

Leadership, Management and Governance (LMG) Practices in Ethiopian Public Hospitals: 2018–and 2019

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Abstract

Background: Optimal Leadership, Management and Governance (LMG) practices are essential to ensure effective, efficient, and high-quality health service that contributes to good health conditions of the population. The aim of this study was to determine the level of LMG practices and identify factors associated with it at public hospitals in the years 2018 and 2019. A total of 250 hospitals (Tertiary hospitals, General hospitals, and Primary hospitals) were included in the study.

Methods: The study used hospital self-assessment reports which were reported in Districts Health Information System II (DHIS2) using quantitative national tools developed by the Ministry of Health. The data was collected by officers that have experience of working in hospitals (that means, those who were familiar with DHIS2) and whom we trained in how to use the data collection tools. The data was cleaned and analyzed using SPSS software. Descriptive statistics was used to measure level of LMG practices and cross-tabulation to identify factors associated with LMG practices.

Results: - The national mean score of LMG practices by hospital standard was 67% in 2018 and 65% in 2019. Overall mean scores were 52.6% and 52.1 for Tertiary hospitals. 72.8% and 69.3% for General hospitals and 65.2%, 67.2% for Primary hospitals, in 2018 and 2019, respectively. Out of the 250 public hospitals, studied, 49% had a well-functioning Health Development Army (HDA) is teams within the department/unit of a hospital. Only 50% of the public hospitals had evaluated the LMG practices of their Chief Executive Officers (CEOs) against the minimum standards set in EHSTG.

Conclusion: the entire variable in the assessment tools was a minimum standard to be fully complied with in all the public hospitals. The results of this study revealed that the LMG practices were below the minimum standard. Well-functioning health development army was missing in many of the hospitals, and this suggests that there remains a lot to improve in health service s delivery in public hospitals. Not evaluating hospital performance against annual plan was found to be a cause of misunderstanding the challenges and not targeting them in future direction to meet requirement. [*Ethiop. J. Health Dev.* 2021; 35(2):97-104]

Keywords: Leadership, Management and Governance practices; public hospitals; health service quality, Ethiopia

Introduction

Institutional Context of LMG (Leadership, Management and Governance) and Responsible Actors:

Leadership, Management and Governance (LMG) practice is one of the major determinants of both failure and success of health facilities in meeting their set objectives. Effective LMG practice in hospitals is performed through Governing Board (GB), Senior Management Team (SMT), and Health Development Army (HDA) ensures high quality health care by motivating all the staff in each department or unit of the hospital for the good of the community (1), (2), (3).

The responsible organs of LMG practices in a hospital are GB, SMT and HDA, in a descending hierarchical order. The overall governor of a hospital is the GB. The GB responsibilities is providing overall guidance and direction, making strategic decisions, selecting a Chief Executive Officer (CEO) and approving the hiring, establishing job description for the CEO in line with the hospital's strategic goals, overseeing overall activities of the hospital, and ensuring the hospital's financial and service quality well-being (4),(5), (6).

According to the Ethiopian Hospital Service Transformation Guideline (EHSTG) that was launched in 2016, a hospital CEO is appointed by the GB and approved by Head of Regional Health Bureau (5), (6). The primary duty of the CEO is gearing all efforts of the hospital's staff towards meeting the goals and

objectives of the hospital and satisfying customers' expectations. The CEO selects and appoints a Medical Director and establishes SMT. The SMT is composed of heads of all departments or units. Each SMT member in turn establishes HDA in the departments or units (7), (8) (9). HDA follows the entire service provided by frontline professionals in the departments of the hospital. All challenges, risk that might have happened at the time-of-service delivery and opportunities are captured and discussed at the HDA meeting, which recommends measures to solve to the problems (1), (10), (11).

Outstanding problems were observed with SMT and hospital's GB. To enable SMT and GB provide solutions for every problem facing the facility, Ethiopian Hospital Service Transformation Guideline had eight minimum standards. The Guideline has been implemented for the last five years in all public hospitals found in Ethiopia. Almost all the public hospitals have Service Quality Improvement Unit led by a medical doctor and Quality Improvement Officers selected from different departments or units (1), (13), (14), (15). Those officers were trained by the Ministry of Health and regional health bureaus in how to implement the Guidelines. Conducting quarterly assessments through EHSTG checklist is one of the main duties of the Service Quality Improvement Officers, who then report the assessment results to the respective higher body through DHIS2. The officer also

helps the department or unit in planning and executing service improvement projects, and in providing supportive supervision and training for all departments to create common understanding (16), (17), (18) (19).

Major challenges of LMG practices in Ethiopia include board member's lack of time to discharge their role and responsibility, their low commitment and high turnover of board members due to political instability across the country. (20), (21) (22).

There is no adequate study done on LMG practices and challenges in public hospitals in Ethiopia. Therefore, this study was aimed to assess LMG practices and their challenges in public hospitals in Ethiopia, which can be the cause of poor service quality (23), (24), (25).

Methods

This study used a quantitative approach with cross-sectional study design to determine the level of leadership, management and governance practices and identify factors associated with LMG. Out of the 348 public hospitals in Ethiopia, the ones that had been registered in and that reported through DHIS2 for the years 2018 and 2019 were included. All levels of public hospitals (Tertiary, Primary, General and Comprehensive, or specialized) in all regions of Ethiopia (Benishangule, Afar, Dire Dawa, Oromyia,

SNNPR, Amhara, Hareri, Gambella, Addis Ababa City Administration, Tigray, Somali and Sidama) were included in the study. Thus, a total of 250 public hospitals were included in this study.

Data Collection

The study used hospital self-assessment reports, reported in DHIS2 starting from July 1, 2018 –to June 30, 2019, G.C with the National Assessment Handbook developed by the Ministry of Health (MoH). The tools were used to assess LMG practices in all types of hospitals (Primary, General, and Comprehensive Specialized) in every quarter of a year and reported through DHIS2. This study used eight consecutive quarters report starting from 2018 up to end of 2019. The data from DHIS2 were checked for completeness, accuracy, clarity, and consistency.

Level of leadership, management and governance practices was calculated against the Assessment Handbook that had eight standards using 37 verification points. Each clause was weighted as “met” (with value 1) when the hospital had fulfilled the verification point to the expected standard or “unmet” (weighted value 0) when the hospital had not fulfilled the verification point to the expected standard. Finally, level of leadership, management and governance practices was determined as percentage.

$$\text{Total LMG Practice} = \frac{\text{Total Met Standard}}{\text{Total Met} + \text{Total unmet Standard}} \times 100$$

Data Analysis

Data entry, coding, cleaning, and data analysis were done by using SPSS version 20 software. Data were checked and cleaned by running frequencies, sorting, and listing variables for consistency. Descriptive analysis, cross tabulation, box plot analyses were used to check for presence of significant difference of LMG practices over time and across types of hospitals.

Ethics

The principal investigator presented a formal written request letter to Policy plan, monitoring and evaluation directorate at the Federal Ministry of Health (FMoH-PPMED) and obtained a written permission through formal Letter. The data collected from DHIS2 was kept in a safe place and used for the purpose of the study only. The assessment findings were reported to regional health bureaus and the Ministry.

Results

Types and Distribution of the Sampled Public Hospitals: Almost all of 348 public hospitals found in Ethiopia at the time of the study were registered in DHIS2. Out of those public hospitals, 34 were Tertiary, 76 General, and 238 Primary. All public hospitals that made reports in the DHIS2 were included in the study (n=250 hospitals). The distribution of those participated hospitals, during the years 2018 and 2019 respectively, was 85 (34%) and 87 (30%) in Oromyia Region, 61(24.4%) and 79 (28%) in Amhara, 46 (18.4%) and 43 (15%) in SNNPR, 22 (8.8%) and 36 (13%) in Tigray, 17 (6.8%) and 8 (3%) Sidama, 5 (2%) and 9 (3%) in Addis Ababa, 5 (2) and 6 (2%) in Afar, and from the 3.6% and 8% in the rest five regions. Twenty-four (9.6%) of those sampled hospitals were compressive specialized hospitals, 63 (25.2%) were general hospitals, and 163 (65.5%) primary hospitals (Table 1).

Table 1: Characteristics of the sample public hospitals by regions and level in Ethiopia from July 1, 2018 – Jun 30, 2019

Region	Study hospitals in 2018	Percentage	#Participant hospitals in 2019	Percentage
1. Oromiya RHB	85	34.0	87	30
2. Amhara RHB	61	24.4	79	28
3. SNNP RHB	46	18.4	43	15
4. Tigray RHB	22	8.8	36	13
5. Sidama RHB	17	6.8	8	3
6. Addis Ababa RHB	5	2.0	9	3
7. Afar RHB	5	2.0	6	2
8. Beneshangul Gumuz RHB	3	1.2	5	2
9. Dire Dawa RHB	2	0.8	2	1
10. Harari RHB	2	0.8	2	1
11. Gambella RHB	1	0.4	2	1
12. Somali RHB	1	0.4	8	3
Total	250	100	287	100
Level of Hospitals				
13. Specialized Compressive	24	9.6	29	10.1
14. General Hospitals	63	25.2	70	24.4
15. Primary Hospitals	163	65.2	188	65.5
Total Hospitals	250	100	287	100

Magnitude of LMG Practice by Region: National mean scores of LMG practice in 2018 and 2019 were 67 and 65, respectively. Mean scores of LMG practice by region were: 82% in 2018 and 56% in 2019 for Dire Dawa, 74% and 71% for Oromiya, 70% and 64% for Tigray, 69% and 65 for Sidama %, 68% and 75% for Benishangul, 70% and 67% for SNNPR, (61% and 59% for Amhara, 61% and 49% for Addis Ababa, 46% and 48% for Afar, 46% and 49% for Harari, 38% and 54% for Somali, and 25% and 31% for Gambella. High LMG inconsistency and was observed in Dire Dawa whereas, low levels of LMG practice were observed in the public hospitals in Afar, Harari, Somali, and Gambella

regional states (Figure 1).

The activities of LMG practice through their actor in the hospitals (GB, SMT, HAD) was low as compared to the requirements set out by the Ministry as a minimum standard. We cannot expect good quality of care with this performance score of leadership managements and governance. In summary, low score in HDA means the activities proposed by the guideline were not performed. This situation creates weak team bond in the HDA result with no common goal between staff and conducting regular transformation forum will be in question.

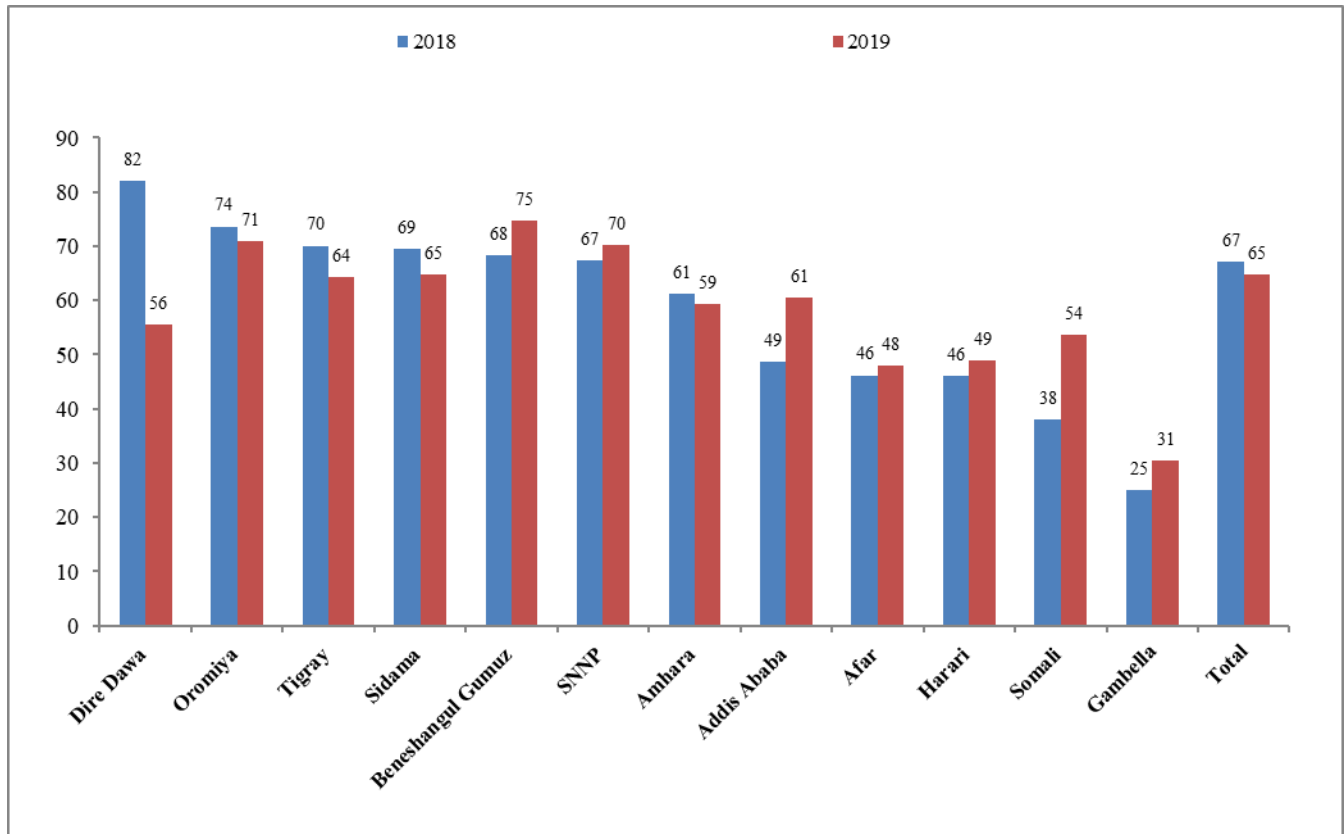


Figure 1: National mean score of Leadership, Management and Governance practices in public hospitals in Ethiopia, July 1, 2018, to Jun 30, 2019

Magnitude of LMG Practices: The national mean score of Leadership, Management and Governance practices in all the three levels of public hospitals were 66%, 66%, 66%, 70%, 62%, 63%, 65%, 63%) in 1st, 2nd, 3rd and 4th quarter of the year 2018 and 1st, 2nd, 3rd and 4th quarter of the year 2019 respectively the national mean score of Leadership, Management and Governance Practices in tertiary public hospitals were 52%, 54%, 49%, 60%, 50%, 47%, 51%, 47% in the eight consecutive quarters of the study period. The national mean scores of LMG practices in General public hospitals were 71%, 71%, 74%, 75%, 68%, 69%, 70%, 65% in 1st, 2nd, 3rd and 4th quarter of year 2018 and 1st, 2nd, 3rd and 4th quarter of the year 2019 respectively. The national mean score of LMG Practice in the primary hospitals was 66%, 67%, 66%, 68%, 62%, 64%, 65%, 64% during the eight quarters of the study period.

The study shows no significant difference observed in across the time (eight quarter of LMG practice) and types of hospitals (Primary, General and Specialized compressive hospitals) but the activities general hospital better than primary and primary hospital better than specialized hospitals in related to adhering LMG chapter EHSTG.

Most specialized hospitals were university hospitals had large number of manpower, many departments, provide bulky health service and give more focus on teaching process rather than providing healthcare. They have also two kinds of board responsible to hospital service and responsible to teaching process. This entire organizational context might be cause of getting low score in LMG practice.

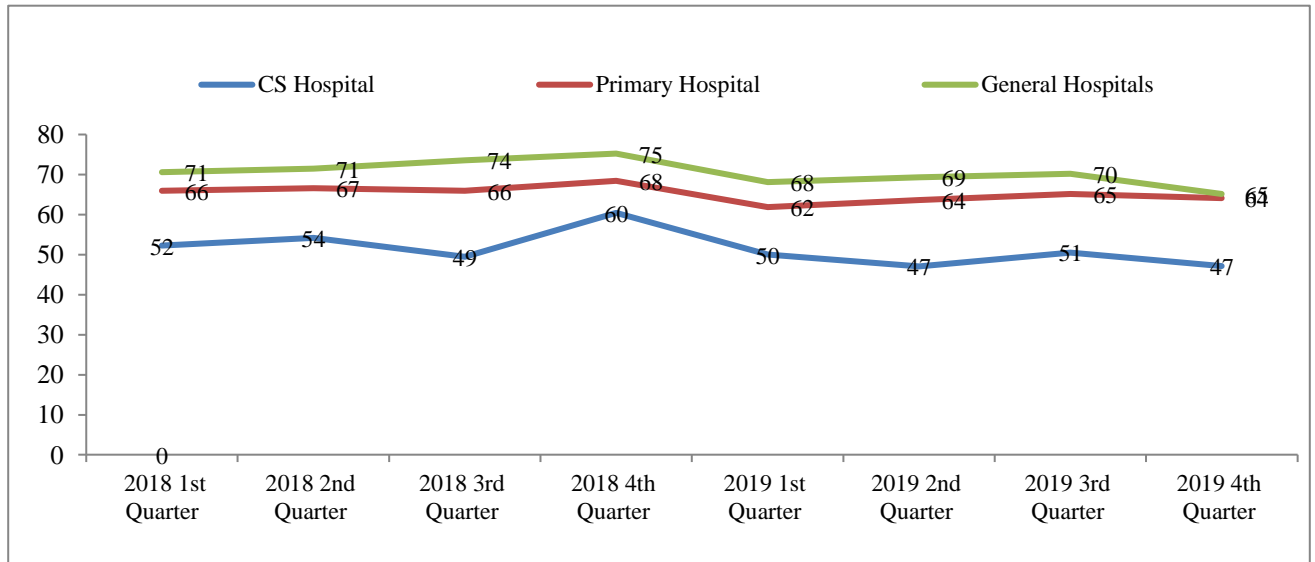


Figure 2: National mean score of Leadership, Management and Governance practices in public hospitals by hospital level and quarters, July 1, 2018, to Jun 30, 2019

Mean Level of Leadership, Management and Governance Practices Score

According to EHSTG, every public hospital should have a functional GB with the aim of controlling the overall operation, establishing the strategic plan and annual plan of the hospital based on the need of catchment population of the hospital. In this regard, 84% of the sampled public hospitals have functional GB but performance of the Board was low. The GB did not do the entire task set for it by the MoH. Similarly, Senior Management Team (SMT) was established in 79% of the public hospitals. This result was low to meet the expected score that is 100%. Every hospital needs to meet the all the minimum requirement which was very important activities to transform healthcare service quality.

In 73% of the hospitals, the GB and SMT have complaints handling mechanisms and ethical violation reporting system had in place. The GBs of 69% of the public hospitals have both additional resource mobilization plan and mechanisms of ensuring effective and efficient utilization of resources. Among the public hospitals studied, 68% have a system and practice of measuring performances and results and recognizing best performer departments and individuals. Sixty-three percent of the hospitals had ongoing capacity building programs, including providing orientation about their responsibility both for GB and SMT. About half (50%) of the public hospitals had performed CEO evaluation and 49% had functional HAD. LMG practices were evaluated through the above eight minimum standards. The composite score was low (67%), which means that there was a 37% gap in efforts to increase quality of care (see Figure 3).

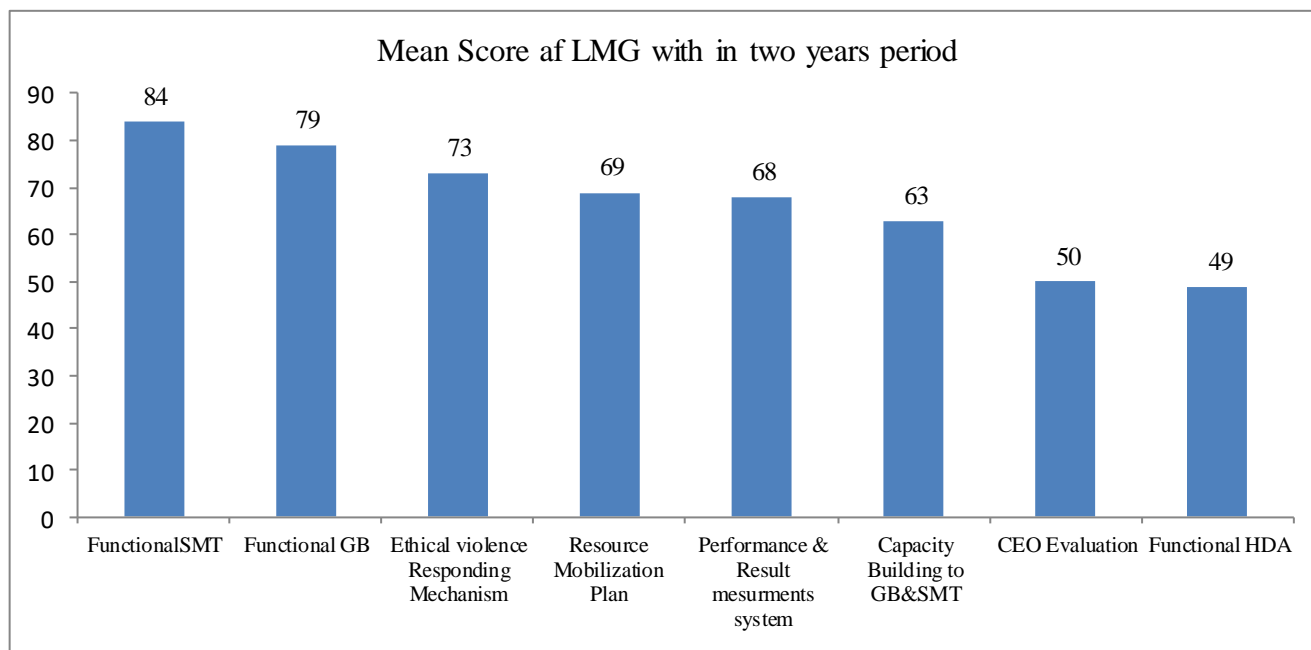


Figure 3: **Mean Score of Leadership, Management and Governance practices against the EHSTG standard in Ethiopian public hospitals, July 1, 2018, to Jun 30, 2019**

Discussion

According to Ethiopian Hospitals Service Transformation Guideline (EHSTG), every public hospital should be led by a Governing Board that Guides the LMG practices toward increased performance, efficiency, and effectiveness of hospitals to the satisfaction of patients' needs. Overall average score of LMG practice in 2018 and 2019 were 67 and 65, respectively. It was low as compared to 100%, minimum standard to be implemented by every public hospital in Ethiopia.

Only about half (i.e. 49%) of the public hospitals had a functioning HDA with 5–9 members in every department with the purpose of delivering high quality health service to the satisfaction of customers. HDA standard is the lowest implementation score. It might be because of lack of commitment by the top management and head of department or chairman has no benefit from this process.

Again, only half of the public hospitals (50%) had CEO evaluated against the EHSTG standards. This evaluation was very important to celebrate the achievements, encourage staff, identify challenges, and to plan next steps with sound strategy to pass the challenge. Despite its profound significance, half of the hospitals did not do it. Those hospitals had missed chances of identifying challenges that was direct input for continual improvements in the subsequent years.

One of the main duties of the GB was approving annual plans of the hospitals by first understanding everything in the hospital's activities in relation to the mission and vision of the hospital. Implementation score, observed in terms of ongoing capacity building program for both GB and SMT standard, was 63% out of the study public hospitals, a score which is below the standard.

That might be because of the GB and SMT members' low commitment and luck of time to get training and orientation.

A hospital's SMT must be functional to regularly manage and execute the overall operations of a hospital. The verification criteria within these standards were expected to meet the hospital's annual plan and strategic plan and to meet every two weeks. Planning, implementing, and evaluating is the main task for SMT. In this regard, 84 of the study hospitals had established functional SMT. A hospital SMT have no plan will not know the starting point and of his work.

Regarding presence of a system and practice of measuring performances and results, appraisals and recognition system for departments and individual best performers in hospitals, the mean score for the standard was found to be 68%, which, again, is far below 100%. This might be because of low awareness about the importance of the standard to improve service quality.

Regarding whether hospitals had a plan to mobilize resources from diverse sources and to make sure resources are utilized effectively and efficiently, 69% of the public hospitals had that plan and had got resource and utilized efficient and effectively. That was not the case with the remaining 31% of the hospitals studied, and thus remains to be a concern.

Hospitals should have ethical violation reporting, complaint handling and reporting system. In this regard, 73% of the public hospitals were having a system for reporting and responding mechanism for ethical violation. This implementation score was less than the minimum standard, and that might be because of low awareness about their responsibility and duties of board members and undermining the importance of this specific standard to health service quality improvement.

All university (teaching) hospitals were categorized as compressive specialize hospital. They have large number of employees trained at high levels. However, compressive specialized hospitals had lower achievement than primary and general hospitals in the implementation score of LMG practices across the country. That might be because the large number of employees made co-ordination to change the environments and work process difficult. There are also diverse specialties and sub-specialties within hospital in different departments, but with poor co-ordination of efforts towards meeting the objectives of the hospitals.

Major challenges of LMG practices in Ethiopia might include lack of time to discharge their role and responsibility, having a low commitment and high turnover of board members due to political instability across the country.

Limitations of the Study

The data used for this study was collected by quality officers in hospitals but not validated by external assessor, so the data was based on self-assessment reports, which may exaggerate some points and under-rate others compared to their actual state. The pictures that we get from this study may thus not accurately show current state of LMG practices in public hospitals in Ethiopia. The hospitals that were included in the study have been much better than the hospitals that have not start to implement the reform (not included hospitals).

Conclusion

The national average leadership, managements and governance practice were 67% and 65% in 2018 and 2019 GC in Ethiopian public hospitals. These scores are below the minimum standard. Those below the standard LMG practices negatively affect quality of health service delivery.

The least score of was observed in the activities that related to establishing functional HDA. The second least score was observed in CEO Evaluation. Whereas the third least score was observed in the activities related to providing capacity building to GB and SMT. The fourth least score of was also observed in the activities of establishing system to measure the performance and result of individuals and organizations.

Finally, all eight standards, needs to be meet 100%, because it's a minimum standard. It needs continual improvement to change the quality of care in every unit of the hospitals.

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The actors of LMG practices within a hospital (GB, SMT, HDA) were too low to discharge their duties and responsibility as per the approved plan by GB. Therefore, attention be given by those higher organs to health service delivery quality improvement is far inadequate and begs for improvements.

Recommendations

To the FMOH: There should be clear guidance to the hospitals' GBs at all levels starting from FMOH which requires them to understand their roles and responsibilities. There should be a national system of according to recognition to best performs and good practices based on the results and a system targeting improvements on weak areas.

To RHBS: RHBS should set regional GB recognition program for best performer hospitals and should create competitive environment after performing credible monitoring and evaluation of performances. Governing boards should get induction orientation and ongoing training program about their roles and responsibilities.

To the Hospital Board Members: Hospitals' GBs should have clear annual plan agreed by the hospitals and the community. GBs should conduct regular monitoring and evaluation for their respective hospitals to achieve the set standards.

Hospitals' GBs should exercise their roles and responsibilities set by regional directives and implementation manuals. GBs should evaluate the performances of the hospitals with community and staffs and create strong bond with the SMT, as well.

To the Hospital SMT: SMT should create conducive environment and clear structure of service areas. Motivating all hospital's staffs members with no discriminations. Conduct staff satisfaction survey on biannual basis and set action plan to fulfill identified gaps with the GBs. SMT should strongly support and monitor performance of service areas and build capacity of staff members.

To improve LMG practices at department or unit level through the HDA. Capacitating and strengthening HDA (team within the departments/units of hospital) to meets the requirement with goal of improving quality of care. This needs serious discussion between staff and the chairman.

To other researchers: Finally, we encourage other researchers to study the subject to explore the issue in more detail.

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