for a gender-based analysis and subsequent advocacy and policy interventions. Standardized, gender-sensitive health indicators exist in some areas, such as gender-based violence, but are lacking in others (Bloom and Arnoff 2012). When sex-disaggregated data are available, the analysis should link any differences in sex with the overarching program logic model or theory of change to demonstrate any effects of gender-related factors on the performance of health programs and health outcomes. If more women than men participate in training events, does it affect service delivery or health outcomes? How? Often this level of analysis is not conducted.

[Box 6](#) (next page) presents some of the objections that are frequently put forward to deter the gathering of gender-related statistics. It also includes clear rationales to counter these objections.



#### BOX 6. Frequently Used Arguments against Producing Gender-Related Statistics

*“We already have gender statistics—all our data are sex-disaggregated.”*

The production of gender-sensitive statistics does not involve only the production of sex-disaggregated datasets—although disaggregated data do form one important component of gender-sensitive statistics. For full gender sensitivity, the data collection system also needs to produce statistics that relate to all the key gender issues in the community or region, and to cover issues (such as maternal mortality or prostate disorders) that might affect only one sex.

*“Women and men in this country already enjoy equality.”*

Women and men will never be exactly the same. Biological differences will persist, as will some social differences. Gender statistics are needed to illustrate both how women and men differ and how they are similar. It is only on the basis of this information that programs and organizations can make sensible policy and be sure that policies regarding gender equality are succeeding.

*“It is normal to have differences in the labor market between women and men because women prefer to stay at home.”*

Gender-sensitive data do not present a value judgment on how the society should look. The task is to produce or access data that accurately reflect the situation among the population served by your health program or health services. It is then up to the policymakers and citizens more generally to decide whether the differences depicted between male and female are “normal” or desirable.

*“Adding a breakdown by sex will cost too much.”*

For the most part, there is a minimal cost attached to producing gender statistics with existing instruments. In some cases, it simply involves the addition of an extra question or column specifying sex. In other cases, it might involve the addition of several questions. At analysis time, the main cost would be the time involved in running extra tabulations but, in many cases, sex can simply be added to existing tabulations. Significant cost is generally incurred only when a completely new investigation specifically to assess gender equity (such as a survey) is carried out.

*“Disaggregating data by sex will adversely affect the quality of the data.”*

On the contrary, the integration of sex-disaggregated data will make it possible to review data from a gender perspective, thereby enriching the information available from the investigation and increasing its explanatory value. The disaggregation by sex also often provides the basis for a more thorough checking of the accuracy of data collection and recording, as it allows for additional logical checks.

Source: *Developing Gender Statistics: A Practical Tool*, by the United Nations Economic Commission for Europe and World Bank Institute, 2010. Reprinted with the permission of the United Nations.

Gender-specific health data can be used to generate studies and documentation of promising practices and thus inform health policies aimed at improving the health of women and families. Sharing this information, such as the sex-disaggregated data collected by MOHs, with stakeholders who need support in their advocacy and policy efforts provides them with “clear language that highlights gender based causes and consequences and their policy implications” (UN, Office of the Special Advisor on Gender Issues 2002, 23). Additionally, gender statistics can be used to identify inequalities resulting from existing laws or policies, and for the development of policies that are not explicitly related to gender but that may have a different impact on men and women.

Additionally, including gender-sensitive indicators in program monitoring plans will help the implementation team track to what extent the program affects gender disparities, particularly in gender-sensitive programs. As noted in a WHO policy brief (Payne 2009), “Indices of gender equality and gender equity are also valuable: they are compiled from data from a range of sources, including censuses, sample surveys and nationally collected statistics, in order to ‘give shape’ to gender-disaggregated data.”

A MEASURE Evaluation PRH [web page](#) has a list of sample gender-sensitive indicators for service delivery.

## ACCESS TO ESSENTIAL MEDICINES

A well-functioning health system ensures equitable access to essential medical products, vaccines, and technologies that are of assured quality, safety, efficacy, and cost-effectiveness, and whose use is scientifically sound and cost-effective. When it comes to access to medicines, it makes a big difference whether you are a man or a woman. Successful policy and strategy implementation promoting access to affordable and reliable medicines requires that we take gender considerations into account. Studies carried out in developing countries reveal that gender-related barriers to access (both to health services and medicines) are greater for women than men, as women often do not have any control over family income and may not be able to purchase medicines without asking their husbands. Geographical constraints, such as long distances and transportation costs to reach health care services (where medicines are dispensed), also put them at a disadvantage (Baghdadi 2005).

Expanding access to high-quality, affordable maternal health medicines is critical to making progress in reducing maternal mortality. However, significant challenges often impede such access. Chief among them is a lack of data on the needs, systems, and financing for maternal health medicines. Inconsistent quality of medicines and lack of skills among providers on their administration also create considerable barriers to appropriate maternal care (UN Population Fund 2012). Many women in rural areas of low-income countries are often illiterate and therefore unable to read information on the leaflets found in some of the medicine packets. And yet women are often the first line of care for their families; outreach targeted to women on the safe use of medicines has been shown to benefit larger numbers of family and extended family members than outreach for which men are the target audience.

## FINANCING

A good health financing system raises adequate funds for health in ways that ensure people can use needed services and are protected from financial catastrophe or impoverishment associated with having to pay for them. For women living in poverty, user fees have direct and obvious links with the ability to pay out of pocket for health care. Where women are struggling to make ends meet, they have little to save for contingencies, including health care. Women may make trade-offs in not seeking health care in order to purchase food or fuel, or they may seek traditional health care that does not address their health needs adequately (Nanda 2002). Without access to the family's resources, and given the traditional decision-making power of the male head of household, out-of-pocket costs such as health care user fees can easily put even the most basic health care out of the reach of poor women. Even where they are exempted, this does not guarantee free care as supplies or drugs may not be included in the exemption, or under-the-table payments are required to be seen at all (Vlassoff 2007).

User fees create inequities not only because they may discourage poor people from accessing services but also because, in the case of catastrophic illness, they can deplete whatever meager resources a family has, pushing any preventive or “minor” health needs of women and children to the back burner.

## LEADERSHIP AND GOVERNANCE

Leadership and governance involves ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system design, and accountability (see Chapter 3). Lack of policies that ensure gender equity in hiring and lack of oversight boards that include women are particular challenges in leadership and governance in health systems. For too long, women have been poorly represented at the highest levels of government and in parliaments, as well as in the governing bodies of both public and private health care organizations at the regional, national, and local levels. Women—the major beneficiaries and consumers of health systems—do not have adequate mechanisms through leadership systems to have their voices heard.

Good governance is about making institutions accountable, transparent, and inclusive. Inclusiveness and transparency create equal opportunity for qualified staff to move into leadership positions. This sounds simple, but in reality is not! The path is full of land mines for the pioneering women who have to walk a fine line between being accepted (and thus conforming to norms and expectations created by the dominant majority) AND making use of their unique skills and viewpoints, which may put them at odds with their male colleagues. They are in a bind: young women look up to them and expect support and maybe even privileges, while their male colleagues or adversaries (of both sexes) point out their each and every mistake, blowing them up out of proportion. However, the effort is worth it; good governance goes hand in hand with good leadership, and women in leadership positions have shown that they are inclusive and collaborative (Wilber 2011).

## Conclusion

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The intent of this chapter is to help leaders and managers of health programs or health services understand why gender mainstreaming is important, how it is done, and how their leadership, management, and governance skills can support them in taking on the challenges that invariably accompany gender mainstreaming.

In the 1990s, gender equality became an international focus, highlighted in such meetings as the International Conference on Population and Development (ICPD 1994), the World Summit for Social Development in Copenhagen in 1995, and the Fourth World Conference on Women in Beijing in 1995. ICPD set out to provide universal access to family planning and sexual and reproductive health services and reproductive rights; to deliver gender equality, the empowerment of women and equal access to education for girls; to address the individual, social, and economic impact of urbanization and migration; and to support sustainable development and address environmental issues associated with population changes. The Beijing Platform of Action included recommendations aimed at empowering women to promote and safeguard their own health, and pointed to the need for mainstreaming gender into all policies and programs. The Millennium Development Goals established in 2000 at the Millennium Summit of the United Nations also specifically and directly address women and health through the goals of reducing maternal mortality and empowering women (Goal 3 and Goal 5).

WHO's Department of Gender and Women's Health prepared a [publication](#) describing the gender considerations for work toward each of the health-related MDGs.

The documents coming from all of these meetings reaffirm women's equal rights and entitlements to social protection and participation. Despite these pronouncements, challenges remain. The Association for Women's Rights in Development highlighted lessons learned in gender mainstreaming and challenges to this process, which include some of the challenges outlined below.

**The concept itself is unclear and misunderstood.** Gender mainstreaming is still difficult because “gender” is still not understood as a social construction of roles and relationships but primarily as attention to biological women. Furthermore, “mainstreaming” has—at best—been viewed as the need to add “women's interests” to “refine” already established settings.

**Mainstreaming has been reduced to a technique.** Because gender mainstreaming seldom contains the necessary funding, staffing, or commitment, it is often reduced to a question of technique and “tool-kits.” And far too often the technique is criticized for any failures in gender mainstreaming, whereas the real problems are lack of commitment and resources and a true acceptance of the equal worth of women and men.

**Mainstreaming as a pretext for saving overall resources.** Often agencies

claim that gender is successfully mainstreamed into their programs and use this to justify the lack of staff, resources, and program planning allocated to specifically address gender and women's issues. Thus, in some cases, gender work today may actually be less equipped in terms of staff and resources than it was in 1995. What we need today is to identify a measure or minimum criteria for what should be labeled as “gender mainstreamed.”

**Gender mainstreaming has not been transformative.** Gender mainstreaming, as it is applied today, basically accepts the status quo and “business as usual”—and then adds gender. Much more far-reaching methods for transforming the agenda are required to put gender into the driver's seat and reorganize and redefine the structure and focus of current work. Current efforts appear to be insufficient.

An [Association for Women's Rights in Development publication](#) provides an in-depth consideration of each of these challenges.

## Proven practices

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As with any change, the first step is becoming aware of one's own behavior as it relates to gender. Only then can we address gender issues in ever-broadening circles of influence: our families, our communities, our workplaces, and our government.

Remember that:

- Gender is a social construct and therefore gender equality is not a static phenomenon. Look for how the roles of men and women in the context of health programs change, even if only slowly.
- Interventions designed to mainstream gender are best built on positive norms and behaviors that benefit both men and women.
- Transformation doesn't happen overnight because of long-standing beliefs related to women and men. Changes to bring about gender equality in health are incremental and build on the efforts of others in other sectors, not just health.
- Gender mainstreaming requires advocates who are willing and able to provide the justifications for promoting gender equality and can speak to both the economic, health-related, and moral imperatives for gender equality.
- Observation, collection of data and analysis, and evidence-based programming are integral parts of the work of gender mainstreaming.

The following are proven practices, which can be adapted, for mainstreaming gender equality in the health sector:

- Gently question gender stereotypes and suggest more equitable norms and practices to support and promote, rather than harm, men and women's health.
- Pay attention to the particular health risks associated with being a woman or a man because of social and biological roles in a particular society. Highlight these and enlist both men and women to reduce those risks.
- Expand the evidence base for informing policies and programs through targeted research showing the relationship between gender inequality and negative health outcomes.
- Support structures, incentives, and accountability mechanisms to empower women to access health care information and resources.
- Address gender inequality in health systems by increasing the awareness of how women and men, boys and girls are affected, both as consumers and providers of health care.

## Glossary of gender terms

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**gender:** Refers to an array of socially constructed qualities, behaviors, and opportunities associated with being male or female as well as with the relationships between men and women. Unlike biological sex, gender characteristics are learned from one's culture or society. A wide range of attributes is associated with gender: dress, household roles, economic status, definitions of success, and so on. Gender roles are not fixed; they can vary widely both within and across cultures, and they can change over time.

**gender-sensitive indicators:** Measure progress in the move towards gender equality. They include the wide range of factors that determine if females and males are treated differently based on gender alone, and can reveal the relative advantage or disadvantage associated with gender.

**gender analysis:** The collection and interpretation of sex-disaggregated data and other information regarding gender-sensitive indicators in order to determine any differential impact of an action on men and women and the effects of gender roles and responsibilities. It also involves qualitative analyses to that help to clarify why these differential roles, responsibilities, and impacts have come about. Gender analysis is often a first step in gender-aware program design and development.

**gender equality:** The objective goal of equal enjoyment by women and men, and boys and girls, of access to services, information, and opportunities as well as socially valued goods, resources, and rewards. It allows all people the full and equal exercise of their human rights and the chance to achieve their full potential. Gender equality does not mean that males and females become the same, only that access to opportunities and life changes is neither dependent on nor constrained by their sex.

**gender equity:** Being fair to women, men, girls, and boys. To ensure fairness, strategies and measures must be available to compensate for historical and social disadvantages based on gender that prevent women and men from otherwise operating on an equal footing. Gender equity leads to gender equality. However, that there is some controversy in international human rights law concerning terms and a preference for the exclusive use of "gender equality."

**gender disparities:** Inequalities or differences that result from the ways men and women, and boys and girls, are treated based on the roles, opportunities, relationships, and so on considered appropriate for each. Examples are differences in health or educational status that stem from differential treatment based on gender.

**gender perspective:** A way of considering how a particular issue is related to the many aspects of gender and applying this to the design, planning, implementation, and evaluation of policies and programs. It is the notion that the implications of gender should be kept in mind when evaluating problems and proposed actions.



**gender mainstreaming:** A process of integrating the implications for women and men, and boys and girls, at all stages and at all levels of any planned action for the purpose of achieving gender equality. With gender mainstreaming, females' as well as males' concerns and experience are integral to the development, implementation, monitoring, and evaluation of policies, programs, and projects in all political, economic, and social spheres. Gender mainstreaming is a strategy for identifying and addressing gender disparities and inequities so that they are not perpetuated.

**sex:** The biological characteristics that differentiate males and females. Sex differences are related to males' and females' physiology and generally remain constant across cultures and over time.

**sex-disaggregated data:** Data that are collected and presented separately on women and men.

## References and resources

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African Development Bank Group. *Gender Mainstreaming Checklist for the Health Sector*. 2009, [http://www.afdb.org/fileadmin/uploads/afdb/Documents/Policy-Documents/Gender-health-chklist-sunita-12-01-09%20\(2\).pdf](http://www.afdb.org/fileadmin/uploads/afdb/Documents/Policy-Documents/Gender-health-chklist-sunita-12-01-09%20(2).pdf) (accessed Feb. 28, 2014).

Association for Women's Rights in Development. "Gender Mainstreaming: Can It Work for Women's Rights?" *Spotlight 3* (2004), <http://www.awid.org/Library/Gender-Mainstreaming-Can-it-work-for-Women-s-Rights> (accessed Feb. 28, 2014).

Baghdadi, Guitelle. "Gender and Medicines: An International Public Health Perspective." *Journal of Women's Health* 14(1) (2005):82–86, <http://online.liebertpub.com/doi/abs/10.1089/jwh.2005.14.82> (accessed Feb. 28, 2014).

Bloom, Shelah, and Elly Arnoff. *Gender and Health Data and Statistics: An Annotated Resource Guide*. Chapel Hill, NC: MEASURE Evaluation, 2012, <http://www.cpc.unc.edu/measure/publications/ms-12-52> (accessed Feb. 28, 2014).

Buvinić, Mayra, André Medici, Elisa Fernández, and Ana Cristina Torres. "Gender Differentials in Health." Chapter 10 of *Disease Control Priorities in Developing Countries*. 2nd ed. Washington (DC): World Bank and Oxford University Press, 2006, <http://www.ncbi.nlm.nih.gov/books/NBK11729/> (accessed March 1, 2014).

Capacity Project. "Handout 1.4.1 Continuum of Gender Strategies." Chapel Hill, NC: IntraHealth International, undated, [http://www.intrahealth.org/files/media/integrating-gender-in-human-resources-for-health-hrh-projects/Handout\\_141\\_Continuum\\_Gender\\_Strategies.pdf](http://www.intrahealth.org/files/media/integrating-gender-in-human-resources-for-health-hrh-projects/Handout_141_Continuum_Gender_Strategies.pdf). This is a resource for the two-module training program *Integrating Gender in Human Resources for Health (HRH) Projects*, found at <http://www.intrahealth.org/page/integrating-gender-in-human-resources-for-health-hrh-projects> (both accessed March 1, 2014).

Caro, Deborah. Adapted from: *A Manual for Integrating Gender Into Reproductive Health and HIV Programs: From Commitment to Action (2nd Edition)*. Interagency Gender Working Group, 2009, [http://www.igwg.org/igwg\\_media/manualintegrgendr09\\_eng.pdf](http://www.igwg.org/igwg_media/manualintegrgendr09_eng.pdf) (accessed March 1, 2014)

- Cerise, Somali, and Francesca Francavilla. *Tackling the root causes of gender inequalities in the post-2015 development agenda*. Paris: OECD Development Centre, 2012, [http://www.wikigender.org/images//d/d1/Tackling\\_the\\_root\\_causes\\_of\\_gender\\_inequalities\\_OECD\\_DEV.pdf](http://www.wikigender.org/images//d/d1/Tackling_the_root_causes_of_gender_inequalities_OECD_DEV.pdf) (accessed Feb. 27, 2014).
- Doggett, Elizabeth, and Tanya Medrano. *Integrating Gender in Care and Support of Vulnerable Children: A Guide for Program Designers and Implementers*. Research Triangle Park, NC: FHI 360, 2012, <http://www.fhi360.org/sites/default/files/media/documents/Integrating%20Gender%20in%20Care%20and%20Support%20of%20Vulnerable%20Children.pdf> (accessed Feb. 27, 2014).
- Education, Livelihoods, WASH, Health, Trainings and Governance. *Challenges to Gender mainstreaming*. p. 6, <http://www.fsnnetwork.org/sites/default/files/bridgegendermainstreaming.pdf>. (accessed Dec. 4, 2013).
- Family Care International. "Advancing Commitments: Sexual and Reproductive Health. Life Cycle Approach." 2001, <http://www.familycareintl.org/UserFiles/File/pdfs/ppts/life-cycle.ppt> (accessed March 1, 2014). This is a PowerPoint presentation.
- Fatalla, Mahmoud. "Issues in Reproductive Health: Health and being a woman." UN News Center. United Nations. Web, <http://www.un.org/womenwatch/daw/csw/issues.htm> (accessed August 26, 2014).
- George, Asha. *Human Resources for Health: A Gender Analysis*. Women and Gender Equity Knowledge Network (WEGKN), 2007, [http://www.who.int/social\\_determinants/resources/human\\_resources\\_for\\_health\\_wgkn\\_2007.pdf](http://www.who.int/social_determinants/resources/human_resources_for_health_wgkn_2007.pdf) (accessed March 2, 2014). This is a background paper prepared for the WGEKN and the Health Systems Knowledge Network of the WHO Commission on Social Determinants of Health.
- Greene, Margaret E. *A Practical Guide for Managing and Conducting Gender Assessments in the Health Sector*. International Gender Working Group, 2013, [http://www.igwg.org/igwg\\_media/IGWG-GenderAssessmentGuide-2013.pdf](http://www.igwg.org/igwg_media/IGWG-GenderAssessmentGuide-2013.pdf) (accessed Feb. 8, 2014).
- Greene, Margaret E., and Andrew Levack. *Synchronizing Gender Strategies: A Cooperative Model for Improving Reproductive Health and Transforming Gender Relations*. For the Interagency Gender Working Group, Washington DC: Population Reference Bureau, 2010, [http://www.engenderhealth.org/files/pubs/gender/synchronizing\\_gender\\_strategies.pdf](http://www.engenderhealth.org/files/pubs/gender/synchronizing_gender_strategies.pdf) (accessed March 2, 2014).
- Green, Sarah. "Best (and Worst) Countries to Be a Woman." *Harvard Business Review Blog Network*, 2013, <http://blogs.hbr.org/2013/10/the-best-and-worst-countries-to-be-a-woman/> (accessed Feb. 27, 2014).
- HPV Information Centre. *Uganda: Human Papillomavirus and Related Cancers, Fact Sheet 2013*. Barcelona: Institut Català d'Oncologia, 2014, [http://www.hpvcentre.net/statistics/reports/UGA\\_FS.pdf](http://www.hpvcentre.net/statistics/reports/UGA_FS.pdf) (accessed Feb. 27, 2014).
- Interagency Gender Working Group. "Case Studies: Gender integration continuum." Undated, [http://www.igwg.org/igwg\\_media/GenderSafeMothrhd/gendr-continuum-case-studies.pdf](http://www.igwg.org/igwg_media/GenderSafeMothrhd/gendr-continuum-case-studies.pdf) (accessed March 8, 2014).
- . "Handout: IGWG Gender Integration Continuum Categories." Interagency Gender Working Group, 2012, [http://www.igwg.org/igwg\\_media/gender101trainingmodule/Handout\\_GenderContinuumCategories.pdf](http://www.igwg.org/igwg_media/gender101trainingmodule/Handout_GenderContinuumCategories.pdf) (accessed March 1, 2014).

- . *How to Integrate Gender into HIV/AIDS Programs: Using Lessons Learned from USAID and Partner Organizations*. With the United States Agency for International Development and the Gender and HIV/AIDS Task Force, 2004, <http://www.prb.org/pdf04/HowToIntegrGendrHIV.pdf> (accessed March 1, 2014).
- Jamison, Dean, Joel G. Breman, Anthony Measham, et al., eds. *Disease Control Priorities in Developing Countries*. 2nd ed. Washington (DC): World Bank and Oxford University Press, 2006.
- Leadership, Management & Governance Project. *An Open Mind and a Hard Back: Conversations with African Women Leaders*. Compiled by Belkis Giorgis, Elly Mugumya, and Sarah Lindsay, 2013, [http://www.lmgforhealth.org/sites/default/files/files/Conversations%20Women%20Leaders%20\\_LMG.pdf](http://www.lmgforhealth.org/sites/default/files/files/Conversations%20Women%20Leaders%20_LMG.pdf) (accessed March 8, 2014).
- MEASURE Evaluation PRH. “Gender sensitivity in the service delivery environment.” PRH Family Planning and Reproductive Health Indicators Database, undated, [http://www.cpc.unc.edu/measure/prh/rh\\_indicators/crosscutting/service-delivery-ii.h.4/gender-sensitivity-in-the-service-delivery](http://www.cpc.unc.edu/measure/prh/rh_indicators/crosscutting/service-delivery-ii.h.4/gender-sensitivity-in-the-service-delivery) (accessed Feb. 28, 2014).
- Mercy Corps. *BRIDGE & Gender Mainstreaming: A Guide for Program Staff. Education, Livelihoods, WASH, Health, Trainings and Governance*. Mercy Corps Sudan/BRIDGE, 2010, <http://www.fsnnetwork.org/sites/default/files/bridgegendermainstreaming.pdf> (accessed Dec. 4, 2013).
- Nanda, Priya. “Gender Dimensions of User Fees: Implications for Women’s Utilization of Health Care.” *Reproductive Health Matters* 10(20) (2002):127–134, [http://www.sarpn.org/documents/d0000174/P165\\_Nanda.pdf](http://www.sarpn.org/documents/d0000174/P165_Nanda.pdf) (accessed Dec. 4, 2013).
- Newman, Constance. *Conceptual and Practical Foundations of Gender and Human Resources for Health*. Chapel Hill, NC: The Capacity Project, [http://www.capacityproject.org/images/stories/files/foundations\\_gender\\_hrh.pdf](http://www.capacityproject.org/images/stories/files/foundations_gender_hrh.pdf) (accessed March 1, 2014).
- Newman, Constance, Crystal Ng, and Sara Pacqué-Margolis. *Technical Brief 7: Strengthening the Health Worker Pipeline through Gender-Transformative Strategies*. CapacityPlus, 2002, <http://www.capacityplus.org/files/resources/strengthening-health-worker-pipeline-gender-transformative-strategies.pdf> (accessed March 1, 2014).
- Overseas Development Institute. “Briefing Paper 42. Gender and the MDGs.” 2008, <http://www.odi.org.uk/sites/odi.org.uk/files/odi-assets/publications-opinion-files/3270.pdf> (accessed March 1, 2014).
- Payne, Sarah. *Policy Brief 12. How can gender equity be addressed through health systems?* Copenhagen: World Health Organization, Regional Office for Europe, 2009, [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0006/64941/E92846.pdf](http://www.euro.who.int/__data/assets/pdf_file/0006/64941/E92846.pdf) (accessed Feb. 28, 2014).
- Sen, Gita, Pirooska Östlin, and Asha George. *Unequal, Unfair, Ineffective and Inefficient. Gender Inequity in Health: Why it exists and how we can change it*. Final report to the WHO Commission on Social Determinants of Health. Women and Gender Equity Knowledge Network, 2007, [http://www.who.int/social\\_determinants/resources/csdh\\_media/wgekn\\_final\\_report\\_07.pdf](http://www.who.int/social_determinants/resources/csdh_media/wgekn_final_report_07.pdf) (accessed Feb. 28, 2014).

- Standing, Hilary. (2000) "Gender—A Missing Dimension in Human Resource Policy and Planning for Health Reforms." *Human Resources for Health Development Journal* 4(1) (2000):30, <http://www.moph.go.th/ops/hrdj/hrdj9/pdf9/Gender41.pdf> (accessed Dec. 4, 2013).
- United Nations. *Report of the Economic and Social Council for 1997*. United Nations, 1997, <http://www.un.org/documents/ga/docs/52/plenary/a52-3.htm> (accessed March 1, 2014).
- United Nations. Division for the Advancement of Women. *Gender Mainstreaming. Extract from the Report of the Economic and Social Council for 1997*. United Nations, 1997, <http://www.un.org/womenwatch/daw/csw/GMS.PDF> (accessed Nov. 14, 2013).
- United Nations. Economic Commission for Europe, and World Bank Institute. *Developing Gender Statistics: A Practical Tool*. Geneva: United Nations, 2010, [http://www.unece.org/fileadmin/DAM/stats/publications/Developing\\_Gender\\_Statistics.pdf](http://www.unece.org/fileadmin/DAM/stats/publications/Developing_Gender_Statistics.pdf) (accessed Dec. 22, 2013).
- United Nations. Office of the Special Advisor on Gender Issues. "Gender Mainstreaming: Strategy for Promoting Gender Equality." United Nations, rev. 2001a, <http://www.un.org/womenwatch/osagi/pdf/factsheet1.pdf> (accessed Nov. 29, 2013).
- . Office of the Special Adviser on Gender Issues. "Important Concepts Underlying Gender Mainstreaming." United Nations, 2001b, <http://www.un.org/womenwatch/osagi/pdf/factsheet2.pdf> (accessed Nov. 29, 2013).
- . *Gender Mainstreaming. An Overview*. New York: United Nations, 2002, <http://www.un.org/womenwatch/osagi/pdf/e65237.pdf> (accessed Feb. 28, 2014).
- United Nations Population Fund. "Data for Development: Mining the Gaps." undated webpage, <http://www.unfpa.org/public/datafordevelopment/gaps> (accessed Feb. 28, 2014).
- . *Engaging Men and Boys: A Brief Summary of UNFPA Experience and Lessons Learned*. New York: United Nations Population Fund, 2013, [http://www.unfpa.org/webdav/site/global/shared/documents/publications/2013/UNFPA%20Engaging%20men%20and%20boys\\_web-2.pdf](http://www.unfpa.org/webdav/site/global/shared/documents/publications/2013/UNFPA%20Engaging%20men%20and%20boys_web-2.pdf) (accessed March 1, 2014).
- . *Medicines for Maternal Health. Key Data and Findings*. United Nations Population Fund, 2012, <http://www.unfpa.org/webdav/site/global/shared/images/publications/2012/Key%20Data%20and%20Findings%20Maternal%20Health%20Medicines-FINAL.pdf> (accessed Dec. 19, 2013).
- United States Agency for International Development. Automated Directive System (ADS), Chapter 205, "Integrating Gender Equality and Female Empowerment in USAID's Program Cycle." 2013, <http://www.usaid.gov/sites/default/files/documents/1870/205.pdf>. Another, ADS-related USAID resource is "Guide to Gender Integration and Analysis: Additional Help for ADS Chapters 201 and 203." 2010, <http://www.usaid.gov/sites/default/files/documents/1865/201sab.pdf> (both accessed May 24, 2014).
- . *Counter-Trafficking in Persons Policy*. Washington, DC: United States Agency for International Development, 2012. [http://pdf.usaid.gov/pdf\\_docs/PDACT111.pdf](http://pdf.usaid.gov/pdf_docs/PDACT111.pdf) (accessed May 24, 2014).

- . *Ending Child Marriage & Meeting the Needs of Married Children—The USAID Vision for Action*. Washington, DC: United States Agency for International Development, 2012. [http://pdf.usaid.gov/pdf\\_docs/PDACU300.pdf](http://pdf.usaid.gov/pdf_docs/PDACU300.pdf) or linked from fact sheet <http://www.usaid.gov/documents/2155/fact-sheet-child-marriage-vision> (both accessed May 24, 2014).
- . *Gender Equality and Female Empowerment Policy*. Washington, DC: United States Agency for International Development, 2012, [http://pdf.usaid.gov/pdf\\_docs/pdact200.pdf](http://pdf.usaid.gov/pdf_docs/pdact200.pdf) (accessed Feb. 27, 2014).
- . *US Strategy to Prevent & Respond to Gender-Based Violence Globally*. Washington, DC: United States Agency for International Development, 2012. [http://pdf.usaid.gov/pdf\\_docs/PDACT888.pdf](http://pdf.usaid.gov/pdf_docs/PDACT888.pdf) or linked from fact sheet [http://www.usaid.gov/sites/default/files/documents/2155/GBV\\_Factsheet.pdf](http://www.usaid.gov/sites/default/files/documents/2155/GBV_Factsheet.pdf) (both accessed May 24, 2014).
- . *USAID Youth in Development Policy: Realizing the Demographic Opportunity*. Washington, DC: United States Agency for International Development, 2012. [http://www.usaid.gov/sites/default/files/documents/1870/Youth\\_in\\_Development\\_Policy\\_0.pdf](http://www.usaid.gov/sites/default/files/documents/1870/Youth_in_Development_Policy_0.pdf) (accessed May 24, 2014).
- Vlassoff, Carol. “Gender Differences in Determinants and Consequences of Health and Illness.” *Journal of Health Population and Nutrition* 25(1) (2007):47–61, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3013263/> (accessed Dec. 4, 2013).
- Wilber, Roxane. “Lessons from Rwanda: How Women Transform Governance.” *Solutions for A Sustainable and Desirable Future* 2(2) (2011), <http://www.thesolutionsjournal.com/node/887> (accessed Feb. 28, 2014).
- World Bank. *World Development Report 2012: Gender Equality and Development*. Washington DC: World Bank, 2012, <http://go.worldbank.org/6R2KGVEXP0> (accessed Feb. 11, 2014).
- World Health Organization. *Gender, Women and Health*. undated webpage, <http://www.who.int/gender/en/> (accessed March 1, 2014). This is WHO’s main webpage on the topic, with links to many useful resources.
- . “What Do We Mean by ‘Sex’ and ‘Gender’?” undated webpage, <http://www.who.int/gender/whatisgender/en/> (accessed March 1, 2014).
- . *Women and Health. Today’s Evidence Tomorrow’s Agenda*. Geneva: World Health Organization, 2009, [http://whqlibdoc.who.int/publications/2009/9789241563857\\_eng.pdf](http://whqlibdoc.who.int/publications/2009/9789241563857_eng.pdf) (accessed Dec. 22, 2013).
- . *Gender, Women and Primary Health Care Renewal: A Discussion Paper*. 2010a, [http://whqlibdoc.who.int/publications/2010/9789241564038\\_eng.pdf](http://whqlibdoc.who.int/publications/2010/9789241564038_eng.pdf) (accessed Feb. 27, 2014).
- . *Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and Their Measurement Strategies*. Geneva: World Health Organization, 2010b, [http://www.who.int/healthinfo/systems/WHO\\_MBHSS\\_2010\\_full\\_web.pdf](http://www.who.int/healthinfo/systems/WHO_MBHSS_2010_full_web.pdf) (accessed March 1, 2014).
- . *Gender Mainstreaming for Health Managers: A Practical Approach. Facilitators’ Guide*. Geneva: World Health Organization, 2011 [http://whqlibdoc.who.int/publications/2011/9789241501071\\_eng.pdf](http://whqlibdoc.who.int/publications/2011/9789241501071_eng.pdf) (accessed Dec. 4, 2013).



———. “Sample Gender Analysis Matrix: HIV.” Annex 3, in *Gender Mainstreaming for Health Managers: A Practical Approach*. Facilitators’ Guide. Geneva: World Health Organization, 2011, 78–83, [http://whqlibdoc.who.int/publications/2011/9789241501071\\_eng\\_Module-2-Annexes.pdf](http://whqlibdoc.who.int/publications/2011/9789241501071_eng_Module-2-Annexes.pdf) (accessed March 1, 2014).

World Health Organization. Department for Health Policy, Development and Services. *Working Paper 10. Towards Better Leadership and Management in Health: Report on an International Consultation on Strengthening Leadership and Management in Low-Income Countries*. Geneva: World Health Organization, 2007, [http://www.who.int/management/working\\_paper\\_10\\_en\\_opt.pdf](http://www.who.int/management/working_paper_10_en_opt.pdf). (accessed Dec. 4, 2013).

World Health Organization. Department of Gender and Women’s Health. *Gender Analysis in Health: A Review of Selected Tools*. Geneva: World Health Organization, 2002, <http://www.who.int/gender/documents/en/Gender.analysis.pdf> (accessed Dec. 5, 2013).

———. ‘En-gendering’ the Millennium Development Goals (MDGs) on Health. Geneva: World Health Organization, 2003, <http://www.who.int/gender/mainstreaming/en/MDG.pdf?ua=1> (accessed Feb. 27, 2014).

World Health Organization. Department of Gender, Women and Health. *Integrating gender into HIV/AIDS programmes in the health sector: Tool to improve responsiveness to women’s needs*. Geneva: World Health Organization, 2009, [http://www.who.int/gender/documents/gender\\_hiv\\_guidelines\\_en.pdf](http://www.who.int/gender/documents/gender_hiv_guidelines_en.pdf) (accessed Dec. 14, 2013).

World Health Organization. Department of Human Resources for Health. “Gender and health workforce statistics.” *Spotlight on Statistics*, Issue 2 (2008), [http://www.who.int/hrh/statistics/spotlight\\_2.pdf](http://www.who.int/hrh/statistics/spotlight_2.pdf) (accessed Dec. 4, 2013).

World Health Organization. Regional Office for Africa. *Gender, Women’s Health and Ageing*. undated webpage, <http://www.afro.who.int/en/clusters-a-programmes/frh/gender-womens-health-a-ageing/overview.html> (accessed Feb. 28, 2014).

Yates, Rob. “Universal health care and the removal of user fees,” *The Lancet* 373(9680) (2009): 2078–2081, <http://www.sciencedirect.com/science/article/pii/S0140673609602580> (accessed March 1, 2014).

———. “Women and children first: an appropriate first step towards universal coverage.” *Bulletin of the World Health Organization* 88 (2010):474–475. Doi: 10.2471/BLT.09.074401 <http://www.who.int/bulletin/volumes/88/6/09-074401/en/> (accessed March 1, 2014).





## CHAPTER 5

# Planning the Work and Working with the Plan

*Judith B. Seltzer*

1. Achieving Results by Strengthening Health Systems
2. Leading and Managing: Critical Competencies for Health Systems Strengthening
3. Governance of Health Systems and Health Organizations
4. Mainstreaming Gender Equality into Health Systems
5. Planning the Work and Working with the Plan
6. Managing Human Resources
7. Managing Finances and Related Systems
8. Managing Medicines and Health Products
9. Managing Information: Monitoring and Evaluation
10. Managing Health Service Delivery

**T**his chapter attempts to simplify planning by introducing and defining a range of essential long- and short-term planning processes that managers of health programs or health services should implement. We focus on the primary organizational planning process: the development of a strategic plan and its conversion into an operational plan.

The chapter sets the stage with a discussion of strategic thinking and then covers each phase of the strategic planning process: analyzing the organization's internal and external environments, articulating or refining a mission, creating a vision, establishing strategic objectives, formulating strategies, and monitoring and evaluating results.

These phases are broken down into their fundamental steps, with definitions, instructions, and tools to help you and members of your planning team understand and apply each step. The chapter then addresses the critical link between strategic and operational planning and includes supplemental information about budgeting.

## Introduction

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The challenges faced by today's health organizations are complex and plentiful—gender inequality, reform processes, changing health needs of the population, lack of sufficient resources, new sources of funding, and new donor priorities, among others. To address these challenges and shape your organization's future, you and your team must do more than contemplate internal and external realities and manage and lead on a daily basis.

The new pressures require both public-sector and nongovernmental organizations to take on the challenge of designing their futures. As a manager of a health program or health services, you need to help your organization develop or re-examine its mission and vision and renew its commitment to that mission and vision. Once the mission and vision is shared by all, you can:

- establish strategic objectives that help achieve the mission;
- formulate strategies that allow your organization to take advantage of opportunities;
- use existing strengths to continuously adjust to the changing situations in the larger environment as well as at the community level.

These actions will help your organization fulfill its mission and turn its vision into reality.

Designing the future means making the right decisions *today* with a vision of tomorrow. To achieve this, an orderly process of reflection is important—this is the essence of what is known as planning. Planning is a tool that enhances the quality of decisions.

A plan functions like a blueprint: it defines the steps and decision points required to achieve a desired result or a larger goal. Although the goal might be, for example, an increase in the contraceptive prevalence rate or a reduction in infant deaths, if resources cannot be aligned with this goal, it may be necessary to find additional resources or adjust the goal to make it more attainable. Good plans, therefore, must be flexible.

Effective managers use plans as guidelines, rather than as rigid, unchangeable prescriptions. They adjust their plans according to changing circumstances and the results of monitoring.

### PLANNING WITH PURPOSE

We plan because the supply of material, financial, and human resources is limited. A carefully developed plan is the best way to guarantee that these limited resources are allocated, properly used, and accounted for during the prescribed time frame.

There are two contexts for planning. In the first, the quantity of resources available might be known with considerable accuracy, and the plan guides the maximum possible progress toward a goal using these available resources. Other times the availability of resources may be less clear, and the plan might be created to justify a request for resources to reach a stated goal. Whether the plan is developed before or after the allocation of resources, it

is intended to ensure the best return on investment, that is, the greatest possible achievement of results with the available resources.

Most important, we plan because planning is a cornerstone of managing and leading teams to achieve results.

## Linking planning to leading and managing for results

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How do good management and leadership contribute to strong plans? As [Figure 1](#) shows, planning is one of the four key management practices. It uses the organization's mission and vision as the bases for establishing its future direction and channeling its collective efforts in the chosen direction. Planning is a fundamental component of management.

Managers who lead effectively know that planning alone is not enough to achieve desired results: they use all the leading and managing practices listed in the framework. Applying these eight practices consistently leads to strong organizational capacity and health services, and, ultimately, lasting improvements in people's health.

Plans can and should be developed by groups and by individuals at different levels—central, provincial, district, facility, and community. Plans can also cover varying time periods: every three to five years, one year, a quarter, or a month. The appropriate type and timing of the plan depend on the organization's needs.

The process for strategic and operational planning can be viewed as a continuum made up of a series of whats and hows, as depicted in [Figure 2](#). The whats represent the steps in the strategic and operational planning continuum; the hows describe the actions needed to complete each step.

### WHY SOME PLANNING DOES NOT SUCCEED

We plan every day as individuals, managing our time and resources so we can achieve our goals. Still, when we plan at work, as part of an organization and a work team, we sometimes view planning as a meaningless ritual and a management burden—a process that consumes valuable time and resources and fails to move us toward the fulfillment of the mission and vision.

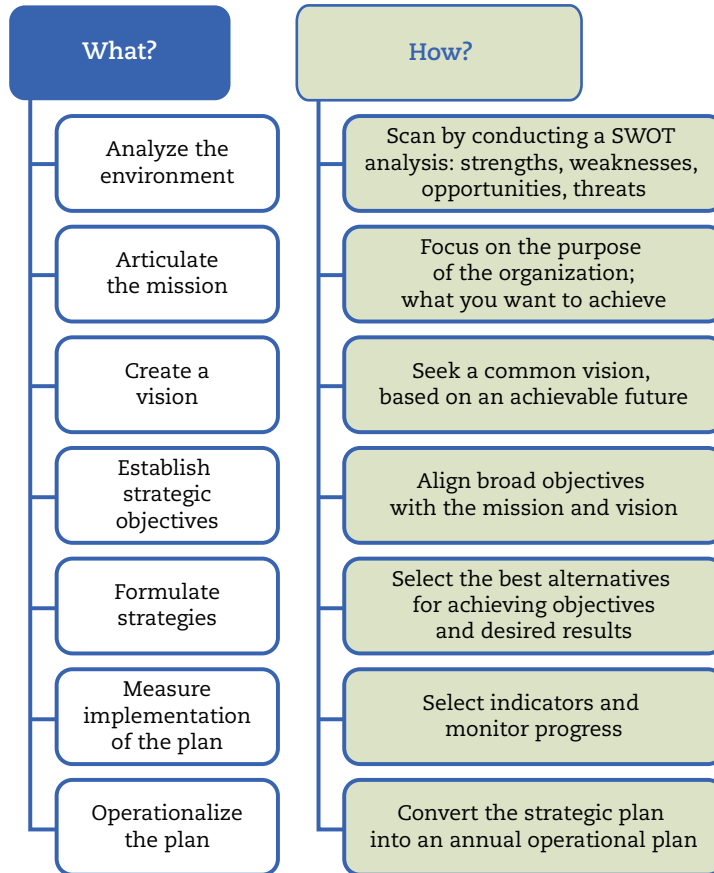
According to Lers Thisayakorn (2008), a consultant based in Thailand, it is not the practice or process of planning that fails. Rather it is the implementation of plans that fails. We have identified five factors that lead to this failure, some of which can be linked to the absence of sound management and leadership practices.

**Leaders fail to motivate staff.** Plans do not implement themselves; they need to be implemented by leaders at all levels of the organization. Implementing a plan requires aligning, motivating, and inspiring people, and assuring them that the results are important and worthy of their efforts.

FIGURE 1. Leading and Managing Framework



FIGURE 2. Strategic and Operational Planning Continuum

**The Planning Continuum**

**The planning process is static.** It is not uncommon for planning to become a routine process that starts with great energy and enthusiasm but evolves into a burden, resulting in a document that is viewed as an end in itself. This happens when planning is an occasion, unrelated to day-to-day responsibilities and forcing all other business aside. Once the plan is completed, normal activities resume and the plan becomes a static document, never to be implemented.

**Analysis is stale and myopic.** Shu Wei Wong, a prominent strategist and planner, asserts that planning is stale or shortsighted when managers focus too firmly on planning by numbers and correctly filling in templates (2007). Managers and their planning teams need to prepare to plan by **scanning** the current internal and external environments and using this information to project what these environments might look like in the future. In other words, they need to anchor the planning process in reliable data. Otherwise, even if the plan is implemented, chances are it will be ineffective.

**Leaders and managers are not aligned.** Great plans are those that are successfully implemented and make a major contribution to the fulfillment of an organization's mission and vision. This requires that leaders and managers **align** with the planning process.

If they are not aligned, the plan is usually relegated to the back burner, and implementation is rarely successful.

**There is a lack of connection between inputs and intended results.** As Stephen Covey (2004) contends, it is important to “start with the end in mind.” By understanding what results you want to produce and what future you want to create, you can plot the steps and actions required to arrive at that destination. Nonetheless, it is not uncommon to find plans in which inputs (resources used, such as personnel and equipment) are inadequate or inappropriate to the achievement of the desired results.

## Types of planning

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Planning is the process of mapping a route from point A to point B. There are several types of planning that can help you map the best way to reach your goal: strategic planning, operational planning, and business planning. These types are the most frequently used, and they are not mutually exclusive. In brief, the strategic plan establishes the general direction and broad goals of the organization over three to five years. The operational plan details the activities that will allow the organization to achieve its short-term goals. The business plan articulates new ideas or expansion efforts (which are often introduced in the strategic plan) and is used to secure funding for their development and launch.

### STRATEGIC PLANNING

Strategic planning is medium- to long-term planning that involves all the organization's management areas and includes goals, strategic objectives, strategies, and measurable results. It focuses on broad and long-lasting issues related to the organization's long-term effectiveness and survival. It asks and answers four questions:

1. Where are we now? (situational analysis: strengths, weaknesses, opportunities, threats)
2. Where do we want to go? (mission, vision, strategic objectives)
3. How will we get there? (strategies)
4. How will we know we are getting there? (measuring implementation, monitoring progress)

An organization's board and management staff are usually responsible for strategic planning. However, the planning process should include input from all levels of the organization as well as stakeholders, for example major donors, relevant ministries and other government agencies, and beneficiaries of the organization's services.

### OPERATIONAL PLANNING

The operational plan has a shorter time span—usually one year. It must be aligned with the strategic plan and define activities and objectives that will contribute in the near future to the strategic objectives and strategies in the strategic plan. The operational plan is more detailed than a strategic plan; it is often referred to as the annual work plan.

## BUSINESS PLANNING

Business planning is short- to mid-term planning. It is used to secure funding and make projections of the estimated financial and social return from the start-up of an organization, formation of a new business unit, or development and introduction of a new product or service offered by an established entity. A good business plan enables an organization to assess the viability of all its products and services and the resources required to launch new products and services.

## PLANNING FOR ALL OCCASIONS

This chapter emphasizes the link between strategic and operational plans. Because strategic plans define relatively ambitious goals, objectives, and strategies that are fundamental to the life and growth of an organization, they are often used to justify the allocation of resources. Strategic plans should be reviewed every year and operational plans aligned accordingly.

### Thinking strategically as a basis for planning

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Because planning is about making the desired future, or your organization's vision, a reality, the decisions you make as a manager or service provider will have an impact on the future of your organization and of the communities it serves. Making such decisions means that you and your planning team must think strategically about the interplay between what is occurring outside the organization and its effects on the internal workings of the organization. Together, you must scan to discern trends and future challenges, so you can best position your organization to respond effectively, and in a sustainable way, to a changing environment.

Strategic thinking promotes the generation of breakthrough ideas, creative concepts that are very different from those that have come before. It breaks through old or conventional ways of doing things, making it possible for you to serve your clients in dramatically new ways.

When embarking on any kind of a plan, strategic thinking will engender a fresh perspective on the issues that your organization is trying to address.

Strategic thinking compels you to ask the following questions before you start planning:

- What are the needs of the population our organization aims to serve?
- Is our organization currently meeting these needs?
- In what way could our organization meet needs that are not currently being met?

Asking and answering these questions may yield critical information about gaps in your organization's services; missed market opportunities; ways in which the organization can extend its reach with minimal incremental costs; and ways in which the organization can improve internally to be more efficient and effective.



## Embarking on the strategic planning process

### FORMING A BALANCED PLANNING TEAM

In his lectures, Edward B. Roberts of the Sloan School of Management at the Massachusetts Institute of Technology describes a high-performing, innovative team as generally having members who possess specific characteristics, take on strategic roles, and carry out well-defined functions. The team often has a blend of characteristics, and individual members play different roles at different times. As the leader of a planning team, you should be aware that all these functions are needed for your team to be effective. It is important that you try to form a team whose members, as a group, possess all these characteristics, and to encourage them to play their roles, contributing in their own way to the team's work.

Note that although the core planning team will likely remain constant, the team will expand, as needed, to include board members and other key staff. [Table 1](#) describes the roles, characteristics, and functions of the members of a balanced team.

Even if you have had the opportunity to work on a balanced, innovative team, you know that a team requires a lot of encouragement to function well. Working as a team is not always easy. Box 1 provides approaches to dealing with the interpersonal issues that planning teams often encounter.

#### BOX 1. Addressing Team Tensions

It is possible for tensions to develop within a team due to the competing demands of planning for the future while implementing for today. Often some people are more committed than others, and they may well carry the entire burden of the work. These issues must be discussed openly among members of the planning team to avoid further tension or misgivings. The person in the role of manager needs to pay attention to the team's dynamics—communication, commitment, and engagement—and take action when the team is not performing as expected.

It is especially important for new teams to be aware of group dynamics, given that there is a tendency during the first stages of a team's formation to pay more attention to being inclusive and achieving group harmony than to acknowledging and appreciating the diversity of thought and experience represented on the team.

The planning team should not seek technical homogeneity. The team should instead embrace the distinct characteristics of team members and use them to stimulate new thinking, which is essential to drafting an effective and meaningful plan of any kind.

TABLE I. A Balanced Team: Roles, Characteristics, and Functions

Roles	Characteristics	Functions
<b>The Idea Generator</b>	This person has very keen technical skills and is considered an expert in his or her field. He or she likes to work on a conceptual level and deals well with abstractions. This person is considered highly innovative and tends to prefer working alone.	You can count on this person to solve problems, generate breakthrough ideas, and test the feasibility of these ideas.
<b>The Entrepreneur</b>	This person has strong application skills. He or she has a wide range of interests, is energetic and determined, and enjoys taking risks.	This person puts into action what others propose, sells the new idea to others in the organization, and secures resources.
<b>The Manager</b>	This person focuses on decision-making. He or she uses the organizational structure and systems to get things done. This person understands how all the functions of the organization fit together and respects procedures and processes. This is a manager who is capable of leading others.	This person provides the team with leadership and motivation. He or she organizes, coordinates, and supervises the team. This person sees that the planning process moves along efficiently and that administrative requirements and organizational needs are met.
<b>The Networker</b>	This person stays informed of what is happening inside and outside the organization. He or she knows what the competition is doing, what funders are looking for, and what clients want.	You can count on this person to gather intelligence and relay important news to others.
<b>The Champion</b>	This person represents the voice of experience. He or she is often more senior and offers objectivity and experience in developing new ideas.	This person provides access to the organization's power base, to get what the team needs from other parts of the organization and provide legitimacy and organizational confidence in the plan, ideas, and activities it contains. Furthermore, this person provides guidance to the team and helps members develop their skills and talents.

## Analyzing the external and internal environments

### Where are we now?



The first stage of the strategic planning process asks: where are we now? The SWOT analysis enables you and your planning team to answer this question by carefully **scan-ning** the trends and conditions—internal and external, positive and negative—that can impact the ability of your organization to fulfill its mission and build a bright future. The SWOT analysis is a tool that helps you identify **opportunities and threats (OT)** in the external environment that are most relevant to your work and the **strengths and weaknesses (SW)** within the organization: the systems, structures, and cultural factors that can enhance or obstruct organizational effectiveness.

You can summarize your findings in the two columns of a SWOT matrix, as demonstrated in Table 2. The left-hand column describes the forces that negatively affect the organization as threats and those that positively affect it as opportunities. In the right-hand column, favorable factors are described as organizational strengths and those that negatively affect the organization are described as weaknesses. It is important to use concrete, current data and to agree on whether a situation is a positive or negative factor.

See [Appendix A](#) for templates for the SWOT matrix and the SWOT matrix with impact ratings.

Once you have classified all the trends and conditions in the external environment as opportunities or threats and those within the organization as strengths or weaknesses, you can rank each one according to its impact on the organization, as illustrated in [Table 3](#). The higher the number, the greater the impact.

TABLE 2. Example of a Completed SWOT Matrix

External Environment		Internal Environment	
Opportunities	USAID is focusing on repositioning family planning; therefore, Global Fund monies available for TB, AIDS, and malaria projects and HIV prevention are strongly tied to family planning and reproductive health.	Strengths	Coverage of our clients with modern methods of contraception increased by 17% over the last year.
Threats	Reductions in donor funding are outpacing efforts to ensure contraceptive security.	Weaknesses	It takes four weeks, on average, to restock modern methods of contraception at most service delivery points; supply is not keeping up with current or projected demand.

TABLE 3. SWOT Matrix with Impact Ratings

	External Environment	Impact		Internal Environment	Impact
Opportunities	USAID is focusing on repositioning family planning; therefore, Global Fund monies available for TB, AIDS, and malaria projects and HIV prevention are strongly tied to family planning and reproductive health.	4	Strengths	Coverage of our clients with modern methods of contraception increased by 17% over the last year.	3
Threats	Reductions in donor funding are outpacing efforts to ensure contraceptive security.	3	Weaknesses	It takes four weeks, on average, to restock modern methods of contraception at most service delivery points; supply is not keeping up with current or projected demand.	2

In addition to depicting your organization's current situation, the SWOT analysis helps you prepare for the next planning steps, articulating the mission and generating a vision of the future.

The results of the SWOT analysis allow you and your organization to gauge where you are relative to where you intend to be. They will help you to frame or revise your organization's mission and to create a vision of the future.

## Articulating the mission



The mission begins the answer to the second strategic planning question: where do we want to go? An organization's mission is its purpose, its reason for being. The mission statement describes clearly and concisely why the organization exists. The mission provides orientation, consistency, and meaning to the organization's decisions and activities at all levels.

Most organizations already have a mission statement, but these statements are often neglected or taken for granted by the staff. The statement of the mission is too important to be ignored or passed over. If there is no mission statement, one needs to be generated. If there is one, it should be re-examined periodically by current staff. For this reason, you and your team will benefit from devoting the early stages of the planning process to reviewing and, if necessary, revising your organization's mission statement.

## WHY DOES AN ORGANIZATION NEED A MISSION?

Consider the following anecdote:

A man walked by two workers who were cutting stones in scorching heat and asked them what they were doing. The first one was annoyed by the interruption: “As you can see,” he exclaimed, “I’m cutting stones.” The second one, in contrast, seemed to be excited by the question. “What I’m doing,” he explained, “is carving the foundation of a beautiful cathedral!”

Both workers were doing the same thing, under the same conditions. What was the reason for such a different response? The second worker was aware of the reason for doing the work, the ultimate purpose. Therefore, he was able to value his contribution to the construction of that beautiful dream. The first one was completely unaware of his contribution.

The mission is what allows members of an organization to clearly understand *why* they are doing the work. Only when health workers are aware of the organizational mission, or ultimate purpose, will they fully understand the meaning and the value of their efforts.

## CONSTRUCTING THE MISSION STATEMENT STEP-BY-STEP

To construct or revise a mission statement, the board of directors and managers and their teams must carefully scan the internal and external environments before answering four basic questions: (1) What do we do? (2) Whom do we serve? (3) How do we do it? and (4) Why do we do it? We discuss each question below and highlight the segment of a sample mission statement that answers that question.

**1. What do we do?** To start articulating or refining the mission, it is essential to describe the purpose of the organization: what it does or, if it is new, what it will do. To answer this question, the planning team must clearly identify and define the needs of the populations to be served and specify which of those needs the organization intends to address.

Our mission is to contribute to reducing the number of unwanted pregnancies [the what] by providing uninterrupted access to high-quality, modern methods of contraception, so that men and women of reproductive age can control the number and spacing of pregnancies.

**2. Whom do we serve?** The second step is to define the target population. It is important to recognize that no organization is large enough to meet the diverse needs of all possible users. Therefore, the mission statement should specify which groups within the target population are the organization’s priorities.

Our mission is to contribute to reducing the number of unwanted pregnancies by providing uninterrupted access to high-quality, modern methods of contraception, so that men and women of reproductive age [the who] can control the number and spacing of pregnancies.

**3. How do we do it?** The answer to this question describes the means, resources, or strategies by which the organization intends to reach its goals.

Our mission is to contribute to reducing the number of unwanted pregnancies by providing uninterrupted access to high-quality, modern methods of contraception [the how], so that men and women of reproductive age can control the number and spacing of pregnancies.

**4. Why do we do it?** The last question explores the basic reasons behind the organization's decision to do what it does. The answer generally describes a response to a broad social problem.

Our mission is to contribute to reducing the number of unwanted pregnancies by providing uninterrupted access to high-quality, modern methods of contraception, so that men and women of reproductive age can control the number and spacing of pregnancies [the why].

A well-framed mission will guide your organization's work over the long term and inspire your staff. You and your team will want to take the time to refine the language, asking for the opinions of staff who know the organization well. With their input, the mission will truly represent the what, whom, how, and why that your organization is about. Then you can finalize and disseminate the mission statement to staff and board members, those who are served by the organization, and the general public.

Box 2 provides two examples of compelling mission statements, one drafted by a local family planning organization and one from an international AIDS organization.

#### BOX 2. Examples of Mission Statements



**PROFAMILIA, Nicaragua:** Profamilia is a nongovernmental organization that contributes to improving the health of the Nicaraguan family, emphasizing sexual and reproductive health, through projects, programs, and educational research and integrated health care services with quality and warmth, and accessible prices.



**The International AIDS Alliance:** The Alliance strives to support communities to reduce the spread of HIV and to meet the challenges of AIDS. The Alliance works to prevent HIV infection; improve access to HIV treatment, care and support; and lessen the impact of HIV and AIDS worldwide, particularly among the most vulnerable and marginalized.

## Creating the vision



When the planning team is clear about current strengths, weaknesses, opportunities, and threats and the fundamental purpose of your organization, you will continue by asking: where are we going? You are now ready to take on the challenge of constructing the desired future. It is the moment to dream, to decide what your organization wants to be in the future and how it wants to be viewed by the outside world.

The vision is like a guiding star. It fosters a shared commitment to the future you want to create and to the principles and values with which you expect to achieve them. It is a powerful picture of a desired state that provides a broad perspective and inspiration to keep working, overcome obstacles, and struggle to achieve results. The vision guides and focuses the organization's efforts and helps to align, inspire, motivate, and secure the commitment of each working group and individual within the organization.

### CREATING A SHARED VISION

Some people think that the vision must come from the organization's upper levels. Experience has shown, however, that a vision is more powerful when a larger number of people from various organizational levels develop it together. People commonly support what they help create, so a vision will be most effective if it is developed and owned by those whose work contributes to reaching it.

Depending on the level at which your planning team operates within the organization, you will want to include key actors from every work group in the process of developing the shared vision. Box 3 gives four examples of how people who study organizational planning describe visions.

#### BOX 3. What Experts Say about Vision

- According to Karl Albrecht (1994), the vision is the shared image of what we want our organization to be or to become.
- Burt Nanus (1986) says, "the vision is a realistic, believable, and attractive future for your organization.... such a motivating idea that it promotes the necessary skills, talents, and resources to make it happen and points out the way we intend to follow."
- For Jay Conger (2000), the vision is a mental image that represents a desirable future state, ideal, or dream with a vast scope.
- For Warren Blank (2001), it is similar to a wide-angle lens of awareness with a broad scope that allows people to investigate the future and encompass broad possibilities.

## CONSTRUCTING THE VISION STEP-BY-STEP

The development of the vision draws on the strategic thinking that brought new information and insights to the planning process. The vision refers to the needs of the target population and the commitment made to meet them, as described in the mission.

An effective vision for your organization will be tangible and descriptive—an image of the future that people can easily visualize. It will be compelling and inspiring—a powerful call to action. It should be challenging enough to demand the best efforts of everyone in the organization, but it must also be achievable so that people will work toward it.

In constructing the vision, you and your planning team should follow four steps:

**Step 1.** Keep the big picture in mind. Refer to your organization's mission and the population you are supposed to serve so that the vision aligns with the mission.

**Step 2.** Answer the following questions:

- What will our organization look like in three to five years?
- What aspects of the mission will we have achieved and in what areas will we excel?
- What will make us most proud? (e.g., the health status of our beneficiaries, the quality of our services, the commitment and creativity of our staff, the financial stability of our organization).
- What values do we uphold, and how will they be reflected in our services and the way we run our organization?

Write down the answers to each of these questions and come to a consensus within your team.

**Step 3.** Look at your organization through the eyes of your target population, beneficiaries, donors, partners, collaborators, competitors, and society in general. For each of these groups, ask:

- How do we want these groups to see our organization in three to five years?
- What will they say about our services?
- What will they say about our staff?
- What will they say about our reputation in their communities?

Write down the answers to these questions and come to a consensus within your team.

**Step 4.** Translate these ideas into a few sentences that describe the desired future in a concrete manner, as seen in the example below:

We are widely recognized as the leading provider of easy and uninterrupted access to high-quality, modern methods of contraception. Our services allow thousands of men and women of reproductive age to determine the number and spacing of their pregnancies.

Visions are often stated in the present tense, but the examples in [Box 4](#) show that this is not a hard and fast rule.



## BOX 4. Examples of Visions



**United Way International:** To be a global leader in intelligent and accountable philanthropy and have an impact in communities worldwide.



**Care International:** CARE International seeks a world of hope, tolerance, and social justice, where poverty has been overcome and people live in dignity and security. CARE will be known everywhere for our unshakable commitment to the dignity of people.



**Stop TB Partnership:** Our vision is a TB-free world: the first children born this millennium will see TB eliminated in their lifetimes.

After you have completed Steps 1–4 and drafted the vision, invite a larger group of colleagues, in addition to the members of the planning team, to a visioning meeting. Gathering input from a group composed of people from different areas and levels will increase the likelihood of constructing a vision that is motivational to all. This larger group will benefit from reviewing examples from comparable organizations.

Once the organizational mission and vision are clear—that is, you know who you are, where you are, and where you want to go—you can celebrate the achievement and share it at all levels of the organization. The next step in the planning process is to contemplate how you are going to fulfill that destiny. This is where an organization's strategic objectives come into play.

## Establishing strategic objectives



The final answer to where are we going lies in the objectives—the desired results—that will help to transform your organization's mission and vision into actionable, measurable pursuits. Objectives set the course for management decisions and become the criteria against which it is possible to measure achievements.

If they are to serve their purpose, objectives must be SMART:

**S** = Specific

**M** = Measurable

**A** = Appropriate to the scope of activities

**R** = Realistic within the allotted time

**T** = Time bound, with a specific date for completion

Just as the types of planning differ in terms of scope, time period, and level of specificity, objectives can fall within a range. Some are broad and long term, the results of organizational strategies that involve the highest management levels. Others are somewhat shorter term and represent the link between the strategic plan and the corresponding operational plan. Their scope of action involves working teams or operational units. The shortest-term objectives are the desired results of a particular activity or task that falls within the scope of a small group or an individual.

## STRATEGIC OBJECTIVES

Strategic objectives are the results the organization intends to achieve in the medium to long term. They derive from the organizational vision and are established by the organization's management, in consultation with the heads of various departments or units. They should be approved by the board of directors in the case of civil society organizations or by a senior management team in the case of a public-sector institution.

Strategic objectives are important because they:

- allow the organization's vision to become a reality;
- serve to direct organizational, departmental/unit, and individual plans;
- provide orientation on the use of the organization's resources;
- constitute the basis for supervising, monitoring, and evaluating results.

## DEVELOPING STRATEGIC OBJECTIVES STEP-BY-STEP

Strategic objectives contain the following elements:

- **Action:** What must be done
- **Subject:** The topic or group the action addresses
- **Description:** The characteristics of the action
- **Where:** The location at which the action will take place
- **When:** By what date the action will be completed
- **Limits/conditions:** The scope or conditions under which the action will be implemented
- **Results:** The measurable effect of implementing the action

These elements are organized in the matrix shown in Table 4.

TABLE 4. Blank Matrix to Develop Strategic Objectives

Action	Subject	Description	Where	When	Limits/ Conditions	Measurable Desired Results

There are three steps to follow when developing strategic objectives, and they require time and focus. They are particularly important and useful if the number and scope of actions proposed exceed available funding and organizational capacity.

**Step 1.** Because the strategic objectives allow the vision to become a reality, the vision is your starting point. You and your planning team can identify and separate the main topics covered in the vision and transform them into SMART strategic objectives.

Look again at our sample vision:

We are widely recognized as the leading provider of easy and uninterrupted access to high-quality, modern methods of contraception. Our services allow thousands of men and women of reproductive age to determine the number and spacing of their pregnancies.

The main topics in the vision are:

- **Topic 1:** Become positioned in the minds of our intended recipients and others as the “leading provider” and the best choice when accessing modern methods of contraception.
- **Topic 2:** Make access to modern methods of contraception “easy.”
- **Topic 3:** Make sure that access to modern methods of contraception is “uninterrupted.”
- **Topic 4:** Provide “high-quality, modern methods of contraception.”

**Step 2.** Complete the matrix in [Table 4](#) for these four topics. For each topic, fill in the information in all columns: the action to be carried out, its subject, description, location, implementation and dates, limits or conditions, and desired measurable result. See [Table 5](#) for an example of how an organization might spell out these details.

**Step 3.** Summarize the information you have entered for each topic as a strategic objective. Write these objectives clearly and check to see that they are SMART: **S**pecific, **M**easurable, **A**ppropriate, **R**ealistic, and **T**ime bound. For example:

By the end of 2013, the organization must:

- position itself in the minds of intended recipients and others as the leading provider of easy and uninterrupted access to high-quality, modern methods of contraception;
- provide regular access to modern methods of contraception in facilities with the highest number of men and women of reproductive age in their catchment areas;
- have a supply chain that functions optimally to ensure an uninterrupted supply of modern methods of contraception;
- maintain client satisfaction levels above 95 percent at all organizational facilities, especially for clients who are new users of modern methods of contraception.

TABLE 5. Matrix to Develop Strategic Objectives: Completed Example

Action	Subject	Description	Where	When	Limits/Conditions	Desired Measurable Results
1 Secure a position	Our organization in the minds of our intended recipients	As the leading provider of easy and uninterrupted access to high-quality, modern methods of contraception	In the entire country	By the end of 2013	Through easy and uninterrupted access to high-quality, modern methods of contraception	By the end of 2013, client survey data will demonstrate that over 80% of respondents consider us the leading provider of easy and uninterrupted access to high-quality, modern methods of contraception
2 Provide access	Facilities	Regular access to modern methods of contraception	Throughout the entire organization	By the end of 2010	Prioritizing the facilities with the highest number of men and women of reproductive age	By the end of 2010, more than 75% of our clients will indicate that they have regular access to modern methods of contraception through our facilities
3 Ensure uninterrupted contraceptive supply	Supply system	Supply chain functions optimally to ensure uninterrupted supply of methods	At the organization and facility levels	By the end of 2010	Offering the best working conditions and incentives in accordance with performance results and quality of care	By the end of 2010, our supply system will conform fully to international standards, ensuring an uninterrupted supply of modern methods of contraception
4 Maintain client satisfaction	Quality of services	Above 95% satisfaction	In all facilities	By the end of 2009	Special attention given to new users of modern methods of contraception	By the end of 2009, client satisfaction levels will be above 95% at all facilities, especially for those clients who are new users of modern methods of contraception

## Formulating strategies



Strategies are statements of what is to be done. By answering the question of how will we get there, they define the route by which an organization will achieve its strategic objectives in the medium and long terms.

There are almost always alternative routes toward the achievement of strategic objectives. To find the best strategies for your organization involves considering all possible strategies and then choosing one or more that will best contribute to the achievement of the corresponding strategic objectives. Desired measurable results are the “measurable outcomes” that will be produced when the strategies are implemented.

To determine which strategies are best suited to helping your organization achieve its strategic objectives, consider the questions in Box 5.

To stimulate your thinking about strategies, there is a list of key questions in the “Strategies” column of [Table 6](#).

Questions like these will help you and your planning team identify possible strategies for achieving your strategic objectives and desired results. You can then use the criteria in Box 5 to choose the best alternatives.

### BOX 5. Which Strategies Are Best?

- Will the strategy contribute to the achievement of your strategic objectives and desired measurable results?
- Does the strategy have the potential to make the greatest contribution while using the fewest resources?
- Can the strategy be implemented, given the resources and context within which you work?
- Is the strategy compatible with other strategies selected for the same and other strategic objectives?
- Will the strategy maximize external opportunities and internal strengths? Will it address internal weaknesses and external threats?

TABLE 6. Matrix to Formulate Strategies to Align with Strategic Objectives

Strategic Objectives	Desired Measurable Results	Strategies
1 Position the organization's image in the minds of our target population as the leading provider of easy and uninterrupted access to high-quality, modern methods of contraception	By the end of 2013, client survey data will demonstrate that over 80% of respondents consider us the leading provider of easy and uninterrupted access to high-quality, modern methods of contraception	What needs to be done to: <ul style="list-style-type: none"> <li>be a leading provider?</li> <li>offer uninterrupted access?</li> </ul>
2 Offer clients the easiest access to modern methods of contraception in the facilities with the highest number of men and women of reproductive age	By the end of 2010, more than 75% of our clients will indicate that they have regular access to modern methods of contraception through our facilities	What needs to be done to: <ul style="list-style-type: none"> <li>determine the facilities with the highest demand?</li> <li>facilitate access to our high-demand facilities?</li> </ul>
3 Have a supply chain that functions optimally to ensure uninterrupted supply of modern methods of contraception	By the end of 2010, our supply system will conform fully to international standards, ensuring an uninterrupted supply of modern methods of contraception	What needs to be done to: <ul style="list-style-type: none"> <li>improve the supply system?</li> <li>hire and retain the best staff to manage the system?</li> <li>meet international standards for a fully functional supply system?</li> </ul>
4 Maintain client satisfaction levels above 95% at all facilities, especially for those clients who are new users of modern methods of contraception	By the end of 2009, client satisfaction levels will be above 95% at all facilities, especially for those clients who are new users of modern methods of contraception	What needs to be done to: <ul style="list-style-type: none"> <li>increase the level of client satisfaction?</li> <li>attract and retain new users of modern methods of contraception?</li> </ul>

## Measuring the implementation of the plan



Your strategic plan sets a direction and strategies for achieving strategic objectives and desired measurable results. It is crucial for you as a manager of a health program or health services to monitor and measure whether and how well your organization is carrying out its strategies and the extent to which you are achieving your strategic objectives.

The backbone of measurement is results. These may be outputs (the immediate or direct product of activities) and outcomes (short-term changes in a beneficiary population as a result of activities). The achievement of those outputs and outcomes is determined by indicators—measurable markers of change in a condition, capability, quantity, or quality over time. The indicators you incorporate into your plan will allow you to regularly monitor progress toward your desired results and to evaluate the actual results achieved.

### SELECTING INDICATORS

When data on the indicator are collected, recorded, and analyzed, a good indicator makes complex concepts readily measurable. A good performance indicator has a number of desirable features (WHO 1994). It should be:

- **valid:** it measures the phenomenon it is intended to measure;
- **reliable:** it produces the same results when used more than once to measure the same thing;
- **precise:** it is defined with clear, specific terms;
- **discrete:** it captures a single component or aspect of a more complex result (it measures only one thing, not a set of things);
- **easily understood:** both experts and nonexperts can grasp its meaning;
- **comparable:** it avoids narrow or unique definitions whose values would be difficult to compare with other results;
- **feasible to use:** it is based on data that are easy and inexpensive to obtain.

Those who analyze data pertaining to results have to be very careful that those results can be attributed to the organization's products, services, or activities. If other factors have contributed to the results, it is important to note them in reports.

If you want to closely track progress toward desired measurable results, you can set milestones. Milestones are verifiable markers that confirm that the proper path is being followed to carry out the strategy and obtain results. For example, if your desired result is to provide modern methods of contraception to 75 percent of your clients, and one strategy is to provide up-to-date information to potential clients, a milestone might be the completion of an accurate determination of the number of women of reproductive age residing in your catchment area. Another strategy to achieve this result might be to provide family planning services at all facilities; milestones might be confirmation that all facilities have a system in place to maintain an adequate supply of high-demand family planning methods.

Although it is important for inputs (such as human resources) to be in place for processes to be carried out as planned and for the immediate outputs (such as the number of new family planning users) to be positive, the true value of an activity lies in the *outcome* (such as the contraceptive prevalence rate among the targeted population). If the intervention has a positive short- to medium-term outcome—a positive effect on the behavior of the target audience—it is likely that, in combination with other interventions, it will contribute to long-term improvements in health.

Although you might want to include some other types of indicators, you can concentrate on output and outcome indicators to monitor the progress and results of your planned interventions. Some examples of persuasive indicators follow.

If a strategic objective is to improve the health behaviors or health status of the target population, you might use outcome indicators to demonstrate:

- changes in health practices;
- changes in health beliefs or attitudes;
- an increase in the level of knowledge of selected health issues.

If a strategic objective is to improve the target population's access to health or social services, you might use output or outcome indicators to demonstrate:

- increases in the availability of health or social services;
- increases in the number of visits to health or social service establishments;
- decreases in the costs to the user to access health or social services.

If a strategic objective is to improve the quality of health or social services offered to the target population, you can use outcome indicators to demonstrate:

- increases in demand for the products or services offered;
- increases in client satisfaction with the products or services offered;
- closer adherence to commonly accepted standards of quality in providing these services or products.

TABLE 7. Blank Results Monitoring Chart

Strategic Objective 1:				
Desired Measurable Result:				
Strategy 1:				
Intermediate Result/Milestone	Date of Completion	Responsible Party	Indicator	Means of Verification



You will find more information about outputs, outcomes, and the selection and use of indicators in Chapter 9 of this handbook.

[Table 7](#) offers a format to help you organize and monitor output and outcome indicators against the strategic objectives, desired measurable results, and strategies in your plan. You and your planning team will want to agree on how often to monitor results and milestones in the strategic plan; many organizations find it useful to do so once or twice a year.

At this point, you and your team have completed the strategic planning process and are ready to produce the plan itself. This document should be simple, readable, and concrete, with a structure that reflects the process. We suggest a structure similar to that presented in Box 6.

The written document should be accompanied by a summary visual presentation in a table (see sample template in [Appendix B](#)).

#### BOX 6. Suggested Structure of the Strategic Plan

- **Introduction.** Briefly explain when and how the planning process took place, which concerns or circumstances the plan responds to, who participated, and how the plan will be used.
- **Analysis of the environment.** Summarize the internal strengths and weaknesses and external opportunities and threats that you identified through the SWOT analysis.
- **The mission, vision, and strategic objectives.** Present the well-written statements of these three critical elements and explain how the mission and vision led to the strategic objectives.
- **Strategies.** Present the strategies that you propose to use to achieve the results of each strategic objective. Write a brief explanation of why each strategy was chosen.
- **Measuring implementation.** Present the [Results Monitoring Chart](#), write a brief explanation of the choice of indicators, and describe the process and schedule for reviewing the plan.
- **Conclusion.** Add any final comments and point out that annual operational plans will be developed on the basis of the strategic plan.

## Converting the strategic plan into an operational plan



When you and your planning team have developed the strategic plan and it has been approved and circulated, your organization will be prepared to produce annual operational plans that will translate strategic objectives and strategies into comprehensive packages of activities. Operational plans refer to the strategic objectives, desired measurable results, and strategies from the strategic plan. You should list selected activities for each strategy, and then for each activity specify the elements shown in [Figure 3](#).

FIGURE 3. Components of an Operational Plan



You will find an operational planning template in [Appendix C](#).

### SELECTING ACTIVITIES

Activities are needed to implement the strategies and achieve the results you have outlined in your strategic plan. Activities should be expressed in clear, concrete terms and in chronological order, as seen in [Table 8](#).

Each activity listed in an operational plan should be specific enough to allow you to:

- assign a cost to it;
- cite deliverables to be produced;
- identify a result to be achieved;
- prepare a schedule for accomplishing it;
- define the quality (controlled through routine monitoring of activities);
- assign people to oversee implementation and monitoring of activities.

Brainstorming possible activities for each strategy can be one of the most exciting parts of planning. It allows you and your team to draw on all your experience and insights to propose creative approaches that will bring the strategies to life.

It is likely that there are many activities that could do the job, and it is equally likely that your organization cannot carry out all of them. If the number and scope of possible activities exceed available funding and organizational capacity, you can use the Feasibility Checklist in [Figure 4](#) and the Activity Selection Decision Tree (see sample in [Table 9](#)) to help you select the activities that have the greatest chance of being carried out successfully.

The Feasibility Checklist presents a series of internal and external conditions that are criteria for assessing an activity. After you and your team have made an exhaustive activity list for each strategy, you may find that you can immediately eliminate several activities because they obviously do not meet some of the criteria. This should leave you with a shorter list of promising activities.

When you have a list of promising activities, you can use the Activity Selection Decision Tree to discuss each activity and generate its score against the criteria. The activities with

TABLE 8. Sample Matrix to Identify Activities That Correspond to Strategies

Strategic Objectives	Desired Measurable Results	Strategies	Activities
1 Position the organization's image in the minds of our target population as the leading provider of easy and uninterrupted access to high-quality, modern methods of contraception.	By the end of 2013, client survey data will demonstrate that over 80% of respondents consider us the leading provider of easy and uninterrupted access to high-quality, modern methods of contraception.	<ul style="list-style-type: none"> <li>■ Determine the unmet needs, desires, and obstacles to access of potential family planning (FP) clients.</li> <li>■ Improve tools for supply chain management.</li> <li>■ Position organization as leading provider of modern methods of contraception.</li> </ul>	<ul style="list-style-type: none"> <li>■ Conduct a survey of women of reproductive age to determine FP preferences and obstacles to access.</li> <li>■ Train clinic staff in approved method of stock control to keep contraceptives available.</li> <li>■ Produce illustrated flyer describing services and featuring quotes from satisfied clients.</li> </ul>

FIGURE 4. Feasibility Checklist

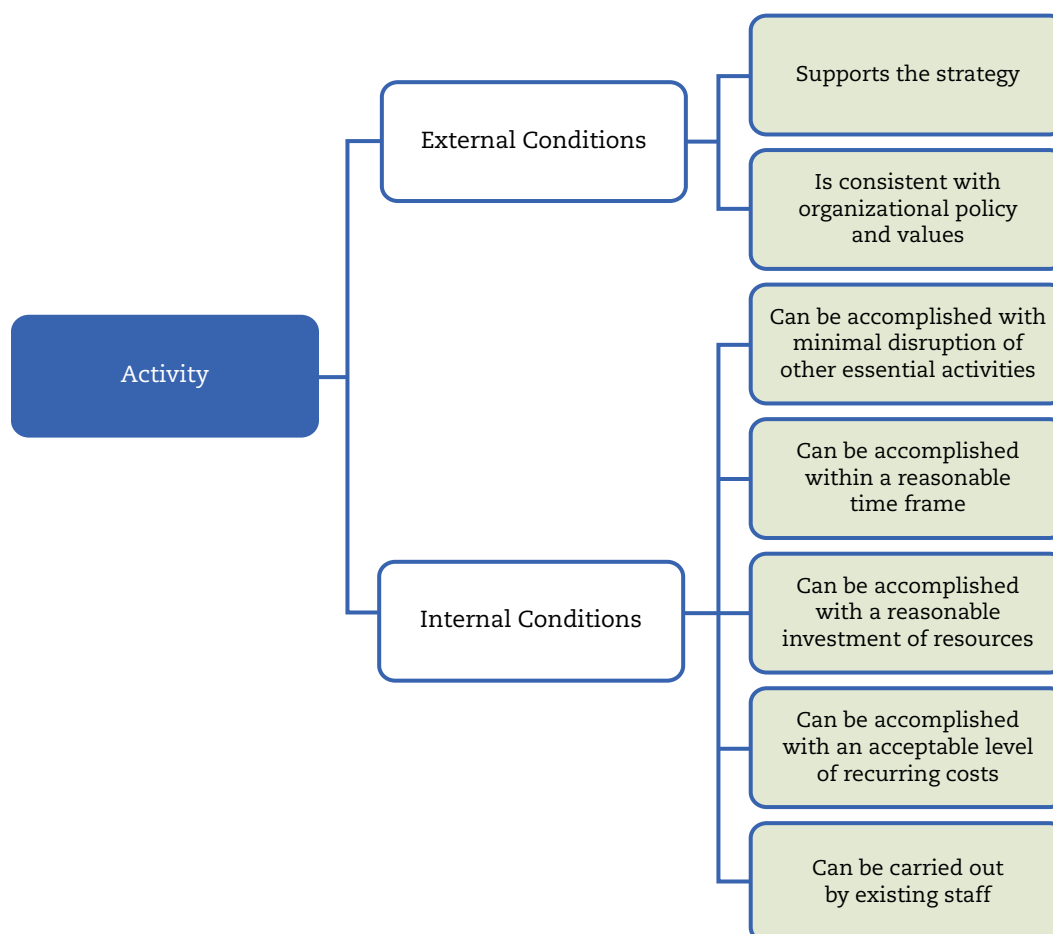


TABLE 9. Sample Activity Selection Decision Tree

Activity: Conduct a mixed media campaign informing clients about our array of modern family planning methods, prices, and the quality of our services.

Conditions and Criteria	Rating (scale of 1–3)	Weight (scale of 1–3)	Total Score (rating × weight)	Evidence
<b>External Conditions</b>				
Activity is socially acceptable	3	2	6	Using modern methods of family planning is a commonly accepted practice in our country.
Activity falls within acceptable policy framework	2	3	6	The country has a national strategy to reposition family planning and is currently developing corresponding policies to promote the procurement, sale, distribution, and use of modern methods of contraception.
<b>Internal Conditions</b>				
Activity supports strategic objectives	3	3	9	Activity strongly supports the strategic objectives of awareness, access, and quality of family planning services and supplies.
Time frame is reasonable	1	1	1	Yes.
Investment is reasonable	3	2	6	The investment is in line with multimedia campaigns for other health promotion activities.
Recurring costs are acceptable	2	3	6	Recurring costs will be acceptable; however, certain media may be used more sparingly due to their relative high cost.
Activity is administratively feasible	3	2	6	This activity is feasible because contracting mechanisms with media outlets are already in place from other similar activities.
Staff are available and qualified	2	3	6	The staff is available and experienced in doing such multimedia campaigns.
<b>Feasibility Rating</b>			46	<b>Comments:</b> The activity proposed here has a score of 46 and therefore is rated as “feasible.”
Range: 8–72			(sum of Total Score column)	
< 24 = not very feasible				
25–50 = feasible				
51–72 = highly feasible				

**Instructions:**

**Rating:** For the proposed activity described at the top of the form, there is a series of **Conditions and Criteria** in the first column that should be met. Assess the extent to which the condition is currently met, and assign a value according to the following scale:  
 1 = does not fit criterion  
 2 = partially fits criterion  
 3 = fully fits criterion

**Weight:** For each of the Conditions and Criteria assign a “weight” that indicates the relative importance of the specific condition or criterion to the execution of the activity, as follows:  
 1 = not relevant to success  
 2 = important for success  
 3 = essential for success

**Evidence:** In the column entitled “Evidence,” please describe the circumstances that support the rating you assigned to each specific Condition or Criterion.

the highest scores are the most likely to be successfully implemented. If several activities come up with the same or similar scores, the team can discuss and come to agreement on the ones that should be initiated first.

In [Appendix D](#), you will find a template for the decision tree. You may wish to change or add criteria to fit your organization's circumstances.

## MONITORING THE OPERATIONAL PLAN

Many organizations find it essential to monitor operational plans in quarterly reviews; some young organizations conduct these reviews every month to be sure that they stay on the path to their desired results. Frequent monitoring serves to identify the “triple threat” of variables: scheduling delays, budget reductions or overruns, or changes in the scope of activities.

When one of these three variables is threatened, another is impacted. As activities get pushed back, the completion of the scope of work is delayed. When the budget is reduced, the full scope of activities cannot be implemented. And when the scope is too great for the budget, the schedule will not be met until more funds are secured. This destructive interaction can be mitigated by tracking activities, budget, and deliverables and making adjustments to align the activities to the budget and the deliverables to the schedule.

Careful tracking often requires breaking each activity down into its discrete tasks. The smaller the task, the more closely you can follow your progress and make any necessary adjustments.

A simple monitoring and evaluation plan will enable you to monitor each indicator, as seen in [Table 10](#).

## COSTING AND BUDGETING ACTIVITIES

A budget projects the costs, and, in many cases, the revenues of an activity, project, or organization. It quantifies the organization's goal and objectives by guiding the allocation of financial and human resources. A budget can be used with periodic expenditure reports to review expected costs against actual spending, identify cost-effective programs, predict cash needs, determine where costs must be cut, and provide input into difficult decisions, such as which projects or activities to discontinue.

Costs or expenses are the financial outlays or resources used to deliver a product or service or to implement a project or activity. Such charges may be related to employing personnel, procuring supplies, and maintaining equipment.

Accurate and complete budgets that are monitored throughout the implementation of the operational plan are critical. Budgets are designed to meet two sets of needs. For operational purposes, budgets help an organization allocate available resources as effectively as possible and monitor and control costs. For management purposes, budgets help managers make decisions about the mix and scope of activities and projects to be undertaken during the year.

TABLE 10. Monitoring and Evaluation Plan

Indicator Status		Monitoring and Evaluation Activities	Persons Responsible	Schedule											
Strategy 1: Determine unmet needs and desires of FP clients															
Indicator	Baseline	Projected		Month											
				1	2	3	4	5	6	7	8	9	10	11	12
Percent of women of reproductive age using modern methods of contraception	20%	40%	Conduct a 30-cluster survey in communities served by clinic	Health educator, nurse midwife											
Strategy 2: Improve tools for supply chain management															
Number of clinic staff trained in stock control methodology															
Strategy 3: Position the organization as leading provider of modern methods of contraception															
Number of flyers produced and distributed															

To prepare the budget for your operational plan, it is important to have the help of someone with solid experience in financial management and budgeting. Technical and program staff who work alongside the budgeter need to specify what is entailed in carrying out the planned activities and gather information about unit costs for key line items, including:

- salaries and wages;
- consultant costs;
- travel and transportation;
- facilities and supplies;
- other direct costs (costs associated solely with the execution of the activity, such as printing or reproduction, communications, postage and shipping, supplies and materials, and outside services);
- other indirect costs (costs that are not exclusively associated with the execution of the activity).

You can read more about budgets and financial management in Chapter 7 of this handbook.

## PLANNING FOR NEW INITIATIVES

At this point in the planning process, you will have developed a strategic plan and converted it into an operational or annual work plan. If your strategic plan indicates that the organization should design and introduce new products or services (such as female condoms or adolescent reproductive health services) or expand the target population in a major way (for example, reaching out to people living with HIV & AIDS as potential family planning clients), you can develop a business plan to gauge the feasibility and risk of these new endeavors. You would use the business plan to secure funding for these new ventures.

Please see [“Business Planning to Transform Your Organization”](#) (MSH 2003) for a detailed discussion of this topic.

Use Box 7 to help you assess the strength of your plan and make sure that you have not overlooked any important points.

### BOX 7. Summary: The Elements of a Good Plan

Successful implementation starts with a good plan. There are elements that will make a plan more likely to be successfully implemented. Ask yourself the following questions to see if you have accounted for all these elements.

- Is the plan simple?
- Is it easy to understand and to act on?
- Does it communicate in a clear and practical way?
- Is the plan specific?
- Are its strategic objectives aligned with the mission and vision?
- Are the strategies in line with the strategic objectives?
- Will the strategies help the organization achieve its desired measurable results?
- Does the plan include specific activities, each with dates of completion, persons responsible, and budget requirements?
- Is the plan realistic?
- Are the measures and schedule for activity completion realistic?



## Proven practices

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- Although planning is one of the four key management practices, planning alone is not enough to achieve desired results. Supporting it with all the other leading and managing practices leads to strong organizational capacity, better services, and, ultimately, lasting improvements in people's health.
- Although strategic plans, operational plans, and business plans have different time spans and are developed and used at different levels, they are not mutually exclusive. In particular, operational or annual plans should be based on the content and strategic priorities outlined in the strategic plan.
- Strategic planning benefits from a well-balanced team composed of an interdisciplinary group of colleagues with distinct characteristics and functions.
- You and your planning team can use your organization's mission to create a future vision that guides the selection of the organization's strategic objectives. You can check the integrity of the strategic objectives by conducting a modified SWOT analysis and then formulate strategies that align with those objectives.
- To convert the strategic plan into an operational plan, you and your team can use the feasibility checklist and priority activity matrix to select the activities that will best fulfill the strategic objectives, define indicators of accomplishment, and assign costs to each activity. You may want to seek expert help in determining costs and preparing the budget.
- Frequent monitoring will help reduce scheduling delays, budget reductions or overruns, or changes in the scope of activities. If you incorporate output and outcome indicators in your operational plan, you can then develop a monitoring and evaluation plan to monitor progress toward your desired results and evaluate the actual results achieved.

## Glossary of planning terms

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**activities:** The specific tasks needed to implement the strategies and meet the strategic objectives outlined in your strategic plan. Activities should be expressed in clear, concrete terms, and in chronological order.

**business planning:** Short- to mid-term planning. A business plan is used to secure funding and make projections of the estimated financial and social return for starting up organization, establishing a new business unit, or—in the case of an ongoing entity—developing and introducing a new product or service. A good business plan enables an organization to assess the viability of all its products and services and the feasibility of new products and services.

**critical factor:** An essential element of the performance of a particular internal system, such as the restocking time of the supply chain system or the timeliness of reports from a financial system.

**indicator:** A measurable marker of change over time in a condition, capability, quantity, or quality. The indicators you incorporate into your plan will allow you to evaluate the actual results achieved by the execution of the activities programmed in your plan.

**measurable results:** The outcomes that will be produced when the strategies are implemented.

**mission:** The statement that describes in a clear and concise manner why the organization exists—its purpose. The mission provides orientation, uniformity, and meaning to the organization's decisions and activities at all levels. It is the core around which staff members focus their best efforts.

**operational objectives:** Short-term goals that represent the link between the strategic plan and a corresponding operational plan. The working teams or operational teams establish and carry out the objectives.

**operational planning:** Has a short-term scope, usually one year. Its focus is achieving objectives and executing activities in the near future. Operational planning is often referred to as the annual operational plan or the annual work plan, and it must be aligned with the strategic plan.

**outcome:** A short-term change in a beneficiary population as a result of an activity or set of activities.

**output:** The immediate or direct product of an activity.

**strategic objectives:** What the organization intends to achieve in the medium to long term. Strategic objectives are established by the organization's management, in consultation with various management units throughout the organization, and approved by the board of directors, in the case of civil society organizations.

**strategic planning:** Medium- to long-term planning that involves all of the organization's management areas. Its content is relatively general and includes goals, strategic objectives, strategies, and measurable results. It focuses on broad and long-lasting issues that will foster the organization's long-term effectiveness and survival.

**strategy:** A statement of what is to be done, that, when accomplished, will signify achievement of the organization's strategic objectives.

**SWOT analysis:** A tool that helps an organization identify opportunities and threats (OT) in the external environment that are most relevant to its work, and the strengths and weaknesses (SW) within the organization: the systems, structures, and cultural factors that can enhance or obstruct organizational effectiveness.

**vision:** The image of an organization's desired future state that a team, organization, project, or program can move toward by taking action.

## References and resources

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- Albrecht, Karl. *The Northbound Train: Finding the Purpose, Setting the Direction, Shaping the Destiny of Your Organization*. New York: AMACOM, 1994.
- Bennis, Warren G., and Burt Nanus. 1986. *Leaders: Strategies for Taking Charge*. New York: HarperBusiness, 1997.
- Blank, Warren. *The 108 Skills of Natural Born Leaders*. New York: AMACOM, 2001.
- Conger, Jay A. "The Vision Thing: Explorations into Visionary Leadership." In *Cutting Edge: Leadership 2000*. Barbara Kellerman and Lorraine R. Matusak, eds. 38–45. College Park, MD: James MacGregor Burns Academy of Leadership, 1998.
- Covey, Stephen R. 2004. *The Seven Habits of Highly Effective People: Restoring the Character Ethic*. 151, 152–54. New York: Free Press, 2004.
- Helfenbein, Saul, Sara Seims, and Deborah Ruhe. "Learning to Think Strategically." *The Family Planning Manager (Boston)* vol. 3, no. 1, 1994, <http://www.msh.org/resources/learning-to-think-strategically> (accessed Mar. 3, 2014).
- Management Sciences for Health. *Managers Who Lead: A Handbook for Improving Health Services*. Cambridge, MA: Management Sciences for Health, 2005. <http://www.msh.org/resources/managers-who-lead-a-handbook-for-improving-health-services> (accessed Mar. 1, 2010).
- . *Virtual Strategic Planning Program*. Cambridge, MA: Management Sciences for Health, 2009. Program information is available at <http://www1.msh.org/projects/lms/ProgramsAndTools/SustainabilityAndScalingUp/VSPP.cfm>.
- Roberts, Edward. "Managing Technical Professionals: Individuals and Teams." Lecture, as part of Technology Management for General Managers (course). MIT Sloan School of Management. Cambridge, MA, 2000.
- Seltzer, Judith B. *Handbook for Developing a District Level Work Plan*. Cambridge, MA: Management Sciences for Health, 1991.
- Seltzer, Judith B., Elizabeth Lewis, Fiona Nauseda, and Stephen Redding. "Business Planning to Transform Your Organization." *The Manager (Boston)* vol. 12, no. 3, 2003, <http://www.msh.org/sites/msh.org/files/Business-Planning-to-Transform-Your-Organization.pdf>.
- Seltzer, Judith B., and Steve Solter. "Conducting Local Rapid Assessments in Districts and Communities." *The Family Planning Manager (Boston)* vol. 7, no. 1, 1998, [http://erc.msh.org/themanager/English/V7\\_N1\\_En\\_Issue.pdf](http://erc.msh.org/themanager/English/V7_N1_En_Issue.pdf) (accessed Jan. 14, 2010).
- Thisayakorn, Lers. "Reasons Why Strategic Planning Fails." GroundReport, <http://www.groundreport.com/Business/Reasons-why-strategic-planning-fails> (accessed Jan. 14, 2010).
- Vriesendorp, Sylvia. *Strategic Planning: Reflections on Process and Practice*. Cambridge, MA: Management Sciences for Health, 1999.
- Wolff, James A., Linda Suttentfield, and Susana C. Binzen, eds. *The Family Planning Manager's Handbook: Basic Skills and Tools for Managing Family Planning Programs*. Hart-

ford, CT: Kumarian Press, 1991.

Wong, Shu Wei. “The Reasons Why Strategic Planning Fails.” Articlesbase, 2007, <http://www.articlesbase.com/strategic-planning-articles/the-reasons-why-strategic-planning-fails-228944.html> (accessed Jan. 14, 2010).

World Health Organization. *Indicators to Monitor Maternal Health Goals*. Geneva: World Health Organization. 1994, [http://whqlibdoc.who.int/HQ/1994/WHO\\_FHE\\_MSM\\_94.14.pdf](http://whqlibdoc.who.int/HQ/1994/WHO_FHE_MSM_94.14.pdf) (accessed Jan 14, 2010).

## Appendices

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**Appendix A.** SWOT Matrixes

**Appendix B.** Strategic Planning Template

**Appendix C.** Operational Planning Template

**Appendix D.** Activity Selection Decision Tree Template

## APPENDIX A. SWOT Matrixes

SWOT Matrix Template

	External Environment		Internal Environment
Opportunities		Strengths	
Threats		Weaknesses	

SWOT Matrix with Impact Ratings

	External Environment	Impact		Internal Environment	Impact
Opportunities			Strengths		
Threats			Weaknesses		

## APPENDIX B. Strategic Planning Template

Mission	Vision	Strategic Objectives	Desired Measurable Results	Strategies							

## APPENDIX C.

[illegible]



## APPENDIX D. Activity Selection Decision Tree Template

Activity:

Conditions and Criteria	Rating (scale of 1–3)	Weight (scale of 1–3)	Total Score (rating × weight)	Evidence
<b>External Conditions</b>				
Activity is socially acceptable				
Activity falls within acceptable policy framework				
<b>Internal Conditions</b>				
Activity supports strategic objectives				
Time frame is reasonable				
Investment is reasonable				
Recurring costs are acceptable				
Activity is administratively feasible				
Staff are available and qualified				
<b>Feasibility Rating</b> Range: 8–72 (sum of Total Score column) < 24 = not very feasible 25–50 = feasible 51–72 = highly feasible				
<b>Comments:</b> Evidence: In the column entitled “Evidence,” please describe the circumstances that support the rating you assigned to each specific Condition or Criterion.				

### Instructions:

**Rating:** For the proposed activity described at the top of the form, there is a series of **Conditions and Criteria** in the first column that should be met. Assess the extent to which the condition is currently met, and assign a value according to the following scale:  
 1 = does not fit criterion  
 2 = partially fits criterion  
 3 = fully fits criterion

**Weight:** For each of the Conditions and Criteria assign a “weight” that indicates the relative importance of the specific condition or criterion to the execution of the activity, as follows:  
 1 = not relevant to success  
 2 = important for success  
 3 = essential for success

**Evidence:** In the column entitled “Evidence,” please describe the circumstances that support the rating you assigned to each specific Condition or Criterion.

## CHAPTER 6

# Managing Human Resources

Mary O'Neil  
Steve Reimann

1. Achieving Results by Strengthening Health Systems
2. Leading and Managing: Critical Competencies for Health Systems Strengthening
3. Governance of Health Systems and Health Organizations
4. Mainstreaming Gender Equality into Health Systems
5. Planning the Work and Working with the Plan
6. Managing Human Resources
7. Managing Finances and Related Systems
8. Managing Medicines and Health Products
9. Managing Information: Monitoring and Evaluation
10. Managing Health Service Delivery

This chapter shows that effective human resource management (HRM) is important in any public- or private-sector organization and essential when public health crises collide with workforce shortages. We present here the three pillars that together form the HRM capacity of an organization—policies, systems, and management and leadership practices—and describe how they can help you to attain your organization's HRM goals.

We then review how you, as a manager of a health program or health services, can be more effective in five areas of critical importance to your staff by:

- setting job responsibilities and work priorities
- encouraging good performance with feedback
- making work meaningful
- improving fairness in the workplace
- offering staff opportunities to grow

To enable your organization to evaluate its HRM capacity, we introduce the Employee Satisfaction Survey and the HRM Rapid Assessment Tool for Health Organizations and show how they can be applied. Finally, we describe how you can link good management practices and HRM systems to propel positive changes in your organization.

## Introduction

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Human resource management is a critical management area that is responsible for any organization's most important asset: its people. HRM typically accounts for 70 percent to 80 percent of an organization's budget. When organizations manage their investment in people wisely, the result is a satisfied and motivated workforce that delivers high-quality health services and an organization that fulfills its mission, meets its health objectives, and contributes to its community by providing excellent services.

### FACING HUMAN RESOURCE CHALLENGES

Despite the critical importance of human resources to the functioning of health systems, few concerted efforts have addressed the severe staff shortages facing the health sector in many developing countries. The AIDS pandemic intensified an already serious situation, and the ability of many countries to meet the Millennium Development Goals is further hampered by deficiencies in organizations' HRM policies and systems.

In many countries, the key challenges include finding ways to:

- increase employee satisfaction and productivity despite understaffing, poor salaries, and lack of resources;
- obtain accurate data and conduct effective workforce planning using under-developed employee information systems;
- obtain workers with needed skills and competencies in the face of reduced staffing levels caused by AIDS, the migration of health professionals, and poor working conditions in remote areas;
- shift tasks to cadres of workers who have, or can easily develop, the needed skills;
- provide efficient and effective HRM and supportive supervision when managers lack HRM skills and there is weak organizational advocacy for HRM.

These challenges can be addressed by an effective HRM infrastructure. However, the reality is that HRM is perhaps the most misunderstood and poorly developed area in the health sector today. As a result, although most organizations claim that their employees are their most important resource, there is widespread neglect of the policies, systems, and management and leadership practices needed to support the critical HRM function.

There is a need to professionalize HRM throughout the health sector by hiring dedicated human resource (HR) staff and developing their ability to manage complex HR issues. HRM systems need to be strengthened in most organizations. In ministries of health and national nongovernmental organizations (NGOs), this should take the form of creating dedicated HRM departments charged with developing, operating, and promoting the policies, systems, and management and leadership practices that address identified HRM challenges.

However, it is the responsibility of all managers and supervisors at every level in an organization to understand and continually practice the principles of effective HRM. Indeed, in smaller organizations, which often lack a dedicated HRM department, it is the collective effort of all managers that will build a human resources for health (HRH) strategy and the HRM infrastructure needed to carry out the strategy.

## The human resources for health action framework

While HRM is at the center of improving retention and performance, a high-quality, sustainable workforce also depends on:

- good employment policies;
- adequate financial resources;
- pre-service education and training institutions to prepare adequate numbers of health workers;
- partnership with local communities, the private sector, donors, and other key stakeholders;
- leadership and advocacy for strengthening HRM practices at all levels.

Figure 1 shows the Human Resources for Health Action Framework, which charts a pathway for developing a comprehensive national HRH strategy to help managers sustain a supply of adequately trained health staff. A consortium from the US Agency for International Development (USAID), World Health Organization (WHO), Global Health Workforce Alliance, partner countries, NGOs, donors, and the academic community developed the HRH Action Framework in 2005.

This framework identifies the six components of planning and managing the workforce and describes the goals of each. When these components are functioning properly, your organization will have appropriately trained staff available in the right place at the right time. The framework also suggests actions policymakers and managers can take to address issues in each of the six areas. HRM systems are at the center because of their importance in integrating all the other components.

[Table 1](#) explains the six HRH components when they are at their most effective.

FIGURE 1. Human Resources for Health Action Framework

Tools for an effective and sustainable health workforce

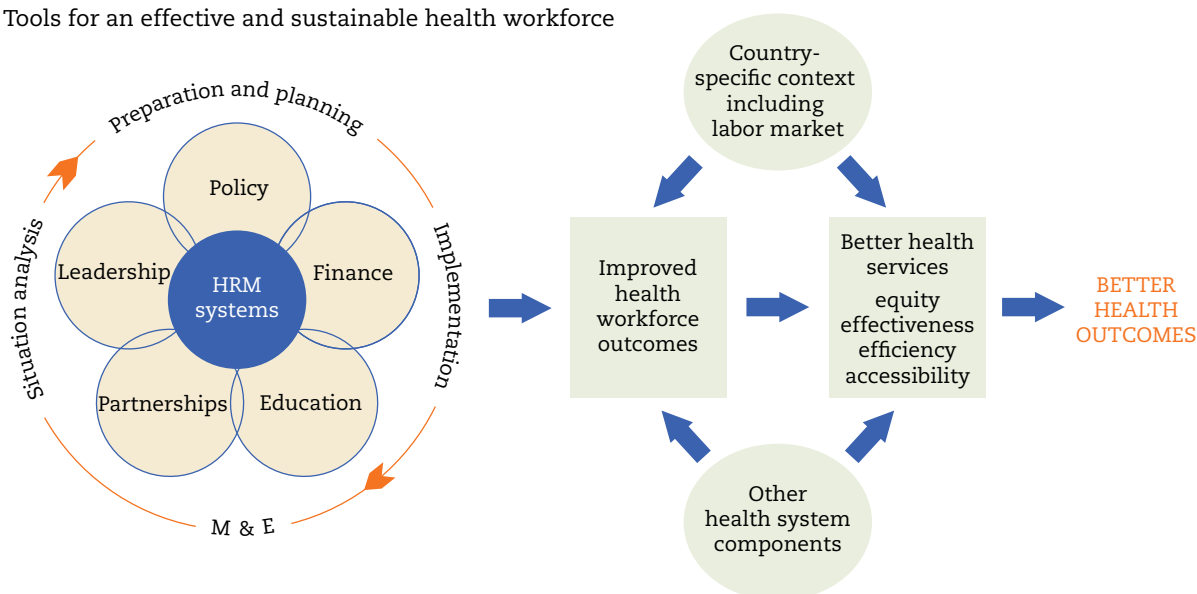


TABLE I. Components of the HRH Action Framework

Component	Goal
HRM systems	HRM systems are in place that result in adequate and timely staffing, staff retention, teamwork, effective planning, and good performance.
Policy	Appropriate human resource policies have been established and are enforced. Government employment processes are streamlined.
Finance	The approved budget is adequate to sustain projected health workforce requirements. Allocation authority is aligned with technical and management planning and decision-making.
Education	Pre-service training institutions have the capacity to meet the demand for essential workers, and they adapt curricula as needed for new content requirements.
Partnerships	Planned linkages among sectors, districts, and NGOs increase human capacity.
Leadership	Managers at all levels demonstrate that they value health workers and provide leadership to help staff face challenges and achieve results.

[Click here](#) for further information about how to use the HRH Action Framework to develop a strategic approach to HRH and what actions to take related to each of the six components of the framework.

## The pillars of effective HRM

### HRM AND ITS PILLARS

HRM is the integrated use of policies, systems, and management and leadership practices to plan for necessary staff and to recruit, motivate, develop, and maintain employees so that an institution or organization can meet its goals. When HRM functions effectively, staff members' skills, job satisfaction, and motivation will improve and, over time, lead to a high level of performance.

This definition of HRM stresses the integration of three pillars, none of which is fully effective on its own and which all apply to each of the components of the HRM Action Framework:

- policies
- systems
- management and leadership practices

A professional HRM system needs to be based on sound HRM policies. Both the HRM system and policies require managers at all levels who not only manage well but also practice leadership by respecting others, communicating well, and advocating for the needs of staff. To be effective, the organizational authority for HRM should be allocated to a designated HRM manager who is a member of the senior management team and participates fully in strategic decision-making for the organization.

TABLE 2. Benefits of a Strong HRM System

Benefits to the Organization	Benefits to the Employee
<ul style="list-style-type: none"> <li>■ Increases the organization's ability to retain staff and achieve its goals</li> <li>■ Increases the level of employee performance</li> <li>■ Uses employees' skills and knowledge efficiently</li> <li>■ Saves costs through the improved efficiency and productivity of workers</li> <li>■ Improves the organization's ability to manage change</li> </ul>	<ul style="list-style-type: none"> <li>■ Provides clarity regarding job responsibilities</li> <li>■ Helps employees understand how their work relates to the mission and values of the organization</li> <li>■ Improves equity between employee compensation and level of responsibility</li> <li>■ Helps motivate employees</li> <li>■ Increases employees' job satisfaction</li> <li>■ Encourages employees to operate as a team</li> </ul>

Table 2 summarizes the benefits, to both organizations and employees, of having a strong HRM system.

[Table 3](#) shows the activities comprising fully functioning HRM systems.

### THE ROLE OF MANAGERS WHO LEAD

Because many organizations have limited HRM capacity, individual managers often lack policies and organizational systems to guide and support their work. The absence of strong HRM policies and systems makes good management and leadership practices essential for providing structure, supportive supervision, fairness, and advocacy for staff. By focusing on these activities, you can improve employee satisfaction, performance, and retention in your unit, department, or work group, even if HRM policies and systems are underdeveloped.

## HRM as a leadership issue

In both public and private organizations where HRM has been sorely neglected, making improvements begins with leadership. We define leadership in HRM as “planning and using human resources efficiently to produce intended results.” To play this leadership role, managers need to take charge, guide the development of strategic partnerships with other key stakeholders, influence policymakers, and forge new directions for HRM in the organization.

### USING THE LEADERSHIP AND MANAGEMENT PRACTICES

As a manager committed to improving HRM, you can make good use of the leadership and management practices detailed in Chapter 2 of this handbook as tools to help you achieve your organization's HRM goals and priorities.

TABLE 3. Elements of HRM Systems

Function	Component
HRM capacity	<ul style="list-style-type: none"> <li>■ HRM budget</li> <li>■ HRM staff</li> <li>■ HR planning</li> </ul>
Personnel policy and practice	<ul style="list-style-type: none"> <li>■ Job classification system</li> <li>■ Compensation and benefits system</li> <li>■ Recruitment, hiring, transfer, and promotion</li> <li>■ Orientation program</li> <li>■ Policy manual</li> <li>■ Discipline, termination, and grievance procedures</li> <li>■ HIV/AIDS workplace prevention program</li> <li>■ Relationships with unions</li> <li>■ Labor law compliance</li> </ul>
HRM data	<ul style="list-style-type: none"> <li>■ Employee data</li> <li>■ Computerization of data</li> <li>■ Personnel files</li> </ul>
Performance management	<ul style="list-style-type: none"> <li>■ Staff retention</li> <li>■ Job descriptions</li> <li>■ Staff supervision</li> <li>■ Work planning and performance review</li> </ul>
Training	<ul style="list-style-type: none"> <li>■ Staff training</li> <li>■ Management and leadership development</li> <li>■ Links to external pre-service training</li> </ul>

You can apply the **leadership** practices to HRM in many ways. For example, you can:

- **scan** for up-to-date knowledge about the HRM situation in your organization and current practices, experiences, and trends in the environment, using such instruments as:
  - the [Employee Satisfaction Survey](#) (described in this chapter);
  - the [HRM Rapid Assessment Tool](#) (described in this chapter);
  - the [Work Climate Assessment Tool](#);
- **focus** on HRM issues and actions that will serve your organizational mission, strategies, and priorities;
- **align and mobilize** stakeholders' and staff's time and energies as well as material and financial resources;
- **inspire** staff to commit to continuous learning so they can adapt to a changing environment and perform effectively to achieve HRM goals.

And you can use the **management** practices to:

- **plan** how to assign resources, accountabilities, and time lines to achieve HRM results;
- **organize** people, structures, systems, and processes to carry out the HRM plan;

- **implement** activities efficiently, effectively, and responsively to achieve defined HRM results;
- **monitor and evaluate** HRM achievements and results against plans, continually update HRM information, and use feedback to adjust plans, structures, systems, and processes for future results.

### LEADERSHIP AT ALL LEVELS IS ESSENTIAL

The capacity to determine and implement national priorities in a given political context is central to sustained progress. This critical leadership function cannot be imported from abroad; it must be developed and nurtured in every country.

Leadership is not the exclusive domain of a small and select group of exceptional men and women. You and your team members can learn together to be leaders by confronting challenges that force you to stretch your limits. To do this, you will need support and feedback from peers, supervisors, mentors, family members, and those whom you respect and admire. Leadership skills are not developed in isolation, and people cannot lead in isolation.

Organizations need strong leaders, both those with direct responsibility for HRM and senior leaders of the organization, to support and integrate all areas of HRM. Leaders can imbue the system with a positive, people-centered philosophy and a set of values that views employees as human beings entitled to equity, respect, appreciation, and support first, and as organizational assets, second.

You will find a comprehensive overview of the HRM problems that contribute to the health worker crisis, strategic actions that should be taken to address these challenges, and innovative ideas for strengthening HRM on a Capacity Project [technical brief](#).

### HRM practices that improve employee satisfaction

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Many factors influence an employee's satisfaction with her or his job. People need fair compensation, but research has shown that money alone does not necessarily improve performance or job satisfaction. A fair salary combined with other critical ingredients—work that contributes to the goals of the organization, the respect of fellow employees, a relationship with a supervisor that is based on mutual respect, and opportunities for skill development—can sustain employees' satisfaction. This satisfaction, in turn, is a critical factor in retaining health workers and improving their performance.

Most employees ask five questions about their work environment:

1. Am I being treated fairly?
2. What am I supposed to do?
3. How well am I doing it?
4. Does my work matter to the organization?
5. How can I develop myself within the organization?



An effective HRM system and managers who practice good HRM can help create an environment that engenders positive answers to questions 1 through 5 and thereby contributes to employee satisfaction, good performance, and retention. In this section of this chapter, we discuss each question and propose concrete actions that you can take to improve the work environment in your unit or organization.

### 1. AM I BEING TREATED FAIRLY?— ESTABLISHING EQUITY IN THE WORKPLACE

Several factors contribute to employees' perception of fairness, which is primarily how they feel they are treated with regard to:

- salary and total compensation (especially important);
- the hiring process;
- the day-to-day application of personnel policies;
- issues such as gender, age, disability, etc.;
- distribution of work among employees;
- support for, and recognition of, employees' contributions.

**Establish equitable salaries and recruitment procedures.** When developing an integrated HRM system, it is important to review your organization's job classifications and related salary scales to be certain that salaries are appropriate to the level of responsibility and are competitive in relation to local economic conditions. There might be little you can do to increase overall salary levels, but you should make every effort to take action so that all staff will receive fair and equitable pay within resource limitations and existing policy guidelines. You will also want to be transparent in the hiring process by adhering to clear and fair recruitment procedures.

The presence of large donors, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the US President's Emergency Fund for AIDS Relief (PEPFAR), among others, might make it difficult to control the salaries of staff because these programs often reimburse staff at much higher rates than those of their counterparts. This imbalance has the potential to drain staff from your organization or to cause serious morale problems if your staff members are working side by side or in teams with people on a higher pay scale. If you are faced with this situation, it is important to advocate strongly for an equitable arrangement, even if it is temporary and lasts only for the life of the program.

**Support fair application of policies.** HRM managers are also responsible for seeing that all managers and staff apply personnel policies fairly on a day-to-day basis and distribute tasks and responsibilities equitably among employees. With issues of equity, always communicate appropriate information to all employees, work on their behalf, and act in a transparent manner.

**Learn more about fairness.** For more information about systems that promote fairness in the workplace, go to the section titled "Developing and Managing Human Resources for Health" in the Manager's Electronic Resource Center and click on the following sub-headings under [HRM Resource Kit](#):

- Developing a Job Classification System, which includes a job analysis methodology and examples of a job classification structure;
- Developing a Salary Policy;
- Guidelines on Recruitment and Hiring;
- Guidelines on Staff Orientation.

## 2. WHAT AM I SUPPOSED TO DO?—

### SETTING JOB RESPONSIBILITIES AND WORK PRIORITIES

People want a specific answer to this question. In many cases, job descriptions are vague or nonexistent, supervisors have not specified their expectations, or managers hire people for a particular job but ask them to perform other duties. If employees do not understand their work priorities or if their supervisors often change their priorities, it is difficult for staff to maintain a consistent level of productivity and sense of self-worth.

**Make sure job descriptions are complete and up-to-date.** One step you can take to strengthen HRM is to make sure that your team has up-to-date job descriptions with information about general and specific duties and responsibilities, as well as their supervisory relationships. Job descriptions also give you a starting point for developing work plans with employees.

You will find more information about the purpose, components, and development of job descriptions, including samples, in [“Developing Job Descriptions”](#), which you can also reach from the page [“Performance Management Tool”](#) in the Electronic Resource Center.

**Clarify current responsibilities.** As essential as job descriptions are, they are typically general. Most employees do not perform all the duties listed in their job descriptions all the time. In addition, job descriptions often do not identify which specific responsibilities or performance objectives are a priority in a given period.

Supervisors and their direct reports should meet and agree on what are currently the most important duties. This can also be the basis for an annual performance review, and it gives both parties a chance to identify any training that might be needed if the staff member is to achieve the planned objectives.

**Use task shifting wisely.** Task shifting is widely viewed as a way to move tasks from one cadre to an existing lower-level cadre or a new cadre developed to meet specific health care goals. It is especially common in the delivery of antiretroviral therapy to HIV-positive clients.

Although this approach can greatly expand service delivery, it can also result in staff feeling overburdened if they are asked to assume new tasks without taking into account their other duties. To avoid this stress while gaining the benefits of task shifting, you can work with staff to clarify roles and balance competing demands for their time.

### 3. HOW WELL AM I DOING MY JOB?— ENCOURAGING GOOD PERFORMANCE WITH FEEDBACK

Employees need regular feedback about their job performance. Anxiety about not performing as well as expected can have a direct impact on motivation and productivity, and often results in denial and avoidance of responsibilities.

**Provide ongoing feedback.** Employees should receive feedback at an annual performance review, but recognition of good performance should occur regularly, not just once a year. As a manager, you should encourage supervisors and all staff to recognize coworkers for their efforts and thank them for a job well done. It is amazing how recognition and appreciation can increase motivation and performance among staff.

People also need to know if they are not performing up to expectations. Although supervisors may be hesitant to hold these conversations, they do not have to be confrontational or critical. Instead, they can be an opportunity for coaching, providing support, resolving misunderstandings, clarifying mutual expectations, and setting goals.

**Check in at least weekly with staff who are dealing with major problems.** See how they are progressing. You will not want to wait for an annual performance review to try to resolve serious ongoing issues. Grave misconduct that puts the organization at risk, such as theft, fraud, or sexual harassment, needs to be documented and dealt with promptly, according to the policies of your organization. Chapter 7 of this handbook, in the section titled “Conflicts of Interest and Unethical Conduct,” offers further discussion of this topic.

**Organize annual performance reviews.** Your HRM department or manager plays a key role in the formal annual employee review system. The HRM manager is responsible for making sure that all supervisors understand and follow the policy and procedures related to the annual review. In smaller organizations without formal HRM departments, a senior manager can take on this responsibility.

As part of the annual review, the supervisor and employee can hold a work-planning meeting and agree on job priorities and measurable performance objectives. These agreed-upon objectives become the basis for the next performance review (usually in 12 months). If you also use the performance review system as the basis for creating personal development plans for your employees, it will also help you align staff development efforts more closely with your organization’s goals.

The absence of an HRM department and/or a formal annual employee review system should not prevent you from holding regular work-planning and performance review meetings with your staff. Develop your own practices and systems; other managers can use them, too, and over time they can become part of an organization-wide HRM system.

**Tie performance reviews to incentives.** Performance reviews should be tied to an organization’s monetary incentive system. Everyone should receive a cost of living increase, but a small additional percentage increase should be available only for people who meet or exceed their performance standards. This is an essential function of HRM; it assures staff

that their work is taken seriously, that they will be held accountable, and that their contributions to the goals of the organization are valued.

**Learn more about feedback.** For links to useful resources, country examples, and extensive information about developing systems and practices that promote feedback, manage conflict, and improve staff motivation, go to [“Supervising and Supporting Your Staff”](#) in the Electronic Resource Center.

#### 4. DOES MY WORK MATTER TO THE ORGANIZATION?— MAKING WORK MEANINGFUL

When employees can answer this question with an emphatic yes, they are more productive. For many people, having skills and competencies and performing well are not motivating. They need more—they need to know that their work is important to the people they serve, essential to fulfilling the organization’s mission and vision, and related to its success.

**Spread the word about employees’ contributions.** Communicating to employees that their work matters is an important element of HRM. Acknowledging the noteworthy performance of a team or specific individuals can be particularly motivating. Informally, this can be accomplished in staff meetings where the director or unit head acknowledges everyone’s accomplishments and contributions. It can also take place at more public meetings, in organizational newsletters, or in the media.

**Offer staff development opportunities.** If you can provide opportunities for training and development, representing the organization or work unit at special events, or contributing to special projects or initiatives, these can be especially powerful motivational tools. In addition, involving staff in work planning and evaluation activities will instill a feeling of ownership in their work and pride in being part of the organization and its successes.

**Help shape the organization’s strategic objectives.** HRM plays a crucial role in strategic planning. Understanding the priorities of your organization and the various skills of employees will make it clear how each person can contribute to achieving the organization’s goals. This understanding will enable staff members to complete work plans that link their work to these goals. Chapter 5 of this handbook offers detailed information about strategic planning.

**Pay attention to the work climate.** Work climate is the prevailing atmosphere as employees experience it: what it feels like to work in a group. Your actions contribute directly to creating a positive work climate. Leadership and management practices that provide clarity, support, and challenge contribute to a positive work climate. A positive work climate increases the level of effort that employees exert above and beyond job expectations and leads to and sustains employee motivation and high performance.

**Learn more about work climate.** For more information about creating a meaningful work climate and assessing work climate in your organization, go to the issue of [The Manager](#) titled “Creating a Work Climate that Motivates Staff and Improves Performance.”

## 5. HOW CAN I DEVELOP MYSELF WITHIN THE ORGANIZATION?— OFFERING STAFF OPPORTUNITIES TO GROW

People feel motivated and challenged when they have opportunities to learn, develop new skills, and assume new responsibilities that will advance their careers. These development opportunities can also be an important way to recognize employees. Participating in training and other activities where people share learning and value each other's experiences builds collaboration and teamwork and can increase overall performance and productivity.

**Incorporate training into the HRM system.** Often training is handled separately from the HRM function, but it would be better if staff development were part of the HRM system. Managers would be able to make decisions about training according to a plan and not in a haphazard manner whenever opportunities arise. Mismanaged training can lead to staff being away from their duty stations for too long, being enrolled in the wrong training course, or being excluded from training opportunities that would be appropriate to their professional development.

An HRM department can introduce new training approaches that minimize the time staff members are away from the office, such as:

- on-the-job learning through mentoring relationships;
- assignments in different work settings;
- membership on taskforces and committees;
- technical presentations at staff meetings;
- discussions of assigned reading (such as a case study or journal article) at staff meetings;
- participation in virtual learning programs online.

Instead of an ad hoc system with little transparency, the HRM department should organize a system based on the real needs of the organization and its personnel. It should also establish clear eligibility and selection criteria. A well-managed training and staff development program that is based on organizational needs and clear eligibility requirements can broaden the skills and competencies of your staff and produce many benefits. Posting and advertising job and training opportunities within the organization and supporting internal candidates will send a message that the organization values the staff's experience.

Even if a training plan is in place, you should always be looking for development opportunities that are right for each individual on your staff, depending on her or his duties and potential for professional growth. You do not have to have an HRM department to do so. You can orchestrate this process yourself—taking special care to treat each of your staff equitably.

**Learn more about staff development.** For more information about determining staff development needs; conducting training-needs assessments; designing, planning, and evaluating training programs; and related topics, follow links on the page [“Training for Effective Performance”](#) in the Electronic Resource Center.

## Incentive programs build employee satisfaction and motivation

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Research on the factors that contribute to employee satisfaction and motivation has provided powerful evidence that organizations should provide a mix of financial and nonfinancial incentives. Studies show that well-designed and administered financial incentives are likely to prevent employee dissatisfaction but do not necessarily lead to employee motivation. It is the combination of financial and nonfinancial incentives that both prevents job dissatisfaction and motivates employees.

### DEVELOPING INCENTIVE PROGRAMS

A good incentive system provides:

- basic financial incentives, such as reasonable wages, salaries, and conditions of employment;
- additional financial incentives, if appropriate (e.g., for achieving certain targets or being posted to a remote location);
- nonfinancial incentives (e.g., providing a positive work environment, providing flexible employment arrangements, supporting professional development, providing intrinsic job rewards).

### TYPES OF INCENTIVES

[Box 1](#) gives examples of the types of incentives that fall under each of the two categories.

In addition, the incentive system should:

- have clear objectives and well-designed strategies that fit the purpose;
- be realistic and contextually appropriate;
- reflect health professionals' needs and preferences;
- be fair, equitable, and transparent;
- be monitored on a regular basis to see how well it is working.

If you want to learn more about incentive programs, [“Guidelines: Incentives for Health Professionals,”](#) produced by the Global Health Workforce Alliance, provides detailed information about incentives for health professionals.

## Managing volunteer staff

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In many health systems, paid staff members are not the only people who provide services. Community health workers, community volunteers, and other unpaid staff are also involved in health care delivery. Some do receive a small salary or allowance, but many are unpaid.

Volunteers and unpaid staff are a critical part of basic health education and care in many countries. Just like paid staff, they must be supported by good HRM policies, systems, and practices.

BOX 1. Types of Incentives	
Financial Incentives	Nonfinancial Incentives
<p><b>Terms and Conditions of Employment</b></p> <ul style="list-style-type: none"> <li>■ Salary/wages</li> <li>■ Pension</li> <li>■ Insurance (e.g., health)</li> <li>■ Allowances (e.g., housing, clothing, transport, parking, child care)</li> <li>■ Paid leave (e.g., holidays, vacation, sick leave)</li> </ul> <p><b>Performance Payments</b></p> <ul style="list-style-type: none"> <li>■ Achievement of performance targets</li> <li>■ Length of service</li> <li>■ Location or type of work (e.g., remote locations)</li> </ul> <p><b>Other Financial Support</b></p> <ul style="list-style-type: none"> <li>■ Fellowships</li> <li>■ Loans</li> </ul>	<p><b>Positive Work Environment</b></p> <ul style="list-style-type: none"> <li>■ Work autonomy and clarity of roles and responsibilities</li> <li>■ Recognition of work and achievement</li> <li>■ Supportive management and peer structures</li> <li>■ Manageable workload and effective workload management</li> <li>■ Effective management of occupational health and safety risks, including a safe and clean workplace</li> <li>■ Effective employee representation and communication</li> <li>■ Enforced equal opportunity policy</li> <li>■ Maternity/paternity leave</li> <li>■ Flexible work hours</li> <li>■ Planned sabbaticals or career breaks</li> </ul> <p><b>Support for Development</b></p> <ul style="list-style-type: none"> <li>■ Effective supervision</li> <li>■ Coaching and mentoring structures</li> <li>■ Access to and support for training and education</li> <li>■ Sabbatical and study leave</li> </ul> <p><b>Access to Services</b></p> <ul style="list-style-type: none"> <li>■ Health</li> <li>■ Child care and schools</li> <li>■ Recreational facilities</li> <li>■ Housing</li> <li>■ Transportation</li> <li>■ Other services</li> </ul> <p><b>Intrinsic Rewards</b></p> <ul style="list-style-type: none"> <li>■ Job satisfaction</li> <li>■ Personal achievement</li> <li>■ Commitment to shared values</li> <li>■ Respect of colleagues and community</li> <li>■ Membership in a team and a sense of belonging</li> </ul>

Source: Used with permission. Global Health Work Alliance/WHO, 2008, p. 12.



The principles and practices of good HRM begin with human resource planning: considering the capacity that volunteers will contribute to the overall workforce. Just as you would develop job descriptions for paid staff, you need to develop clear scopes of work for volunteers so that everyone understands their roles. As discussed in Chapter 3, this is also true for volunteers, including board members, who do not provide services directly.

Volunteers should be screened, just as is done for paid staff, to be sure that they have the skills or potential to carry out their assignments and that the job will be mutually beneficial for both the volunteer and the organization. Having a system in place to screen and assign volunteer staff also sends a signal that their work is considered valuable to the organization and that it is worth your time to plan for it carefully.

By definition, volunteers are not paid a salary, but they do need to be given money for day-to-day expenses or any costs related to their work. In addition, nonfinancial incentives—a positive work environment, personal respect, and support for development—are especially relevant for unpaid staff. Other nonfinancial incentives include the tools needed to do their jobs, such as bicycles, checklists, educational materials, or commodities. They can be rewarded and recognized by receiving items such as T-shirts or bags imprinted with your organization's logo.

Supervision should be a part of your volunteer system. Every volunteer worker needs the support of an individual who can provide guidance, evaluate performance, address performance issues, reward achievements, and terminate the volunteer's service, if necessary.

## Using a survey to improve HRM policies and practices

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The Employee Satisfaction Survey in [Box 2](#) is a questionnaire that measures employee satisfaction as it relates to the five aspects of the work environment described earlier, namely:

1. job responsibilities and work priorities;
2. encouragement, with feedback, for good performance;
3. meaningful work;
4. fairness in the workplace;
5. opportunities for growth.

### DEFINING EMPLOYEE SATISFACTION

Employee satisfaction can be described as the staff member's sense of well-being within his or her work environment. It results from a combination of financial and nonfinancial rewards and is closely linked to employee performance and to the retention of valued staff. Positive changes in HRM systems and interactions among managers, supervisors, and staff on HRM issues can greatly increase employee satisfaction.

An Adobe Acrobat (PDF) file of the [survey](#) is available.



## BOX 2. Sample Employee Satisfaction Survey

Dear Staff Member,

The director and HRM department are interested in better understanding your level of satisfaction with different aspects of the organization. Your feedback and comments on this questionnaire will help us make improvements in our HRM policies and practices. We appreciate your taking a few minutes to respond to these 10 questions. Your responses will be kept confidential. Please return completed questionnaires to \_\_\_\_\_ by \_\_\_\_\_.

Thank you.

**Instructions:** For each of the statements below, please circle the number that best represents your opinion.

Question	Scale = 1–5 (Disagree Strongly = 1; Completely Agree = 5)
1. My salary is fair compared to that of other staff with the same level of responsibility.	1 2 3 4 5
2. My benefits are fair compared to those of other staff at my level.	1 2 3 4 5
3. My job description is accurate and up-to-date.	1 2 3 4 5
4. My supervisor and I have agreed on the priorities of my job.	1 2 3 4 5
5. I get clear feedback from my supervisor about how well I am performing in my job.	1 2 3 4 5
6. My annual performance appraisal is based on the priorities in my work plan.	1 2 3 4 5
7. My supervisor seeks my input when he or she is faced with a challenge or problem.	1 2 3 4 5
8. The organization acknowledges and values my work.	1 2 3 4 5
9. The organization provides me with the essential coaching and training to do my job.	1 2 3 4 5
10. The organization works (as much as possible) to provide me with opportunities for career growth.	1 2 3 4 5

## HOW TO USE THE SURVEY

You can use the survey to establish baseline data before initiating improvements to your HRM system. The same questionnaire can be used about one year later to measure the impact of actions taken. Employees will be able to complete the survey in 10 minutes or less.

If your organization is small you can administer the questionnaire to all staff members. However, if it is a large organization and it is impractical to include everyone, you should give the questionnaire to a randomly selected sample group of staff representing from 15 percent to 20 percent of the total workforce. It is important to include staff from all levels and departments and to guarantee that all responses are kept strictly confidential. You can also use the questionnaire with only members of your unit if you want to assess satisfaction there.

## HRM Strengthening and Service Improvement in Action— Country Examples from Mozambique, Kenya, and Egypt

Interventions in three countries show how improving aspects of HRM has led to better services and positive health outcomes.

### **Mozambique: Creating a Proactive Leadership Mindset in HRM**

In a poor, rural province in Mozambique, health units in the most remote areas were found to be delivering a low quality of health services. Problems included a lack of communication between the provincial and district levels, low employee morale, high staff turnover, and a large demand for services combined with a constant shortage of personnel. Senior officials determined that the main cause of these problems was a lack of human resource capacity in leadership and management in a health care system undergoing rapid decentralization. (Some of issues presented by decentralization are discussed in the section in Chapter 3 of this handbook titled “Governance structures at central, provincial, and district levels.”)

The Challenges Program was introduced in health units to engage staff in setting goals and solving problems. It integrated leadership strengthening into the day-to-day work of staff. It developed skills in communication, coaching and mentoring, negotiation, motivation, teamwork, and action planning. In the process, the program generated a culture of results and gave managers and health care providers a sense of control over their actions.

After the program, staff no longer waited to be trained; they proactively requested training in needed areas. Employee morale improved greatly through the creation of participatory teams in a traditionally hierarchical structure. These teams took on basic challenges such as improving cleanliness, improving biosecurity, decreasing clients’ waiting time, and increasing the number of attended births. Despite no operating budget for much of the program, 10 of the 11 health units achieved most of their goals and improved the quality of health services.

You can find more information about developing HRM leadership and management practices in an organization with no HRM infrastructure on the [Human Resources for Health website](#).

### **Kenya: Involving Stakeholders to Speed Hiring and Improve Retention**

Despite a pool of unemployed health staff in Kenya, only 50 percent of the positions at most facilities were filled. Lopsided distribution of staff left many HIV-positive people without access to antiretroviral therapy. Even when funding was available, it routinely took from one to two years to fill vacant positions. Kenya needed an emergency approach to fast-track the hiring and deployment process.

A stakeholder group was formed to bring together leaders from several sectors. Their task was to design and implement a hiring and deployment model that would mobilize 830 additional health workers. This model used the private sector to recruit new health workers from the ranks of the unemployed and to manage the payroll and employment contracts, with an agreement to transfer these staff to the government after three years.

As a result of the work of the stakeholder group, the recruitment process was shortened to less than three months. Once the new staff members were deployed, they received detailed orientation to their jobs and on-time paychecks. These two factors were found to increase employee retention and satisfaction.

For more information on how to establish partnerships and foster commitment and collaboration to create HRM changes, go to the [Human Resources for Health website](#).

(continued)

### **Egypt: Achieving Performance Improvement by Creating a Meaningful Work Climate**

A Leadership Development Program (LDP) in the Aswan Governorate in Upper Egypt aimed to change management practices among national, district, and health facility teams. The program promoted a culture of team problem solving and planning, supportive supervision, performance feedback, and personal responsibility and empowerment. Participants embraced the LDP, and more than 100 health facilities had taken part by the end of its third year.

Some of the positive public health results were:

- Just one year after the initial LDP workshops, three districts had increased the number of new family planning visits by 36, 68, and 20 percent, respectively.
- Maternal mortality in the Aswan Governorate dropped in one year from 50 per 100,000 live births to 35.5 per 100,000.
- Local health workers scaled up the LDP to include all Aswan facilities, and other governorates adopted the program using local resources.

[A documentary film](#) about this LDP shows how HRM leadership and management practices created a sustaining work climate that improved services and health indicators.

Explain the purpose of the questionnaire and assure staff that their responses are completely confidential. The results can give you insights into the areas of the work environment that are the greatest source of dissatisfaction, and you can begin to work on changing these negative aspects. You will also learn the areas that provide the greatest satisfaction, and you can be sure to maintain those.

## **Assessing the HRM capacity of your organization**

One of the most important ways to establish a strong HRM infrastructure is to gather the information that will help you plan and implement improvements. A comprehensive HRM assessment will help you address your organization's policy, planning, training, and management in an integrated way. To do this, you need to determine your organization's strengths and weaknesses, prioritize the weaknesses, and develop an HRM action plan to address your most urgent challenges.

### **USING THE HRM RAPID ASSESSMENT TOOL**

Organizations of any size or level of development can use the HRM Rapid Assessment Tool for Health Organizations (see [Appendix A](#) in this chapter) to assess the status of their HRM infrastructure, identify the areas they need to strengthen, and take action to improve those areas.

Your assessment should look at your organization's HRM infrastructure in five areas:

1. HRM capacity
2. personnel policies and practices
3. HRM data

4. performance management
5. training and staff development

Earlier in this chapter, you saw [Table 3](#), which shows the 22 HRM components that fall within these five areas. [Table 4](#) explains why each component is important to the HRM system and, thereby, to the overall management of the organization.

The assessment tool is organized according to these HRM areas and components. Each component is followed by a description of four possible stages of development that range from the least developed to the most fully developed. People completing the survey indicate where they think their organizations are currently functioning relative to each component.

The characteristics of the four stages provide useful information for developing a plan of action for your organization to improve those HRM areas that need strengthening.

### WORKING WITH A BROAD-BASED TEAM

The HRM assessment will benefit from varied perspectives within your organization. You can form a team with members from different departments and different levels to:

- conduct the assessment;
- discuss the findings;
- prioritize areas of need;
- develop an action plan;
- implement the plan;
- generate wider support for ongoing HRM efforts in your organization.

#### The HRM Rapid Assessment Tool in Action—An Example from Uganda

In 2001, the Family Life Education Programme (FLEP) of Busoga Diocese began to see an increase in staff turnover and a decrease in overall organizational performance. The workplace climate was poor, and fewer and fewer people were coming for services. An external assessment found that the staff were not providing health services of an acceptable quality.

FLEP's leaders turned to the HRM Rapid Assessment Tool found in [Appendix A](#) of this handbook to analyze the strengths and weaknesses of their HRM system and determine areas that needed to be improved. They used these findings to determine the priority actions needed to professionalize the HRM approach and make it more responsive to FLEP's needs. They revised and updated the personnel policy manual; brought personnel files up-to-date and made them open to staff; updated job descriptions; developed a new process for performance appraisal and supportive supervision; and improved communication among the 40 clinics, which were geographically dispersed.

Within 12 months, an employee satisfaction survey showed that employee satisfaction and commitment had increased significantly. This led to decreased staff turnover and better performance. FLEP's clients responded to these changes, and the use of health services increased.

You can find more details about this HRM success story on the [Human Resources for Health website](#).

TABLE 4. Importance of HRM Components

HRM Area and Component	Importance
<b>HRM Capacity</b>	
HR staff	<ul style="list-style-type: none"> <li>Staff dedicated to HRM are essential to policy development and implementation</li> </ul>
HRM budget	<ul style="list-style-type: none"> <li>Allows for consistent HR planning and for relating costs to results</li> </ul>
HR planning	<ul style="list-style-type: none"> <li>Allows HRM resources to be used efficiently in support of organizational goals</li> </ul>
<b>Personnel Policy and Practice</b>	
Job classification system	<ul style="list-style-type: none"> <li>Allows organization to standardize the jobs and types of skills it requires</li> </ul>
Compensation and benefits system	<ul style="list-style-type: none"> <li>Allows for equity in employee salary and benefits tied to local economy</li> </ul>
Recruitment, hiring, transfer, and promotion	<ul style="list-style-type: none"> <li>Assures fair and open process based on candidates' job qualifications</li> </ul>
Orientation program	<ul style="list-style-type: none"> <li>Helps new employees identify with the organization and its goals/values</li> </ul>
Policy manual	<ul style="list-style-type: none"> <li>Provides rules and regulations that govern how employees work and state what to expect</li> </ul>
Discipline, termination, and grievance procedures	<ul style="list-style-type: none"> <li>Provides fair and consistent guidelines for addressing performance problems</li> </ul>
HIV & AIDS workplace prevention programs	<ul style="list-style-type: none"> <li>Ensures that all staff have the systems and knowledge required to prevent the spread of HIV &amp; AIDS</li> </ul>
Relationships with unions	<ul style="list-style-type: none"> <li>Promotes understanding of common goals and decreases adversarial behaviors</li> </ul>
Labor law compliance	<ul style="list-style-type: none"> <li>Allows organization to function legally and avoid litigation</li> </ul>
<b>HRM Data</b>	
Employee data	<ul style="list-style-type: none"> <li>Allows for appropriate allocation and training of staff and tracking of personnel costs</li> </ul>
Computerization of data	<ul style="list-style-type: none"> <li>Provides accessible, accurate, and timely data, which is essential for good planning</li> </ul>
Personnel files	<ul style="list-style-type: none"> <li>Provides essential data on employee's work history in the organization</li> </ul>
<b>Performance Management</b>	
Staff retention	<ul style="list-style-type: none"> <li>Ensures that the organization views staff as strategic resources. High employee turnover can be very costly and lower internal morale</li> </ul>
Job descriptions	<ul style="list-style-type: none"> <li>Defines what people do and how they work together</li> </ul>
Staff supervision	<ul style="list-style-type: none"> <li>Provides a system to develop work plans and monitor performance</li> </ul>
Work planning and performance review	<ul style="list-style-type: none"> <li>Provides information to staff about job duties and level of performance</li> </ul>
<b>Training</b>	
Staff training	<ul style="list-style-type: none"> <li>A cost-effective way to develop staff and organizational capacity</li> </ul>
Management and leadership development	<ul style="list-style-type: none"> <li>Leadership and good management are keys to sustainability</li> </ul>
Links to external pre-service training	<ul style="list-style-type: none"> <li>Pre-service training based on skills needed in the workplace is cost effective</li> </ul>

Working in a cross-cutting team will also help increase the appreciation of the entire staff for HRM concerns and priorities.

You can access the [HRM Rapid Assessment Tool](#) and guidelines for using it on the Internet. An example from Uganda describes how the tool helped a Ugandan organization improve staff morale and performance and increase the use of its services.

## Revitalizing HRM with your actions and example

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The dimensions of the human resource crisis in health have been reported in stark terms in many articles and publications in recent years. You have probably heard statistics and stories about the emigration of many health professionals each year from Africa to other continents and how the staff left behind suffer from work overload and low morale.

Some people believe that the answer lies in training more health staff. Training is, indeed, important, but you cannot create a sustainable workforce by simply training more health staff and sending them into poorly managed environments, which they will leave at the first opportunity. No health organization, public or private, can fulfill its mission with a staff that is coming and going through a revolving door.

Good HRM policies, systems, and management and leadership practices can be powerful agents of change. They can transform a dismal work climate, foster job satisfaction, motivate people to perform at a higher level, and increase staff retention.

We have learned that there is resistance to investing in the HRM infrastructure when organizations see only the costs and not the benefits, which is why leadership in HRM is so important.

Managers who lead have a vision of the future; realize that their staff is at the core of that vision; and can advocate for the HRM infrastructure that is essential to retaining a satisfied, productive workforce. In addition, managers who “walk the talk” and continually use leadership and management practices that promote employee satisfaction, performance, and retention are role models. They can inspire others throughout the organization to change their behavior.

It is not uncommon for every level of the health system to lack a critical mass of managers—both in HRM and in general—who know how to lead and influence these human resource changes within and outside their organizations. If you and your team institute a solid HRM approach and good HRM practices, the resulting improvements in staff performance and services will move more and more people in your organization to support your efforts.

There is still much to be done. We encourage you to use the tools and approaches you have encountered in this chapter to strengthen the components of your organization’s HRM system. In so doing, you will be creating a positive climate for human resources and demonstrating that, even with limited resources, the work environment as well as staff morale and performance can change for the better.

Do not underestimate what you can accomplish when you work together with your colleagues and base your recommendations on concrete data gathered from within your organization. All over the world, effective leadership has mobilized influential people to support positive change in human resources. As a manager who leads, you can point the way in your organization.

## Proven practices

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- To achieve measurable results, developing a comprehensive human resource management strategy linked to your organization's mission is more effective than working on one HR issue at a time. Single-focus HR interventions do not lead to sustainable improvements in staff retention and performance.
- You can best sustain HR changes by grounding solutions in the day-to-day management systems of your organization.
- As a manager, you and your work teams can make good use of leadership and management practices to explore new solutions to overcome chronic HRM issues. These practices will help you to develop strategic partnerships, influence policymakers, and forge new directions for HRM in your organization.
- It is important to involve all relevant sectors—finance, education, civil service, local governments, and NGOs—in strengthening HRM. This includes communicating regularly with donors to get their support and input.
- You can use the [Employee Satisfaction Tool](#) to assess staff satisfaction in your organization and plan HR strategies to increase levels of satisfaction.
- The [HRM Rapid Assessment Tool](#) will help you identify the strengths and weaknesses of your HRM system and develop an action plan.
- An employee incentive program should mix financial and nonfinancial incentives to foster job satisfaction and motivate employees. Nonfinancial incentives include providing a positive work environment, flexible employment arrangements, professional development, and other intrinsic rewards.



## Glossary of human resource management terms

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**compensation and benefits:** The annual base salary paid to employees for a particular job, including the added benefits that are customarily allowed (e.g., health, vacation, housing, loans, sick leave). **discrimination:** In the workplace, the act of treating an employee unfairly or placing them at a disadvantage in comparison to others in a similar situation because of gender, physical condition, ethnicity, etc.

**employee policy manual:** A document made available to all employees that describes the organization's policies and procedures as well as other expectations of employees and clarifies acceptable and unacceptable behaviors.

**human resource management (HRM):** The integrated use of policies, systems, and management and leadership practices to plan for necessary staff and to recruit, motivate, develop, and maintain employees so an institution or organization can meet its goals.

**human resource plan:** The document that results from annual (or longer-term) planning, describing the goals and priorities for staffing, training, and other HRM activities and how they are related to the organization's mission. It includes a budget for achieving these goals.

**incentives:** Rewards, often monetary, that are used to reward staff for good performance and/or to attract staff to remote and rural areas.

**job classification system:** The scheme that the organization develops to classify jobs according to their function and level of responsibility. It includes job descriptions for each position.

**job description:** A document that states the job title and describes the responsibilities of the position, the direct supervisory relationship with other staff, and the skills and qualifications required for the position.

**performance management:** The policies, systems, and procedures used by an organization to define and monitor the work that people do and to make sure that the tasks and priorities of employees support the mission and goals of the organization.

**performance review:** An examination of the employee's performance by the supervisor and employee based on jointly established work plans and performance objectives.

**personal development plan:** Typically, a written document developed jointly by the supervisor and employee that describes the employee's professional development objectives and the educational and/or on-the-job activities that will facilitate their achievement.

**recruitment:** Activities undertaken by the organization to attract well-qualified job candidates.

**work climate:** Employees' direct or indirect experience of the workplace—what it feels like to work in an organization or group. Work climate is considered to be a determinant of employee behavior.



## References and resources

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- Adano, Ummuro. "The Health Worker Recruitment and Deployment Process in Kenya: An Emergency Hiring Program." *Human Resources for Health* vol. 6, no. 19, 2008, <http://www.human-resources-health.com/content/6/1/19/> (accessed July 9, 2009).
- Adano, Ummuro, Jim McCaffery, Paul Ruwoldt, and Barbara Stilwell. *Human Resources for Health: Tackling the Human Resource Management Piece of the Puzzle*. Technical Brief 14. Chapel Hill, NC: IntraHealth International, The Capacity Project, 2008, [http://www.capacityproject.org/images/stories/files/techbrief\\_14.pdf](http://www.capacityproject.org/images/stories/files/techbrief_14.pdf) (accessed July 9, 2009).
- Global Health Workforce Alliance/World Health Organization. *Guidelines: Incentives for Health Professionals*, 2008, Geneva: Global Health Workforce Alliance, [http://www.who.int/workforcealliance/documents/Incentives\\_Guidelines%20EN.pdf](http://www.who.int/workforcealliance/documents/Incentives_Guidelines%20EN.pdf) (accessed July 9, 2009).
- Management Sciences for Health. "Human Resources: Managing and Developing Your Most Important Asset." *The Manager* (Boston) vol. 8, no. 1, 1999, [http://erc.msh.org/TheManager/English/V8\\_N1\\_En\\_Issue.pdf](http://erc.msh.org/TheManager/English/V8_N1_En_Issue.pdf) (accessed July 9, 2009).
- . "Developing Managers Who Lead." *The Manager* (Boston) vol. 10, no. 3, 2001, <http://www.msh.org/resource-center/developing-managers-who-lead.cfm> (accessed July 9, 2009).
- . "Creating a Climate that Motivates Staff and Improves Performance." *The Manager* (Boston) vol. 11, no. 3, 2002, [http://erc.msh.org/newpages/english/leadership/work\\_climate.pdf](http://erc.msh.org/newpages/english/leadership/work_climate.pdf) (accessed Dec. 29, 2009).
- . *Managers Who Lead: A Handbook for Improving Health Services*. Cambridge, MA: Management Sciences for Health, 2005. [www.msh.org/resource-center/managers-who-lead.cfm](http://www.msh.org/resource-center/managers-who-lead.cfm) (accessed April 23, 2010).
- . *Human Resource Management Rapid Assessment Tool for Health Organizations*. 2nd edition. Cambridge, MA: Management Sciences for Health, 2009, [http://erc.msh.org/toolkit/toolkitfiles/file/HRM%20tool%202009%20final\\_intranet.pdf](http://erc.msh.org/toolkit/toolkitfiles/file/HRM%20tool%202009%20final_intranet.pdf) (accessed July 9, 2009).
- . "Strengthening Human Resource Management to Improve Health Outcomes." *The eManager* (Cambridge) no. 1, 2009, [http://www.msh.org/sites/msh.org/files/emanager\\_2009no1\\_hrm\\_english.pdf](http://www.msh.org/sites/msh.org/files/emanager_2009no1_hrm_english.pdf) (accessed Mar. 6, 2014).
- Management Sciences for Health and the World Health Organization. *Tools for Planning and Developing Human Resources for HIV/AIDS and Other Health Services*. Cambridge, MA: Management Sciences for Health, 2006. You can order this book from the MSH website: <http://www.msh.org/resources/tools-for-planning-and-developing-human-resources-for-hiv-aids-and-other-health-services> (accessed Mar. 6, 2014).
- O'Neil, Mary L. "Human Resource Leadership: The key to improved results in health." *Human Resources for Health*, vol. 6, no. 10, 2008, <http://www.human-resources-health.com/content/6/1/10> (accessed Jan. 19, 2010).
- O'Neil, Mary L., and Michael Paydos. "Improving Retention and Performance in Civil Society in Uganda." *Human Resources for Health* vol. 6, no. 11, 2008, <http://www.human-resources-health.com/content/6/1/11> (accessed July 9, 2009).

Perry, Cary. "Empowering Primary Care Workers to Improve Health Services: Results from Mozambique's Leadership and Management Development Program." *Human Resources for Health* vol. 6, no. 14, 2008, <http://www.human-resources-health.com/content/6/1/14/> (accessed July 9, 2009).

World Health Organization. *The World Health Report 2006: Working Together for Health*. Geneva: World Health Organization, 2006, <http://www.who.int/whr/2006/en/> (accessed July 9, 2009).

### IN ADDITION...

Management Sciences for Health. "Human Resources Management Resource Kit." Cambridge, MA: Management Sciences for Health, <http://erc.msh.org/toolkit/Tool.cfm?lang=1&CID=5&TID=230>. This online resource provides materials about the following HRM topics:

- Organizing and Staffing the HRM Office
- Developing a Job Classification System
- Developing a Salary Policy
- Guidelines on Recruitment and Hiring
- Guidelines on Staff Orientation
- Developing a Personnel Policy Manual
- Developing a Workplace Prevention Program (HIV & AIDS)
- Developing a Performance Planning and Review System
- Supervisory Competency Self-Assessment Inventory
- Supervision Manual
- Conducting a Training Needs Assessment
- Developing an Annual Training Plan
- Assessing Trainer Competency
- Contracting Out for Training

## APPENDIX A. Using the Human Resource Management Rapid Assessment Tool

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The *Human Resource Management Rapid Assessment Tool for Health Organizations: A Guide for Strengthening HRM Systems*, introduced in 1999 and later modified on the basis of field experience, has been used by health managers in public and private organizations around the world. The tool stresses the importance of all the human resource functions and organizes them so people can easily understand how they interconnect with one another. Its premise is that these functions must be integrated to yield the most value.

The application of the tool encourages communication about important issues among different units in the organization. Using this tool will help you channel that communication toward agreement about which HRM functions are working well and which are not. Your organization can then use the tool to refocus and make needed improvements.

In the introduction to this chapter, we defined HRM as “the integrated use of policies, systems, and management and leadership practices to plan for necessary staff and to recruit, motivate, develop, and maintain employees so an institution or organization can meet its goals.” Based on this definition, HRM is responsible for a broad range of functions, from recruitment and hiring to developing staff to termination of employment. HRM is most effective when its authority is located at the senior management level of an organization. This status is appropriate because the HR functions touch and strengthen the entire organization using expertise not widely held by unit managers.

The HRM Rapid Assessment Tool identifies the characteristics and capacity of an organization’s HRM infrastructure and helps an organization develop an action plan for improving its infrastructure. The tool uses a matrix with:

- five broad areas of HRM;
- twenty-two human resource components;
- four possible stages of development for each component;
- the characteristics of each component at each stage of development;
- blank spaces where users indicate the stage they consider appropriate to each component;
- blank spaces for briefly describing the specific circumstances that are evidence of the ways the organization has reached a particular stage of development.

### USING THE HRM RAPID ASSESSMENT TOOL TO IDENTIFY THE STAGE OF DEVELOPMENT OF HRM SYSTEMS

**HRM components.** The five core functions of an effective HRM infrastructure have from three to nine components associated with them and a total of 22 components among them (see [Table A-1](#)). Using a set of characteristics that describes stages of HRM development for each component, the tool provides a process through which an organization can assess how well it is functioning in relation to each component and determine what steps it can take to function more effectively.

TABLE A-1. Elements of HRM Systems

Function	Component
HRM capacity	<ul style="list-style-type: none"> <li>■ HRM budget</li> <li>■ HRM staff</li> <li>■ HR planning</li> </ul>
Personnel policy and practice	<ul style="list-style-type: none"> <li>■ Job classification system</li> <li>■ Compensation and benefits system</li> <li>■ Recruitment, hiring, transfer, and promotion</li> <li>■ Orientation program</li> <li>■ Policy manual</li> <li>■ Discipline, termination, and grievance procedures</li> <li>■ HIV &amp; AIDS workplace prevention program</li> <li>■ Relationships with unions</li> <li>■ Labor law compliance</li> </ul>
HRM data	<ul style="list-style-type: none"> <li>■ Employee data</li> <li>■ Computerization of data</li> <li>■ Personnel files</li> </ul>
Performance management	<ul style="list-style-type: none"> <li>■ Staff retention</li> <li>■ Job descriptions</li> <li>■ Staff supervision</li> <li>■ Work planning and performance review</li> </ul>
Training	<ul style="list-style-type: none"> <li>■ Staff training</li> <li>■ Management and leadership development</li> <li>■ Links to external pre-service training</li> </ul>

TABLE A-2. Example of Stages of Development

Component	Level 1	Level 2	Level 3	Level 4
HRM staff	There are no staff specifically charged with responsibility for HRM functions.	There are HRM staff in the organization, but they have limited experience related to this field (personnel, recruitment, management) and/or have other functions in the organization as well as HRM.	There are trained HRM staff in the organization, but only at a level to maintain basic procedures and record-keeping functions.	There are experienced HRM staff in the organization who maintain HRM functions. They participate in long-range planning for the organization.

**Stages of organizational development.** As organizations grow, strengthen, and mature, they evolve through several stages of development. [Table A-2](#) gives an example of one component (HRM staff, a component of HRM capacity). The numbered levels at the top of the table refer to the stages of development. Organizations pass through these stages at different rates and tend to remain at a particular stage until they have developed a clear mission, good management structures and systems, and skilled managers and staff who use these structures and systems effectively.

Most organizations are at different stages of development for different HRM components at any given time because the components received different levels of attention as the organizations grew. For example, many organizations manage training well because funding is available for this activity. At the same time, the personnel policy is out of date and does not serve managers and supervisors well.

**HRM characteristics.** For each HRM component, the tool provides a statement that describes the common characteristics of organizations at four stages of development. These characteristics build on the characteristics of the previous stage(s). At the first stage, the characteristics describe an organization that is just beginning to develop capacity in the component or has not paid it much attention. At the fourth stage, the characteristics describe an organization that is operating extremely effectively with regard to that component and can probably direct its energies to components that are at lower stages of development.

MSH's [Electric Resource Center](#) makes available an Adobe Acrobat (PDF) file of the [Rapid Assessment Tool](#).

## APPLYING THE HRM RAPID ASSESSMENT TOOL AND INTERPRETING RESULTS

There are two phases when using the tool:

1. assessment of the current HRM infrastructure
2. discussion of findings and action planning

A diverse group of staff in the organization, such as the CEO and representatives from senior staff and/or the board of directors, should introduce and champion the assessment and planning processes. It is often useful for an external consultant to facilitate and administer the related activities.

**Conducting individual assessments.** Each person participating in the assessment should individually review the characteristics of every HRM component at each stage of development and then circle the characteristic that he or she believes best represents the current state of development for that component. If only part of the characteristic applies, the person should circle the previous characteristic.

Because the users of this tool come from many different parts of the organization, they often differ in their perceptions of whether the organization meets all the characteristics of a particular stage. Each participant should write one or two specific, concrete observations that show how the organization fits the characteristics of the stage he or she selected in

**BOX A-1. What Is Evidence?**

Evidence is a fact or concrete observation that supports the condition or stage of development. It answers the question, “What can we see or hear that tells us our assessment is accurate?”

For example, someone who places the organization’s compensation and benefits system in Stage 3 might write as evidence that there are fixed salary ranges with a maximum and minimum for each category of employee and that these standards are adhered to for hiring and merit pay.

the blank space labeled “Evidence.” (Box A-1 describes evidence.) This information will be used to help resolve differences.

**Reaching agreement on the assessment results.** After all respondents have completed their assessments, they share their results with the group and, taking one component at a time, discuss the evidence. Agreement is based on two assumptions. The first is that no single member of an organization possesses the complete truth. Every person at all levels of the organization possesses some part of the truth, and an accurate picture is best obtained by combining these individual perceptions. The second assumption is that carefully chosen reasons for the scoring can provide convincing factual evidence and allow a group of people to come to agreement on what might initially seem to be incompatible viewpoints.

The organization reaches agreement not by voting but by patiently sorting through all opinions and coming to a decision that every member can accept and work with, even if it does not completely match his or her preference.

**Interpreting the results.** When agreement has been reached about the results, it is time to review and analyze them. The group must now agree on those areas that require immediate action and those that should be part of a longer-term plan to strengthen HRM. Participants need to determine the priorities among the areas needing improvement.

## HRM PRIORITY AREAS

The HRM components relate to different parts of an HRM infrastructure. Some of these describe structural and organizational elements (e.g., staffing and budgeting), while others describe policy requirements. Some of the components describe management systems that are critical to managing human resources, such as performance management and supervision, and others relate to staff training and development activities. An effective HRM infrastructure integrates all these components.

In proposing solutions to HRM challenges, the group should first focus on specific core functions and the performance weaknesses identified within them. Typically, the order of importance for improving HRM functions is as follows:

1. **HRM capacity.** It is critical that you address this area first. If your assessment for HRM capacity (budget, staff, human resource planning) is at Stage 1 or 2—there are no qualified staff charged with HRM responsibility and

there is no HRM budget or human resource planning—then your organization cannot address the other HRM components described below.

2. **Personnel policy and practice.** All of the components included in personnel policy and practice provide an essential framework for defining the terms and conditions of work. They need to be in place before effective performance management and supervision can be implemented.
3. **HRM data.** All organizations require some means of gathering data about the people who work for them. They need employee information to accurately project employment needs.
4. **Performance management.** Performance management and supervision systems define how people will formally interact with each other and how the work that they do will support the goals of the institution or organization.
5. **Training.** Training is essential to an effective HRM capacity, but it is most effective when it is integrated into human resource planning, HRM policy, and performance management.

### REACHING AGREEMENT ON PRIORITY STRATEGIES

Within the priority areas, the group probably will have identified several weaknesses that undermine HRM capacity. The group will need to decide which weaknesses they will address and how. Some weaknesses are more serious than others and may need to be addressed first. Solutions for a weakness in one component may require an integrated response with various other components.

The characteristics of each stage of development provide useful information for determining possible actions to address the high-priority areas. For example, if your organization does not have adequate numbers of staff, priority strategies will address retention, recruitment, and links with pre-service training institutions. If these measures do not yield the desired results, priority strategies may include redefining the job descriptions of current staff and providing them with training to take on their new responsibilities. If low morale is an issue, strategies focusing on supervision and management are appropriate.

Strategies required for making improvements are not necessarily costly, but if resources are limited, you will want to prioritize strategies that:

- can be accomplished quickly and require few resources;
- will have the biggest impact on organizational goals, even if those take longer to accomplish;
- provide a basis for many other activities.

While it is necessary to focus first on a manageable number of components, it is also important to remember that the long-term effectiveness of HRM is only achieved when all components are addressed in an integrated manner. For example, a focus on in-service training is not sustainable if it is not linked to an overall retention strategy.

Whatever the amount of time and resources required, your organization's investment in HRM will make a major contribution to fulfilling its mission, achieving its goals, and serving its clients.

## DEVELOPING AND IMPLEMENTING THE PLAN

After the group agrees on the priority areas and strategies, it should develop an action plan. The characteristics of the next-higher state for each HRM component can serve as guides for formulating targets for desired performance and defining tasks for the action plan. Although it might not be possible to make the leap to the next level in all regards, defining optimal performance will help establish the interim steps. Long-lasting change is a gradual process, so it is best to set realistic goals, allow sufficient time to achieve them, and move logically from one step to the next. Your action plan should include activities and timelines and identify the persons responsible.

Before implementing your action plan, secure the commitment of leadership and other stakeholders. Explain the anticipated results and how they can help improve or address people's HRM concerns. By involving others you will have active support when difficult decisions regarding the use of human and financial resources must be made, and prior involvement can help diminish resistance to change.

## Conclusion

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Careful and thorough use of the Human Resource Management Rapid Assessment Tool to gather information and develop an action plan can direct your organization's focus and commitment to the areas of its HRM system that most urgently need improvement. You might also find that the process itself will educate staff, including managers, about the important and interconnected nature of the components of HRM, improve communication among staff, and motivate them to use their positions to contribute to the maintenance of healthy HRM systems.

Straightforward and relatively quick and easy to use, the tool can be a catalyst for valuable and long-lasting improvement in your organization's functioning and hasten achievement of its goals.





# Managing Finances and Related Systems

Natalie Merlini Gaul

1. Achieving Results by Strengthening Health Systems
2. Leading and Managing: Critical Competencies for Health Systems Strengthening
3. Governance of Health Systems and Health Organizations
4. Mainstreaming Gender Equality into Health Systems
5. Planning the Work and Working with the Plan
6. Managing Human Resources
7. Managing Finances and Related Systems
8. Managing Medicines and Health Products
9. Managing Information: Monitoring and Evaluation
10. Managing Health Service Delivery

In this chapter, we examine aspects of financial management and related office operations systems. Financial management is concerned with accounting and budgeting, along with reporting and analysis, that allow managers, donors, and overseeing bodies not only to know about revenue obtained or generated, assets owned, and expenses incurred but also to compare that information to previous years or desired results.

Operations management focuses on systems that support the organization in reaching its objectives. These systems include procurement (also known as purchasing), travel management, inventory management, and personnel management systems such as payroll and benefits. These systems are closely linked to financial management because they have a direct bearing on how funds are spent and reported, how the organization's assets are monitored and safeguarded, and how employees are compensated.

Chapter 6 of this handbook covers the policies, systems, and leadership and management practices that together make up human resource management (HRM). Information systems are presented in Chapter 9.

As a manager of a health program or health services, you can use information in this chapter to guide you in establishing internal controls as a framework for all financial management activities. Internal control mechanisms provide a basis for making sure that the use of an organization's precious resources is appropriate and that the resources serve the organization's mission, maximize impact,

comply with laws and donor regulations, and meet established standards for ethical conduct and sound operational practices.

You will also find both tools and links to help you assess the status of your organization's financial and operations management, and suggestions to strengthen any weaknesses you might find.

The breadth of topics and the array of basic information in this chapter and its appendixes make it the longest in this handbook. If you do not directly manage or oversee an area related to financial management and operations, you can selectively familiarize yourself with how these critical functions affect your organization's ability to meet its strategic objectives and also learn how you can support sound financial management.

## Introduction

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Increasing global awareness of the serious health problems faced by developing countries has resulted in a widespread desire to address these issues. This requires strengthening the ability of governments and civil society organizations (CSOs)—faith-based, community-based, and nongovernmental organizations (NGOs)—to manage health projects and service delivery programs effectively and efficiently. To fulfill their growing responsibilities, both public- and private-sector entities must manage funds with the utmost care and integrity. They share similar needs for efficiency, effectiveness, and transparent use of financial and other resources.

Shifts in donor priorities or the economic climate may reduce the amount of funding available to support health programs. Economic factors may raise the costs of required goods, labor, and services. To cope with these scenarios, public health managers at all levels must understand and implement sound accounting and financial management principles to safeguard their scarce resources and respond to changing economic conditions.

In addition to efficient and effective operations, financial management, and accounting systems, organizations must have strong internal control mechanisms to guard against misappropriation or fraud. Well-documented policies and procedures will both support the workforce and demonstrate fiduciary responsibility and stewardship to funders.

Organizations that demonstrate these high standards have the best chance of securing and maintaining donor funds and protecting their own working capital.

The leadership and management practices shown in the Leading and Managing Framework in Chapter 2 of this handbook all apply to financial management.

You and the leaders of your organization, including its board of directors, must **scan** for risks that might impact the financial health of the organization as well as for opportunities to generate support and funding for the organization's mission. Scanning will also uncover best practices related to financial management as well as constraints that may affect the organization.

As a manager who leads, you should **focus** financial management actions so they reflect the organization's mission. You must determine priorities related to generating funding, investing in staff or equipment, or managing expenses to achieve the strategic objectives of the organization.

You need to **align** your organization's financial goals and expectations, operations systems, and practices with its mission and vision. You must also **mobilize** resources, including capable staff, so that finance and operations systems operate optimally.

A critical, but sometimes overlooked, role of leaders with regard to financial management is **inspiring** staff to comply with policies and procedures related to financial dealings, use resources wisely, and avoid conflicts of interest and unethical behavior related to financial transactions.

To serve as a role model, you should demonstrate honesty and integrity in the use of the organization's resources. You must also demonstrate understanding of and respect for prudent fiscal behavior and the related internal controls. Your deeds and example will speak louder than your words.

The organization's activity, finance, and administrative managers engage in the four management practices with regard to financial management.

You and other managers carry out a variety of **planning** activities, such as drafting operating budgets for the current year and projections for future years based on the organization's strategic plans. You develop purchasing plans for needed equipment and other capital assets. And you develop plans to prevent or respond to potential risks that might impact the financial health of the organization.

Managers **organize** systems, structures, work processes, and policies. They recruit and train staff to ensure that efficient, transparent, and appropriate financial and administrative actions are executed.

Finance managers **implement** the established policies and practices. Managers across the organization must use financial information to make decisions about activities and adjust plans as circumstances or available resources change.

Finance and general managers must **monitor** the financial activities of the organization, **evaluate** the results, and identify needed changes to work processes and procedures, budgets, or planned uses of resources.

Financial management focuses on controlling, accounting for, conserving, and investing an organization's resources (cash, employees, inventory, equipment, and time) to meet planned objectives.

There is a perception that financial management is a narrow discipline, similar to compensation management or the management of medicines and health products, or that only accountants and bookkeepers need to understand financial information. For those who lack formal financial training, the unique vocabulary and rules of financial management are sometimes regarded as too complex, dull, or even intimidating.

However, all managers—even those not directly connected with the accounting functions—benefit greatly from having a basic knowledge of the principles and tools of financial management. Managers at all levels of an organization must concern themselves with financial matters or they will soon find that they do not have the resources they need to accomplish long-term goals or maintain day-to-day operations.

Financial management skills include:

- **accounting** for financial transactions;
- **planning** for operational activities, equipment purchases, and uses of labor;
- **costing** and **pricing** of goods and services;
- **forecasting** revenues and future expenses (sources and uses of funds);
- **monitoring** and **controlling** the use of resources.

Financial management uses these skills to maximize the use of assets, control costs, and plan activities to have the greatest impact and achieve desired goals.

#### Two Financial Truths

1. Assets, including time, are always limited.
2. Organizational objectives and needs are ever changing and seemingly unlimited.

In this chapter, we cover the following topics:

- [Financial Management and Operations Management \(Overview\)](#)
- [Assessing Your Organization's Financial and Operations Systems](#)
- [Accounting and Financial Management Basics](#)
- [Managing Risk](#)
- [Conflicts of Interest and Unethical Conflict](#)
- [Procurement Management](#)
- [Travel Management](#)
- [Asset Management](#)
- [Cash Management](#)
- [Internal Control Requirements and Guidelines](#)
- [Using Policies and Procedures to Enhance Internal Control](#)

Depending on your interests, time, and the needs of your organization, you may wish to focus on specific sections and their related resources. You can read these sections, with the exception of the overview, in any order or selectively.

## Overview of financial management and operations management

Financial management and related operations management play a vital role in your organization's achievement of its goals. It is not uncommon for conflicts to arise between the finance, operations, and administrative components of the organization and the technical or program staff who are designing and implementing health programs or providing services to clients.

Perhaps you have heard statements such as:

- Finance and operations staff, with all their rules and regulations, cause too many delays and bottlenecks!
- Finance and operations staff don't understand the needs or challenges of the service delivery teams!

In reality, all program, operations, and finance staff have roles and responsibilities related to managing risks and producing results for the organization. Tension among different functions is generally healthy and often unavoidable. When staff understand and respect each other's roles and can evaluate conflicting needs in a broad context, the degree of tension will be minimized.

All staff should understand that finance staff must ensure that resources are available and that the organization maintains its economic health and conducts its affairs in a transparent manner. It must be accountable to its clients and donors and must act in accordance with rules of law, international standards for sound business practices, and ethical behavior. This is the finance staff's contribution to fulfillment of the organization's mission.

By sharing analysis of past financial results and trends, your financial staff can influence programmatic decisions, such as:

- pricing or cost recovery schemes for services;
- determining whether to expand or eliminate programs;
- improving work processes and increasing technological capacity, staff levels, or compensation;
- expanding fund-raising or capital generation to meet projected shortfalls that will prevent the achievement of short- or long-range goals.

If the programmatic, technical, and operational elements of your organization are well integrated at all stages of planning and implementation, conflicts will be minimized or eliminated. Include the finance and operations manager(s) in annual and strategic planning from the start so they are not simply creating budgets for plans that were developed without their input. And you should instill an understanding in all staff of financial constraints, sound organizational practices, and ethical behavior with relation to how the organization's assets are used. The ideal is an ongoing, two-way loop of communication and engagement that draws upon the expertise of—and considers the needs of—all functions.

You can help your colleagues understand how the finance function contributes to the success of their programs by documenting and distributing policies and procedures, as defined in [Box 1](#), throughout your organization; by training staff in the application of these policies and procedures; and by communicating how all staff are expected to comply with and enforce financial management policies.

When thinking about financial management, it is easy to become narrowly focused on choices related to accounting activities, such as:

- how to organize financial reports and budgets;
- how to track and consolidate financial transactions;

### BOX 1. Definitions of Policies and Procedures

**What Is a Policy?** A policy is a managerial directive pertaining to accepted business strategies, objectives, and standards. It answers the question: what will be done?

**How Are Policies Determined?** Boards of directors and senior managers generally set policies that reflect the mission, strategic objectives, and standards of the organization. An organization may also need to adopt or adapt policies to comply with rules and regulations established by donors and governments. Policies should reflect the values of the founders, owners, directors, staff, and volunteers of the organization.

**What Is a Procedure?** A procedure is a methodology or series of actions that is followed to carry out a policy. It answers the question: how will it be done?

- whether to keep detailed accounts or summaries by broad account categories;
- which software to use to capture financial transactions;
- whether to pool costs by department, project, and program objectives or by organizational level;
- the most efficient and cost-effective way to staff and organize the financial management function.

If your interest in financial management within the organization is limited to accounting activities, it is focused on the past, rather than the present and future, because accounting is generally the recording and reporting of financial transactions that have already occurred. It results in the financial reports needed to satisfy tax requirements, convince a bank or donor to provide funding, or equip a manager with historical data needed to create projections and budgets for future activities.

But broadening the financial management perspective to include procurement, travel and logistics, and facilities management moves the focus to the present and future. The emphasis is no longer only on recording what has already happened; the emphasis is also on influencing how funds will be expended now and in the future.

The benefits of integrating financial management and operations management include:

- ensuring that assets already obtained will be kept safe, in good working order, and available for the use of programs that require them;
- deciding what will be bought and how, so that the best value is obtained;
- allowing for enhanced revenue generation through proper pricing of goods and services that is acceptable to clients;
- safeguarding the organization and the individuals involved in its ownership, management, or program implementation by ensuring that financial transactions are conducted lawfully and ethically;
- creating an organization that fairly compensates staff for their work while at the same time allowing for the provision of quality services that serve the broadest possible client base.

**A word of caution.** The materials in this chapter are of a general nature and represent best practices that should be relevant worldwide. It is not possible, however, to address all the country-specific situations that could have an impact on your individual organization.

This chapter is intended to inform you as a manager of a health program or health services and enhance your ability to manage program activities by understanding the role of finance and operations. This understanding should be combined with:

- recruitment of financial managers and operations managers who have the relevant education and work experience;
- active involvement of finance and operations managers in program management activities, especially planning;
- engagement of public or chartered accounting firms or audit firms to routinely review your financial statements and internal control systems;
- seeking advice from lawyers or tax accountants who understand the country context, applicable laws, and requirements for an organization of your type. Professional advice can prevent major issues, including fines or lawsuits resulting from noncompliance with laws and regulations.

## Assessing your organization's financial and operations systems

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An assessment of the current financial health of an organization and its prospects for the future should include a review of:

- the financial and operations systems, structures, policies, procedures, and practices;
- the organization's capacity to provide services;
- the availability of capital from donors or the government or revenue generated from the sales of services and commodities.

Depending on the size and staffing of your organization, you may want to hire a consultant to help conduct the assessment, analyze the results, and implement needed changes.

Three tools—QuickStart, the Financial Management Assessment Tool, and the Management and Organizational Sustainability Tool (MOST)—can help your organization check its financial management systems.

- [QuickStart](#) is a relatively simple assessment tool that is most appropriate for small, fledgling organizations or organizations interested in obtaining a quick snapshot of their capabilities and weaknesses in accounting, financial management, and operations systems. The answer key serves as a basis for staff development and systems strengthening.
- [MOST](#) takes an in-depth view of the organization's overall management, including financial management, and is better suited to slightly more mature organizations.
- The [Financial Management Assessment Tool](#) provides a detailed look at the financial management systems of an organization and is best suited to large, complex organizations.

Your organization might decide that strengthening financial management systems will require major capital outlays for initiatives such as the installation of a sophisticated



accounting software package; recruitment of additional accounting, administrative, and support staff; or expansion of fund-raising activities to generate additional funding or win new contracts.

However, most organizations find that relatively small improvements, at low or no cost, are all that is needed to reap significant benefits. Such improvements generally involve strengthening internal control systems, documenting financial policies and procedures and communicating them to staff, and instilling in all staff members an understanding of how they contribute to maintaining the financial health of the organization.

In the past decade, the cost of computer equipment has decreased significantly, and access is far greater. Many accounting software packages geared toward small organizations are commercially available and require little modification to be applicable to nonprofit organizations.

Staff members are increasingly likely to have computer skills, including the ability to use spreadsheets and databases, which greatly increase their capacity to do financial analysis, use forms and templates, and generate reports. Many large organizations provide staff with Internet access, and some have internal websites that are a major resource for performance improvement and the sharing of financial information.

Not only will improvements in finance and operations systems strengthen the health of the organization, sound management practices will also make a good impression on potential contributors. They will be more inclined to award projects or make donations because they have confidence that the funds will be used appropriately, desired results can be achieved, and the results will be accurately documented and shared.

## Accounting and financial management basics

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Valuable lessons learned from history help us prepare better for the future. Financial data provide a powerful history lesson that allows managers to better budget for future costs, project cash needs, and forecast growth for their organization. These lessons are often communicated by the organization's financial management staff through their routine reporting and financial analysis.

### WHAT IS ACCOUNTING?

The section below outlines accounting methods, basic principles, and reports. If you have experience in financial management, you may wish to skip this section. If you are unfamiliar with accounting terminology, consult the [Glossary](#) in this chapter for definitions.

Accounting is a system of consistently recording financial transactions. In the simplest terms, the goal of accounting is to document what an organization owns, its debtors (those who owe it money) and creditors (those to whom the organization owes money), income, and donations. Analysis of accounting data helps determine whether revenue or funding is sufficient to cover costs and allow for growth. It is a mix of art and science.

The science comes from the application of rules and standards. Accounting standards are dictated by national governments, tax authorities, and the international community of accounting professionals. Standards focus on the ethical and appropriate use of resources and how financial transactions are reported. These standards attempt to ensure that similar transactions are treated consistently and that revenue is linked with the expenses incurred to generate it.

The concept of linking revenue to related expenses is known as the matching principle. This makes it possible to compare results from year to year, and to some degree, among organizations. Financial information must be gathered completely and accurately to guarantee the reliability of financial statements.

Accounting standards provide guidelines on how the principal financial reports use measurements and are organized, recorded, and reported. These standards are documented in a publication called the *Generally Accepted Accounting Principles* (GAAP). The standards of the United States and the United Kingdom are used throughout the world, but other standards exist to meet unique conditions found in other countries.

The art of accounting is evident when financial reports are created in a way that tells a story and provides sufficient information for administrators and technical activity managers to make sound operational decisions. A well-designed chart of accounts (see Box 2) that determines how information is categorized and summarized is key to the ability to create analytical reports that easily allow managers to interpret financial results.

For more information, see [“Sources of data for reporting”](#) in this chapter.

#### BOX 2. The Chart of Accounts

The chart of accounts is a list of the categories of financial transactions that will be tracked in the accounting system and flow to various financial reports. To make data entry and tracking easier, these account types are generally assigned an identification number.

Although the chart of accounts varies among organizations, there are some generally accepted standard categories:

- **Assets:** what is owned, including cash, investments, equipment, furniture, or what is due from others, such as clients or donors;
- **Liabilities:** short- and long-term debt that is owed to vendors, banks, staff, or government agencies;
- **Equity:** cash, property, inventory, and equipment that belong to owners, partners, or shareholders after deducting liabilities from the organization's assets;
- **Income:** revenue generated through operations, sales, donations, and fees for services;
- **Expenses:** costs for materials, supplies, travel, wages, services, facilities, medicines, commodities, etc. This is often the lengthiest section because a detailed list of such costs is useful for financial management, reporting, and budget monitoring.

Accounting that is executed in accordance with all the rules does not necessarily guarantee useful management information. Reports must be clear enough to be interpreted accurately, and they must reach the people who have the power to make operational decisions. Needed reports must also be timely to allow managers enough time to take corrective action, if necessary. All too often, financial reports are designed only to satisfy governments or donors at the expense of meeting the needs of the organization. Although satisfying these requirements is essential to receiving future funding, it may be necessary to negotiate report formats or prepare multiple financial reports to satisfy both sets of needs.

If you understand how to interpret financial statements and analyze results, you are less likely to make poor decisions or jump to false conclusions. It is especially important to understand if the reports disclose all costs, including indirect ones.

The accuracy of financial data is paramount, but the statements must also tell a true story by reporting the right (relevant) data, as soon as possible after the transactions occurred (timely), and in a clear (simple) format. Financial statements should illustrate, rather than obscure, the fiscal position of the organization.

In other chapters we review SMART criteria for defining objectives. Here's a memory tool for keeping the SMART in financial reports:

- S** = Simple
- M** = Meaningful
- A** = Accurate
- R** = Relevant
- T** = Timely

## STANDARD ACCOUNTING REPORTS

As a manager, you probably receive several standard accounting reports designed to help you determine the financial health of your organization. Some managers make a major mistake by not reading them. If your organization uses computerized accounting software, key reports should reach you early enough to help you make important adjustments in activities and programs when actual results are not in line with budget expectations.

Accountants report on historical financial events and performance using two primary reporting tools: the balance sheet and the income statement. These reports reflect the health of an organization at a specific point in time. They are generated quarterly or monthly.

The more frequent and current the reports, the greater the possibility that you can make decisions while there is adequate time to influence future financial results. Most organizations will want—and may be required—to have these reports prepared or reviewed annually by an outside accounting or audit firm.

**The balance sheet.** The balance sheet focuses on the assets, liabilities, and equity of an organization. (See [Appendix A](#) for an example.) It is a snapshot of account balances at a specific time. The fundamental principle of accounting is that assets equal liabilities plus equity. The standard format of a balance sheet contains two schedules. One sched-

ule reports on the value of the assets of the organization. The second schedule details the liabilities and the equity of the organization. The total of the first schedule will equal the total of the second schedule. This is the concept of balanced books—the two schedules must offset one another to show the overall value of the organization.

The balance sheet can take a variety of formats, depending on the level of detail desired, but will always include:

- the total value of assets on the date specified;
- the total value of liabilities on the date specified;
- the total value of equity on the date specified.

**The income statement.** The income statement (also known as a profit and loss statement) reports on income and expenses resulting from the organization's operations. (See [Appendix B](#) for an example.) The format lists all sources of income first, followed by expenses. The end of the report is an expression of income minus expenses that determines what is often referred to as the bottom line. A positive result indicates a profit from operations; a negative result indicates a loss.

Income statements are often categorized by departments, divisions, or geographic location. This makes it easier to determine which departments or service areas are covering costs, generating profit, or running at a deficit. Nonprofit entities may not prepare income statements, but they will need to prepare similar reports on the sources and uses of funds. Regardless of their status, however, all organizations must be concerned with covering the full costs of operations and generating funds for future expansion and growth.

Two other key financial management tools that focus on the future are budgets and cash flow statements.

**Budgets.** Budgets are expressions of expected future income and expenses. They are generally based on historical data, if available, and adjusted based on assumptions regarding inflation, increases or decreases in income or expenses, and expected expansion of programs and services. Once created, budgets become a tool to monitor current operating performance: Are costs higher than planned for? Are sales or services less than expected? Is funding less than expected?

Reviewing budget results and reacting quickly allows you to take corrective action before too much money or other resources are lost, or to use unanticipated resources to capitalize on opportunities that have arisen.

If there are variances between budgets (planned) and results (actual), it is important to analyze the reasons. You can begin by looking at the big picture:

- Did we do what we planned to do?
- Did it cost what we expected?
- Has our income or funding been at the planned levels?

There are further questions you can ask to determine the causes of budget variances:

- Is there an error in the budget values or the financial results due to a clerical error or miscoding?
- Were the budget assumptions inaccurate or incomplete?
- Is the variance related to timing of income or expenses that will self-correct in the next accounting period?
- Has the market changed, resulting in higher or lower costs or more or less demand for services or commodities?
- Were the historical data incomplete, inaccurate, or misinterpreted, leading to flawed budget amounts?
- Are the variances an indication of poor performance, misuse of funds, or changes beyond the control of the staff of the organizations?

Once you have analyzed the reasons for the variances, you can respond to them by asking four key questions:

1. Do you need to adjust the budgets and, as a result, expectations about future spending or income levels?
2. Is it necessary to cut activities or reduce costs?
3. If budget variances are positive, is it possible to increase activities or invest in long-term assets?
4. Should you do nothing, expecting that the variance will self-correct? If you choose to do nothing, it must be a deliberate decision and not the result of ignoring the financial data.

The answers to these questions will help you create better budgets in the future, as well as provide insights into market trends or inefficiencies within your organization.

**Cash flow statements.** Cash flow statements detail cash coming into the organization from donors, customers, and investment income as well as cash spent for general and administrative costs, program expense, or investments. Cash flow statements are concerned only with cash position, so factors such as accounts receivable and accounts payable that have not yet impacted cash are not considered. These statements help managers predict needs for cash and plan the timing of income and expenditures. These projections are critical because an organization can find itself in trouble if cash is not available when expenses are incurred. Ideally, cash flow in will be greater than cash flow out.

## SOURCES OF DATA FOR REPORTING

The backbone of financial reports is the chart of accounts and the general ledger.

**The chart of accounts.** This is a listing of code numbers and descriptions that itemize the types of income, expenses, assets, and liabilities about which information will be accumulated, tracked, and reported. The chart of accounts should reflect a balance between what the accountant needs to satisfy statutory requirements and standard accounting practice and what program managers need to plan and monitor. It should be detailed enough to give you sufficient data to make decisions and plan for relevant categories or types of expenses. However, the account codes should not be so numerous or complex that coding, recording, sorting, and reporting on financial transactions become labor intensive or costly.

Often the creation of the chart of accounts is left to the accountant. It is essential, nevertheless, that managers in the organization are clear about the types of information and reports they need, so that a useful chart of accounts can be created and maintained.

For example, it is difficult to provide monthly data on the cost of gasoline if the costs of water, oil, electricity, and gasoline are all summarized under Utilities. The use of computers to process financial information has increased the ability to expand coding and reporting possibilities without greatly increasing costs or labor.

**The general ledger.** This is the primary financial record of an organization. All financial transactions are recorded in it, either in detail or summarized from other subsidiary journals or ledgers that track items such as revenue, expenses, and labor costs. Transactions are recorded in an orderly fashion, by date, and in accordance with the chart of accounts.

Sometimes the general ledger is a very large book, completed in pen and ink, but today it is more often a data file and a series of computer-generated reports.

As a manager, you will be most efficient if you can link an expense with the activity, service, or department that generated it, so that you can analyze the cost in relation to the benefit received. Many managers recognize the need for integrated systems in which financial information interacts meaningfully with operational and program data, and accounting information is linked to budgets.

New technology such as computer disks that can store vast amounts of data, readily available and user-friendly accounting software, and lower costs for high-speed computers are making it easier for managers to satisfy their need for integrated information.

## DEBITS AND CREDITS

Accounting has a unique vocabulary. Assets, liability, equity, income, and expenses have already been mentioned. Debit and credit are two other important terms that originated in the earliest days of double-entry bookkeeping. Whether accounts are kept in paper ledgers or in computerized files, debits are treated as positive numbers and credits as negative numbers. In keeping with the principle of balanced books, the net result of the debits and the credits must be zero.

**Debits.** A debit is a positive number, recorded in the left-hand column of a manual ledger. It is used to record increases in assets or expenses and decreases to liabilities and equity. This statement might appear counterintuitive, but it is the generally accepted accounting protocol. This principle can be memorized.

**Credits.** Credits, posted in the right-hand column of a manual ledger, are negative numbers and are used to record increases to liabilities, equity, or income and decreases to assets and expenses. For each financial transaction, there are offsetting entries of debits and credits. The net effect is a balanced transaction totaling zero. See [Box 3](#) for an example.

It should be noted that in a computerized accounting system the user may not always see columns or the placement of the debits and credits because the software will assign the

**BOX 3. A Debit and Credit Example**

You wish to purchase an order of paper for the printer that costs \$1,000. This will be recorded to an expense account called Office Supplies. This transaction requires the use of funds being held in a checking account, which are tracked as an asset.

The office supplies account is increased by \$1,000 (the debit entry, or positive number).

The checking account is decreased by \$1,000 (the credit entry, or negative number).

$\$1,000 - \$1,000 = 0$ , indicating that the books are in balance.

Cash Account	Expense Account	Net
Checking	Office Supplies	
– \$1,000	+ \$1,000	0
(credit entry)	(debit entry)	(balanced books)

proper status based on the nature of the transaction being posted. However, it is important to understand this principle because some entries, such as general journal entries or adjusting entries will normally require the accountant to manually indicate the debit and the credit sides of the entry.

## ACCOUNTING METHODOLOGIES

This section discusses three accounting methodologies: **cash basis accounting**, **accrual basis accounting**, and **activity-based cost accounting**.

**Cash basis accounting.** Cash basis accounting is relatively unsophisticated. Revenue is recorded when it is received, and expenses are reported when they are paid. The focus is solely on when cash enters or leaves the organization and not on when the revenue was actually earned or when the expense was actually owed or incurred. This method of accounting can seriously misrepresent the present financial position of an organization.

For example, if an organization elected to prepay the next year's rent and purchase all the supplies needed for the upcoming year in December, the bottom line at the end of December might reflect expenses far exceeding income. It would not show that these expenses purchased assets and inventory that will be used at a later date.

Similarly, if expenses have been incurred, but payment for them has not been made, financial results will seem more positive than they actually are. With this accounting methodology, it would be possible to manipulate financial results to appear more profitable or to reduce income tax liabilities by timing the payment of debts.

**Accrual basis accounting.** To present a more accurate financial position, an organization can use accrual basis accounting. In this methodology, revenue is recorded when it is earned and expenses are recorded when they are incurred, without regard to when the cash changes hands.



Two special balance sheet accounts, **accounts receivable** and **accounts payable**, are used to recognize income and expenses as they are incurred. They are cleared when the payment is actually received or a vendor invoice is actually paid. This leads to a more accurate profit and loss statement that is free of the misrepresentations possible in the cash-based method.

Returning to the previous example, in an accrual-based system, the prepaid rent or supplies would be recorded as assets in December, with no effect on the expense accounts until the rent is owed and the inventory used. Each month in the following year, you would make entries to reduce the prepaid accounts and recognize the actual expenses.

You can account for the usage of assets, such as buildings, vehicles, or equipment, by recording depreciation, which distributes the cost of the asset over its useful life. For example, only one-fifth of the cost of a truck, expected to be in service for five years, would be charged as an expense each year. Similarly, the cost of major expenditures, such as research and development, are often amortized—spread out—over a period of time.

**Activity-based cost accounting.** Activity-based cost accounting attempts to calculate the full cost of an activity, project, or service through the allocation and attribution of support costs. For example, the cost of providing a medical exam includes not only the doctor or nurse's time and supplies used during the exam, but also some portion of the clinic rent for an exam room, use of equipment, and even a small portion of the salary for a clinic manager, receptionist, and accountant.

The goal of activity-based cost accounting is to track and disclose the total costs of all technical activities, including a fair proportion of the indirect costs incurred in execution of these activities. There are two major reasons for you to use activity-based cost accounting:

1. If an organization is self-sustaining, it is critical for you to understand the full cost of activities because this allows you to make well-informed decisions about pricing, cost recovery, and service mix.
2. In a multidonor environment, using this type of accounting allows you to charge donors only for the costs they have agreed to support.

## TYPES OF COSTS

There are two general types of costs that are incurred within your organization: direct costs and indirect costs.

Direct costs are incurred exclusively for a given project or program activity. For example, an organization might purchase and distribute condoms as part of a family planning project. The cost of the condoms would be a direct cost to that project because there is a direct link to that, and only that, activity.

There are two basic categories of indirect costs: (1) general and administrative costs that cannot be assigned to any particular activity, and (2) indirect costs related to programmatic activities but not exclusively to a single project or program.



**General and administrative (G&A) costs.** G&A costs, also called overhead, are expended for the benefit of the entire organization. They are essential for the execution of the technical work but cannot be assigned directly to a particular project or activity. Examples are:

- real property: literally, the roof overhead, including rent and utilities;
- labor: salaries for administrative, accounting, maintenance, and general management staff who provide support to all projects;
- general office supplies, such as paper, computer supplies, and cleaning supplies, if shared by all;
- shared office equipment, repairs, and services such as photocopying, postage, telephone, and Internet access.

**The indirect costs of technical activities, including related management.** These are costs incurred specifically for the benefit of programmatic activities, but that are shared among several projects or activities. These can include salaries, supplies, equipment or other costs that are expended solely for the benefit of specific program activities.

Donors often restrict the amount of funding that can be applied to overhead costs by setting limits on the overhead rates in project budgets; they prefer that the funds be used for activities in the project or program they are sponsoring rather than for general organizational support. With this understanding, your organization may be able to legitimately shift some traditionally indirect costs to direct costs if you have the technology to minimize the accounting burden.

For example, photocopiers and telephone systems can often be modified to require charge codes that make it possible to analyze bills by activity code. Usage logs can also be maintained by hand for these types of charges. However, the discipline required to maintain such logs consistently, as well as the effort required to analyze and tabulate the logs each month, might not be worth the benefit derived from allocating these costs directly.

The methods used and systems required to attribute costs directly to projects should not be so time-consuming, costly, or onerous that the burden outweighs the benefits.

Indirect costs can be further defined as either **allocable costs** or **attributable costs**. They are treated separately in [Appendix C](#). [Appendix D](#) shows how to calculate an indirect cost rate.

When costs benefiting multiple activities are to be apportioned among those activities, the rationale for distributing those costs should reasonably reflect the benefit. For example, if an organization wanted to allocate the cost of an Internet connection and email server, it could use a percentage based on the number of staff working on a particular activity. An activity with more staff would bear a larger share of the cost of the Internet services.

## IMPLEMENTING ACTIVITY-BASED COST ACCOUNTING

First, your organization must determine how it will define its activities (see [Box 4](#)) and at what level of detail. This fundamental decision affects the type of accounting system required and might lead to a decision about how records are organized, whether records are compiled manually, or whether new software is needed. Information about selecting

#### BOX 4. Defining Activities

What your organization defines as an activity (or project or subproject) is often based on in what form donors or boards require financial reports or how program staff members manage and monitor operational plans and budgets.

The definitions of activities, projects, or subprojects depend on:

- the source of funds, such as a donor agreement or contract;
- health outcome areas, such as family planning, infectious disease, or child survival;
- geographic regions;
- program interventions, such as service delivery, training, or behavior change communication;
- operating departments.

accounting software appears in [Appendix E](#), and [Appendix F](#) provides tips about implementing new software.

Implementation of an activity-based cost accounting system requires that the costs be assigned to the applicable activity *at the time it is incurred*. This requires an accounting system that can track and report costs in this manner by using such processes as:

- timesheets on which staff indicate the amount of time they spend supporting each coded activity;
- purchase orders or procurement requests that indicate which activity a particular good or service is for;
- the assignment of travel costs (including use of the organization's vehicles), to the activity that incurs the transportation, lodging, meals, or other costs related to travel.

All staff, not just the accounting staff, must use these processes because only the originator of the cost may know which activity the cost is supporting. There may be some resistance to using the new processes and forms if your organization has not already established this system. Because management systems depend on people, communicating to your staff the rationale behind the changes will encourage them to cooperate. You can apply the principles of leading and managing through change described in this handbook, most notably in Chapter 2, as you make the transition.

### EFFICIENT USE OF RESOURCES

Anyone in an organization who has control over the use or purchase of resources is a financial manager. This role is not limited to the accounting staff or managers who approve budgets or sign checks. To varying degrees, *all* staff members act as stewards and custodians of assets on behalf of donors, sponsors, owners, and especially the clients being served.

If you have the ability to incur a cost, use an asset, develop or approve a budget, or obligate the organization financially, you must occasionally wear the hat of a financial manager. Any decision you make that affects the use of the organization's resources impacts its ability to provide the desired quality and quantity of health care services.

### BOX 5. Three Powerful Money-Saving Practices for Financial Managers

**Substitution.** If your review of the budget or financial statements reveals a shortfall, you may be able to substitute lower-cost inputs: labor, supplies, outsourced services, or modes of travel, for example. Looking for new suppliers who offer lower prices, or flying in economy class rather than business class are examples.

**Economies of scale.** You may be able to negotiate better prices for needed goods and services by purchasing in larger quantities or establishing long-term contracts with vendors. This can be a wise approach if there is adequate cash or credit available for the purchases and if stockpiled supplies can be protected from loss, theft, and spoilage.

It is important to balance the savings of buying in bulk with the cost of possible spoilage and the cash drain of having too much money tied up in idle inventory rather than being available for immediate needs.

**Reduction of idle capacity.** If staff or facilities are not fully used, you may be able to assign them additional functions or loan or rent them to others. For example, empty offices might be leased to another organization or a secretary with free time during the day might be trained to take on some accounting duties. These staff or facilities represent sunk (fixed) costs. Although the total costs of these resources will not change, the outputs from those costs can increase or additional funds can be generated to offset some of them.

Therefore, it's important to be able to recognize a **financial obligation**, which can be defined as an agreement to hand over an organization's assets, generally cash, in exchange for goods, services, or other assets. You commit to such an obligation when you issue a purchase order, sign a rental agreement or lease, award a contract to a consultant or vendor, or make an employment offer to a staff member on behalf of your organization.

As a manager, you must continuously seek the most efficient uses of limited resources to achieve the goals and strategic plans of your organization. The environment is constantly changing because of factors such as new technology, demands in the marketplace, availability of scarce resources, and political situations.

Financial management requires you to use management and leadership practices such as scanning the environment and monitoring changes to look for opportunities to change operational practices or alter plans so that your organization can take advantage of—or counteract—these changes.

Examples of the steps managers can use to address shortfalls and variances from plans include:

- **cutting costs** by taking measures such as reducing staff or changing operating hours;
- **raising prices** for services or commodities;
- **marketing** to increase sales;
- **changing service or product mixes** to eliminate less profitable elements;
- **changing the timing of activities or expansion** to better meet the timing of revenue;
- **creating a staffing structure** that establishes segregation of duties;

- **implementing policies of internal control** that safeguard against theft, fraud, misuse, or loss of resources;
- **hiring competent accounting staff and external auditors** as well as orienting general managers to their role in the financial management and health of the organization.

**Box 5** shows other ways of making the most of scarce resources.

As a manager you have to keep in mind the ultimate goal: providing quality services at a price that clients can pay or that can be supported through other funding sources. Depending on circumstances, your ability to influence the situation might be limited. Donors often specify how donated funds can be used and require reporting as a condition of their donation. Donors may set approved budget limits and cost ceilings.

Donated funds may also come with cost principles outlining what types of costs are allowable or unallowable, such as prohibitions on the use of funds for entertainment or alcohol.

## Managing risk

Finance managers are often given the task of managing risk for the organization. Although some risks are programmatic, many fall into the realm of financial management.

Risks have three common elements: a negative event or practice, the probability of occurrence, and the severity of occurrence. Costs or losses can be monetary or intangible, such as the tarnishing of the organization's reputation or a decline in clients' confidence or a donor's trust.

### SOME RISKS RELATED TO FINANCIAL MANAGEMENT

Financial managers must contend with and manage numerous risks, such as:

- lack of information about the true costs of providing products or services;
- assuming you can make it up in volume without recognizing that if you are generating losses, volume only creates larger losses;
- dependency on donors or a limited number of donors;
- setting prices for services too low;
- failure to monitor the changing environment;
- condoning poor budgeting, planning, and reporting practices;
- failure to take advantage of opportunities;
- failure to cover overhead costs.

Strategies for dealing with risk include acceptance, avoidance, and control. You can accept the risk and take the loss, avoid the risk, or control it through mitigation and contingency.

**Risk:** The potential for occurrence of an event with negative consequences.

Risk = the cost of a negative event × the probability of the event happening.

**Mitigation.** Mitigation is a before-the-fact technique. It requires analyzing what could happen, the probability that it will happen, and how damaging the results would be. The aim is to put policies and procedures in place to monitor any events or circumstances that might trigger risk events and to prevent them, control them, or lessen their severity. Analysis of financial data is one way to monitor risk and quantify results.

**Contingency.** Contingency is an after-the-fact technique. It involves having plans in place that can be quickly mobilized if the unfortunate event occurs. By carefully identifying possible risks, you may be able to identify possible solutions. Contingency provides a “cure” for the consequences after a negative event has occurred. It is wise to build schedule and budget reserves into project plans to cover risks that cannot be mitigated.

Guidelines for preparing a risk management plan appear in [Appendix G](#).

## DOCUMENTATION OF FINANCIAL TRANSACTIONS AND AUDIT TRAILS

All financial transactions must be thoroughly documented, from the initial approval to final payment. This includes approved purchase orders, shipping receipts, and dated and itemized vendor invoices. All transactions must be traceable to the financial reports and bank records. This is generally done by assigning a unique transaction number to each financial transaction that flows from the source documentation to the accounting system and subsequent reports.

All transactions should show prior approval by the appropriate, authorized director or activity manager. Prior approval is an essential element of financial control. If approval is not in place until after the transaction has occurred and the check is being signed, it is too late to prevent an unallowable use or misuse of funds. Box 6 offers ways to be certain that approval is warranted.

The documentation should make the purpose of the expenditure and, when applicable, the appropriate donor contract or funding source clear. If activity-based cost accounting is used in your organization, the activity and its assigned code should appear on the documentation.

### BOX 6. Questions to Ask During the Approval Process

- Are the desired goods or services required for the activity or for general operations?
- Is this transaction in accordance with the organization’s policies and donor requirements, and with the rules of law?
- Is the pricing reasonable?
- Is there money in the budget to support this cost?
- Does this cost represent the best interest of the organization and those it serves, rather than the personal aims of staff or management?

## ILLUSTRATIVE DOCUMENTATION BY EXPENSE TYPE

Invoices should be issued to the organization and not to individual employees, except for travel reimbursements, which will be in the name of the traveler. This indicates that the costs being billed are business, not personal, expenses.

In addition, all receipts and invoices must clearly identify the name and address of the vendor issuing the invoice, full details of the goods or services that were provided, and the itemized costs. Vouchers should be used. A voucher is a cover sheet that provides an at-a-glance summary of the transaction: check number, amount, account coding, activity coding, date of transaction, and approval.

**Salaries and employee benefits.** Documentation needed to pay salaries and provide benefits includes:

- signed, dated, and approved timesheets for each employee;
- spreadsheets or other records indicating deductions for taxes or other withholdings;
- records showing, by employee, paid time off, pension, and other benefits;
- documentation regarding pay increases, approved by an authorized official;
- documented personnel policies and salary scales that outline the benefits an employee is entitled to and the withholding to which an employee is subject.

**Consultant or subcontractor payments.** The following documents should be required for these payments:

- a copy of the signed contract or consultant agreement outlining the payment terms and requirements for acceptance of the technical services;
- a scope of work;
- an invoice from subcontractor or consultant;
- written approval by the technical supervisor that the work is completed and its quality is acceptable.

**Materials and supplies.** Paying for materials and supplies requires:

- an approved purchase request or requisition order;
- an approved purchase order;
- a detailed vendor invoice;
- proof of receipt of all goods in usable condition and as specified;
- approval of the final costs and coding.

**Rent and occupancy costs.** Documents should include:

- the signed lease agreement;
- detailed bills from utility companies;
- rent receipt.

**Equipment and capital assets.** These are generally costly items that are durable and have a useful life of more than one year. The organization or its funder sets thresholds for the cost and useful life of equipment and other capital assets. There should be:

- a documented procurement process, including technical specifications, price quotes, and selection notes;
- approval of the board of directors or tender committee, if applicable;
- a vendor invoice;
- proof that the item was delivered and was in acceptable condition;
- information enabling you to trace assets to inventory records, such as serial numbers, model numbers, asset descriptions, date put into service, cost, and physical location of the asset;
- details about the disposition or retirement of assets that are no longer serviceable or needed.

**Travel expense reimbursements.** If travel expenses are paid directly by staff and reimbursed by the organization, the following documentation should be required:

- travel expense claims signed and dated by the traveler, including a complete itinerary stating the purpose for the trip;
- lodging receipts, if applicable;
- receipts for other travel costs such as taxi fares, airplane fares, and payments for visas;
- proof that the travel was approved by an authorized person or the donor before the trip.

In addition to documentation related to specific financial transactions, it is essential to have well-documented financial and operational policies and procedures. They provide the framework within which your staff perform their duties, and they set expectations for performance. These policies and procedures also provide the background against which your organization will be audited and held accountable by management, owners, and funders.

Funders often require clear, documented policies and procedures to provide evidence of a controlled environment and to assure that assets will be treated in accordance with sound management practices and in a manner that supports the mission. The importance of policies and procedures and guidelines for establishing and documenting standard operating procedures (SOPs) are discussed in the section [“Using Policies and Procedures to Enhance Internal Control.”](#)

## Conflicts of interest and unethical conduct

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A conflict of interest exists when a person in a position of power or trust has competing personal or professional interests that make it difficult to carry out his or her duties impartially. For example, an employee could exploit his or her professional capacity for personal or professional gain by working for a competing employer.

A conflict of interest can exist even if it does not result in any improper acts. If the public might consider a relationship or action to be improper, even this possible *appearance* of a conflict of interest must be avoided.

## TYPES OF CONFLICTS OF INTEREST

Several situations can create a conflict of interest or the appearance of a conflict of interest:

- Outside employment can cause the interests of one job to conflict or compete with the interests of the other.
- If a spouse or close relative is employed by a firm selling goods or services to your organization, an impartial decision may be, or appear to be, impossible.
- Hiring or promoting a close family member can appear to be nepotism—favoritism based on a family relationship.
- Gifts from friends or associates seeking to do business with your organization could be, or appear to be, a form of bribery.
- If a purchasing agent is given a bonus based on how much purchasing is under budget for the year, the financial incentive may motivate that person to purchase substandard items at the lowest price rather than to seek goods that represent the best value for the organization.

## OTHER IMPROPER ACTS

The use of organizational or government assets and equipment for personal use or benefit is generally considered unethical. Such use constitutes fraud.

## WAYS TO MITIGATE CONFLICTS OF INTEREST

The best way to handle conflicts of interest is to avoid them entirely, but this is not always possible. Ways to limit the influence of conflicts of interest include the following:

- **Recusal:** abstaining from participating in an organizational decision in which one has a real or apparent conflict of interest.
- **Disclosure:** publicly identifying any potential conflicts of interest so that it is clear if a decision might be unduly influenced.
- **Third-party evaluations:** hiring an independent, well-qualified, respected firm to make an organizational decision when the person who might otherwise make the decision has a conflict of interest.
- **Codes of ethics:** written guidelines that spell out expected behavior, actions to be taken when a conflict of interest exists, and prohibited acts.

Evidence of potential conflicts could cause donors to withhold business or lead competitors to file a complaint or make a public statement that damages the reputation of your organization. If public funds are used, claims of corruption could lead to legal suits, fines, or even prison terms. In addition, if your staff members feel that procurement staff are benefiting personally from their positions by receiving gifts or privileges from vendors for themselves or family members, low morale can damage the atmosphere and performance of your organization.



Chapter 3 of this handbook includes discussion about preventing conflicts of interest, especially for board members.

## PREQUALIFICATION OF VENDORS

Although it is recommended that your organization use full and open competition to select vendors, doing this for every transaction can be time consuming and costly. One common technique that is useful for recurrent purchases, such as for office supplies or travel services, is prequalification.

To prequalify a vendor, follow the full procurement process to select a vendor that provides the best value for specific types of goods or services. Once the selection is made, this vendor can be qualified as the vendor of choice for that type of goods or services for a specified period (generally one year or less) and within a specified cost range. Using a [blanket purchase order/agreement](#), you can use this vendor for future similar purchases without obtaining additional quotes or bids.

The process used and the prequalification criteria, including provision for review and recertification, should be thoroughly documented. This streamlines the process and saves time and effort.

## Procurement management

Procurement encompasses the processes for purchasing or contracting for services and goods, including medicines and contraceptives. These processes may include commercial goods and services widely available in the marketplace or specialized technical services provided under contract by consultants and contractors.

Because a significant amount of your organization's financial resources is likely to be committed during the procurement process, sound procurement practices are critical. Policies and procedures should be in place to guide spending that is appropriate and ethical, and free from corruption, fraud, or employee self-interest. If public or donor funds are used, procurement may be subject to strict laws and regulations that prohibit bribery and acceptance of kickbacks (defined in Box 7) and require disclosure of potential [conflicts of interest](#).

### BOX 7. What Are Kickbacks?

Kickbacks are payments or other types of compensation made to influence and gain profit from an individual or company. In essence, kickbacks are bribes paid by potential vendors. An individual or company uses kickbacks to gain an unearned advantage, benefit, or opportunity over other potential suppliers, even if others are more qualified or offer more competitive prices. Both the giving and receiving of kickbacks are considered a crime in many countries because kickbacks interfere with the functioning of competition in the marketplace and with offering “a level playing field”—an equal opportunity—to all potential suppliers.

Your organization's policies and procedures for procurement must be documented in writing and shared with all staff in the position to purchase goods or services for the organization. Procurement policies and practices must comply with local law, generally accepted accounting practices, and donor requirements, when applicable.

Policies and procedures should also reflect the philosophy and values of the organization and its funders. Finally, procurement policies and procedures should be in the best interest of the organization but flexible enough to deal with additional requirements if you have multiple donors.

Two other basic principles apply to all procurement activities:

1. Personal preference should not factor into the purchasing decision. All offers should be considered objectively.
2. Procurement must be—and appear to be—open and fair. The organization is using other people's money, whether it comes from a donor, private contributors, owners, or stockholders. Proper stewardship of these funds is essential.

The use of donor or government funds might require additional rules or levels of complexity, including some that conflict with your organization's common practices or the standard business practices in your location. The organization must weigh its willingness and capacity to conform to these rules before accepting the funds. If you do accept the funds, your organizational policies, procedures, and operating structures must guarantee compliance with those requirements.

## ESSENTIAL PROCUREMENT PROCEDURES

There are several procedures that an organization must follow when procuring goods and services:

- All procurements must be properly authorized before purchase, based on the internal controls and signatory authorities established within the organization.
- Procurements must be reasonable and necessary for the activities or operations.
- There must be adequate funding available to cover procurements. If funds are not in the budget, they must be raised, or a decision must be made to reduce or eliminate other costs.
- Purchase orders should be issued for the purchase of all goods except those purchased with petty cash. Purchase orders form the basis of an agreement between the organization and the vendor, spelling out the rights and responsibilities of both parties.
- The items purchased should be most advantageous to the organization when price, quality, and other factors are considered. The focus is on obtaining the best overall value and not necessarily the lowest price.

Open competition involves seeking multiple bids from potential suppliers, to help you obtain the lowest prices or best value. Open competition helps prevent collusion between

purchasing agents and vendors that could lead to price fixing, bribery, kickbacks, or other unethical conduct. The level of competition should reflect the level of risk the organization faces and the consequences of an improper practice.

## ELEMENTS OF SOUND PROCUREMENT PRACTICES

Common sense and practicality are important assets in developing procurement practices. For the sake of efficiency, processes and documentation requirements should not be more cumbersome than necessary for the risk involved. Generally, procedures cover various spending levels and become more detailed and complex as the risk increases. The processes should be applied uniformly for all purchases of a similar nature, scope, and size—regardless of who is receiving the goods or services.

Your organization should strive to select goods and services that provide the best value and recognize that value does not necessarily mean the lowest price (see Box 8). Purchases should provide quality for the money spent, meeting but not necessarily exceeding the selection criteria.

The criteria used and the analysis of the offers should be in writing and kept with the procurement files. A selection note is used to document how the selection was made and what criteria were considered. No conflict of interest should exist, or appear to exist, that prevents impartial selection or results in certain staff members reaping personal gain.

Items to be purchased must be clearly defined with technical specifications or a scope of work. This reduces risk, helps you obtain what you need, and clarifies your expectations for the vendor.

The correct use of procurement instruments—purchase orders, consultant letters or contracts, and subcontracts—is discussed in detail in a [subsequent section](#).

### BOX 8. Obtaining Best Value

Although obtaining a low price is always desirable, there are other factors to consider when determining which vendor is offering the best value. These factors include:

- the quality and features of the proposed goods or services;
- the availability and time of delivery of needed goods or services;
- additional costs, which must be added to base prices to reflect the full cost of an item. Examples are:
  - delivery and installation charges;
  - anticipated costs for routine maintenance, service, and replacement parts;
  - hidden costs related to inefficient operation of equipment, delays in delivery, or poor quality that affect other processes;
  - reputation of the vendor and its policies and practices related to warranties and guarantees;
  - payment terms.

Involve those who will use the goods or services to help you analyze quality and hidden costs and determine the best value.

## THE PROCUREMENT CYCLE

Procurement generally follows the sequence of events outlined below:

1. Determination of need, as determined by asking:
  - What goods or services will be required?
2. Determination of procurement strategy, as determined by asking:
  - What type of purchasing mechanism will be used (e.g., purchase order, contract)?
  - What level of competition is required?
  - What policies and procedures are applicable to this type and magnitude of purchase?
3. Issuance of solicitation document, which generally includes:
  - a scope of work for services;
  - technical specifications for goods;
  - the selection criteria that will be used.
4. Selection of vendor, which should include documentation of how and why the choice was made, especially if the vendor does not offer the lowest price;
5. Negotiation of price and terms;
6. Final award of contract or purchase order to vendor;
7. Receipt of goods or services;
8. Closeout, acceptance, and payment, followed by filing the procurement documentation.

## SOLICITATION REQUIREMENTS

Solicitations are requests issued to potential vendors when you wish to procure services, commodities, or other products. The format and content of the solicitation will vary, depending on the complexity of the proposed purchase. However, all solicitations should include:

- a clear and accurate description of the technical requirements for the material, product, or service to be procured:
  - In competitive procurements, such a description should not contain features that unnecessarily restrict competition to a specific brand or individual.
- requirements that the bidder or seller must fulfill as well as any other factors used to evaluate bids or proposals;
- a description, whenever practical, of technical requirements: functions to be performed or performance required, including the range of acceptable characteristics or minimum acceptable quality standards;
- the specific features that bidders are required to meet when such items are included in the solicitation;
- if desired, features such as energy efficiency, environmental friendliness, or other factors that are specific to the values of the organization.

Two common forms of solicitations are a request for quotation and a request for proposal, as described below.

**Request for quotation (RFQ).** RFQs are generally used for commercial goods and routine services. A vendor is asked to state the cost of the described goods or services. The vendor may also be requested to provide additional information, such as delivery time and charges, maintenance fees, and installation fees. You should let the vendor know which elements will be considered in the final selection process. The quotations provided are nonbinding but may become the basis for a binding purchase order.

**Request for proposal (RFP).** RFPs are generally used for procuring technical services. The resulting offers presented by potential vendors are binding, generally within a disclosed time frame. An RFP provides considerable detail about the work to be performed, the terms of delivery, and other criteria that must be met. If you take the time and care to craft a clear and comprehensive request, the result should be high-quality offers that can be easily evaluated.

## PROCUREMENT INSTRUMENTS

A procurement instrument is a document or contract that binds the organization and vendor and details the terms of the sale. The type of procurement instrument used should be appropriate to the goods or services being purchased. It should provide all details required by the vendor to guarantee that the desired goods or services are provided within the time frame required. It should also document the price and payment terms agreed upon and any provision for cancellation or modification. These details help eliminate potential confusion, legal disputes, and financial claims.

Several common procurement instruments are outlined below. We have not provided specific examples because countries' legal requirements vary, and donor constraints might need to be included, if applicable. We have included the elements that you should include in each instrument to guarantee that it is accurate and adequately documented and that there is a clear understanding between your organization and vendors. The forms you use should be customized with your organization's logo, address, and contact information.

**Purchase orders** are generally used for the procurement of commercially available goods. They outline:

- the quantity and description of items to be provided (might include part or model numbers);
- the date by which the items are required to be delivered;
- the quoted price;
- payment and billing terms;
- delivery instructions.

A **purchase order** for services may be used for the procurement of administrative and support services such as accounting, office cleaning, office security, secretarial services, or legal services. These services are commercially available in the marketplace. A purchase order for services may also be used when the outcome of the service is more like a product. Training materials and translations of documents are examples of such products.

A purchase order for services generally outlines:

- the period of performance;
- a scope of work or terms of reference;
- the supervisor for the work;
- a list of any deliverables, such as a report, that must accompany the work;
- the price to be paid;
- payment and billing terms.

**Consultant letters** or **contracts** are used to procure short-term technical services from an individual. Such individuals are independent, and not the employees of other organizations or government agencies. Technical services are related to the organization's core mission and program activities. Such services could be provided by a staff member, but they may be procured from an external source for one or more reasons, as follows:

- The organization is short staffed.
- The service is required only for a short time and does not warrant hiring long-term staff.
- The organization's staff members lack the expertise or skills needed for the service to be provided.
- Training staff to perform the service is more expensive and less efficient than hiring an expert on a short-term basis.

Consultant letters or contracts generally specify:

- the level of effort the consultant is expected to provide (normally expressed in days);
- the daily rate to be paid for the services;
- an agreement on any travel or out-of-pocket expenses that can be reimbursed;
- the period of performance, the dates during which services are to be performed;
- a detailed scope of work that outlines the nature of the services to be provided;
- a list of related deliverables that must be provided, such as reports;
- a technical supervisor in the hiring organization;
- billing instructions, including to whom the invoice should be sent and by when.

A **subcontract** is used to procure technical services from an organization. Payment is made to the recipient organization, which subsequently compensates the individuals who provided the work. The solicitation should state what kind of contracting instrument will be used for the award. Fixed price or cost reimbursement subcontracts are the two most common types of subcontracts.

- A **fixed price subcontract** pays the organization providing the services a flat fee, regardless of the actual cost the organization incurs to provide the service. A fixed price award is less burdensome to administer, but it requires that both the offerer and the purchaser have sufficient knowledge and information to agree upon the fixed price.
- A **cost reimbursement subcontract** reimburses the provider for all costs actually incurred in providing the service, up to an authorized limit.

All procurement agreements, such as purchase orders for services, consultant agreements, and subcontracts, must be negotiated and signed *before* the work begins. Following this process means that all agreed-upon terms and prices are accepted before funds are committed.

## PURCHASE REQUESTS

Purchase requests are internal control documents used by a staff person who identifies the need to purchase a good or service. This form is a means of obtaining prior approval from the budget holder or authorized manager and beginning a procurement process.

Purchase requests can be made through memos or email, but a standard form is recommended to summarize all the required information and serve as a vital piece of documentation for the procurement file. Purchase requests should include:

- complete and accurate specifications for the good or service to be purchased, including pricing information, when available;
- the quantity required;
- any associated services that are necessary (e.g., installation, ongoing maintenance);
- possible suppliers, if appropriate or known;
- the intended recipient and destination for delivery;
- the date by which delivery is required;
- any special contractual requirements;
- any special selection criteria.

An approved purchase request begins the procurement cycle and provides the initial information required by the purchasing agent or tender committee.

## Travel management

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In many ways, travel policies and procedures follow all the guidelines established for general procurement because transportation, lodging, and related services are being procured. There are some elements specific to travel, however, that you should consider.

Before you undertake improvement of travel procedures, analyze the types of trips your organization's staff take most often, as well as the factors below.

- Is most travel related to attending meetings or running errands in the local area? Travel to rural or remote regions to conduct program activities? International travel to attend conferences?
- Is travel conducted by most members of the staff, or is it limited to senior management?
- Are travel costs funded by donors? Donors often impose strict policies for travel and related costs.
- Does your organization own vehicle(s)? Are staff expected to use their own vehicles for business travel?

- What public transportation is available, and what is the state of the transportation system?
- Does your organization face other travel-related concerns?

## COMPLYING WITH LAWS AND REGULATIONS

First and foremost, you must draft travel policies that require adherence to local laws and donors' requirements and put procedures in place so that these policies are consistently followed. If your organization has multiple funding sources, travel policies should either satisfy all requirements or be well documented and capable of being adjusted to comply with varied funding circumstances.

Some common requirements address:

- registration, taxation, and insurance of vehicles owned by the organization;
- liability insurance to cover medical costs and other costs of passengers if your organization's vehicle is involved in a traffic accident;
- policies regarding safe operation of vehicles, such as a prohibition against drunk driving and a requirement that drivers and passengers wear safety belts;
- limitation of the use of vehicles provided or supported by donors to official, not personal, use;
- restriction of travel costs (transportation and lodging) to economy or standard class, with business class allowed in some circumstances. (Most donors prohibit using their funding for first-class or luxury-class transportation and lodging so that more funding is available for program activities.)

Often donors and governments establish rates or methodologies for reimbursing staff for meals and other travel costs incurred during work-related trips. Procedures and policies must be established to ensure compliance with these regulations.

Your organization should also consider whether these policies will apply to travel funded through other sources. There are benefits to having a uniform travel policy, but implementing highly restrictive donor rules for all travel undertaken by the organization may not be in its best interest.

## SETTING STANDARDS AND RATES FOR PER DIEM

If per diem and travel cost thresholds or policies are not prescribed by donors or government agencies, your organization will need to establish its own criteria. Among the elements to consider are the needs of the traveler:

- What types of business facilities will travelers require? Work demands often make services in hotels such as reliable Internet connectivity, well-equipped meeting rooms and conference centers, and other business services an essential element of travel.
- Are staff traveling to foreign areas? Will language, food requirements, or religious or cultural factors affect the choice of acceptable hotels or the costs of food and incidental travel expenses?



- What means of transport or agreements regarding travel days, stopovers, and the like will guarantee cost-effectiveness and the safety, well-being, and productivity of the staff?

### KEEPING STAFF AND VEHICLES SAFE

Travel policies should include elements that safeguard the safety of the staff while in the organization's vehicles or while using public transportation. These policies will be influenced by the local environment. Common prohibitions, requirements, and limitations include:

- prohibiting or limiting travel after dark or on certain roads;
- prohibiting driving violations, such as speeding, and requiring staff to pay the fines for any violations from personal funds;
- requiring staff to wear safety belts;
- requiring that vehicles be adequately maintained and carry spare tires, basic tools, and first-aid supplies;
- requiring that company vehicles or rented vehicles be driven only by drivers who have proper training and experience, as well as any required licenses or permits;
- requiring that vehicles be guarded or otherwise secured at night or while drivers are waiting for passengers;
- limiting the types of local transportation that may be used and under what circumstances;
- limiting the use of low-cost airlines and transportation providers that have or have had known safety violations;
- requiring the selection of hotels or other lodging choices that provide adequate safety, security, and access to administrative services.

### GUARDING AGAINST EXCESS AND ABUSE RELATED TO TRAVEL

Travel costs are closely watched by donors and the public because they are common areas for excess and abuse. General principles to apply are:

- All travel charged to your organization or passed on to donors must be for costs required to conduct or oversee program activities.
- Costs should be ordinary, necessary, and reasonable for meeting the planned work, considering the answer to three questions:
  - Is the proposed travel necessary? Could a telephone call or email achieve the same result?
  - Can the travel be coordinated with other travel needs?
  - What is the most cost-effective means of travel? Time for travel should be considered when calculating the cost. A bus ride that takes a full day may not be the most cost-effective mode of travel if a one-hour flight is available.

You will need to be attentive to the following:

- **Costs for premium-class transportation and lodging, and travel by family members:** Such costs are closely scrutinized. Costs that cover staff members' spouses and family members or weekend and holiday travel are also scrutinized. Travel by senior managers and board members is of special concern because this travel often can be a “perk” or benefit, rather than a necessity for work.
- **Costs for meals:** Meals should be reasonable for the work and location, but not lavish. The organization should consider whether the cost of alcohol will be allowable for work-related travel.
- **Flat rates versus reimbursement:** Whether the organization pays the traveler a flat rate or reimburses actual costs should be considered. Flat rates are generally easier to administer. They involve giving travelers a fixed amount per day to cover meals and lodging. A hybrid method is commonly used: it fixes the rate assumed to cover meals and small incidental costs, but reimburses only actual lodging costs, up to a maximum limit. Local law should be consulted because flat-rate per diem schemes often have income tax implications. For example, many countries impose income tax on meal allowances that exceed the actual costs of meals. [Appendix H](#) provides a guide for creating a per diem scheme.
- **Receipts:** Travelers should be required to provide original receipts that prove that they actually spent money for such services such as meals and lodging costs and transportation. Alternatively, a fixed daily allowance may be provided to cover meals, without presentation of receipts. The daily allowance must cover normal meals in the area where travel is conducted.

Finally, policies concerning travel must be fair for all staff. Any impression that travel and per diem are benefits for senior staff is likely to have a negative effect on staff morale.

### PRIOR APPROVAL FOR TRAVEL AND TRAVEL PLANNING

In general, travel policies should require that all but routine travel be approved in advance. In addition, it is wise to require that adequate time be allowed to plan all but emergency travel. Prior approval is an internal control element for all procurements; some donors require prior approval.

Prior approval means there is an opportunity to assess if the travel is necessary for program activities and if there is adequate money in the budget to support the travel. In addition, planning travel well in advance allows the best chance of obtaining reasonable rates for transportation and lodging. Reasonable choices often sell out first. Transportation, especially airfare, often has much higher rates for last-minute purchases.

Starting early also provides an opportunity to plan coverage for needed tasks while the traveler is out of the office. Planning for the use of the organization's vehicles makes it possible to coordinate conflicting requests and combine trips and/or routes in a way that conserves time and fuel.

## TOOLS FOR TRAVEL MANAGEMENT

Some basic forms should be in place to manage and control travel, as follows:

- **Travel authorization form.** This can be a modified purchase request form. In addition to obtaining permission for the travel from an authorized manager, the form should also be used to approve specific travel elements, including transportation, lodging, and meals or per diem.
- **Travel logistics form.** This may be a separate document or built into the travel authorization form. This form is used to gather details about the traveler's needs: travel dates, lodging requirements, transportation needs, and other costs such as conference rooms.
- **Travel expense report.** This form is used for reporting actual costs incurred. Original receipts are submitted with the form.

These forms will differ from organization to organization because they should reflect an organization's policies and work flow. Whether forms are paper or electronic, they must facilitate gathering and documenting essential information as well as approval from an authorized manager or budget holder.

## Asset management

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**Fixed assets** or **capital assets** are tangible, durable goods that are generally expensive and have an expected useful life of at least a year. Common fixed assets are furniture, office equipment, computer equipment, and vehicles. Cost thresholds and lifespan (for example, \$1,000 unit cost and useful life of one year) are often established in local tax laws and generally accepted accounting principles and are linked to rules related to depreciating costs in accounting records.

Funders may impose their own definitions and thresholds, which may differ from the standards set by an organization. If your organization has multiple donors, you will need a robust system for tracking capital assets, including who ultimately owns the asset. Often the donor retains the ownership title.

### DEFINING CAPITAL ASSETS

An organization may set a standard definition for all fixed assets, or there may be different thresholds for different types of assets.

The first component of a capital asset policy should be the definition(s) the organization will follow in determining which assets are capital assets. Defining capital assets should be done in collaboration with the accounting team or external auditors to ensure compliance with local law. The policy should detail types of assets, cost thresholds, and lifespan and should include a requirement that these definitions be applied consistently and uniformly. Procedurally, the accounting records should have separate accounts for tracking the various types of capital assets and their associated depreciation.

## TRACKING CAPITAL ASSETS

In addition to the tracking that occurs through the accounting records, fixed assets must also be tracked through more detailed records and physical inventories. Some office furniture and equipment may not meet the organization's definition or thresholds for capital assets; items such as mobile telephones, office furniture, printers, and some computers may not be expensive enough to include in the capital asset register.

It is reasonable, however, to maintain a record of these items in some type of register to avoid giving the impression that they are not controlled, which might open the door to improper use or theft. For adequate management and control, details about the items, their location, and the staff member who has been entrusted with them should be documented.

All items purchased or received through donation that meet the definitions of capital assets should also be documented in an asset register. The register should include:

- a detailed description of the item;
- a unique identification number assigned by the organization and marked on the asset itself, making it easier to track multiple similar items;
- the date the item was purchased or received;
- the date it was disposed of or taken out of service;
- vendor information;
- model numbers and serial numbers, if applicable;
- location where the item is put into service: the office, the employee who has custody, etc.;
- title or ownership:
  - If an item was received from or paid for by donors, you should be careful to observe any rules about who has title to assets that might be included in the donor agreement. For example, the donor may retain ownership and request the items back at the end of a project or stipulate that they be delivered to another recipient.

**The asset register.** The register may be a handwritten ledger, computerized spreadsheet, or set of inventory cards. However, it is highly recommended that a computerized database or spreadsheet be used because it makes it much easier to sort and report on the data.

The asset register should be updated frequently, preferably as soon as the items are received or paid for. External auditors may ask to review the asset register to test the accuracy of the accounting records and depreciation costs.

It is important to have the asset register verified at least once a year through a physical inventory. The inventory should be conducted by an independent source, not the person in charge of receiving the assets or updating the register.

When assets such as computers or mobile telephones are given to staff, the recipients should be required to sign a document that indicates that they received the items and that they agree to safeguard them, use them only for work-related purposes, and return them when they terminate their employment. A copy of these documents should be kept in the

employee's file. Upon termination, return of the items should be verified before the organization makes final payments to the employee.

Items that are used only occasionally, such as an LCD projector, should be kept in a secure, preferably locked, place. Staff should be required to sign the item out when they use it. The office manager or assigned custodian should verify that the item is returned to stock after use.

Policies should document the consequences if staff fail to safeguard or return your organization's assets. These consequences often involve a requirement that the staff person replace or pay for the repair or replacement of missing or damaged items. If the staff person leaves the organization without returning an asset, his or her severance pay or final wages may be reduced to cover the loss or damage.

## Cash management

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To follow the general principles of cash management, your organization should:

- store petty cash securely in a safe or locked box;
- limit access to cash and restrict its use;
- follow a complete procurement process to the greatest extent possible, and pay for purchases by check;
- implement a system for tracking cash advances issued and collecting overdue outstanding advances;
- provide evidence that cash was actually disbursed for the stated purpose and received by the intended recipient;
- use reputable banks or exchange houses for currency exchanges and document exchange rates;
- make sure employees use caution when transporting cash and limit the amount of cash they carry on their person;
- record all cash transactions in the accounting records and reconcile accounts monthly;
- limit access to bank accounts to the president, chief financial officer, chief of party or senior technical officer, and operations or finance manager;
- authorize the board or management committee to open a bank account;
- maintain a copy of bank records in the organization's records;
- permit expenditures for allowable work-related costs only, prohibiting personal expenses or expenses that are deemed unallowable by donor agreements.

### CASH ADVANCES

Cash advances are generally issued to cover travel costs but may be issued to cover other work-related expenses that a staff member will be expected to pay for in cash. A request for an advance must include documentation about the purpose of the advance, and it must be approved by the appropriate manager.

A cash advance given to staff is a debt obligation between the individual and the organization. It should be limited to an amount that can be readily recovered, such as one month's salary. The terms for repayment or for clearing the advance through presentation of receipts and other documentation should be clearly defined.

The organization should set a policy about whether advances will be given against future wages, and, if so, under what circumstance. This is often not practical or allowable, and it is recommended that it be limited to extraordinary circumstances, such as catastrophic illness. The circumstances of such loans should be documented in the employee handbook and considered part of the employee benefits package.

## PAYMENTS

For internal control purposes, almost all payments should be made by check or bank transfer. Payments that cannot be made by check but are larger than conventional petty cash transactions require complete documentation about the nature of the expenditure, as well as a signed and dated receipt showing that the cash was received by the intended recipient.

Blank checks should not be signed. A check should not be issued payable to cash but in the name of the person who will cash it. This practice prevents misappropriation if the check is lost or stolen.

All voided checks (checks to be destroyed because of a mistake) must be accounted for in the accounting records and the physical check rendered unusable, to prevent fraud. This is done by writing across the face of the check and removing any signature.

Put in place systems to make it possible to take advantage of any prompt payment discounts and to prevent incurring finance charges or late fees for failing to pay on time (these may be unallowable expenses). It is also necessary to guard against duplicate payments.

## USE OF PETTY CASH

Petty cash is used for small, routine, or urgent purchases only and not as a means for avoiding the prescribed procurement systems and practices. Petty cash should be maintained as an **imprest fund**, meaning that the amount of cash and receipts in the fund must always equal the established fund amount. Petty cash is replenished only for the amount of completed receipts on hand. Although petty cash funds may seem inconsequential, they often provide temptations and are prone to misuse or inadequate controls, which can lead to financial losses over time.

Good practices for managing petty cash include the following.

- Keep petty cash in a locked box or safe and authorize access by a limited number of staff.
- Keep minimal amounts of cash on hand. The total fund should equal no more than approximately one month of anticipated petty cash needs, and it may be prudent to maintain a lower level.

- One person only should be the custodian of petty cash. For good segregation of duties, this is generally someone other than the accountant.
- Obtain signed receipts for advances issued from petty cash. Such advances should be small and very short term, generally for same-day purchases.
- Whenever possible, obtain receipts from vendors and attach them to the petty cash slips. If it is not possible to obtain a vendor receipt (for example, from a taxi driver), simple receipts, which may be purchased from an office supply store or printed on a computer, may be used.
- Someone who is not the custodian of the petty cash fund should reconcile and replenish the petty cash fund at least once per month. Someone else should approve the reconciliation and sign the replenishment check.

## Internal control requirements and guidelines

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All CSOs, NGOs, government agencies, and for-profit entities engaged in providing health services have the same obligations to their constituencies, whether they are citizens, taxpayers, owners, donors, or stockholders. These organizations are responsible for fulfilling a mission, often for the benefit of the most vulnerable populations. To carry out their responsibilities, they must have adequate management and operating systems, good internal controls, and competent staff. Services, materials, and supplies must be available for staff to carry out planned activities. Organizations must be able to account to donors and the larger society concerning the efficient and appropriate use of resources.

With the similarities in their obligations come similar desires and constraints.

- Each organization has a vested interest in protecting its assets—including cash, equipment, and real property—from theft, fraud, and misuse by management, staff, and people outside the organization.
- Donors want assurances that their funds will be used and managed wisely before they entrust them to a contractor or grantee.
- Boards of directors, government agencies, donors, and external credit sources want assurances that financial statements are accurate and timely.

This section explains the concept of internal control and the importance of supporting it with clearly documented policies and SOPs.

**Internal control** is an operating structure and a system of management policies and processes designed to provide reasonable assurance of:

- effective and efficient operations;
- control over and accountability concerning assets—including cash and equipment and other property—to safeguard against loss, theft, misuse, or unauthorized disposition;
- the reliability of financial reporting based on financial transactions that have been properly executed, recorded, and allocated;
- compliance with internal policies and procedures, generally accepted accounting principles, and sound management practices;
- compliance with donors' contract provisions and government statutes.

Adequate internal control is a function of sound policies and well-documented procedures as well as staff who are trained regarding these requirements and agree to comply with them. All staff should be trained in the procedures they will be called upon to use, including travel, timekeeping, and purchase requisition.

## ELEMENTS OF INTERNAL CONTROL

In addition to establishing policies and procedures and conducting training, organizations exercise financial control by creating a controlled environment and segregating people's duties. These elements are discussed in subsequent sections. Other internal controls generally address administrative, accounting, and data processing functions.

- **Administrative controls** relate to decision-making and transaction authorizations, for example, the approval of timesheets, travel authorization, or approval of purchase orders.
- **Accounting controls** detect errors before financial transactions are recorded. Financial transactions include sales, purchasing, receipts of cash from sales or funding sources, payment of payroll, etc. Such controls ensure that the entries are in accordance with accounting standards, mathematically correct, and properly charged to accounts or budgets. Accounting controls help safeguard the organization's assets.
- **Data processing controls** guard against errors that might occur when financial or accounting records are input into computer systems and later reported in financial and managerial reports. Examples include use of passwords and access rights to prevent inappropriate entries, changes, or deletions of data.

Internal controls related to personnel, policies, procedures, and some other aspects of the organization's day-to-day functions are reviewed below.

### Personnel

- Financial responsibilities and authority are defined in employee job descriptions.
- An organizational chart shows lines of responsibility.
- Finance and operations staff possess the needed education, training, and experience to carry out their functions, and they receive supervision and additional training as warranted.

### Policies

- Policies are in place to guard against a conflict of interest, especially if it is related to staff who make procurement decisions.
- All affected staff have access to policy manuals.
- All affected staff are oriented to and trained on organizational policies when they are hired and throughout their tenure, especially when policies are added, modified, or rescinded.
- Policy manuals are reviewed, maintained, and updated routinely.



## Procedures

- Written procedures are maintained regarding financial and accounting practices, account coding, and activity coding schemes (see [Appendix D](#) on coding and [Appendix F](#) on coding structures).
- Written procedures exist for travel and procurement.
- Expenses are controlled through the use of operating budgets, purchase orders, and travel authorization. These systems are documented and uniformly applied to all applicable transactions.
- Subsidiary accounts (accounts payable, accounts receivable, staff advances, and bank and cash accounts) are reconciled to the consolidated general ledger every month. Discrepancies detected during this reconciliation process can indicate weaknesses in the systems as well as possible financial malfeasance. As a manager, you must determine whether the size of a transaction error in a subsidiary account significantly alters the nature of a transaction or quality of a financial report. The cost or effort required to fix the problem may not be worth the effort.
- Financial records are subject to internal and/or external audit routinely, preferably once a year. All variances from budgets or expected results are documented and reconciled promptly, and disciplinary action taken when warranted.
- Standard forms and templates, such as travel authorizations, purchase orders, timesheets, and leave requests, are used for planning and documenting routine administrative activities.
- Procurement policies are documented and applied consistently to enable fair and open competition to the greatest extent practical.
- [Best value](#) is considered when making purchasing decisions.
- Purchasing functions are kept separate from accounting functions.
- Financial transactions and related operational activities are approved before the organization commits resources and in accordance with approved work plans and operating budgets.

## Other Elements

- Checks and cash are maintained in a secure area, generally a fireproof safe, with limited access.
- Records are maintained of any prior approval required by donor agreement. This may include approval for international travel, purchase of equipment, or salaries.
- Records are maintained of any approvals issued by the board of directors.
- Any revisions to policy or procedure that are identified or necessitated through minutes of board meetings, memos from owners or senior managers, or new government edicts are promptly added to the organization's policy and procedure manuals, and staff are alerted of changes in processes.
- Systems are in place to ensure the appropriate business use of supplies, equipment, and other assets.
- Property and other assets are protected or insured to the greatest extent possible against theft, fraud, fire, or other catastrophic loss.

- Someone who does not normally have responsibility for receiving or tracking assets conducts a physical inventory at least once a year to verify the location and condition of all assets.
- Financial records are safeguarded and retained, as necessary.
  - Computerized financial records are archived for future reference and to satisfy tax, donor, and audit requirements. Computerized accounting and operations files are protected from damage caused by power outages and surges and are routinely backed up.
  - Paper documents are maintained in an orderly manner and kept on file for the mandated number of years to satisfy audit or donor requirements. Paper files are protected from fire and water damage.
  - Access to paper and/or computer files is limited to those who have a professional need and adequate authority, and sensitive and confidential files are maintained in password-protected files, locked files, or secure offices.

### CREATING A CONTROLLED ENVIRONMENT

Written policies and procedures for operations and finance must be established, routinely reviewed and updated, and distributed to all staff. It is impossible to hold staff accountable for certain behaviors if expectations are not in writing and training is not provided.

Compliance with the stated policies and procedures is required, and an employee's failure to follow prescribed procedures should be subject to disciplinary action. Breaches are grounds for reprimand or dismissal.

Managers' roles and responsibilities related to financial dealings must be clearly defined in their job descriptions, and the managers must have adequate skills, knowledge, and authority to carry out their responsibilities. This should include nonfinance managers who have responsibilities for managing budgets or approving costs on behalf of their programs and projects. Support and program staff with responsibility for compliance must also be trained and have adequate skills, knowledge, and authority to carry out their roles.

When you and other managers demonstrate respect for policies, procedures, laws, and contract requirements, you will help create the right work environment for staff. As a manager, you must respond to all questioned costs and procedures uncovered during an audit process, whether conducted by internal or external auditors. Problems must be corrected and procedures put in place so that the problems do not reoccur.

**Box 9** summarizes some of the actions your organization can take to create and maintain a controlled environment.

**Monitoring.** Safeguards should be in place to guard against fraud and misuse or theft of assets. Routine monitoring should include report reconciliation (a review tied to other sources such as bank statements or subsidiary ledgers), internal and external audits, and financial analysis to uncover problems and prompt action. Equipment, inventories (including medicines and contraceptives), and cash should be subject to routine physical counts and verified against written records. (See Chapter 8 for a section on inventory management.)

### BOX 9. Creating and Maintaining a Controlled Environment

- Establish and disseminate clear, written policies and procedures.
- Have policies and procedures reviewed routinely and modified as necessary to reflect the current situation.
- Train or retrain staff in the policies and procedures that apply to their work.
- Set aside time and resources to address operational issues and complete necessary tasks, such as procurement.
- Address the human factors that may cause employees to avoid rules and procedures that are time-consuming or restrictive.
- Make sure that staff understand the reasons for internal controls and operational policies; compliance is more likely when the why is communicated.
- Employ a best practices model, engaging staff in a performance improvement activity to strengthen financial and organizational management, rather than simply imposing what might appear to be arbitrary rules.
  - This process is likely to result in the same procedures being adopted and increase the likelihood that they will be followed.
  - When staff members have participated in creating new practices and feel that the practices make them more efficient, successful, and up-to-date technologically, they may be proud to comply, rather than feeling constrained by rules.
- Enforce existing policies uniformly and consistently.
  - Official consequences foster compliance.
  - If some people are allowed to bend or break the rules, others will tend to ignore the rules as well.
- Model expected behavior with regard to compliance with sound financial management principles.
  - If senior managers set an example that shows they value fiscal responsibility and appropriate behavior, the rest of the staff is more likely to exhibit these behaviors as well.
- The computer system(s) used for financial recording and reporting must have data entry controls, access controls, and security controls, including the use of passwords and other mechanisms.
- Computers should be protected—by means of uninterruptible power sources and routine file backup procedures—from damage or loss of data due to power fluctuations. In addition, antivirus and hacking protection should be installed and routinely updated.

Your organization should hire professional external auditors to review financial statements. They generally also perform an assessment of internal control and management systems.

But because auditors may focus more on the internal controls related to accounting, you might want to explore the control systems of broader operational activities, either using the organization's staff or with the assistance of a paid consultant. The assessment tool [QuickStart](#) is a good starting point for this internal review. QuickStart's assessment will provide you with a comprehensive understanding of the basic elements of internal control and cash control that should be present in your organization's accounting and financial management systems.

Prompt corrective action must be taken to deal with irregularities and noncompliance uncovered by monitoring and audit activities. In the case of CSOs, the board of directors is responsible for seeing that this standard management practice is carried out. Chapter 3 of this handbook offers information on the role of the board in providing financial oversight. Staff and donors alike will take notice of leaders' actions, as noted in Box 10.

Organizations with small or inexperienced accounting staff should undertake more frequent or stringent internal or external audit reviews to verify that sound practices are being followed and financial transactions comply with policies and contractual agreements. A grantor or donor will probably require stronger monitoring and audit requirements for such organizations than for those with more experienced accounting staff.

### SEGREGATION OF DUTIES

A fundamental principle of sound internal control is the concept of segregation of duties. See Box 11 for examples. To the maximum extent possible, financial duties should be distributed among staff in a manner that prevents one person from having control over all phases of any financial transaction. Without adequate checks and balances in place the opportunity exists for funds and other assets to be inappropriately used or reported as the result of error or fraud.

Job descriptions should clearly articulate the various roles and responsibilities within the finance and administrative staff. The fiduciary responsibilities of managers, such as authority to sign checks, approve expenditures, or open bank accounts, should also be incorporated into job descriptions. Signatory authority lists should detail any limits to the amounts or types of expenditures that may be authorized. Large financial transactions often require dual signatures.

#### BOX 10. Don't Underestimate the Power of Leadership

- If staff observe senior managers complying with policies and procedures, they will feel more inclined to act the same way.
- Rank and privilege do not come with permission to bend the rules but with the responsibility to model expected behavior.

#### BOX 11. Examples of Segregation of Duties

- The person who authorizes purchases or expenditures does not issue the payments to vendors.
- The person who records transactions in the accounting records does not issue the payments.
- The person who issues checks for payments does not reconcile the cash and bank accounts.
- The person who prepares the payroll does not distribute the paychecks.

Segregation of duties can be difficult in a small organization. A senior manager such as the chief financial officer, at a minimum should approve large expenditures before they are made. The definition of “large” will vary from organization to organization and may be defined by both monetary value and type of expense. However, all purchases of equipment and furniture fall into the large category. It is common for the board of directors to play a role in authorizing the largest expenditures.

In organizations with multiple levels of budgetary authority, there is often a range of thresholds for prior approval that are assigned to the various managerial levels. The roles, monetary limits included in the approval authority, and any limits on the types of transactions that these roles can authorize should be detailed in writing and circulated to staff.

After the transaction has been executed at a lower level, a senior manager should examine the expenditure documentation, sign the checks, and review and approve the bank reconciliation reports.

The use of tender or procurement committees to review and approve substantial purchases also plays an important role in a controlled financial environment. Some segregation of duties can also be achieved by assigning some tasks to nontraditional positions, such as receptionists and secretarial staff.

## Using policies and procedures to enhance internal control

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Clear and comprehensive policies and procedures related to finance and operations are essential to an efficient and controlled work environment. Because they provide the framework within which staff are expected to conduct themselves and carry out various functions, they must be accessible to all staff, part of orientation, and updated as circumstances require.

You can refer to [Box 1](#) to refresh your memory about definitions of policies and procedures.

### THE NEED FOR DOCUMENTATION

There are several compelling reasons why your organization should thoroughly document expectations regarding financial management, office operations transactions, personnel management, and purchasing.

One practical reason, and often the one that initiates documentation activity, is that a potential donor is likely to require such documentation as evidence of adequate business capability. The requested policy documentation will generally cover cash and asset management practices, procurement policies, travel management, and personnel management, including compensation, benefits, and supervision systems.

These policies and procedures vary from organization to organization, due to local law, the environment, donors’ regulations, clients’ expectations, and strategic decisions made

by the board about the use of resources. However, there will be many similarities stemming from compliance with generally accepted accounting standards, common ideas about sound business practices, and ethical conduct.

Auditors are also likely to examine policy and procedure manuals, practices for reviewing and approving expenses, and standard forms and templates as part of their review of your organization's financial situation.

**Benefits of complete, up-to-date documentation.** In addition to pragmatic reasons such as satisfying auditors' scrutiny or meeting donors' requirements, having well-articulated policies and procedures offers important benefits to your organization.

- Policies and procedures provide a framework and context for employees. Without them, work becomes a series of costly and inefficient trials, mistakes, and corrective actions. When policies and procedures are in place, the desired result is more likely to be obtained the first time.
- Documented policies and procedures record for posterity the lessons learned, so that future actions will be completed more easily.
- Written policies and procedures create a framework for holding employees accountable for poor performance or financial malfeasance. Clear policies and procedures help eliminate ambiguities; without them, it is harder to distinguish deliberate attempts to commit fraud or deception from simple human errors or misunderstandings.
- Documented policies and procedures help define the roles, responsibilities, and decision-making authority of staff and members of the board of directors.
- Comprehensive policies and procedures free up your time as a manager to do your job. Subordinates who are clear about their responsibilities are generally free to carry out their work without seeking constant guidance or additional approval.

## HOW TO DOCUMENT POLICIES AND PROCEDURES

If your organization does not have well-documented policies and procedures, creating them might seem like a daunting task involving a review of policies, procedures, and work flows for logic, efficiency, existence of necessary internal controls, segregation of duties, and accuracy. To make the task manageable, it is generally best to start with small pieces, rather than attempting to create the entire policy manual at once.

If you and other managers begin by identifying key activities in each operating area, you can document the policies and procedures related to those activities. For example, purchasing a plane ticket might follow a routine process that you could document by writing down:

- the steps that must be taken to purchase a ticket;
- any rules imposed by the board, senior management, or the donor related to this purchase (such as a prohibition against purchasing a business-class airplane ticket or a requirement to have advance approval for international travel);

- the key players in this process, for example, the requestor, approver, purchasing agent, or vendor;
- definitions for all terms that might be unfamiliar or need clarification.

A sample template for documenting SOPs and capturing the elements of a process appears in [Appendix I](#) of this chapter. The template, which includes hints for completing the form, is a suggested format and model for documenting policies and operating procedures in a comprehensive and clear manner.

We provide this model for organizations that are just beginning the documentation process. If your organization uses a different model to document policies and procedures, we recommend reviewing your format to make sure the following eight elements are present:

1. **Purpose:** What does this policy statement and related procedure define?
2. **Revision history:** Have changes been made to an existing policy or process? If so, record the date, revision number, and reference section, and briefly describe the change.
3. **Positions affected:** Which positions does the policy or procedure affect, and what are the responsibilities involved at each step of implementation?
4. **Applicable policies:** What rules of the organization or donor govern the activity being defined?
5. **Definitions:** What terms and acronyms need to be defined because they might not be familiar to all staff?
6. **Procedure:** What are the detailed procedural steps to follow?
  - a. Include all steps, clearly articulated, to prevent confusion. Having people from different parts and levels of the organization review the procedures is useful.
  - b. Review whether the current practices are logical and efficient. Can steps be eliminated or improved to increase efficiency? Do internal controls need to be strengthened?
7. **Responsibilities:** What roles are played by the various people affected? For example, do they request, approve, implement, or document?
8. **Reference materials:** What copies or links to related forms and other reference materials are needed? These materials will build the knowledge people need to execute the procedures or comply with the policy. The materials may be on paper or in electronic files shared through a computer network.

If any of these elements are not covered by your organization's format, consider modifying it to include them. It is highly recommended that, as much as possible, you use a standard method and format to document all policies and procedures so that your staff become comfortable with the presentation.

Policies may come from a variety of sources:

- decisions made by the board and recorded in board meeting minutes;
- emails or other memos from senior management circulated to staff;
- applicable laws or donor regulations;
- the organization's mission and value statements.



Once the SOP is drafted, it is important to review it carefully and test it with the staff involved in all stages of the process. Obtaining various perspectives will help you see any problems with the process or the documentation.

The review process should include the following questions:

- Is the work flow complete?
- Is the responsibility for each step clearly defined?
- Is the process logical?
- Are adequate internal controls built into the process?
- Is the policy statement clear and accurate?

Your organization will want to verify all policies. Many operating procedures evolve from de facto policies or practices that have never been formally approved by management or reviewed to be sure that they reflect the organization's mission, strategic objectives, and standards. A historical precedent should not become a policy or operational standard without being reviewed and purposefully accepted.

As individual processes are documented, a complete policy and procedure manual will begin to take shape. Generally an introduction, documentation of overarching principles, and a table of contents are all that are needed to complete the manual. Developing SOPs in this way, one by one, results in a manual that is easy to maintain because individual SOPs can be updated without rewriting the entire manual.

## Proven practices

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- Senior management and the board of directors must demonstrate that financial accountability and compliance are expected at all levels of your organization. If it appears that rules apply only to subordinates, compliance throughout the organization is likely to diminish and the possibilities of fraud might increase.
- Organizational guidelines in the areas of financial management and procurement should prohibit fraud and embezzlement, and forbid all staff from giving or receiving bribes and kickbacks or having inappropriate financial dealings with family members.
- Financial policies and standards of practice for essential accounting and office operations functions should be clearly documented and shared with all staff. As a manager, you can make sure that orientation, training, revision, and review occur on a routine basis.
- Financial policies and procedures should be crafted in a way that protects your organization from risk. These policies and procedures should comply with applicable laws and donor requirements and should support the organization's mission and financial goals.



- It is a good idea to seek professional guidance from labor lawyers and taxation specialists to ensure that your organization's policies and practices are in accordance with all applicable laws. These complex areas often fall outside the expertise of staff accountants, and noncompliance or evasion can result in significant penalties or legal action.
- Be sure to hire finance and operations staff with appropriate education and work experience. The risks associated with tax and labor issues and audit findings far outweigh any perceived savings from hiring less specialized staff. Some small organizations obtain high-caliber staff by hiring part-time employees, contract employees, or consultants.
- Good internal control and financial oversight begin long before transactions reach the accounting office. If you dedicate time and resources to making sure that purchasing systems, travel, and office management systems work together, your organization's money will be spent wisely.
- The principles of good internal control and financial oversight should be built into organizational systems. These principles are: obtaining the best value for your organization; adhering to previously budgeted and approved spending limits; and complying with government, donor, or management policies that determine allowable costs.

## Glossary of accounting and procurement terms

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### ACCOUNTING TERMS

**account reconciliation:** Determination of the items or adjustments necessary to bring two or more related statements or accounts into balance. For example, reconciliation is frequently used to balance field accounts with corporate accounts, or bank accounts with corporate accounts.

**accounting:** The language, processes, and procedures of business that are used to measure, record, report, and interpret the financial aspects of an organization.

**accounts payable:** Bills to be paid. *See also* **liabilities**.

**accounts receivable:** Money to be collected from others. *See also* **assets**.

**accrual basis accounting:** An accounting methodology in which expenses are recorded on the books when they are incurred and income is recognized when it is earned, regardless of when cash to complete the transaction actually changes hands.

**activity-based cost accounting:** An accounting methodology that calculates the full cost of an activity, project, or service through the allocation and attribution of support costs.

**amortization:** Reduction of an amount over time, often used to spread major expenditures that were paid in a lump sum over future accounting periods.

**assets:** The cash, property, inventory, and equipment owned by an organization or due from others, such as clients or donors.

**balance sheet:** A record of the assets, liabilities, and equity of an organization.

**balanced books:** The fundamental principle of accounting, by which assets must equal liabilities plus equity. What an organization owes must be offset by what it owns.

**budgets:** Expressions of expected future income and expenses. They are based on historical data, if available, and adjusted based on assumptions about inflation, increases/decreases in income or expenses, and expansion. Budgets are a tool to monitor organizational performance.

**capital assets:** Durable equipment, furniture, and fixtures, generally costly, that are expected to have a long useful life and be available for the organization's use for an extended period. The organization generally sets limits on both the cost and life expectancy of items considered capital assets. *Also called **fixed assets**.*

**cash basis accounting:** An accounting methodology in which expenses are booked when cash is disbursed to satisfy an obligation. Income is recognized when the payment is received.

**cash flow statements:** Financial reports that help managers predict the needs for cash and the timing of income and expenditures. They provide an analysis of the inflow and the outflow of cash and provide an indicator of the organization's ability to meet its short-term obligations.

**chart of accounts:** A listing of code numbers and descriptions that itemize the types of income, expenses, assets, and liabilities that will be accumulated, tracked, and reported.

**chief financial officer (CFO):** The executive with full financial authority and responsibility. The CFO's duties include financial planning and oversight of appropriations and expenditures, record-keeping, and financial reports.

**commodities:** Manufactured goods, agricultural products, or natural resources that are bought and sold in the commercial marketplace.

**compliance audit:** Examination of specific financial and administrative transactions to determine whether they were performed as prescribed by law, donor contract or agreement, and organizational policies or specified purpose.

**conflict of interest:** A personal connection that might influence one's ability to make an impartial decision related to the organization's financial dealings. For example, a purchasing agent with family or business ties to a potential vendor would have a conflict of interest.

**credit:** In double-entry bookkeeping, the entries in the right column of the paper ledger. Revenue, liabilities, and owner equity generally appear as credits. In computerized systems, the credits are normally expressed as negative numbers. In double-entry bookkeeping, the credits must equal the debits.

**current assets:** Cash and other assets that can be converted to cash in less than one year, such as accounts receivable.

**debit:** In double-entry bookkeeping, the entries in the left column of the paper ledger. Assets and expenses generally appear as debits. In computerized systems, the debits are normally expressed as positive numbers. In double-entry bookkeeping, the debits must equal the credits.

**depreciation:** A periodic diminishing of the value of a capital asset over the expected lifetime of the asset, to reflect usage of the asset.

**equity:** Reserve or net worth of the organization, calculated by subtracting the value of liabilities (what is owed) from the value of assets (what is owned).

**exchange rate:** The ratio of one unit of currency to another.

**expenses:** The cost of doing business (resources procured), including supplies, wages, and services paid for.

**financial audit program:** The scope of work and procedures to be carried out by auditors when examining financial records and accounting practices. It includes a description of the work to be performed, the time frame to be examined and the time frame for the review itself, and personnel to do the audit, as well as an indication of the scope of the investigation.

**financial obligation:** An agreement to hand over one of the organization's assets, generally cash, in exchange for goods, services, or other assets.

**fixed assets:** Equipment, furniture, or fixtures required for operation of the business and not intended for sale to customers. They have an expected useful life of more than one year and are generally depreciated over time. *Also called* **capital assets**.

**fixed costs:** Costs to which the organization is committed and which do not vary based on current operations and activities, such as rent.

**fully loaded costs:** Costs of operations and activities that include both the direct costs for the activity and the indirect (overhead) costs, including general and administrative costs.

**general ledger:** The primary financial record of an organization. All financial transactions are recorded in it, either in detail or summarized from other journals or ledgers.

**imprest fund:** A cash fund that is maintained as a fixed amount, with cash replenished based on the exact amount of the expenses incurred. Petty cash is generally maintained as an imprest fund.

**income:** Money earned through operations, sales, donations, and fees for services.

**income statement:** A report of the organization's income and expenses. *Also called* **profit and loss statement**.

**incurred costs:** Costs related to transactions that have occurred, even if they have not been paid for yet.

**internal control:** Procedures and policies that regulate how financial transactions occur in an organization. Some points of focus include prior approval of expenditures, cash control, including prompt bank statement reconciliations, and accurate documentation of costs.

**liabilities:** Long- and short-term debts owed to outsiders, including banks, investors, and vendors.

**net profit/loss:** The difference between total income and expenses.

**operational audit:** An examination performed by an internal or external reviewer to determine if an organization's operational policies and procedures are efficient and appropriate. It looks at organizational structure and controls as well as the ability of management to adhere to policies.

**petty cash:** A limited amount of cash kept on hand and used to pay for small, routine, or urgent purchases.

**revenue:** Money generated through the sale of goods and services performed by the organization and from donors that is available to pay operating expenses or make capital improvements.

**sunk costs:** Major costs that have been incurred, such as for the organization's property, capital equipment, and vehicles, etc., and which do not vary based on the organization's program activities. *See also* **fixed costs**.

**value vs. price:** Value is what a good or service is worth, or what it costs to produce it. Price is what the customer is willing to pay to obtain the goods or services.

**voucher:** Document used to capture the details of a financial transaction, including authorization and approval.

## PROCUREMENT TERMS

**best value:** The trade-off between price and other performance factors—such as quality, delivery time, and warranties—that provides the greatest overall benefit in light of selection criteria.

**blanket purchase order/agreement:** A standardized format used when multiple, recurrent purchases are anticipated for the same goods or services and that will not require reoccurring bids or quotes.

**kickback:** Payment or other type of compensation made to influence and gain profit from an individual or company. Essentially, kickbacks are bribes paid by potential vendors.

**request for proposal (RFP):** A form of solicitation, generally used for procuring technical services, which provides substantial detail regarding the work to be performed and the terms of delivery and other criteria which must be met.

**request for quotation (RFQ):** A form of solicitation, generally used for commercial goods and routine services, in which a vendor is asked to state the cost of the described goods or services.

## References and resources

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Dropkin, Murray, and James Halpin. *Bookkeeping for Non-Profits*. San Francisco, CA: John Wiley & Sons, 2005.

Management Sciences for Health. *Management and Organizational Sustainability Tool (MOST)*, 3rd ed. Cambridge, MA: Management Sciences for Health, 2010, <http://www.msh.org/resources/management-and-organizational-sustainability-tool-most> (accessed Mar. 6, 2014).

- . *The Financial Management Assessment Tool*. Cambridge, MA: Management Sciences for Health, 2004, <http://erc.msh.org/toolkit/Tool.cfm?lang=1&TID=134&CID=3> (accessed Dec. 24, 2009).
- . *QuickStart: For Accountable Administrative and Financial Systems and Controls*. Cambridge, MA: Management Sciences for Health, updated 2006, [http://erc.msh.org/toolkit/toolkitfiles/file/MSH\\_QuickStart\\_November\\_20062.pdf](http://erc.msh.org/toolkit/toolkitfiles/file/MSH_QuickStart_November_20062.pdf) (accessed Dec. 24, 2009).
- McMillan, Edward J. *Policies and Procedures to Prevent Fraud and Embezzlement: Guidance, Internal Controls and Investigation*. Hoboken, NJ: John Wiley and Sons, 2006.
- Page, Stephen. *Establishing a System of Policies and Procedures; Seven Steps to Better Written Policies and Procedures; Best Practices in Policies and Procedures; Achieving 100 Percent Compliance in Policies and Procedures*. Four-part series. Westerville, OH: Process Improvement Publishing, 1998.
- Pritchard, Carl L. *Risk Management: Concepts and Guidance*, 3rd ed. Arlington, VA: ESI International, 2005.
- Ruegg, Debra L., and Lisa M. Venlatrathnam. *Bookkeeping Basics: What Every Non-Profit Bookkeeper Needs to Know*. Saint Paul, MN: Amherst H. Wilder Foundation, 2003.
- Shim, Jae K., and Joel G. Siegel. *The Encyclopedic Dictionary of Accounting and Finance*. Saddle River, NJ: Prentice-Hall, Inc., 1989.

## Appendices

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- Appendix A.** Sample Balance Sheet
- Appendix B.** Sample Income Statement
- Appendix C.** Attributable and Allocable Costs
- Appendix D.** Indirect Cost Rates
- Appendix E.** Selecting and Preparing to Implement Accounting Software
- Appendix F.** Tips for Implementing Accounting Software
- Appendix G.** Planning for Risk and Developing a Project Risk Action Plan
- Appendix H.** Guidelines for Setting Per Diem Rates
- Appendix I.** Policy and Procedure Template

## APPENDIX A. Sample Balance Sheet

### NGO Nonprofit STATEMENT OF FINANCIAL POSITION\* FOR THE YEAR ENDED DECEMBER 31, 20XX

#### ASSETS

##### Current Assets:

Cash on Hand	** 95,000
Donations Receivable	150,500
Prepaid Rent	5,000
Prepaid Insurance	2,000
Total Current Assets	<u>252,500</u>

##### Long-Term Assets:

Unrestricted Investments	125,600
Restricted Investments	400,250
Furniture, Fixtures, & Equipment	535,900
Less: Accumulated Depreciation	<u>(350,000)</u>
Total Long-Term Assets	<u>711,750</u>

**TOTAL ASSETS**      **\*\* 964,250**

#### LIABILITIES AND EQUITY

##### Current Liabilities:

Accounts Payable	** 35,275
Accrued Salaries and Wages	15,800
Other Accrued Expenses	9,800
Total Current Liabilities	<u>60,875</u>

##### Equity:

Unrestricted Equity	27,450
Restricted Equity	875,925
Total Equity	<u>903,375</u>

**TOTAL LIABILITIES AND EQUITY**      **\*\* 964,250**

\* This is a sample of a balance sheet, also referred to as a statement of financial position, for a small, nonprofit NGO. The content will vary from organization to organization but the common elements are:

- it is a snapshot of the financial position on a given date;
- it is organized in two sections: Assets and Liabilities and Equity;
- the sum of assets will always equal the sum of liabilities and equity;
- it is generally organized into current and long-term sections.

\*\* Insert the symbol for the currency here.

## APPENDIX B. Sample Income Statement

### NGO Nonprofit STATEMENT OF SUPPORT, REVENUE, AND EXPENSES\* FOR THE YEAR ENDED DECEMBER 31, 20XX

#### SUPPORT AND REVENUE

##### Support:

Donor Awards and Grants	** 450,000
Public Contributions	15,000
In-Kind Contributions:	
Equipment	29,000
Facilities	5,000
Services and Volunteer Labor	17,650
Total Support	516,650

##### Revenue:

Training Fees	32,500
Royalties from Publications	10,050
Fees for Services	17,600
Income from Investments	4,250
Total Revenue	64,400

**TOTAL SUPPORT AND REVENUE \*\* 581,050**

#### EXPENSES

##### Program Activities

Salaries, Wages, Benefits	** 125,850
Travel	29,450
Supplies	11,425
Other Expenses	15,000
Total Program Activities	181,725

##### Development Activities

Salaries, Wages, Benefits	32,000
Travel	9,500
Supplies	1,750
Other Expenses	2,950
Total Development Activities	46,200

##### Fund-raising Activities

Salaries, Wages, Benefits	29,750
Travel	8,350
Supplies	3,280
Printing	2,450
Shipping and Couriers	1,295
Other Expenses	2,300
Total Fund-raising Activities	47,425

**General and Administrative**

Salaries, Wages, Benefits	49,625
Travel	7,500
Supplies	12,550
Rent and Office Expenses	27,525
Insurance	2,450
Printing	3,100
Shipping and Couriers	1,250
Other Expenses	6,325
Total General and Administrative	<u>110,325</u>

**TOTAL EXPENSES** 385,675

**NET EQUITY** \*\* 195,375

\* This is a sample statement of support, revenue, and expenses for a small, nonprofit organization. A similar financial report for a for-profit organization is referred to as an income statement or a profit and loss statement. A sample statement of support, revenue, and expenses:

- reflects cumulative results throughout the period;
- is organized in sections that reflect support and revenue (or income) and expenses.

The difference between revenue and expenses is a change in net equity that flows to the balance sheet, or statement of financial position. In a for-profit organization, a positive net result is a profit, and a negative result is an operating loss.

\*\* Insert the symbol for the currency here.



## APPENDIX C. Attributable and Allocable Costs

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Attributable and allocable costs are components of the technical activity category, in that a direct link may be made between the cost incurred and an activity or project. For ease and efficiency of accounting, these costs are given special consideration. Identifying attributable and allocable costs accurately allows your organization to know the true cost of conducting its technical activities or programs. It also serves to reduce the costs that might flow to general and administrative costs (often called overhead). Many funders are reluctant to fund costs for the general operations of the organization but will fund defensible costs for carrying out public health interventions.

### ATTRIBUTABLE COSTS

Attributable costs cannot easily be directly charged to a single activity, often because it would be too time consuming or costly. To give an extreme example, office supplies are needed for several different, but identifiable, activities or programs, but it would be a time-consuming accounting activity to track each time a pen was used. Although it might be more accurate to attempt to direct charge nearly all costs, it would be too laborious to track the use of every piece of paper or pen.

It would also not be reasonable to purchase separate supplies for each activity because it is generally less expensive to buy in bulk. Your organization might opt to do an attribution of costs at the end of the month, based on well-thought-out percentages and assumptions about usage by the different activities. Cost distribution should be done in a method that is fair, uniform, sensible, consistent, and documented. The cost of supplies, staff, or equipment used only for a specific project or activity would be attributed to that project only.

As an example, you could pool costs specifically related to conducting training and later attribute some of those costs to those training activities, but not to unrelated service delivery activities.

Some traditional overhead costs may also be attributed to program activities using a rational cost formula. For example, the rent for the office might be broken down based on the head count of the organization's staff. Individual programs could be charged a portion of the rent, based on the number of staff who work on that program.

### ALLOCABLE COSTS

Allocable costs cannot be directly linked to a single programmatic activity or project but are necessary for its successful completion. Note that these costs are exclusively for programs, unlike those indirect costs that are considered general and administrative for the entire organization.

One way to handle allocable costs is to post them to a cost center that is then allocated at the end of the financial period using some predefined, logical method. For example, if managers' efforts contribute to more than one project, an activity code can be created for project management costs that indicates the projects to which the costs are posted in the accounting system. At the end of the accounting period, all expenditures posted to the

project management code are distributed among project activities based on a ratio. One methodology would be to allocate the costs in proportion to the direct expenses for the activity based on budgets and work plans for the year.

It is possible to estimate the rate at which project management costs should be applied to projects. This rate is often called the allocable cost factor (ACF).

If you are soliciting a donor for additional funding to expand a program or for a new project or activity, it is necessary to include the anticipated direct costs of the new or expanded project in the projection of the ACF. The rate will likely go down from prior periods because the project management costs will now be distributed over a larger base of direct project costs.

#### How to Calculate an Indirect Cost Rate (Organization-wide Overhead Rate)

The formula for an indirect cost rate is as follows:

$$\text{total indirect costs} \div \text{allocation base (generally total direct costs for program activities, minus exclusions)}$$

This indirect cost rate can be applied to the direct costs of a project or activity to calculate the full cost of that project or activity. Exclusions from the allocation base often include major expenditures for equipment or vehicles, construction projects, or pass-through funds going to grantees or subcontractors that might distort the rate.

Appendix D provides a more detailed example on calculating indirect cost rates.

If an indirect cost rate is being developed for a donor-funded activity, it is important to also exclude from the calculation any unallowable costs outlined in the donor's cost principles.

Note that donors may negotiate a ceiling on indirect cost rates. In this case, indirect costs may be billed only up to the ceiling amount, regardless of the actual final rate. The organization will need to identify another source of funds to cover the remaining costs.

**Tip:** Use a separate chart of account numbers to segregate allowable indirect costs and unallowable and allowable direct costs in your financial records.

Careful consideration of all attributable and allocable costs is essential for creating budgets and reporting financial results. These fully loaded costs become the basis for setting prices in a fee-for-service environment. If it is determined that the full costs cannot be recovered, a conscious and informed decision may be to subsidize the cost of some activities. It must be remembered that the overruns must be recovered from somewhere, be it a donation or other highly profitable services in the portfolio. Failure to cover costs will, over time, eat into capital reserves and jeopardize the survival of the organization.

#### What Is a Fully Loaded Cost?

A fully loaded cost is the true cost of an activity or project. It includes all direct costs, including allocable and attributable costs, as well as the applicable portion of the organization's indirect or overhead costs.

## APPENDIX D. Indirect Cost Rates

Indirect costs are not identifiable with any one project, program, or activity, but they are essential for conducting these activities and are incurred for the overall operation of the organization.

Indirect costs are sometimes referred to as general and administrative costs. Typical indirect costs include:

- occupancy costs, such as rent and utilities;
- depreciation on nonproject equipment;
- general-purpose activities, such as telephone, postage, photocopying;
- salaries for staff in support services such as accounting, building maintenance, business management, secretarial services, or office of the president.

Although some types of costs are traditionally either direct or indirect, it is not possible to make a broad statement about them. The nature of a cost is determined by which programs or activities benefit from it, and to what extent.

It may be possible to shift some traditionally indirect costs to direct costs if it is possible to reasonably determine the cost driver and accurately apportion costs among programs or activities. The burden of determining the allocation to direct charges should be considered. If a donor has caps or ceilings on indirect costs, it is often worthwhile to create coding and accounting methodologies that allow for more precise direct charging of costs, so more costs can be recovered. For example, occupancy costs might be apportioned based on the number of staff or the square footage used, rather than booked to an overhead account.

$$\text{Simplified indirect cost rate} = \text{indirect cost pool} / \text{allocation base} \\ \text{(generally total direct costs minus exclusions)}$$

For an allocation base to be acceptable, it must be capable of allocating indirect costs equitably to all awards and contracts, regardless of whether they will actually be recovered from individual donors. For US Government (USG) awards, the key principle is that the USG is willing to pay its full share, but no more than its full share. There are rare instances when a government agency agrees to pay many indirect costs, more than its fair share, specifically to support the start-up or expansion of an organization that helps it reach its program objectives. However, this is generally done when there is a plan to achieve financial sustainability in the near future.

Some costs may distort the rate, so they are often eliminated from the base. Common exclusions include major equipment, large subcontracts, and construction costs.

**Multiple allocation base method.** If an organization has very different programs that require a substantially different level of overhead support, it can create multiple rates using different allocation bases. This is often difficult to justify and requires a sophisticated accounting system and greater financial analysis than is necessary for a single rate.

If a rate is being developed for a USG-funded activity, it is important to also exclude any unallowable costs from the calculation. Details on unallowable costs and indirect cost rates for US Government awards may be found in the [Office of Management and Budget Circular A-122](#).

Indirect cost rates must be applied equally to all direct projects, regardless of whether they are limited by donor ceilings. The costs must be recognized even if they cannot be recovered.

## FRINGE BENEFITS

Just like overhead rates, fringe benefit rates are subject to review and audit by donors. Fringe benefits should be put in a pool that can be allocated to donor projects based on direct wages charged. This ensures that labor-intensive programs receive a fair proportion of related labor costs, such as paid holidays, sick time, vacation, employer taxes, and insurance.

Some fringe benefits are mandated by law. Others are discretionary and are used to attract and maintain qualified staff. Common discretionary benefits include pension plans, life insurance, and health plans. Employee morale costs may also be included in fringe benefits. Such costs might include an employee cafeteria, day care center, or recreational facilities.

$$\text{Fringe benefit rate (\%)} = \frac{\text{fringe benefit expenses (including leave)}}{\text{total salaries net of leave}}$$

Once the fringe benefit rate is determined, it is possible to apply the rate to direct salaries as they are charged. This is far easier and more accurate than trying to allocate the benefit costs when they are actually paid. The fringe benefits charged to indirect salaries flow to the indirect cost pool.

It is preferable to accrue vacation and other fringe benefits monthly and put a cap on the number of days that may be carried forward. This method ensures that liabilities for vacation, sick time, or other fringe benefit obligations are budgeted for and subtracted from available cash. This also prevents a problem that would occur if the program which incurred the liabilities for the benefits was no longer active when the benefits were actually taken.

**Example of a holiday, sick, and vacation rate.** For one person, the total person-days of work possible = 52 weeks × 5 days per week, or 260 days.

Paid time off:

Vacation	20 days
Sick	10 days
Holiday	<u>12 days</u>
	42 days

$$\text{Paid work days} = 218 \text{ days } (260 - 42 = 218)$$

It would be reasonable to assign 218 days of a project person's wages as direct charges and put 42 days into the fringe pool.

**Provisional rate:** An estimated indirect cost rate, before final costs are known. Used for budgeting and billing purposes.

**Final rate:** The actual indirect rate, after the completion of financial statements, when true costs are known. Donor billing is generally adjusted up or down to correct provisional rates to actual. Final rates are generally verified by an independent auditor.

Note that donors may negotiate a ceiling on indirect cost rates so that indirect costs can be billed only up to the ceiling amount, regardless of the actual final rate.

## INDIRECT COST PROPOSALS

**Required documentation.** Several documents are required for an indirect cost proposal to the US Agency for International Development (USAID):

- indirect cost pool schedules by cost element;
- identification of unallowable costs excluded;
- identification of other costs excluded, such as major equipment purchases;
- schedule of labor: job title, salary, direct or indirect classification;
- explanation of the allocation base used;
- identification of donor contracts;
- reconciliation of costs to financial statements.

## MANAGEMENT OF INDIRECT COSTS

It is important to pay attention to the management of indirect costs, as well as programs. An organization that controls its indirect costs is more marketable to donors. Changes in the indirect cost rate may be indicative of the organization's financial health. When overhead rates go up, either indirect costs have risen or program costs have fallen. It is important to understand which is occurring so that appropriate measures can be taken.

**Comparing rates.** It is not a simple task to compare rates among organizations. It is necessary to understand factors such as what their allocation base is and what costs have been excluded. It is more important to pay attention to the equity of the rate, rather than the rate itself. One organization may go to great measures to direct charge everything. Another might allow many costs to flow to overhead.

What is most important is the overall cost to carry out the activity, not necessarily the distribution between direct and indirect costs. Presentation of the costs, however, may influence a donor's willingness to pay. A lower overhead rate may be easier to market.

## APPENDIX E. Selecting and Preparing to Implement Accounting Software

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All organizations, regardless of size, must be concerned with operational control, human resource management, and financial management. Modern automated accounting systems can make performing these functions more efficient and allow staff to “work smarter.” It must be stressed that this software is a tool that provides the data and structure that help a business manager make sound decisions. Computerized systems cannot think or make business decisions. Nor can the new system eliminate all errors, although it should provide features to verify data accuracy to the greatest extent possible. Automated accounting is only one part of a well-organized business system.

Although office automation is a major capital expense, it is most sensible to regard it as an investment in the organization. If the right software is selected and then correctly installed and implemented, it can pay large dividends. Computerized accounting has moved away from pure bookkeeping into management information systems and operations support, providing services to areas of the company not previously directly served by the accounting system.

### IDENTIFYING SYSTEM NEEDS

Throughout the needs definition process, each staff member should focus on the internal customers they serve. What system features can help them meet the needs of these customers in a more accurate, timely manner? In addition to satisfying the requirements of auditors and tax and statutory bodies, the new systems can facilitate budgeting and forecasting; enhance project and program management, planning, and control; help prevent fraud; and provide nearly instant access to information.

To capture some of the additional information desired, such as better allocation of expenses by donor or project, more data will need to be collected during transaction processing. This could increase processing time for some routine functions, such as accounts payable and payroll. The benefits of gathering additional data must be balanced with the amount of time, labor, and associated cost to collect it. If data will not be used, reconsider whether it should be gathered just in case.

### PLANNING FOR THE UPGRADE

The organization may be forced to accept compromises during the process of upgrading the accounting system. Slower data entry may be a necessary tradeoff for access to much more data and increased efficiency in generating financial reports. The flexibility of writing checks daily might need to be exchanged for the efficiency and accuracy—and reduced frequency—of batch entry of computer-generated checks. To allocate personnel costs accurately to projects or departments, the current timekeeping systems will probably need to become more sophisticated. Decisions will have to be made regarding what present operational standards and processes must be changed to support and feed into the new financial system. If selecting a particular software would force changes unacceptable to the organization, it should be eliminated from consideration.

It is important to discuss these possibilities with staff to eliminate surprises when the new system is put in place. Since the new system will require new processes, staff should be consulted, or at least informed, about these upcoming changes. Change is stressful, even if the changes are positive, and staff members' coping skills will vary. Frequent communications, involvement in decision-making and system design, and training will help minimize anxiety. The more users are included in the planning and implementation, the easier it will be for them to adapt to the changes.

The upgrade of a financial management system may add tasks and responsibilities to people's jobs. As the nature of these changes becomes clearer, job descriptions should be changed and new tasks assigned. Current staff may lack needed skills and require training or even reassignment. New recruitment may be necessary.

The success of a software implementation depends on having a solid manual accounting system prior to starting the process. It is important to analyze the present system to determine areas that need strengthening. These improvements should be made before implementation begins. Some areas that require particular attention are the chart of accounts, internal control, and records management. All journals, bank accounts, and the general ledger must be in balance before the installation begins.

Although automated accounting will eliminate the need for many of the handwritten journals, the computer will create a new set of reports and audit trails, and they must be retained. Arrangements will need to be made for safeguarding tape backups and archives, including routinely storing critical data off site, so it will be possible to restore the system in the event of fire or other damage to the office. Before the start of installation, organize a cleanup of files, deleting or archiving records that are no longer needed, and arrange office space to maximize comfort and access to needed hardware, such as printers.

The increased reliance on computer-generated information may cause increased noise and heat from printers, processors, and perhaps generators, or cause bottlenecks as staff gather around printers waiting for output. Small changes to office layout may improve these situations, which, although seemingly minor, may become major annoyances over time.

Other factors that will foster successful software implementation are information gathering, a methodical approach to the process, the cooperation of all staff members, the committed support from management, and patience. Implementing the new software will be an evolution, not an instantaneous event. The process must be allowed to follow its natural course. Timelines are only targets, which should be modified in favor of doing thorough analysis, planning properly, and starting up with accuracy. Chapter 2 has information that can help you lead and manage through this change.

## SOFTWARE SELECTION

During the software selection process, gather as much information as possible about the possible software solutions, vendors, value-added resellers (organizations that buy hardware and software from manufacturers and sell it to the general public), and what the staff hope to get from the new system.



You may be tempted to expect the new system to satisfy every desire of every staff member. There are systems on the market that can do virtually everything, if you are willing and able to pay for them. However, the goal is to select the software that matches most needs and desires and satisfies all critical requirements at an affordable price. Highly sophisticated systems can offer too much technology, which is difficult to control and will probably frustrate finance staff if they are inexperienced with computerized systems.

### TIPS FOR UPGRADING SYSTEMS SUCCESSFULLY

- Appoint a project manager to oversee the entire process. This person will coordinate meetings with vendors, assign tasks to staff members, and update management and staff on progress made and what to expect next. Since this will be a time-consuming task, the person should be given the time and resources needed to do the job.
- Appoint a steering committee of key staff members from the accounting, operations management, and project management groups to make decisions about the features required and final software selected. Also include staff members who will be responsible for daily data entry. The computer network administrator should also be asked to provide a perspective on hardware and memory needs. The committee members will work with their departments or project staff to define needs and requirements and communicate results.
- Review and update the current accounting manual to accurately reflect the current system.
- Analyze the current systems and procedures for inefficiencies and make whatever corrections are possible prior to implementation. These changes should be reviewed with your accounting group or audit firm, if you have one.
- Be sure that the present system is balanced and reconciled. Any corrections and adjustments resulting from the current audit should be completed.
- Contact references and current clients of the software vendors you are considering. Discuss their successes and problems with the software and vendor service. How has the software improved their operations and decision-making? Were there any disasters? Compare the reference organizations' size, complexity, and system design with those of your organization to assess how the software might operate in your organization's environment. Ask the vendors' clients if they would select the same software and vendor again.
- Appoint someone (possibly the project manager) to create and maintain the project plan and supporting documents. Correspondence, responses from vendors, and minutes from meetings should be stored for future reference. In the worst case, this documentation might help settle a dispute with the vendor.

### QUESTIONS FOR SYSTEM USERS AND VENDORS

- What are your present needs? How well does the software being presented meet these needs?
- What are your future needs or desires? How well does the proposed software meet these? How extensive will modifications be to accommodate growth or procedural changes?
- What features or functions will be improvements over the present system? How well does the proposed software solve current problems?



- Are the data-entry screens easy to use? How long will it take to enter routine transactions? Is this speed and performance acceptable? Have those responsible for data entry evaluated these features?
- Does the menu structure clearly lead you to desired functions?
- What level of online help is available? Is on-site help available? At what cost?
- What kinds of manuals and training materials are provided? Are they easy to read?
- Is this application too complex? Will it improve or hinder daily operations?
- Would all classes of employees who use the system be able to do so comfortably? Are advanced computer skills required?
- How much training will be required for staff members to become skilled enough to operate the system? Who will provide this training? At what cost?
- How much customization will be required to meet minimal requirements? Desired requirements?
- Are third-party applications required to perform standard functions, such as reporting or payroll? How are these applications supported? Is the integration between the packages seamless?
- How are budgets input and updated? Are budget tools sophisticated enough to meet project management needs?
- Does the software interface with other tools, such as spreadsheets, form letters, or creating charts? How easy is this?
- Can the vendor's clients currently using this software be contacted for references?
- Which standard reports are included in the software application? What tools are available for creating custom reports? How difficult is the report design to use?
- Do any features affect the operation of the software system in the current business environment? Is this problem solvable? If not, consider alternate software.
- Did the vendor seem well-informed about the software? How well does the vendor understand accounting and your business needs?
- How long has the vendor been in business? How many staff or consultants will be provided to install and implement the software and train staff?
- Did the vendor instill trust about their ability to provide service, support, and training after installation? Would you and others be comfortable having a long-term business relationship with this firm and salesperson?
- What were your first impressions of the software? Did those initial judgments change after further experimentation and demonstration?

## APPENDIX F Tips for Implementing Accounting Software

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### PREPARE FOR CHANGE

Change always brings risks and fear, based on the abandonment of the familiar and known in favor of the unknown. Have faith that the change will ultimately lead to an improved work environment. Embrace the opportunity to learn new skills, concepts, and practices. The new accounting system should position your organization to perform more effectively in the upcoming years. Chapter 2 has information that can help you lead and manage at times of change.

### COMMUNICATE WITH STAFF TO FOSTER THEIR COMMITMENT

The success of the software implementation is directly connected to how committed the staff are to learn what the software can do, devote the time necessary to prepare for the installation, thoroughly plan for the new system, and work through difficulties as they occur.

The entire organization, not just the finance department, needs to commit to graciously accept the minor disruptions in service that will be necessary for completing the implementation. The results—increased efficiency and quicker access to management data—will be worth it.

The installation and implementation period will pose many challenges, especially as people try to balance the demands of daily work and the additional tasks related to the system implementation. Leadership and teamwork will be necessary to meet these challenges. If you communicate regularly with staff members, they will know what to expect, and when. Also, if you keep communication channels open, they will freely share their questions and concerns with you.

### HOLD PROGRESS MEETINGS

The implementation phase will span two to four months. It will be necessary to hold frequent progress meetings to keep all staff, managers, and the board informed of progress and to alert the vendor to problems and training issues.

### ASK QUESTIONS

Throughout the installation, implementation, and switch to the new system, numerous aspects will be confusing. The vendor is an expert who is available to answer questions and clarify processes. Use that company's expertise. The only bad questions are those that go unasked.

### DOCUMENT, DOCUMENT, DOCUMENT!

- Keep very detailed paper trails of all installation decisions, such as master file and lookup table contents. Save these documents for troubleshooting problems at start-up and also for review by the auditors, if necessary.
- Maintain a complete project file that includes the resource materials and reports that have already been prepared. Consolidate all information from

vendors and consultants, along with the implementation plans and documents. These documents should be kept readily available for review.

### READ THE MANUALS

To supplement training sessions and on-the-job learning, all members of the accounting staff should read the system manuals. These manuals will document features that might not be thoroughly covered in training and describe in greater detail how the various modules and processes link together.

### DEVELOP A TEAM OF STAFF EXPERTS

Some staff members will find the new system easier to use because they have greater aptitude or experience with computers. Encourage these “stars” to coach and train others who need assistance.

### UPDATE THE ACCOUNTING MANUAL

The accounting procedures manual must be updated to include new procedures, new forms, and the revised chart of accounts.

### DETERMINE CODING STRUCTURES

- Ask the vendor to provide the architecture of the master files, so the coding structure can be set up accordingly.
- Decide whether all existing accounts payable vendors will be added to the system or if they will be added one at a time as they are used. Since vendor information changes frequently or many vendors are only used once or twice, it might be sensible to add only the common vendors at first.
- Decide what levels of detail you want to capture, such as department, project, donor, and location—or more. Remember that each additional level of coding increases data-entry time, so your choices should be based on real business information needs.
- To the greatest extent possible, incorporate currently used coding structures into the new system. The more familiar things seem, the easier the transition will be.

### PREPARE FOR DATA ENTRY

- Update the chart of accounts to include all accounts currently in use. Decide on any additional accounts you would like to add.
- Reconcile all bank accounts.
- Be sure the trial balance is in balance.
- Gather all data on bank account numbers, addresses, etc.
- Gather all data on vendors that must be entered into the system, including any recurring monthly payments.
- Prepare a listing of all open invoices remaining to be paid. To the greatest extent possible, pay all outstanding bills to minimize data to be carried into the new system.
- Prepare a list of any open purchase orders.

- Prepare a list of all accounts receivable still due.
- Have employees verify all personal data that will be entered into the payroll module. Prepare a record of all wages paid, deductions, allowances, and tax information from the current fiscal year that must be entered.
- Prepare, or gather, all budgets for projects and departments.
- Assess the set-up of the accounting department offices. Determine if the computers and peripheral hardware are placed so they will be fully used. Some employees will spend a lot of time doing data entry, so be certain that their work areas have proper lighting, seating, and are equipped to prevent repetitive stress injuries.

### ESTABLISH SECURITY PROTOCOLS

- Decide who will have system administrator or supervisor's rights.
- Decide who will have access to the various software modules and what level of access they will have (such as the ability to add, delete, or modify records) and set up passwords accordingly.
- Determine backup procedures, including off-site storage and storage of critical backups in a fireproof safe. It should not be the sole responsibility of the local area network (LAN) administrator to back up the accounting system because routine full LAN backups (done daily as a matter of good practice) may not be frequent enough to safeguard valuable financial data. The accountant should always back up financial data before running any critical transactions, after processing large amounts of data, etc. This is especially critical in areas that are prone to electricity fluctuations, power outages, or lightning strikes that can seriously damage or destroy electronic files.
- Computerization is not the creation of a paperless workplace! Set up a plan for report storage and distribution because computer reports may be bulkier and more numerous than those currently in use.
- Locate the printer(s) so that confidentiality of reports or checks is not compromised. Since the accounting area will generate a lot of reports, it should have at least one dedicated printer.
- Decide what types of transaction reports are desired to create adequate audit trails. Because some transaction reports are snapshots of data at a specific time, they cannot be recreated later.
- Decide which backups should be retained, and for how long, and which can be overwritten, and how long they must be available before being overwritten.
- When setting up system security, be sure that there is enough redundancy of skills so that if someone is out of the office, all functions can still be performed smoothly.

### NOTIFY STAFF OF WORK SCHEDULES DURING IMPLEMENTATION

- Installation on weekends or evenings usually causes less disruption of daily routines but may mean extra time commitments from the staff. Be sure expectations are clear.
- Will there be any expected delays in processing vendor payments or other accounting office activities? Alert staff or others to this possibility.

- Notify all staff of training commitments that will limit the availability of finance staff.
- Notify the auditors, donors, and board of directors if the implementation schedule will delay the preparation of year-end statements. Work with the vendor to alter the schedule if those deadlines cannot be missed.

### DEVELOP A TRAINING STRATEGY

- Decide who will be trained. Distribute the training schedule to all staff involved to ensure their presence at all required training sessions. Have sufficient training materials available for all staff, and set aside adequate time for successful training.
- Schedule training sessions and set up the training rooms to minimize distractions and interruptions. Notify all staff when trainings are in session, so meetings or other disruptions do not interfere with the lessons.

### PLAN FOR THE USE OF COMPUTER-GENERATED CHECKS

- If you intend to generate checks using the computer, obtain the printing specifications and order checks early, to ensure that they are available when the system is installed.
- Be sure to get check writing supplies that are compatible with the available printers, or make a decision about purchasing a more appropriate printer model.
- Are several types of checks required for accessing different bank accounts or for payroll? Be sure to order all the needed checks; lower prices are usually available for bulk orders.
- Make a policy regarding when, or if, manual checks will be written, because processing manual checks requires additional data-entry time and may side-step normal internal control procedures.

### ESTABLISH PROCESSING PROTOCOLS

- Make checklists of the processing steps required for running various routines. These lists will be helpful until procedures become second nature. It will be necessary to remind staff about performing backups and running certain transaction reports.
- Determine how often transactions will be posted to the general ledger and by whom.
- Decide how source documents will be prepared for data entry. Since the computer will allow for the collection of additional data, it might be helpful to design cover sheets or rubber stamps that simplify the coding process.
- Who will review and audit batches? How will transactions be corrected?
- Develop a mechanism for tracking additions to vendor lists, personnel lists, and the general ledger. Decide who is authorized to make these additions.
- Since the accounts payable module allows for posting to past periods, it should be decided whether this is a desirable option.

- Decide which reports should be printed routinely. Although a software package typically allows you to print more than 250 reports, it doesn't mean you should!

### CONSIDER NEEDS FOR SUPPLIES AND HARDWARE

- Be sure to have adequate supplies of paper, toner, backup tapes or disks on hand because these needs will increase as a result of the computerization.
- Determine if additional computers, printers, electricity regulators, generators, and related equipment are required and make arrangements to purchase them. Budget for system support or upgrades after the first year.

### SCHEDULE A PARTY!

Set a target date for when the new system will be fully functional, and plan to celebrate all the hard work and commitment that made it possible to get the new system successfully up and running.

### SCHEDULE A MIDTERM REVIEW

Several months after implementing the new system, after any glitches have been resolved, do a systematic review of the system. Workloads should be assessed. Some people's jobs should have become streamlined as a result of the computerization. It may be possible to reassign tasks, take on new activities, or take advantage of new proficiencies.

## APPENDIX G. Planning for Risk and Developing a Project Risk Action Plan

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*Risk remains a secondary issue only as long as an organization's luck holds out or until a grand opportunity is missed.*

Carl L. Pritchard  
*Risk Management Concepts and Guidance*

Risks include failures to satisfy quality, budget, or performance objectives. Each of these risks would cost time and money, and possibly lose opportunities. The goal is to prevent injurious risk, but it is not always possible.

### MANAGING RISKS SHOULD BE COUPLED WITH MANAGING OPPORTUNITIES

Some risk is desirable because it presents opportunity and the potential of profits, success, or other benefits. Most people fear and avoid risks more than they like and accept the challenges presented by opportunities. However, taking risks can be tied to reaping rewards. It takes wisdom to avoid or prevent the risks that will damage a project and courage to accept the risks that will benefit it.

Risk management is not an instinctual reaction to events. It involves a culture within the organization of protocols and practices that are consistently applied. The most critical phase in the risk management process may be risk detection. How can you know when you are about to encounter risk?

**Risks.** Risks have three common elements:

- an event
- probability of occurrence
- cost or loss if the event occurs (severity)

**Opportunities.** Opportunities also have three common elements, the first two of which are the same as those for risk):

- an event
- probability of occurrence
- profit or benefit if the event occurs (impact)

You must attempt to quantify consequences and probabilities in realistic terms, especially the costs or benefits that might be achieved. To the greatest extent possible, this should be a scientific and mathematical exercise, although “gut feelings” do play a part in the quantification of risk. See [Box G-1](#).

**BOX G-1. Quantifying Risks and Opportunities**

**Risk:** Potential for an event to have negative consequences

**Opportunity:** Potential for an event to have positive consequences

**Risk** = “Cost” of unwanted event  $\times$  probability of event’s occurrence

**Opportunity** = Benefit of hoped-for event  $\times$  probability of event’s occurrence

Successful risk management requires an environment that allows and encourages honest and open communication about possible risks. If managers are discouraged from bearing bad news, valuable time that could have been used for mitigation or contingency planning may be lost. Opportunities may also be lost. If you are responsible for monitoring risk, be sure to clearly communicate the risks and potential consequences, as well as the possible opportunities, to those empowered to make decisions.

### STRATEGIES FOR DEALING WITH RISK AND OPPORTUNITY

Strategies for dealing with risk follow:

- Accept the risk and take any loss, but be sure that the project team and management know.
- Avoid risk, and miss potential opportunities as well.
- Control risk through contingency and mitigation.

Strategies for dealing with opportunity are:

- Passive: Take an opportunity if it comes along.
- Active: Pursue opportunities actively.

The time and resources required to do risk planning are likely to cost far less than dealing with the consequences of a risk event. The greater the advance notice of risk, resulting from good project planning, the greater the possibility to compensate for or avoid the problem.

### SOURCES OF RISK

There are external and internal sources of risk. Risks from external sources include:

- fire, famine, flood, war, and disease (environmental);
- changes in laws or regulations (governmental);
- loss of market share, introduction of competitors, and loss of suppliers (economic).

Risks from internal sources include:

- changes in board of directors’ strategies and priorities, or funding agencies’ politics;
- stakeholder changes;
- subcontractor failures, scheduling delays, cost overruns, technical surprises;
- loss of key staff;



- schedule delays and cost overruns due to poor planning and budgeting (e.g., unrealistic or incomplete).

There are inherent risks from project plans that are imposed by donors, customers, or senior management who desire results faster, cheaper, or with more functionality than is reasonable. Project managers must be honest enough and brave enough to point out these risks and substantiate them with sound, detailed budgets and schedules.

## RISKS RELATED TO FINANCIAL MANAGEMENT

Some risks are related to financial management rather than to a specific project. Examples include:

- failing to stay informed about the true costs of doing business;
- assuming you can make up losses by delivering a larger volume of services.  
If you are generating losses, larger volume might only create larger losses;
- depending on donors;
- setting prices too low, for example, so you can win a contract;
- failing to scan and monitor the changing environment;
- condoning poor budgeting, planning, and reporting practices;
- not taking advantage of opportunities;
- not covering overhead costs.

## PLANNING TO DEAL WITH RISK IN A PROJECT OR PROGRAM

*Sooner or later, bad things happen to good projects, and a project manager without a clear strategy will pay a price.*

Carl L. Pritchard  
*Risk Management Concepts and Guidance*

All major projects or programs should have some documented risk management activity in the scope of work and a documented risk management plan in circulation.

Risk events, probabilities, and impacts are unlikely to remain static over the life of the project. The longer the duration of the project, the truer this statement becomes. Therefore, the steps that follow should be undertaken continuously throughout the project. Risk identification and monitoring should trigger further planning.

**Step 1: Identify risks.** Identify sources of potential risk and specifically define them, including the likelihood of occurrence and the costs if the risk event occurs. It is important to describe the potential risk event in specific detail. Ask questions such as: How would it occur? What might occur? How seriously would it affect the project or the organization?

Don't forget to look at the possible benefits that might be gained from a risky opportunity.

Have a team of people looking at risk. Their varying perspectives, attitudes, and experiences with risk; their visions; and their tolerance for negative outcomes or risk-taking will give you a more balanced view of the potential risks. Include both risk-averse people and risk-takers.

Throughout the project, you should also make a point of getting a fresh perspective on potential risk events from experts or sources outside of the project itself. Staff members who are deeply involved in a project—including yourself—may be oblivious to changes in the environment that could result in new risks.

A good way to identify all potential risk events is to create a structure for the project, if you don't already have one. By breaking processes and activities into their smallest components, it is easier to readily identify risks that might remain hidden if you focus only on the big picture. Ask:

- What activities do we always follow?
- What are the core processes for these activities?
- What are the key elements and subactivities of these processes?
- What risks are common to these?

In addition, the team has a responsibility to research the history of other, roughly comparable projects. No project, no matter how advanced or unique, represents a totally new system. Projects originate and evolve from existing or past projects. There should be documentation of the risks encountered in those projects and the mitigation and contingency techniques used. The new project team should review those documents and use the lessons learned—or be destined to repeat them.

**Step 2: Create a risk management plan.** A risk management plan is an important tool to document and share risks and opportunities throughout the project. The components of a risk plan are:

- risk identification;
- risk assessment (probabilities);
- risk quantification (costs);
- response development (mitigation plans and contingency plans);
- a monitoring and control plan.

Create a matrix of possible risks to the project by asking:

- What risks can we avoid?
- What risks must we take?
- What risks can we ignore for now because the probability of their occurring is extremely low?

Identify possible risk events and break them into smaller events that are easier to control. Do this early, even in the development stage of a project.

Specifically define the risk event and estimate the probability of occurrence and the cost if it does. If it is not possible to scientifically document probabilities or assign accurate dollar values, it is possible to use percentages or high-medium-low scales. Clearly communicate the probability and cost of risk events to decision-makers.

Once you have identified the resident risks (the ones generally expected for the given activity), you can build in control mechanisms to deal with them. (See [Box 2.](#)) This should

**BOX G-2. Resident Risk: Project Management Examples**

A common resident risk is that an activity will fall behind schedule. There may be a good reason to allow a project to run late (such as waiting for legislation to be passed). However, this should be a conscious decision, not an unconscious one. A project should not fall behind schedule simply because someone was not watching the clock.

Another common resident risk is that the project will lack resources (not enough, not available at the right time, or not the right ones). Securing adequate resources (especially people) and ensuring that they are available when the project requires them is an essential task for the project manager and should be properly addressed in the risk management plan.

be done as part of project planning. This preparation will free up time and resources to deal with unexpected things that occur during project implementation.

One way to identify risks is to draw on the history of past projects and the risks they encountered and solutions they used to mitigate them. Using consistent forms and protocols to capture these lessons makes it easier to record and later interpret this information. Consider the following questions:

- What happened?
- Why did the event happen?
- How did it happen?
- What was the corporate, project, and market environment at the time?
- Who was involved?

You should also consult with experts, brainstorm with the project team, and use data from similar projects (gathered from journals, institutional memory, and other organizations).

Your task will be easier if the lessons learned were recorded at the time they were recognized; time dulls the memories and details. Many projects err by waiting until the end of the project to try to recall lessons learned. This may be several years from the time of the actual events and might be colored by the glow of the eventual success of the finished project.

As a manager of a health program or health services, you can make risk identification easier for your organization and others in the future if, at the time they occur, you document, share, and archive your own project risks and opportunities, their consequences, and subsequent actions.

**Step 3: Design mitigation and contingency plans.** To effectively manage risk, an organization should establish a plan to identify potential risks, quantify the impact they would have on the organization, and outline strategies to prevent them from happening (through mitigation planning) or limit their damage (through contingency planning).

The organization should develop a triage process for managing its risks. Determine and react first to the risk events that pose the greatest threat, not those that seem to cause the greatest commotion. Hospital emergency rooms use this technique to categorize patients

according to who faces the greatest risk of serious complications or death and then treating them first. Triage involves the careful following of established protocols that are taught to all medical students, such as assessing physical appearance, mental state, and recognized symptoms.

All employees should understand the work environment and know the protocols for handling risk events. Similar to the hospital triage example, the organization should establish protocols for identifying potential risks, identifying those that could result in serious injury or “death” to the organization, and selecting the appropriate responses to manage these risks.

**Mitigation** is a before-the-fact technique. Having identified what could happen, the probability that it will, and how damaging the results would be, you can take steps to reduce the probability that the risk event will take place. Normally this is done for the risks with the highest probability and/or with the most severe potential impact on the organization. Taking precautions to prevent a fire or diminish its impact by purchasing fire extinguishers, backing up critical data off site, and conducting fire drills are examples of mitigation strategies. In keeping with the health analogy above, mitigation techniques are similar to routine medical check-ups, immunizations, and other preventive care.

**Contingency** is an after-the-fact technique. It involves having plans in place that can be quickly mobilized in the event that the unfortunate event occurs. By carefully identifying possible risks, it may be possible to identify possible solutions. Contingency provides a “cure” for the consequences after a risk event has occurred. For example, you might be able to identify sources of rental office equipment or temporary quarters to be used in the event of a fire. It is wise to build schedule and budget reserves into project plans to cover risks that cannot be mitigated.

Some risks stand out as “showstoppers” that would result in the “death” of the project or program, or even the entire organization. If these occur you cannot achieve your goals. The possibility of this type of risk might mean that the activity should not be undertaken. It is critical to know when to discontinue an unsuccessful or too risky activity. Determine what loss is considered acceptable as well as what is unacceptable. What cost can your organization accept? What risk can it endure?

Many organizations suffer huge setbacks because they prefer to keep projects on the equivalent of life support rather than make the difficult decision to end the project and move on. The answer to these questions will vary among organizations based on their financial reserves, ability to cover losses, and even the overall optimism or pessimism of the organization’s leadership.

It is necessary to determine which risks are worth an investment of time and energy. Some risks are worth taking, because their severity is low or the probability of their occurrence is low (or both). Some risks are worth taking because the opportunities and gains they represent are great and can be controlled with proper management, planning, and project execution.

There are two forms of risk acceptance: passive and active.

**Passive risk acceptance** means accepting a risk without doing anything to resolve, manage, or cope with it. Note the key word: acceptance. Ignorance of risk is not appropriate.

**Active risk acceptance** means acknowledging that risk exists without planning for mitigation. Contingency plans or reserves are put in place instead.

When you design mitigation and contingency plans, it is critical that such plans not take longer or cost more than the project itself! Risk management techniques should not trigger additional major risk.

When you are developing responses, a good technique is to brainstorm multiple options. Then you can analyze them to determine which ones can be implemented quickly, with the lowest cost or project impact. The goal is to implement strategies with the greatest overall positive impact (or lowest negative impact) on the project.

**Step 4: Set up a plan to monitor risks.** The higher the probability of the occurrence of a risk event and the closer the time frame for the possible risk event, the greater the need to monitor for that event and communicate with the project team and stakeholders.

Some suggested tools for planning for, monitoring, and mitigating risks are:

- probability-impact matrixes (see Table A);
- decision trees or matrixes and probability trees, to quantify risk probabilities;
- three-point planning (best scenario, most likely scenario, worst scenario);
- statistical analysis: Target for the mean plus 1 standard deviation;
- assignment of utilities (the perceived value of a potential event): This type of analysis can help you decide whether to take a risk. The greater the potential gain, the more likely you are to accept the risk;
- division of a large risk into smaller pieces that are easier to manage so you are in a better position to mitigate the situation.

TABLE A. Probability-Impact Matrix

High Probability 66%–99%	High – Low LATER RESPONSE	High – Moderate THIRD RESPONSE	High – High* FIRST RESPONSE
Moderate Probability 33%–65%	Moderate – Low LATER RESPONSE	Moderate – Moderate LATER RESPONSE	Moderate – High SECOND RESPONSE
Low Probability 1%–32%	Low – Low LATER RESPONSE	Low – Moderate LATER RESPONSE	Low – High SECOND RESPONSE
Relative Weight = Probability × Impact	Low Impact	Moderate Impact	High Impact

\* A High – High event should be analyzed to determine if it is a “showstopper.”

As [Table A](#) shows, events with the highest relative weight are addressed first, so a high-probability, high-impact event would get the first response. Risks with lesser relative weights are dealt with as time and money allow.

The criteria for assigning impact should be agreed upon within the organization because this is a highly subjective concept. Attempts should be made to make the quantification more specific.

Table B shows that when risks are relatively low and opportunities relatively high, an organization is generally wise to invest resources necessary to capitalize on the opportunity. When risks are high and opportunities are low, steps should be taken to actively avoid the event. Further study is generally required in more moderate circumstances to determine if steps can be taken to mitigate the risks or enhance the opportunities.

**TABLE B. Risk-Opportunity Decision Matrix**

<b>High Risk</b> 66%–99%	High – Low AVOID	High – Moderate STUDY FURTHER	High – High AVOID
<b>Moderate Risk</b> 33%–65%	Moderate – Low AVOID	Moderate – Moderate STUDY FURTHER	Moderate – High STUDY FURTHER
<b>Low Risk</b> 1%–32%	Low – Low IGNORE	Low – Moderate INVEST	Low – High INVEST
	<b>Low Opportunity</b>	<b>Moderate Opportunity</b>	<b>High Opportunity</b>

## APPENDIX H. Guidelines for Setting Per Diem Rates

Staff and clients, such as training participants, often incur costs for meals and accommodations while traveling or away from home on official business. To achieve consistency, minimize the burdens on the traveler to track and report costs, and maintain ease of accounting, many organizations opt to set a rate for meals and lodging.

Commonly, the traveler receives a flat allowance to cover meals and does not have to present receipts for the actual meals purchased. Lodging is often reimbursed on an actual basis, pending submission of a receipt from the hotel. To contain costs and prevent abuse, a maximum rate is generally established.

The rates are generally based on actual costs likely to be incurred in a given area. Depending on the size and diversity of the travel area, multiple rates may be established, generally by the city, region, or country where the travel occurs.

Below are some additional requirements and guidelines for establishing local per diem rates.

### STEPS TO TAKE BEFORE SETTING LOCAL RATES

- Consult with the donor about any required local rates in effect.
- The Ministry of Health or local tax authority might have local per diem rates that can serve as guidelines.
  - Be careful of schemes that would be deemed salary enhancements rather than appropriate to cover actual costs of business travel.
- Survey similar organizations or collaborators regarding the rates they use and set a similar rate.
- Set independent rates, based on surveys of actual costs in areas where business travel occurs. Travelers or country office managers should survey the costs to obtain acceptable meals in a given area. Meals should be provided by restaurants or hotels that meet standards for cleanliness and any religious or dietary needs and preferences of local staff. The meals should not be lavish. In addition to a rate to cover meals, an additional 20 percent should be added to the rate to cover the incidental expenses of travelers.

### SETTING PER DIEM RATES FOR WORKSHOP PARTICIPANTS

To eliminate many administrative burdens and risks related to payments of per diem rates to workshop/training participants, many organizations opt to provide full board (and lodging if appropriate) for workshop participants. Although not all participants may appreciate eliminating cash payments, this approach provides several benefits to the project:

- Costs can be controlled through package rates negotiated with hotels.
- There is no need to carry large sums of cash, collect receipts, and process the paperwork required to document per diem payments.
- Participants do not have to leave the venue in search of meals or to cash per diem checks.
- Communal dining provides networking and learning opportunities.

## USING PREFERRED HOTELS

A preferred hotel is a hotel selected by the organization to provide lodging for all staff and consultants working in a specific area or for visitors providing technical assistance to the field office itself. Creating a list of preferred hotels allows the organization to control costs by negotiating favorable rates with hotels. It also simplifies the routine travel process because it is not necessary to search for hotels within per diem limits for individual trips.

Pledging substantial business to a hotel often makes it possible to obtain other needed services for free or at a reduced rate. This also provides cost savings for projects. These services might include:

- free or low cost Internet and business center services;
- discounts on conference room rentals;
- free airport transfers.

Selecting hotels in convenient locations, such as within walking distance of the office or counterparts, can eliminate the cost and inconvenience of obtaining ground transportation.

It is often practical to select more than one preferred hotel in a location, either to serve as a backup if the first choice has no vacancies or for different business purposes. For example, one hotel might be a preferred choice as a workshop venue and another as a location for travelers on out-of-town assignments.

## CRITERIA FOR SELECTING HOTELS

Below are some criteria for selecting preferred hotels:

- clean rooms, bedding, and restaurants
- secure environment (the neighborhood as well as the building itself)
- air conditioning, fans, or heat, as appropriate
- location near work assignments
- meals available in the hotel or nearby restaurants
- availability of required business services, especially Internet access and telephone service

The choice of hotels is often subjective. It is important that staff feel comfortable, secure, and able to be productive in their environment. It is strongly suggested that frequent travelers be part of the selection committee for establishing the list of preferred hotels.

## FULL BOARD LODGING

In some locations, the best lodging choice is a guest house that also includes meals in the rate. In this case, travelers are still entitled to a per diem allowance to cover incidentals only.

## UPDATING MEAL ALLOWANCES AND HOTEL CHOICES

Inflation may cause costs to rise. New hotels may appear on the scene and selected hotels may no longer provide the quality or services expected. It is essential that there be a means of feedback for travelers to report rising costs or changes in the quality of hotels.



International rates may change as frequently as monthly. This frequency is not normally necessary at the local level, but routine reviews every six months are reasonable. Sudden or dramatic changes in circumstances may also trigger ad hoc reviews of rates or hotel selections.

## APPENDIX I. Policy and Procedure Template

The notes below will assist you with understanding what should be included in each section.

1. **Topic** (Insert the name only of the process or activity.)

Policy or Procedure Name (Provide a unique number to make future updates easier. Document any dates, revisions, and approval of the board or management.)	Document No.	
	Effective Date	
	Revision Date	
	Revision No.	
	Approval	

2. **Purpose** (Insert a brief sentence or two that describe the policy or process.)

3. **Revision History**

Date	
Revision No.	
Change	
Ref. Section	

4. **People Affected** (Identify the various positions—not individuals' names—that are involved in the process being documented. This should include all roles that are involved, from the initiation to the conclusion of the process.)
5. **Applicable Policies** (Detail any rules, organizational or donor restrictions, or policies that apply to this procedure.)
6. **Definitions** (Define any terms or acronyms used in this document that might not be understood by all staff.)
7. **Procedure** (Carefully outline each phase and procedural step from initiation to completion, ensuring that they are logical and efficient.)
8. **Responsibilities** (Outline the roles played by the various positions affected. Do they involve requests, approvals, implementation, documentation, etc.?)
9. **Reference Materials** (Attach any forms, templates, tools, samples, or additional materials that document or support the process.)



# Managing Medicines and Health Products

Malcolm Clark  
Andy Barraclough

1. Achieving Results by Strengthening Health Systems
2. Leading and Managing: Critical Competencies for Health Systems Strengthening
3. Governance of Health Systems and Health Organizations
4. Mainstreaming Gender Equality into Health Systems
5. Planning the Work and Working with the Plan
6. Managing Human Resources
7. Managing Finances and Related Systems
8. Managing Medicines and Health Products
9. Managing Information: Monitoring and Evaluation
10. Managing Health Service Delivery

Effective supply management has the potential to make a powerful contribution to the reliable availability of essential medicines, which are a crucial part of the delivery of high-quality health care services. Because medicines are costly and poor management so often results in waste, good supply management is also crucial to the cost-effectiveness of providing medicines.

Officials with national-level responsibilities manage the full, integrated system described by the pharmaceutical management cycle (Figure 2). Theirs is a complex task that demands the highest level of leadership, management, and technical skills.

But even where good national policies and systems exist, unless those managing the “last mile” of the supply chain—from the district or organization to the health facility to the patient—fully appreciate the impact of their work and are trained to carry out their responsibilities, essential medicines and supplies will fail to reach medical staff and patients.

As a manager of a health program or health services at the district or health facility level, you can successfully accomplish this by using the practices described in this chapter, which focuses on supply management and use of medicines.

Supply management does not operate in isolation. At the center of the pharmaceutical management cycle is a set of core management practices and systems interlinking with the overall management of health services. Other chapters of this handbook cover these topics, as follows:

- planning and organizing (Chapter 5)
- human resource management (Chapter 6)
- financial management (Chapter 7)
- information management (Chapter 9)
- delivering health services (Chapter 10)

The entire pharmaceutical management cycle rests on a policy and legal framework that establishes and supports the public commitment to supplying essential medicines. The eight major sections of this chapter provide guidance on the following aspects of the management of the cycle:

- storage management
- inventory management and stock control
- distribution of stock from the health facility storeroom
- good dispensing practices
- rational prescription and use of medicines
- disposal of expired, damaged, or obsolete items
- training and performance improvement of supply staff
- supervision of supply management

This chapter outlines the essential elements of managing supplies at the district and sub-district levels and in nongovernmental organizations (NGOs), provides practical guidance in assessing and improving the supply system at that level, and offers a range of other technical and managerial resources and references that will enable you to improve your management skills and study the areas that interest you further. Each section also provides overviews, guidelines, and checklists that will help you and your team identify and resolve major problems.

## Introduction

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Most leading causes of death and disability in developing countries can be prevented, treated, or alleviated with cost-effective essential medicines. Despite this fact, hundreds of millions of people do not have access to essential medicines, and for those who do have access, incorrect use of medicines limits their effectiveness.

Even when we invest large amounts of money in medicines, we often do not make the best use of that resource. Poor leadership and management can result in wastage in all its forms—from expired medicines to damaged stock to medicines that are never used—and underlie the failure to make the best use of medicines.

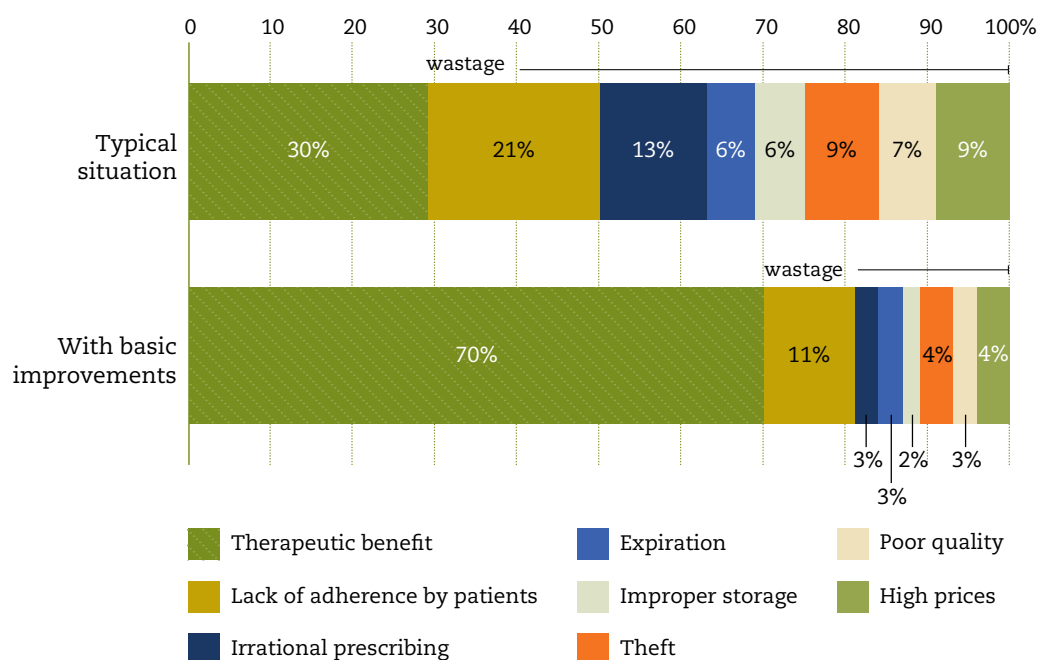
This chapter recommends practical ways in which the diverse players involved in a supply management system can improve the performance of their facility or organization.

Although written primarily for district managers and health facility staff, this chapter also provides information and insights for government policymakers, managers of essential medicine programs, NGOs, and donors interested in improving the functioning of public health supply systems.

Because medicines are costly—they frequently account for 30 to 50 percent of health budgets—and their management is quite different from that of other consumer products, handling by specialists is needed to ensure maintenance of their potency and effectiveness. In addition to their direct value to individuals, medicines also serve to generate trust and participation in health services. A health center without medicines to dispense, no matter how well staffed and maintained, soon loses its credibility in the community.

Improved supply management can bring dramatic improvements in the availability of medicines and the effectiveness of their provision. In a typical supply system, up to 70 percent of the funding invested in essential medicines can be lost or wasted. With only basic management improvements, it is possible to make a significant change, as Figure 1 illustrates. Note that all the categories except “therapeutic benefit” represent various types of wastage.

FIGURE 1. How Reducing Common Types of Wastage Can Increase Therapeutic Benefit



Note: Percentages add to more than 100% because of rounding.

In 1975 the World Health Organization (WHO) defined essential medicines as those medicines that meet the needs of the majority of the population. Since that time, much experience has been acquired in managing medicines, and some broad lessons have emerged from that experience, including the following:

- A national policy provides the necessary sound foundation for managing medicine supply.
- Prudent selection of medicines and the use of an essential drugs list (EDL) underlie all other improvements.
- Effective supply chain management saves time and money and improves performance: you cannot afford *not* to invest in effective supply management.
- Rational use of medicines requires far more than pharmaceutical information.
- Systematic assessment and monitoring are essential to the supply management system.

The recommendations and information in this chapter fall within this broad supply management framework. Logistics can be complex, with many interlinking components and factors, but it is possible, using the resources already available in most developing countries, to ensure an uninterrupted supply of medicines at the point of service, even in the most challenging environments. The use of computer technology has added greatly to the ease and practicality of data processing and the provision of the information needed for management decisions.

## THE PHARMACEUTICAL MANAGEMENT CYCLE

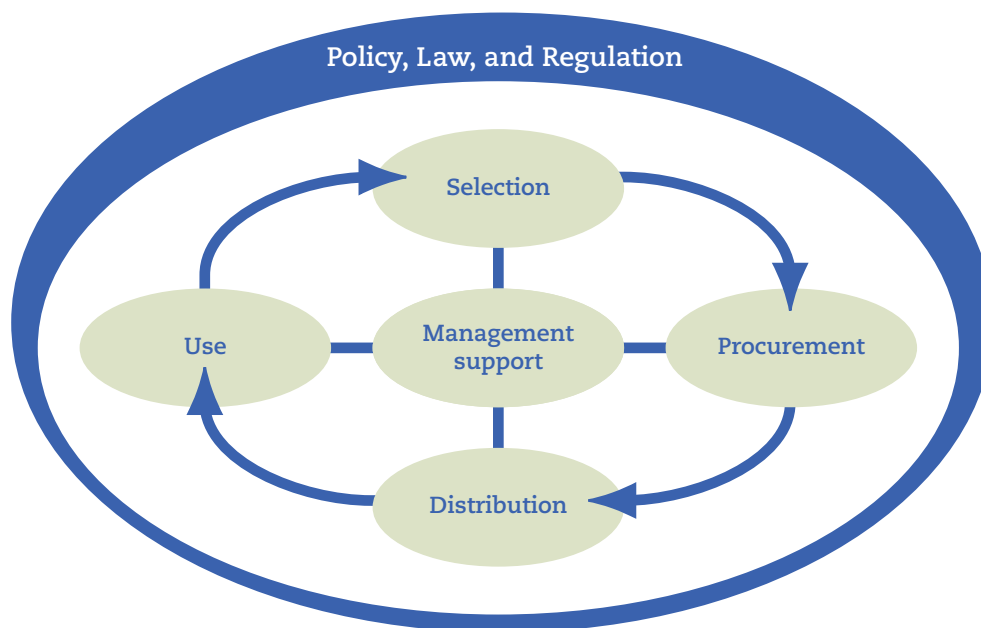
Pharmaceutical management comprises four basic functions: selection, procurement, distribution, and use.

- **Selection** involves reviewing the prevalent health problems, identifying treatments of choice, choosing individual medicines and dosage forms, and deciding which medicines will be available at each level of the health system.
- **Procurement** includes quantifying medicine requirements, selecting procurement methods, managing tenders, establishing contract terms, and ensuring pharmaceutical quality adherence to contract terms.
- **Distribution** includes clearing customs, stock control, store management, and delivery to depots, pharmacies, and health facilities.
- **Use** includes diagnosing, prescribing, dispensing, and proper consumption by the patient.

In the pharmaceutical management cycle (see [Figure 2](#)), each major function builds on the previous function and leads logically to the next. Selection should be based on actual experience with health needs and medicine use; procurement requirements follow from selection decisions, and so forth.

At the center of the pharmaceutical management cycle is the core of related management support systems, including the planning and organization of services, financing and financial management, information management, and human resource management. These management support systems hold the pharmaceutical management cycle together.

FIGURE 2. Pharmaceutical Management Cycle



Although individual parts of the cycle may function independently for a short time, the cycle as a whole will soon cease to operate and patient care will suffer without effective leadership, a functional organizational structure, adequate and sustainable financing, reliable management information, and motivated staff.

Finally, the entire cycle rests on a policy and legal framework that establishes and supports the public commitment to essential medicine supply.

In NGOs and at the district level, the focus of management activities in this chapter, the most relevant elements of the pharmaceutical management cycle are distribution, including storage and stock management, and use. This chapter concentrates on those areas. For those interested in reading more widely about the pharmaceutical management cycle, please refer to Chapter 46 of *MDS-3: Managing Access to Medicines and Health Technologies* (MSH 2012).

#### Managing and leading practices are important for effective supply management.

Why is it so difficult to make supply management work effectively? Supply management is not difficult, but it does require:

- recognition of the value of supply management to the public health system;
- the commitment of funding and resources (which will be amply repaid in greatly reduced wastage);
- willingness to systematically apply the simple supply management techniques described in this chapter
- effective leadership and management practices, as discussed in Chapter 2:
  - **scanning** the system for problems and opportunities to ensure proper management of supplies;
  - **focusing** resources based on a well-defined plan to properly procure, store, and distribute supplies;



- **aligning** stakeholders, including staff at all levels, around a shared vision of proper supply management and mobilizing resources to reach that goal;
- **inspiring** teams to maintain the diligence necessary to ensure effective supply management;
- **planning** the quantities and use of supplies at all levels;
- **organizing** the structures, systems, and processes necessary for efficient supply management;
- **implementing** plans successfully to achieve appropriate storage, inventory levels, and use of supplies;
- **monitoring and evaluating** the supply chain continuously to ensure the system works well.

### Global Fund Procurement

Procurement regulations for the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) seek to promote good procurement practice. In general, they follow regulations similar to the rules of other institutions and donor agencies. There are, however, demanding requirements related to product and supplier selection, which are designed to ensure product quality and maintain an audit trail that will promote the integrity and quality of the procurement process.

The practical impact of these requirements is that procurement with GFATM funds can by and large be satisfactorily carried out only by principal recipients at the national level, where procurement requirements can be pooled and a procurement team experienced in international purchasing can manage the process and ensure compliance with GFATM policies and requirements.

For district officers and others involved in GFATM programs, however, it may be interesting to know something about GFATM policies and procedures in relation to procurement. The GFATM [publication](#) “Guide to the Global Fund’s Policies on Procurement and Supply Management” provides this information.

The Global Fund’s voluntary pooled procurement (VPP) mechanism, initiated in May 2009, will be of special interest to those receiving small grants and those with little experience with international procurement mechanisms. Principal recipients wishing to use this mechanism will be able to procure first- and second-line antiretrovirals (ARVs), medicines for artemisinin-based combination therapy (ACT), and the long-lasting insecticide-treated nets (LLINs) recommended by the WHO Pesticide Evaluation Scheme (WHOPES). In addition, a broader range of health products is available to meet the individual needs of principal recipients.

More information on the VPP mechanism can be found on the GFATM web page titled, [Procurement Support Services](#).

Further information from the Global Fund and WHO on LLINs covers the following topics:

- [procuring long-lasting insecticidal nets](#)
- [recommended long-lasting insecticidal nets](#)
- WHO’s [World Malaria Reports](#)
- [specifications for public health pesticides](#)

## Managing the storage of medicines and health products

This section of the chapter provides detailed information that health workers who handle medicines and medical supplies need to know. The content is organized into eight subsections, which are numbered for ease of reference. The links below will allow you to navigate easily to find the section in which you are interested.

- |    |       |   |
|----|-------|---|
| 1. | I.    | <a href="#"><u>How to Set Up, Maintain, and Organize a Pharmacy Store</u></a> |
| 2. | II.   | <a href="#"><u>Organizing Supplies in the Storage Area</u></a>                |
| 3. | III.  | <a href="#"><u>Receiving and Arrangement of Stock</u></a>                     |
| 4. | IV.   | <a href="#"><u>Stock Rotation and Expiry Monitoring</u></a>                   |
| 5. | V.    | <a href="#"><u>Products that Require Special Storage Conditions</u></a>       |
| 6. | VI.   | <a href="#"><u>Conducting a Physical Inventory</u></a>                        |
| 7. | VII.  | <a href="#"><u>Maintaining the Quality of Products in Storage</u></a>         |
| 8. | VIII. | <a href="#"><u>Waste Management</u></a>                                       |

### I. HOW TO SET UP, MAINTAIN, AND ORGANIZE A PHARMACY STORE

All health facilities, from health posts to comprehensive health clinics and large hospitals, use medicines and related supplies. It takes a team effort to manage these supplies, involving all types and levels of staff: doctors, nurses, health workers, and storekeepers. This is especially true in small facilities with only one or two health workers. Each staff member has an important role and should know how to manage all supplies at the health facility correctly.

Medicines and related supplies are expensive and valuable. They need care so they will not deteriorate. If they deteriorate, they may lose their potency, have the wrong effects on patients, or, in the case of test kits, may produce incorrect results.

This section provides an overview on preparing a store at your health care facility. For a quick reference on procedures related to physical conditions, see the Physical Conditions Checklist in [Appendix A](#) in this chapter.

**Choosing a secured room to serve as a store.** A store is a simple way to keep supplies safe. Having all stock in one place also makes it easier for you to know what you have.

Your health facility should have a room that can be locked, is in good condition, and is well organized. That room will be your pharmacy store. It should be separate from where you dispense medicines. You should keep all supplies in the store and take (or issue) what you need daily from the store to a dispensing area. If your health facility does not have a room to use as a pharmacy store, you should have a lockable cupboard or cabinet with shelves to serve as your store.

The store should be large enough to fit all the supplies. Inside the store, there should be an additional secured area where narcotics and expensive items such as ARV medicines are kept.

Secure all openings (such as windows) with grills or bars to deter theft. Lock your store and limit the number of keys that are made, especially for areas where narcotics and expensive items are kept. Limit access to the store. Only the most senior storekeeper or pharmacist, and perhaps one other staff member, should have access to the store.

Your country's laws and regulations about the storage of pharmaceuticals and medical supplies must be adhered to. The national regulatory authority in each country will be able to give advice on this and provide relevant guidelines.

**Keeping your store in good condition.** Extreme temperatures, light, or humidity may cause medicines to deteriorate. Heat affects all medicines, especially liquids, ointments, and suppositories. Some medicines that are light sensitive, such as injectables, spoil very quickly when exposed to light. Humidity can spoil tablets and capsules because they easily absorb water from the air, making them sticky and causing them to deteriorate.

All products need to be kept in their original packaging, containers, or boxes. Follow the storage instructions given on the labels.

Keep your store clean and organized. This will make it easy to find supplies and help keep supplies in good condition and ready to be used.

**Maintaining and using refrigerators and freezers.** If there is a refrigerator or freezer, keep it in good working condition. Opening and closing the door frequently will increase the temperature and cause medicines or test kits to deteriorate. Do not keep staff food in the refrigerator.

Follow the instructions you received from your supervisor or district coordinator on how to pack a refrigerator or freezer. Check that there is enough space around the refrigerator so that air can move freely. Record the temperature inside the refrigerator or freezer daily.

**Organizing medicines and health products in your store.** The following principles will help you organize supplies in your main storage area, refrigerated area, and secure area. The more detailed guidance in [Section III](#) also generally holds true for a pharmacy store.

**Store similar items together.** “Similar” refers to the route of administration (external, internal, or injectable) and form of preparation (dry or liquid medicines). Store medicines in the following groups: externals, internals, and injectables. Shelf tablets and capsules together. Shelf liquids and ointments together. Shelf other health products and supplies together. Organizing each group of items in alphabetical order often improves store organization and simplifies stock management.

See the information in Section II about [controlling access](#) to medicines requiring special attention or control, such as ARVs and controlled substances.

[Box 1](#) provides three examples of storing similar medicines together.

### BOX 1. Examples of Storing Similar Medicines Together

- Ketoconazole 2% cream and ketoconazole 200 mg tablets are available. The cream is put on the skin (external) and the tablets are taken orally (internal). The health worker stores the cream with the externals and the tablets with the internals.
- Amoxicillin 250 mg tablets and amoxicillin 125 mg/5 ml oral suspension are also available. Both items are internals. The health worker stores the tablets with the other tablets and capsules. The oral suspension is placed with other liquids.
- A new supply of nevirapine tablets has arrived. The health worker stores the tablets in a locked cabinet with the other ARV tablets.

If there are three or more shelves in your store, organize your supplies as follows:

- **Top shelves:** Store dry medicines (tablets, capsules, oral rehydration packets) on the top shelves. Use airtight containers. If the top shelf is near the ceiling or out of your reach, use that shelf to store items that are not sensitive to heat and not used regularly.
- **Middle shelves:** Store liquids, including injectables and ointments, on the middle shelves. Do not put dry medicines below them. If liquids leak, the dry medicines may spoil.
- **Bottom shelves.** Store other supplies, such as surgical items, laboratory supplies, condoms, and labels on the lowest shelves.

**Identify the products' generic names.** Find the generic name of each medicine in your store. The generic name is the chemical name of a medicine and should be listed on its label. The generic name is different from the brand name, which is the name given by the manufacturer.

There may be many brand names for the same generic medicine. For example, some of the brand names for cotrimoxazole (sulfamethoxazole plus trimethoprim) are Cotrex, Cotrim, Bactrim, and Septrin.

**Arrange and label the supplies.** Arrange and label the supplies on the shelves as follows:

- Within each group, arrange the supplies in alphabetical order by generic name. Allow enough space for each item.
- Group identical items in amounts that are easy to count, such as in pairs or groups of 5 or 10.
- Print the generic name of each item on labels. Attach a label to the front of each item on the shelf.

When you organize your supplies in this way, it will be easy for you to see what and how much you have. You will be less likely to confuse items that are similar in appearance or name.

**Group products by expiry date.** The expiry date is very useful in storing and managing the stocks of pharmaceuticals.

The **first expiry, first out (FEFO)** method of inventory management involves issuing products with the earliest expiry date first, regardless of the order in which they are received. This method helps prevent expiration of valuable pharmaceuticals.

All pharmaceuticals have labels that include an expiry date established by the manufacturer. This is a very important piece of information for the dispenser and patient, because if the medicine is used after this date, its quality and efficacy are not guaranteed and the patient cannot be sure it will have the desired treatment effect. If pharmaceutical labels do not include an expiry date, this can be an indication of poor-quality manufacturing. You should bring this omission to the attention of the appropriate supervisor.

Pharmaceutical stock must therefore be stored and controlled so that the stock that will expire first is issued first. Newly arrived stock sometimes has an earlier expiry date than stock already in the store—especially when there are multiple sources of supply for an item, or stock is returned or transferred from another store. In a FEFO system, first-expiring stock is “promoted” to make sure it is issued first. Such promotion is usually a combination of physical placement—the earliest-expiring stock is placed at the front of the shelf so that will be picked first—and good record control, which tracks the expiry dates of all items in stock.

For example, if you have received two shipments of amoxicillin, and the first shipment received has an expiry date of November 2012, while the second shipment has an expiry date of August 2011, you would issue the stock that expires in August 2011 first, even though you received it after the stock that expires in 2012.

You should store medical supplies and other commodities without expiry dates using **first in, first out (FIFO)** procedures. For items that arrive without expiry or manufacture dates, record the date of arrival on the stock and the records, and use a FIFO system. It follows the same principles as the FEFO system—the stock that expires soonest goes at the front of the shelf—but you track the receipt dates rather than the expiry dates.

Follow these steps to remove expired and poor-quality items from the store:

- Identify all expired and other poor-quality medicines and related supplies.
- Identify overstocked items and any items that are no longer used at your health facility.
- If items are still within their expiry date, arrange for them to be returned to central stores or sent to other facilities where they are needed. Follow your health facility’s policy to remove these items. In case of doubt, contact your supervisor or district coordinator.
- Keep a record of the removal of medicines and related supplies.
- Indicators of poor-quality or damaged supplies appear in [Section VII](#) of this chapter. Use it to help you determine unacceptable items in your store.

## II. ORGANIZING SUPPLIES IN THE STORAGE AREA

Storage areas must be clean, properly arranged, and secured. The temperature must also be controlled (if needed, an air conditioner or ceiling fan should be installed) and the area well-ventilated but not exposed to dust. One rule of thumb is that if you feel too hot in the storeroom, the products are also being exposed to high temperatures.

Even though most medicines are packaged in sealed containers, moisture can still be more damaging to medicines than high temperatures. So there must be proper drainage, and no boxes or goods should ever be in direct contact with the floor. They must be placed on pallets or racks. Many products, particularly injectable forms, are sensitive to direct sunlight. Keep the vials in their boxes and if necessary hang curtains on the windows.

Regardless of the type of storage (warehouse, storeroom, shelves, or a cupboard), the products must be systematically arranged. There are several ways of classifying medicines and health products. Whichever system is used, it is important that all employees know the system being used and can work with it effectively.

Module 3 of [Managing TB Medicines at the Primary Level](#) (Rational Pharmaceutical Management Plus 2007) contains useful guidance on storage of tuberculosis (TB) medicines, much of which is generally applicable to all medicines.

You can also use Appendix B in this chapter, the [Storage Procedures Checklist](#), with your team to determine how well storage is being managed and plan improvements.

**Principles of good storage.** For all types of storage:

- Follow the manufacturer or shipper's directions when stacking, and follow labels for storage conditions.
- Place liquid products on the lower shelves or on the bottom of stacks.
- Store products that require cold storage in appropriate temperature-controlled zones.
- Store high-security and high-value products in appropriate security zones.
- Separate damaged or expired products from usable stock without delay, and dispose of them using established disposal procedures. See the sections on [waste management](#) and [disposal](#).
- Store all commodities in a manner that facilitates FEFO policy for stock management.
- Arrange cartons so arrows point up and identification labels, expiry dates, and manufacturing dates are visible. If this is not possible, write the product name and expiry date clearly on the visible side.

**Common classification systems for smaller stores and dispensaries.** There are three common classification systems for smaller stores and dispensaries: by generic name in alphabetical order, by dosage form, or by therapeutic category.

- **In alphabetical order by generic name.** This classification is found in both large and small facilities.
- **By dosage form.** Similar dosage forms (for example, tablets, injectables, oral liquids, ointments, etc.) can be stored together. Products are sorted

alphabetically within each category. This method is simple to apply and maintain. It does not require much medical knowledge, and it allows the optimal use of the storage space because packages of similar size and requiring similar storage conditions are kept together.

- **By therapeutic category.** You can store products with the same therapeutic properties together, using the classification from the list of essential medicines. For example, all antibiotics can be stored together, all antihypertensive medicines can be stored together, and so on. Products are then sorted alphabetically within each category. This method is more complex to maintain and is best suited to stores or dispensaries where the staff responsible for the storeroom are knowledgeable about the therapeutic class of each product.

**Classification systems for larger stores.** In large stores, where the range and quantity of stock being held are greater, different systems are needed. In these settings, the following systems are most common.

- **Health system level.** In this system, items for different levels of the health care system are kept together. This works well in central or regional stores when, for example, essential medicines kits (compilations of common medicines in kit form) for primary health care are in use.
- **Frequency of use.** Fast-moving products are placed in the front of the working area in this system, to minimize the amount of movement required to pick and pack the items that are ready for dispatch to the customer.
- **Random location.** A specific storage space, such as a pallet or shelf, is assigned a unique location code that corresponds to its aisle, shelf, and position on the shelf. This system works best with a computerized warehouse management system.

**Arranging stock by expiry date.** Once a classification method is chosen, items with an expiry date have to be stored using the FEFO method. Items with a shorter expiry date should be stored in front of those with a longer expiry date.

If the products do not have any expiry date, the FIFO method should be used. Items newly received should be stored behind the ones already on the shelves.

**Controlled access.** Some products need storage in an environment with controlled access. It is important to identify products that are at risk of theft or abuse, have the potential for addiction, or have legal or regulatory requirements; be sure to provide increased security for those items.

Controlled products should include those that are in high demand or have the potential for resale on the black market. Medicines such as ARVs and ACT may need to be kept in secure storage because they are scarce, expensive, and in high demand and short supply.

Examples of controlled products requiring special attention also include narcotics (such as pethidine and morphine), opioids and strong analgesics (such as codeine), and psychotropic medicines (such as diazepam).



Some of these medicines are **controlled substances**, which are medicines handled under international control. These medicines need greater attention. There are specific procedures in place for the procurement, reception, storage, dispensing, and administration of controlled substances.

**Secure, access-controlled storage.** If you have products that need increased security, such as ARVs, new antibiotics, or any items with value in the local market, you must establish access-controlled storage.

It is essential to be fully aware of the regulatory requirements for the storage of controlled substances in your country. In addition to the security measures detailed below, it may be necessary to register the premises, use two-key or double-padlock systems so that two staff members must always be present when the medicines are being accessed, and have a staff member with specific qualifications (typically a senior pharmacist) be in control of access and all stock transactions.

Security measures will probably include storing the products in a separate locked room, cabinet, or safe, or a locked wire cage within the storage facility. These areas should be set up so that an alarm is activated if the products are accessed improperly. Entry to such areas must be limited to the most senior staff. Limit the number of keys made for the controlled location and keep a list of people who have keys.

**Donated products.** Managing the storage of donated medicines can be complicated by donors' requirements to store and account for them in ways different from those for other medicines. Some donor organizations require that medicines from different funding rounds be stored and reported separately. Supply management, and effective use of available storage space, is easier if such a requirement is not imposed. Wherever possible, it is best if the donating organization can be persuaded not to require separate storage and to accept the storage and inventory reporting systems in common use. When this is not possible, the donated medicines will have to be stored apart from general stocks, and you will have to use separate stock records and reports.

### III. RECEIVING AND ARRANGEMENT OF STOCK

**Seven things to do when receiving supplies.** Following some basic steps will help you and your staff check the completeness and quality of deliveries of medicines and protect your facility or organization in case of fraud or theft.

**1. Receive the supplies in person.** All supplies should be received by at least one staff member at the time of delivery. Sometimes there will be an additional designated person to receive specific items, for controlled substances, for example. If this is the case at your health facility, both you and the designated person must be available to receive and check the supplies.

Check the delivery documentation against the original order. Make sure the number of boxes delivered matches what the medical store informs you was sent. This is often written on the delivery document.



**2. Check the outside of the boxes for any signs of damage or opening that could indicate theft.** Check for opened boxes. The bottom of a box may have been opened and carefully resealed after removing items. For example, someone may empty the contents from a tin and place the empty tin back into the carton.

Simply checking the number and quality of boxes can act as a deterrent to someone considering stealing supplies from your order.

**3. Keep a record of deliveries.** Delivery trucks often carry orders for several health care facilities on a delivery route. Supplies intended for your store or health facility may be delivered to another health facility by mistake. Keeping records of deliveries helps you to find and correct problems that may occur.

Record the delivery information each time you receive supplies and have the driver/person delivering countersign the document. Use a pen for this record so it cannot be easily changed.

At a minimum, the following information should be recorded at the time of delivery:

- date of delivery
- requisition/order number or, if that is not used, any information that would identify the order you placed
- issue voucher or delivery note number
- delivery person's name and signature
- delivery vehicle registration or license number
- number of boxes delivered
- signature of staff member(s) who received the supplies

Give a copy of the signed document to the driver for the supplier's records when the driver returns to the medical store. Keep delivery information in a secure and easily retrievable file.

If your health facility does not have a delivery form, you can make a form that includes all the essential information.

**4. Check the supplies received against the items ordered and items identified as delivered on the delivery note.** Remove the supplies from the boxes and read the original order and delivery forms. Review the items delivered against the quantities you ordered and received. Check that what you ordered is the same as what you received. Where the supplier has informed you that not everything you ordered was available, check that what you received is what the supplier says was sent.

If items are missing, order them again. If fewer supplies were received than were ordered, keep and use them, but plan on reordering these items soon. Notify your supervisor or local supply coordinator.

If you receive items that were not ordered or that are not listed on the requisition form, follow your policy for returning them. You may be able to keep and use some of the extra items, but be careful to check their expiry dates before accepting them. Check with your supervisor or local supply coordinator. If keeping the extra items means that your store will be overstocked or that items with shorter expiry dates will expire before you use them, return the extra items to the supplier.

**5. Check the expiry dates of all items.** Never accept expired items. Expired items may harm a patient or have no therapeutic effect. Check the expiry date against your receiving policy—which could be six months remaining until expiry, at a minimum. Follow your policy to return or dispose of them, and notify your supervisor or local coordinator.

**6. Check the basic quality of all items in the delivery.** Check for visual signs of damage or deterioration. Do not accept medicines that are poor quality or appear to have been tampered with.

Check and store all refrigerated items first. If refrigerated items, such as vaccines, are not packed in cold packs, they may have spoiled. *Do not accept them.* Look for temperature indicators—usually cards with a colored spot, which are increasingly being used to make certain that cold-chain temperatures are maintained throughout transit.

The section [“Maintaining the Quality of Products in Storage”](#) provides more detailed information about maintaining product quality.

Put any damaged or poor-quality items in a box to return to the supplier or medical store. Dispose of or return expired and poor-quality supplies as soon as possible, following the appropriate policy on removing poor-quality items from your store.

**7. Document all discrepancies.** Documenting discrepancies protects you. If any medicines or health products are missing or were overissued, expired, damaged or of poor quality, tell your supervisor and record the problem in writing.

- If you notice the discrepancy at the time of delivery, ask the driver or delivery person about it and note it on the delivery form.
- If you find the discrepancy after the delivery, contact the supplier and follow your policy on reporting a discrepancy.

A discrepancy report form provides an easy way to record discrepancies. Record all missing or overissued supplies and expired, damaged, and poor-quality items. Sign the record and keep it on file.

If you do not have a form, write a letter about the discrepancy, including all the information described in this section. Agree with your supervisor about who should receive the letter. Usually you should send a copy to the appropriate authority and the supplier or medical store, and keep one on file. Health facilities and lower-level medical stores usually receive medicines and health products from a central or regional medical store or from other sources, such as donors. Module 1 of [Managing TB Medicines at the Primary Level](#) contains guidance on receiving TB medicines, much of which is generally applicable to all medicines.

In some settings, supplies are delivered to the health facility, while in others supplies are collected from the medical store. Either way, when supplies are received, the responsible person who receives them should:

- make sure there is sufficient storage space;
- prepare and clean the areas used for receiving and storing the products.

It is important that what is delivered is the same as what was ordered. The person receiving stock must have a copy of the order and should check against both the order and delivery paperwork to make sure that no supplies have been lost, stolen, or damaged and that the delivered items are of the expected quality and not expired or near their expiry date.

If the products are not the same as you ordered, either in specification or quantity:

- If there is time, check with the relevant authority—pharmacy, laboratory, or other clinical section—to see if you can accept them or not.
- If there is not time to obtain clarification on acceptance while the truck is there, accept the goods provisionally or conditionally, marking the delivery note to that effect. Quarantine the supplies until clarification is obtained, and then either accept them into stock or arrange to return them.

If products appear damaged or expired:

- Separate the damaged or expired stock from the usable stock.
- If damage or expiry is discovered while the delivery truck is still at your site, refuse to accept the products and note the problem(s) on the delivery note.
- If damage or expiry is discovered after the delivery truck has departed, follow your facility's procedures for handling damaged or expired stock.

If products do not appear damaged or expired:

- Count the number of units of each product received and compare your count to the issue voucher.
- Record the date and the quantity received on the stock card and bin card, if applicable. (A bin card is a stock card kept on the shelf with the product that records the amount in that location only.)
- Make sure the expiry date is visibly marked on every package or unit.
- Arrange products in the storage area to facilitate the FEFO procedure.

Discrepancies in orders are common. They may include missing items or smaller quantities than ordered. They may also include items that are or are nearly expired, damaged, or of poor quality. Discrepancies are very costly and should not be ignored. For a quick reference on receiving supplies, see the [Receiving Supplies Checklist](#) in Appendix C.

#### IV. STOCK ROTATION AND EXPIRY MONITORING

When you issue products that have an expiry date, follow the FEFO guidelines to minimize wastage from product expiry:

- Always issue products that will expire first, double-checking to make sure that they are not too close to or past their expiration date. The shelf life remaining must be sufficient for the product to be used before the expiry date. Take special care with TB treatment kits: these contain medicines for a six-month treatment period, and so must have a minimum of a six-month expiry time remaining when they are issued to health facilities or dispensing centers.

- ARVs and other products that have come from the United States may have the date in the month-day-year format instead of the customary international standard of day, month, and year.
- To facilitate FEFO, place products that will expire first in front of products with a later expiry date.
- Write expiry dates on stock cards, so stocks can be sent to facilities at least six months before they expire.

## V. PRODUCTS THAT REQUIRE SPECIAL STORAGE CONDITIONS

The storage of flammables, corrosives, and products that require temperature-controlled conditions is discussed in this section.

**Flammables.** Some flammable liquids commonly used by the health care facilities include acetone, anesthetic ether, alcohols (before dilution), and kerosene. Large quantities of flammables can be stored on the premises if necessary, but they should be kept in a separate location away from the main storeroom. Large quantities of flammables should never be stored in the same areas as medicines.

A small stock of flammables may be kept in a steel cabinet in a well-ventilated area, away from open flames and electrical appliances in the main store. Whether you are storing large or small quantities of flammables, always store them in their original containers. The shelves of the cabinet should be designed to contain and isolate spillage. Mark the cabinets to indicate that they contain highly flammable liquids, and display an international hazard symbol like this one.



It is very important to store flammable materials in the coolest location possible and never in direct sunlight. It is also important to control the evaporation rate and avoid the buildup of pressure. This can be done, initially, through good design: providing temperature control and good open (nonmechanical) ventilation. The design for a small store of flammables may be as simple as locating it in a shaded area with double-layer roofing and open-block-style walls (in other words, if the structure is made of small bricks, every other brick in the wall is missing) or ventilation or “air” bricks that have holes in them. During hot weather, it may be necessary to spray water over the structure and to place especially volatile items, such as ether, in dishes of water.

The flammables store should be at least 20 meters away from other buildings. Fire-fighting equipment should be readily available.

**Corrosives.** Corrosive substances commonly found in hospitals or other high-level health facilities include acetic acid, concentrated ammonia solutions, silver nitrate, and sodium nitrate.

Never store corrosive substances close to flammables. Ideally, corrosive materials should be stored in a separate steel cabinet to prevent leakage. Use appropriate industrial protective gloves and eyeglasses when handling these items. Protect workers by making the necessary safety equipment available for the quantities of corrosive stored, which for large quantities may include eyewash and flood showers.

**Temperature-controlled products.** Cold-chain defects are a frequent cause of problems in immunization programs. The potency of vaccines, blood products, test kits, and many other items depends on cold storage. Vaccines, in particular, must be kept at precisely controlled temperatures from the point of manufacture to the point of administration.

National and regional vaccine stores should be equipped with standby generators; ideally, district vaccine stores should have them as well. Having backups ensures that vaccines and other products are protected in the event of a power failure.

A collaboration between WHO and PATH, known as [Optimize: Immunization Systems and Technologies for Tomorrow](#), has published comprehensive materials on assessing, designing, and implementing a cold chain. Please refer to this material for detailed technical advice. Box 2 lists some relevant publications.

## VI. CONDUCTING A PHYSICAL INVENTORY

A physical inventory is the process of counting by hand the number of each type of product in your store at any given time. A physical inventory allows you to check that the stock on hand matches stockkeeping records. When you conduct a physical inventory, count each product individually by generic name, dosage form, and strength.

There are two common kinds of physical inventory: a complete physical inventory and a cyclic or perpetual physical inventory.

**Complete physical inventory.** In a complete inventory, all products are counted at the same time. A complete inventory should be done at least once a year in all stores, but more frequent inventories (quarterly or monthly) are recommended. A complete physical inventory is easier to conduct regularly at facilities that manage small quantities of products. If you manage a large warehouse, you may need to close the storage facility for a day or longer.

**Cyclic or perpetual physical inventory.** In a cyclic or perpetual inventory, selected products are counted and checked against the stockkeeping records on a rotating or regular basis throughout the year. Cyclic or perpetual physical inventories are usually appropriate at facilities that manage large quantities of products. If a cyclic physical inventory is used, count each product at least once during the year. Count fast-moving and sensitive products more frequently.

### BOX 2. Publications about the Cold Chain

- PATH and WHO. [“2009–2012 Optimize Strategy.”](#)
- PATH and WHO. [“Landscape Analysis: Analysis of EVSM.”](#) [effective vaccine stores management] February 2008.
- PATH and WHO. [“Landscape Analysis: Analysis of VMAT.”](#) [vaccine management assessment tool] October 2008.
- PATH and WHO. [“Landscape Analysis: Cool Chain Technologies.”](#) June 2008.
- PATH and WHO. [“Developing a Vision for Immunization Supply Systems in 2020: Landscape Analysis Summaries.”](#) 2011.

**Organizing a cyclic physical inventory.** There are a number of ways to organize a cyclic physical inventory. The most common are by:

- **Dosage form:** Count tablets in January, capsules in February, liquids in March, etc.
- **Location in the storeroom:** Count shelves 1–4 in January, 5–8 in February, etc.
- **Time availability:** Count a few items each day whenever staff have time. In large stores, a full-time staff is needed for conducting cyclic physical inventory checks.
- **Stock on hand:** Periodically count each item for which stock on hand is at or below the minimum inventory level.

## VII. MAINTAINING THE QUALITY OF PRODUCTS IN STORAGE

This section covers five topics: indicators of quality problems, preventing damage in general, protecting against fire, preventing pests, and preventing theft. The specific checklists for each topic are in [Appendix D](#) in this chapter and will help you train your staff and manage these potential problems.

Products of different types show damage in different ways. Some indicators you can use to detect damage appear in [Table 1](#).

Damaged products should never be issued to facilities or dispensed to patients. If you are not sure if a product is damaged, check with someone who knows. Do not issue or dispense products that you suspect are damaged.

When your supervisor or local coordinator or an inspector visits your facility, report any problems to him or her. The following list describes areas where you, as manager of a health program or health services, can prevent damage or loss.

**Physical damage.** Avoid crushing products stored in bulk. As a general rule, do not stack them higher than 2.5 meters (8 feet). Heavy or fragile items (such as those packaged in glass) should be placed in small stacks. Bind sharp edges or corners in the store with tape. Most important, arrange products so that nothing in the store can fall and injure members of the staff.

**Cleaning.** Sweep and mop or scrub the floors of the storeroom regularly. Wipe down the shelves and products to remove dust and dirt. Dispose of garbage and other waste often and in a manner that avoids attracting pests. Store garbage in covered bins.

**Heat and humidity.** Try to maintain the store at a constant temperature. Use a wall thermometer to monitor and record the temperature at least daily.

Simple ventilation systems such as extract fans can reduce both the temperature and humidity.

In cold countries, protect the store from frost damage using insulation. If necessary, a low-powered covered light bulb (“hot box”) heater or oil immersion heater can be used

TABLE 1. Indicators of Damage to Pharmaceutical Products

Type of Product	Signs of Damage
All products	<ul style="list-style-type: none"> <li>■ broken or ripped packaging (vials, bottles, boxes, etc.)</li> <li>■ missing, incomplete, or unreadable label(s)</li> <li>■ blackening of the packing, which may indicate fungal growth in the packing material from extreme humidity, water damage, leakage of liquids, or low-quality glue used in the packing material</li> </ul>
Liquids	<ul style="list-style-type: none"> <li>■ discoloration</li> <li>■ cloudiness</li> <li>■ sediment</li> <li>■ broken seal on bottle</li> <li>■ cracks in ampoule, bottle, or vial</li> <li>■ dampness or moisture in the packaging</li> </ul>
Light-sensitive products (such as X-ray film)	<ul style="list-style-type: none"> <li>■ torn or ripped packaging</li> </ul>
Latex products	<ul style="list-style-type: none"> <li>■ dryness</li> <li>■ brittleness</li> <li>■ cracks</li> </ul>
Lubricated latex products	<ul style="list-style-type: none"> <li>■ sticky packaging</li> <li>■ discolored product or lubricant</li> <li>■ stained packaging</li> <li>■ leakage of the lubricant (moist or damp packaging)</li> </ul>
Tablets	<ul style="list-style-type: none"> <li>■ discoloration</li> <li>■ crumbled pills</li> <li>■ missing pills (from blister pack)</li> <li>■ stickiness (especially coated tablets)</li> <li>■ unusual smell</li> </ul>
Injectables	<ul style="list-style-type: none"> <li>■ liquid that does not return to suspension after being shaken</li> <li>■ foreign particles</li> </ul>
Sterile products (including IUDs)	<ul style="list-style-type: none"> <li>■ torn or ripped packaging</li> <li>■ missing parts</li> <li>■ broken or bent parts</li> <li>■ moisture inside the packaging</li> <li>■ stained packaging</li> </ul>
Capsules	<ul style="list-style-type: none"> <li>■ discoloration</li> <li>■ stickiness</li> <li>■ crushed capsules</li> </ul>
Tubes	<ul style="list-style-type: none"> <li>■ sticky tube(s)</li> <li>■ leaking contents</li> <li>■ perforations or holes in the tube</li> </ul>
Foil packs	<ul style="list-style-type: none"> <li>■ perforated packaging</li> </ul>
Chemical reagents	<ul style="list-style-type: none"> <li>■ discoloration</li> </ul>



to provide protection from freezing during the colder months. In countries with severely cold winters, vaccines must also be protected against freezing and frost damage.

Make certain that boxes are at least 10 cms above floors and at least 30 cms away from walls and ceilings to enable adequate air circulation.

**Water damage.** In flood-prone areas, stack boxes well off the ground, at least 1 m. Keep roof gutters and external drainage such as monsoon ditches clear and inspect them regularly. If the roof might be subject to storm damage, consider covering the tops of all shelving with waterproof plastic sheets.

**Protecting against fire.** Use the following guidelines to prevent damage to products from fire.

- Remove waste and packing materials from the store. If you wish to sell or recycle the packing materials, store them away from the medicines until they are collected.
- Make standard fire extinguishers available in every storage facility according to national regulations.
- Visually inspect fire extinguishers every two to three months to check that their pressures have been maintained and the extinguishers are ready for use.
- Service fire extinguishers at least once a year.
- Place smoke detectors throughout the storage facility and check them every two to three months to make sure that they are working properly.
- Strictly prohibit smoking in the store.
- Conduct fire drills for personnel every six months.
- Clearly mark emergency exits and check regularly to be sure they are not blocked or inaccessible.
- Display fire precaution signs in appropriate places in the storage facility (especially in locations where flammables are stored).
- Use sand to extinguish fires where there are no fire extinguishers. Place buckets of sand near the door.

Be sure medical store staff are trained to use fire extinguishers correctly. [Appendix D](#) in this chapter provides more information about the types and uses of fire extinguishers.

**Preventing pests.** The [section on cleaning](#) above provides guidance on basic ways to prevent infestations by pests. [Appendix D](#) provides detailed checklists for preventing pest infestation inside and outside the storage facility. Click [here](#) for additional information on this topic.

**Protecting against theft.** Typically, between 10 and 20 percent of the medicines you stock will account for more than 70 percent of the total cost of all medicines used. These are the medicines that should be monitored most frequently.



To carry out additional monitoring of products likely to be stolen or misused:

- Check inventory records for stock on hand. Then conduct a physical inventory and compare the results.
- Check the inventory records to determine the consumption during a specified period. Then check medical charts or prescription ledgers, and count the number of treatment courses during the same period. Convert treatment courses into dose units, and compare this figure with the stock issued from the storage area.

If you find a significant discrepancy, report it to your supervisor and investigate further.

Signs of corrupt activity can include:

- overcharging of patients
- substitution of medicines or other essential supplies
- bribery or acceptance of unauthorized payments from patients or staff
- abuse of authority
- travel-related fraud, including falsely claiming per diems

Reporting suspicions of theft or other corrupt actions is most safe and effective when there is an explicit whistle-blower policy that encourages such reporting and provides a reporting mechanism that protects the person reporting the suspicion. In the absence of such a policy and mechanism, reports should be made only to someone in authority in whom you have complete confidence. Your report should contain the following information:

- what alleged wrongdoing you are reporting
- where and when (dates and times if available) the incident took place
- who the perpetrator(s) is
- how the individual or firm committed the alleged wrongdoing

Box 3 contains links to useful guidelines and information on the issue of corruption.

#### BOX 3. Links to Information about Corruption

- From the World Bank, a list of [anticorruption links](#);
- From WHO, [“Good Governance for Medicines”](#);
- From WHO, [“Curbing Corruption in Medicines Regulation and Supply”](#);
- From WHO, [“Good Governance for Medicines Program Progress”](#);
- Checklists for preventing theft during transport, in storage, and at health facilities are provided in [Appendix D](#).

## VIII. WASTE MANAGEMENT

It is important to dispose of pharmaceuticals properly because there can be serious negative consequences from improper disposal. Improper disposal can result in:

- environmental impacts, which may include contaminated water supplies, damage to flora (plants) and fauna (wildlife), and increases in antimicrobial resistance to medicines that have been inappropriately released into the environment;
- the diversion and resale of expired or inactive medicines;
- air pollution from improperly incinerated products.

Always follow your facility's procedures for handling damaged or expired medicines. In most cases, this will mean that you should send the products back to the warehouse that provides you with your supplies. Safe disposal of modern medicines is a specialized task that can often only be undertaken economically in bulk disposal facilities. Bearing this in mind, you might have to refer any need for medicine disposal to your regional or national health authority.

Storage facility grounds, including the area around health centers, must remain free of health care waste and other garbage. Maintaining a clean environment where pharmaceuticals and other health supplies are stored will reduce the number of pests, such as insects and rodents, and reduce the number of people, including children, who may be injured by used medical equipment or discarded medicines.

Check with local officials about laws that pertain to health care waste management and environmental protection before instituting a disposal technique.

Plan storage, transportation, and disposal techniques that are practical and simple. Monitor disposal practices on a regular, frequent basis.

[Appendix E](#) in this chapter provides guidelines for managing different kinds of waste. More detailed information can be found on the [WHO website](#).

## Inventory management and stock control

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A well-functioning supply management system is essential for the effectiveness of the health system as a whole and, therefore, to the well-being of patients.

### INVENTORY MANAGEMENT

**Benefits of a successful inventory control system at the facility level.** Maintaining a sufficient stock of items at a health facility has many benefits. Patients receive medicines promptly, and stock-outs can be prevented even when deliveries to the store are delayed. Supplies can be replenished at scheduled intervals, saving on administrative costs and transport time. Patients have confidence in the facility and seek help when they are ill. In addition, an effective inventory control system keeps track of and guarantees accountability for supplies.

Stock cards are the inventory management tool used to monitor stock level and consumption of medicines and health supplies. By monitoring the rate of consumption, the staff responsible for managing stocks can forecast future requirements with accuracy.

**Problems arising from poor stock control.** When inventory control fails, problems occur. A patient's condition may worsen because of a delay in treatment, or antimicrobial resistance may develop because a course of treatment was not completed. A patient may even die if a lifesaving medicine is out of stock. If medicines are not available in rural facilities, patients may have to make long and expensive journeys to obtain treatment. If the availability of medicines at the secondary level is better than at the primary level, the community will lose confidence in primary health care and seek hospital treatment instead.

Frequent stock-outs may establish or reinforce poor prescribing habits. For example, when a medicine is out of stock, a less suitable alternative may be prescribed. Emergency orders, which are expensive for the purchaser and inconvenient for the supplier, may be required.

**Cost of maintaining stock.** Stocking a new health facility can account for a significant amount of the facility's total annual budget. If stock is managed well, however, future expenses will be consistent with use. An efficient inventory control system saves money. Poor inventory control leads to wastage or increased costs for holding stock. For example:

- Overstocking of certain items may tie up a substantial portion of the pharmaceutical budget, leaving insufficient funds for other important, perhaps lifesaving, medicines.
  - Overstocked medicines often expire.
  - Poor storage conditions may result in spoiled stock (for example, dressings may be soaked by a leak in the roof, or injectable medicines may lose potency if the storeroom is too hot).
  - Poor stock records and poor security make theft easier.
  - A change in prescribing policy or practice may make a medicine obsolete.
- Without good inventory control, such changes may result in excessive wastage.

**The role of leaders and managers in improving inventory management.** Whether you are a supply officer, facility manager or clinic director, district manager or local supply coordinator, or provincial or national manager of medicines, you play a critical role in helping staff and stakeholders understand the costs and benefits of good management of medicines and health products. You apply good leadership and management practices in your work, for example, by inspiring staff and organizing them to implement improvements to inventory management systems.

Staff sometimes resist the implementation of inventory control systems. The reasons should not be ignored but rather brought out into the open for discussion. Common reasons for resistance are a perceived lack of time for record-keeping or the feeling that “this is not my job.” Lack of appropriate training may also play a major role in resistance to new systems.

An advocate on staff can demonstrate that the time used for inventory management activities is time well spent. Patients also need to understand that the time health workers spend to maintain records helps ensure that their medicines will be available during their next visit.

**Using stock records for ordering stock.** Successful supply management means that the required items are available for the patients who need them. Supplies are more likely to be available if you order them regularly and in the correct quantities. In general, the amount of supplies to be ordered should be based on the amount that is used or their past consumption. Well-maintained stock records contain all the data required for deciding what to order, when to order, and the quantities to order.

For a quick reference on supply ordering, see the [Ordering Supplies Checklist](#) in Appendix F.

## STOCK CONTROL

**Standard list of stock items.** Each medical store should maintain a standard list of stock items that includes all the products it handles, with their specifications, including form, strength, and quantity per package. The list should be regularly updated and distributed to substores and units.

Do not order products that are not on the standard list unless you have specific permission. You should not accept deliveries of products not on the list unless special circumstances have been identified.

Stock records should be maintained for all products on the list.

**Stock records.** It is important to keep good records of all the medicines and related supplies you have in stock. This helps you understand the flow of supplies into and out of your health care facility. It will also help you know:

- what items are available in stock
- how much is available of each item in stock
- how much stock is used on a regular basis

In addition, keeping records serves as the basis for the information needed when ordering new stocks of medicines and other supplies.

Keeping records saves you time and protects all the supply staff. If there are accusations of theft or misuse of supplies, you will be able to refer to your records and provide a clear audit trail and evidence. Your records will document the movement of supplies. They can show that you are not responsible for the problem.

There are different ways of keeping records. The procedures recommended in this section are based on the use of a typical stock card format. Your store, health care facility, or organization may have its own stock card format. Stock cards can be made or modified to fit most types of record-keeping systems.

For a quick reference on record-keeping procedures, see the [Stock Card Checklist](#) in Appendix F. Modules 2 and 4 of [Managing TB Medicines at the Primary Level](#) also contains useful guidance on keeping records and calculating orders for TB medicines, much of which is generally applicable to all medicines.

## THE STOCK CARD AND STOCK CARD SYSTEM

Stock cards are essential to manage supplies correctly. You will refer to the information recorded on the cards as you manage medicines and related supplies. A good reference for explaining the value of stock cards and training staff in their use is Andy Gray's [“Using Stock Cards to Improve Drug Management.”](#)

There should be a stock card for each item in your store. In small stores, keep the stock card with the item on the shelf. Use the stock card to track the movement of the item. Record when and how the item is used. This includes all movements, such as when a new shipment of an item arrives at the store, when an item is moved out of the storeroom to the dispensary, or when an item is dispensed directly to a patient.

If your store receives supplies from donors, there may be special requirements. Follow the instructions you have received from your supervisor or local coordinator.

A typical stock card, such as the one illustrated in [Figure 3](#), would record the following information at the top:

- **item:** generic name of product, including its form and strength;
- **code number:** number that identifies the item, if there is one;
- **unit and size:** type of container (tin, bottle, tube, blister package, etc.) and the amount of item in the container;
- **price or per unit cost:** if this information is collected at your store.

There may be an item in your store that has different forms, strengths or unit sizes. Examples of differences include:

- **forms:** medicine can be in tablet, liquid, or ointment form;
- **strengths:** for example, amoxicillin can be in 250 mg tablets or 500 mg tablets;
- **unit sizes:** a tin of tablets can contain 50, 100, 500, or more tablets.

If you have an item in your store with more than one form, strength, or unit size, use a separate stock card for each one. Treat each different form, strength, or unit size as a separate stock item.

A typical stock card also has columns for recording information about the movement of the item:

- **date:** when the item is received into the store or issued out of the store;
- **received from:** name of supplier or medical store;
- **quantity received:** number of units received at the store;
- **issued to:** name of health facility and/or dispensing area where the item will be used or dispensed to patients;
- **quantity issued:** number of units issued from the store;
- **stock balance:** number of units remaining in the store;
- **remarks:** important information about the movement of the item, such as batch numbers and expiry dates;
- **signature:** person who records the movement of the item.

FIGURE 3. Typical Stock Card

COMMUNITY HEALTH NGO PROVIDED SERVICES — Medicines Stock Control Card							
Item Name: Depo Provera							
Strength: 150mg/ml				Dosage Form: Vial			
Unit: 100 vials				Price/Unit: \$1.09			
Date	Received From	Quantity Received	Issued To	Quantity Issued	Stock Balance	Remarks	Signature
1/6/08	B/F				125	Balance brought forward	
4/6/08			Family Planning Center I	30	95		
5/6/08			Family Planning Center II	20	75		
9/6/08			Health Post	8	67		
14/6/08			Health Center	61	6		
18/6/08	UNFPA	200			161	100 vials broken when box dropped	

**How to record information on stock cards.** When you record information on a stock card:

- Use a *pen* to record the item, code number, unit, and size and all information about the movement of the item. This information does not change.
- Use a *pencil* for the **price**. This information may change.
- Use a *pen* to make all stock entries and record issues and balance information.
- If you make a mistake on an entry, do *not* use correcting fluid. Cross out the incorrect entry, and make a correct entry on the line below. Enter the reason for the correction in the Remarks column.
- Use a different color, such as red, only for recording physical stock counts or making any other adjustments, for example, if you find an arithmetical error in the balance. Write the correction in red ink with an explanation in the Remarks column.

The information that you write in the Stock Balance column helps you determine when it is time to order more and how much to order. In the Remarks column, record information about the stock, such as the following:

- In the first line of a new stock card, write “balance brought forward” if this is a replacement stock card or “new stock” if this is the first time you are keeping this item in your store.
- For new or reordered stock, record the order requisition number, expiry date, and price, if necessary.
- For expired, poor-quality, or overstocked items, record information about the removal of the items.
- Record any other information that is important to the management of medicines and health products at your facility, such as the consignment arrived with a number of broken bottles, the color of the packaging has changed, storage instructions have been revised, etc.

Make an entry every time you receive or issue an item. Record only one movement (that is, one receipt or one issue) per line. It is very important that you write the record at the time of movement. See [Figure 3](#) for an example of a stock card.

**How to manage stock cards.** One of the key aspects of good stock management is keeping accurate records. It means that at any time the physical stock of a product should match the quantity recorded on the stock card.

This can be easily achieved only if the stock card is updated at the time the transaction occurs, that is, when items are received or issued. *Quantities received or issued should not be entered on a separate ledger or a piece of paper and the stock card updated at a later date.*

In small stores, it is helpful to keep the stock card with the products to facilitate and speed the maintenance of the record.

**Entering data on the stock card.** Any time information is entered, the date of the transaction is entered first and whoever enters the transaction on the card must initial the entry. Guidance on entering information on stock cards is provided in [“How to Record Information on Stock Cards.”](#)

At the health facility, the stock may be divided into two categories: the **bulk stock** and the **dispensing stock**.

- The **bulk stock** is stored in the main storeroom, if there is one, or on the shelves or in the cupboard of the facility.
- The **dispensing stock** is kept in the dispensing area. The dispenser fills prescriptions from the dispensing stock only.

Staff should use the bin card kept with a product in bulk stock to record only the issues made from the bulk stock to the dispensing stock, not every pharmaceutical dispensed to a patient.

When a container from the dispensing stock is empty, the supply officer replenishes its stock with another one from the bulk stock.

**How to enter receipts.** When the goods that have been ordered arrive, the quantities received should be checked against the accompanying delivery documentation. If there are any discrepancies, the following should be checked:

- Were all the boxes received?
- Was anything broken?
- Were any goods delivered that were not ordered?

If these issues cannot be resolved, the supplying organization must be contacted.

To accurately reflect the stock balance, all receipts must be recorded following the guidelines previously listed in [“How to Record Information on Stock Cards.”](#) To keep an accurate balance, other types of receivables (exchanges between districts or facilities, goods returned, etc.) should be entered in the same way.

After recording the receipts, the supply officer places the new stock alongside the regular stock on the shelves using the FEFO or FIFO method.

**Inventory adjustment when a product is expired, broken, or damaged.** At regular intervals (for example, every three months), check the expiration date of the various batches, and discard expired, damaged, or obsolete items. The stock card should be updated as follows:

- **date:** the date the expired medicines were removed from the shelf;
- **to/from:** the name of the institution to which the item is being returned for disposal. Otherwise write the word “destroyed”;
- **quantity issued:** the quantity removed from the shelves. The quantity is circled, preferably with a colored pen, to indicate that it was not issued for use by a health facility or patient;
- **stock balance:** the stock balance, which equals the previous stock balance minus the quantity issued;
- **remarks:** an indication that the item was “expired,” “broken,” or “damaged.” Record the expiry date of the batch that has been removed.

## STOCK CONTROL AND BUDGET MANAGEMENT

Budget management is an integral part of supply management in many countries. It is essential that managers at the district- and health-facility levels, as well as NGOs working in the system, use budget management to optimize the use of resources, which are becoming more limited from year to year. Please see Chapter 7 of this handbook, which is about financial management, for more information on creating and monitoring budgets and the efficient use of resources.

**Analyzing the costs of products and total expenditures on medicines.** The stock card can assist the budget management process by providing essential information on product consumption. Once the consumption of the most frequently used items is



**BOX 4. Formula for Calculating the Total Cost of a Product Used during a Specific Period**

estimated cost of item “A” for a specific period =  
total consumption for that period × last cost paid per item

**BOX 5. Formula for Calculating a Facility’s Total Expenditures on Medicines in a Specific Period**

total facility expenditures for a specific period = sum of receipts for that period

compiled for a particular period (a year, for example), it is easy to multiply the consumption figures (obtained from the stock cards) by the latest cost (which was recorded on the stock card after the last receipt) and get a clear idea of the cost of this particular item. Box 4 shows this simple formula.

All receipts can be costed and totals for the year calculated. This will give you a clear picture of the total expenditures for the facility. See Box 5.

The next step is to identify what percentage of the overall expenditures is spent on the most prescribed or most used products. See Box 6 for an example.

When a computerized system is available, it is quite easy to perform this exercise for all items. However, when you do the exercise manually, focus on the most popular items and the most expensive ones.

**BOX 6. Calculating the Percentage of Overall Expenditures on the Most Popular Items****Formula**

percentage of total expenditures spent on item “A” for a specific period “x” =  
estimated item A cost for that period/total facility expenditures for that period × 100

**Example**

The total quantity of paracetamol issued during the last financial year equals 1,000 units. The price charged during the last delivery was \$1.50 per issue unit. The product cost for the last financial year therefore equals \$1,500, as follows:

$$1,000 \times \$1.50 = \$1,500$$

During this period, the total value of the medicines received amounted to \$30,000. Therefore, this product represents 5 percent of the overall expenditures for this particular financial year. Using the above formula, that is:

$$(1,500 \div 30,000) \times 100 = 5\%$$

**Using ABC analysis.** As a rule of thumb, when you do this analysis, called **Pareto** or **ABC analysis**, if you classify the items by descending order according to their value (the most expensive on the top), you will find that about:

- 15 to 20 percent of the top number of items are responsible for about 70 to 80 percent of the expenses (Class A);
- 10 to 15 percent of the next number of items are responsible for about 10 to 15 percent of the expenses (Class B);
- 60 to 80 percent of the last number of items are responsible for only 5 to 15 percent of the expenses (Class C).

There are two main reasons for an item to belong to Class A:

- It is an inexpensive item (such as paracetamol tablets) but is widely used.
- It is an expensive item (such as third-generation cephalosporins) whose use should be restricted to some specific conditions, but it is misused or over-prescribed.

It is, therefore, important to identify the items that belong to Class A. Any changes in the consumption or prices of one of these items will have a significant impact on overall expenditures.

**Using VEN classification.** As a manager responsible for the supply of medicines, you can use ABC analysis to find out “where the money goes,” but it will not indicate whether the money is being spent on the right products. To complement this exercise, therefore, you also need to classify each item into one of three categories—vital (V), essential (E), or nonessential (N)—as follows:

- **V = vital** items (such as ACT or IV fluids) which are potentially lifesaving and have a significant negative impact if they are not available;
- **E = essential** items, which are effective against less severe, but nevertheless significant forms of illness (such as antibiotics and medicines for chronic conditions);
- **N = nonessential** items, which are used for minor or self-limited illnesses or are of questionable efficacy, and high-cost items with a marginal therapeutic advantage (such as cough mixtures, vitamins, or antacids).

There are no standard VEN classifications, since priorities change according to the level of care that a particular facility is expected to deliver or the geographical location of the facility. For example, malaria medicines are essential or vital in malaria-infected areas but are nonessential in malaria-free zones.

Once the Class A items are identified and tagged according to the VEN classification, you would expect to have only V or E items in Class A. Any N items that belong to A should be investigated, and you should aim to substantially reduce stock levels and orders of those items. Prescribers and patients should be informed about these measures, and you should provide ongoing education to staff as part of supervision.

## ORDERING NEW STOCK

This section focuses on estimating needs for medicines and health products, based on historical data on consumption, and determining the quantities to order.

**How to estimate future needs.** There are two methods commonly used to estimate product needs for a procurement system: the **consumption method**, which uses historical consumption data, and the **morbidity method**, which is based on the number of cases of each major prevalent disease or health condition. The two methods are not exclusive, and each has strengths and weaknesses.

**Consumption method.** This section focuses on the consumption method through the use of the data recorded on the stock cards. The consumption method is the simplest, and often most accurate, way for you to calculate medicine requirements, because you (or the supply officer) has the information on medicines dispensed readily available on stock cards.

Nevertheless, it is important to realize that other factors, such as stock-outs, seasonal variations, short shelf life, and storage space, can affect the accuracy of consumption data. Formulary changes can also affect the accuracy of consumption data, for example, if new medicines are added or older ones removed. You will need to consider these factors when planning orders.

**Morbidity method.** The morbidity method takes into consideration the prevalence of various diseases in the community and the number and ages of patients to be treated. Pharmaceutical requirements are then estimated using standard treatment guidelines. The morbidity method can be useful, especially when you are planning new programs or scaling up programs, but it requires data that are generally not readily available to district and health facility staff.

Furthermore, data analysis can be difficult, since a larger data set is required to accurately assess disease patterns in a particular country. Its accuracy also depends on prescribers following standard treatment guidelines, which is often not the case and is beyond the control of supply managers.

Morbidity analysis is useful, however, when no consumption records are available, as a check on the accuracy of the consumption data, or when you are assessing whether prescription of medicines is being done in accordance with standard treatment guidelines.

**Comparison of the consumption and morbidity methods.** [Table 2](#) compares the consumption and morbidity methods of quantifying pharmaceutical needs.

## CALCULATING MONTHLY CONSUMPTION

Monthly consumption is one of the most critical pieces of information for forecasting your needs. At the start of each month, and for each stock item, you should calculate the quantity used during the previous month. The result is either entered onto the stock card, if it provides an appropriate space for that data, or recorded on a separate form or ledger.

TABLE 2. Comparison of the Consumption and Morbidity Quantification Methods

	Consumption	Morbidity
<b>Uses</b>	<ul style="list-style-type: none"> <li>First choice for procurement forecasts if reliable data are available</li> <li>Most reliable predictor when consumption pattern remains unchanged</li> </ul>	<ul style="list-style-type: none"> <li>Estimating needs in new and scaling-up programs or for disaster assistance</li> <li>Comparing use with theoretical needs</li> <li>Developing and justifying budgets</li> </ul>
<b>Essential data</b>	<ul style="list-style-type: none"> <li>Reliable inventory records</li> <li>Records of supplier lead time</li> <li>Projected medicine costs</li> </ul>	<ul style="list-style-type: none"> <li>Data on population and patient attendance</li> <li>Actual or projected incidence of health problems</li> <li>Standard treatments (ideal, actual)</li> <li>Records of supplier lead times</li> <li>Projected medicine costs</li> </ul>
<b>Limitations</b>	<ul style="list-style-type: none"> <li>Must have accurate consumption data</li> <li>Can perpetuate irrational use</li> </ul>	<ul style="list-style-type: none"> <li>Morbidity data not available for all diseases</li> <li>Accurate attendance data not available</li> <li>Standard treatments may not really be used</li> </ul>

There are two ways to calculate monthly consumption:

- Add all quantities of a specific pharmaceutical or contraceptive issued during this period.
- Add the quantity of medicines received during the month to the balance at the beginning of the month, and subtract the month-end stock balance from this subtotal.

See [Box 7](#) for the formula for the second method and an example.

There are three kinds of figures in the monthly consumption:

- **A positive number:** If a product was issued during the previous month to at least one health facility or patient, the monthly consumption should be positive.
- **Zero:** If a product was not issued during the previous month, the monthly consumption is zero.
- **O/S (out of stock):** If the medicine was out of stock during the whole month, “O/S” should be entered in the corresponding box.

It is not possible for the monthly consumption of a given pharmaceutical to be a negative number, since this would mean that the pharmaceutical was distributed although the

### BOX 7. Calculating Monthly Consumption

#### Formula

$$\text{monthly consumption} = (\text{beginning of month stock} + \text{monthly receipts}) - \text{month-end stock balance}$$

#### Example

A stock card for paracetamol 500 mg tablets shows the following:

- Beginning of April stock balance = 200 packs of 10
- Total receipts during April = 100 packs of 10
- Stock balance at the end of April = 50 packs of 10

Therefore, the monthly consumption during the month of April =  $(200 + 100) - 50 = 250$  (250 packs of 10)

**Note:** The quantities added for the month must reflect only the quantities issued to your own health facility or patients. Quantities “issued” for the following reasons should not be included:

- expired or damaged
- stock adjustment or stock loaned to another facility

If the quantities issued under these circumstances are circled on the stock cards, it is easier to identify them.

facility was out of stock. If the monthly consumption appears to be a negative number, check the calculations for an error, or check the inventory card to verify that the data recorded are accurate.

**Calculating average monthly consumption.** The next step is to determine the average monthly consumption. The average monthly consumption is calculated for a particular period, which usually does not exceed 12 months. The method to calculate the average monthly consumption for a particular period is simple and involves the following parameters:

- **forecasting period:** the number of months included in the period, for example, 12 months;
- **total consumption:** the sum of the monthly issues obtained from the record containing each of the monthly issues, as described in the previous [section on monthly consumption](#);
- **number of months out of stock:** the number of months included in that period during which the product was out of stock.

The average monthly consumption can be calculated using the formula in [Box 8](#).

In the example in Box 8, the total usage for the fiscal year (606 units) is divided by 10, not by 12, because the item was out of stock for two months (January and May) during that period. Therefore, the average monthly consumption equals  $606 \div (12 - 2) = 60.6$ , which can be rounded up to 61 units.

Once the average monthly consumption is known, you can use this information as a guideline to anticipate future pharmaceutical needs.

**BOX 8. Calculating Average Monthly Consumption****Formula**

average monthly consumption = total consumption for a given period ÷  
(number of months covered by consumption period – number of months out of stock)

**Example**

Fiscal Year	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Usage	Expired
FY 2008/09	80	67	0	45	90	80	O/S	60	50	45	O/S	89	606	10

**Calculating annual consumption.** In the example in Box 8, the first month of the consumption table is not the first month of the calendar year but the first month of the fiscal year. Because budget monitoring is an essential concern, having the months in this order will facilitate the analysis of information for the fiscal year.

At the beginning of each fiscal year, total the monthly consumption of each pharmaceutical over the past year. Enter the result in the “Usage” column. Next to it in the “Expired” box, record the total expired quantities that were removed from stock.

In the example in Box 8, the consumption for the fiscal year is 606 units, that is, the sum of all the monthly consumption.

**Assessing your stock status.** To estimate how long the current stock will adequately meet the needs of your facility, district, or area (your **stock status**), divide the stock on hand by the average monthly consumption, as shown in Box 9.

Once you know the average monthly consumption of a product, it is a very useful and easy exercise to check the stock status of essential items routinely, especially for Category A items (which account for most of the spending on medicines).

**BOX 9. Determining Your Stock Status****Formula**

stock status (in months) = stock on hand ÷ average monthly consumption

**Example**

If the average monthly consumption of amoxicillin 250 mg capsules is 40 packs of 50 capsules per month, and the current stock is 160 packs of 50 capsules, the stock status equals 4 ( $160 \div 40 = 4$ ). It means that the quantity in stock should last for another four months. This is true, of course, only if there are no major changes in the consumption pattern.

If the current stock of amoxicillin 250 mg capsules were 400 packs of 50 capsules, the stock status would equal 10 ( $400 \div 40 = 10$ ). The next step is to determine if the product is overstocked.

When items are overstocked, they should be returned to either the depot (or hospital) or redistributed to other health facilities. District or regional meetings are excellent opportunities for you to explore with other supply managers the possibility of redistributing overstocked items.

**Factors that influence order quantity.** When calculating the quantity to order, you need to consider many factors. These factors can be divided into two broad categories:

- **Constant factors:** These factors do not vary too much from month to month. Their values are reasonably predictable and can be easily calculated from historical data.
- **Variable factors:** These vary regularly or cannot be anticipated.

Constant factors include:

- **Average monthly consumption:** the average quantity used per month;
- **Supplier lead time:** the length of time that elapses between the time the order is placed and the time the order is received at your store or facility;
- **Stock balance:** the balance in stock at the time of the order;
- **Procurement period/order frequency:** the length of time between two orders or how often an order is placed;
- **Storage capacity:** the smaller the facility storage, the less it can store.

Variable factors include:

- **Health campaigns:** If a campaign is launched to promote a particular product (such as contraceptives or vaccines), you can expect its consumption to increase during the campaign;
- **Disease outbreaks:** If there is an outbreak of a disease, the consumption of the products that are needed to treat this outbreak can be expected to increase;
- **Seasonal factors:** Some diseases are more frequent during a particular period of the year. Therefore, the consumption of the recommended medicines for these diseases increases. Examples include influenza in winter and diarrhea during the rainy season;
- **New prescribers:** If a new prescriber is appointed at the facility, you can expect some changes in the use of certain products;
- **Budget allocations:** When products are purchased within a limited facility budget, health workers have to make choices, and sometimes they decrease the use and order quantity of some nonessential items.

Ideally, you should have a clear idea of how all these factors influence the quantity to order. However, although some of them can be clearly defined, others are unpredictable.

The easiest option would be to order enough not to have to worry about potential stock-outs, but financial resources are always limited. Remember that the greater the stock, the more funds are invested, and the greater the likelihood that stocks will expire.

## BOX 10. Benefits and Costs of Keeping Inventory

**Benefits**

Minimize life-threatening shortages

Facilitate bulk purchasing

Increase transportation efficiency

Protect against fluctuations

**Costs**

Capital cost

Expiration

Spoilage

Obsolescence

Storage

Pilferage

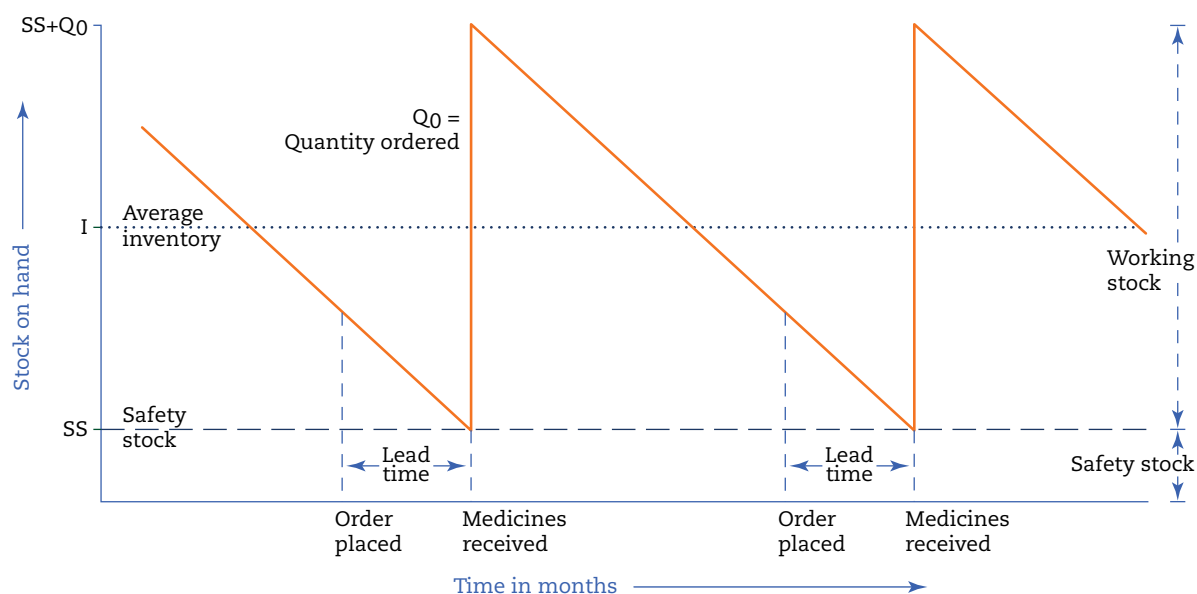
The art of good inventory management is to keep a balance between the benefits of keeping inventory and the costs associated with it. Box 10 lists some of these benefits and costs.

**How to calculate the maximum stock.** Besides monitoring stock status, the main objective of keeping good stock records is so you can order the right quantity at the right time, that is, have enough stock to supply health facilities or to dispense to patients until the next order arrives. This section presents two calculations you need to make to manage stock reordering:

- calculating the maximum stock
- calculating the quantity to order

In a typical inventory management graph, such as Figure 4, the stock level goes down with time, during which period an order is placed, ideally before the safety stock level is reached. When the order arrives, the stock level rises to its maximum. The quantity starts to be used again, and the stock level goes down over time, etc.

FIGURE 4. Ideal Inventory Control Model





The art of inventory management is to replenish the stock before the stock level falls below the safety stock level while not going over the maximum stock level.

In this model, orders are placed at regular intervals. When an order is placed, the quantity ordered should be just enough to bring the stock balance to the maximum stock level. However, because of unexpected changes in consumption patterns that can occur during the lead-time period, average monthly consumption could change. When the goods are received, therefore, the stock level would not match the maximum stock level. It could be lower or higher than the maximum stock level. You can correct the situation when the next order is placed.

This section describes the **maximum stock approach**, which means replenishing the stock to an optimal maximum stock level every time an order comes. This is a simple and reliable method, suitable for health facility and district stores. There are variations on this approach, such as those described in *The Logistics Handbook: A Practical Guide for Supply Chain Managers in Family Planning and Health Programs* (USAID | DELIVER Project, 2011), available at [John Snow, Inc.](#)

The maximum stock level is usually defined as having enough stock to cover both known times for processing reorders and any unforeseen delays. In general, this is the lead time plus order frequency period, with an additional amount for safety stock.

In most cases, the **safety stock** should be enough to last one lead-time period, in order to cover for any delays in delivery or unforeseen increases in consumption while you are awaiting the delivery. In essence, the formula doubles the lead-time period to allow for exceptional delays and unforeseen increases in usage.

**Using maximum stock factors.** To simplify calculation, you can use a predefined **maximum stock factor**. The system used by the Department of Health of the Eastern Cape Province in South Africa is shown as an example in Table 3. The maximum stock factor varies with the frequency of orders and the lead time.

In this example, with a lead time of four weeks (one month) and an order frequency of one month, the maximum stock factor in the table is 3, which is:

$$\text{the lead time (1) + order frequency period (1) + safety stock sufficient to cover the lead time (1)}$$

TABLE 3. Maximum Stock Factor

Order Frequency	Lead Time (Weeks)			
	1	2	4	6
Weekly	1	1	2	3
Every 2 weeks	1	2	3	4
Monthly	2	2	3	4
Every 6 weeks	2	3	4	5
Every 2 months	3	3	4	5
Every 3 months	4	4	5	6

**BOX 11. Calculating the Maximum Stock****Formula**

$$\text{maximum stock (in issue units)} = \text{average monthly consumption} \times \text{maximum stock factor}$$

**Three examples**

1. If supplies are ordered once a month and the lead time is four weeks (one month), then the maximum stock factor is three. The average monthly consumption equals 50 units, and the current stock balance is 80 units. Therefore, the maximum stock is:

$$50 \text{ units (average monthly consumption)} \times 3 \text{ (maximum stock factor)} = 150 \text{ units}$$

In this example, the current stock balance of 80 is below the recommended maximum stock level of 150, so you would need to place an order for this item.

2. If supplies are ordered once a week and the lead time from the source is two weeks, then the maximum stock factor is one. The average monthly consumption equals 40 units, and the current stock balance is 58 units. Then the maximum stock is:

$$40 \text{ units (average monthly consumption)} \times 1 \text{ (maximum stock factor)} = 40 \text{ units}$$

In this case, because the stock balance (58) is greater than the recommended maximum stock, you do not need to place an order.

3. If supplies are ordered every two weeks and the lead time from the provider is four weeks, then the maximum stock factor equals three. The average monthly consumption equals 30 units, and the current stock balance is 85 units. Then the maximum stock is:

$$30 \text{ units (average monthly consumption)} \times 3 \text{ (maximum stock factor)} = 90 \text{ units}$$

Since the stock balance is just under the maximum stock, you could order a small quantity. A larger quantity can be ordered with the next scheduled order.

With a lead time of four weeks and an order frequency of six weeks (1.5 months), the maximum stock factor would be:

$$\text{lead time (1)} + \text{order frequency (1.5)} + \text{safety stock (1)} = 3.5$$

In this example, the sum would be rounded up to a maximum stock factor of 4.

**Calculating the maximum stock.** Once you have identified the maximum stock factor, the next step is to calculate the maximum stock using the formula in Box 11.

Then compare this maximum stock with the current stock balance of usable stock (without any expired or damaged items) to make a decision about whether to order stock:

- If the current stock balance is greater or equal to the maximum stock, there is no need to place an order.
- If the current stock balance is smaller than the maximum stock then you should place an order, unless the product is discontinued or its use is influenced by external factors such as the end of the rainy season, end of a campaign, or modification of the essential medicines list or standard treatment guidelines.

## HOW TO CALCULATE THE QUANTITY TO ORDER

This section describes how to calculate the quantity to order so you can avoid stock-outs or overstocks.

Without knowing the exact average monthly consumption, it is impossible to determine with accuracy how much to order. This highlights the importance of maintaining up-to-date and accurate stock records.

One very common mistake is to order the quantity that equals the maximum stock minus the current stock. This does not work, because during the lead-time period issues are made from the stock. There is always a delay between ordering and receiving goods, which must be taken into account in the order quantity.

In effect, when the order is received, the stock balance is less than at the time of the order, and the sum of the stock plus the quantity received is not sufficient to reach the maximum stock. The solution is to add to the order a quantity equivalent to the amount likely to be issued during the lead-time period.

The concept behind calculating the quantity to order is simple: when the order is received, the quantity ordered should replenish the stock so that it returns to the maximum level. As explained in [Box 11](#), if the maximum stock is greater than the stock balance, there is no need to place an order. So you must know the maximum stock before making any decision.

When you are ready to place an order, you need information about:

- the average monthly consumption
- the stock balance when the order is placed

[Average monthly consumption](#) has already been discussed in detail. The stock balance is available from the stock card or from a physical count if necessary.

In addition, you also need to know two relatively constant parameters:

- the lead time
- the order frequency

You should know the lead time and order frequency from experience, or you can consult the order schedule.

**Determining reorder factors.** To simplify decision-making, you can develop a **reorder factor table**. See [Table 4](#), in which the lead time is added to the maximum stock factor for several combinations of lead time and order frequency. For example, in the maximum stock factor table ([Table 3](#)), the maximum stock factor for a four-week lead time and a monthly order frequency is 3. To determine the reorder factor, you add the lead time (one month) to this value, which gives you a reorder factor of 4.

TABLE 4. Reorder Factor Table

Order Frequency	Lead Time (Weeks)			
	1	2	4	6
Weekly	1.25	1.50	3.00	4.50
Every 2 weeks	1.25	2.50	4.00	5.50
Monthly	2.25	2.50	4.00	5.50
Every 6 weeks	2.25	3.50	5.00	6.50
Every 2 months	3.25	3.50	5.00	6.50
Every 3 months	4.25	4.50	6.00	7.50

Once you have identified the reorder factor, the next step is to calculate the quantity to order, using the formula in Box 12.

If the suggested order quantity is very small, you might decide to postpone ordering until the next scheduled date. Or, if the demand for a product is related to a particular season and the season is over, you would decrease the quantity to order or order nothing.

**Combining the maximum stock and reorder factors.** Once you have mastered using the maximum stock factor and the reorder factor, you can use both factors together to calculate the quantity of an item to order.

[Appendix F](#) in this chapter contains examples using these tables.

**A caveat.** These formulas should be used only as guidelines in estimating the precise quantities to order. A modification in any component of the procurement cycle (time of delivery, expiration date, disease outbreak, etc.) will influence the entire system. Your experience and the nature of each medicine or product are essential considerations in arriving at a final decision about the quantities to order.

**Emergency orders.** If there is an epidemic, emergency, or seasonal disease, do not follow the procedures for ordering supplies based on past consumption. Plan for the new situation after seeking the guidance of your supervisor or local supply coordinator.

For an epidemic or emergency, determine your emergency needs based on anticipated monthly consumption. Estimate what emergency supplies you will need and place an urgent order. Make sure that you know where and how to get these supplies as quickly as possible.

For a seasonal disease, order enough of the appropriate supplies well in advance of when you think the disease season will begin. Determine the amount you order based on how much you used during the previous season, such as last year or last rainy season or drought.

#### BOX 12. Formula for Calculating the Quantity to Order

$$\text{quantity to order (in issue units)} = (\text{average monthly consumption} \times \text{reorder factor}) - \text{stock on hand}$$

TABLE 5. Combined Maximum Stock and Reorder Factor Table

Order Frequency	Lead Time (Weeks)							
	1		2		4		6	
	Maximum Stock Factor	Reorder Factor	Maximum Stock Factor	Reorder Factor	Maximum Stock Factor	Reorder Factor	Maximum Stock Factor	Reorder Factor
Weekly	1	1.25	1	1.50	2	3	3	4.50
Every 2 weeks	1	1.25	2	2.50	3	4	4	5.50
Monthly	2	2.25	2	2.50	3	4	4	5.50
Every 6 weeks	2	2.25	3	3.50	4	5	5	6.50
Every 2 months	3	3.25	3	3.50	4	5	5	6.50
Every 3 months	4	4.25	4	4.50	5	6	6	7.50

In case of poor weather, which can cause delays in supplies reaching the facility, avoid delivery delays by planning ahead. If the rainy season is approaching and roads will be flooded, the supplies will need to reach the health care facility before the rains begin. Order extra supplies, increase buffer stocks, or place an order earlier than planned. Determine the quantity to be ordered based on the estimated number of months to be covered.

### MONTH-END PROCEDURES FOR STOCK CONTROL

It is a good practice to check your stock regularly, and the end of the month is a good time to do so. You might want to do this on a rotating basis, which means checking the tablets and ointments, for example, one month and checking the injectables and large-volume parenteral preparations the next month, and so on.

Another good practice is to draw a line on your stock card to indicate the end of the month using a red or green pen. This allows you to identify the month quickly and make consumption calculations for it.

### EVALUATION OF INVENTORY MANAGEMENT SYSTEMS

When you evaluate an inventory management system, you are not looking for complicated mathematics. Instead, you should be looking to see if:

- there are reasonable rules for determining order quantities (such as the system described in [“Ordering New Stock;”](#))
- the rules are widely understood and accepted, and applied consistently;
- basic stock records are maintained, are accurate, and are up-to-date;
- important parameters are kept up-to-date (minimum and maximum levels are reviewed, for example);
- senior staff show leadership by taking inventory management seriously.

The problem is that many organizations think that they do these things, but few actually do in practice. You can use the [Inventory Management Assessment Tool \(IMAT\)](#) to examine the effectiveness of inventory monitoring and record-keeping practices in warehouses

and helps users identify suggestions for improvement. This tool provides simple indicators of problems with inventory management; you can easily collect the information and rapidly make the calculations you need.

While IMAT does not offer a complete analysis of the reasons for any problems you identify with the supply officer or supply management team, it provides useful tips about where problems lie and suggests further work to fully understand those problems and develop possible solutions.

## Distributing stock from the health facility storeroom

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Medicines and supplies need to be moved from the facility store to the places where they are used, such as treatment areas, wards, or outpatient facilities. The procedures are similar, whatever the size of the facility. For details, see [Chapter 46](#), “Pharmaceutical Management for Health Systems,” in *MDS-3: Managing Access to Medicines and Health Technologies* (MSH 2012).

### DISTRIBUTION IN SMALL HEALTH FACILITIES

Small facilities may not have a separate pharmacy, but they should have a storeroom or cupboard for medicines and a separate dispensing and treatment area. A working stock (often a single container) of common medications should be kept in the treatment area. You can store oral medications in a lockable trolley cart, cupboard, or dispensing box. A small stock of common injectable medicines should be kept on a covered tray in the treatment room. There is usually a separate area for cleaning and dressing wounds, where an appropriate range of items should be kept on trolley carts and in lockable cupboards.

Replenish these working stocks from the storeroom daily. Working-stock containers must be kept closed, except when they are actually being used, to avoid deterioration and loss of therapeutic value. Details appear in the section of this chapter headed [“Good Dispensing Practices.”](#)

### DISTRIBUTION IN HOSPITAL PHARMACY DEPARTMENTS

The movement and control of stock is more complex in larger facilities where medical, surgical, and maternity care are provided. Each type of ward should have its own stock list to facilitate control and reduce the potential for misuse, and separate storerooms may be needed. The hospital pharmacy should be responsible for restocking all medicine storage areas and may also dispense to individual inpatients and outpatients. The volume of outpatient prescriptions may justify an outpatient dispensary separate from the main pharmacy. An option for hospitals serving patients with chronic conditions is to refer established patients to local health facilities for their medications, which reduces the time and cost of travel for patients.

The hospital pharmacy may have working stock from which it dispenses medications to inpatients and upon their discharge, to outpatients, and to wards, departments, and emergency trays. A “want list” should be compiled throughout the day, for daily replenishment from the storeroom. This responsibility will normally rest with a limited number of individuals; this work is done on a rotating basis in many hospital wards.

**Prepacking for outpatient dispensing.** To save time for both staff and patients in busy facilities that dispense a high volume of prescriptions, prepacking commonly dispensed oral medications in appropriate quantities for standard treatment courses is useful. This packing can be done at quiet times of the day or week. Prepacking is also necessary when quantities smaller than the original pack are needed for ward stocks.

In some countries, purchasing commonly used medicines commercially prepacked in unit-of-use (course-of-therapy) containers may be cost-effective. This is especially appropriate for long-term therapies, such as those for TB, where use of the TB kits provided by the Global Drug Facility has been especially beneficial. Prepacked medicines are also appropriate for high-volume items such as malaria treatments.

Important considerations when repacking medicines are:

- use containers suited for maintaining pharmaceutical quality;
- avoid contaminating or mixing different batches of medicines;
- label containers appropriately and assign a new “use by” date.

**Supplying inpatients.** There are three basic techniques for hospital pharmaceutical distribution to inpatients:

- bulk ward stock
- individual medicine orders
- unit dose distribution

The bulk ward stock system is still used in many countries. The imprest, exchange, or topping-up system is a common method for supplying wards with bulk stock. Empty containers are returned for refilling, with the empty container being exchanged for a full one (the “full-for-empty” method) at weekly or twice-weekly intervals. Each ward should have a box that can be locked by both pharmacy and ward staff for transferring supplies between the two units. Stricter security procedures should be applied for antibiotics, items with a high value in the local market, and narcotics.

In a ward stock system, the pharmacy should provide a schedule indicating on which day each ward or department is to be supplied and specifying the category of supplies. Pharmacy, stores, and ward staff must decide together about the types and quantities of medicines required based on usage data, and pharmacy staff members must monitor ward stock storage and record-keeping.

**Emergency trays.** A selection of medicines and equipment for emergencies should be placed in wards and outpatient departments. The contents should be recorded on a list and checked regularly. Whenever an item is used, it should be restocked immediately. The emergency tray should not be used for routine supplies.

**Table 6** indicates the contents of an emergency tray at a rural health center. This example is from Zimbabwe and is indicative of what could be used in similar settings.

TABLE 6. Medicines for an Emergency Tray at a Health Post

<ul style="list-style-type: none"> <li>■ Ampicillin powder for injection, 1 g (as sodium salt) in vial</li> <li>■ Atropine injection, 1 mg (sulfate) in 1 mL ampoule</li> <li>■ Calcium gluconate injection, 100 mg/mL in 10 mL ampoule</li> <li>■ Charcoal, activated powder for oral suspension, bottle, 50 g</li> <li>■ Chloramphenicol powder for injection, 1 g (sodium succinate) in vial</li> <li>■ Diazepam injection, 5 mg/mL ampoule (intravenous or rectal)</li> <li>■ Epinephrine/adrenaline injection, 1 mg (as hydrochloride or hydrogen tartrate) in 1 mL ampoule</li> <li>■ Ergometrine injection, 200 µg (hydrogen maleate) in 1 mL ampoule</li> <li>■ Gentamicin injection, 40 mg (as sulfate)/mL in 2 mL vial</li> <li>■ Glucose injectible solution, 5% in 1 L bag</li> </ul>	<ul style="list-style-type: none"> <li>■ Glucose injectible solution, 50% hypertonic</li> <li>■ Hydrocortisone powder for injection, 100 mg (as sodium succinate) in vial</li> <li>■ Phytomenadione (vitamin K1) injection, 10 mg/mL in 1 mL ampoule (adult)</li> <li>■ Promethazine injection, 25 mg (as hydrochloride)/mL in 2 mL ampoule</li> <li>■ Magnesium sulfate injection, 500 mg/mL in 10 mL ampoule for use in eclampsia and severe preeclampsia and not for other convulsant disorders; available for trained midwives</li> <li>■ Magnesium sulfate powder</li> <li>■ Nifedipine scored tablet, 10 mg</li> <li>■ Quinine injection, 300 mg (as dihydrochloride)/mL in 2 mL ampoule</li> <li>■ Salbutamol injection, 50 µg (as sulfate)/mL in 5 mL ampoule</li> <li>■ Sodium lactate, compound solution injectible solution, 1 L bag</li> </ul>
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Source: Timor-Leste Ministry of Health 2004.

## SUPPLYING COMMUNITY-BASED HEALTH WORKERS

Community health workers (CHWs) usually have a limited selection of the most commonly used items. A topping-up system, whereby stock levels are checked and then resupplied to a predefined level, can be used to replenish stocks as long as requirements are small and the health center is reliably stocked. A monthly supply interval is usually adequate.

## HOME-BASED CARE KITS

The family is usually the source of long-term care for chronic conditions such as AIDS and TB. Home-based care kits can be supplied to CHWs to distribute to caregivers. Kits should be designed according to the individual condition, but at a minimum they should contain appropriate essential medicines, such as painkillers and antidiarrheals, as well as supplies such as gloves, soap, and disinfectant.

Basic care information written in local languages and using diagrams and drawings should be included. CHWs should restock the kits regularly from the supplies at dispensaries and health centers.



## Good dispensing practices

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The aim of all pharmaceutical management systems is to deliver the correct medicine to the patient. The steps in the pharmaceutical management cycle of selection, procurement, and distribution are essential steps in the rational use of medicines.

A critical component of rational use is correct dispensing of medication, including providing patients with appropriate information about their medication. Correct dispensing is, therefore, a vital part of the daily work of primary health care facilities and district hospitals.

Good dispensing practices ensure that an effective form of the correct medicine is delivered to the right patient, in the prescribed dosage and quantity, with clear instructions, and in a package that maintains the medicine's potency. Dispensing includes all the activities that occur between the time the prescription is presented and the medicines are issued to the patient.

A safe, clean, and organized working environment provides a basis for good practice. Dispensing must be performed accurately and should be done in an orderly manner, with disciplined use of effective procedures. [Appendix G](#) in this chapter provides a detailed guide to dispensing principles and procedures.

## Rational prescription and use of medicines

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The goal of good pharmaceutical management practices is having the correct medicines prescribed for and used by the patient. According to WHO, “the rational use of drugs requires that patients receive medications appropriate to their clinical needs, in doses that meet their own individual requirements, for an adequate period of time, and at the lowest cost to them and their community” (WHO 1987).

Many factors influence rational use, and it is essential to formulate an overall policy for rational use of medicines and detailed procedures to address each of the component areas. However, the following criteria are central to any policy on rational prescribing and use:

- correct medicine;
- appropriate indication: the reason for prescribing is based on sound medical considerations;
- appropriate medicine, considering efficacy, safety, suitability for the patient, and cost;
- appropriate dosage, administration, and duration of treatment;
- appropriate patient: no contraindications exist, and the likelihood of adverse reactions to the medicine is minimal;
- correct dispensing, including appropriate information for the patients about the prescribed medicines;
- patient adherence to treatment.

More information about rational prescribing and use can be found in the Human Resources section of [MDS-3: Managing Access to Medicines and Health Supplies](#) (MSH 2012).

## Dealing with expired, damaged, or obsolete items

Expired goods should not be accepted from the supplier; they must be sent back immediately. The resources of the health facility should not be used to pay for these items.

Sometimes having expired items becomes unavoidable, however. For example, items may be held in reserve for emergencies, they might be vital items that are not used regularly, or they were overstocked and were not redistributed to another health facility. Remove any expired, damaged, or obsolete items immediately from the storage area and secure them in a clearly labeled container or box with a label warning others not to use the contents. Indicate that the items are going to be destroyed. This box should be stored in a different room, away from any regular stock.

If feasible, this box should be returned to the supplier (pharmaceutical depot or hospital). If it is not feasible, the items have to be destroyed at the facility.

Disposal methods are discussed in the next section. Regardless of the method, the destruction of pharmaceutical waste should be undertaken by a team under supervision and not by an individual. The team must witness the actual destruction of the product, that is, its entry into an incinerator or transport to and discharge at a dump site.

The procedure should be documented in a dedicated ledger. The following information should be recorded:

- date, time, and place of disposal
- disposal method
- list of the items disposed of and reason(s) for
- estimated value of the items disposed of
- composition of the team
- name and signature of the team leader and one witness

### METHODS OF DISPOSAL

The following guidelines are derived from a [WHO document](#), “Guidelines for Safe Disposal of Unwanted Pharmaceuticals in and after Emergencies.”

In general, expired pharmaceuticals do not represent a serious threat to public health or the environment. Improper disposal may be hazardous if it leads to contamination of water supplies or local resources used by nearby communities or wildlife. *Expired medicines may fall into the hands of scavengers and children if a landfill is insecure.* Most expired pharmaceuticals become less efficacious, and a few may develop a different adverse reaction profile.

Many methods exist to dispose of pharmaceuticals. In this section, we look at the methods that should (or should not) be used at the facility level. The methods used depend on the nature of the medicines and their pharmaceutical forms. These methods are summarized in the table in [Appendix E](#) in this chapter.

**Open, uncontrolled, nonengineered dump.** A nonengineered dump is probably the most common method of land disposal of wastes. Untreated waste disposal into an open, uncontrolled, nonengineered dump does not protect the local environment and should not be used unless the products are immobilized, for example by being encased in concrete.

If it is not possible to immobilize the waste pharmaceuticals, using a nonengineered dump should be the last resort. The untreated waste must be covered rapidly with large quantities of municipal waste to prevent scavenging. Discarding in open, uncontrolled dumps with insufficient isolation from the aquifer or other watercourses can lead to pollution, and, in the worst cases, contaminate drinking water.

**Engineered landfill.** Such a landfill has some features to protect against loss of chemicals into the aquifer. Direct deposit of pharmaceuticals into an engineered landfill is the second-best option.

**Waste immobilization by encapsulation.** The best option is disposal of encapsulated pharmaceuticals into an engineered dump. Encapsulation involves immobilizing the pharmaceuticals in a solid block within a plastic or steel drum. Drums should be cleaned prior to use and should not have contained any hazardous materials previously. They are filled to 75 percent capacity with solid and semisolid pharmaceuticals, and the remaining space is filled by pouring in cement, a cement-lime mixture, or a bituminous mixture, such as road tar. The sealed drums should be placed at the base of the landfill and covered with fresh municipal solid waste.

**Sewer.** Some liquid pharmaceuticals, such as syrups and intravenous fluids, can be diluted with water and flushed into sewers in small quantities over a period of time without serious public health or environmental effects. Fast-flowing watercourses may likewise be used to flush small quantities of well-diluted liquid pharmaceuticals or antiseptics. If in doubt, check with your environmental health authority.

**Burning in open containers.** You should not destroy pharmaceuticals by burning them at low temperatures in open containers, because toxic pollutants may be released into the air. Paper and cardboard packaging may be burnt. Polyvinyl chloride (PVC) plastic, however, must not be burnt. While burning pharmaceutical waste is not advocated as a method of disposal, we recognize that it is sometimes used. We strongly recommend that only a very small quantity (less than 5 kg) of waste pharmaceuticals be disposed of in this way.

**Incineration.** Waste pharmaceuticals can be destroyed in high-temperature incinerators. A minimum temperature of 850°C is required. Hospital incinerators may be used for this purpose if they meet the necessary temperature requirements.

**Disposal by specialists.** Increasingly, environmental concerns and stricter regulations are leading to the need to use specialized disposal operators—especially when there are significant quantities of medicines to be destroyed. These operators typically use recycling techniques for packaging materials, and fully oxidant, high-temperature incineration with controlled and monitored gaseous discharge, followed by ash encapsulation and land site dumping. Costs are naturally high, but it is a component of the management of medicines to make adequate cost provisions for the destruction of expired and damaged medicines.

[Appendix E](#) in this chapter identifies appropriate disposal methods for various categories of pharmaceuticals. Detailed information can be found in WHO's, [Guidelines for Safe Disposal of Unwanted Pharmaceuticals in and after Emergencies](#) (1999).

## Training and performance improvement of supply staff

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Effective pharmaceutical management depends on the people who carry out the work, as well as those who lead and manage it. Staff members who handle medicines and health products in district medical stores and public and NGO health facilities need training so that they have a minimum set of skills, competencies, and knowledge in the following subjects:

- setting up a storeroom and good storage practices
- inventory management and use of stock control forms, including requisitions, stock records, and prescriptions
- receiving and issuing stock
- good dispensing practice
- handling expired and damaged stock
- cold-chain procedures, including the use and maintenance of refrigerators
- security and theft control
- pest control

There are no standard training courses that are perfectly suited for all countries and settings, since different countries manage the delivery and distribution of medicines and health products in various ways. Some of the procedures described in this chapter may differ from the practices in your country. Some of the tasks described may not be relevant for some settings. Consult national or local authorities for help in developing a training program customized for your situation.

To develop a training program that meets local requirements, carry out a rapid assessment of training needs by:

- reviewing previous assessment findings and/or conducting a new assessment;
- observing staff performing their normal duties;
- interviewing staff and others;
- reviewing activities in relation to standard operating procedures;
- studying routine reports and performance reviews, along with job descriptions.

Then you can design a training program to improve the performance of a particular task or set of tasks, taking into account the demands of standard procedures, the educational level of the personnel, and the time and resources available for training. For health facility and district-level training, options would normally range from on-the-job training to short courses. Long-term placements in academic institutions might be considered for some staff, such as pharmacists, depending on local circumstances and the particular needs of the individuals concerned. In general, however, such placements would not be warranted for health facility and district staff.

### BOX 13. Training Programs and Resources

**Supply Management Training for Primary Health Care Facilities.** The [WHO drug supply management training program](#) describes all major medicine and supply management tasks at first-level health care facilities and is a useful resource for training program development.

**Training in Pharmaceutical Management.** MDS-3 Chapter 52 discusses the design and management of training programs for supply system staff in more detail. A related [training series](#) is available from Management Sciences for Health for use in training programs.

**Training in Logistics.** The [Logistics Workbook—A Companion to the Logistics Handbook](#) from the USAID | DELIVER Project contains a series of distance-learning exercises that can be undertaken at your own pace and used as a method of self-development.

The workbook should be used in conjunction with [The Logistics Handbook: A Practical Guide for Supply Chain Managers in Family Planning and Health Programs](#).

One challenge when training lower-level staff is that they may not be sufficiently fluent in the official national language to benefit from a course conducted entirely in that language. To overcome this problem in Senegal, where many storekeepers at the health facility level spoke only their local languages, the DELIVER Project designed a series of culturally sensitive visual aids for supply training. Key logistics concepts, such as average monthly consumption and months of stock on hand, were depicted using calabashes to represent quantities and crescent moons to represent time. The materials not only communicated advanced logistics concepts to storekeepers with low French literacy but also enhanced supervision because storekeepers' tasks became clearer.

In any case, apply the leadership practices of **scanning** and **focusing**: weigh your options against the immediate operational needs of the drug supply system. Then **plan, organize, implement**, and **evaluate** the training, making sure the running of health facilities and medical stores is not compromised when staff are in training courses. Box 13 summarizes some training programs and resources for your consideration.

Performance improvement goes beyond pre-service training to include on-the-job training, team problem solving, and supportive supervision. As a manager, you should introduce the standard management procedures for medicines to your staff and provide opportunities, for example during regular meetings, for continuing education on specific topics. Whenever possible, all the facility's staff should rotate through the pharmacy store and dispensary to learn these procedures so that supplies will be managed correctly.

The Physical Conditions Checklist in [Appendix A](#) in this chapter provides a starting point for training and for taking a team approach to making improvements.

Follow up with health workers who have been trained, using structured supervisory visits to make sure that the techniques of good pharmaceutical management are being implemented correctly. These visits are opportunities for health workers to receive support to continuously improve supply management.

## Supervising supply management

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This section is intended for the person who supervises the staff responsible for managing essential medicines and health products. In addition, logistics staff can use this section to informally evaluate their logistics system.

A useful source is [\*The Pocket Guide to Managing Contraceptive Supplies\*](#). Module 6 of [\*Managing TB Medicines at the Primary Level\*](#) also contains useful guidance on supervision and self-monitoring at the primary health care level. While the indicators suggested are geared toward managing TB medications, most of them can be easily adapted for general management of medicines.

### PRINCIPLES OF SUPERVISION

Good supervision is essential to a well-run supply system. A supervisor's primary job is to guide and support staff so they can perform their tasks well. The supervisor must make sure that staff have the knowledge, skills, motivation, and support to carry out their supply management activities. This may mean providing on-the-job training and constructive feedback if an employee's skills need improvement. It is just as important for a supervisor to notice and comment on things that are being properly managed as it is to help solve problems.

A supervisor's tasks are to:

- praise and reinforce good work;
- support employees by helping them get what they need to do their jobs well;
- work with staff to resolve problems;
- identify staff training needs;
- train staff in the necessary skills or arrange for training;
- follow up on problems and requests;
- motivate staff and remind them of the principles and goals of the health supply system;
- make sure that established supply guidelines and procedures are known and followed.

Supervision provides opportunities to use the leadership practices described in Chapter 2 of this handbook. For example, **scan** for strengths and areas to improve; **focus** on the highest-priority problems; **align and mobilize** staff to address the problems; and **inspire** staff so that the system functions effectively and clients get the medicines they need. See Chapter 6 of this handbook for more details on managing performance.

### CONDUCTING A SUPERVISORY VISIT

When a supervisor visits a medical store or health facility at the district level, the core supply functions of inventory management and storage should be examined. The supervisor can use all or some of the questions from the checklists on inventory management and storage management that follow to check whether the supply system is operating properly. Any No answer indicates a problem that should be addressed.

## CHECKLIST FOR INVENTORY MANAGEMENT

Review a sample of records and carry out informal interviews and observations to answer the following questions.

### Record-keeping

- Are the inventory records up-to-date? Check the stock cards to see how recently they have been used.
- Are the inventory records accurate? Do they agree with what is on the shelves?
- Is the arithmetic correct?
- Are complete records kept of the quantities of medicines and supplies dispensed to patients?
- Do the calculated quantities on the stock cards generally agree with the physical inventory quantities?

### Stock levels

- Are minimum and/or maximum stock levels calculated for each item?
- Has the average monthly consumption been calculated recently and accurately?
- Has the store successfully avoided stock-outs?

### Quality assurance

- Is there a system for performing quality checks to make certain that all medicines are usable by patients (that is, not expired or damaged)?
- Are medicines and supplies checked for quality immediately upon arrival and before they are dispensed to patients?
- Are all reported problems documented?
- Are all documented problems reported?

### Physical inventory

- Is a physical inventory conducted at least once a year? (In a small facility it should be done more frequently, for example, every one to two months.)

### Ordering

- If the facility orders its supplies, are orders placed on time in order to maintain inventories at agreed stock levels?
- Are the quantities to order calculated correctly?
- Has an ABC and/or VEN analysis been performed?

### Reporting

- Are reports submitted on time?
- Are any reports missing in the last six months?
- Are reports filled out correctly?
- Is the information in the reports accurate?

## Disposal

- Is there an annual survey of expired or damaged medicines and supplies, or physical inventories of unusable stock that is set aside?
- Are damaged or expired products removed and disposed of according to government guidelines?

## Materials

- Is there an up-to-date supply manual available to the staff?
- Is there an adequate supply of the correct forms for recording stock movements, reporting, and ordering?

If the answer to any of the questions is No, the situation needs to be corrected.

## CHECKLIST FOR STORAGE CONDITIONS

### Properly stacked supplies

- Are cartons stacked no more than 2.5 m high?
- Are stacks off the floor (on pallets or shelves)?
- Are stacks away from the wall?
- Is there adequate space (at least 30 cms/1 foot) between stacks?

### Organization

- Are the most frequently used commodities stored in an easily accessible place?
- Are the unusable products stored away from the usable ones?

### Preventing expiration

- Are the boxes clearly marked with expiry dates?
- Are the boxes arranged according to FEFO? (Are the commodities that will expire first kept in front or in a more readily accessible location?)

### Temperature

- Is the temperature of the storage area below 35°C?

### Ventilation

- Are there fans or a ventilation system to circulate air throughout the storage area during hot weather?

### Dryness

- Are the floors and walls dry?
- Are roofs, windows, and doorways without leaks?

### Workspace

- Is there sufficient storage space for all the needed commodities?
- Is the storage area large enough to allow for distributing, receiving, and checking supplies?



### Lighting

- Is there sufficient light to read product identification marks and labels easily?
- Are medicines protected from direct sunlight and fluorescent light?

### Cleanliness

- Is the storage area clean, tidy, and free of dust?

### Orderliness

- Are only medicines and other medical supplies kept in the medical storage area?
- Are flammable and corrosive products stored appropriately (separate from other products, away from each other, and in secure storage)?

### Pests

- Are storage areas free from signs of pests and rodents (live or dead insects, insect eggs, cartons that show signs of chewing or boring)?

### Security and safety

- Is there a security system that limits access to the storage area?
- If the storage area has doors and windows, are they secured?
- Are fire extinguishers readily accessible and in working condition?

### Access

- Is an authorized person with a key available during all service hours so that clinic staff can get supplies when they need them?

If the answer to any of the questions is No, the situation needs to be corrected.

Your job as a supply manager and supervisor is to:

- search out the necessary information for identifying the causes of a problem;
- analyze it;
- decide in consultation with staff what actions need to be taken;
- work with facility/warehouse staff to provide feedback on the strengths and weaknesses of the storage practices and conditions and develop solutions together for areas needing improvement.

If you find a problem on one visit and work with the staff to identify a solution, you should check that situation again on the next visit to see if things are going well or more assistance is needed. In addition to asking the questions above, a supervisor must consider the following situations:

- Has there been a change in demand lately? Look at the trend in average monthly consumption.
- Have there been any shortages or stock-outs? If so, identify the cause.
- Have there been any problems in getting supplies, such as delays and insufficient quantities sent?

- What is the rate of loss of commodities in the system (due to expiration, damage, disappearance, etc.)? Is this rate so high that it constitutes a problem?
- What are all the supply management activities that have been well managed lately?

## Proven practices

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- Successful supply management at the district and subdistrict levels requires a national framework because it typically represents up to 30 percent of the health care budget. Senior, national-level health care leaders and managers should demonstrate that they recognize the importance of effective supply management.
- Recognition of the value of effective supply management must be paired with an allocation of resources for supply management that is commensurate with its importance to the functioning of health services.
- Successful inventory management systems exhibit the following characteristics:
  - There are written rules for determining order quantities that are widely understood and accepted.
  - These rules are applied consistently.
  - Basic stock records that record all essential stock movements at the time transactions take place are maintained and are accurate and up-to-date.
- Regular physical stock checks are a routine part of supply management activities. In smaller stores, these checks take place monthly. All discrepancies are investigated and reconciled.
- The store is secure, in good condition, clean, and well organized. At a hospital or health facility, the store is separate from the dispensary.
- Good storage practice is followed at all times to maintain product quality and facilitate good management. This includes:
  - Products are stored in their original packaging.
  - Label directions for storage conditions are followed.
  - Liquids are placed on the lower shelves or on the bottom of stacks.
  - Products that require cold storage are stored in appropriate temperature-controlled zones.
  - High-security and high-value products are stored in appropriate security zones.
  - Damaged or expired products are immediately separated from usable stock and disposed of using formal disposal procedures.
  - All commodities are stored in a manner that facilitates a FEFO policy for stock management.
  - Cartons are arranged so arrows point up and identification labels, expiry dates, and manufacturing dates are visible.

- Good dispensing practices will make certain that an effective form of the correct medicine is delivered to the right patients, in the prescribed dosage and quantity, with clear instructions, and in a package that preserves the potency of the medicine. And not only is the patient correctly treated, good dispensing practices lessen the likelihood of developing a resistance to the medicine.

## Glossary of supply management terms

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**ABC analysis:** Method by which pharmaceuticals are divided, according to their annual usage, into Class A, B, and C items. Class A products usually account for 10 percent to 20 percent of items, but 75 percent to 80 percent of the value of pharmaceuticals supplied. Class B represents intermediate usage rates, while Class C contains the vast majority of products but accounts for only 5 percent to 10 percent of the value. ABC analysis is used to identify products in Class A, which should be given priority in terms of inventory management. *Also called* **Pareto analysis**.

**antineoplastics:** Pharmaceuticals used in chemotherapy to control or kill cancer cells. They all have unpleasant side effects that may include nausea, vomiting, hair loss, and suppression of bone marrow function.

**average monthly consumption:** The average amount issued to clients or patients each month over a period of time, normally not more than 12 months. It is calculated by dividing the total consumption for a given period by the number of months covered by the consumption period taking into account time out of stock. This information is vital to accurately determining how much to order.

**bin card:** A stockkeeping record that records receipts, issues, and balances of a single product in a single store location or shelf. It is kept on the shelf or pallet with the item.

**central stores:** A national location for receiving, storing, and distributing medical materials. *Also known as* **central medical stores**.

**cold chain:** A fully integrated system of maintaining products at a controlled temperature, requiring freezers, refrigerators, cold boxes, and other devices. It is used especially for vaccines and other products requiring temperature control, from the point of manufacture to the point of administration.

**consumption:** The rate at which items are issued to clients or patients. *Also known as* **demand**.

**corrosive:** Characteristic of a substance that will destroy or irreversibly damage another substance with which it comes in contact. The main hazards to people include damage to the eyes, skin, and tissue under the skin, but inhalation or ingestion of a corrosive substance can damage the respiratory and gastrointestinal tracts. Exposure results in chemical burns.

**cost of holding stock:** The cost of keeping inventory/stock in storage. *Also known as* **holding costs**.

**dispense:** To prepare and distribute to a patient a course of therapy on the basis of a prescription.

**essential medicines:** Essential medicines are those that satisfy the priority health care needs of the population. They are selected with regard to public health relevance, evidence on efficacy and safety, and comparative cost-effectiveness. Essential medicines are intended to be available within the context of functioning health systems at all times in adequate amounts, in the appropriate dosage forms, with ensured quality and adequate information, and at a price the individual and the community can afford. The implementation of the concept of essential medicines is intended to be flexible and adaptable to many different situations. The determination of which medicines are regarded as essential is a national responsibility.

**expiry date:** The date appearing on a pharmaceutical product and established by the manufacturer, beyond which the manufacturer will not guarantee the quality and efficacy of the product.

**first expiry, first out (FEFO):** A method of inventory management in which products with the earliest expiry date are the first products to be issued, regardless of the order in which they are received.

**first in, first out (FIFO):** A method of inventory management in which the first products received are the first products issued.

**flammable:** Characteristic of a substance that will easily burn or ignite, causing fire or combustion.

**forecasting:** Management function that estimates the quantities of products a program will dispense to users for a specific period of time in the future.

**formulary:** A list of pharmaceuticals approved for use in a specific health care setting.

**generic pharmaceuticals:** Products marketed by any producer under nonproprietary or approved names.

**immobilized pharmaceuticals:** Pharmaceutical materials that have been encased in an inert material, such as concrete, for disposal purposes.

**imprest system:** A form of periodic inventory control in which stocks are replenished up to a pre-established level. No running stock records are kept. The only stock control document is a preprinted sheet showing each item, its description, the unit of issue, and the imprest level. An imprest system is normally used only in small systems, such as hospital wards.

**inventory:** The sum of all items held in stock.

**lead time:** The time between when new stock is ordered and when it is received and available for use.

**losses:** The quantity of stock removed from inventory for any reason other than consumption by clients (for example, expiry or damage).

**maximum stock:** The level of stock above which inventory levels should not rise under normal conditions.

**nonimmobilized pharmaceuticals:** Pharmaceutical materials that have not been encased in an inert material, such as concrete, for disposal purposes.

**order quantity:** The amount of stock to be ordered via a requisition or purchase order from a supplier or other supply agency.

**out of stock:** Having no stock available to provide to the requesting party.

**pharmaceutical use:** The process of diagnosis, prescribing, labeling, packaging, and dispensing and of adherence to pharmaceutical treatment.

**physical inventory:** The process of counting by hand the total number of units of each commodity in a store or health facility.

**quantification:** System for calculating order quantities and budget requirements.

**safety stock:** The buffer, cushion, or reserve stock kept on hand to protect against stock-outs caused by delayed deliveries or markedly increased demand.

**stock:** The items stored in the warehouse or facility for future use.

**stock card:** An individual stockkeeping card that contains information about the full quantity of stock of a product.

**stock records:** A generic term for all types of records, including bin cards, stock cards, stock ledgers, and computer files, that provide basic essential information for inventory management. Used to record all transactions for an item, including receipts, issues, stock balances, and stock losses.

**stock status:** The number of weeks or months that existing stocks will last at current or anticipated rates of consumption. It is normally calculated by dividing the stock on hand by the average monthly consumption.

**VEN classification:** A system of prioritizing pharmaceuticals and the amount to have in stock according to their therapeutic importance. An analysis of the products in use divides the pharmaceutical products into **V**ital, **E**ssential, and **N**onessential categories.

**wastage:** The quantity of stock removed from inventory for any reason other than consumption by clients (for example, losses, expiry, and damage). *See also* **losses**.

**waste encapsulation:** Handling of hazardous waste by placing it into a container that is then closed with a cover.

**waste inertization:** Method for treating hazardous waste material contaminated with heavy metals so as to neutralize it and make it inert.

## References and resources

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Centers for Disease Control and Prevention, and John Snow, Inc. *The Pocket Guide to Managing Contraceptive Supplies*. Arlington, VA: CDC/JSI Family Planning Logistics Management, 2000, [http://deliver.jsi.com/dlvr\\_content/resources/allpubs/guidelines/PockGuidManaCont.pdf](http://deliver.jsi.com/dlvr_content/resources/allpubs/guidelines/PockGuidManaCont.pdf) (accessed Dec. 24, 2009).

DELIVER Project. *The Logistics Workbook—A Companion to the Logistics Handbook*. Arlington, VA: DELIVER Project for the U.S. Agency for International Development, 2000, [http://deliver.jsi.com/dlvr\\_content/resources/allpubs/guidelines/LogiWork.pdf](http://deliver.jsi.com/dlvr_content/resources/allpubs/guidelines/LogiWork.pdf) (accessed Dec. 24, 2009).

Family Planning Logistics Management/John Snow, Inc. 2000. *Programs That Deliver: Logistics' Contributions to Better Health in Developing Countries*. Published for the U.S. Agency for International Development (USAID), Arlington, VA: Family Planning Logistics Management/John Snow, Inc.

Gray, Andy. "Using Stock Cards to Improve Drug Management." Durban, South Africa: Health Systems Trust, Initiative for Sub-District Support, 1998, <http://www.hst.org.za/uploads/files/kwiksk13.pdf> (accessed Dec. 24, 2009).

John Snow, Inc./DELIVER. *Guidelines for Warehousing Health Commodities*. Arlington, VA: John Snow, Inc./DELIVER, for the U.S. Agency for International Development, 2005, [http://deliver.jsi.com/dlvr\\_content/resources/allpubs/guidelines/GuidWareHealComm.pdf](http://deliver.jsi.com/dlvr_content/resources/allpubs/guidelines/GuidWareHealComm.pdf) (accessed Dec. 24, 2009).

John Snow, Inc./DELIVER in collaboration with the World Health Organization. *Guidelines for the Storage of Essential Medicines and Other Health Commodities*. Arlington, VA: John Snow, Inc./DELIVER, for the U.S. Agency for International Development, 2003, [http://www.who.int/3by5/en/storage\\_pocketguide.pdf](http://www.who.int/3by5/en/storage_pocketguide.pdf) (accessed Dec. 24, 2009).

Management Sciences for Health. "Improving Contraceptive Supply Management." *The Family Planning Manager* (Boston) vol. 1, no. 4, 1992, [http://erc.msh.org/TheManager/English/V1\\_N4\\_En\\_Issue.pdf](http://erc.msh.org/TheManager/English/V1_N4_En_Issue.pdf) (accessed Dec. 24, 2009).

———. *IMAT: Inventory Management Assessment Tool*. Cambridge, MA: MSH, 1997. <http://erc.msh.org/toolkit/Tool.cfm?lang=1&CID=2&TID=151> (accessed Dec. 24, 2009).

———. "Managing Drug Supply for Health Institutions." Developed for the Province of Eastern Cape (Republic of South Africa) through the USAID-funded Equity Project, Boston: Management Sciences for Health, 2000.

Optimize | PATH and World Health Organization. "Landscape Analysis: Analysis of EVSM Indicators." Ferney Voltaire, France: Optimize, 2008, [http://www.who.int/immunization\\_delivery/systems\\_policy/EVSM\\_Indicators.pdf](http://www.who.int/immunization_delivery/systems_policy/EVSM_Indicators.pdf) (accessed Dec. 24, 2009). *Note:* EVSM refers to the Effective Vaccine Stores Management assessment tool.

———. "Landscape Analysis: Cool Chain Technologies." Ferney Voltaire, France: Optimize, June 2008, [http://www.who.int/immunization\\_delivery/systems\\_policy/Cool\\_Chain\\_Technologies.pdf](http://www.who.int/immunization_delivery/systems_policy/Cool_Chain_Technologies.pdf) (accessed Dec. 24, 2009).

———. "Landscape Analysis: Analysis of VMAT Indicators." Ferney Voltaire, France: Optimize, October 2008, [http://www.who.int/immunization\\_delivery/systems\\_policy/VMAT\\_Indicators.pdf](http://www.who.int/immunization_delivery/systems_policy/VMAT_Indicators.pdf) (accessed Dec. 24, 2009). *Note:* VMAT refers to the Vaccine Management Assessment Tool.

Rational Pharmaceutical Management Plus. *Managing TB Medicines at the Primary Level*. Submitted to the U.S. Agency for International Development by the Rational Pharmaceutical Management Plus Program, Arlington, VA: Management Sciences for Health, 2007, [http://erc.msh.org/toolkit/toolkitfiles/file/TB-Primary-Level-Guide-April-2008\\_final-English.pdf](http://erc.msh.org/toolkit/toolkitfiles/file/TB-Primary-Level-Guide-April-2008_final-English.pdf) (English version); [http://pdf.usaid.gov/pdf\\_docs/PNADN078.pdf](http://pdf.usaid.gov/pdf_docs/PNADN078.pdf) (French version) (both accessed March 14, 2014).

USAID | DELIVER Project, Task Order 1. *The Logistics Handbook: A Practical Guide for Supply Chain Managers in Family Planning and Health Programs*. Arlington, VA: US-AID | DELIVER Project, 2011, [http://deliver.jsi.com/dlvr\\_content/resources/allpubs/guidelines/LogiHand.pdf](http://deliver.jsi.com/dlvr_content/resources/allpubs/guidelines/LogiHand.pdf) (accessed Dec. 24, 2009).

World Health Organization. *The Rational Use of Drugs: Report of the Conference of Experts (1985: Nairobi, Kenya)*. Geneva: World Health Organization, 1987.

———. *Guidelines for Safe Disposal of Unwanted Pharmaceuticals in and after Emergencies*. Geneva: World Health Organization, 1999, [http://www.who.int/water\\_sanitation\\_health/medicalwaste/unwantpharm.pdf](http://www.who.int/water_sanitation_health/medicalwaste/unwantpharm.pdf).

———. *Handbook of Supply Management at First-Level Health Care Facilities* 1st version for country adaptation. Geneva: World Health Organization, 2006, <http://www.who.int/medicinedocs/index/assoc/s14137e/s14137e.pdf>.

———. *Procurement & Supply Management (PSM) Toolbox*. Geneva: World Health Organization, 2009, <http://www.psmtoolbox.org/en/index.php> (accessed Dec. 24, 2009). Developed by the WHO AIDS Medicines and Diagnostics Service and its partner organizations—including MSH—the Procurement & Supply Management (PSM) Toolbox is a web-based resource for HIV-related health commodities. The tool box's website features a user-friendly search engine, regularly updated content, a forum to share experiences using the tool, and weekly tool highlights and related news. For users with limited or no Internet connections, an offline version of the PSM Toolbox is available on CD-ROM at no cost. Currently most of the content focuses on HIV & AIDS, but the addition of TB and malaria tools is ongoing.

World Health Organization and Optimize. “2009–2012 Optimize Strategy.” 2009, [http://www.who.int/immunization/programmes\\_systems/supply\\_chain/optimize/Optimize\\_Strategy\\_EN.pdf?ua=1](http://www.who.int/immunization/programmes_systems/supply_chain/optimize/Optimize_Strategy_EN.pdf?ua=1) (accessed March 7, 2014).

———. “Optimize: Rethinking the Vaccine Supply Chain.” Geneva: World Health Organization, 2009, [http://www.who.int/immunization/programmes\\_systems/supply\\_chain/resources/tools/en/](http://www.who.int/immunization/programmes_systems/supply_chain/resources/tools/en/) (accessed March 7, 2014).

## Appendices

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- Appendix A.** Physical Conditions Checklist
- Appendix B.** Storage Procedures Checklist
- Appendix C.** Receiving Supplies Checklist
- Appendix D.** Checklists for Maintaining Good Storage Conditions
- Appendix E.** Managing Different Types of Waste
- Appendix F.** Checklists and Links for Stock Control and Inventory Management Section
- Appendix G.** Checklist for Good Dispensing Practice



## APPENDIX A. Physical Conditions Checklist

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How does your store match up to a well-run store? Answer YES or NO to the following questions. Answering No indicates an area requiring improvement.

1. The store is separate from the dispensary; medicines are not dispensed to patients from the store.
2. The store is large enough to hold all of the supplies.
3. The door to the store has two locks; each lock has a separate key.
4. The store is kept locked at all times it is not in use.
5. The store structure is in good condition; there are no cracks, holes, or signs of water damage.
6. There is a ceiling in the store, and the ceiling is in good condition.
7. Air moves freely in the store; fans and screens are in good condition.
8. The windows are painted white or have curtains; windows are secured and have grilles.
9. The store is free of pests; there are no signs of pest infestations.
10. The store is tidy; the shelves are dusted, floor is swept, and walls are clean.
11. Supplies are stored neatly on shelves or in boxes.
12. Shelves and boxes are raised off the floor on pallets or on boards and bricks.
13. The refrigerator is in good condition; there is no staff food in the refrigerator.

## APPENDIX B. Storage Procedures Checklist

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How well organized is your store? Answer YES or NO to the following questions. Answering No indicates an area requiring improvement.

1. Supplies are shelved in groups: externals, internals, and injectables.
2. Tablets, capsules, and other dry medicines (such as packets of oral rehydration salts) are stored in airtight containers on the upper shelves.
3. Liquids, ointments, and injectables are stored on the middle shelves.
4. Supplies, such as surgical items, condoms, and labels, are stored on the bottom shelves.
5. Cold-chain items are stored in the refrigerator.
6. Controlled substances are kept separate in a double-locked storage space.
7. Supplies are arranged on the shelves in alphabetical order by generic name.
8. Items are grouped in amounts that are easy to count.
9. There are no expired items in the store.
10. Items with shorter expiry dates are placed in front of those with later expiry dates.
11. For items with the same expiry date, newly received items are placed behind those already on the shelves.
12. Supplies with no expiry or manufacture date are stored in the order received (FIFO).
13. Supplies with no expiry date but with a manufacture date are placed so that those with later dates are behind those with earlier dates.
14. There are no poor-quality items on the shelves, such as expired medicines or broken bottles.
15. On the shelves, there are no overstocked items or items that are no longer used.
16. There is a record of the removal of items; the record includes date, time, witness, and manner of removal.

## APPENDIX C. Receiving Supplies Checklist

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How are supplies received at your store? Answer YES or NO to the following questions. Answering No indicates an area requiring improvement.

1. A health worker receives deliveries in person.
2. The health worker checks the outside of the boxes for damage at the time of delivery.
3. The health worker keeps a written record of deliveries.
4. The delivery person signs the form before he or she leaves the health care facility.
5. The health worker checks the supplies received against the items listed on the delivery's requisition form.
6. The health worker checks the expiry dates of all items.
7. The health worker checks for poor-quality items, such as:
  - poorly packaged refrigerated items;
  - discolored medicines and vaccines;
  - broken containers and supplies spoiled by leakage;
  - unsealed and unlabeled items.
8. If deterioration is suspected, the health worker checks for:
  - unusual odors of tablets and capsules;
  - damaged tablets or capsules;
  - injectables with small particles that reflect light.
9. The health worker does not accept expired or poor-quality items.
10. The health worker documents all discrepancies.
11. The health worker stores the supplies; the movement of each item is recorded on its stock card.

## APPENDIX D. Checklists for Maintaining Good Storage Conditions

To maintain good storage conditions, you should take the following steps.

- Inspect the physical structure of the store regularly.
- Repair any damage to the roof, walls, door, windows, and floor.
- Control the temperature in the store to the extent possible. Install a ceiling fan if possible.
- Provide good ventilation that allows warm air to escape. Put air vents in the walls or ceiling.
- Be aware that refrigerators standing in the same room generate additional heat and raise the temperature in the room. If you have a fan, use it. Keep it in good working condition. If your store is small and refrigerators raise the temperature, move them to another place and put security locks on their doors.
- Control the light in the store. If light enters the store through windows, block the direct light. Either paint the windows white or hang curtains.
- Prevent water damage and control humidity. Check that there is good drainage. There should be drainage channels around your store. The roof should have gutters. Repair leaks as soon as they occur to reduce moisture and water damage.
- Containers of tablets and capsules may be packed with a sachet of desiccant (nonedible drying crystals). The desiccant keeps the inside of the container dry. Do not open the sachet. Keep the sachet in the container. Keep the container closed except when dispensing the medicines.
- Keep the store free of pests, such as rats, cockroaches, ants, and wasps. Spilled items may attract pests. Clean spills and remove broken containers immediately. Use screens on windows to keep out insects.
- Clean the store and keep it tidy. Clean up spills and leakages immediately. Keep dust to a minimum, since it can contaminate supplies and make labels difficult to read. Mop the floor, dust the shelves, and wipe down the walls regularly.
- Store supplies on shelves. If there are no shelves in your store, make temporary shelves. Use boxes, stacked bricks and boards, or pallets. Do not put boxes directly on the floor, which may be or become wet. Moisture can rot cardboard or wood.
- Boxes and boards should be regarded as a temporary measure while you wait for adequate shelves to be made. Air should circulate around the boxes, which should be stored with sufficient space from the wall and from the floor.

### CHECKLIST FOR PREVENTING PESTS

#### Inside the Storage Facility

- Provide adequate toilet facilities for staff.
- Establish a dedicated eating area, preferably outside the main store but if necessary within the store but with rigorous cleanliness.
- Do not permit eating outside the designated area.
- Do not store or leave food in the storage facility.
- Design or modify the storeroom to facilitate cleaning and prevent moisture.

- Maintain a clean environment to prevent conditions that favor pests. For example, store garbage in covered garbage bins. Regularly clean floors and shelves.
- Keep the interior of the building as dry as possible.
- Paint or varnish wood, as needed.
- Use pallets and shelving.
- Prevent pests from entering the facility.
- Inspect the storage facility regularly for evidence of pests, and if detected conduct a vigorous eradication exercise.
- Shrink-wrapping cartons can also assist in preventing pest damage.

### Outside the Storage Facility

- Regularly inspect and clean the outside premises of the storage facility, especially areas where garbage is stored. Check for any rodent burrows, and be sure that garbage and other waste are stored in covered containers.
- Check for still or stagnant pools of water in and around the premises, and be sure that there are no buckets, old tires, or other items holding water.
- Treat wood-frame facilities with water sealant, as needed.
- Use mercury vapor lighting where possible, and locate lighting away from the building to minimize the attraction of pests.

## CHECKLIST FOR PREVENTING THEFT

### During Transport

- Verify documents.
- Make certain that packing seals are used.
- Use strong boxes or other containers.
- Provide reliable, well-maintained vehicles.
- Make sure drivers are reliable.
- Expedite clearance at airports and seaports and through on-land borders.

### At Storage Facilities

- Limit access to designated staff.
- Limit the number of keys made for the facility; keep a list of people who have keys.
- Secure all locks and doors.
- Make unannounced spot-checks.
- Have an independent stock count or inventory control done.

### In Health Centers

- Lock the storeroom or cupboards.
- Have inventory control cards for each product.
- Set maximum dispensing quantities.
- Have dispensers record individual prescriptions and maintain prescription or dispensing registers.
- Limit dispensing to authorized staff members.

### Monitor Selected Products

As additional protection against theft, monitor items that are fast moving, chronically in short supply, in high demand by customers, expensive, lifesaving, and easy to hide or disguise.

## CHECKLIST FOR ROUTINE STORAGE MANAGEMENT TASKS

### Daily/Weekly

- Monitor storage conditions.
- Clean receiving, storage, packing, and shipping areas.
- Sweep or scrub floors.
- Remove garbage.
- Clean bins, shelves, and cupboards, as needed.
- Check that aisles are clear.
- Make sure there is adequate ventilation and cooling.
- Protect products from direct sunlight.
- Monitor store security and safety.
- Check the store roof for leaks, especially during the rainy season and during or after a storm.
- Monitor product quality (visually inspect commodities and check expiration dates).
- Ensure that products are stacked correctly. (Are the lower cartons being crushed?)
- Update stock records and maintain files.
- If cycle counting is being done, conduct a physical inventory and update stockkeeping records.
- Monitor stock levels, stock quantities, and safety stocks.
- Submit emergency orders as needed, using local guidelines.
- Update backup files for computerized inventory control records.
- Update bin cards.
- Separate expired stocks and move them to a secure area.

### Monthly

- Conduct a physical inventory or cycle count and update stockkeeping records.
- Run the generator to check that the system is working correctly; check the level of fuel and add fuel, if needed.
- Check for signs of rodents, insects, or roof leaks.
- Inspect the storage structure for damage, including the walls, floors, roof, windows, and doors.

### Every Three Months

- Use established procedures to dispose of expired or damaged products.
- Visually inspect fire extinguishers to make sure their pressures have been maintained and the extinguishers are ready for use.

### Every Six Months

- Conduct fire drills and review fire safety procedures.
- Inspect trees near the medical store, and cut down or trim any trees with weak branches.

### Annually

- Service fire extinguishers and smoke detectors.
- Conduct a complete physical inventory and update stockkeeping records.

## FIRE EXTINGUISHERS

There are four main types of fire extinguishers. The following table provides a summary of each of them.

Type of Fire Extinguisher	Description and Use
Dry chemical	Contains an extinguishing agent such as potassium bicarbonate (similar to baking soda) and uses a compressed gas as a propellant. They are effective for multiple types of fires, including combustible solids like wood or paper, combustible liquids like gasoline or grease, and electrical fires.
Water	Contains water and compressed gas and should be used only on ordinary combustibles, such as paper and wood. Never use water on fires caused by liquids (such as gasoline or kerosene) or on electrical fires.
Carbon dioxide (CO <sub>2</sub> )	Most effective on fires caused by liquids (such as gasoline or kerosene) and electrical fires, but not on fires caused by combustibles like paper, cardboard, or lumber. The gas disperses quickly and does not leave any harmful residue.
Halon	Often used in areas with computer equipment or other machinery because it leaves no residue. Halon can be used on common combustibles, flammable liquids, and electrical fires. However, it is dangerous to inhale and harmful to the environment. Halon is most effective in confined spaces, but the area will need to be ventilated before it can be reoccupied.

Source of Appendix D: John Snow, Inc./DELIVER and the World Health Organization (WHO). [\*Guidelines for the Storage of Essential Medicines and Other Health Commodities\*](#), 2003.

## APPENDIX E. Managing Different Types of Waste

The following table provides an overview of the major types of waste that must be destroyed safely and effectively.

Nonmedical Waste	Methods of Disposal
Garden rubbish	Compost leaves, sticks, weeds, and trimmings from shrubs and trees, if feasible. Designate a separate area for composting.
Cardboard cartons	If possible, recycle cardboard; otherwise, treat it like ordinary rubbish.
Ordinary rubbish	Where municipal solid waste facilities exist, dispose of ordinary rubbish in the municipal dump. Otherwise, burn or bury it.
Human waste	Use pit latrines or other toileting facilities to dispose of all human waste.

Health Care Waste	Definitions
Sharps	Single-use disposable needles, needles from auto-disable syringes, scalpel blades, disposable trocars, sharp instruments requiring disposal, and sharps waste from laboratory procedures.
Other hazardous medical waste	Waste contaminated with blood, body fluids, human tissue; compounds such as mercury; pressurized containers; and wastes with high heavy metal content.
Pharmaceuticals	Expired, damaged, or otherwise unusable medicines and items contaminated by or containing medicinal substances.

The disposal methods for various categories of pharmaceuticals are identified in the following [table](#).

### SHARPS CONTAINERS

Sharps containers or safety boxes are puncture- and water-resistant, impermeable containers. When used correctly, they reduce the risk of skin-puncture injuries that may spread disease. Once filled, the sharps boxes are disposed of either by incinerating them or by filling them with bleach to remove biological hazards and then putting them in a landfill.



Category	Disposal Methods	Comments
<b>Solids</b> <b>Semisolids</b> <b>Powders</b>	<ul style="list-style-type: none"> <li>Landfill</li> <li>Waste encapsulation</li> <li>Waste inertization</li> <li>Medium- and high-temperature incineration (cement kiln incinerator)</li> </ul>	<ul style="list-style-type: none"> <li>No more than 1% of daily municipal waste should be disposed of in an untreated form (nonimmobilized) in a landfill.</li> </ul>
<b>Liquids</b>	<ul style="list-style-type: none"> <li>Sewer</li> <li>High-temperature incineration (cement kiln incinerator)</li> </ul>	<ul style="list-style-type: none"> <li>Antineoplastics should not be disposed of in the sewer due to the high risk they present to anyone coming into contact with them.</li> </ul>
<b>Ampoules</b>	<ul style="list-style-type: none"> <li>Crush ampoules and flush diluted fluid into sewer</li> </ul>	<ul style="list-style-type: none"> <li>Antineoplastics should not be disposed of in the sewer due to the high risk they present to anyone coming into contact with them.</li> </ul>
<b>Anti-infective medicines</b>	<ul style="list-style-type: none"> <li>Waste encapsulation</li> <li>Waste inertization</li> <li>Medium- and high-temperature incineration (cement kiln incinerator)</li> </ul>	<ul style="list-style-type: none"> <li>Liquid antibiotics may be diluted with water, left to stand for several weeks, and discharged to a sewer.</li> </ul>
<b>Antineoplastics</b>	<ul style="list-style-type: none"> <li>Return to donor or manufacturer</li> <li>Waste encapsulation</li> <li>Waste inertization</li> <li>High-temperature incineration (cement kiln incinerator)</li> <li>Chemical decomposition</li> </ul>	<ul style="list-style-type: none"> <li>Not to landfill unless encapsulated</li> <li>Not to sewer</li> <li>No medium-temperature incineration</li> </ul>
<b>Controlled medicines</b>	<ul style="list-style-type: none"> <li>Waste encapsulation</li> <li>Waste inertization</li> <li>Medium- and high-temperature incineration (cement kiln incinerator)</li> </ul>	<ul style="list-style-type: none"> <li>Not to landfill unless encapsulated</li> </ul>
<b>Aerosol canisters</b>	<ul style="list-style-type: none"> <li>Landfill</li> <li>Waste encapsulation</li> </ul>	<ul style="list-style-type: none"> <li>Not to be burnt: may explode</li> </ul>
<b>Disinfectants</b>	<ul style="list-style-type: none"> <li>To sewer or fast-flowing watercourse: small quantities of diluted disinfectants (max. 50 liters per day under supervision)</li> </ul>	<ul style="list-style-type: none"> <li>No undiluted disinfectants to sewers or watercourses</li> <li>Maximum 50 liters per day diluted to sewer or fast-flowing watercourse.</li> <li>No disinfectants at all to slow-moving or stagnant watercourses</li> </ul>
<b>PVC plastic, glass</b>	<ul style="list-style-type: none"> <li>Landfill</li> </ul>	<ul style="list-style-type: none"> <li>Not for burning in open containers</li> </ul>
<b>Paper, cardboard</b>	<ul style="list-style-type: none"> <li>Recycle, burn, landfill</li> </ul>	

Source: World Health Organization, [Guidelines for Safe Disposal of Unwanted Pharmaceuticals in and after Emergencies 1999](#).

## APPENDIX F. Checklists for Inventory Management and Stock Control

### EXAMPLES OF CALCULATING ORDER QUANTITY USING MAXIMUM STOCK AND REORDER FACTOR TABLES

The following examples demonstrate how to use the tables and methods described in the section of this chapter titled [“How to calculate the quantity to order.”](#)

#### Example 1

The average monthly consumption (AMC) of Product A equals 45 units. This product is ordered every two weeks, and the lead time is four weeks. The current stock is 60 units. If an order has to be placed, how much has to be ordered?

1. First, identify the maximum stock factor. In this case it is 3. Therefore, the maximum stock equals 135, using the following formula:  $45 \text{ (AMC)} \times 3 \text{ (maximum stock factor)} = 135 \text{ (maximum stock, in issue units)}$ . Since the current stock balance is 60, an order has to be placed.
2. Second, identify the reorder factor. The information above, when used in conjunction with the [reorder factor table](#), shows that, the reorder factor equals 4.
3. Third, calculate the quantity to order using the recommended formula:  
 $\text{quantity to order} = [45 \text{ (AMC)} \times 4 \text{ (reorder factor)}] - 60 \text{ (stock)} = 120$

#### Example 2

Product B's average monthly consumption is 30 units. This product is ordered once a month, and the lead time equals six weeks. The stock balance is 90 units. How much should be ordered?

1. First, identify the maximum stock factor. In this case it equals 4. Therefore, the maximum stock is equal to 120, using the formula:  $30 \text{ (AMC)} \times 4 \text{ (maximum stock factor)} = 120 \text{ (maximum stock, in issue units)}$ . The current stock balance is 90, so an order has to be placed.
2. Second, identify the reorder factor using the [reorder factor table](#). The reorder factor is 5.5.
3. Third, calculate the quantity to order using the recommended formula:  
 $\text{quantity to order} = [30 \text{ (AMC)} \times 5.5 \text{ (reorder factor)}] - 90 \text{ (stock)} = 75$ .

### STOCK CARD CHECKLIST

How are the stock cards used in your store or facility? (A sample stock card appears in [Figure 3](#) in this chapter.) Perform this self-assessment, and share the results with your health team and/or your supervisor.

There is a stock card for each item in the store.

- All information on the stock card is up-to-date and accurate.
- The stock card is kept on the same shelf as the item.
- Information is recorded on the stock card at the time of movement.

- There is an accurate running tally kept in the Balance column.
- A physical count is made at regular intervals, such as once a month.

Once your assessment is completed, identify what can be done immediately to solve the highest-priority issues, and implement the changes that are required.

### ORDERING SUPPLIES CHECKLIST

Answer the following questions. If delivery schedules change, erase and record the new delivery information. Keep the answers current.

- When are supplies delivered?
- How often are supplies delivered?
- What is your facility's order frequency?
- What is your lead time?

### SELF-ASSESSMENT

Perform this self-assessment by answering YES or NO to the following statements. Share the results with your health team and/or your supervisor.

- You know how to calculate the average monthly consumption (AMC).
- You take stock-out periods into consideration when calculating the AMC.
- You calculate the maximum stock by multiplying the AMC by the maximum stock factor.
- The maximum stock has been calculated for each item in the store.
- The maximum stock is recorded on each item's stock card.
- You place your order when the stock balance *is less* than the maximum stock.
- When you order, you use the formula for quantity to order.
- All orders are placed in writing using the prescribed forms.
- All information on the requisition is complete, accurate, and written clearly.

Once your assessment is completed, identify what can be done immediately to solve the most pressing issues and implement the changes that are required.

## APPENDIX G. Checklist for Good Dispensing Practices

### PREPARE YOUR DAILY SUPPLIES

Before dispensing medicines to patients, you should do the following:

- Check the quantities that are available in the dispensing area.
- Estimate the number of units of each item that will be needed for the day or the clinic session. Base the amount on past use and the clinics that are operating that day. If necessary, ask someone with experience in issuing supplies to help you.
- Go into the store and request the stock you need from the storekeeper. Once the storekeeper issues the fresh supplies to you, place the items on a tray or trolley and take them to the dispensing area.
- If, later in the day, items are running short, the same procedure should be followed to replenish those stocks.
- Make sure that the stock records in the store are updated immediately by recording the movement of each item that you issue out of the store on its stock card.
- Once items are issued to a dispensing area, do not return them to the store. Keep them in the dispensing area.
- Keep supplies in the dispensing area safe and organized.
- Make sure that the security in the dispensary is the same as in the pharmacy store. Staff should always be present in the dispensing area when it is not locked. Do not leave the area unattended and unlocked.
- Organize supplies in the same way as they are organized in the store. Organize by route of administration and by form of preparation. Arrange each group of items in alphabetical order by generic name.

Medicines and other supplies should be collected from the dispensary shelves according to FEFO or FIFO rules.

Some facilities use stock cards in the dispensary as well as in the store. Stock cards used in this way become dispensing records. However, health workers, administrators, and accountants often need to collect information about medicines and related supplies given to patients to treat certain illnesses. It is therefore usually better to use a notebook or dispensing ledger to keep dispensing records of medicines on a daily or weekly basis. This approach can be especially useful when you are scaling up services; it will allow you to monitor rapidly changing consumption patterns.

### PRINCIPLES OF DISPENSING TO THE PATIENT

In all health care facilities, the person dispensing medicines to the patient must understand and follow five principles.

1. When a medicine is given to a patient, it is important that the patient receives:
  - the correct medicine;
  - the correct amount of the medicine;
  - the correct information on how to take the medicine.

2. Dispensing to a patient consists of:
  - checking the prescription;
  - collecting, counting, and packaging the medicine;
  - transferring ownership to the patient;
  - providing information to the patient (or caregiver of children).
3. Carefully and clearly explain to patients how to take their medicine. This is very important. Medicines are effective only if taken correctly. Then check that patients understand how to take their medicines. Patients should be able to repeat to you how they will take their medicines.
4. To dispense properly, you need to know:
  - how to prepare medicines and related supplies;
  - how to give them to patients;
  - how to interact effectively with patients to ensure they understand.
5. Prescribing and dispensing medicines are two separate activities in a health care facility. Prescribe medicines in the clinical area. Dispense medicines from a dispensing area (or dispensary). Keep the areas separate, if possible. Do not dispense to patients directly from the store! The dispensary may be a room, part of a room, a cabinet, or a dispensing trolley.

### DISPENSING PROCEDURES CHECKLIST

To dispense a medicine (or other item) to a patient, follow these steps:

1. **Check that the prescription is appropriate for the patient.**
  - Review the prescription.
  - Find the generic name of the medicine. If you cannot read it or if you have any questions about a prescription, ask the person who wrote it to explain it to you.
  - Check that the prescription is appropriate for the age, weight, and sex of the patient.
  - Where feasible, also check that the medicine prescribed is appropriate in form, strength, and dosage and in line with the standard treatment guidelines for this medicine. If you have any doubt about this, ask the person who wrote the prescription to confirm it for you.
2. **Prepare one prescribed item at a time.** If more than one item has been prescribed, do not combine them.
  - Collect a bottle, strip, tube, or container of the item, and check its expiry date.
  - Read the generic name on the label of the container.
  - Check that it is the correct medicine.
    - ▶ **Remember that some medicines look the same** and can easily be confused.
  - Check that it is the correct form, strength, and unit size.
  - Check that the item has not expired.
  - Collect a medicine envelope or container to package the item for the patient.

3. **Label the package** to be given to the patient.
  - Some packages will have preprinted labels on them. Some will not have labels, or the labels will not be in the operating language of your country/region, and you will need to prepare a label.
  - Print clearly on the label. Include the following information:
    - patient's name
    - patient's age
    - the day's date
    - generic name of the item
    - strength
    - form
    - quantity dispensed
    - expiry date
    - dosage: instructions that tell the patient when, how much, for how long, and how the medicine should be taken, for example, "Take two tablets with food every morning for five days."
    - any advisory or warning instructions, such as "May cause drowsiness," "Do not drive while taking this medicine," etc.
  - Use pictures or numbers to record the dose. Include written instructions also. Patients who cannot read may need pictures for instructions and should have someone at home who can read the instructions to them.
  - After you record the information on the label, attach it to the empty package.
    - ▶ **A clearly written label is important.** When a patient returns to a health care facility with a previous prescription, any health worker should be able to read it.
4. **Open the bulk medicine container and check the quality of its contents.**
  - If medicines have an odd smell, they may have deteriorated. If tablets or capsules are cracked, broken, powdery, or sticky, they are damaged. If capsules are swollen, softened, or stuck together, they are damaged.
    - ▶ **Never give patients poor-quality medicines.** Dispose of those medicines properly.
5. **Count the quantity needed in a clean, safe manner.**
  - Count tablets or capsules using a counting tray.
  - If you do not have a tray, you can make one from a sheet of paper or used X-ray film, or you can use a clean surface covered with paper.
  - Count the tablets or capsules with a clean spatula. Do not use your hands. You may contaminate both the medicine and your hands.
  - Do not use the same tray to count new medicines without cleaning the tray. If you use a sheet of paper to count, use a new sheet each time. If you reuse the same tray or paper, you may contaminate both the medicines and yourself.

6. **Put the correct amount of the medicine into the package** for the patient to take home.
  - Put the medicine into its own labeled package using the tray and spatula (or measuring device for liquids).
  - Do not mix prescriptions or medicines.
7. **Immediately put any extra tablets or capsules back into the appropriate container.**
  - If more than one medicine has been prescribed, close one container before you open another container.
  - Prepare all of the prescribed items before you dispense them to the patient.
  - Before closing the container, check the container's details against the prescription. This is simply to confirm to yourself that you have dispensed the correct medicine.
8. **Give the package to the patient.**
  - If the patient is a child, go through the following steps with the mother (or caretaker).
  - Explain to the patient how to take the medicines (see Step 10).
  - If the patient has more than one prescription, dispense one item at a time.
9. **Advise and counsel the patient on how to take the medicine.**
  - **Tell the patient the name of the medicine**, its **form** (tablet, syrup, etc.), **what it is for**, and the **dosage**. The dosage includes:
    - when to take the medicine (for example, in the morning)
    - how much of the medicine to take (for example, one tablet)
    - how long to take the medicine (for example, two days)
    - how to take the medicine (for example, with food)

You may decide to display the dosage instructions about how to take the most common medicines in the dispensary. Then your staff will be more likely to give the same (and correct!) instructions to patients. In addition, you may consider displaying some instructional materials for frequently used medicines on a wall where patients can see them. This makes your message more meaningful.

- **Show the patient how to prepare the dose.** Allow the patient to practice before he or she leaves the dispensary.
  - If a dose is less than a whole tablet, show the patient how to divide the tablet.
  - If the medicine should be mixed with food, show how to crush the tablet and mix it with food.
  - If you are dispensing syrup, show how to measure the correct amount. Use the cap of the syrup bottle or show the patient common spoons to use.
  - Ask the patient to practice measuring the dose. Use the medicine that you have already packaged for the patient to take home.
  - When you are confident that the patient understands how to prepare the dose, ask him/her to take the first dose.

- **Tell the patient to take *all* of the prescribed medicines.**
    - Sometimes patients will feel better before they finish all of the prescribed medicines. Tell patients that, even if they feel better, it is important to take all of the medicines to stay well. This is especially true of antibiotics or antimalarials because bacteria or parasites may still be present. Also tell patients with chronic conditions, such as those with hypertension or those taking ARVs, that they need to return for follow-up treatment.
  - **Ask patients to tell you how they will take the medicine.**
    - Each time you dispense a medicine, check the patient's understanding.
    - If patients answer correctly, compliment them! If not, explain the dosage to them again. Explain until they can answer you correctly.
    - If you are giving patients more than one prescription, give them one item at a time. Give the next item only after you are sure that patients know how to take the medicines you have just given them.
    - Medicines are effective only if patients take them correctly. Sometimes even intelligent patients who are sick do not understand how to take their medicines. Medicines taken incorrectly may be ineffective or even poisonous. *Always check the patient's understanding.*
10. **Tell the patient to keep all medicines and related medical supplies in a safe place** at home and out of the reach of children.
- Tell the patient that medicines are expensive and dangerous and need to be stored in a special place at home.
  - The place must be cool, dark, and dry, safe from pests, and out of the reach of children.
  - Recommend places typically found in homes in your area where patients could store their medicines.
11. **Keep accurate dispensing records.**
- Complete dispensing records in accordance with the instructions given by your supervisor or local supply coordinator.
  - Be sure to follow any special requirements for controlled substances and medicines from donor programs to which separate recording requirements may apply.





# Managing Information: Monitoring and Evaluation

Nancy LeMay

1. Achieving Results by Strengthening Health Systems
2. Leading and Managing: Critical Competencies for Health Systems Strengthening
3. Governance of Health Systems and Health Organizations
4. Mainstreaming Gender Equality into Health Systems
5. Planning the Work and Working with the Plan
6. Managing Human Resources
7. Managing Finances and Related Systems
8. Managing Medicines and Health Products
9. Managing Information: Monitoring and Evaluation
10. Managing Health Service Delivery

This chapter is a practical guide that you, as the manager of a health program or health services, can use to understand and organize essential practices that will improve the monitoring and evaluation (M&E) of health services. It explains the role and function of an effective health information system (HIS). It describes monitoring and evaluation as key program management functions, explains the difference between the two, and offers considerations for making each function more useful to you for learning and action. It also shows how good leadership and management practices are relevant to M&E.

You can use the information in this chapter to:

- enhance the effectiveness of an HIS;
- use routine monitoring to improve the performance of organizational activities;
- produce actionable data for making informed decisions;
- avoid common M&E pitfalls;
- design an evaluation;
- use frameworks to develop a logical plan for program activities;
- prepare an M&E plan.

The chapter concludes with a story that emphasizes the human element in M&E. The story describes how using less-than-perfect data from an HIS can be beneficial and instill confidence in the system. The story also offers several proven practices in M&E that are relevant to your work as a health manager.

## Introduction

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Within the development community a strong and growing emphasis on producing quantifiable results has increased attention to, and interest in, M&E. There is much discussion about results-based planning, results frameworks, and results teams. But people are also frequently confused about what to monitor, what to evaluate, and how best to carry out both tasks.

There is a tendency to forget the importance of good, solid monitoring, which is essential for providing managers the information they need to take action and produce results. In the rush to evaluate, some organizations downplay monitoring in favor of evaluation, in order to show results. Monitoring is an often-underused management practice that can get lost between the evaluators and the planners.

In your role as a manager, you and your team need the information gained from both monitoring and evaluation to manage activities and produce results. You are likely to use your M&E skills to measure health inputs, activities, outputs, and outcomes (terms that are discussed later in this chapter). You will probably not be asked to measure impact. Except for large, well-established, and well-funded organizations, impact assessment is usually the responsibility of the Ministry of Health or the donor. Although impact assessment falls outside the scope of the chapter, you will find links to useful materials on the topic.

This chapter is not just for M&E or HIS staff. The audience is much broader and includes:

- directors and other senior managers in civil society organizations (CSOs), including nongovernmental organizations (NGOs), faith-based organizations (FBOs), and other nonprofit organizations;
- managers of donor-funded projects implemented by CSOs;
- district- and facility-level managers from the public sector;
- M&E and HIS staff from public-sector and donor-funded organizations.

## Information for managing health services

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It is widely accepted that health managers and service providers need better access to reliable information and better ways to use this information to monitor performance and manage services. The effective management of the entire health system depends on the appropriate use of timely and accurate information by personnel at all levels. This use of information depends, in turn, on the ability of the HIS to generate useful information.

### SUBSYSTEMS AND CYCLES OF A HEALTH INFORMATION SYSTEM

In *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action*, the World Health Organization (WHO) shows that information is one of the six essential building blocks of any health system. WHO defines a well-functioning HIS as “one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance, and health status” (WHO 2007). The term HIS usually encompasses the many subsystems that

provide the necessary information for managing health services. Figure 1 provides an overview of the common subsystems within an HIS.

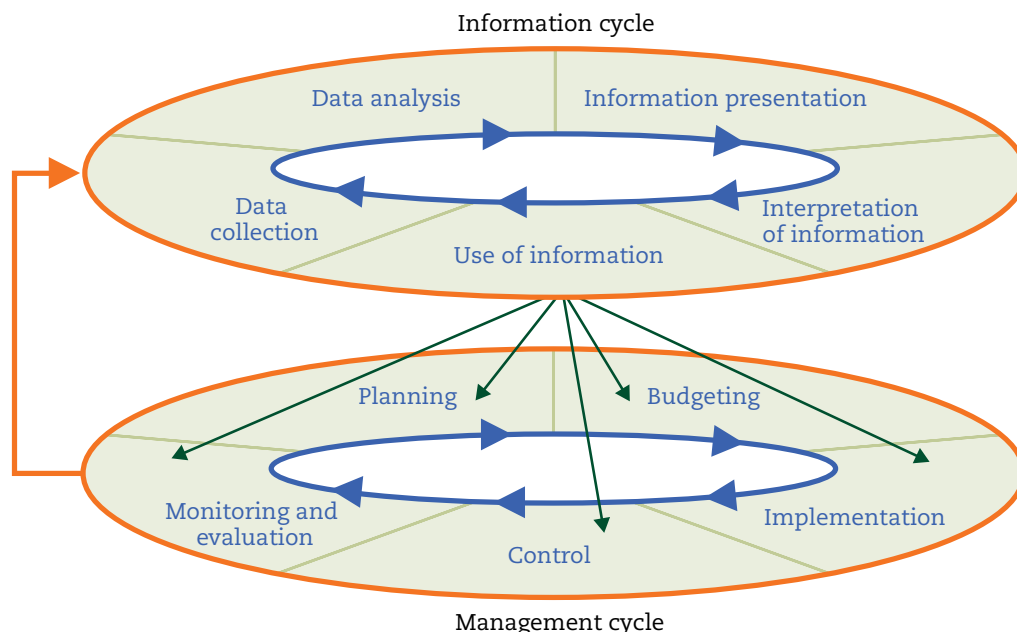
An HIS that is well designed and functions well should support the key processes needed to manage health services. These processes are cyclical and ongoing, and the collection, analysis, and use of information to carry out health management functions also create a cyclical process.

[Figure 2](#) shows M&E as one element of a typical management cycle, feeding data into an information cycle. There it is processed and turned into information, which is fed back into the various functions of the management cycle.

**FIGURE 1. Common Health Information Subsystems**



FIGURE 2. Relationship between Information and Management Cycles



### DISTINCTIONS BETWEEN MONITORING AND EVALUATION

Monitoring and evaluation are key management functions of an organization. Together, they serve to support informed decisions, the best use of resources, and an objective assessment of the extent to which an organization's services and other activities have led to a desired result.

To make informed decisions, health care managers need an M&E system that yields reliable information about such factors as:

- the health needs of the people in their catchment area—the area from which clients are drawn to receive services;
- the priorities of the country, province, district, and communities they serve;
- the quality and coverage of the services they offer;
- the resources they have used and resources still available;
- progress in the implementation of their activities.

Both monitoring and evaluation activities are necessary to satisfy these information needs. But which should be used when? The differences between monitoring and evaluation lie in their purposes, time frames, and sources of information.

**Monitoring** is used to regularly track changes in indicators—measurable markers of change over time—in order to manage the implementation of a program. Monitoring measures progress toward results by collecting information on inputs, activities, outputs, and sometimes short-term outcomes. For you, the manager, this may involve monitoring progress against your operational plans and/or monitoring the services you provide.

Common procedures for program monitoring include tracking service statistics and reviewing records and training reports. Regular, systematic monitoring provides information for planning purposes and a reliable basis for an evaluation.

**Evaluation**, on the other hand, is used to assess the effectiveness (and sometimes the cost) of efforts to improve services and to prevent and manage priority health problems. Evaluation measures outcomes and impact. It assesses the extent to which your organization achieves its desired results and helps you understand why the results were or were not achieved. Evaluation also provides an opportunity for continuous learning from experience.

Thus, the first factor that separates monitoring from evaluation is a difference in *purpose*. Monitoring is driven by a management need, whereas evaluation is driven by the need to document outcomes of an intervention and report to a donor or other stakeholder. Monitoring thus focuses on operational implementation, while evaluation focuses on the effects of the activities on the health of the target population.

This leads to a second critical difference: the time frame when each is used. Monitoring is an ongoing, routine process used throughout an intervention. Evaluation requires the collection of baseline and post-intervention data that allow you to compare changes during the period of the intervention and, sometimes, after a suitable follow-up period.

Finally, a third difference is related to the sources each function uses for information. Monitoring data usually come from what is readily available: the health information system or routine service records. Service statistics provide such monitoring data as supply inventories, numbers of vaccine doses administered monthly, and patient outcomes. Monitoring data can also be obtained by compiling routine organizational records. For example, participant lists from a training workshop can supply information on the number of people trained on a given topic.

Outcome and impact indicators require measurements at the beneficiary or population level, which must be obtained through an evaluation. For example, to determine the outcome of a family planning counseling initiative, you would need to know the percentage of women among those counseled who actually adopted a family planning method. You could not derive that information from service statistics or routine organizational records; you would need to conduct a survey to collect the data.

Common measures in an evaluation include changes in the use of health services from one period to another, proportions of safe deliveries, coverage of immunization services, and changes in the knowledge, attitudes, or behavior of a target group.

**Leading and managing practices for monitoring and evaluation.** Despite the differences between monitoring and evaluation, both functions will be optimized if you use the other leading and managing practices when you are carrying out monitoring or evaluating tasks. For example, monitoring and evaluation—one of the managing practices discussed in Chapter 2 of this handbook—require you to **focus** on goals and priorities and use your **scanning** skills to collect and analyze appropriate data. In response to the results collected through monitoring and evaluation, you may need to **focus** and **align and mobilize** staff in order to modify intervention plans to better achieve results. Depending on whether

activities are meeting their objectives and achieving the expected results, you could also use M&E information to **inspire** staff to improve their performance or, alternatively, to keep up the good job.

In managing M&E activities, you will need to develop an M&E **plan** and then **organize** the structures, subsystems, and processes to **implement** the plan. And of course you will **monitor and evaluate** the M&E program itself to determine progress toward and achievement of results.

The leading and managing practices discussed here and in Chapter 2 of this handbook are also fully described on MSH's Electronic Resource Center in the Leadership Development section titled ["Developing Managers Who Lead."](#)

## Who owns M&E?

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Who is the M&E client? Who needs health information? Managers at all levels of an organization have a stake in using information as the basis for taking action. This allows them to lead and manage effectively at any level. In fact, managers provide the foundation of the M&E system.

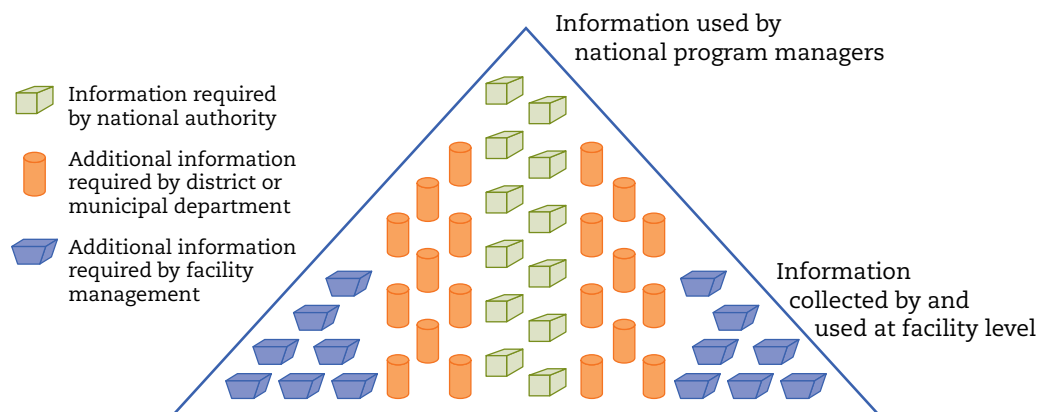
The trouble is that the M&E function is not always integrated into the organization. In many cases, organizations—and sometimes donors—operate as if M&E were the sole responsibility of the M&E staff. Without an adequate communication and feedback process, the information and knowledge could remain in the hands of the M&E staff. As a consequence, results (both good and bad) are not always fed back to the people who need them, and the information is not used for management decisions.

Too often, for example, an evaluation is conducted and information is produced to meet the needs of a donor or a government agency, rather than to improve an organization's services. One way to be sure that evaluation results are used is for managers at all levels of an organization, from the health center to the Ministry of Health, to own the M&E processes and results.

**Information needs at different levels.** Not all information is needed at all levels at all times. Managers, donors, and the central government may need different information at different times to meet their reporting requirements and make decisions. For example, managers of donor-funded projects typically work on a quarterly or biannual reporting cycle and the donor on an annual reporting cycle, while the Ministry of Health may require three to five years' worth of data to demonstrate impact and report it to politicians and the media.

Information needs in a health system can be viewed as a hierarchy. [Figure 3](#) shows that decreasing amounts of information are needed as you move up the levels of an organization. There is a core set of information that managers at all levels need, but only the smallest subset of that information is needed at the national level. At the district and facility levels, managers need disaggregated information on an ongoing basis because this is where actions are taken in response to operational data (e.g., stock-outs and dropouts).

FIGURE 3. Hierarchy of Information Needs



Source: Recreated with permission from [“Health Information System Reform in South Africa: Developing an Essential Data Set,”](#) by Vincent Shaw, 2005..

Monitoring operational indicators is less important at the national level. Rather, national-level decision-makers need indicators that measure the impact of health programs and services on health status over a longer term. Therefore, an HIS should be designed to serve all its clients by providing reliable information in the short, intermediate, and long terms.

At the facility level, for example, managers would collect and use information on the monthly distribution of contraceptives, stock-outs, and dropouts. At the district or provincial level, or at the headquarters of a large NGO, the most useful information would be annual contraceptive prevalence rates, while for the Ministry of Health it might be maternal morbidity and mortality rates at intervals of three to five years.

For further discussion of the hierarchy of information needs, please see an [article on the WHO website](#).

**Principles for improving information management.** Chapter 1 of this handbook points out that no management system can be strengthened if people are left out of the process. Strengthening an HIS is no different. It requires working with the people involved: the owners of the system who record, transfer, analyze, communicate, and use data and information to manage services.

**How should we work with people in the HIS?** [Box 1](#) presents guiding principles for designing an effective HIS or improving information management. The purpose is to improve the availability and reliability of information so it can be more effectively used in managing health organizations and services. These principles emphasize the need to fully involve all HIS staff and managers and service providers who will be using the information.



### BOX 1. Guiding Principles for Improving Information Management

**Understand health service functions and responsibilities.** Because an HIS is linked to the health management cycle, a prerequisite for improving an HIS is a clear understanding of the functions and responsibilities of each health service, program, level of operations, and sector (public, private, community, CSO, NGO) involved in delivering health services.

**Focus on improving health and health services.** Any change to health recording and reporting should be made for the purpose of improving the performance of health services. It is important to seek ways to meet information needs at higher levels of the health system without asking managers and providers to record and report data not used at the service delivery level.

**Strengthen existing systems.** Although it may be tempting to completely redesign systems and integrate parallel, program-specific reporting systems, the time, money, disruption, and other costs of doing so often outweigh the potential benefits. Few efforts to develop fully integrated HISs have proven successful. A better alternative is to set standards for data formats and coding that facilitate the exchange of data between separate systems.

**Ensure national ownership.** All activities to develop or improve an information system should be carried out by in-country working groups, managed by national staff. It is essential to involve not only information systems staff but also the managers and service providers who are the primary users of the information. If an external consultant is necessary, this person should assume a facilitating role that allows local personnel to develop their own system. Through active participation, they will understand and own the methods and instruments in the system and, in the process, become better able to maintain it.

**Build the skills of health personnel.** These skills include the recording, reporting, transmission, processing, presentation, analysis and interpretation of data, and the use of data for decision-making. How to use and maintain computer systems can also be taught. The recommended approach for building these skills is “learning by doing” through:

- in-service workshops in which health service staff and data managers work together to solve real problems using real data;
- involving national personnel in planning and implementing studies and designing system changes;
- clarifying roles and responsibilities through consensus building.

**Use technology appropriately.** You can use computers for database maintenance, report generation, data analysis, and communications if your computer systems and software can be maintained locally with existing staff. But make sure that computerization does not slow the flow and access to data, add an excessive burden to workloads, or encourage falsification, thereby reducing data reliability.

Go to MSH's [Electronic Resource Center](#) for links to additional guidance on managing information.

## Monitoring as a path to action

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### THE IMPORTANCE OF ROUTINE MONITORING

Why is evaluation not sufficient on its own? In the development community, some organizations tend to rely more on evaluation studies than on solid program monitoring. Many intend to carry out both monitoring and evaluation but, in practice, they commonly focus more time and resources on evaluation.

Donors, governments, and organizations might favor evaluations because they give hard evidence of progress, such as contraceptive prevalence (a typical outcome measure for family planning/reproductive health) measured through an annual household survey.

Monitoring cannot produce the result or outcome indicator—the hard evidence that these contraceptives are actually being used. It can only provide a progress indicator or benchmark, such as the monthly distribution of contraceptives, that enable you to track progress toward operational goals. You can monitor the distribution of products but cannot conclude that the products were actually used.

But for you, the manager, distribution data represent exactly the type of information you need to show progress toward your goal and to do your job effectively.

Take, for example, a behavioral change intervention in Peru described and analyzed in the [following box](#).

In the context of government health services, district and facility managers need to monitor both output and coverage indicators. Indicators of coverage tell the health manager whether essential services are being provided for specific target groups so that rapid action can be taken to address gaps in services for underserved communities or subgroups.

A good monitoring system gives you the critical information to manage the intervention and take prompt corrective action. An evaluation cannot give you this type of information. When you see a good monitoring system, therefore, a manager is usually driving it because he or she needs actionable monitoring information from the M&E system.

### PRODUCING ACTIONABLE INFORMATION

Actionable information is data you can use to make a decision and take action. It helps you identify gaps in performance and find ways to fill these gaps. To be actionable, information gained from monitoring must be based on *useful indicators* produced in a *simple format* that is *on time* for the planning or reporting cycle.

“Actionable” means different things to different clients. The information the manager needs is not the same type of information the executive director of an organization or the minister of health would use for reporting to donors, politicians, or the media.

How can actionable information be produced for the manager?

### Monitoring for Better Program Management in Action— An Example from Peru

A local family planning organization in Peru carried out a communication campaign to increase contraceptive prevalence in the organization's catchment area. They developed the materials and trained community health workers to educate the women in their villages. The organization planned to conduct only a baseline survey and follow up with knowledge, attitudes, and practices (KAP) surveys. These were necessary first steps and good methods to evaluate the effectiveness of the campaign, but would they provide actionable and sufficient data to meet the manager's needs? No, because the results would come in *after* the campaign was completed. The manager needed information to take corrective measures *while* the communication campaign was in progress.

Put yourself in the place of the manager in this scenario. What do you need to monitor? You could start with monthly contraceptive distribution during the communication campaign, using data that are easy to obtain from the commodity warehouse. Stock movements of contraceptive products in the supply chain would indicate that the campaign was creating demand, while no movement could indicate that the campaign or the supply system is not working properly. Are you seeing spikes in distribution during the campaign? Is there greater movement of contraceptives during the campaign than there was before it?

If you see no change after two to three months, you know that something needs to be fixed with the communication campaign or the supply chain, or both. You will need to make site visits to pinpoint the reasons. Are stock-outs the problem? Is there no change in distribution because there are no products? Or is there no change because the radio station did not air the communication spot? Or perhaps the community-based distribution (CBD) agents never received the flip charts and models they needed to educate women in their communities?

First, the indicators must be useful to the manager. They must be directly related to the organization's operational plan (or the intervention plan) and the expected results. Some organizations have a tendency to focus on **process monitoring** between KAP surveys. This means they monitor processes such as training: who was trained, on what topics, and when. This is important, but it is not enough. Process monitoring does not monitor progress toward results. It simply tracks the completion of activities.

In addition to process monitoring, managers also need to monitor **proxy indicators**, which are as close as you can get to the actual results during the implementation of a set of activities when results are not yet easily measurable. Proxy indicators are indirect measures that approximate or represent a target or result when direct information is not available.

In the case of delivery of family planning services, for example, because certain contraceptives are distributed through the health center, monitoring data should come from the health center. While you cannot conclude that the target result has been achieved—that the products are actually being used by the beneficiary population—the distribution information gives you clues about the potential success of the activities. Most of the data for monitoring proxy indicators can be obtained from the HIS.

Next, actionable information should be provided in a **usable format**. Often managers are given too much information in a format that is too complicated. You need a simple tool

that feeds back only the essential information. You can learn more about such tools in the section of this chapter entitled [“Features of a Good Monitoring Tool.”](#)

Finally, managers need to receive the information on time so they can act on it. Projects implemented by organizations and funded by the government or a donor often run on two time frames.

For example, you may be managing a project that runs for five years, broken down into annual reporting cycles based on annual operational plans. To monitor the annual plan and file your required reports, however, you need information quarterly. If your health centers submit their data after the designated deadline, the information will come in too late for your reports.

#### Information in Action to Improve Services— Experiences from Bolivia and South Africa

**Using Information to mobilize the supply chain.** The iron folate supplementation program in Bolivia was a community mobilization activity implemented by several NGOs in rural areas of the country.

A problem showed up only after three months of implementation. If the manager had relied solely on process monitoring, she would have seen that all activities had been carried out on time and as planned. However, monthly data from the health centers in the catchment areas served by the program showed that in many communities, distribution of iron folate to pregnant women had remained at zero since the first month of program implementation.

The manager immediately investigated and found out there were stock-outs in 16 health centers. Even though there was a written protocol for the distribution of iron folate, and all health centers were supposed to stock it among their supplies, historically there had been no demand for this product. The health centers had long ago decided to stop carrying it.

The manager brought the problem to the attention of the vice minister of health, and within days the Ministry of Health mobilized its entire supply chain to ensure sufficient inventory throughout the chain. By the end of the year, iron folate supplementation had dramatically improved across the country. All this happened thanks to a simple monthly monitoring tool that allowed the manager to take corrective actions early during implementation.

**Simplifying data collection and encouraging use of the data.** It is generally acknowledged that if data collection and processing are too cumbersome, data quality and use will tend to decline. In South Africa, nurses in health centers are often required to carry out two functions: (1) to provide care to their clients and (2) to collect and use data. The problem is that the nurses are primarily dedicated to caregiving and view data collection as an unnecessary burden on top of their other daily responsibilities.

A group of South African nurses who recognized the importance of information in the provision of services wanted to make the collection and use of routine data part of their daily work. They realized that it was necessary to both reduce the amount of data needed and simplify the collection process.

As a result, they created a simple “tick register”—a checklist—that allowed them to see, at the end of each day, a snapshot of the care they had provided. At the end of the month, they could quickly tabulate and analyze the data on their services. This type of daily and monthly summary of their activities was immensely satisfying. It motivated their ongoing use of the register to track, analyze, and improve services.

## Practical M&E tools and approaches

### FRAMEWORKS FOR THE DESIGN AND M&E OF HEALTH SERVICES

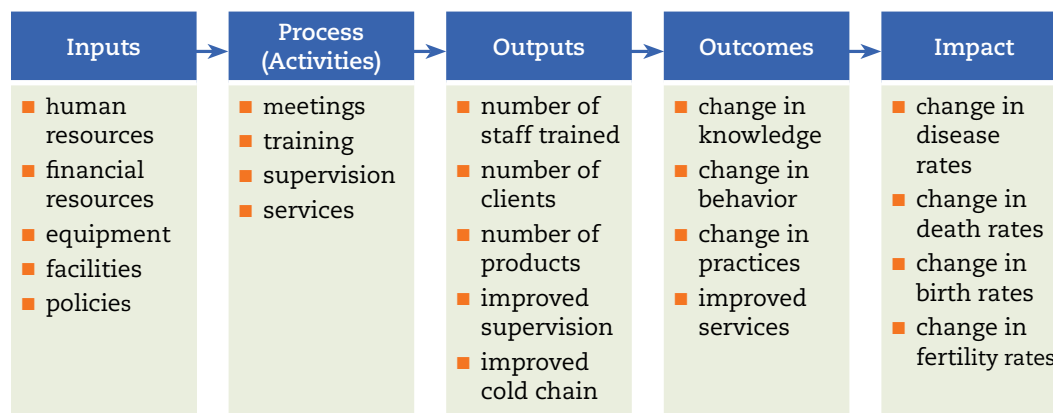
The results of health services and programmatic interventions can be measured at different levels. Many M&E guidelines are based on a chain of five levels of results: inputs, activities, outputs, outcomes, and impact. Figure 4 summarizes the results levels that can be monitored and evaluated.

To better understand the results chain, consider the following definitions:

- **Input:** The materials and resources needed to carry out your team or unit's implementation plan and achieve the desired result. Examples include financial, technical, human, supply, and commodity resources.
- **Process:** The activities carried out through your implementation plan. Examples include training service providers, improving the supply management system, and distributing family planning methods.
- **Output:** The immediate product of an activity. Examples include the number of people trained, number of new users of contraceptives, and the quantity of products distributed.
- **Outcome:** A short-term change in a population group as a result of a set of activities. Examples include changes in coverage of prenatal care, proportion of safe deliveries, knowledge and attitudes of FP/RH methods, unmet need for family planning, and contraceptive prevalence rates.
- **Impact:** Long-term changes within a beneficiary of population group. Examples include changes in the total fertility rate and maternal morbidity and mortality rates.

Two types of frameworks are commonly used to plan and organize the design of an intervention or service and its M&E plan: logical frameworks and conceptual frameworks.

FIGURE 4. Levels in the Results Chain



## LOGICAL FRAMEWORKS

Since the development of the logical framework approach for the US Agency for International Development (USAID) in 1969, Logical frameworks (also called LogFrames or Logic Models) have been adopted with various adaptations by numerous bilateral and international development organizations.


Figure 5 shows the elements of a LogFrame.

The LogFrame helps managers and teams answer the four key questions:

1. What are we trying to accomplish and why?
2. How will we measure success?
3. What conditions must exist at each stage of our intervention?
4. What resources and processes will we need to get there?

LogFrames help identify the causal links in the results chain: inputs → processes (activities) → outputs → outcomes → impact. These causal links shape the logic of the intervention and guide the selection of indicators for each stage in the results chain.

FIGURE 5. Typical Elements of a Logical Framework



Objectives	Indicators	Means of Verification	Assumptions
<b>Goal</b> The ultimate aim or intended impact of the intervention	Measures used to assess the degree to which the goal has been achieved	Methods and sources of information for measuring or assessing goal indicators	Factors or conditions necessary for long-term sustainability
<b>Purpose/Outcome</b> The expected benefits or changes to be achieved among clients, communities, organizations, or systems	Measures used to assess the degree to which the purpose/outcome has been achieved	Methods and sources of information for measuring or assessing purpose/outcome indicators	Factors or conditions necessary for program success at this level and progression to the next
<b>Outputs</b> The tangible, direct results of program activities expected to attain the purpose	Measures used to assess the degree to which the outputs have been produced	Methods and sources of information for measuring or assessing output indicators	Factors or conditions necessary for program success at this level and progression to the next
<b>Processes/Activities</b> The actions a program takes to achieve the stated objectives	<b>Inputs/Resources</b> People, time, materials, funds needed to carry out activities	Methods and sources of information used to show that activities have been completed	Factors or conditions necessary for program success at this level and progression to the next

TABLE 1. Overview of the Logical Framework

Advantages	Disadvantages
<ul style="list-style-type: none"> <li>■ Improves the quality of intervention plans by requiring the definition of clear objectives and indicators and the analysis of assumptions and risks.</li> <li>■ When used regularly during an intervention, an effective management tool to guide implementation and M&amp;E.</li> <li>■ Summarizes the design of complex plans.</li> <li>■ Supports the preparation of detailed implementation plans.</li> </ul>	<ul style="list-style-type: none"> <li>■ Assumes a linear relationship between inputs-outputs-outcomes that does not take into account other influencing factors.</li> <li>■ If used rigidly during the design process, may stifle creativity and innovation.</li> <li>■ If not updated during implementation, can be a static tool that does not reflect changing conditions.</li> <li>■ Training and follow-up often necessary to use this approach correctly.</li> </ul>

To understand how a LogFrame makes explicit the logic of an intervention, take another look at [Figure 5](#). A series of “if-then” relationships connects each component of the LogFrame.

1. *If* the necessary resources are available, and assuming that specific favorable conditions exist, *then* program activities can be implemented, and...
2. ...*if* program activities are implemented successfully, and assuming that specific favorable conditions exist, *then* the desired outputs and outcomes can be attained, and...
3. ...*if* the desired outputs and outcomes are attained, and assuming that specific favorable conditions exist, *then* the strategic goal can be met.

The LogFrame can be useful in conceptualizing a project during the planning period and in reviewing progress and taking corrective action during implementation. Like any framework, it has advantages and disadvantages, as seen in Table 1.

[Appendix A](#) in this chapter provides an illustrative LogFrame for a home visiting program developed by the Inter-American Development Bank.

## CONCEPTUAL FRAMEWORKS

These frameworks are similar to LogFrames in that they describe a chain of results, but they take into account the underlying reasons *why* changes occur along the results chain. Where LogFrames merely state that activities will lead to ever-larger results, conceptual frameworks allow you to map out the factors you believe to be critical and to explain why these factors are important to success.

This type of mapping helps you decide which factors should be monitored during the implementation of activities. When the data show that these critical elements have or have not been achieved, you can better understand why an intervention was or was not successful and what could be changed in the future.

You can see the advantages and disadvantages of conceptual frameworks in [Table 2](#).



TABLE 2. Overview of the Conceptual Framework

Advantages	Disadvantages
<ul style="list-style-type: none"> <li>■ Provides a flexible, visual mapping of complex intervention plans</li> <li>■ When used regularly during implementation, allows early feedback about what is or is not working and why</li> <li>■ Assists in the identification of unintended side effects</li> <li>■ Helps in prioritizing which issues to investigate in greater depth, perhaps using more focused data collection methods or more sophisticated M&amp;E techniques</li> </ul>	<ul style="list-style-type: none"> <li>■ Can become overly complex if the scale of activities is large or if an exhaustive list of factors and assumptions is assembled</li> <li>■ Stakeholders might disagree about which determining factors they feel are the most important</li> </ul>

The Pathway to Change is a particularly useful example of a conceptual framework. This model uses an “if-then” format to show, step-by-step, how the outcomes were conceptualized and will be achieved. [Figure 6](#) is an example of a Pathway to Change for a six-month municipal health project in Nicaragua.

**The Pathway to Change.** The Pathway to Change is featured in this chapter because of its usefulness to managers and its benefits as a team-building activity. Developing a Pathway to Change is usually a participatory process that allows your team or unit and other stakeholders to design an intervention and determine how it will work. The final product is a map that shows how one action relates to another and another and how they all add up to the desired result. Constructing a pathway often exposes the underlying beliefs that people in an organization hold about how their actions achieve change.

Creating a Pathway to Change has several benefits. First, it requires your team to examine each proposed action and answer these questions:

- Does every activity lead to our desired result? If not, should some activities be changed, added, or eliminated?
- Are the activities sequential? Are they connected in a logical way? Do they build upon one another as a rational and coherent set of actions?
- Have we thought of all the outputs and outcomes needed to reach our desired result?
- Do we have the resources we need to implement our proposed activities?
- How long will it take to reach our desired result?
- What other factors might enhance or impede each of the activities in the pathway?

Second, your team must make explicit, and agree on, the underlying logic of an intervention plan. That is, they must show, on paper, how each action will lead to the desired change at each level of the map. Finally, the pathway outlines what outputs and outcomes the team should monitor and which indicators you should use.



```

graph BT
    subgraph Activities
        A1[Activity 1: Conduct patient flow survey and carry out recommendations]
        A2[Activity 2: Convert corner of health center for patient counseling]
        A3[Activity 3: Mobilize NGO partners to print IEC pamphlets]
        A4[Activity 4: Mobilize NGO partners to train/equip female volunteers]
        A5[Activity 5: Recruit community leaders to support weekly RH talks]
        A6[Activity 6: Develop recording and ordering system for contraceptive supplies]
    end

    subgraph Outputs
        O1{{Output 1: Waiting times at the health center are reduced from 40 to 20 minutes}}
        O2{{Output 2: All patients are offered counseling in a private space at the health center}}
        O3{{Output 3: Female volunteers conduct weekly talks on RH topics in the community}}
        O4{{Output 4: All contraceptive stocks are monitored weekly}}
    end

    subgraph Outcomes
        O1_1{{Outcome 1: 80% of patients are satisfied with services provided at the health center}}
        O1_2{{Outcome 2: 60% of women 15-49 years in the health center catchment area understand the importance of FP for birth spacing}}
        O1_3{{Outcome 3: All modern contraceptive methods are available at the health center}}
    end

    subgraph Result
        R[Desired Result: Increase in the percent of family planning users from 50% to 52% during the period June 2006 to December 2006]
    end

    A1 --> O1
    A2 --> O1
    A2 --> O2
    A3 --> O2
    A4 --> O2
    A4 --> O3
    A5 --> O3
    A6 --> O4
    O1 --> O1_1
    O2 --> O1_1
    O2 --> O1_2
    O3 --> O1_2
    O4 --> O1_3
    O1_1 --> R
    O1_2 --> R
    O1_3 --> R
  
```

**Desired Result:**  
Increase in the percent of family planning users from 50% to 52% during the period June 2006 to December 2006

**Outcome 1:** 80% of patients are satisfied with services provided at the health center

**Outcome 2:** 60% of women 15-49 years in the health center catchment area understand the importance of FP for birth spacing

**Outcome 3:** All modern contraceptive methods are available at the health center

**Output 1:** Waiting times at the health center are reduced from 40 to 20 minutes

**Output 2:** All patients are offered counseling in a private space at the health center

**Output 3:** Female volunteers conduct weekly talks on RH topics in the community

**Output 4:** All contraceptive stocks are monitored weekly

**Activity 1:** Conduct patient flow survey and carry out recommendations

**Activity 2:** Convert corner of health center for patient counseling

**Activity 3:** Mobilize NGO partners to print IEC pamphlets

**Activity 4:** Mobilize NGO partners to train/equip female volunteers

**Activity 5:** Recruit community leaders to support weekly RH talks

**Activity 6:** Develop recording and ordering system for contraceptive supplies

When read from bottom to top, the map shows which activities are needed to get to the outputs, and which outcomes are needed to reach the top. You must always be able to trace a pathway from the beginning of your actions to the expected result.

HEALTH SYSTEMS IN ACTION

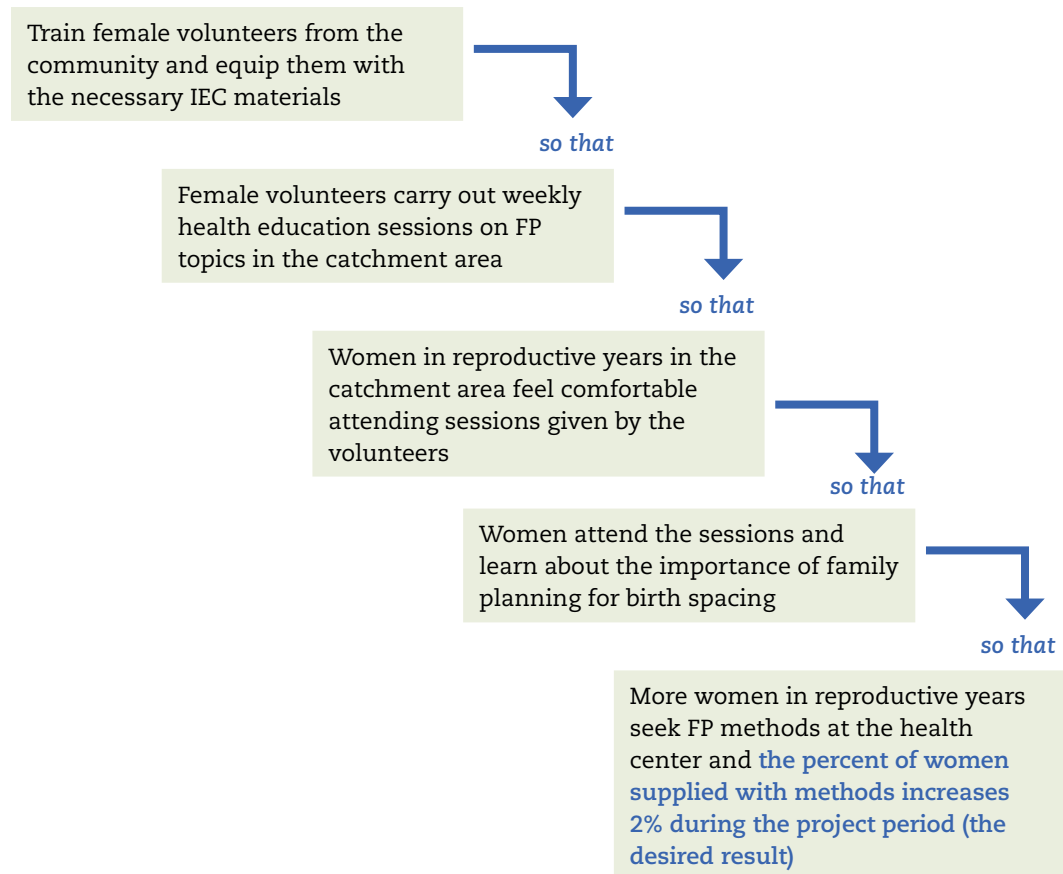
**Creating a Pathway to Change.** To develop a Pathway to Change, your team maps the change backwards. You start at the end of the pathway (the top of the chain) and define the long-term goal of the organization or the desired result of an intervention. Then you fill in the map by working from top to bottom, where you finally identify the main activities: the first elements in your implementation plan.

As you move down the pathway, ask three questions: What outcomes need to happen to contribute to the long-term goal? What outputs need to happen before that to achieve the outcomes? and What activities need to happen before that to produce the outputs?

Designing an intervention in this way can help reveal the necessary conditions for reaching the outcomes and long-term goal. It may take several tries to develop a Pathway to Change that everyone can agree on. Outcomes, outputs, and actions may be added, changed, and removed until eventually a map emerges that tells a story your team can agree on. The debate is often the most valuable part of the experience, because the team jointly defines the expectations, assumptions, and features of the change process.

**Using a “so that” chain to check the pathways in a Pathway to Change.** A good way to check the logic of your pathway map is to reverse the process and create a “so that” chain for each activity. The example in Figure 7 shows how to do this for Activity 5 in [Figure 6](#).

FIGURE 7. “So That” Chain for One Activity in a Pathway to Change



The movement in the “so that” chain is the exact opposite of the Pathway to Change. You place each activity at the top of its own chain and move *down* through the chain to the goal or desired result. This sequence helps to confirm that each individual pathway in the larger Pathway to Change makes logical sense.

To use this technique, you need to create a separate “so that” chain for each activity in your Pathway to Change. You begin by describing each activity and adding the phrase “so that,” followed by a description of what will happen next if that activity is completed. Continue doing this until you reach your long-term goal or desired result.

## Steps in developing an M&E plan

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One of your essential M&E tasks as a manager who leads is to develop a plan that will help you and your team determine whether you have achieved your desired results and to track progress toward those results during implementation. This requires you to not only choose reliable indicators but also to measure these indicators in an organized way. Your M&E plan should specify which indicators you will measure, how they will be measured, when, and by whom.

A well-designed M&E plan answers five questions:

1. Is your expected result measurable?
2. What indicators will you use to monitor your outputs and evaluate your outcomes?
3. What are your data sources and how will you gather data from these sources?
4. What are the time frames for each indicator?
5. Who will collect the data?

These questions are important because, without a valid M&E plan, you may misinterpret the effects of your intervention. You may decide that it has had no effect when it actually has produced some positive results, or you may conclude that it had a positive effect when in fact it achieved no results at all—a more common and destructive error.

Developing and using an M&E plan ensures that comparable data will be collected on a regular and timely basis, even when staff changes over time. [Table 3](#) summarizes the steps in developing and implementing an M&E plan. The rest of this section describe each step in detail.

### STEP 1: DEFINE THE EXPECTED RESULTS

The first step in developing the M&E plan is to determine an appropriate level for results. Together, the type and scope of the intervention, available resources, and time frame for implementation determine a feasible result.

As you saw earlier in this chapter, interventions led by donor-funded organizations and government services typically lead to outputs or outcomes. Although impact takes a long time to achieve and is usually not within the scope of a single set of activities, it is important to include it in your M&E plan so it is clear what your intervention will contribute to in the long term.

TABLE 3. Steps for Developing and Using an M&amp;E Plan

Steps	Pointers
1. Define expected results	<ul style="list-style-type: none"> <li>Results should be identified according to the scope and time frame of your intervention.</li> <li>Results should meet the SMART criteria (Specific, Measurable, Appropriate, Realistic, Time bound).</li> </ul>
2. Select indicators	<ul style="list-style-type: none"> <li>Indicators should conform to the qualities of a good indicator.</li> <li>Indicators should be affordable, easy to collect, and comparable over time and in different locations.</li> <li>For priority health problems and essential services, use standard or national core indicators.</li> <li>Select a minimum number of key indicators, making sure that selected indicators are really necessary to measure your desired results.</li> </ul>
3. Identify data sources	<ul style="list-style-type: none"> <li>Identify where the data for each indicator will come from. Common data sources include service statistics, organizational records, clients, or the community.</li> </ul>
4. Determine data collection methods	<ul style="list-style-type: none"> <li>Select the most appropriate and reliable data collection method for each indicator. These could include a review of logbooks or registers for service statistics, the use of observation checklists, client exit interviews, or a sample survey for community-based data.</li> <li>Decide on the frequency of data collection. You could collect only baseline and post-intervention data or you may need to collect daily, monthly, or quarterly data, depending on the type of indicator.</li> <li>For each indicator, assign responsibility for data collection to a particular office, team, or individual.</li> </ul>
5. Collect baseline and post-intervention data	<ul style="list-style-type: none"> <li>Recognize that baseline results will be used to determine your targets.</li> <li>Clearly define the duration covered by the baseline, since you need a similar time period for comparison at the end of the implementation period.</li> <li>Use the same methodology and tools for data collection as for the baseline and post-intervention measures.</li> </ul>
6. Share and use your results	<ul style="list-style-type: none"> <li>Schedule meetings, workshops, and reports to present results to project staff, management, and other key stakeholders.</li> <li>Present options for learning and action based on M&amp;E results.</li> </ul>

To determine at which level you should monitor and evaluate your results, it is useful to revisit and expand on the results chain, beginning on the right with the ultimate result (impact) and moving back to the necessary materials and resources (inputs).

Inputs → Processes → Outputs → Outcomes → Impact

- **Impact:** These results are measured at the population level, take a relatively long time to achieve (usually three to five years), and require the combined effort of several interventions and even several organizations. As a manager, you may not be responsible for measuring impact, but you will want to include it in the logic of your M&E plan so you know what your organization and its partners aim to achieve in the long run.

- **Outcome:** In most cases, managers are responsible for measuring results at the output and/or outcome levels. Outcomes are a result of activities designed to produce a behavioral change in providers or clients. Outcomes are often measured in terms of changes in service coverage and changes in the knowledge, attitudes, and practices of a beneficiary population.

An outcome could be the initiation of a proven practice for service delivery, the adoption of new management approaches, or the successful advocacy for health policy design. It could also be an increase in women delivering at a health facility or children fully immunized. In most cases, a clear relationship between outputs and outcomes can be established.

- **Outputs:** Outputs are the direct products of activities. They should be monitored throughout implementation as an essential element of good management. M&E plans should define the expected output of each activity as a product. For service delivery units, this usually means service outputs (for example, number of clients served or length of client waiting times).

For organizations that do not provide direct health services, this might mean the distribution of health products or the provision of training (for example, number of family planning commodities distributed or number of participants trained).

- **Processes:** Monitoring of processes or activities is largely an accountability measure, ensuring that activities are conducted on time and with sufficient resources. Monitoring at this level plots progress in implementation against proposed time frames and the use of resources against budgets. It is usually carried out through traditional quarterly, semiannual, and annual reporting.
- **Inputs:** When developing an intervention, you must identify the number and types of resources needed to implement the activities. Performance can be monitored in terms of the quantity and types of inputs provided and the number and timing of activities carried out.

The next step in defining the expected results is to make sure that they meet the SMART criteria (see [Table 4](#)). You can monitor and evaluate progress toward a result only if that result has been defined in measurable terms.

Here is an example of a measurable result for an intervention whose purpose is to promote immunization coverage in children between the ages of 12 and 24 months: *The proportion of fully vaccinated children aged 12–24 months in the catchment area will increase to 70 percent within the next year.*

TABLE 4. Criteria of a SMART Result

Criterion	Description
<b>Specific (S)</b>	Clearly written and understood. The desired result is specific enough to be measured by a frequency, percentage, or number.
<b>Measurable (M)</b>	It is possible to monitor progress and evaluate results. The desired result is framed in terms that are measurable.
<b>Appropriate (A)</b>	The desired result is appropriate to the scope of your work and the mission of your organization.
<b>Realistic (R)</b>	The desired result is achievable and within the control of your organization. It can be realistically achieved using the resources available and within the time frame of your implementation plan.
<b>Time bound (T)</b>	There is a specific time period for achieving the desired result.

## STEP 2: IDENTIFY THE INDICATORS AND THEIR DEFINITIONS

Indicators are normally percentages or proportions representing the extent of a specific condition in the population of interest. They also can be an absolute value, such as the number of occurrences of a health event (e.g., a maternal death or a case of malaria).

Every indicator needs a detailed definition. Is it a qualitative or quantitative indicator? If it is a percentage, what are the numerator and denominator? The definition should be detailed enough to ensure that different people at different times can collect identical types of data for the indicator.

You will see what characterizes a good indicator in [Box 2](#).

Indicators can be classified as indicators of health status or of the performance of services.

Indicators of health status might include the:

- number of cases and deaths due to specific diseases in a given time period;
- proportion of the population that has a disease or condition at a particular point in time or over a period of time;
- proportion of the population with a factor or condition that puts them at risk of disease such as low knowledge or unsafe behavior.

Indicators of performance might include the:

- proportion of a beneficiary population having received a specific service;
- proportion of a beneficiary population demonstrating specific health knowledge and behaviors;
- proportion of facilities and staff demonstrating adherence to particular service standards or achieving stated objectives;
- proportion of facilities adhering to defined standards of functional management (e.g., staffing, availability of medicines, recording, and reporting).

## BOX 2. Qualities of a Good Indicator

**Valid:** The indicator measures what it is intended to measure.

**Reliable:** Measurement of the indicator would be the same no matter how many times measurement is carried out.

**Precise:** The indicator is defined in clear, specific terms so that it can be measured. The indicator may be qualitative (descriptive), discrete (Yes/No), or based on quantitative levels or proportions, as long as it is clearly measurable.

**Easily understood:** Both experts and nonexperts can grasp the meaning of the indicator.

**Discrete:** The indicator captures a single component or aspect of a more complex result. It measures only one thing, not a set of things.

**Timely:** The indicator can be measured at appropriate time intervals according to the availability of data.

**Comparable:** When possible, the indicator avoids narrow or unique definitions whose values would be difficult to compare with other results.

**Feasible to use:** Data for the indicator are easy to obtain from a credible source and relatively inexpensive—affordable within your organization's resources. If such data are not available, methods exist for obtaining them in the future.

Additional guidance on indicators can be found in: [“Compendium of Indicators for Evaluating Reproductive Health Programs”](#) and [“Menu of Indicators on Management and Leadership Capacity Development”](#)

## STEP 3: IDENTIFY THE DATA SOURCES

You now need to identify a data source for each indicator in the M&E plan, selecting data that are readily available from a credible source and that your organization can afford. Ideally you would choose data that are already available through the organization rather than launch a new data collection strategy, which could be costly and time-consuming.

A good way to start is by asking: What data do we already collect routinely and systematically? You should always consider the advantages and disadvantages of each data source. Please refer to the section [“Selecting Your Data Sources”](#) for more information on the pros and cons of some common data sources.

You should be as specific as possible about the data source, so the same source can be used consistently throughout your intervention. Changing data sources for the same indicator can lead to inconsistencies and misinterpretations. For example, if you are measuring infant mortality rates, switching from estimates based on a large-scale survey to estimates based on hospital statistics can lead to a false impression of change.

## STEP 4: DETERMINE DATA COLLECTION METHODS

The next step is to define the methods or tools that you will use to collect data for each indicator. For indicators based on **primary data** (data that you collect yourself), you should describe the type of instrument needed to gather the data. Examples might be structured questionnaires, direct observation checklists, or scales to weigh infants.

For **secondary data** (data collected by others that is available for your use), you should explain the method of calculating the indicator and the source of data, providing enough detail on the calculation method so that others can replicate it. Remember, while it is easier and less expensive to use secondary data, its quality is often less reliable than that of primary data.

It is also important to note the frequency of data collection for each indicator. Depending on the type of indicator, you may need to collect data monthly, quarterly, annually, or even less frequently. When developing the data collection schedule for each indicator, consider the need to provide timely information to decision-makers in your organization. Assigning responsibility for data collection to individuals or groups in your staff will help ensure that the data are collected on time.

The information from Steps 1–4 will provide the content of your monitoring and evaluation plan. [Table 5](#) shows the elements of an M&E plan for a clinical mentoring program for voluntary counseling and testing (VCT) facilities.

## STEP 5: COLLECT BASELINE AND FOLLOW-UP DATA

Collecting accurate baseline data is one of your most important M&E tasks. Baseline data provides the starting point for setting the goals that you and your team hope to reach and for tracking changes in indicators over the life of your intervention. In this way, baseline data help fine-tune an expected end result.

You will need to collect baseline data on each indicator *before* your activities begin. These data identify the starting point from which you can assess progress. Then, at different points during implementation, you will collect follow-up data on each indicator for comparison with baseline levels and anticipated results. This allows you and other decision-makers in your organization to assess the progress of each intervention or service and make needed changes along the way.

Consider the example in [Box 3](#).

Why track changes in indicators during implementation? The indicators in an M&E plan are linked to the immediate (output) and long-term results (outcomes) that managers need to monitor. Changes in indicator values over time show whether these results are moving up or down, or staying the same. This tells the manager whether the interventions and strategies are working as planned to reach the desired results.

At the end of the implementation period, you will need to collect data on your indicators in order to compare final levels to your baseline and to your anticipated results. Depending



TABLE 5. Example of a Monitoring and Evaluation Plan

**Objective:** Health care workers (HCWs) who have received classroom training improve their ability to provide antiretroviral therapy (ART) according to national guidelines

Activity/ Output	Indicator	Data Source	Frequency of Data Collection	Responsible Person	Timeline/ Deadline
Experienced HIV clinicians recruited to serve as clinical mentors at five regional hospitals	Number of mentors recruited and placed at regional hospitals	Employment records	As completed	Deputy director for clinical programs	September 2008
Physicians at five regional hospitals receive one-on-one mentoring in ART	Number of sites receiving clinical mentoring Number of physicians receiving one-on-one mentoring Number of days of clinical mentoring provided	Mentor monthly reports	Monthly	Mentors	March 2009
Outcome	Indicator	Data Source	Frequency of Data Collection	Responsible Person	
HCWs increase knowledge of ART	80% of participants achieve score 85% or more correct on posttest				
HCWs improve skills in delivering ART	Percent of skills demonstrated on competency checklist	Special study	Dates TBD	Deputy director for clinical programs	

Source: [International Training and Education Center on HIV, p. 2.](#)

**BOX 3. Using Baseline Data to Adjust Results**

A child survival team is proposing an intervention with a specific and measurable result, as follows: In the next 12 months, 40 percent of children aged 12–24 months in the catchment area will be fully immunized.

To determine whether their program can actually achieve this result, staff need to measure current vaccination levels. Their review of the data shows that only 10 percent of children in the catchment area are fully immunized by the age of 24 months. That is their baseline.

The manager realizes it will not be possible to reach the target level of 40 percent immunization coverage in just 12 months. So the manager and her team revise their expected result to something that is more realistic reasonable but still significant: In the next 12 months, 20 percent of children aged 12–24 months in the catchment area will be fully immunized.

on your indicators, you may also need to collect follow-up data at an agreed-on time to determine whether the changes are maintained after the completion of your intervention.

**A note on using indicators for an evaluation.** Most M&E efforts emphasize the selection of well-defined indicators to set goals and measure changes in health conditions or services.

But it is important to remember that indicators simply serve as markers. Indicator data provide clues as to *whether* an intervention or set of activities is on schedule and expected results are being achieved. They do not answer questions about *why* results are—or are not—achieved. They do not explain unintended results, linkages between interventions and results, or causes of perceived results that arise outside the intervention. Thus, they cannot prescribe actions that should be taken to improve results.

Indicator data must, therefore, be interpreted carefully. They simply point to results that need further exploration, rather than providing a definitive assessment of success or failure. An evaluation study is normally carried out to determine whether an intervention can be considered a success and why.

In general, as you move up the hierarchy from activities to long-term outcomes, M&E becomes more complicated. At the process and output levels, you can easily track which activities have been completed and their immediate results. This is operational information—information you can use for day-to-day management decisions. However, to identify and measure the outcomes that result from the synergy of outputs, you will probably need to integrate qualitative and quantitative information and rely less on single quantitative indicators.

Remember that when a desired improvement—in service performance, providers’ or beneficiaries’ knowledge and behavior, or the trend of a health problem—is confirmed through M&E, it does not prove that the intervention itself brought about that change. Other things may have been going on within the service or in the larger environment that caused the change. Of course the same is true for negative results or results indicating no change in outcomes.

### Using Results to Improve Routine Data in Action— An Example from Pakistan

In Pakistan, through the support of the PRIDE Project, 10 subdistrict teams applied the Performance Assessment and Improvement Process—Public Health (PIP-PH) set of procedures and formats to address health problems that they identified as most serious for their populations. They used the PIP-PH to prioritize problems and services most needing short-term attention for improvement.

As part of the PIP-PH process the teams also designed a format for a Health Watch Framework for their subdistricts as a whole and the facilities within them. Each team selected indicators to measure the status of two priority public health problems, the related essential services, and the constraints affecting those services.

The teams used the Health Watch forms to establish baseline values for the indicators and then to monitor these values as the interventions proceeded over time. Facilities reviewed and updated the form each month; the subdistrict teams, including facility managers, reviewed and discussed the revised forms each quarter.

The subdistrict teams used the information to analyze the reasons for progress or lack of progress so that they could provide support to facility managers. The process spurred facility managers to improve the completeness and accuracy of routine data so that they could use the information to more effectively monitor health events and essential services and make needed improvements.

Examples and detailed information about the PIP-PH and the Health Watch Framework appear in the PRIDE Project 2007 [Annual Report](#).

For additional approaches to using data to improve the performance of an organization, team, health service, or intervention, please see [Performance Assessment and Improvement \(PAI\) process on the Leadership, Management and Sustainability \(LMS\) Program website](#).

## STEP 6: SHARE AND USE YOUR DATA

In the rush to start collecting data, some managers forget to plan a process for reflecting on the information and making changes to improve the performance of activities. To make sure that data will be used—not just collected—think about how you and your team will disseminate the M&E information and obtain feedback from different stakeholders. A few basic questions will guide you:

- Who needs what kind of information and when do they need it?
- What type of setting should you use to communicate results to staff, senior management, and other key stakeholders? Is it sufficient to circulate a report, or should you organize a meeting or workshop?
- Should you also organize community meetings to solicit feedback from your beneficiaries on the initial M&E findings?
- How should you present information so it will be useful to different decision-makers? Should the information be presented visually, in charts, graphs, or maps? For guidance on the presentation of data and results, please see the [M&E Guide for Facilitators of Leadership Development Programs](#).

M&E should be undertaken with the purpose of immediately *using* the results to identify gaps in performance and take action to reduce or fill those gaps. You should always plan ways to use M&E results for learning and action. For example, if project activities are not leading to the desired products, what should you do about it? If essential services are not achieving anticipated coverage levels or reaching specific groups of people, what needs to change? And how can you bring these facts to the attention of the right people in order to obtain a rapid response?

## Designing an M&E tool

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### MONITORING AND EVALUATION TRAPS

There are a number of common pitfalls that can prevent you, as a manager, from improving the M&E function in your organization.

- **Over- or under-planning.** Some of you may spend too much time developing the M&E plan, which can lead to elaborate plans that are too complicated to use. Or managers who are overeager to implement M&E interventions may get started before they have completed an M&E plan. This means that, by the time the plan is worked out, it is often too late to get a viable baseline and M&E must be deferred. In these cases, the manager may have to settle for some sort of evaluation later, without baseline data to use for comparison.
- **Neglecting continuous monitoring.** Another trap that is easy to fall into is the failure to build continuous monitoring into the implementation of activities. This is often due to lack of experience. Many managers have not had access to useful monitoring tools (which are rare). They may not have received timely results or feedback from the M&E system in the past, so they may not see the value of routine monitoring. In addition, managers can easily get caught up in the details of implementation and neglect routine monitoring.
- **Overdoing it.** Still another monitoring trap is trying to track data on every possible indicator. Attempting to capture data on too many factors makes the monitoring process so complicated that it becomes imprecise. It also slows the process, so that by the time the data are collected and analyzed, they are no longer useful. Monitoring tools that are too long and complicated do not get used. What happens then? The manager skips monitoring altogether and has to resort to evaluation.

If you have encountered these problems, it is time to change your approach. You can develop a simple M&E plan and use simple monitoring tools. Figure out what you should measure in order to obtain data within three to six months; the time frame will depend on your organization's planning and reporting cycles. Also figure out what, at a minimum, should be measured in a longer-term evaluation. Aim for simplicity even in the context of a complex set of activities.

Try to include only what you need to know. You can screen all proposed indicators before including them in the M&E plan, asking: Who needs to use this information, when, and for what purpose? If one output indicator is enough, perfect! Do not overburden monitoring with unnecessary indicators. In many cases, fewer data actually provide more information.

## FEATURES OF A GOOD MONITORING TOOL

As a manager, you do not need to know everything to manage a service or intervention. You need information now. You need a monitoring tool that can deliver sufficient information in time to identify and correct problems as soon as they emerge.

A monitoring tool should be easy to construct and use. Tables, checklists, and simple graphs are particularly useful methods of collecting, organizing, and presenting monitoring information.

At a minimum, your monitoring tool should enable you and your team to track:

- the status of activity implementation;
- the delivery of outputs;
- the status of key outcome indicators vis-à-vis anticipated results, if appropriate;
- budget expenditures;
- the availability of human and financial resources;
- obstacles to implementation and what is being done to overcome them.

You need to be able to answer the following questions on a periodic basis:

- Have activities been implemented as planned, on time, and within the budget?
- What additional, unplanned activities have been carried out?
- What direct, tangible products or services have been delivered as a result of activities we have implemented?
- Are we on track for reaching our outcomes?
- Do we have the necessary resources (staff, money, medicines and supplies, etc.) to stay on track?

Box 4 illustrates the basic components of a simple monitoring tool.

### BOX 4. A Simple Monitoring Tool

Review Date:		Outcome Targets:			
Activities (per Implementation Plan)	Status to Date	Expected Outputs	Dates for Completion	Status to Date	Comments
Challenges and Opportunities:					

When used correctly, new technologies (e.g., Personal Digital Assistants or PDAs, “smart phones,” handheld computers) can make monitoring easier and increase the benefits of monitoring activities. Automated monitoring—data that can be pulled and processed automatically—can produce an easy-to-read, one-page summary of key indicators in a color-coded format that alerts the manager to areas that need attention. Timely information on a few key indicators allows the manager to monitor progress and take corrective actions.

This visual display of the most important information needed to manage a project is generally known as a **performance dashboard**. Performance dashboards can be used in any organization, department, or division. In public health organizations, dashboards are often used to monitor programmatic and financial indicators as well as the coverage, production, effectiveness, and quality of specific health services. A human resources dashboard, for example, would include relevant indicators for managing:

- employee retention
- employee turnover
- employee training
- skill gaps
- employee satisfaction
- employee costs, benefits, and overhead

Table 6 shows a performance dashboard created to monitor key indicators for voluntary surgical contraception (VSC) services.

**TABLE 6. Illustrative Performance Dashboard for VSC Services**

Service: Voluntary surgical contraception  
Reporting Period: January 2009

No.	Service Provision/Cost/ Quality Indicator	Programmatic or Financial Goal/ Threshold		Number Achieved	Percent Completed									
		Min.	Max		10	20	30	40	50	60	70	80	90	100
1	Number of VSCs performed during the month	8	10	7										
2	Average cost of VSCs in US\$	100	120	110										
3	Monthly budget of income from VSCs performed, in US\$	800	1200	770										
4	Percent of VSCs performed by qualified personnel	—	100%	60										
5	Percent of VSCs with no complications	95	100	100										
6	Percent of users satisfied with treatment received from personnel performing VSC	90	100	90										

Adapted from Colindres, 2008, p. 6.

You will find a description of the use of a performance dashboard for routine monitoring in a [case study](#) from a Bolivian NGO, the Center for Research, Education and Services (CIES).

For information on designing a dashboard, please see [“Using Performance Dashboards to Monitor Organizational Achievements.”](#) This paper helps to clarify concepts and defines key steps for developing performance dashboards.

## Design an evaluation for learning

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Despite the importance of routine monitoring, monitoring is not sufficient for you to be able to answer the “So what?” question. In other words, how have your activities and products contributed to improving coverage of services, increasing knowledge, or encouraging health-enhancing behaviors?

Maybe a family planning communication campaign designed to increase contraceptive prevalence has led the government to stock district warehouses with contraceptive supplies. So they can learn from this experience and design more effective campaigns in the future, the project managers still want to know whether the products were actually dispensed to health facilities and distributed to clients. This section discusses how to design an evaluation for learning purposes.

There are two reasons for carrying out an evaluation.

1. Evaluation provides information about the success of your team, unit, or organization in meeting its objectives. This information helps determine which activities to expand, modify, or eliminate. It can also reveal ways to improve the design and management of future activities.
2. Evaluation can demonstrate accountability to your donor and other stakeholders, including your government and the beneficiaries of your services.

### FORMATIVE AND SUMMATIVE EVALUATIONS

Managers can carry out two broad types of evaluations: formative and summative.

**Formative evaluation.** This type of evaluation is conducted during the development and implementation of a program. Its purpose is to guide the design and implementation of activities that include the best or most promising practices that will increase the chances of success. Formative evaluation is more commonly used by large or long-term projects rather than small, short-term ones. However, small projects should at least conduct a brief review of best practices during the planning phase to support the logic and proposed content of the activities.

Formative evaluation includes a needs assessment to discern the desires and requirements of a population group and determine how best to meet them. It also includes **process evaluation** to investigate the process used for delivering an intervention. You can use process evaluation to assess whether activities have been conducted according to plan—in terms of the original design, estimated costs, and number of people to be served—and whether the quality of the processes used is in accord with the best known practices.

A process evaluation typically includes several approaches. It may involve a review of output data (e.g., number of bednets provided, number of training workshops conducted, number of workshop participants) as well as individual interviews or focus groups among beneficiaries. It is good practice for small interventions to carry out process evaluation, even if it is limited to participant feedback.

**Summative evaluation.** This type of evaluation is conducted after the completion of a set of activities or intervention to assess the quality of the intervention and its key results. Summative evaluation includes outcome evaluation, impact evaluation, cost-effectiveness and cost-benefit analysis, and operations research.

Summative evaluation includes **outcome evaluation**, which assesses the extent to which a team, unit, or entire organization has achieved its intended results. Outcome evaluation is used to demonstrate accountability, improve the design of organizational activities, better allocate resources, and promote successful future interventions. The main questions addressed are: What has changed in the lives of individuals, families, or the community as a result of our work? What difference did we make?

As pointed out earlier in this chapter, outcomes are typically measurable and/or observable changes in two dimensions. The first dimension encompasses awareness, knowledge, attitudes, values, and skills of participants in a program or beneficiaries of services during or after their involvement in the intervention. The second dimension involves changes in behavior in these same groups.

Ideally, both dimensions should be measured at three points: at the beginning and end of the implementation period, and, if possible, after a suitable follow-up period. If the follow-up measurement is not feasible, at least baseline and post-intervention measures should be compared. In many cases, the changes may be modest, but there must be some improvement in at least one or two outcomes for the intervention to be considered a success.

Outcome evaluation attempts to distinguish between the influence of the intervention on these changes and the influence of other, external factors. However, evaluators often have to settle for partial attribution of an outcome to a specific intervention or service because of the difficulty in determining a direct, causal relationship between the service provided and a given change.

Outcome evaluations typically use a nonexperimental design (often called “pre-post evaluation”) that simply measures changes before and after an intervention, as opposed to an experimental design (comparing participants to a control group with random assignment to both groups) or quasi-experimental design (comparing participants to a control group, but with no random assignment).

The nonexperimental design is acceptable for standard outcome measurement and reporting purposes. NGOs rarely use experimental designs. Although a large, well-funded organization might occasionally obtain expert assistance for an experimental design, most NGOs find that ethical and logistical considerations prevent the random assignment of participants to intervention and control groups. In addition, the costs of collecting data from a control group are likely to be too high.



**Impact evaluation** is another component of summative evaluation. It is broader than outcome evaluation and assesses the overall or net effects—both intended and unintended—of an entire program, group of programs, or group of organizations. Impact evaluations usually take place over three to five years.

## OTHER TYPES OF EVALUATION

**Cost-effectiveness and cost-benefit analysis.** These types of analysis address an intervention's efficiency by analyzing outcomes in terms of their financial costs and value.

**Operations research (OR).** OR is the assessment or evaluation of a specific intervention within the context of a broader program that is delivering a number of interventions. OR is used to test and evaluate new approaches in delivering health services. It is also used to identify problems in service delivery and to develop solutions.

OR is a powerful tool that program managers and decision-makers can use to improve and expand services. OR studies compare interventions that are within the manager's sphere of influence. Examples include evaluating the effectiveness of a new HIV & AIDS prevention strategy, a new training course, a new set of procedures for managing medicines, a new contraceptive method, or a new reproductive health service.

The Population Council's [Horizons Operations Research on HIV/AIDS Toolkit](#) provides step-by-step information for designing an OR study.

## CONSIDERATIONS FOR DESIGNING AN EVALUATION

**What should you evaluate to answer the “So what?” question?** If you, as a manager, want to know when your activities are really successful, you need to design all interventions with evaluation in mind and incorporate evaluation into your overall organizational planning. When defining objectives, you should ask, how will we know whether we are meeting these objectives? This is the starting place for the evaluation.

Regardless of the size of your intervention or service and the scope of the evaluation, you need to answer three questions during the design and planning phase:

1. What will your intervention or service achieve in the short and long terms?  
If you successfully implement a set of activities over time, what will be different?
2. How do you conceptualize your activities—what is the underlying logic?  
Two approaches for identifying the program logic are discussed in this chapter under [Practical M&E Tools and Approaches](#).
3. Which indicators can you use to identify progress toward the outcomes?

To answer the So what? question, you need to assess factors over which you have reasonable control. For example, a new service designed to provide housing for people living with AIDS (PLWA) cannot control or affect the life expectancy of the people it serves. By providing a stable living environment, however, the service can reduce the stress and improve the quality of life of PLWA who were previously forced to move frequently.

Once you have addressed the So what? question, you should also make sure that the evaluation is designed so that when the process is complete you can address five key evaluation topics:

1. **Relevance:** Was the intervention a good idea, given the situation and the need for improvement? Did it deal with the priorities of the target or beneficiary group? Why or why not?
2. **Effectiveness:** Have the intended outcomes, outputs, and activities been achieved? Why or why not? Is the intervention logic correct?
3. **Efficiency:** Were inputs (resources and time) used in the best possible way to achieve outcomes? Why or why not? What could you and your team do differently in the future to maximize outcome results at an acceptable cost?
4. **Impact:** To what extent has your intervention contributed to longer-term or national goals? What unintended consequences (positive or negative) did your activities have? Why did these consequences arise?
5. **Sustainability:** Will there likely be continued positive results once your intervention has ended? Why or why not?

A final word of caution here: like monitoring, evaluation can be made too complicated. When developing an evaluation plan, you will be wise to select a small set of key indicators and resist the urge to evaluate every aspect of your intervention.

Like monitoring, evaluation is useful only if the information is fed back on time to the manager and other decision-makers and stakeholders. A common problem with midterm evaluations is that results often come back six to eight (or more) months later, leaving only one to two years to make lasting changes before donor or government funding runs out.

## SELECTING YOUR DATA SOURCES

This section describes three types of data sources that are commonly used for an evaluation: routinely collected data, large-scale surveys, and rapid assessment techniques, including participatory appraisal.

**Routine data.** Data collected and analyzed on a routine basis by an HIS are referred to as “service statistics.” You can draw on several routine service information systems to monitor services. These include the basic HIS recording and reporting system; special program reporting systems (e.g., TB, malaria, immunization, HIV, family planning, etc.); special community agent reporting systems (e.g., community health workers’ records); the disease surveillance and outbreak control notification and response information system; and reports for special support systems (e.g., medicines, referrals, and human resources and financial management).

These systems provide data that are readily available and are intended to tell you what is happening in the health sector. Examples of routine data include, for example, the number of prenatal visits at a clinic, the number and type of vaccinations provided on site, or the number and types of contraceptives supplied each month.

Data on services are generally collected by health centers or health posts and sent up to the next level in the system (usually the district) to be aggregated. These data may then be

sent upward to the next level (regional or provincial) for further aggregation before they finally arrive at the central level of the Ministry of Health.

Ideally, managers in health facilities and at the district level would use these data to guide daily operations, track performance and accountability, and make decisions that will continuously improve performance. But there are many impediments to this use.

All too often, routine data are inaccurate or incomplete. While those who use the HIS attempt to produce timely information of high quality, there are many opportunities for errors. There may be little support for managers and their staffs to focus on procedures for collecting, recording, and aggregating data correctly.

Health systems in many countries emphasize the importance of submitting reports to higher levels; they have not developed procedures and incentives to encourage those who provide information to use it, even when the data are of good quality.

Another drawback is that service statistics provide information only about the clients who use health services. They cannot provide the information about the many people who do not use the services.

For these reasons, you cannot rely on service statistics alone for an evaluation. Service statistics are more appropriately used for routine monitoring of public health problems and related essential services.

**Large-scale surveys.** Large-scale surveys constitute another readily available source of information. These include population-based surveys such as the Demographic and Health Surveys (DHS), comprehensive facility assessments such as the Population Council's Situation Analysis, and the national census. In many cases, managers can use data from an existing large-scale survey to provide context for interpreting the data captured through their own evaluations.

For example, the DHS is carried out periodically to characterize the health situation in a country or large geographic region for numerous subpopulations: men, women, children, infants, and so on. But the DHS data cannot usually be disaggregated for managers to use at the district or community level.

Further, because they are carried out only every three to five years, the information they provide may not be sufficiently up-to-date for managers' evaluation needs. Despite these drawbacks, DHS data are useful for understanding national or regional trends that may help explain data gathered in a focused evaluation.

**Rapid assessments.** These are quick, inexpensive ways to obtain information for decision-making, especially at the activity level. Examples include client exit interviews, small-scale facility assessments, rapid sample surveys, record reviews, focus group interviews, and other participatory methods.

You may use rapid assessment techniques to supplement information from routine data or large-scale surveys. Rapid assessments can provide you with valuable information about

your catchment area and your wider responsibility area—the communities and populations that are supposed to have access to essential services provided by a given facility. They can also provide context and qualitative understanding of quantitative data collected by more formal methods.

Within the category of rapid assessments, participatory methods and rapid sample surveys deserve your attention.

**Participatory methods (also called participatory learning and action).** These techniques and methods aim to incorporate the knowledge and opinions of community members in planning and managing development projects, influencing policy, and implementing programs. They enable voices from the community to be included in policy, planning, and research and generate a sense of ownership in the M&E results and the recommendations made by both the organization and its beneficiaries.

Unlike other techniques for rapid assessment, participatory methods are not based on samples. They use individual or key informant interviews (including client exit interviews), group interviews, case studies, and other qualitative approaches to identify local conditions and understand local perspectives and priorities.

In many locations community members cannot read and write, so participatory methods often rely on oral communication supported by pictures, symbols, physical objects, and group memory.

Participatory methods can be used before, during, and after implementation of an intervention or set of activities. They provide information for both design and evaluation and allow active involvement of stakeholders in decision-making. During implementation, participatory methods are a useful approach for identifying and trouble-shooting problems.

You might want to take advantage of a listing of [online resources on qualitative research and guidelines on focus group discussions in the Community Tool Box at Kansas University](#).

**Rapid sample surveys.** These surveys can be used to collect standardized information from a carefully selected, small sample of people or households in a beneficiary area. These surveys can describe conditions in a particular community or target group and allow comparison of different groups at a given point in time or changes in the same group over time. They also permit the comparison of actual conditions with planned results.

- One of the most common small-sample surveys is the **knowledge, attitudes, and practices (KAP) survey** based on a 30-cluster sample.
- **Lot Quality Assurance Sampling (LQAS).** This is another rapid assessment technique that is becoming widely used in public health. LQAS employs very small samples to obtain reliable information on a small geographic area or administrative unit. LQAS can be used to accurately detect the extremes of performance—to determine whether an intervention has exceeded an upper threshold of performance or has failed to meet a lower threshold of performance in terms of quality or coverage. The lot samples can also be combined to provide coverage estimates in a wider geographic area.

TABLE 7. Overview of Three Common Data Sources for an Evaluation

Data Source	Strengths	Limitations
<b>Service Statistics:</b> Data on the client population and clinic services that are routinely collected in client registers and clinical records	<ul style="list-style-type: none"> <li>Readily available</li> <li>Cover all types of health services and all areas of a country</li> <li>Can be disaggregated to district and local levels</li> <li>Inexpensive to use</li> </ul>	<ul style="list-style-type: none"> <li>Only tell you about current clients, with no information about the people who do not use the health services and might be potential users</li> <li>Do not provide information about community values, perceptions, or behaviors</li> <li>Do not reflect people who turn to private sources for services</li> <li>Can be inaccurate if service sites fail to record data accurately, legibly, and on time</li> </ul>
<b>Large-Scale Surveys:</b> Population-based surveys and large-scale facility assessments	<ul style="list-style-type: none"> <li>Relevant, precise, reliable data</li> <li>Can measure national health trends, identify problem areas, and help focus country resources on areas of greatest need</li> <li>Generate averages for rural and urban areas, regions, and provinces</li> <li>Provide a context for interpreting data collected locally</li> <li>Can generate additional information from their computerized data sets</li> </ul>	<ul style="list-style-type: none"> <li>Usually cannot disaggregate data to provide averages for subregional areas (districts or municipalities)</li> <li>Usually not conducted annually; data become quickly outdated if populations or health conditions are changing rapidly</li> </ul>
<b>Rapid Assessments:</b> Focused methods for assessing local needs and making local decisions	<ul style="list-style-type: none"> <li>Quick and inexpensive</li> <li>Lead to local action</li> <li>Guidelines exist to assist managers in many of these techniques</li> <li>Empower managers to collect the data they need</li> <li>Household surveys (e.g., LQAS or KAP) can achieve sufficient precision for evaluation purposes</li> </ul>	<ul style="list-style-type: none"> <li>Balance the need for representative, objective results with the need to use slightly less rigorous designs that are most feasible in local areas</li> <li>Use reduced scope and scale to produce timely and low-cost results</li> </ul>

A search of the web will uncover useful resources; here are one on [KAP surveys](#) and another on [LQAS](#). The M&E area of the CORE Group [website](#) includes links to valuable rapid assessment tools and resources created by CORE Group's M&E Working Group.

As a manager, you should review all existing data sources before planning your evaluation. [Table 7](#) displays the advantages and disadvantages of the three main data sources that were discussed above: routine service statistics, large-scale surveys, and rapid assessment techniques.

How *good* do HIS data have to be in order to be useful—how complete, accurate, and timely? For your management needs, data that are less than perfect may be good enough to have a powerful effect, as shown in an example from Madagascar.

### Using and Improving Imperfect HIS Data— An Example from Madagascar

**A more timely, accurate community-based HIS.** A project in Madagascar implemented a community-based approach to increasing the use of family planning methods called “Champion Communes” in 50 of the country’s 110 districts. This approach relied exclusively on HIS data for monitoring and evaluating achievements among participating communes.

First, a baseline was established for each commune, using data from its health center. Then, health center staff and community representatives identified goals for 10 indicators that would determine whether a commune had reached champion status after 12 months of implementation. Each commune monitored its own progress at a quarterly check-in meeting.

After the 12 months, the project staff returned to each commune to evaluate results. They reviewed data from each health center’s routine monitoring report for each indicator. They also prepared a report on the data for each commune and sent it to the district-level supervisor for validation based on the district’s computerized records. The data sources for the health center reports and district records were the same (health center registers), so there was rarely a discrepancy. But the point was to involve the district supervisor in reviewing health center data and to show the utility of using even simple data at this level.

The project also worked with the Ministry of Health at the district level to improve the accuracy, completeness, and timeliness of the HIS. The emphasis was on obtaining more complete data from the health centers and reducing the district health office’s turnaround time—the time it took to receive the health center report, review it, return it to the health center for correction, retrieve it, enter the data into the system, and send the data to the central level. The districts were responsible for working with health centers to improve data recording and upgrading their own data-processing techniques.

After two years of technical assistance, the HIS had indeed improved, according to indicators for accuracy, completion, and timeliness. The greatest improvements were seen in timeliness; the turnaround time decreased from 12 months to 3 months.

**Imperfect, but still valuable.** It should be pointed out that the Champion Communes project did very well with imperfect data. Their numerator (the number of regular family planning users) was detailed and accurate. But their estimates of the contraceptive prevalence rates (CPR) were not accurate because the denominator (the number of women of reproductive age) was only an estimate, based on an out-of-date census and the government’s annual estimated updates on growth percentages.



(continued)

However, the project determined that the CPR was good enough to track the performance of the communities participating in the Champion Communes approach. The project staff also supplemented comparisons of CPRs with comparisons of the numerator values: simple numbers that made sense to health center staff and communities alike.

The central level began organizing quarterly regional workshops to disseminate results to the district level. Together, managers from the central, regional, and district levels analyzed progress and rated the districts on the basis of their performance. They used root cause analysis—a process for identifying the underlying causes of a problem—to understand obstacles facing the low performers. (See Appendix A in Chapter 2 of this handbook for more about root cause analysis.) Then the Ministry of Health mobilized support from donors and partner organizations to help them improve.

The ministry began to use health information to truly manage the health system. Before this intervention, few organizations had trusted or used HIS data. But once it became clear that the system was functional, the donors believed in it, partner organizations used it, and the ministry was proud. For the first time, they had a clear picture of what was happening throughout the country, and they could use this information to advocate for donor support where needed.

Similarly, health centers had rarely used their own data. They had simply filled out registers and sent them up to the district office, without ever receiving feedback in return. After project completion, they saw how more precise data could be used to benefit them and their communities.

The districts also had been operating in an uninformed way. Each district had relied only on its own data, operating in a vacuum. The changes in the HIS and the encouragement of the central government provided districts with opportunities to compare their work—and learn from—one another.

**Learning from more accurate, complete, and timely data.** Data are often used to make comparisons, but they are less often used as a learning tool. In this instance, once the reports were coming in on time, the Ministry of Health used data—including less than perfect data—to detect which districts were underperforming and which were outperforming the rest. They learned from the best performers by asking: Why were their results so high? What were they doing differently? What could be replicated? They then applied what they learned, using these districts as models and providing support to the underperformers.

The entire health system became excited about the information it could produce and use. Starting at the top, this excitement trickled down to the lower levels, motivating them to improve their data collection and processing.

## HIS data: Strengths and limitations

Underestimating the value and utility of the HIS is an unfortunate trend. It is true that the HIS system is often broken, but it often has potential. As seen in Madagascar, the Champion Communes project greatly improved the system over two years. In this case, the system was already fairly functional because earlier projects had invested in a major effort to put the system in place and make it basically sound. By improving the way the system was managed and the data were used, the most recent project was able to make a big difference with small changes.

HIS data are not 100 percent accurate and never will be. That is the reality all managers have to work with. But data do not need to be perfect to be useful. You can still monitor and manage with imperfect data. Timely information that is 75 percent accurate is better than information that is 95 percent accurate but arrives several months too late.

Despite its great value, HIS data alone will not meet all the information needs of many organizations. Some organizations and donors need data that require special systems or assessments. In addition, many interventions are designed to change the knowledge, attitudes, and practices of beneficiaries, which are not captured in service data. It is important to use HIS data when possible and to supplement it with local assessments when needed.

As the manager of a health program or health services, one part of your job should be to improve the HIS in the country where you work. The HIS is the only sustainable information system in most countries. Information systems that are created and maintained by donors or external organizations have limited life spans, but the HIS is a permanent part of your legacy.

If all partners and donors work with the Ministry of Health to provide technical and financial assistance for the HIS, it can yield information that greatly improves health services and more than justifies the investment.

## Proven practices

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- An M&E system should give managers what they need to know to take action. It must be based on relevant indicators, easy to use, and on time for planning or reporting cycles.
- M&E results are not just for your organization's M&E staff or your donor. M&E information is a vital resource for action and learning. If your M&E process has feedback mechanisms that allow decision-makers to reflect on the findings and absorb what they need for their own purposes, they will own the process and will use what it yields.
- If you design your M&E at the beginning of an intervention or project, in conjunction with the action plan for the project, you will better able to guide and track the implementation of activities.
- M&E plans that are too elaborate and complicated do not get used. Develop a simple M&E plan, choose easy-to-use monitoring tools, and select the fewest possible indicators to track progress and make necessary changes along the way.
- Strengthening an HIS requires working with the people involved: the owners of the system who record, transfer, analyze, communicate, and use data and information to manage services.



- In providing HIS data to decision-makers, you should recognize differences in the frequency of reporting and the amounts of aggregated and disaggregated data needed at different levels of government or by nongovernmental organizations.
- Routine monitoring gives you, the manager, the information you need to track progress toward your goal and to run your unit effectively. It allows you to spot a problem and make changes quickly. An evaluation cannot give you this type of information.
- In many cases, timely but imperfect data are sufficient to meet basic management needs.
- Support health facility staff in using available data promptly to monitor and manage services, even if the data are of poor quality. If they routinely use the data that they collect, they will see why data quality is important. They will then be more likely to take the necessary steps to improve their data collection and processing and generate more complete and valid data.
- You can use service statistics to collect data specific to a catchment area and supplement these data with other approaches—such as rapid assessment tools—to gather additional information about your wider areas of responsibility.

## Glossary of M&E terms

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**baseline:** Data collected during the initial stages of a project, before beginning activities. Baseline data identifies the starting point from which you can assess progress towards intended results.

**catchment area:** The area from which clients are drawn to service facilities.

**conceptual framework:** A diagram of a set of theoretical links between activities and a variety of other factors believed to lead to desired outputs and outcomes. Unlike the LogFrame, the conceptual framework does not assume a simple, linear cause-and-effect relationship among inputs, outputs, and outcomes.

**data source:** Where information regarding an indicator comes from. Every indicator has its own data source. Common data sources include service statistics, organizational records, clients, and the community.

**evaluation:** Assessment of the extent to which results are achieved. Evaluation's purpose is also to understand why the results were or were not achieved. It is usually based on information from routine monitoring combined with the measurement of outcomes and impact.

**formative evaluation:** Used to guide the design and implementation of a program or intervention. It is used to ensure that activities include the “best” or “promising” practices to increase the chances of success. It includes needs assessment and process evaluation.

**goals:** Organizational or national-level long-term results that an intervention is intended to achieve.

**health information system (HIS):** Usually refers to the many different subsystems that provide the necessary routine information for managing health services. *Sometimes called health management information system (HMIS) or management information system (MIS).*

**impact:** Long-term change in the health status of a population, usually the combined result of several programs over time (for example, total fertility rate, maternal morbidity and mortality rates).

**indicator:** A quantitative or qualitative factor associated with assessing change or the performance of a specific activity. A marker of change over time.

**input:** The resources needed to achieve a desired result (e.g., financial, human, supplies, commodities, facilities).

**logical framework:** A management tool that uses a matrix to outline project objectives, the causal links in the results chain (inputs → processes (activity) → outputs → outcomes → impact), key assumptions, and how outputs and outcomes will be monitored and evaluated. *Also called LogFrame or logic model.*

**monitoring:** Regularly tracking changes in indicators over time in order to measure progress toward results by collecting information on inputs, processes, and outputs.

**monitoring and evaluation (M&E) plan:** Outlines which indicators will be measured, how they will be measured, when, and by whom. An M&E plan helps managers choose reliable indicators and measure these indicators in an organized way.

**outcome:** Short-term changes in a beneficiary population as a result of a set of activities.

**output:** The immediate or direct product of activities (e.g., number of people trained, number of new users of family planning, number of products distributed).

**participatory assessment:** Techniques and methods that aim to incorporate the knowledge and opinions of community members in planning and implementing health programs. *Also called participatory learning and action.*

**performance dashboard:** A one-page visual display of the most important information needed to manage a project.

**primary data:** Information that you collect yourself, for example, through a rapid assessment technique or key informant interviews using a structured guide.

**process:** The activities carried out through your implementation plan (e.g., providing new methods of contraception, developing a curriculum, training service providers).

**process monitoring:** Selecting and tracking the inputs and outputs of activities, for example, who was trained, in what topics, and how often. Process monitoring does not monitor progress toward goals. It simply tracks activity completion.

**proxy indicator:** An indirect measure that approximates or represents a target or result when direct information is not available. For example, couple-years of protection (CYP) is a common proxy indicator for family planning use when data on the contraceptive prevalence rate are not available.

**rapid assessment:** Quick, inexpensive ways to rapidly provide information for decision-

making, especially at the activity level. Examples include client exit interviews, small-scale facility assessments, rapid sample surveys, record reviews, focus group interviews, other participatory methods.

**result:** The logical expected accomplishment that can be measured after implementing a program or service.

**results chain:** The sequential, causal relationships among results levels outlined in the logical framework (inputs, activities, outputs, outcomes, and impact).

**results levels:** The various stages of results outlined in the results chain.

**routine data:** Information about health service delivery collected on a regular basis through the health information system. *Also called service statistics.*

**secondary data:** Information from existing sources (such as routine data, a census, or Demographic and Health Survey) in contrast to primary data, which one collects oneself.

**SMART criteria:** Set of five standards used to check that a result or objective is developed in measurable terms. The criteria are: Specific, Measurable, Appropriate, Realistic, and Time bound.

**summative evaluation:** An assessment conducted to measure quality of performance and achievement of key results after the completion of an intervention or set of activities. Summative evaluations include outcome evaluation, impact evaluation, cost-effectiveness evaluation, and operations research.

## References and resources

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### INFORMATION FOR MANAGING HEALTH SERVICES

Bertrand, Jane T., Robert J. Magnani, and Naomi Rutenberg. *Evaluating Family Planning Programs, with Adaptations for Reproductive Health*. Chapel Hill, NC: The EVALUATION Project, 1996, <http://www.cpc.unc.edu/measure/publications/pdf/ms-96-03.pdf> (accessed Jan. 22, 2010).

Management Sciences for Health. "Using Evaluation as a Management Tool." *The Manager* (Boston) vol. 6, no.1, 1997, linked on <http://erc.msh.org/mainpage.cfm?file=2.3.1.htm&module=info&language=English> (access Jan. 22, 2010).

———. "Information for Health Management: The MSH Approach." 2005, linked on <http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=info&language=English> (accessed Jan. 22, 2010).

Patton, Michael Quinn. *Qualitative Evaluation and Research Methods*. Newbury Park, CA: Sage Publications, 1990.

Rossi, Peter H., Howard E. Freeman, and Mark Lipsey. *Evaluation: A Systematic Approach*. Thousand Oaks, CA: Sage Publications, 1999.

Shaw, Vincent. "Health Information System Reform in South Africa: Developing an Essential Data Set." *Bulletin of the World Health Organization* vol. 83, no. 8, pp. 632–36, 2005, [http://www.scielo.org/scielo.php?script=sci\\_arttext&pid=S0042-96862005000800018&lng=en&nrm=iso](http://www.scielo.org/scielo.php?script=sci_arttext&pid=S0042-96862005000800018&lng=en&nrm=iso) (accessed Jan. 22, 2010).

UNAIDS, World Health Organization, and MEASURE Evaluation. *National AIDS Programmes: A Guide to Monitoring and Evaluation*. Chapel Hill, NC: Carolina Population Center, 2000, [http://www.who.int/hiv/pub/epidemiology/en/JC427-Mon\\_Ev-Full\\_en.pdf](http://www.who.int/hiv/pub/epidemiology/en/JC427-Mon_Ev-Full_en.pdf) (accessed Jan. 22, 2010).

World Bank Group and Carleton University. “Data Collection Methods.” Module 8 of the *International Program for Development Evaluation Training*. Ottawa: IPDET.

World Health Organization. *Everybody’s Business: Strengthening Health Systems to Improve Health Outcomes: WHO’s Framework for Action*. Geneva: World Health Organization, 2007, [http://www.who.int/healthsystems/strategy/everybodys\\_business.pdf](http://www.who.int/healthsystems/strategy/everybodys_business.pdf) (accessed March 7, 2014).

## MONITORING FOR ACTION

International Training and Education Center on HIV. “Illustrative Monitoring and Evaluation Plans for a Clinical Mentoring Program: I-TECH Clinical Mentoring Toolkit. [http://www.go2itech.org/HTML/CM08/toolkit/programs/print/managing/Illus\\_ME\\_Plan\\_CM.doc](http://www.go2itech.org/HTML/CM08/toolkit/programs/print/managing/Illus_ME_Plan_CM.doc) (accessed Jan. 27, 2010).

Launiala, Annika. “How Much Can a KAP Survey Tell Us about People’s Knowledge, Attitudes and Practices? Some Observations from Medical Anthropology Research on Malaria in Pregnancy in Malawi.” *Anthropology Matters Journal* vol. 11, no. 1, 2009, [http://www.anthropologymatters.com/index.php?journal=anth\\_matters&page=article&op=viewArticle&path\[\]=31&path\[\]=53](http://www.anthropologymatters.com/index.php?journal=anth_matters&page=article&op=viewArticle&path[]=31&path[]=53) (accessed April 1, 2010).

Management Sciences for Health. “Using Service Data: Tools for Taking Action.” *The Family Planning Manager* (Boston) vol. 1, no. 2, 1992, <http://www.msh.org/resource-center/using-service-data-tools-for-taking-action.cfm> (accessed Jan. 26, 2010).

———. “Conducting Local Rapid Assessments in Districts and Communities.” *The Manager* (Boston) vol. 7, no. 1, 1998. <http://www.msh.org/resource-center/conducting-local-rapid-assessments-in-districts-and-communities.cfm> (accessed Jan. 27, 2010).

———. “Use of Data.” On the Electronic Resource Center, undated, <http://erc.msh.org/mainpage.cfm?file=2.2.0.htm&module=info&language=English> (accessed Jan. 27, 2010).

World Health Organization. Tools and resources on information systems for frontline managers at <http://www.who.int/management/resources/information/en/> (accessed March 6, 2014).

———. Tools and resources on M&E techniques for district and higher-level managers from the WHO website: [http://www.who.int/management/district/monitoring\\_evaluation/en/index.html](http://www.who.int/management/district/monitoring_evaluation/en/index.html) (accessed Jan. 27, 2010).

## PRACTICAL M&E TOOLS AND APPROACHES

Aubel, Judi. “Participatory Program Evaluation Manual: Involving Program Stakeholders in the Evaluation Process.” Calverton, MD: ORC Macro, 1999, [http://www.idrc.ca/uploads/user-S/10504133390Participatory\\_Program\\_Evaluation\\_Manual.pdf](http://www.idrc.ca/uploads/user-S/10504133390Participatory_Program_Evaluation_Manual.pdf) (accessed Nov. 18, 2009).

Bertrand, Jane T., and Gabriela Escudero. *Compendium of Indicators for Evaluating Reproductive Health Programs*. Measure Evaluation Manual Series vol. 1, no. 6, 2002, <http://www.cpc.unc.edu/measure/publications/html/ms-02-06.html> (accessed Jan. 22, 2010).

Colindres, Héctor. “Using Performance Dashboards to Monitor Organizational Achievements.” Boston: Management Sciences for Health, <http://globalexchange.msh.org/assets/globalexchange/files/Using%20Performance%20Dashboards%20to%20Monitor%20Organizational%20Achievements.pdf> (accessed Jan. 22, 2010).

Guijt, Irene, and John Gaventa. “Participatory Monitoring and Evaluation: Learning from Change.” *IDS Policy Briefing* Issue 12 (November 1998), Brighton, UK: Institute of Development Studies, University of Sussex, 1998, <http://www.ids.ac.uk/index.cfm?objectid=01D512C5-5056-8171-7BA528050E140ED9> (accessed Jan. 22, 2010).

Lippeveld, Theo, Rainer Sauerborn, and Claude Bodart. *Design and Implementation of Health Information Systems*. Geneva: World Health Organization, 2000.

Management Sciences for Health (MSH). “Menu of Indicators on Management and Leadership Capacity Development.” 2006, linked on <http://erc.msh.org/toolkit/Tool.cfm?lang=1&CID=11&TID=156> (accessed Jan. 22, 2010).

———. “From Vision to Action: A Course on Monitoring and Evaluation for Facilitators of Leadership Development Programs.” Cambridge, MA: Management Sciences for Health, 2007, <http://leadernet.msh.org/page.cfm?c1=90&nav=58> (accessed Jan. 22, 2010). You need to register on LeaderNet to access the course; registration is free.

Marsh, David R., Juan Carlos Alegre and Karen Z. Waltensperger. “A Results Framework Serves Both Program Design and Delivery Science.” *Journal of Nutrition* 138: 630–633, 2008. <http://jn.nutrition.org/cgi/content/full/138/3/630> (accessed Jan. 22, 2010).

Patton, Michael Quinn. *Utilization-Focused Evaluation: The New Century Text*. Newbury Park, CA: Sage Publications, 1997, 215–38.

Sapsford, R. *Survey Research*. Newbury Park, CA: Sage Publications, 1999.

Sartorius, Rolf H. “The Logical Framework Approach to Project Design and Management.” In *Evaluation Practice* 1991, vol. 12, no. 2, 139–47.

US Agency for International Development. *Monitoring and Evaluation (M&E) Fundamentals*. Course on the USAID Global Health e-Learning Center, <http://globalhealthlearning.org/login.cfm> (accessed Jan. 22, 2010).

———. Performance Monitoring and Evaluation TIPS on M&E practices. Nos. 2 (*Conducting Key Informant Interviews*), 4 (*Using Direct Observation Techniques*), 5 (*Using Rapid Appraisal Methods*), and 10 (*Conducting Focus Group Interviews*), all 1996 (accessed March 6, 2014).

W. K. Kellogg Foundation. “Logic Model Development Guide.” Battle Creek, MI: Kellogg Foundation, 2004, <http://www.wkkf.org/resource-directory/resource/2006/02/wk-kellogg-foundation-logic-model-development-guide> (accessed March 7, 2014).

## EVALUATION FOR LEARNING

Donabedian, Avedis. *The Definition of Quality and Approaches to Its Assessment*. Ann Arbor, Michigan: Health Administration Press, 1980.

Management Sciences for Health. “Managing and Using Information.” In *The Family Planning Manager’s Handbook*. Cambridge, MA: Management Sciences for Health, 1991, <http://erc.msh.org/mainpage.cfm?file=2.2.6.htm&module=info&language=English> (accessed Jan. 13, 2010).

Reisman, Jane, and Judith Clegg. *Outcomes for Success!* Seattle, WA: Organizational Research Services, Inc. & Clegg and Associates, Inc., 2000.

Veney, James, and Arnold Kaluzny. *Evaluation and Decision Making for Health Services*. Ann Arbor, MI: Health Administration Press, 1991.

Winch, Peter, et al. *Qualitative Research for Improved Health Programs: A Guide to Manuals for Qualitative and Participatory Research on Child Health, Nutrition, and Reproductive Health*. Baltimore, MD: Johns Hopkins University, 2000, <http://www.k4health.org/toolkits/m-and-e/qualitative-research-improved-health-programs-guide-manuals-qualitative-and> (accessed March 6, 2014).

World Health Organization. “Health Programme Evaluation: Guiding Principles for its Application in the Managerial Process for National Health Development.” Geneva: World Health Organization, 1981.

———. “A common framework for monitoring performance and evaluation of the scale-up for better health.” Geneva: World Health Organization, 2008, [http://www.who.int/healthsystems/IHP\\_M&E\\_briefing\\_30\\_Jan\\_2008.pdf](http://www.who.int/healthsystems/IHP_M&E_briefing_30_Jan_2008.pdf) (accessed Jan. 22, 2010).

## APPENDIX A. Example of a Logical Framework from the Inter-American Development Bank

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The logic for this [framework](#):

1. *If* the activities (promotion, training, and so on) are carried out well, and assuming favorable political and economic conditions and the availability of resources (monetary, human, and technological), *then* parents will be enrolled, home visitors and other staff will be trained, materials will be available, home visits will have been made, and an administrative system and MIS will be functioning.
2. *If* the outputs are obtained, and assuming low turnover of home visitors and other staff, *then* changes will occur in parental practices and in the home environment with which the child interacts.
3. *If* parental behavior and the home environment improve, and assuming that the trained caregivers continue to provide care and that the family structure is maintained or improves, *then* the health, nutritional, and psychosocial status of children will improve.



Logical framework for a home-visiting program with parental education			
<b>Goal</b> <b>(general objective)</b> Improve the development of young children, from birth to age 3, in urban marginal areas	<b>Indicator</b> Raise the developmental status of x children by x% over 5 years, as indicated by measures of health status, nutritional status, and psychosocial development	<b>Verification</b> Health: Health care net for each child Nutrition: Growth monitoring records in center Psychosocial: Performance on standardized tests	
<b>Purpose</b> <b>(specific objective)</b> Provide children with quality care and education through improved child rearing practices and changes in the home environment	<b>Indicators</b> Changes in practices of x% of participating parents Changes in the home environment	<b>Verification</b> Periodic observations of a sample of parents and homes: interaction with children, questionnaires, supervisory reports	<b>Assumptions</b> Trained parents or other caregivers continue to provide care Continuity in economic and family conditions
<b>Outputs</b> Participants enrolled Trained home visitors, supervisors, and directors Materials developed Home visits Parental training carried out Administrative system in place MIS in place	<b>Indicators</b> x low-income participants enrolled x caregivers trained Parental guides developed and distributed to x families Home visits made Functioning MIS and administrative system	<b>Verification</b> Data from MIS on trainees, parents, and materials Evaluations of trainee knowledge and skills after initial training and during course of continuous training; observation of interaction between home visitor and parents Questionnaires tapping parental knowledge and attitudes	<b>Assumptions</b> Low turnover of home visitors and other staff Ability to reach the desired population
<b>Activities</b> Enroll parents Select and train home visitors and other staff Develop materials Develop administrative system Provide continuous training and supervision Carry out home visits Develop monitoring and evaluation system	<b>Resources</b> Budget Technology Human resources	<b>Verification</b> Plan of action, budgets, and accounting records Studies showing that the chosen model and curriculum work Evaluations to see that the activities were not only carried out but also done well Curriculum vitae	<b>Assumptions</b> Political will Reasonable economic and political stability

Source: Inter-American Development Bank.





# Managing Health Service Delivery

*Ann Buxbaum*

1. Achieving Results by Strengthening Health Systems
2. Leading and Managing: Critical Competencies for Health Systems Strengthening
3. Governance of Health Systems and Health Organizations
4. Mainstreaming Gender Equality into Health Systems
5. Planning the Work and Working with the Plan
6. Managing Human Resources
7. Managing Finances and Related Systems
8. Managing Medicines and Health Products
9. Managing Information: Monitoring and Evaluation
10. Managing Health Service Delivery

This chapter explores the ways in which the health service delivery system interfaces with and builds on the management systems discussed in the earlier chapters of this handbook. You will see how improving the management and leadership of the health service delivery system improves access to and the quality of services. You will observe the importance of strong systems in fostering a positive relationship between clients and providers at service delivery sites—“points of care”—at all levels of the health system, leading to desired health outcomes.

This chapter deals with some of the most critical elements of health services:

- establishing and maintaining high-quality services
- assuring equitable access
- providing integrated services
- scaling up
- providing community-based primary health care
- working with the private for-profit sector

The chapter presents issues that health care managers and providers face in managing each of these elements. You will become familiar with tools and approaches that have proven effective in addressing each of these issues and with organizations that have successfully addressed the management issues, strengthened the key elements of health service delivery, and brought better health to the populations they serve.

## Introduction

So far in this handbook we've covered topics such as the six World Health Organization (WHO) building blocks of the health system and the people-centered approach that places the human capacity to lead and manage at the core of health systems strengthening (Chapter 1). The following chapters discussed leadership and management competencies and practices that health care professionals can apply in strengthening essential health systems (Chapter 2); gender considerations (Chapter 4); and specific management systems and subsystems related to governance, planning, human resource management, financial management, supply management, and measurement and monitoring and evaluation (Chapters 3 and 4 through 9, respectively).

We now turn to the health service delivery system, which brings all the building blocks, management and leadership practices, and management systems and subsystems together at central, regional, and district levels, as well as at the service delivery site or point of care (see Box 1).

As a health manager or provider of health services at the provincial or district level of government, within an NGO, or in a private-sector facility, you are at or close to the point of care. You can see for yourself how the management systems and subsystems discussed in this handbook affect the relationship between the client and the provider. You can also see how you can use your leadership and management practices to tailor services to local needs by:

- **Scanning** to understand priority health needs of the local population;
- **Focusing** on the health services that have the highest priority and can best be provided with the resources you have available;

### BOX 1. Management Systems at the Point of Care

In attempting to improve national-, regional-, and district-level health systems and their management systems, it is easy to lose sight of the individual, day-to-day encounters between clients and health service providers.

These encounters take place at points of care, wherever the client and provider meet. They include the full range of care, such as what's provided by:

- a village health volunteer providing health information to her neighbors in their homes;
- a nurse treating a child's high fever in a community health center;
- a surgeon or other medical specialist caring for patients in a tertiary hospital.

Point of care is where strong management systems and subsystems come together to support high-quality preventive and curative health services. These systems:

- give health managers and providers the capacity to offer each client the best possible health services that are appropriate to his or her needs and desires;
- help clients understand the value of available preventive and curative services and to know when and how to seek those services for themselves and their families;
- help build the foundation for an informed and engaged community that feels ownership of its services, takes on some responsibility for overseeing them, and supports all its citizens in making wise health choices and maintaining healthy behaviors.

- **Planning** strategies and activities that will bring priority health services to the people in your area;
- **Organizing** structure and systems to deliver the priority services;
- **Aligning** local stakeholders and **mobilizing** resources;
- **Implementing** planned activities through integrating systems and coordinating the work flow;
- Engaging local representatives in using data to **monitor and evaluate** services from the community perspective;
- Creating a positive work climate and producing results that **inspire** the commitment of staff and stakeholders.

## Elements of the health service delivery system

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Six elements of the health service delivery system apply to the other management systems addressed in this handbook. These six are critical to the provision of health services at all levels, as follows.

1. Establishing and maintaining the **quality of services**, in accordance with WHO's definition of quality: "...the 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" (Kols and Sherman 1998).
2. Ensuring **equitable access** for all people and communities, with an emphasis on gender disparities and the special needs of youth.
3. Providing **integrated services** that offer the many advantages of integration while incorporating the benefits of vertical services.
4. **Scaling up** (expanding services) in the face of limited resources and geographic, political, and sociocultural barriers.
5. Providing **community-based primary health care (PHC)** that promotes active community participation, provides access to community resources, and takes full advantage of the potential of community health workers.
6. Working with the **private for-profit sector** to create a balanced public-private mix that fosters quality, access, and efficiency.

We now explore each element by looking at its key issues as well as the approaches and tools that managers and providers have used to markedly improve in their service delivery systems and the health of those they serve.

## Element 1: Establishing and maintaining high-quality services

*At first glance, high-quality health services may appear to be a luxury beyond the budgetary limits of most [developing country] health systems. However, improving quality often does not cost, it pays. Attention to quality is essential to the success of primary health care programs, a fact that health managers with restricted budgets cannot afford to ignore.*

Lori DiPrete Brown et al.

*Quality Assurance of Health Care in Developing Countries*

### BUILDING AND MAINTAINING QUALITY SERVICES: THE CONTEXT

Quality assurance (QA) is a familiar term to most health managers and providers. It implies a planned, systematic approach with standards, protocols, and procedures that enable you, as a health manager or provider, to bring high-quality health services to your clients, continuously and within the resources available to you.

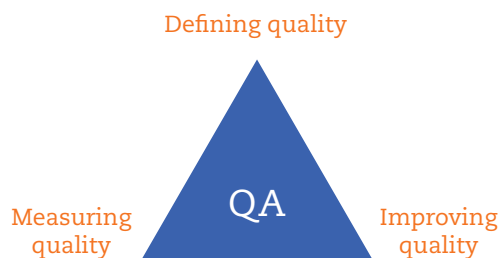
US Agency for International Development's (USAID) Quality Assurance Project (QAP)—predecessor to the current Health Care Improvement (HCI) Project—introduced the Quality Triangle found in Figure 1, a model of the three functions of quality assurance: defining, improving, and measuring quality. The triangle conveys the idea that quality of care is best achieved when all three functions are implemented in a coordinated fashion.

There is no “correct” sequence to implementing these three functions; where you and your colleagues begin depends on the capacity of the health care system or facility and the interests of the providers. You might want to begin with a major effort to define standards, a small quality-improvement activity, or monitoring current activities. Some teams might begin by working on two functions at once.

Under the Quality Assurance Project, University Research Company applied the [quality triangle](#) to define, measure, and improve the quality of family planning supervision at the district level in Zimbabwe.

In defining the desired quality, the project relied on supervision standards developed by Zimbabwean stakeholders. A team of supervisors and researchers then measured the performance of supervisors in selected supervisory practices, collecting data from struc-

FIGURE 1. Quality Triangle



Source: Adapted with permission from University Research Company

tured observations, audiotapes of supervisor-provider interactions, and recording supervisory activities and interviews with supervisors and supervisees.

QAP built on the study's results and designed a course that enhanced supervisors' strengths and directly addressed their most salient weaknesses. As a result, the supervisors' performance improved.

The Health Care Improvement Project [website](#) has a report with details of this intervention that you can download.

## BUILDING AND MAINTAINING QUALITY SERVICES: KEY ISSUES

This section explores the functions of defining, measuring, and improving quality.

**Defining quality: Synthesizing perspectives and setting standards.** The quality of services can be viewed through many different lenses, depending on the priorities of different stakeholders. For example:

- **Clients** often emphasize the human aspects of care—respectful treatment, privacy and confidentiality, information, and counseling—in addition to safety, convenient locations and hours, reasonable waiting times, affordable cost, and a clean, comfortable facility.
- **Providers** tend to highlight technical competence, infrastructure, and logistical support. Managers might stress management systems—especially logistics and information systems.
- **Policymakers and donors** take the broader view, which WHO defines as “the 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” (Creel 2009).

These varied perspectives on quality can be simply stated as “offering a range of safe, effective services that meet evidence-based standards while satisfying clients' needs and desires.” To this end, the Quality Assurance Project synthesized ideas from quality experts and defined nine dimensions of quality, as shown in [Box 2](#).

Defining quality involves setting evidence-based standards—expectations of performance—for all these dimensions and at all levels of the broad health care system. Standards are explicit statements of how to perform a health care activity so that it produces the desired outcomes. In some cases, universally accepted standards exist and can be adopted or adapted so that health workers can use them as guides to acceptable performance.

**Measuring quality: Identifying gaps and demonstrating changes.** Once standards have been developed or updated and communicated, key indicators can be selected, measured at the baseline, and monitored over time to detect changes in quality. You and your team should carefully choose a small number of indicators of the various dimensions of quality for which you can measure small changes over time.

## BOX 2. Dimensions of Quality

1. **Technical performance:** compliance with standards—the degree to which tasks carried out by health workers and facilities follow standards or meet technical expectations.
2. **Access to services:** lack of geographic, economic, sociocultural (including gender), organizational, or linguistic barriers to services.
3. **Effectiveness of care:** the degree to which desired results or outcomes are achieved.
4. **Efficiency of service delivery:** the appropriate use of resources to produce effective services.
5. **Interpersonal relations:** effective listening and communication between provider and client that is based on trust, respect, confidentiality, and responsiveness to client concerns. This includes nondiscrimination.
6. **Continuity of services:** delivery of care by the same health care provider throughout the course of care (when feasible and appropriate), as well as timely referral and communication between providers when multiple providers are necessary.
7. **Safety:** the degree to which the risks of injury, infection, or other harmful side effects are minimized.
8. **Physical infrastructure and comfort:** the physical appearance and cleanliness of the environment of care and the comfort and privacy it affords clients and health workers.
9. **Choice:** client choice of provider, treatment, or insurance plan, as appropriate and feasible. Inherent in this dimension is access to information that enables the client to make an informed choice.

As discussed in Chapter 9 of this handbook, you should, as much as possible, find data sources for measuring quality indicators in routine service reports, such as community-based health information (usually collected by health workers or community workers) and facility-based patients' charts, supervisory checklists, logbooks, and inventories.

Three aspects of quality that can be measured against standards of performance: structure, process, and outcomes. All three have advantages and disadvantages as indicators of quality.

1. **Structural indicators** include material characteristics (physical infrastructure, medicines and health products, number of assigned personnel, tools, technology); organizational resources; and financing of care (levels of funding, payment schemes, and incentives). Because structural measures are relatively easy to obtain, these are used most often in studies of quality in developing countries. However, structural indicators give only a partial picture of quality when used by themselves.
2. **Process indicators** track the completion of activities. They describe the interactions between caregivers and patients and are measured by the provider's accurate diagnosis and clinical treatment that conforms to guidelines, as well as by "softer" indicators such as counseling skills; demonstrated respect for the client; and provision of accurate, understandable information and clear instructions. Many studies have shown that certain processes generally lead

to better health outcomes, but it is not easy to measure the processes that take place during the private interaction between client and provider.

3. **Outcome indicators** are measures of change in a beneficiary population as a result of a set of activities. They can be long term (e.g., use of health services; changes in clients' knowledge, attitudes, and behaviors) or short term (e.g., client satisfaction, adherence to recommended treatment). Long-term outcomes may not be the best measure of quality: a patient may receive poor-quality care and make a full recovery or, on the other hand, receive high-quality care and not recover from a chronic or fatal illness. Short-term outcomes—client satisfaction and response to treatment—offer the client's perspective but may not fully reflect other dimensions of quality.

A combination of these three dimensions can yield useful quality measures at relatively low cost.

The traditional facility audit reveals the presence or absence of the essential physical requirements for quality services. Record reviews can be supplemented by observations of client-provider interactions or written vignettes in which providers are asked to take a history, do an examination, order tests, make a diagnosis, and specify a treatment plan.

These observations may give an imperfect picture of what actually happens in unobserved encounters, but they do demonstrate the provider's skills in coping with a variety of clinical conditions. Exit interviews can be used to obtain the client's perspective on the visit and his or her understanding of the diagnosis and recommended treatment.

**Improving quality: Meeting or surpassing standards of performance.** Improvements can pertain to all the dimensions of quality above. To be useful, national standards must be current, evidence-based, and relevant to the services being offered. They should be developed in a process that involves providers, thereby encouraging ownership and adherence by those who are expected to work to the standards.

The standards must be readily available and communicated not only to providers but also to individual clients and community members. It is important for health care providers to tell a client when his or her specific treatment request fails to meet standards of care, to fully explain the reasons, and to recommend the appropriate treatment alternative.

For example, if a patient requests an antibiotic injection to relieve the symptoms of a cold, a health provider can cite the standards for administering antibiotics, explain the reasons for those standards, and offer other options (relief of symptoms) that conform to the standards.

**Improving quality in decentralized settings.** Quality improvement is a particular challenge in settings where decentralization is taking place. Decentralization means that, to varying degrees, central-level managers set policy and plan strategically while local managers take increasing responsibility for providing health care and are held accountable for the health of the populations they serve.



As responsibilities are transferred to managers at peripheral levels, these managers must build experience and acquire new technical and managerial knowledge. The central government, in turn, must build its capacity to set clear national standards and service norms and establish a system for ongoing monitoring of performance.

These new roles should be clearly delineated and agreed to, and the priorities of all levels should be acknowledged. Otherwise, there will be duplication, confusion, and conflict—hardly conducive to improvements in the quality of services.

Experience with decentralization in many countries has shown that it is possible to improve services rapidly while strengthening the capabilities of local health teams. With facilitators from the central or provincial Ministry of Health (MOH) or from NGOs, district or municipal teams engage in a logical, sequenced performance improvement process. They use available data to assess current health conditions and service performance and then select one or two high-priority health concerns to work on. They define desired performance against standards, identify gaps, analyze the causes of the gaps, design their own solutions, mobilize support for implementing the solutions, and monitor their progress to measure changes in performance.

Many of these teams have never worked together systematically to address specific health problems. The performance improvement process gives them experience in a new methodology as well as the gratification of a real achievement: a realistic plan for improving performance in areas that they consider priorities.

## BUILDING AND MAINTAINING QUALITY SERVICES: APPROACHES AND TOOLS

This section briefly describes five approaches that you may find useful in building and maintaining the quality of services in your organization: performance-based financing, from improvement collaboratives, partnership defined quality, COPE (client-oriented, provider-efficient services), and standards-based management and recognition.

**Performance-based financing (PBF).** PBF is a powerful mechanism for improving the quality and increasing the use of health services by setting performance goals based on agreed-upon standards and indicators. The cornerstone of PBF is “payment for performance,” based on a negotiated contract between the funding agency and a service-providing organization. This contract establishes indicators of performance that clearly define performance targets. It requires the organization to complete a set of actions or achieve a measurable performance goal before receiving a transfer of money or goods.

While rewarding the completion of activities and the accomplishment of immediate outputs, PBF capitalizes on these short-term results to achieve longer-term health outcomes. In this way, it encourages governments, NGOs, other private service-delivery organizations, and funding agencies to strengthen management capacity, estimate costs, set fees, and bolster systems for financial and information management.

PBF empowers health managers to allocate resources in a way that rewards meeting health goals. By improving financial and information management capacity and expertise, PBF strengthens the sustainability and performance of ministries of health, district and

### Performance-Based Financing in Action—An Example from Rwanda

**Applying PBF in Rwanda.** PBF is at the core of USAID's flagship HIV/Performance-Based Financing Project in Rwanda, a collaboration between the Rwandan Ministry of Health and Management Sciences for Health (MSH) and its partners. The goal of the project was to support both the quality and quantity of services delivered through health facilities in all of the country's districts.

Initially, the project contracted directly with 85 health facilities to provide incentive payments for quantity in the delivery of specific HIV & AIDS and related services, and with districts to monitor indicators of quality of care. In fewer than two years, the project surpassed its objectives. In comparison to control districts where PBF had not been introduced, the PBF districts achieved significant improvements in the services delivered.

To support this incentive system based on performance, MSH provided technical assistance to build staff capacity, strengthen systems (especially data flow and analysis), and improve QA policies and protocols. For the final two years of the project, PBF was established throughout the national health system, including its more than 400 health centers. The project transferred all its PBF contracts to five partners and concentrated on helping the MOH continue to strengthen its quality improvement management systems, management structure, operations, and information systems.

The HIV/PBF project ended in 2009, but the team has continued to work, via a follow-on project, with the MOH on health systems strengthening.

You can read more about PBF in a [handbook on the subject as well as in the PBF/HIV project's end-of-project report](#).

community institutions, and NGOs. Performance-based grants or contracts have proven effective in increasing the use of health care services, stabilizing or decreasing costs of these services, contributing to the wise use of limited resources, and improving staff motivation, morale, and retention.

**The improvement collaborative approach.** This methodology is designed to rapidly achieve significant—often dramatic—improvements in a focused technical area such as treatment of multidrug-resistant tuberculosis, provision of neonatal care, or management of a chronic disease. Improvement collaboratives supplement the elements of traditional public health interventions (standards, training, job aids, supplies, and equipment) with modern quality improvement features (teamwork, process analysis, monitoring of results, and client satisfaction).

This approach engages large numbers of teams working in different health facilities and geographic areas in a joint effort to improve quality and access by achieving shared objectives in the specified area. These collaboratives seek not only to improve quality at each facility but also to rapidly disseminate successful practices to multiple settings through the efforts of all the teams.

To this end, there are two types of collaboratives.

1. **Demonstration collaboratives** are the initial facility-based teams that work out the details of implementing agreed-upon best practices and then carry out those practices at their sites. The participating teams work together to develop a common set of indicators to measure their desired outcomes. Each team collects data on the indicators for its facility and regularly reports these data to the other teams. Because they track progress and results and share their experiences, teams can quickly benefit from the knowledge gained from both successful and unsuccessful changes by any other team.
2. **Expansion collaboratives** seek to scale up proven improvements, spreading them beyond the initial teams to their facilities and then to a larger group of organizations. In meeting these objectives, participating teams are taking on a challenge, and they can draw on all the managing and leading practices described in Chapter 2 of this handbook.

For more information on improvement collaboratives, the [Quality Assurance Project](#) provides information, as does the [Institute for Healthcare Improvement](#).

**Partnership Defined Quality (PDQ).** PDQ is an easy-to-use tool that can bridge the gap in perceptions of health care providers and community members and make health care more responsive to the needs of communities. It engages communities in defining, implementing, and monitoring the quality-improvement process while helping eliminate social and cultural barriers to better health, strengthening the capacity of communities to improve health, and creating a mechanism for rapid mobilization around health priorities.

PDQ helps community members and providers develop a shared vision of quality improvement that involves agreement on standards of performance, and it empowers them to work together to achieve their vision.

PDQ encourages health care providers and communities to look beyond the health system and seek solutions to health care deficiencies at the community level. Individuals, communities, health-facility staff, and district-level managers form partnerships and take on shared responsibility for improving health services.

Users of the PDQ tool generally form quality improvement (QI) teams so they can help communities continue monitor their own form of quality and maintain improved access to and use of services. Once community members become empowered to work together, they often achieve additional nonhealth benefits in such areas as food security, education, and economic opportunity.

You will find more information about PDQ from the [Extending Service Delivery project website](#).

**COPE (client-oriented, provider-efficient services).** COPE is a quality-improvement process that enables service providers and other staff at a health facility to work with their supervisors to assess their services using self-assessment guides based on international standards and known best practices.

With the guidance of a facilitator, staff and supervisors draw on a variety of mechanisms—especially structured interviews with clients, nonusers of services, and internal customers—to identify problems, find root causes, seek effective solutions, and create realistic action plans. This self-assessment approach creates ownership of and continuing involvement in the quality-improvement process.

Many COPE activities are carried out while staff are doing their routine work, to avoid interfering with the regular work day. Site supervisors are trained to facilitate the COPE process so that they can conduct follow-up sessions and introduce COPE at new sites. Ongoing COPE committees ensure long-term follow-up and ongoing institutional support of the process.

[\*The COPE Handbook: A Process for Improving Quality in Health Services\*](#) offers guidance to COPE facilitators in orienting managers, training site facilitators, guiding facility staff in using COPE tools, and adapting the COPE process and tools to a facility's needs. The handbook is supplemented by COPE tool books that contain the self-assessment guides, record-review checklists, client-interview guides, and client-flow analysis forms.

The [EngenderHealth website](#) also offers information about COPE.

**Standards-based management and recognition (SBM-R).** This is a practical, proactive management approach for improving the performance and quality of health services. Rather than emphasizing problems, SBM-R focuses on the standardized level of performance and quality to be attained by:

- setting performance standards around clearly defined service delivery processes or specific content areas;
- implementing the standards in a streamlined, systematic way;
- measuring progress to guide the improvement process toward these standards;
- rewarding achievement of standards through recognition mechanisms.

#### Standards-Based Management and Recognition in Action in Malawi

In collaboration with the Malawi Ministry of Health, the international health organization Jhpiego has applied SBM-R to infection prevention and control practices, with the goal of protecting clients and health workers from acquiring blood-borne infections and TB. First implemented at seven hospitals in three regions, the Hygiene is Life initiative has now been expanded to 35 hospitals nationwide. Local media coverage has helped generate demand for the initiative at hospitals in others areas of the country and has elicited interest from local leaders, providers, and community members.

You can go to the [Jhpiego website](#) for further information about [SBM-R success stories](#) from other countries.

## Element 2:

### Assuring equitable access for all people and communities

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*...the greatest gains in maternal, neonatal and child survival depend on effectively reaching the poorest and the most marginalized, who suffer the greatest burden of disease.*

Cesar G. Victora

*Towards Greater Equity in Health for Mothers and Newborns*

#### EQUITABLE ACCESS FOR ALL: THE CONTEXT

Among the barriers that delay or prevent poor households from accessing health care, the quality of available care is a critical factor. Clients may choose not to go to health facilities if they have to wait for a long time, if the medicines or contraceptives they need are unavailable, if they do not feel welcomed and respected, or if the facility staff lack the skills to provide appropriate treatment.

However, even when the quality of services is acceptable, other serious barriers exist. The most widely acknowledged are distance, geography, and the opportunity cost of lost time and wages. Social and cultural disparities that are equally critical are often less obvious. One of the most complex is class: differences in economic status, education, language, ethnicity, values and customs, and social standing between clients or potential clients and the health providers who serve them.

Disparities in access lead to highly significant disparities in use of services and, consequently, in health outcomes. Recent studies in several sub-Saharan African countries have looked at a package of four essential interventions: prenatal care, skilled attendance at delivery, postnatal care, and childhood immunization. In sub-Saharan Africa and South Asia, use of these interventions was about four times higher among the richest groups than among the poorest groups. It is not surprising that maternal, neonatal, and child mortality follow the same pattern of marked socioeconomic variations (UNICEF 2009).

Economic, social, and cultural inequities are especially daunting for marginalized groups: the rural poor, slum dwellers, those most at risk for HIV and AIDS, and—increasingly—the elderly. The most effective health service managers and providers in both the public and private sectors are alert to the causes of inequitable access in their communities. They pay attention to their own sociocultural biases and make every effort to recognize the dignity of all clients and treat them with respect and courtesy.

As a health manager or health service provider, you can look closely at your organization's management systems and use management and leadership practices to eliminate or reduce the systemic factors that keep certain populations from making full use of services. For example, you can **scan** service data and constantly **monitor** progress to be sure that your services are reaching the poorest citizens; you can formulate the objectives of strategic and operational **plans** to include the underserved; and you can work to sensitize and **align** colleagues and local leaders around values, systems, and daily activities that promote equity.

The barriers to access are not limited to the marginalized populations mentioned above. Two additional factors can stand in the way of access to appropriate services: gender and age. In this context, we will look at the particular needs of both women and men, and of youth.

## GENDER EQUITY

*[G]ender significantly influences a person's ability to access health services. ... In many places, most women are still marginalized. Their status—economic, social, and political—has ... deteriorated under worsening economic conditions. They often receive far fewer of the benefits from socioeconomic development than do men. The inequities make women more vulnerable to health risks. They are less likely to receive the right services and treatment. ... [And] attitudes towards "masculinity" may result in some men continuing sexual practices that affect their own health and endanger the health and lives of their families.*

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The Manager, vol. 9, no. 3

## GENDER EQUITY: KEY ISSUES

**Defining gender.** As discussed in Chapter 2, by “gender” we mean the characteristics, roles, and responsibilities that society expects of women and men, girls and boys. These expectations are based on social attitudes rather than biological differences. Gender is expressed in the relations between the sexes and in assumptions about so-called appropriate behaviors. Attitudes and expectations related to gender are learned and can change from generation to generation, from culture to culture, and from one social, ethnic, or racial group to another within the same culture.

**Fostering gender sensitivity.** Gender sensitivity moves beyond the traditional focus on inequities that affect only women, without denying a tradition of male dominance that has made women more vulnerable and less powerful. This perspective recognizes that women's ability to benefit from health, education, and economic opportunities cannot be improved without involving men in the process.

If women and men are to be partners in progress, jointly contributing to social and economic development, the goal is not to substitute one group's interests over another's; it is to open up discussion and work toward a new, shared vision in which all will benefit.

This approach takes into account the different roles, social and economic relationships, and access to resources that society imposes on women and men. It recognizes the financial costs, opportunity costs, and social and cultural restraints faced by women and men seeking services. In the realm of health, for example, inequities in influence and power may prevent women from traveling to a health facility for care, or determine their willingness to purchase or use a contraceptive.

On the other hand, societal interpretations of “masculinity” may discourage men from acquiring health information, using condoms, or seeking treatment for sexually transmitted infections (STIs).

## Using a Gender Perspective to Reduce Barriers— Country Examples from Afghanistan, Peru, and Jordan

**Competency-based education of midwives in Afghanistan.** In Afghanistan, maternal mortality—the deaths of women during pregnancy or shortly after giving birth from causes related to childbearing—is among the highest in the world. Geographic barriers and societal restrictions make it extremely difficult for women in rural areas to go to health facilities for prenatal and postnatal care and delivery.

To bring these services to women where they live, USAID’s REACH Program collaborated with the Ministry of Public Health and other stakeholders to introduce competency-based education and accreditation of community-based midwives. The program trained more than 700 women who made the commitment to practice in their own communities after training. The program took special care to guarantee a safe living environment for the students, many of whom were away from their homes for the first time. It included a social network that cared for their children during the training period.

**Autodiagnóstico (self-assessment) in Peru.** The ReproSalud Project, supported by USAID in Peru, was designed to reduce social barriers to women’s access to reproductive health services, including limited power to negotiate within sexual relationships, social isolation, domestic violence, lack of cash, and low self-esteem. It targeted the poorest, hardest-to-reach, most underserved Peruvian women, aiming to improve sexual and reproductive health through individual and community empowerment.

The project featured the *autodiagnóstico*—a self-assessment process that groups of women used to identify their greatest reproductive health concerns or problems and to plan small “projects” to address these problems, the most common of which were vaginal infections, “too many children,” and “suffering during pregnancy.” The results of the *autodiagnósticos* were used to develop training programs for selected community women to qualify as volunteer health promoters and provide basic family planning and reproductive health services in their villages.

The project also worked with village health committees and clinics to incorporate traditional customs (lighting, furniture, position during the birth), creating more comfortable, homelike settings for women during childbirth. The results were impressive: 5,000 women trained and working as health promoters; a contraceptive prevalence rate that increased by 23 percent; and 82 percent of participants having their babies with the assistance of skilled birth attendants.

**Male involvement in Jordan.** USAID supported Johns Hopkins University’s Center for Communication Programs in a six-year initiative that promoted male involvement in family planning and reproductive health in Jordan. By providing credible, accurate information and engaging Islamic clergy, this program counteracted prevailing myths about family planning, reproductive health, and Islamic principles.

Men who were reached through the program significantly increased their knowledge of birth spacing methods, displayed more positive attitudes toward birth spacing, and increased spousal communication and the inclusion of their wives in decisions about birth spacing. A large part of the program’s success was attributed to its respect for and adherence to principles in Islamic *Sharia* (law), the Jordanian Constitution, human rights values, and the values of Jordanian society.



As a manager of a health program or health services, you will increase your effectiveness and bring better health results to your clients if you have a gender-sensitive perspective. You will need to consider women's and men's differing health needs and the constraints they face in accessing services within your geographic area and cultural environment. And you will be the most successful if you engage your entire staff in this endeavor.

**Mainstreaming and sustaining gender-sensitive services.** As a manager or provider, you can take a leadership role in bringing a gender-sensitive approach to your services. You will not need to devote a separate program to gender equity; the most successful organizations mainstream gender across all their programs and services by building and maintaining a core set of skills and attitudes among all staff:

- awareness and understanding of gender issues;
- a commitment to address gender issues that obstruct access to services;
- the ability to adapt systems and procedures to accommodate a gender perspective;
- the ability to design, implement, and evaluate gender-sensitive services and activities.

Your organization should also work to maintain gender equity as much as possible within the local context. This means an appropriate distribution of male and female managers and providers, as well as the assignment of tasks that are appropriate to the skills of staff and the needs of clients, rather than to any traditional gender roles.

## GENDER EQUITY: APPROACHES AND TOOLS

**Gender analysis.** This is a systematic approach you can use to examine factors related to gender in the use of your services, or to design, implement, and evaluate projects. [Appendix A](#) contains a framework for gender analysis that defines the most critical factors that affect the health of women, men, girls, and boys. These include the general environment; the activities of these groups (including paid and unpaid labor); their different levels of decision-making power; their access to and control over resources; and the prevailing gender norms.

With your staff, you can use the gender analysis framework to discuss how each of these factors affects your clients and potential clients, to be sure that your organization's health services fully address the roles, needs, and participation of both males and females.

**Checklist for managing health services with a gender perspective.** You and your staff can use a simple checklist to assess gender sensitivity in your organization and begin to make improvements. The checklist in [Box 3](#) should cover the steps you will take to bring a gender perspective to health services.

There are many examples of creative approaches to addressing gender inequities in health care. Here are three initiatives that brought needed health services to underserved clients by incorporating a gender perspective.



### BOX 3. Checklist for Managing with a Gender Perspective

- Review the reasons for a gender perspective in managing health services.
- Review gender concepts and issues.
  - Introduce gender awareness, conduct a gender analysis, and scan organizational characteristics and systems that have relevance to gender-sensitive services.
- Look at prejudices, biases, and preconceptions that you and others may hold, and examine the evidence that refutes those stereotypes.
  - Set gender-related goals and objectives for your services.
  - Identify strategies, activities, and indicators of success.
- Sustain the gender perspective whenever you undertake new services or activities.
- Share your results and experience with other organizations that could benefit.

## MEETING THE SPECIAL NEEDS OF YOUTH

*The young are the future of society, but they are also very much its present. ...As evidence from statistics and the experience of youth-serving NGOs shows, adolescents who are healthy and happy are better equipped to contribute to their communities as young citizens despite the major shifts occurring in the world they are about to inherit.*

United Nations  
World Youth Report 2003

## THE NEEDS OF YOUTH: KEY ISSUES

**The reproductive health burden for youth.** USAID's [Fact Sheet on Youth Reproductive Health Policy](#) points out that young people in developing countries bear a disproportionate share of unintended pregnancies, sexually transmitted infections (including HIV), sexual violence, and other serious social and reproductive health problems. Young women are particularly vulnerable because of their immature reproductive tracts and societal norms and pressures to have early and unprotected sex.

USAID has set forth policy goals for the reproductive health of youth:

- encouraging healthy, wanted pregnancy
- preventing STI/HIV infection
- improving nutritional status
- reducing harmful cultural practices
- reducing human trafficking and sexual abuse/coercion
- stimulating economic development and reducing poverty

To contribute to meeting these six policy goals, organizations that are concerned with youth need to recognize that young people tend to have less access to accurate information about HIV and other STIs, family planning options, and other reproductive health issues than adults do. They are less likely to seek services because of stigma, societal pressures, cost, and fear that they will be looked down on by health providers.

In fact, many health providers refuse to diagnose and treat youth with STIs or other reproductive health concerns, or to offer family planning advice and methods either because of restrictive policies (local or donor driven) or because they disapprove of sexual activity among young people.

## THE NEEDS OF YOUTH: APPROACHES AND TOOLS

**Community education and advocacy.** As a manager or provider of health services, you can make a major contribution to the health of the young people in the communities you serve by recognizing and explaining that pregnancy, HIV, and STIs are health concerns rather than moral issues. You can advocate for comprehensive sexuality education programs in schools, which give youth the information they need to make sound reproductive health choices while respecting local values.

The [Interagency Youth Working Group \(IYWG\)](#) is a useful resource in this effort. Funded by USAID, this is a network of NGOs, donors, and cooperating agencies that provides global technical leadership to advance the reproductive health and HIV & AIDS outcomes of young people.

IYWG shares research and lessons learned with the reproductive health, HIV, and youth development communities; promotes strategies that move promising research findings and best practices into programs and policies; and advocates for greater focus on youth within reproductive health and HIV programs. The IYWG network brings information to those working with young people through [Youth InfoNet](#), a monthly electronic publication with program resources and research summaries.

**Youth-friendly services.** Youth-friendly reproductive health care is best provided through stand-alone clinics or “youth corners,” where nonjudgmental providers make sexually active, unmarried youth feel welcomed and comfortable. These facilities should provide comprehensive, confidential reproductive health services that include STI care, family planning, and voluntary counseling and testing for youth. They should have staff skilled in counseling young people on sexuality, safer sex, pregnancy prevention, and STI and HIV prevention.

The most youth-friendly settings engage young people as full partners in planning and implementing projects. They seek recommendations from youth—both clients and nonclients—on changes to make services more comfortable and responsive. They involve youth in making decisions about how services are delivered through focus groups, interviews, or membership on advisory committees. And they recruit, train, and supervise peer counselors, providing nonmonetary rewards for good performance.

You can find a helpful guide in [“A Rapid Assessment of Youth Friendly Reproductive Health Services.”](#) This hands-on tool is designed for managers and providers to assess and improve youth services. Staff can record data covering background information, client volume, range of services provided, schedule of available services by each day, and details related to personnel and supervision. The guide includes sections where staff can record information on 12 youth-friendly characteristics: location, hours, facility environment,

staff preparedness, services provided, peer education/counseling, educational activities, youth involvement, supportive policies, administrative procedures, publicity/recruitment, and fees.

Introducing youth-friendly services may require cross-sectoral or cross-departmental planning at the central level of the Ministry of Health and other ministries, with some redistribution of line items in the budget.

### Young People in Action—Country Examples from Haiti and Mozambique

**Leadership development for youth in Haiti.** In Haiti's Cité Soleil, young people have participated in the first Leadership Development Program (LDP) for young people, supported by USAID and cofacilitated by MSH with two local organizations, *Fondation pour la Santé Reproductrice et l'Education Familiale* (FOSREF) and *Maison l'Arc-en-Ciel* (MAEC), as well as Haiti's Ministry of Health.

Over several months, participant teams learned the practices of leadership and management and applied these practices to HIV & AIDS and other sexual and reproductive health challenges in their communities. They set measurable goals, drew up action plans, and reached out to mobilize other community members. By the time they completed the LDP, the teams had trained 4,450 young people on HIV prevention; trained another 252 youth on issues related to HIV & AIDS discrimination and stigmatization; and trained 90 youth as peer educators to do further outreach on HIV prevention, sexually transmitted infections, and teen pregnancy prevention.

#### Excerpts from a rap song created by young LDP participants (translated from Haitian Creole)

*AIDS is our biggest challenge and its spread has caused much suffering.  
Confronting this challenge will not stop the disease  
But it is a way to prevent others from being infected. ...*

*Listen to why leadership and management go hand in hand:  
If you're informed, you can plan, you can concentrate, organize.  
One must have vision, clarity, support to confront challenges.*

*Young people, stand up! Let us engage in this struggle together."*

**Preventing HIV among youth in Mozambique.** Pathfinder International's Youth in Action project strengthened school- and community-based initiatives to prevent HIV among adolescents and other youth in Mozambique. Working through local youth associations and NGOs, the project enabled young people in one district to not only protect themselves from STI/HIV infection but also develop and maintain healthy lifestyles; it engaged the youth as advocates for change in their communities, capable of impacting the knowledge, attitudes, and practices of their generation. The project, supported by Trocaire, an Irish NGO, emphasized building the capacity of youth associations to develop and maintain their own sustainable programs and to advocate for local and national policies and programs favorable to youth-oriented services.

## Element 3: Providing integrated services

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*The limited evidence available suggests that integrated approaches to delivering health services, compared with vertical approaches, improve outcomes in selected areas. ...In practice, most health services combine vertical and integrated elements, with varying degrees of balance between them.*

WHO European Ministerial Conference on Health Systems  
Policy Brief, 2008

### PROVIDING INTEGRATED SERVICES: THE CONTEXT

The debate about the advantages and disadvantages of integrated and vertical services has persisted throughout the history of foreign assistance. Those who are in favor of **vertical services**—those which focus on a specific demographic population, disease, or health intervention—point out the following advantages to vertical services:

- Staff roles and responsibilities can be clearly defined and focused on a set of tasks that individual staff can reasonably master.
- It is easier to make rapid decisions, monitor progress, and evaluate results.
- Vertical services can usually muster more resources to address public health crises.
- Integrated services can require systems and skills that place too great a burden on service providers, supervisors, and managers, leading to a decline in the quality of care in all services.

Those who support **integrated services**—packages of preventive and curative health interventions that address interrelated health problems for large populations—respond with the following:

- Integrated services offer more convenient and comprehensive services to the client.
- They make possible more streamlined and cost-effective management systems and subsystems (supervision, clinic schedules, logistics, etc.) at the service delivery site.
- Integration is already a reality at lower-level facilities, where one or two people provide all services.
- The formal integration of systems supports providers in sharpening their counseling and clinical skills.
- Top-down vertical programs foster confusion, duplication, and waste by imposing different funding mechanisms, training curricula, supervisory systems, information systems, and reporting requirements on providers.

The [WHO website](#) offers more information about integrated services, as do two issues of *The Manager*, [one](#) about managing integrated services, and [the other](#) about integrating STD and HIV Services into reproductive health settings. In addition, an MSH [position paper](#) describes a systems approach to combating HIV & AIDS.

## PROVIDING INTEGRATED SERVICES: KEY ISSUES

**Defining integration.** Integrated health services can be defined along a continuum, ranging from the narrowest sense—the combination of two formerly separate services into a single, coordinated service—to a full package of preventive and curative health services available at a multipurpose service delivery point under one manager.

The definitions also vary with the different perspectives of clients, providers, health managers, and policymakers.

- For the **client**, integration means health care that is seamless, easy to navigate, and coordinated. It means not having to make separate visits to a health facility to address different health concerns. It means both health workers who care for the whole person rather than for one particular illness and good communication among health workers at different levels of the health structure.
- For **providers**, integration means coordination of the management systems for different technical services, particularly management of medicines, information, and finances. This coordination differs at different levels of the system. At the primary level, where there is often only one health worker, integrated delivery of services is a reality, but his or her job may be made easier or harder depending on how management support systems are organized. A tertiary hospital, at the other end of the spectrum, will be staffed by several specialists who need to communicate well to coordinate the care of each patient and to use equipment, supplies, space and staff efficiently.
- For **health managers and policymakers**, whether at district, provincial, or national levels, integration happens when leaders of different technical programs in public, private, and voluntary health sectors break through the walls that divide them and make joint decisions on policies, financing, regulation, and delivery.

**Blending integrated and vertical services.** Despite the arguments for and against integrated and vertical services, the trend throughout the developing world is toward integration of related services, even within vertical programs. Good examples are the integration of HIV prevention, treatment, and care with TB services under the US President's Emergency Plan for AIDS Relief (PEPFAR), or the addition of Vitamin A or bednets to national immunization days.

The decision to integrate is generally made at the highest levels of donor and government agencies. However, you need to work productively under whichever approach prevails at your level. The challenge is to make sure that the basic package of health services—however that package is defined in your setting—is available to all those who come to a service delivery site.

The availability of a basic package of health services would mean that, at the service delivery site, health workers are trained and supervised to provide the full range of services—or to refer clients to a higher-level facility—in a way that assures access, makes effective use of service staff, guarantees privacy, and minimizes costs (including time lost) to those who seek those services. At higher levels, it requires a coordinated, multisectoral approach to support and reinforce the services.

**Preventing missed opportunities.** One of the strongest arguments for integrating services is the potential for using a client visit to recommend or provide interventions beyond those that the client is seeking. For example:

- When a mother brings in a sick child, a nurse who has been trained to provide integrated services can give nutritional advice, provide or schedule immunizations, and counsel the mother on family planning. He or she can inquire about the health of other family members and identify warning signs of potential problems.
- A patient who comes for curative care can be offered a wide range of preventive services for her/himself and other family members.
- A prenatal visit can be the occasion for STI diagnosis and treatment, HIV counseling and testing, and, if appropriate, services for prevention of mother-to-child transmission (PMTCT).
- A patient who is receiving HIV services of any kind is a candidate for STI prevention and detection, family planning counseling, services to help prevent HIV transmission, and diagnosis and treatment of tuberculosis.

There are many instances where two or more existing vertical programs are brought together into an integrated package of services; two are shown in Box 4.

All forms of integration will require changes that may be difficult for managers, providers, and other stakeholders. The shift from vertical to more integrated programs cannot take place without political, technical, and administrative action throughout the broad health system, beginning with commitment from donors and the top tier of government.

#### BOX 4. Shifting from Vertical to Integrated Programs

**Integrating management of childhood illness.** Integrated management of childhood illness (IMCI) is a strategy to address the five major causes of under-five death in the developing world: diarrhea, pneumonia, malaria, measles, and malnutrition. The IMCI strategy is based on the realization that many children present with overlapping signs and symptoms of diseases, making a single diagnosis and treatment inappropriate.

Under IMCI, health workers are trained to assess, classify, and treat the whole child, rather than dealing with only one specific health problem. The strategy includes facility-based care, home care and care seeking, treatment at the community level, and referrals to and supervision from facilities. IMCI also recognizes the importance of improving the management systems that support these workers: drug supply, supervision, financial management, and information systems. In India and some other countries, neonatal care has been added to the package, and IMNCI has become the new acronym for this integrated approach.

**Integrating HIV prevention and family planning.** Another recent instance of integration is between HIV and family planning, two programs that have traditionally been quite separate. The benefit of integrating these services is to avoid the missed opportunities that have become increasingly apparent as more women and men of reproductive age become infected with HIV or are at risk of infection.

Key messages about unprotected sex and the communication and negotiation skills that people need to make responsible choices are at the core of successful efforts to reduce HIV transmission and avoid unintended pregnancy.

The shift may place a severe strain on programs that have been receiving financial and technical assistance focused on one health issue. Within a decentralized system, management and leadership skills are required at each level to support and coordinate the needed changes in policy and financing, and in institutional systems, processes, roles, and responsibilities.

Those who have worked under a mostly vertical system are likely to be loyal to it and resistant to changes in practices with which they have become comfortable. Managers of newly integrated programs must have the understanding and determination to help stakeholders (including staff) through the change process. Providers of integrated services will need solid training and ongoing supervision to master the new skills to search for, diagnose, and resolve complex problems covering a range of health components.

providing integrated services: approaches and tools

**Guidelines, frameworks, and checklists for integrating HIV and family planning.** A [K4Health Toolkit](#) includes links to guidelines, research, job aids, and other resources and tools for integrating family planning and HIV services.

A 2007 USAID [document](#), *A Framework for Integrating Family Planning and Antiretroviral Therapy Services*, includes comprehensive charts of entry points and levels for integrated family planning and HIV information and services.

Many programs are a combination of vertical and integrated systems and services. The Electronic Resource Center section on [Managing Integrated Services](#) includes the Sample Integration Assessment Checklist, which you can use to analyze the extent to which your organization's or program's management systems are integrated.

This tool covers eight systems: planning/budgeting, internal organization, staff roles and responsibilities, training, supervision, logistics (including vehicles), management information systems/monitoring, and client services. It describes the characteristics of fully vertical, mixed, or fully integrated management for each of these systems and offers suggestions for improving the systems to make an integrated program more effective.

**Integrating TB and HIV testing in Rwanda.** Tuberculosis is the most common opportunistic disease and leading cause of death among people who are HIV-positive. Testing HIV-positive people for TB and TB patients for HIV enables them to be treated for and counseled on living with both diseases.

With funding from PEPFAR, Rwanda has developed national protocols for integrating TB and HIV testing. HIV-positive clients in all health centers are being tested for TB, and between 2005 and 2006, the percentage of TB patients tested for HIV rose from 40 percent to 75 percent. PEPFAR/Rwanda's success in rapidly integrating TB and HIV & AIDS interventions is credited to cooperation with the Government of Rwanda, the ability to do HIV testing in TB wards, and the widespread use of community-based education and case management.



**Integrating family planning into HIV care and treatment in East Africa.** In the mid-1990s, Pathfinder International recognized that many HIV-positive women in East Africa were not obtaining contraception at health facilities because providers felt that they should not be sexually active. To combat this discrimination, Pathfinder added a multi-country community home-based care (CHBC) program into its community-based family planning distribution.

Under the integrated program, volunteers in Ethiopia, Kenya, and Tanzania have been trained to provide HIV-positive clients, their households, and community members a full spectrum of HIV prevention and AIDS care and support services. The volunteer CHBC providers are especially suited to address the family planning needs of HIV-affected households because many of them are HIV-positive themselves. This integrated service is building synergies for safer sex education, promotion of dual protection, and reduced stigma.

## Element 4: Scaling up

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*At times, good ideas spread of their own accord. They may be so groundbreaking, involve such pioneering technology and meet such pressing needs that they proliferate seamlessly. Most good ideas, however, do not spread with such ease. They require the backing and energies of committed individuals and organizations to design and carry out strategies for expansion that are carefully tailored to the realities of their settings. The question of sustainable scaling up is at issue.*

Ruth Simmons, Peter Fajans, and Laura Ghiron  
Scaling Up Health Service Delivery

### SCALING UP: THE CONTEXT

There are many definitions of scale-up. A WHO Technical Brief, “Scaling Up Health Services: Challenges and Choices,” offers one of the clearest and most comprehensive: “the effort to magnify the impact of health service innovations successfully tested in pilot or experimental projects, so as to benefit more people and to foster policy and programme development on a lasting basis” (WHO 2008b).

This definition implies that equity and sustainability are essential elements of scale-up. The definition applies not only to innovative pilot programs; it is equally applicable to increasing coverage for well-recognized interventions such as immunization and birth spacing.

WHO delineates scale-up at four levels that mirror the results levels discussed in this handbook in the section of Chapter 9 titled “Frameworks for the Design and M&E of Health Services”:

- **inputs/resources:** mobilizing more funds, more staff
- **outputs:** providing more services (access, range); performing better (quality, efficiency)
- **outcomes:** reaching more people (coverage), attracting more clients (utilization)
- **impact:** reducing morbidity or mortality



## SCALING UP: KEY ISSUES

**Choosing and adapting evidence-based practices.** You will want to gather information on practices that have been successfully scaled up in comparable service delivery contexts. You are likely to find many appealing examples from a variety of settings. Your task is to select the most appropriate practices from those that you have considered—practices that you and your staff have the capability and resources to adapt for your organization’s needs.

You may then need to make the case for your choices with decision-makers in and beyond your organization, persuasively communicating the results of your search and the justification for choosing to adopt new practices.

Finding freely available information about evidence-based practices on the Internet requires you to seek accurate, trustworthy sources and weed out those that might seem convincing but are actually biased, inaccurate, and misleading. Start with focused searches of reputable websites such as those listed in [Box 5](#).

Here are some tips for getting the information you want from a website.

- Using the subject headings provided on websites, rather than searching for key words, will often unearth information faster.
- If you must use key words in your search, define your topic as precisely as possible. For example, a search for “children HIV AIDS Africa programs 2007 to 2010” will return more pertinent information on current interventions than simply “children HIV AIDS Africa.”
- Search engines such as Google or bing! may point you to subscription-only journals, which limit the amount of information you can obtain at no cost. You can work around this challenge by using “information portals”—sites that consolidate different types of information from many sources. WHO’s [Global Health Library](#) ([www.globalhealthlibrary.net](http://www.globalhealthlibrary.net)) and the US Government’s [Partners in Information Access](#) ([www.phpartners.org](http://www.phpartners.org)) are good examples, as are the [Cochrane Library](#) and [Knowledge for Health](#) websites described in [Box 5](#).
- Not all journals are subscription-based. [The Directory of Open Access Journals](#) ([www.doaj.org](http://www.doaj.org)) links to numerous public health journals whose contents are peer-reviewed and made freely available around the world. Many of these journals are included in the information portals noted above.

**Identifying and addressing constraints.** If change in general is so prevalent in the health sector, why is scale-up so difficult and successful scale-up so rare? In general, failures are attributed to limited resources and formidable geographical, political, and sociocultural barriers. These general constraints are manifested in four areas:

- **disbursement of funds:** the lack of funds or, even when funds are available, the absence of an efficient system for disbursing them;
- **communication:** unshared technical and financial information, which otherwise would allow people in many places to adapt the intervention(s) to suit their own local values or circumstances;
- **demand:** the failure of demand for services to match the scaled-up supply;
- **the political and legal environment:** policies or laws that block progress.

#### BOX 5. Some Internet Sources of Information on Evidence-Based Practices

- **Cochrane Library** (<http://www.thecochranelibrary.com/view/0/index.html>) provides information on the effects of clinical practices and reviews interventions that are intended to help health workers make informed decisions.
- **Knowledge for Health** (<https://www.k4health.org>) offers information on practices for family planning/reproductive health and HIV & AIDS, with toolkits for training, policy, knowledge, and advocacy. The site houses five free online courses on specific diseases, policies, and practices. Within this site, you will find Family Planning: A Global Handbook for Providers, which contains up-to-date information and guidelines for all family planning methods.
- **The Lancet Series** (<http://www.thelancet.com/series>) is a collection of related articles that address clinically important topics and areas of health and medicine often overlooked by mainstream research programs and medical publications. For example, the Series theme in January 2010 was neglected tropical diseases.
- **MedLine Plus** (<http://www.nlm.nih.gov/medlineplus/healthtopics.html>) is jointly produced by the National Institutes of Health and the US National Library of Medicine. MedLine Plus provides basic information on numerous health topics; links to up-to-date research, including clinical trials; and dictionaries and glossaries.
- **MSH Health Manager's Toolkit** (<http://erc.msh.org/toolkit>) is a compendium of tools developed and tested by organizations throughout the world that are helping health professionals provide accessible, high-quality, sustainable health services.
- **The Joint United Nations Programme on HIV/AIDS (UNAIDS) Knowledge Center** (<http://www.unaids.org/>) provides many resources related to HIV and AIDS. The site provides a wealth of information about UNAIDS policies, each of its 10 targets and HIV/AIDS elimination commitments, regional and national data, publications, and other resources.
- **World Health Organization Health Topics** (<http://www.who.int/topics/en/>) contains general and technical information and recent publications about a wide range of health topics, as well as information about WHO programs that focus on particular health areas.

Underlying these constraints may be not only a lack of managerial or technical capacity on the part of potential adopters of an intervention but also the absence of a political commitment or local ownership.

The conference on Scaling up for Health organized by BRAC (an international NGO primarily focused on economic development), the Gates Foundation, and the Rockefeller Foundation (IDS 2008), defined key requirements for overcoming barriers to scale-up:

- Planning for scale-up at the outset of an intervention;
- Drawing on a set of skills different from those needed to develop the intervention. These include political analysis (to know who will win or lose from the proposed changes); institutional analysis (to assess the capacity of organizations to scale up and regulations to change, as needed); mobilization (to generate demand); communication (to craft messages that explain and encourage effective use); risk assessment (to allow for and manage unanticipated events);

- Acknowledging failure and learning from it. This requires the ability to solve problems as they arise and the flexibility to move in new directions when events do not work as planned;
- Conducting monitoring and evaluation during both the trial and scale-up, to distinguish between the effectiveness of the intervention itself and the effectiveness of the scale-up process, as well as to track costs in both phases.

**The call for intersectoral collaboration.** Recent sources of health funding—the Global Fund to Fight AIDS, Tuberculosis and Malaria; PEPFAR; the President’s Malaria Initiative (PMI); the World Bank—reflect an understanding that no single sector can successfully address all constraints and bring about all needed changes.

Collaboration for scale-up usually involves both the public and private sectors, which make their unique contributions by reaching different population groups, working in different settings, providing different kinds of technical and management expertise, and developing innovations geared to different needs. Intersectoral collaboration for scale-up of health practices can also bring to bear the contributions of all the economic/social sectors—not only health care but also education, agriculture, and industry.

**Scale-up and change.** Scale-up at any level requires changes in clinical practices, health care providers’ practices, management practices, and management systems. Resources must be reallocated and roles adapted, possibly resulting in loss of status for some people. Larger scale-up may involve changes in organizational strategies and structures. Over the years, health and development professionals have learned that successful change takes time and strong leadership.

All who are working to improve health—from international donors to clinic nurses to village leaders—are involved in encouraging, leading, or implementing change. According to Everett Rogers, pioneer of the diffusion of innovations theory about how new ideas, products, or behaviors spread, there are five kinds of adopters (2003). The characterizations that follow apply to both individuals and organizations.

- **Innovators.** Innovators are relatively rare; they are the first to embrace a new idea, technology, or approach, even if it involves risk.
- **Early adopters** are not far behind, and they adopt new ideas as soon as benefits are apparent. They are quick to see how a new practice can help them reach their goals and are also willing to take on risk.
- **Early majority** and **late majority.** Together, these groups include more than half the population. The early majority wants proof of benefits, ease of adoption, and reasonable cost. The late majority dislikes risk, is uncomfortable with new ideas, and is even slower and more reluctant to adopt innovation.
- **Slow changers.** These laggards are usually a small percentage of any group. They might resist the change until they can no longer discount improved results or are required to adopt the new practice if they are to keep their jobs.

You are likely to find that people react to change in a variety of ways. Key roles in the diffusion of innovations follow.

- **Opinion leaders.** Opinion leaders can spread ideas through their social networks, and their ideas and behaviors are important to others. The support of an opinion leader will help you implement change.
- **Change agent.** If you are convinced that a practice or set of practices that has worked in one setting can be scaled up to improve services in other settings, you can act as a change agent, transmitting your commitment and enthusiasm and gaining the buy-in of those staff members who will do the hard, day-to-day work of implementing the change.
- **Change team.** The task will be much easier if you work with a change team that shares your view of the importance of the new practices. The majority of staff need to become aware of how the changes will help meet an organizational challenge and improve the care of clients.

No matter which category they fit into, potential implementers must be convinced that the new practice:

- addresses identified challenges and offers clear benefits to them and to the people they serve;
- can be tested without a huge investment or risk;
- is consistent with organizational values;
- can be carried out without seriously disrupting current services.

## SCALING UP: APPROACHES AND TOOLS

**A conceptual framework and steps for a scaling-up strategy.** The publication *Practical Guidance for Scaling Up Health Service Innovations* provides a framework that offers a context and process for scale-up efforts (WHO 2009). This conceptual framework encompasses five essential elements of successful scale-up:

1. The **innovation** (a health intervention or package of interventions);
2. The **user organization** (the organization that is expected to adopt the innovation);
3. The **external environment** (conditions and institutions that affect the prospects for scaling up);
4. The **resource team** (individuals and organizations that will promote wider use of the innovation);
5. The **strategic choice areas** (plans, actions, and strategic choices for establishing the innovation in policies, programs, and services).

These elements translate into the steps needed for successful scale-up. The framework is grounded in the principles of “respect for, fulfillment of and promotion of human rights. This means integrating human rights norms into scaling-up initiatives, including human dignity, attention to the needs and rights of vulnerable groups and an emphasis on ensuring that quality health services are accessible to all” (WHO 2009).

## Building on Experience, Data, and Enthusiasm to Scale Up— Country Examples from Senegal and Egypt

**Scaling up postabortion care (PAC) in Senegal.** In the late 1990s, the Ministry of Health of Senegal initiated a pilot study of a postabortion care model based on community and service provider partnerships; counseling; treatment; contraceptive, family planning, and reproductive health services; and other health care services. The pilot study showed that the PAC model could work well in secondary and tertiary settings. Later studies conducted by IntraHealth and EngenderHealth in a few rural districts showed that the model could also succeed at primary and community facilities.

On the basis of these studies, MSH collaborated with the Ministry of Health to implement the model in 23 rural health districts that covered more than half the population of Senegal. The scale-up had four phases. It began with an assessment of availability and quality of postabortion treatment in rural areas. It then provided training geared to the capabilities and needs of providers and supervisors, nearly 90 percent of whom were midwives, nurses, and counselors at health posts and health centers. Data were collected through a PAC register at all intervention facilities.

Finally, the scale-up effort incorporated supportive supervision that engaged providers, district health care management teams, and well-educated community members in planning and implementing PAC improvements. This carefully phased scale-up more than doubled the number of women seeking and receiving PAC services at health posts and clinics and quadrupled the number leaving the facility with a modern family planning method.

**Scaling up good leadership and management in Egypt.** When the Aswan Governorate in Egypt completed MSH's leadership development program in 2003, the 10 participating teams—doctors, nurses, and outreach workers from hospitals and clinics throughout the region—were so enthusiastic about the results they had achieved that they continued the program with their own resources.

By applying leadership and management practices to health care service challenges, they had significantly improved service delivery indicators and the operations of primary health units.

They saw striking changes in the way staff worked with their coworkers and the way clients were being cared for.

One and one-half years later, the program had spread to cover 78 rural health units in five districts of Aswan, and the ground was laid to scale up the program nationally. Participants in the second year of the LDP increased the volume of prenatal and child care visits, created a new medical information system, and increased the use of contraceptives. Program materials were standardized, new LDP facilitators were recruited and trained, and management systems were strengthened to provide continued support for the effort in other governorates across Egypt.

In 2005, 15 doctors from Afghanistan visited the Aswan program, saw the similarities in the concerns and cultures of Afghanistan and Egypt, and returned to initiate a highly successful leadership development program in their own country.

**The improvement collaborative approach.** As described under [Element 1: Establishing and Maintaining High-Quality Services](#), this approach engages teams at different sites in a joint effort to meet common objectives. In addition to the focus on quality, improvement collaboratives are designed to scale up improvements by rapidly disseminating successful practices to the organization(s) participating in the collaborative and eventually to other organizations as well.

**The change process.** To scale up relatively small changes, health managers and providers can implement the change process in phases that reflect the management and leadership practices:

- **Phase 1:** Recognize a challenge—the gap between desired achievement and actual achievement. ([Scan](#))
- **Phase 2:** Identify promising practices for improving services. ([Focus](#))
- **Phase 3:** Adapt and test one promising practice or set of practices to make sure it fits the context and to work out any difficulties in a limited setting. ([Organize](#))
- **Phase 4:** Implement the new practice(s), building a support base that will make it possible to move from adaptation to actual application. ([Organize, align/mobilize, implement](#))
- **Phase 5:** Scale up the successful new practice(s) and the systems that underpin it. ([All managing and leading practices](#))

## Element 5: Providing community-based primary health care

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*The gathering of health ministers from around the world at Alma-Ata, Kazakhstan, in 1978 was arguably the most influential meeting of its kind in the history of public health. The Declaration of Alma-Ata remains one of the most influential yet debated documents in the field of health, with its call for meaningful involvement of communities in the design and control of affordable health services. Can it work for the billions of poor today?... Surely yes!*

Jon Rohde and John Wyon

*Community-Based Health Care: Lessons from Bangladesh to Boston*

### COMMUNITY-BASED HEALTH CARE: THE CONTEXT

What are the characteristics of successful, lasting community-based health services?

A task force of the International Health Section of the American Public Health Association recently completed a study of the effectiveness of community-based primary health care (CBPHC) in improving the health of children in high-mortality, resource-poor settings. The reviewers studied CBPHC programs that had been in effect for 10 years or more and had succeeded in improving the health of children. In all instances they found:

- a broad array of primary health care services, including family planning and reproductive health;
- referral for care at higher levels;
- use of CHWs and support for them through strong training and supervision;



- routine, systematic home visits;
- a strong partnership between the community and the government health program;
- a high level of community trust in the health program;
- treatment of clients with a high level of respect.

The challenge for managers and providers is to bring these characteristics to life in the communities they serve.

## COMMUNITY-BASED HEALTH CARE: KEY ISSUES

**Building community participation.** Communities that engage actively in promoting, delivering, and supporting their health services have a greater understanding of and commitment to healthy choices. Engaged communities establish an environment that encourages more residents to use health services.

Their involvement makes it more likely that they will contribute financially and in-kind and will help identify supplementary funding sources outside the community, enabling health programs to reach new segments of the population. Community participation also brings local solutions to service delivery problems, responding directly to the concerns and needs of clients and potential clients.

To reap these benefits, the participation must be real and meaningful. National policy must actively promote community involvement and give civil society organizations, community advisory committees, formal and informal community leaders, local government, and community-based providers a substantive role in decisions about their health services. To play their roles effectively, these groups and individuals need to build skills in planning, training, supervision, and monitoring of activities and funds.

**Community-based delivery of health services.** The delivery of health services within the community depends on community health workers (CHWs): community members who are motivated, thoroughly trained, and well supervised, and who have the medicines and supplies they need to provide health education and basic care to their neighbors.

CHWs can perform a wide range of services. They can promote healthy lifestyle choices, provide preventive care, monitor the community's health, identify patients at particular risk, diagnose and treat common conditions, provide basic curative services, and distribute condoms and resupply oral contraceptives and injectables. They can make referrals to health facilities and act as the critical liaison between the community and the facilities, interpreting the social climate to facility-based providers and acting as a first alert for emerging public health issues.

The range of services CHWs are permitted to provide is largely determined by government policy. In many countries, a lack of effective leadership and vision at the national and provincial levels has prohibited CHWs from providing care that could have a real impact. One example is the reluctance of governments to allow CHWs to treat children with pneumonia with antibiotics—despite a joint statement in which WHO and UNICEF endorsed this practice (WHO/UNICEF 2004).

Another example is the refusal of some authorities to allow CHWs to administer contraceptive injections or resupply oral contraceptives.

When doctors or nurses are unavailable and health facilities are inaccessible, these restrictions mean that clients are left without any effective services to meet common health needs.

**Community links with health facilities.** Health facilities are critical for the performance of several functions that support community-based care: the training and supervision of CHWs, referrals and counter-referrals, lab tests, and, in some settings, the provision of pharmaceuticals and medical supplies.

The quality of CHWs' work depends largely on the quality of training and supervision provided by facility-based staff. Trainers and supervisors need to be secure in their knowledge of all the areas for which the CHWs are responsible. They need specific skills to provide hands-on adult learning experiences geared to the educational levels, culture, and values of CHWs.

Trainers and supervisors also need to be able to provide supportive supervision that features two-way communication as well as performance planning and monitoring. And they need a reliable source of medicines, contraceptives, and other supplies; a safe place to store them; and systems for procuring and distributing them, as detailed in Chapter 8 of this handbook.

The health facility also functions as the repository for the referral of patients for more complex services: long-term contraceptives, treatment of severe illnesses, or response to danger signs. *Community Case Management Essentials: Treating Common Childhood Illnesses in the Community* (CoreGroup, Save the Children, USAID 2009) points out that the most efficient referral systems have proven to be those in which the CHW:

- provides initial treatment prior to referral;
- promotes compliance by counseling families about why referral is necessary and making a formal written referral;
- monitors the referral process by:
  - recording referrals in a register
  - receiving a “counter-referral” from the facility health worker—a note to the CHW stating the outcome and explaining desired follow-up;
  - tracking the referral and counter-referral in a health information system and discussing the process in supervisory visits or monthly meetings;
- addresses geographic and financial barriers to referral by doing one of the following:
  - inquiring about barriers and working with the family to address them;
  - identifying a source of funds or emergency transport at the community level;
  - accompanying the family to the health facility to ensure that they receive immediate care.



## COMMUNITY-BASED HEALTH CARE: APPROACHES AND TOOLS

**Community case management (CCM).** Community Case Management (CCM) is a strategy to deliver lifesaving curative interventions for common childhood illnesses where access to facility-based services is low. The publication cited above, *Community Case Management Essentials: Treating Common Childhood Illnesses in the Community*, is a “how-to” guide for program managers to use in starting a new CCM program, improving an existing one, or expanding CCM to new geographic areas. It provides operational guidance to design, plan, implement, monitor, and/or advocate for CCM that responds to local needs (CoreGroup, Save the Children, USAID 2009).

*Community Case Management Essentials* was developed by a network of NGO partners that generates collaborative action and learning to improve and expand community-focused public health practices for women of reproductive age and children under five. This guide draws on the experiences of 18 CORE Group member organizations that have worked with Ministries of Health, USAID, and community-based partners to implement long-lasting CCM programs in more than 27 countries.

**Community COPE.** This approach is an adaptation of the COPE (client-oriented, provider-efficient services) process discussed under [Element 1: Establishing and Maintaining High-Quality Services](#). Community COPE encourages the community to take ownership of quality improvement at facility and community levels. It helps supervisors and staff at service delivery sites gather information from the community about the strengths and weaknesses of the facility’s services, and it engages community members in helping remedy the weaknesses. Community COPE involves a participatory process with tools for each phase:

- meeting with local leaders
- identifying community groups to work with
- conducting participatory activities
- developing, prioritizing, and implementing an action plan
- ensuring ongoing quality improvement (EngenderHealth 2002)

**Community mapping in Bangladesh.** In the late 1980s, Technical Assistance Incorporated (TAI) and MSH worked with field-workers and community volunteers in Bangladesh to develop a type of community mapping known as ELCO maps, showing where ELigible COuples (married couples of reproductive age) lived and what method of contraception they used.

More than 33,000 volunteers, most of whom could not read or write, were trained to talk to their neighbors about family planning and to distribute contraceptives. To track their efforts, they drew simple maps that provided a quick, accurate picture of a community and its family planning needs. ELCO maps proved useful on every level—from the community volunteers and their supervisors to regional health professionals and government officials.

The technique was later adapted in India to enable community health volunteers to track prenatal and postnatal care, immunizations, and child health services as well as family planning. They used ELCO maps to plot the best routes for home visits; track clients’ health status; motivate clients to adopt healthy behaviors and use health services; and provide follow-up.

**The community mirror in Guinea.** In USAID's PRISM Project in Guinea, MSH introduced the community mirror or *miroir de santé communautaire*—a tool that helps communities monitor their health needs so that they can advocate for services to meet those needs.

The “mirror” is a chart that uses pictures to depict health areas that community members feel are most critical. For each area, activities are counted each month and written in columns. For example, in the area of child health, one community mirror provided columns to track the children who came to the CHW with diarrhea and how many of them received oral dehydration salts.

Each month, representatives from several villages come together to compile and compare the information in their community mirrors and provide the results to the regional health center. The community mirror is displayed publicly in the village so that all villagers can see and learn about the status of their village's health. They can then use that information to advocate with their CHWs and health facilities for improvements in services.

## Element 6: Working with the private for-profit sector

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*The objective is to use the private sector more effectively to meet public health goals by identifying policies that can improve the quality, distribution, and cost-effectiveness of the private production of health services.... In the simplest terms, the desired public-private mix is often assessed as a matter of balancing efficiency and equity considerations. From this perspective, the private sector is typically seen as being more efficient and the public sector as more equitable.*

Carlos J. Cuéllar, William Newbrander, and Gail Price  
Extending Access to Health Care through  
Public-Private Partnerships: The ProSalud Experience

### WORKING WITH THE PRIVATE SECTOR: THE CONTEXT

The private sector covers a broad array of entities, including civil society organizations, nongovernmental organizations, and faith-based organizations with which resource-limited governments often contract to provide services. In this section, however, we are focusing on the for-profit sector, which presents a particular set of opportunities and challenges. This sector comprises:

- commercial suppliers, distributors, wholesalers, and retailers who market and distribute health products or health-related products (soap, fortified foods);
- banks, phone companies, and other large commercial institutions that support health services or their employees, their families, and other population groups;
- private health providers who diagnose and treat a variety of health conditions among rural and poor populations; this includes participants in the informal health sector: traditional healers, midwives, and individual medicine sellers.

Among the poorest populations in the world, a significant and growing proportion of health care is provided through the private for-profit sector. The Global Health Council

reports that in sub-Saharan Africa, more than 40 percent of the people obtain their health care from this sector; the figure rises to more than 50 percent of rural populations in Uganda and Nigeria (Global Health Council 2008).

Private providers are sometimes the only source of health care for the poor. They are often closer than government facilities and may be less expensive once lost working time, travel, and unofficial user fees are taken into account. However, the quality of care is inconsistent, and poor clients may get inadequate services for their money.

## WORKING WITH THE PRIVATE SECTOR: KEY ISSUES

**Benefits of partnering with the private for-profit sector.** Given the prevalence of private-sector care and the limited resources available in the public sector, many governments acknowledge that public health requires actions by both public and private providers through public-private partnerships (PPPs). There is general agreement that the public sector must focus on providing critical health care to the poorest while creating an environment in which the private sector can help the state achieve its public health goals (International Finance Corporation 2007).

Collaboration with the private sector extends the reach of the public sector in the face of severe budgetary constraints. Private-sector services are self-sustaining; they do not require support from donors or governments. Public-private collaboration allows the public sector to devote its resources to those most in need, encouraging those who can pay to use the private sector. In this model, the government acts as a steward, providing guidance to private providers and users of private services.

**Barriers to PPP.** Despite the general acknowledgment of the important contribution the private sector can make to public health, there are major barriers that make it hard for the public sector to ascertain and maintain the quality of private-sector services.

- Ministries of health often lack information on the reach and capacity of the private sector.
- The private health sector tends to be fragmented and disorganized, with weak professional associations and few networks representing private-sector perspective and interests.
- Private-sector providers often lack information on public-sector health priorities and standards of care; they have little access to training opportunities.
- It is difficult to make the profit motive compatible with the public health mission and goals.
- There is a long history of mistrust and poor communication between the public and private sectors.

Although the private for-profit health sector seeks to make a profit, this can be compatible with a concern to deliver quality services and an interest in the clients' well-being. This compatibility with public health goals is not always understood.

## Public-Private Collaborations in Action for Better Health— Country Examples from Tanzania and India

**Working with private drug shops in Tanzania.** For many years the Tanzania Food and Drugs Authority authorized *Duka la dawa baridi* (DLDB), or private drug shops, to provide nonprescription medicines in the private sector. With an estimated 6,000+ stores, DLDB constituted the largest licensed retail outlets for purchasing medicines in Tanzania.

MSH's USAID-supported Accredited Drug Dispensing Outlets (ADDO) program was designed to improve key aspects of the DLDB enterprises: the physical premises, stock maintained by the owner, consumer choices, interactions with dispensers, and recommended treatments. In addition, the government systems in which DLDBs are embedded—licensing, supply, training, and inspection—had to be strengthened.

After gaining support from key stakeholders, the Food and Drugs Authority and regional government collaborated with MSH to implement the ADDO initiative, combining commercial incentives with decentralized regulatory oversight. ADDO provided education, training, and supervision for independent shop owners and dispensing staff. The quality of products and services was assured through accreditation based on the achievement of pre-established standards. Routine monitoring by district and local government and community structures reinforced and helped maintain those standards.

**Marketing condoms in India.** Through USAID's PSP-One India project, Abt Associates and its media partner, LOWE India, developed a prize-winning campaign to “normalize” the condom, positioning it as a product like any other. The *Condom Bindaas Bol!* (Condoms—Just Say It!) campaign aimed to increase the use of condoms and expand the condom market. The campaign included humorous television commercials, newspaper and cinema advertisements, and community contests built around the TV advertisements.

To supplement the mass media activities, *Bindaas Bol* reached out to more than 40,000 chemists, retailers stocking condoms, and indigenous medical practitioners and asked them to be agents of behavioral change by selling condoms openly and without embarrassment and by encouraging their customers to ask for condoms without hesitation. The project partnered with these condom marketers to enhance retail visibility and access, and to stress the importance of correct and consistent use of condoms. A well-publicized contest rewarded the retailers who had the best display of condoms and openly discussed condoms with their customers.

## WORKING WITH THE PRIVATE SECTOR: APPROACHES AND TOOLS

**Division of labor between the government and private sector.** To determine the best mix of public and private health care provision and financing, it is necessary to define which sets of services each sector can handle most effectively, make certain that complementary work is done in both sectors, and find a public-private mix that reduces differences in health care that are unnecessary, avoidable, and unjust.

The appropriate mix will vary from place to place, depending on the demand for services and the ability and willingness of consumers to pay for care. This division of labor depends on common objectives and complementary resources. Public-sector policymakers must join with professional associations and networks to agree on health goals, standards of care, and indicators of success.

**Harnessing the power of the government.** To succeed with limited resources, the public sector must devote some of its resources to making the private sector as effective as possible in meeting public health goals. Governments can be effective stewards of the private sector's contributions by applying systems, standards, and protocols to ensure the quality of private-sector services.

Information dissemination and training can improve the case management practices of private practitioners and commercial distributors. Government mandates and regulations pertaining to periodic renewal of licenses and accreditation of practitioners and facilities can be used to guarantee the quality of health services.

**Motivating providers.** The right incentives can motivate private-sector providers to emphasize essential care over nonessential care, and preventive services over curative services. Public financing can provide powerful incentives for private providers and distributors to conform to treatment standards. In child health services, for example, the government might extend insurance to cover immunization services offered by private providers and make free vaccines available to private-sector providers who deliver immunization services.

A very important nonfinancial motivator is the inclusion of private-sector providers and distributors in appropriate government training programs. All these measures would require mechanisms to monitor progress against shared public health indicators.

## In summary

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The health service delivery system is the focal point for all the other people-centered management systems discussed in this handbook. The cross-cutting elements described in this chapter are the core ingredients of an effective health service delivery system in which:

- high-quality, integrated health services are available to all, especially those poor and marginalized people who do not now have access;
- successful initiatives are widely known and adopted by decision-makers in new settings;
- skilled community health workers provide an array of services with the support of local health facilities;
- the private for-profit sector provides services that adhere to government standards.

The opportunity and responsibility for bringing about these ideal conditions rests on the shoulders of our intended readers. You are the health managers and providers whose workplaces are physically close to the communities you serve, who are attuned to the health needs and cultural preferences of community members, and who have the commitment and skills to bring about change.

## Proven practices

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- As a health manager or provider at the provincial or district level of government, within an NGO, or in a public- or private-sector facility, you can join with your colleagues to strengthen the key management systems that contribute to desired health outcomes.
- Scan available information about current best practices through interviews, observation, and reading to increase your understanding of health management systems and guide you in your systems-strengthening efforts. Good leadership and management practices will help you tailor services to manage the six critical elements of health services: high quality, equitable access, integrated services, scale-up, community-based primary health care, and work with the private for-profit sector.
- If you explore the evidence-based approaches and tools and references in this chapter and the earlier chapters of this handbook, you are likely to find several that you and your colleagues can apply or adapt to meet the needs of your clients.

## Glossary of service delivery terms

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**Accredited Drug Dispensing Outlets (ADDO):** An initiative to provide nonprescription medicines in the private sector in Tanzania.

**Autodiagnóstico:** A self-assessment process that groups can use to identify and assess concerns or problems and plan how to address them.

**community case management (CCM):** A strategy to deliver lifesaving curative interventions for common childhood illnesses where access to facility-based services is low.

**Community COPE:** An adaptation of the COPE process that encourages the community to take ownership of quality improvement at facility and community levels.

**community mirror (*miroir de santé communautaire*):** A tool that helps communities to monitor their health needs so that they can advocate for services to meet those needs.

**COPE (client-oriented, provider-efficient services):** A quality-improvement process that enables service providers and other staff at a health facility to work with their supervisors to assess their services by using self-assessment guides based on international standards and known best practices.

**ELCO (ELigible COuples) map:** A type of community mapping that shows where married couples of reproductive age live and what method of contraception they use.

**gender:** The characteristics, roles, and responsibilities that society expects of women and men, girls and boys, based on social attitudes rather than biological differences.

**gender analysis:** A systematic approach used to examine factors related to gender in the use of services, or to design, implement, and evaluate projects.

**improvement collaborative approach:** An approach that engages teams at different sites in a joint effort to meet common objectives and scale up improvements by rapidly disseminating successful practices.

**integrated health services:** Provision of two or more services at the same time and place. Can range from the combination of two formerly separate services into a single, coordinated service to a full package of preventive and curative health services available at a multipurpose service delivery point under one manager.

**integrated management of childhood and neonatal illness (IMCNI):** IMCI with neonatal health added.

**integrated management of childhood illness (IMCI):** A strategy to address the five major causes of under-five death in the developing world by training health workers to assess, classify, and treat the whole child, rather than dealing with only one specific health problem.

**Leadership Development Program (LDP):** A Management Sciences for Health program that strengthens the capacity of health teams to identify and address health challenges using leadership and management practices.

**outcome indicators:** Measures of change in a beneficiary population as a result of a set of activities.

**Partnership Defined Quality (PDQ):** A tool that enables community members and providers to develop a shared vision of quality improvement that involves agreement on standards of performance and empowers them to work together to achieve their vision.

**performance-based financing (PBF):** A mechanism for improving the quality and increasing the use of health services by setting performance goals based on agreed-upon standards and indicators. It requires the organization to complete a set of actions or achieve a measurable performance goal before receiving a transfer of money or goods.

**process indicators:** Measures of the completion of activities.

**quality assurance:** A planned, systematic approach with standards, protocols, and procedures that enable health managers and providers to continuously bring high-quality health services to their clients, using available resources that are available to them.

**scale-up:** “The effort to magnify the impact of health service innovations successfully tested in pilot or experimental projects, so as to benefit more people and to foster policy and programme development on a lasting basis” (WHO definition).

**standards-based management and recognition (SBM-R):** A management approach for improving the performance and quality of health services by focusing on the standardized level of performance and quality to be attained.

**structural indicators:** Measures of material characteristics (physical infrastructure; medicines and health products; number of assigned personnel, tools, technology); organizational resources; and financing of care (levels of funding, payment schemes, and incentives).



## References and resources

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- AIDSTAR-Two Project. *The PBF Handbook: Designing and Implementing Effective Performance-Based Financing Programs*. Version 1.0. Cambridge: Management Sciences for Health, 2011, [http://pdf.usaid.gov/pdf\\_docs/pnadz370.pdf](http://pdf.usaid.gov/pdf_docs/pnadz370.pdf) (accessed March 10, 2014).
- Al Wakeel, Dina. "Male Involvement in Family Planning Yields Positive Results: Communication Programme Helps Change Male Attitudes Towards Reproductive Health." Washington, DC: USAID, 2003.
- Brown, Lori DePrete, et al. *Quality Assurance of Health Care in Developing Countries*. Bethesda, MD: Quality Assurance Project, 1993, [http://pdf.usaid.gov/pdf\\_docs/PNABQ044.pdf](http://pdf.usaid.gov/pdf_docs/PNABQ044.pdf) (accessed March 12, 2014).
- CORE Group, Save the Children, USAID. *Community Case Management Essentials—Treating Common Childhood Illnesses in the Community: A Guide for Program Managers*. Draft chapter, Washington, DC: USAID, 2009, <http://www.coregroup.org/our-technical-work/initiatives/ccm> (accessed March 12, 2014).
- Creel, Liz C., Justine C. Sass, and Nancy V. Yinger. "Overview of Quality of Care in Reproductive Health: Definitions and Measurements of Quality." Washington, DC: Population Reference Bureau, 2009, <http://www.prb.org/Publications/PolicyBriefs/OverviewofQualityofCareinReproductiveHealthDefinitionsandMeasurements.aspx> (accessed Jan. 25, 2010).
- Cuéllar, Carlos J., William Newbrander, and Gail Price. *Extending Access to Health Care through Public-Private Partnerships: The PROSALUD Experience*. Boston, MA: Management Sciences for Health, 2000.
- EngenderHealth. *Community COPE: Building Partnerships with the Community to Improve Health Services*. New York: EngenderHealth, 2002, <http://www.engenderhealth.org/files/pubs/qi/toolbook/commcope.pdf> (accessed March 12, 2014).
- . *COPE Handbook: A Process for Improving Quality in Health Service* rev. ed. New York: EngenderHealth, 2003, <http://www.engenderhealth.org/pubs/quality/cope-handbook.php> (accessed Jan. 26, 2010).
- Extending Service Delivery Project for USAID. "Partnership Defined Quality (PDQ)." *Best Practice Tools Series # 4*. Washington, DC: Extending Service Delivery Project, 2007, [http://www.esdproj.org/site/DocServer/Partnership\\_Defined\\_Quality\\_ESD\\_Final\\_Branding\\_Edited.pdf?docID=2181](http://www.esdproj.org/site/DocServer/Partnership_Defined_Quality_ESD_Final_Branding_Edited.pdf?docID=2181) (accessed Jan. 25, 2010).
- Farrell, Betty L. "Family Planning—Integrated HIV Services: A Framework for Family Planning and Antiretroviral Services." New York: EngenderHealth/The Acquire Project, 2007, [http://www.acquireproject.org/fileadmin/user\\_upload/ACQUIRE/Publications/FP-HIV-Integration\\_framework\\_final.pdf](http://www.acquireproject.org/fileadmin/user_upload/ACQUIRE/Publications/FP-HIV-Integration_framework_final.pdf) (accessed Jan. 25, 2010).
- Gender and Health Group, Liverpool School of Tropical Medicine. Guidelines for the Analysis of Gender and Health. Undated website, <http://www.lstmliverpool.ac.uk/research/departments/international-public-health/gender-and-health-group/guidelines/> (accessed March 12, 2014).
- Global Health Council. "Funding by Sector." Undated web page, <http://www.globalhealth.org/resources/global-health-101/funding-by-sector/> (accessed March 12, 2014).



- Haddad, Lawrence. "Scaling Up for Health." Summary of Conference, Brighton, UK: Institute of Development Studies, University of Sussex, 2008. <http://www.ids.ac.uk/go/news/scaling-up-for-health> (accessed Jan. 24, 2010).
- International Bank for Reconstruction and Development/The World Bank. *Disease Control Priorities in Developing Countries* 2nd ed. Chapter 70: "Improving the Quality of Care in Developing Countries." New York: Oxford University Press, 2006, <http://www.ncbi.nlm.nih.gov/books/NBK10264/> (accessed March 12, 2014).
- International Finance Corporation, World Bank Group. *The Business of Health in Africa: Partnering with the Private Sector to Improve People's Lives*. Washington, DC: International Finance Corporation, World Bank Group, 2007, <http://documents.worldbank.org/curated/en/2008/01/9526453/business-health-africa-partnering-private-sector-improve-peoples-lives> (accessed March 12, 2014).
- Jhpiego. "Focus on: Standards-Based Management and Recognition: A Process for Improving the Quality of Health Services." Baltimore, MD: Jhpiego, Undated web page, [http://www.jhpiego.org/files/JHPinfo\\_SBMR.pdf](http://www.jhpiego.org/files/JHPinfo_SBMR.pdf) (accessed March 14, 2014).
- Kim, Young Mi et al. "The Quality of Supervisor-Provider Interactions in Zimbabwe." *Operations Research Results* vol. 1, no. 5 (2000). Bethesda, MD: The Quality Assurance Project, <http://www.ponline.org/node/174762> (accessed March 12, 2014).
- Kolehmainen-Aitken, Ritta-Liisa, ed. "Myths and Realities about the Decentralization of Health Systems." Cambridge, MA: Management Sciences for Health Publications, 1999, <http://www.ponline.org/node/527098> (accessed March 12, 2014).
- Kols, Adrienne J., and Jill E. Sherman. "Family Planning Programs: Improving Quality." *Population Reports* vol. 26, no. 3 (1998). Baltimore, MD: Population Information Program, Johns Hopkins University School of Public Health, <http://www.ncbi.nlm.nih.gov/pubmed/9926377> (accessed March 14, 2014).
- Lovich, Ronnie, et al. *Partnership Defined Quality: A Tool Book for Participatory Quality Improvement*. Washington, DC: Save the Children/US, 2003, [http://www.coregroup.org/storage/documents/Diffusion\\_of\\_Innovation/PDQ-Manual-Updated-Nigeria.pdf](http://www.coregroup.org/storage/documents/Diffusion_of_Innovation/PDQ-Manual-Updated-Nigeria.pdf) (accessed March 12, 2014).
- Management Sciences for Health. "Increasing Community Participation in Family Planning Programs." *The Family Planning Manager* (Boston) vol. 3, no.2, 1994a, <http://www.msh.org/resource-center/increasing-community-participation-in-family-planning-programs.cfm> (accessed Jan. 25, 2010).
- . "Managing Integrated Services." *The Family Planning Manager* (Boston) vol. 3, no. 3, 1994b, <http://www.msh.org/resource-center/managing-integrated-services.cfm> (accessed Jan. 22, 2010).
- . "Integrating STD/HIV Services into Reproductive Health Settings: Strategic and Management Issues." *The Manager* (Boston) vol. 7, no. 3, 1998, <http://www.msh.org/resource-center/integrating-std-hiv-services-into-reproductive-health-settings.cfm> (accessed Jan. 25, 2010).

- . “Managing Reproductive Health Services with a Gender Perspective.” *The Manager* (Boston) vol. 9, nos. 3 & 4, 2000–2001, <http://www.msh.org/resource-center/managing-reproductive-health-services-with-a-gender-perspective.cfm> (accessed Jan. 26, 2010).
- . “Managing Performance Improvement of Decentralized Health Services.” *The Manager* (Boston) vol. 13, no. 1, 2004a, <http://www.msh.org/resource-center/managing-performance-improvement-of-decentralized-health-services.cfm> (accessed Jan. 26, 2010).
- . “Leading Changes in Practices to Improve Health.” *The Manager* (Boston) vol. 13, no. 3, 2004b, <http://www.msh.org/resource-center/leading-changes-in-practices-to-improve-health.cfm> (accessed Jan. 25, 2010).
- Pathfinder International. “Youth in Action.” Mozambique: Projects, Undated web page, Watertown, MA: Pathfinder International, [http://www.pathfind.org/site/PageServer?pagename=Programs\\_Mozambique\\_Projects\\_YouthinAction](http://www.pathfind.org/site/PageServer?pagename=Programs_Mozambique_Projects_YouthinAction) (accessed Jan. 25, 2010).
- Pollock, John, et al. “Improving Health Outcomes through Performance-Based Financing.” Presentation at USAID Mini-University, Johannesburg, South Africa, 2008.
- Quick, Jonathan, et al. “Reversing the AIDS Epidemic through Third-Generation Health Systems: A Call to Action.” Cambridge, MA: Management Sciences for Health, 2009, <http://www.msh.org/resources/reversing-the-aids-epidemic-through-third-generation-health-systems-a-call-to-action> (accessed March 12, 2014).
- Rogers, Everett M. *Diffusion of Innovations*. New York: Free Press, 2003.
- Rohde, Jon, and John Wyon, eds. *Community-Based Health Care: Lessons from Bangladesh to Boston*. Cambridge, MA: Management Sciences for Health, 2002.
- Senderowitz, Judith, Gwyn Hainsworth, and Cathy Solter. “A Rapid Assessment of Youth Friendly Reproductive Health Services.” *Technical Guidance Series* no. 4 (2003), [http://www.pathfind.org/site/DocServer/YFS\\_TG\\_Final\\_web\\_version.pdf?docID=762](http://www.pathfind.org/site/DocServer/YFS_TG_Final_web_version.pdf?docID=762) (accessed Jan. 25, 2010).
- Sharma, Suneeta. *The Private Sector and Child Health Care*. Washington, DC: Futures Group International, 2001, [http://www.policyproject.com/pubs/countryreports/Final\\_-\\_WHO\\_2.pdf](http://www.policyproject.com/pubs/countryreports/Final_-_WHO_2.pdf) (accessed Jan. 26, 2010).
- Silimperi, Diana, Lynne Miller Franco, tisna Veldhuyzen van Zanten, and Catherine MacAuley. “A Framework for Institutionalizing Quality Assurance.” *International Journal for Quality in Health Care*, Vol. 14, Supplement 1 (2002), 67–73, [http://intqhc.oxford-journals.org/content/14/suppl\\_1/67.full.pdf](http://intqhc.oxford-journals.org/content/14/suppl_1/67.full.pdf) (accessed March 6, 2014).
- Simmons, Ruth, Peter Fajans, and Laura Ghiron, eds. *Scaling Up Health Service Delivery: From Pilot Innovations to Policies and Programmes*. Geneva: World Health Organization Press, 2007, [http://books.google.com/books?id=rswy2UJM-QC&printsec=frontcover&dq=Scaling+Up+Health+Service+Delivery:+From+Pilot+Innovations+to+Policies+and+Programmes&source=bl&ots=WBoILVNiOi&sig=ssXC\\_EM2nYiqOHGfq4IgsGRR6rA&hl=en&ei=z1zkS5zYL8H68AbmyZygDw&sa=X&oi=book\\_result&ct=result&resnum=1&ved=0CBcQ6AEwAA#v=onepage&q&f=false](http://books.google.com/books?id=rswy2UJM-QC&printsec=frontcover&dq=Scaling+Up+Health+Service+Delivery:+From+Pilot+Innovations+to+Policies+and+Programmes&source=bl&ots=WBoILVNiOi&sig=ssXC_EM2nYiqOHGfq4IgsGRR6rA&hl=en&ei=z1zkS5zYL8H68AbmyZygDw&sa=X&oi=book_result&ct=result&resnum=1&ved=0CBcQ6AEwAA#v=onepage&q&f=false) (accessed Jan. 26, 2010).

United Nations. “Youth and Youth Issues.” Chapter 4 in *World Youth Report 2003*, New York: United Nations Publications, 2003.

USAID. “STI Management: Fact Sheet on Youth Reproductive Health Policy.” Washington, DC: USAID, 2007a, <http://www.youth-policy.com/index.cfm?page=STI> (accessed Jan. 26, 2010).

———. “Partnership Defined Quality (PDQ).” Extending Service Delivery Project: Best Practice Tools Series # 4. Washington, DC: USAID, 2007b, [http://www.esdproj.org/site/DocServer/Partnership\\_Defined\\_Quality\\_ESD\\_Final\\_Branding\\_Edited.pdf?docID=2181](http://www.esdproj.org/site/DocServer/Partnership_Defined_Quality_ESD_Final_Branding_Edited.pdf?docID=2181) (accessed Jan. 26, 2010).

USAID Child Survival and Health Grants Program (CSHGP). “Quality Assurance.” Technical Reference Materials. Washington, DC: USAID, 2007, download file from [http://www.mchipngo.net/controllers/link.cfc?method=tools\\_cross](http://www.mchipngo.net/controllers/link.cfc?method=tools_cross) (accessed Mar. 12, 2014).

USAID Health Care Improvement Project. “Family Planning/HIV Integration: Technical Guidance for USAID-Supported Field Programs.” Washington, DC: USAID, 2003, [http://pdf.usaid.gov/pdf\\_docs/pnacu444.pdf](http://pdf.usaid.gov/pdf_docs/pnacu444.pdf) (accessed March 12, 2014).

———. “The Improvement Collaborative: An Approach to Rapidly Improve Health Care and Scale Up Quality Services.” Bethesda, MD: University Research Co., LLC (URC), 2008, <http://www.urc-chs.com/resource?ResourceID=23> (accessed March 12, 2014).

USAID/Rwanda. “TB and HIV Integration Saves Lives in Rwanda.” USAID on-line Newsroom, 2006.

Victora, Cesar G. *The State of the World's Children 2009*. Panel 2.4: “Towards Greater Equity in Health for Mothers and Newborns.” New York, NY: UNICEF, 2008, <http://www.unicef.org/sowc09/docs/SOWC09-Panel-2.4-EN.pdf> (accessed Jan. 26, 2010).

WHO European Ministerial Conference on Health Systems. “Health Systems, Health and Wealth.” Report, Copenhagen: WHO Regional Office for Europe, 2008. <http://www.euro.who.int/en/publications/policy-documents/tallinn-charter-health-systems-for-health-and-wealth> (accessed March 12, 2014).

World Health Organization. “Integrated Health Services—What and Why?” *Technical Brief* no.1 (May 2008), [http://www.who.int/healthsystems/technical\\_brief\\_final.pdf](http://www.who.int/healthsystems/technical_brief_final.pdf) (accessed Jan. 26, 2010).

———. “Scaling Up Health Services: Challenges and Choices.” *Technical Brief* no. 3, draft 3 (June 2008), [http://www.who.int/healthsystems/topics/delivery/technical\\_brief\\_scale-up\\_june12.pdf](http://www.who.int/healthsystems/topics/delivery/technical_brief_scale-up_june12.pdf) (accessed Jan. 26, 2010).

———. *Practical Guidance for Scaling Up Health Service Innovations*. Geneva: World Health Organization Press, 2009.

World Health Organization and UNICEF. “Management of Pneumonia in Community Settings.” Joint statement, 2004, [http://whqlibdoc.who.int/hq/2004/WHO\\_FCH\\_CAH\\_04.06.pdf](http://whqlibdoc.who.int/hq/2004/WHO_FCH_CAH_04.06.pdf) (accessed Jan. 26, 2010).

## APPENDIX A. Framework for Gender Analysis

Gender Differences in Health	Women	Men	Girls	Boys
<b>How does the ENVIRONMENT influence who becomes ill and how they respond to their illness?</b>				
Living conditions: Clean water, sanitation, ventilation, hygiene				
Working conditions: Use of equipment, ventilation, exposure to noise, hygiene arrangements, working hours, exposure to risk				
Geographic location and climate				
Food and nutrition				
General social and economic conditions				
<b>How do the ACTIVITIES of men and women influence their health and use of available health services?</b>				
What males and females do daily				
Health risks associated with particular activities				
Health risks associated with excessive burdens of work				
Health risks associated with lack of work				
<b>How does the DECISION-MAKING POWER of males and females influence their health?</b>				
The extent to which males and females can make independent decisions regarding their health and its protection				
Gender differences in the ability to negotiate with others about their health protection				
<b>How does access to and control over RESOURCES influence the health of males and females?</b>				
Differences in male's and female's access to or control over financial and other resources that affect their health or their ability to protect their health				
<b>How do GENDER NORMS influence health?</b>				
Attitudes toward sexual violence				
Educational disparities				
Cultural norms and practices				

Adapted from: "Guidelines for the Analysis of Gender and Health" The Gender and Health Group at the Liverpool School of Tropical Medicine.



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## About Management Sciences for Health

**Management Sciences for Health (MSH)** is a nonprofit global health organization that is working to save lives and improve health by strengthening health systems in more than 70 countries.

MSH works to save lives by closing the gap between knowledge and action in public health. Since 1971, we have worked with policymakers, health professionals, and communities in over 150 countries to improve the quality, availability, and affordability of health services. For more information about MSH and our work, please visit our website at [www.msh.org](http://www.msh.org).

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