



## Policy Brief No.2



**Preparing Nurses  
for  
Facility Management**



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### Preparing Nurses for Facility Management

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*In 1997 and in the Coast Province of Kenya the Aga Khan Health Services, working in close collaboration with the Kenya Ministry of Health, began the Kwale Health Systems Strengthening Project (KHSSP), which aims to improve the quality of health care at the dispensary level. One of the main concerns of the project has been to build the capacity of the committees of community representatives who now have a strong role in the management of the dispensaries. This second of a series of 'policy briefs' focuses on a related, and most significant, issue – the changing role of the dispensary nurse as the committee members become more empowered.*

*These briefs are primarily intended for directors and managers of community-based health care programmes – whether working within ministries of health, international donor agencies or non-government organisations. For such people this second brief takes up a number of likely questions about the management functions of the nurses in charge of small, local health facilities:*

*How prepared are 'nurses in charge' for carrying out administrative and management functions?*

*How should they relate to the new management committees?*

*What additional training do they need?*

*What are the lessons from the Kwale project – lessons about the training of nurses – that can be applied elsewhere?*

### The Context

In 1997, when KHSSP began, Kwale (apart from the narrow tourist belt along its coastline) was reckoned to be among the poorest districts in Kenya. The following statistics from 1997 bear this out:

- 89% of the households were engaged in subsistence agriculture;
- Less than 2% of the households earned more than Ksh.2,000 per month (about US\$30) from the sale of crops or livestock;
- 80% of the households had annual incomes of less than Ksh.61,300 (less than US\$1,000);
- The overall level of literacy was 41% – but for men it was as high as 63% and for women as low as 23%.

Not surprisingly, given the relationship between poverty and poor health, the following figures from the same year indicate the vast challenge the project accepted:

- 68% of children aged six to 60 months were malnourished;

- 17% of the children aged from 12 to 23 months were classified as 'severely underweight';
- Only 56% of the population had knowledge of family planning methods.
- Only 50% of the mothers could name two immunisable diseases;
- Only 33% could correctly interpret the growth curves of their children.

### The Project

KHSSP recognised that one of the most effective, and most equitable, ways to improve the health status of the communities would be to enhance the facilities of the local dispensaries and to strengthen their curative and preventative services. For most people in districts such as Kwale, the dispensaries are the primary facilities for health care and health education in the community. But, as with most districts in developing countries, the Ministry of Health's dispensaries in Kwale suffered from a lack of manpower and a shortage of financial resources. The ministry was unable to

maintain a consistent supply of drugs in its health facilities; it was unable to provide adequate supervision of the staff who worked in them. The solution envisaged by KHSSP was to make the ministry's dispensaries more self-sufficient.

Most initiatives to stimulate community participation in health care have concentrated on activities outside the government health facilities – promoting pharmacies according to the Bamako community-based model, or utilising volunteers in community-focused health education programmes. KHSSP, however, has concentrated its activities inside health facilities. The project has focused on building the capacities of the dispensary health committees (DHCs), comprising representatives drawn from the village health committees of the catchment areas. The objective has been to enable the DHCs to raise and monitor the use of funds, to oversee the health care services provided by the facility, and to promote outreach health education activities.

This, then, raises some very interesting questions about the roles and responsibilities of the nurses working within the dispensaries – especially the nurses in charge. How should the nurses relate to the DHCs? To what extent are they accountable to the DHCs?

### The Main Issue

In the early 1990s, when the Kenya Ministry of Health was making a training needs assessment for its officers in charge of health facilities, one of the community nurses said: 'When I qualified from the Medical Training College, I was posted as the In-Charge of a dispensary.... I knew a lot about treating patients. But I knew next to nothing about managing a health facility.'

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## THE MAIN ISSUE: FROM PAGE 3

Ten years later, the nurses employed in the ministry's dispensaries in Kwale were saying the same thing. Even if management topics had appeared on their training college curriculum, they had usually been covered in a transmittal and theoretical manner – a 'chalk and talk' manner. It is one thing to write an essay on leadership and styles of management, based on notes taken from lectures or from books, in order to pass an exam – it is another thing to manage, in real – and often constrained – circumstances.

As many projects involving health workers in charge of

facilities have discovered, there is a need for re-addressing their administrative functions and enhancing their management skills – in a manner that is practical and that takes into account their own and actual experiences. And the Kwale project had to address the complex, and sometimes delicate, issue of the relationship between the In-Charge nurse and the DHC, in a situation where the DHC was being asked to manage without having much 'legitimate' authority, and where the In Charge was being asked to defer, in certain respects, to a group of community representatives who had not been exposed to his kind of professional – both clinical and administrative – training.

## Reflections on Pre-Service Training

*Immaculate Akumu is the nurse in charge at the Mazeras Dispensary in Kwale. She talked about the pre-service training she experienced at the Medical Training College, when she was there from 1993 to 1995:*

'Yes, we learnt something about the administration of community health,' she says. 'We learnt that we should ensure everything in the facility should run smoothly. We learnt how to address problems. For instance, if a member of the subordinate staff was coming to work late – we learnt how to deal with that situation. We were told that you should give a verbal warning first – and then a written one. We were told that there should be three warnings.....'

'Did we role-play any situations like this? No, it was just a lecture, and we took notes...'

'Did we discuss anything about the role of the facility management committees? No, not at all. We were never told that we would one day meet a facility committee..... But now I'm working with one!'

'Maintenance of the facility? What we learnt on that was very, very shallow. But they told us that we should make up a duty roster for the staff, that we should make sure the ward is clean. If there is any other kind of problem – like a leaking roof, then we should inform the officers at the District.'

'Leadership? We were just taught the theory part of it. I think if I had come here as a fresher straight from college, I don't think I would have managed.'

*Corridon Muta, the nurse in charge of Mwanda Dispensary, also in Kwale, did his pre-service training much earlier – from 1976 to 1979.*

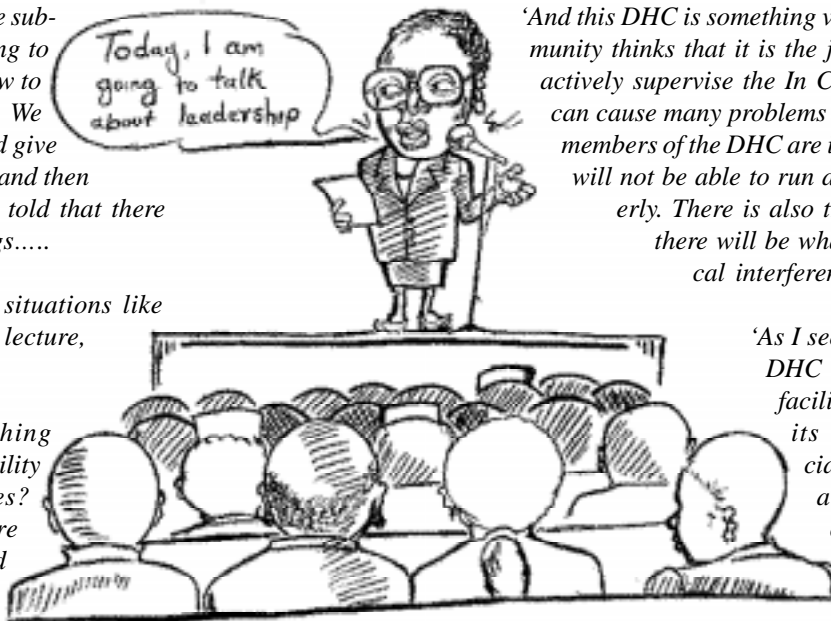
'Our training then was only about service giving and not about administration,' he says. 'Anything to do with managing a facility like this one – I learnt all that 'on the job' and in the different places where I have worked.'

'And this DHC is something very new. The community thinks that it is the job of the DHC to actively supervise the In Charge.... And this can cause many problems in a dispensary. If members of the DHC are illiterate, then they will not be able to run a dispensary properly. There is also the possibility that there will be what we call "political interference".'

'As I see it, the role of the DHC is to maintain the facility and to develop its services – especially improving the awareness of the community about health matters. But they often need the direction of the In Charge, so that they know what to do.'

'But they can also ask good questions of the In Charge – questions like, "Why do we have no drugs in the dispensary?" or "Why is the compound so bushy?" And if the public is complaining about the way in which an In-Charge is doing his job, then they have a right to try to sort out the problem.'

'The only training I have had on such matters as how to relate to the DHC..... the only training has been through the KHSSP project.'



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## Implications

The comments of the two In-Charges, Immaculate and Corridon – one quite young and the other very experienced – are representative of the views of nurses employed in Kenya’s dispensaries and health centres. Two main conclusions can be drawn.

The first conclusion is that, even if administration and management topics are included in the pre-service training programmes for nurses, they are likely to be taught in a transmittal and theoretical rather than a participatory and practical manner. There are many reasons for this, in Kenya and other developing countries:

- Trainers have not been exposed to experiential methods of teaching related to administration and management topics;
- Class sizes are often very large, so action-oriented teaching methods are more difficult to apply;
- There is a lack of training manuals and study materials incorporating experiential methods;

- Examinations test ‘book knowledge’ rather than analytical or practical skills;
- The teaching model used in primary and secondary schooling is usually ‘chalk and talk’ – and this is often carried over into college-based training programmes.

The second conclusion is that the recent emphasis on involving community representatives in the management of health facilities, in Kenya and other developing countries, has generated a whole new set of issues to be explored – in training programmes for nurses as well as for the committee members. As the comments by Corridon Muta indicate, the boundaries of authority for the facility committees are not always clear. Even if they are called ‘management’ committees – just what they are managing can often be disputed. As will be illustrated below, the training programme developed by the Ministry of Health and KHSSP of the Aga Khan Health Service was designed to address the range of new management responsibilities of nurses as well as committee members.

## Dispensary Committees and Decentralisation Policies



The Kwale project has run a series of workshops for DHC members and nursing staff on a range of topics to do with the running of a dispensary or any kind of small clinic. The training programme has covered such topics as:

- Clarifying the roles and responsibilities of the DHC and the professional staff;
- Exploring the relationship between the DHC and the In-Charge;
- Managing the clinics finances;
- Collecting and utilising information on the health status of the community and on the work of the dispensary;
- Maintaining the building and its equipment;
- Setting targets and planning work programmes for the dispensary;

- Implementing health care and health education outreach activities;
- Defining the role of the DHC in relation to quality assurance.

In the handbook that has been developed out of this training programme – a handbook called ‘Managing a Facility’ – this is the example given of the responsibilities of a dispensary committee:

- To oversee the management of the clinic and its community health programme.
- To initiate, implement and monitor community health projects within the catchment area of the clinic.
- To assist in the selection of community health workers (peer educators, traditional birth attendants and people involved in folk media productions) involved in the health education programmes of the clinic.
- To supervise the general (non-clinical) work of the staff employed in the clinic.
- To receive quarterly reports from the clinic nurse about the work of the previous quarter and the action plans for the next one.
- To monitor the clinic’s finances.
- To receive quarterly reports from the hospital on the clinic’s income and expenditure.
- To initiate and implement fund-raising activities.

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- To provide the clinic staff houses, water and other facilities.
- To oversee the maintenance of the clinic compound, buildings and facilities.
- To provide for the security of the compound, clinic and housing.

This set of responsibilities for the DHC is in line with the decentralisation policies of the Kenya Ministry of Health. In order to decentralise the management of health services in the country, the Ministry in the early 1990s established District Health Management Boards (DHMBs); in the mid-1990's it set up Hospital Management Boards. In the late 1990s the Ministry encouraged the creation of Rural Health Facility Management Committees to assist in the management of its health centres and dispensaries – an initiative that was expected to enhance community participation in the planning and development of local health facilities.

The Ministry's stipulation was that the Health Centre or Dispensary Committee members should be elected by the community. The committees would consist of 10 members. They should hold office for three years and would be eligible for re-election. The Officer-in-Charge of the facility should be the Secretary to the Committee.

The Ministry Circular presented the roles and responsibilities of the Committees as follows:

- To oversee the general operations and management of the health facility.
- To advise the community on matters related to the promotion of health services.
- To represent and articulate community interests on matters pertaining to health in local development forums.
- To facilitate a feedback process to the community pertaining to the operations and management of the health facility.
- To implement community decisions pertaining to their health.
- To mobilise community resources towards the development of health services within the area.

- Any other roles and responsibilities as provided in the 'Rural Health Facility Management Committee Manual', and as may be determined by the District Health Management Boards.

This health service decentralisation policy and local management structures are being set up not only in Kenya but also in many other African countries.

## Interpretations

In both the above lists of roles and responsibilities for the facility management committees, the key word is 'oversee'. This can, of course, have 'strong' or 'weak' interpretations. It can imply that the committees have the authority to supervise all who work in the facilities – including the In-Charges. It can also be taken to mean simply 'keeping an eye on things' – in a supportive rather than a supervisory manner.

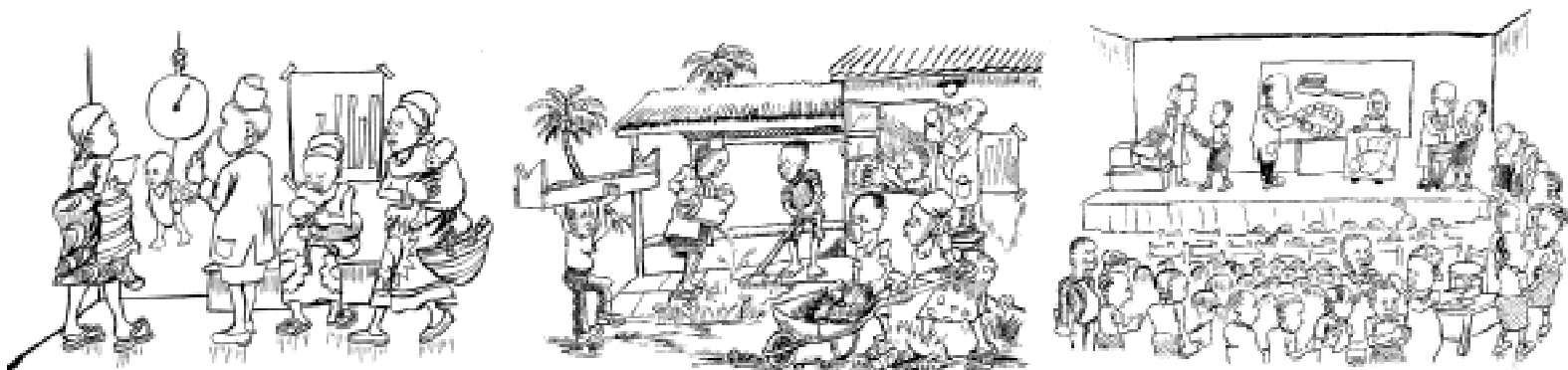
It seems that even those health ministries that have set up such committee structures – from the national, through district, and to facility levels – may not be quite sure about the degree of authority that should be given to these lay committees. Should they have mainly advisory or supportive functions – as Parent-Teacher Associations in schools – or should they have executive and managing functions – as do the lay Governors of schools?

## The KHSSP Training Programme

The Kwale project ran a series of workshops for the members of the DHCs. In the process, the project developed a handbook for the committees and a set of guidelines for those who facilitate the training programme.

The programme begins by focusing on the DHC, and prompts members to reflect on how fully they represent the varied communities that they are serving. It then asks the members to consider the 'powers' they think they should have (in the light of Health Ministry policies and in keeping with the available capacities) – and then to identify the functions that would have to be exercised in

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relation to these powers. It takes the committees through the process of drafting a set of 'by-laws' or a 'constitution' that clarifies roles and responsibilities – and especially the working relationship between the committee members and the In-Charges.

The discussion on the constitution leads to an exploration of the key competencies needed for the DHC (which includes the In-Charge, as the Secretary) to effectively 'over-see' the running of the dispensary:

- Managing people: by exercising leadership, establishing good communication and resolving conflicts;
- Managing money: by understanding budgets and using basic book-keeping skills;
- Managing assets: by understanding basic maintenance issues and supervising the work of subordinate staff;
- Managing health care: by being able to interpret and display key information about the health status of the people in the dispensaries catchment area – and by participating in community-based health education programmes.

One section of the 'Managing a Dispensary' handbook is concerned with the types of issues explored in this project brief – issues that focus on the relationship between the Committee and the In-Charge. The preamble to the section argues that one of the crucial issues that every committee has to face is how to establish a good working partnership with the dispensary nurse – one in which the committee is neither a 'rubber stamp' for the decisions of the professional health staff – whether the nurse or her senior officers – nor a 'take-over' group in the running of the facility.

The handbook presents a number of small case studies that highlight some important aspects of effective leadership and sensitive communication in the management of a small clinic. They are scenarios that can be role-played in a workshop setting.

For the first two of the scenarios the workshop participants are asked to imagine themselves the Dispensary Nurse – on the one hand, dealing with an assistant who is



'going off the rails' by frequently arriving late for work, dressing untidily, and smelling of drink, and, on the other hand, handling a Chairman of the DHC (a retired senior public health officer) who is getting involved in the day-to-day work of the facility.

For the other three scenarios, the participants identify with a DHC Chairman being challenged by three awkward situations: a very untidy clinic, an MP who complains that he has been treated (in a non-clinical sense) badly by the nurse, and a couple whose constant arguing disrupts DHC meetings.



From the responses to these and other case studies in the handbook, it is possible to distinguish between 'directing' and 'facilitating' styles of management – and to discuss which and when either of these two styles is appropriate in the management of a health facility team.

There are five important outcomes from this analysis:

- A clear distinction between clinical matters that are not the business of the DHC – and all other matters to do with the running of the facility (such as communication with the public, management of finances, and maintenance of the building) that are the proper business of the DHC;
- An appreciation of the complementary roles of the committee members and the nurses;
- A recognition that, even if the DHC does not have power – directing, hiring or firing the nurses – it can have a very creative influence on them.
- A realisation, on the part of nurses, that, even though the committee members might not have clinical expertise, they often have other important experience that can be extremely useful in the management of a health facility;
- A conviction that the management of a health facility can be both efficient and satisfying if the lay committee members, the nurses and the subordinate staff, work as a team.

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### TRAINING PROGRAMME: FROM PAGE 7

One of the crucial lessons of KHSSP is that nurses as well as management committee members can gain enormous benefit from a training programme that focuses on the management of facilities, that prompts a reflection on roles and responsibilities, and that provides opportunities for a discussion of main issues and the practice of key skills.

Complementing efforts to enhance clinical expertise, there is a need for training programmes that develop the man-

agement and administrative skills of nurses in charge of health facilities. The manuals and workshops developed in the Kwale project were designed to do that. Another lesson that emerges from the project is that, in such a training programme, nurses and committee members should participate together – so that, jointly and collaboratively, they can clarify their specific management functions and determine the most effective ways of working together in providing the most effective health service possible in their particular circumstances.

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The training package is available in printed form and on a CD. It can be obtained from:

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### Training Programme on Dispensary Management

Much of the material for this policy brief is drawn from the training package, *Managing a Dispensary*, that has been developed from the experiences of KHSSP.

The package is in three parts:

1. A Participatory Model: an introductory pamphlet;
2. A Handbook for Committee Members and Nursing Staff;
3. Guidelines for Facilitators.