



# Managerial Policy Share in the Poor Performance of Municipal Health Facilities in Zio District in Togo from 2012 to 2015

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## Abstract:

Countries develop national health policies, strategies, and plans to overturn the global burden of disease. Managerial policy practice questions the policy share in the poor performance of public health facilities. We designed a descriptive observational study to analyze the root causes of low coverage of health services in municipal health facilities in Zio District. The study, a managerial policy analysis, covered the period of implementation of the 2012-2015 national strategic plan (NSP). Our findings showed that apart from vaccination, in which Tsévié and Agbélouvé performed well, municipal health facilities did not reach the targets of the 2012-2015

NSP. Health information system and health services delivery accounted for 51% of the dysfunctions causing the poor performance. Compliance with standards was the leading root cause (72%) of poor performance of municipal health facilities. More than two-thirds (68%) of the corrective policies were operational. The corrective policies must be enacted in 31% by the central level. The municipal health facilities also share a proportion of 31%. This study showed the important share of managerial policies, especially that of operational policies. The study adds to the previous ones to highlight the quality mindset needed in Togo health system. The next steps before the creation of a training program for quality specialists will have to resolve the questions of their number and assignment positions.

**Keywords:** *managerial policy, district health systems, performance, root cause analysis, policy share.*

## Introduction

Countries develop national health policies, strategies, and plans (WHO, 2010) to overturn the global burden of disease (Murray & Lopez, 1996; Murray & Lopez, 2013). In Togo until

2015, two (02) national health policies backed by three (03) national strategic plans and varied operational plans were implemented (Ministère de la santé, 2011; Ministère de la santé, 2012; Ministère de la santé et de la protection sociale, 2016). However, the performance of the health



systems is low. This managerial policy issue (Hower, 1942; Dunn, 2018) questions the policy share in that poor performance.

## Materials and Methods

We designed a descriptive observational study to analyze the root causes of low coverage of health services in municipal health facilities in Zio District. The study, a managerial policy analysis, covered the period of implementation of the 2012-2015 national strategic plan (NSP) and was carried out from December 2 to 30, 2019. Managerial policies are the thoughts and actions of leaders to resolve issues (Hower, 1942).

Zio health district is one of the seven (07) districts of the maritime health region. It is subdivided into four (04) municipalities and covered an area of 2191.5 sq. km for a population of 335,657 inhabitants in 2015. For a capacity of 216 beds in 2015, it has 36 public health facilities, four (04) of which (Polyclinique de Tsévié, CMS Agbélouvé, CMS Kovié and CMS Gapé-Centre) are in the capitals of municipalities. From now, they are referred to as respectively Tsévié, Agbélouvé, Kovié and Gapé-Centre. Tsévié in Zio 1 municipality, Kovié in Zio 2, Agbélouvé in Zio 3, and Gapé Centre in Zio 4 covered respectively a population of 65,524; 13,596; 18,125; and 9,126 inhabitants in 2015. These four health facilities covered 32% of the district's population in 2015.

Health district is responsible for implementing strategic primary health care policies (Amonoo-Lartson, Ebrahim, Lovel & Ranken, 1984; Goergen & Schmidt-Ehry, 2004).

After the implementation of the 2012-2015 NSP, Zio Health District was poorly performing in the coverage of 4 antenatal consultations (ANC4), coverage of deliveries attended by skilled health workers (DASH), coverage of 3 doses of the pentavalent vaccine (P3), coverage of 3 doses of intermittent preventive treatment of malaria during pregnancy (IPT3), outpatient contacts per capita (OPC), contraceptive coverage (CC) and reduction in malaria cumulative incidence (MCI). These indicators were also used during the study. Operational

plans are implemented routinely and the best way to study them is by monthly assessment.

Performance data were collected from records and activity reports. Policy data were collected from administrative records and activity reports. Data were collected during 48 monthly observation-points and analyzed with Excel. During data collection, we could not find evidence of policies enacted at the level of health facilities. Thereby, the descriptive statistics of policies were based on data available at Zio Health District Management. Because the performance of health facilities is monitored monthly, performance data were analyzed monthly. For administrative data, the results are that compiled for the 48 months.

Root cause analysis of the poor performance based on the 5-whys (Westcott, et al., 2014) was performed using the methodology proposed by Cross, Hardee, and Jewell (2001). Firstly, the analysis was performed with health workers at the facilities level. Then, it was done with the focal points of concerned programs and the members of the management team of Zio Health District to deepen and refine the results of the previous stage. The results were first schematized on a cause & effect diagram based on health systems' six building blocks: health services delivery; health workforce; medical products, vaccines, and technologies; leadership and governance; health information system; health financing (World Health Organization, 2007). Finally, the results were synthesized on a Pareto chart. In the analysis, we used a medical lens to consider underlying problems (Tague, 2005) that cause the low performance as dysfunctions. A dysfunction is any anomaly or disturbance in the operation (Quevauvilliers & Fingerhut, 2001) of a team, unit, facility, or system. As for the issues (Dunn, 2018), each dysfunction was classified according to a hierarchy of types: major, secondary, functional, and minor. For each dysfunction, corrective actions were identified and for each action, the level of decision-making (central, regional, district, facility, maternity ward, and community) and the type of policy (operational and strategic) (Dunn, 2018) was also identified. These data

allowed the estimation of policy share as a proportion.

The study protocol was approved by the Bioethics Committee (Avis No. 02/2020 of

January 29, 2020). The District Public Health Director also authorized the study.

**Table 1. Description of Monthly Performance of Municipal Health Facilities**

	Tsévié	Agbélouvé	Kovié	Gapé-Centre	NSP Target
ANC4: median (IQR)	22.79% (11.65)	27.20% (30.08)	8,00% (0)	15.62% (11.49)	60%
DASH: mean (SD)	31.48% (6.06)	49.59% (19.77) *	29.99% (11.93)	42.08% (13.20)	73%
P3: median (IQR)	102.48% (5.11)	99.19% (42.28)	77.78% (27.09)	87.78% (14.20)**	90%
IPT3: mean (SD)	29.45% (19.33)	24.04% (13.95)	23.55% (16.11)	15.48% (56.25) *	76.2%
CC: median (IQR)	2.83% (4.06)	5.84% (2.43)	2.47% (2.25)	1.47% (2.44)	52%
OPC: median (IQR)	0.2 (0.06)	0.4 (0.13)	0.1 (0.04)	0.3 (0.09)	0.5
MCI: per 1000 (IQR)	45 (26)	188 (92)	65 (79)	155 (51) **	25.3

**Note:** \* Median (IQR) \*\* mean (SD); IQR: interquartile range SD: standard deviation

**Source:** From this study

## Results

### Descriptive Statistics

Municipal health facilities performed poorly during 2012-2015 (Table 1). Apart from vaccination, in which Tsévié and Agbélouvé performed well, municipal health facilities did not reach the targets of the 2012-2015 NSP. During 2012-2015, operational policies represented 82% of policies implemented at municipal health facilities (Table 2). As expected

for public health facilities, all major policies were strategic.

### Root cause analysis

Service delivery followed by leadership and governance had more dysfunctions causing poor performance in outpatient contacts per capita. These two building blocks accounted for 53.33% of dysfunctions resulting in low outpatient contact per capita at the four health facilities.

**Table 2. Classes and Types of Policies Implemented in Municipal Health Facilities**

	Maj	Maj	Sec	Sec	Fun	Fun	Min	Min	T	T
	#	%	#	%	#	%	#	%	#	%
O	0	0	6	29	207	95	21	72	234	82
S	16	100	15	71	12	5	8	28	51	18
T	16	100	21	100	219	100	29	100	285	100

**Note:** O: Operational; S: Strategic; T: Total; Maj: Major; Sec: Secondary; Fun: Functional; Min: Minor

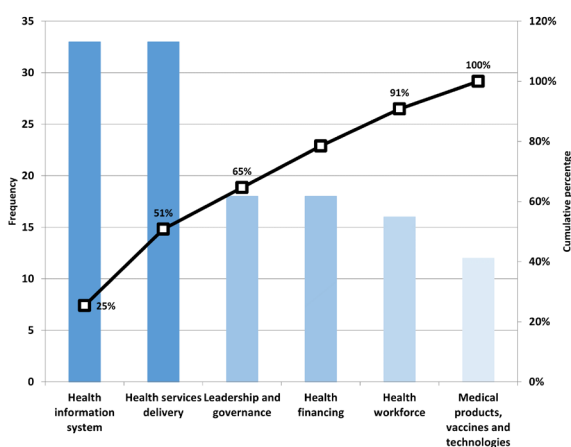
**Source:** From this study.

Regarding the high incidence of malaria, health information system and service delivery had more dysfunctions. They accounted for 46.15% of dysfunctions. Similarly, these two building blocks (health information system and service delivery) accounted for 55.56% of the

dysfunctions causing poor performance in the coverage of 4 antenatal consultations. Low performance in skilled birth attendance was mostly due to dysfunctions in service delivery followed by health information system and leadership and governance. Health information

system and service delivery had more dysfunctions responsible for low performance in contraceptive coverage. These two building blocks were also responsible for the low coverage of 3 doses of the pentavalent vaccine in the two non-performing health facilities.

The synthesis of the root cause analysis is presented by the Pareto chart of Figure 1. Overall, health information system and health services delivery accounted for 51% of the dysfunctions causing the poor performance of municipal health facilities. Compliance with standards was the leading root cause (72%) of poor performance of municipal health facilities.



**Figure 1. Pareto chart synthesizing and prioritizing the results of the root cause analysis. Source: From this study**

## Managerial policy share

More than two-thirds (68%) of the corrective actions of poor performance were operational policies (Table 3). The corrective policies must be enacted by the central level (31%) and the communal health facilities (31%).

Ultimately, we can say that high impact interventions have low coverage in municipal health facilities because in 72% standards are not complied with and in 62% central level and municipal health facilities do not enact any policy to correct them.

## Discussion

Managerial policy practice questions the policy share in the poor performance of public health facilities. Our findings showed that apart from vaccination, in which Tsévié and Agbélouvé performed well, municipal health facilities did not reach the targets of the 2012-2015 NSP. Health information system and health services delivery accounted for 51% of the dysfunctions causing the poor performance. Compliance with standards was the leading root cause (72%) of poor performance of municipal health facilities. More than two-thirds (68%) of the corrective policies were operational. The corrective policies must be enacted in 31% by the central level. The municipal health facilities also share a proportion of 31%.

**Table 3. Summary of Managerial Policy Share in the Poor Performance of Municipal Health Facilities**

	ANC4	ANC4	DASH	DASH	P3	P3	IPT3	IPT3	CC	CC	OPC	OPC	MCI	MCI	All	All
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
LR																
Ce	5	22	6	30	9	32	5	22	6	40	8	57	2	29	41	31
R	1	4	2	10	1	4	1	4	0	0	0	0	0	0	5	4
D	1	4	2	10	2	7	1	4	0	0	0	0	0	0	6	5
F	5	22	4	20	15	54	5	22	4	27	4	29	3	43	40	31
M	7	30	3	15	0	0	7	30	2	13	0	0	0	0	19	14
Co	4	17	3	15	1	4	4	17	3	20	2	14	2	29	19	15
T	23	100	20	100	28	100	23	100	15	100	14	100	7	100	130	100
TP																
O	18	78	14	70	19	68	18	78	9	60	6	43	5	71	89	68
S	5	22	6	30	9	32	5	22	6	40	8	57	2	29	41	32
T	23	100	20	100	28	100	23	100	15	100	14	100	7	100	130	100

**Note:** LR: Level of responsibility; Ce: Central; R: Regional; D: District; F: Health Facility; M: Maternity; Co: Community; TP: Type of policy; O: Operational; S: Strategic; T: Total

**Source:** From this study



Low coverage of high impact interventions is the cause of why people continue to die (Jones, et al., 2003; Darmstadt, et al., 2005; Bryce, et al., 2010; Narayan, Benjamin, Gregg, Norris, & Engelgau, 2004; Alwan, et al., 2010; Bhutta, et al., 2010; Bryce, et al., 2006; Countdown Coverage Writing Group, 2008). Low coverage exhibits important characteristics of policy problems like interdependency, subjectivity, artificiality, instability (Dunn, 2018). In fact, low coverage is what Dunn (2018) called systems of problems or messes because it is part of whole systems of problems. Low coverage of high impact interventions is a policy problem.

Policy problems are unrealized needs, values, or opportunities for improvement (Dunn, 2018). Information about the nature, scope, and severity of a problem is produced by applying the policy-analytic procedure of problem structuring, as in this study. If problem structuring is not done, the wrong problem will be solved. Policy analysis is a dynamic, multilevel process in which methods of problem structuring are essential to the success of methods of problem solving (Dunn, 2018).

According to the issues, policies are strategic and operational. A strategic policy involves actions that cannot be reversed for many years and their consequences are relatively irreversible. An operational policy does not involve the risks and uncertainty present at higher levels and the consequences of decisions are relatively reversible (Dunn, 2018). Strategic policy is a written statement of an organization's strategic direction (what it aims to achieve and how it will achieve it) in its operating environment (Bianca, 2022; Programme, Financial and Administrative Committee, 2009).

In this work, we noticed at all levels that the operational policies were the most questionable.

National strategic policies provide the overall vision and framework for government action. To be successful, national policies must be translated into programs that will achieve the goals set at the national level. Moving from national policies to local programs requires the

design and implementation of operational policies which, in turn, have a decisive influence on health management and services (Cross, Hardee, & Jewell, 2001). Operational policies govern the “operating system” of public sector programs and are akin to every clinic, health post, and hospital (Cross, Hardee, & Jewell, 2001). Using a computer analogy, one could say that operational policies are the “language” that directs the relationships between inputs (resources) and outputs (outcomes) of the health system. If the language does not lead effectively, the operating system is bound to fail. Symptoms of failure are like a computer crash when the machine simply stops working as expected (Cross, Hardee, & Jewell, 2001). Operational policies also include a critical economic aspect. They are the determinants of how health care system inputs (resources such as personnel, equipment, and transportation) are distributed and deployed once health care priorities are determined. In many cases, programmatic shortcomings are due to inadequate, inappropriate, or outdated operational policies (Cross, Hardee, & Jewell, 2001). Inadequate or poor operational policies can limit the production of quality health care outcomes and lead to inefficiency and waste in health care programs, clinics, health posts, and hospitals (Cross, Hardee, & Jewell, 2001). In addition, operational policies negatively affect healthcare personnel and individual clients (Cross, Hardee, & Jewell, 2001).

In this work, we used the technocratic guidance and counsel postures of an analyst.

Under the technocratic guidance posture, the corresponding author, a public health director, is used as instruments of everyday politics. The findings of this policy analysis will be used for political purposes. The use of specialized policy analyst's knowledge to make policy choices adds a measure of credibility to the technocratic counsel perspective (Dunn, 2018).

This work highlighted a real public health inquiry, i.e. the implementation of operational policies. It used the rigorous and powerful analytical tools of statistical process control

(SPC). Studies have shown that the performance indicators of health facilities can be improved by applying SPC tools (Thor, et al., 2007). In Togo, the first uses of SPC tools in the health system date back to 2015 (Afanvi, 2015; Afanvi K, Kassankogno Y, Ekouevi K., 2015). These studies add to another one published in this journal (Afanvi, Dogo, Aziagbé, Adjoh, & Ekouévi, 2023) to highlight the quality mindset.

## Conclusion

The policy share in the poor performance of health facilities questioned was studied through a managerial policy analysis. Findings showed their important share, especially that of operational policies. The study adds to the previous ones to highlight the quality mindset needed in Togo health system.

The next steps before the creation of a training program for quality specialists will have to resolve the questions of their number and assignment positions.

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## Conflict of Interests

No conflict of interest.

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